



# 2013

*Every Woman,  
Every Child:*  
Strengthening  
Equity and Dignity  
through Health

The Second Report of  
the independent Expert  
Review Group (iERG)  
on Information and  
Accountability for Women's  
and Children's Health

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## PREFACE

Welcome to the second report of the independent Expert Review Group on Information and Accountability for Women's and Children's Health. We have now reached the half-way point in our work for the UN Secretary-General, Ban Ki-moon. Our objective is to make accountability a central element of his ambitious *Every Woman, Every Child* initiative. The pace of change for women's and children's health is rapid and sometimes hard to keep up with. Countries are moving quickly to do all they can to meet their Millennium Development Goal (MDG) targets. The global community is continuously devising visionary initiatives to catalyse progress internationally, regionally, and in countries. And a constant stream of new evidence is being generated to help policymakers make more reliable and informed decisions.

Amid this welcome activity is the need for someone to step back and ask: what is actually being achieved for women and children? Are the promises made at international conferences being delivered? What tangible and material benefits are women and children seeing from these commitments? What barriers exist to prevent political momentum from being converted into better results? In this year's report, we look at global progress towards the aims of *Every Woman, Every Child*. We survey advances made on the recommendations of the Commission on Information and Accountability. And we take two new subjects—country accountability and adolescents—and review progress in both areas. We also make six new recommendations, in addition to those we made last year, and we review how the proposals we made in 2012 have been received and responded to by partners.

Although we are "independent", the iERG is a strong supporter of *Every Woman, Every Child*, and we see our role as advocates for, and contributors to, women's and children's health worldwide. Like many others, we are anxious that the gains made during the past decade are not lost as we move from the era of the MDGs to the epoch of the SDGs, or Sustainable Development Goals. In this report, we therefore pay special attention to the post-2015 development process and the need to put women and children (and adolescents) at the centre of development (and health) for the next decade. We very much look forward to your feedback on our work, as always. Please contact us directly at [ierg\\_secretariat@who.int](mailto:iERG_secretariat@who.int). Thank you.

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# ABBREVIATIONS

CARMMA	Campaign on Accelerated Reduction in Maternal Mortality in Africa
CIES	Centre for Investigation, Education, and Services
CoIA	Commission on Information and Accountability for Women's and Children's Health
CRVS	Civil registration and vital statistics
EmOC	Emergency Obstetric Care
EWEC	<i>Every Woman, Every Child</i>
FCI	Family Care International
FGM	Female genital mutilation / cutting
FP2020	Family Planning 2020
GAVI	The Global Alliance for Vaccines and Immunisation
GBD	Global burden of disease
G8	The Group of Eight
H4+	WHO, UNFPA, UNICEF, UNAIDS, UN Women, and the World Bank
HIV	Human immunodeficiency virus
HIB	Haemophilus influenzae type B vaccine
HMN	Health Metrics Network
HPV	Human papillomavirus
HRH	Human resources for health
IDA	International Development Association
ICT	Information and communication technologies
iERG	independent Expert Review Group
IHME	Institute for Health Metrics and Evaluation
IHP+	International Health Partnership
IPU	Inter-Parliamentary Union
IPPF	International Planned Parenthood Federation
IT	Information technologies
ITU	International Telecommunications Union
MDG	Millennium Development Goals
MDSR	Maternal death surveillance and response
MMR	Maternal mortality ratio
NGO	Non-governmental organization
NCDs	Non-communicable diseases
ODA	Official development assistance
OECD-DAC	Organisation for Economic Co-operation and Development – Development Assistance Committee
ORS	Oral rehydration salts
PMNCH	Partnership for Maternal, Newborn, and Child Health
PSC	Programme support cost
RMNCH	Reproductive, maternal, newborn, and child health
SRH	Sexual and reproductive health
TB	Tuberculosis
U5MR	Under-five mortality ratio
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNECA	UN Economic Commission for Africa
UNESCAP	UN Economic and Social Commission for Asia and the Pacific
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WHO DG	World Health Organization's Director-General

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## EXECUTIVE SUMMARY

### The iERG's 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 towards delivering 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

## EVERY WOMAN, EVERY CHILD: A MID-TERM PROGRESS REPORT

Political momentum for women's and children's health has continued to grow at an extraordinary pace during 2012 and 2013. The crystallisation of work around Family Planning 2020, A Promise Renewed, and the Commission on Life-Saving Commodities has added valuable new energy to the UN Secretary-General's *Every Woman, Every Child* initiative. The World Bank has become a vocal new supporter for women and children, and the debate on the post-2015 development agenda has provided a further opportunity to accelerate progress on MDGs 4, 5, and 1c. That said, the proximity of 2015 is a critical transition moment. It is vital that the gains of the past decade are protected and augmented beyond 2015. To help deliver continuity over the coming years, we believe it is essential to have a clear ethical framework to guide strategic thinking during this fluid period. The principles guiding the iERG's work are: strengthening equity and dignity for women and children; establishing

person-centred, not intervention-centred, care; adopting a life-course approach; working for equitable and sustainable development; and insisting on independent accountability in countries and globally.

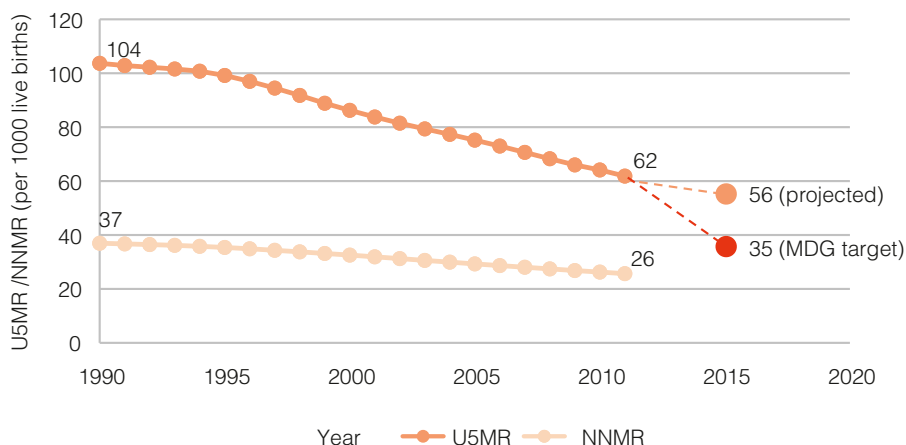
Although *Every Woman, Every Child* has increased global advocacy for women's and children's health, only 17 of 75 iERG countries are projected to achieve MDG-4 by 2015 (see figure), and only 9 of 75 countries are expected to achieve MDG-5 (see figure). Commitments to *Every Woman, Every Child* have been rising, but the number being added has diminished over time. There is a severe funding shortfall too, raising concerns that the UN Secretary-General's ambitions may not be fully realised. There are also substantial variations and disparities in commitments to countries triggered by *Every Woman, Every Child*. Still, the generation of new evidence about the importance of undernutrition, together with better clarity

about interventions that could eliminate preventable childhood deaths from pneumonia and diarrhoea, offer powerful new intervention opportunities for partners to support.

However, the iERG is concerned that the administrative bureaucracies developing around

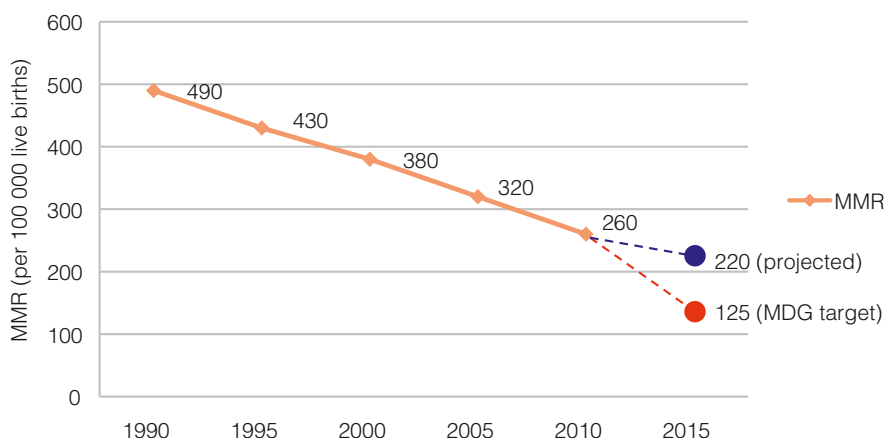
new global initiatives, such as Family Planning 2020, the Commodities Commission, and A Promise Renewed, are harming coordination in countries, causing duplication of processes, and exacerbating inefficiencies. In sum, we see a troubling gap between the goals of *Every Woman, Every Child* and the evidence of progress provided to us.

### Under-5 mortality and neonatal mortality in 75 iERG countries, 1990-2011



Source: UN-IGME, 2012

### Maternal mortality ratio in 75 iERG countries, 1990-2010



Source: WHO/UNICEF/UNFPA/World Bank. Trends in maternal mortality: 1990 to 2010. WHO, UNICEF, UNFPA, and The World Bank estimates. Geneva, World Health Organization, 2012.

## THE CoIA: DELIVERING ACCOUNTABILITY

The iERG’s assessment of progress on the recommendations of the Commission on Information and Accountability is shown in the panel. We judge that half of the recommendations are currently off track, meaning that they will be difficult or impossible to achieve by 2015.

2013 was the target date for one Commission goal—transparency (“By 2013, all stakeholders are publicly sharing information on commitments, resources provided, and results achieved annually, at both national and international levels”). In WHO’s report to the iERG, progress on transparency is

labelled red, and we agree: this goal will be difficult or impossible to achieve at current rates of progress. Transparency is also much more than providing access to data. Transparency means being able to understand and act on those data. For the iERG, this means linking transparency to the process of accountability—the use of information in an open, inclusive, and participatory mechanism that enables the free exchange of evidence to improve the health of women and children. A commitment to transparency therefore means a commitment to building capacity to understand and use information. We see little evidence that partners are addressing this issue. WHO identifies two further areas of weakness in efforts to achieve transparency. First, the lack of engagement of media to amplify messages about women’s and children’s health. And second, the absence of civil society from country accountability mechanisms. Both of these weaknesses are being addressed by, among others, PMNCH.

We draw several lessons from this review of progress on the Commission’s recommendations. First, there is tangible progress in the Commission’s work. But, as we concluded last year, WHO and its partners need to adopt a more critical and evaluative perspective when working together to monitor progress towards the Commission’s recommendations. There is a tendency to interpret activity as progress, to emphasise the positive without fully taking account of the threats and risks to sustaining what progress has been made. There is also a reticence about being a stronger advocate for areas where there is a clear country and global need, such as strengthening CRVS systems. Second, we need much more country-level detail about how the Commission’s recommendations are leading to change and action. What changes are being made? How are these changes being implemented? And by whom? This descriptive detail is important. Without it, we cannot properly assess the work of partners in countries. The iERG also realises that we will need to engage more deeply with countries ourselves if we are to answer these questions fully.

### Summary of global progress on implementation of the recommendations from the Commission on Information and Accountability

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

- 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

## ACCOUNTABILITY IN COUNTRIES: ENHANCING NATIONAL OVERSIGHT

In our 2012 report, we focused on global accountability. This year we turn our attention to countries. The Commission made a specific recommendation about national oversight of women’s and children’s health—“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.” 17 iERG countries will not have held a health-sector review in 2013, according to WHO. Those that do have adopted diverse models.

There is no fixed way to complete a review of services for women and children. It is likely that a mix of data gathering, field visits, and inclusion of government departments, development partners, civil society and professional bodies, and service providers will be necessary. The evidence we have received lays particular emphasis on the role of civil society. And here we flag a concern. In devising country accountability frameworks, civil society has been, in some cases, significantly under-represented. The concern raised with us is that governments and WHO may be limiting opportunities for civil society participation.

We see special opportunities to strengthen country accountability through greater engagement by national parliaments and “Country Countdown” meetings. The Inter-Parliamentary Union has worked hard to promote women’s and children’s health among its members, passing a resolution in 2012 to hold parliaments accountable for addressing key challenges affecting women and children. The Countdown to 2015 group, a global network of scientists, health workers, and policymakers, has a strong commitment to conduct Country Countdowns, where evidence is promoted as a tool to improve decision making. Both mechanisms can make use of a range of human rights tools, such as

a General Comment on the meaning of a child’s right to health, passed by the UN Committee on the Rights of the Child in February, 2013.

Although work is progressing on strengthening national oversight and accountability mechanisms, that work needs to be accelerated, not only for the purpose of moving faster towards MDG goals and targets, but also for preparing countries and partners for what follows the MDGs, which will almost certainly continue to include ambitious commitments for women and children. Our assessment is that national oversight has been insufficiently prioritised by countries and partners. We believe we need further analyses to understand better how oversight mechanisms lead to change and action in countries. Currently, this evidence is largely lacking. The Countdown country case studies provide potentially the most powerful means to examine the links between accountability and outcomes. We also want to see ways in which country oversight processes can be better connected to global tracking of results and resources. Currently, there is often a disconnect between global impressions about progress on accountability and the reality in countries. This zone between the technical and the political is always fraught with difficulty.

## ADOLESCENTS: A GAP IN GLOBAL AND NATIONAL ACCOUNTABILITY

Adolescence extends from 10 to 19 years of age, overlapping with a period designated “youth” (15-24 years of age). There are 1.2 billion adolescents in the world, more than double the number in 1950, and the largest number the world has ever known. Almost 90% of adolescents live in low- and middle-income countries. Adolescents possess many distinctive features and they endure unique risks. 16 million girls aged 15-19 years become pregnant every year. Unsafe abortion poses high risks for adolescent girls. Children born to adolescent girls have a greater risk of morbidity and mortality than children born to older parents. And worldwide, up to 50% of sexual assaults are committed against girls under 16 years. Although the Global Strategy has led to strong commitments from countries and NGOs, commitments from multilateral institutions, foundations, and the private sector have been disappointing. Adolescents are simply not on the political radar of many donors. We see adolescents as a group where the intersection of human rights with health could have special value—eg, preventing early and forced marriage, addressing violence against young women, and removing barriers to access contraception.

Historically UNFPA and UNICEF have done more than most other agencies to put adolescents higher on the political agenda. UNICEF has described adolescence as an “age of opportunity.” But why have adolescents been so pervasively neglected? The reason is partly because there has been no consensus about how to monitor adolescent health. But there is also a complex political and social context that makes adolescent health a very difficult challenge—lack of protective legal frameworks, cultural “conservatism”, forced child marriage, substance use, violence (often sexual) against women, gender inequity, patriarchy, and displacement during times of war and conflict, to name only a few.

A further challenge is that there is no single agency or institution with a mandate focused primarily on young people or adolescents. However, there are powerful advocacy movements on behalf of adolescents. These civil society actors at the national level are taking action and seeing results. But, despite isolated pockets of advocacy, there are no adolescent-specific outcomes in *Every Woman, Every Child* and there has been little focus on adolescent health in discussions about accountability, either globally or in countries.

## CONCLUSIONS

Global health is entering a critical transition—from a stable era based around a poverty-focused agenda (the MDGs), to one that will embrace considerably more uncertainty (environmental damage, climate change) and so will require a broader and more adaptable framework that can accommodate “unknown unknowns.” There are, however, some certainties—notably, demographic and environmental change. The share and number of children living in the world’s most resource-poor regions will grow rapidly. By 2050, 1 in every 3 births will be African. Under-5 deaths will continue to concentrate in Africa. Within countries, those deaths are likely to be concentrated still further among the poorest populations. When one examines evidence concerning the intersection of population, human consumption, and the environment, one quickly sees that the way we live now is unsustainable. All societies have to break the cycle of unsustainable consumption and one of the most powerful groups to do so is women. It is often women who can make the first move to a different societal or development trajectory—by resetting the norms (eg, around fertility rate or consumption patterns).

We provide a brief update on progress regarding our 6 recommendations from 2012.

*Devise a global investment framework for women’s and children’s health.* An investment framework will be published in 2013. In collaboration with the University of Washington and PMNCH, WHO is currently overseeing the development of an investment framework as part of a larger project on investing in health, also to be published in 2013, in the twentieth anniversary year of the 1993 World Development Report on Investing in Health. This investment framework will be a critical document for mobilising future action and commitment globally and in countries, especially given recent slowdowns in donor aid for maternal, newborn, and child health.

*Strengthen the global governance framework for women’s and children’s health.* Here progress has been less positive than we would have hoped for, despite general agreement that “unregulated energy can lead to chaos.” On accountability, the hope was that important parallel initiatives in women’s and children’s health could have used the iERG as a mechanism to identify a single global locus of independent accountability. Although there were expressions of strong interest from some partners—eg, A Promise Renewed, Family Planning 2020, the Commission on Life-Saving Commodities—the tangible contributions from these initiatives to the

iERG have so far been small. More hopefully, a step towards enhanced global governance has been taken with the creation of an RMNCH Steering Committee to more closely harmonise and coordinate activities and funding. The Steering Committee noted that countries still suffer “unnecessary distraction, inefficiencies, and high transaction costs” because of the multiple global initiatives they must absorb. Often lip-service is paid to the umbrella of *Every Woman, Every Child* under which multiple initiatives are supposed to sit. But, as we have described, frequently these initiatives are flagship projects for donors, with burgeoning governing bodies, secretariats, and working groups underpinning their work. We question the value of these parallel bureaucracies. The work of the Steering Committee is therefore of the utmost importance and we commend partners for taking this important step towards alignment and harmonisation.

*Strengthen human rights tools and frameworks to achieve better health and accountability for women and children.* WHO, PMNCH, and the Office of the UN High Commissioner for Human Rights have come together to incorporate human rights more fully into accountability mechanisms for women’s and children’s health. The 2013 accountability workplan now includes a human rights component where partners will support a series of rights-based reviews in Malawi, Tanzania, Uganda, and Nepal to analyse laws and policies bearing on maternal and child health. The case studies and recommendations that result from these reviews will be shared in late 2013. Two important advances in the field of human rights and women’s and children’s health took place this year. First, the adoption by the Human Rights Council of a resolution on the child’s right to health. This resolution asks for a study of child mortality as a human rights concern to be completed. The results of this study will be presented to the Human Rights Council in September, 2013. Second, a two-year process concluded in 2013 with the adoption of General Comment 15 on the Child’s Right to Health.

*Set clearer country-specific strategic priorities for implementing the Global Strategy and test innovative mechanisms for delivering those priorities.* WHO judges that country-specific strategic priorities are being set through Country Accountability Frameworks. But, as we have noted elsewhere, national oversight mechanisms in countries are weak, poorly understood, and in some cases entirely missing. It is true that 54 countries have accelerated their progress towards MDG-4 from 2000-10 compared with 1990-2000; and 53 countries have done the same for MDG-5. But we cannot be sure that an inclusive,

transparent, and participatory process is in place in countries to ensure further progress towards the MDGs.

*Accelerate the uptake and evaluation of eHealth and mHealth technologies.* WHO argues that eHealth is addressed in Commission Recommendation 3. While this is true, our intent was to see evidence of acceleration of action rather than merely adhering to a goal that we had previously indicated seemed some way off. We have not seen that accelerated action over the past year. We believe that the survey to be completed this year by ITU will help to set priorities for developing and strengthening national eHealth plans.

*Expand the commitment and capacity to evaluate initiatives for women's and children's health.* The scientific community has continued to generate large amounts of high-quality original and synthesised knowledge that should have a profound effect on policymaking. In PMNCH's assessment of commitments made to evaluation, most were dedicated to operational research, policy research, biomedical science, and intervention impact studies. There were worrying gaps in this support—capacity building and financing for research received much less attention, a trend that PMNCH suggests might adversely affect the quality and quantity of research in the long term. We again stress the importance of research as an accountability tool in its own right.

## THE IERG'S 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**

The most consistent message the iERG received from submitted and commissioned evidence was the importance of strengthening accountability mechanisms for women's and children's health within countries, and ensuring meaningful civil society participation in those mechanisms. Ministers of Health often have overall responsibility for leading accountability efforts in health, but implementation of these efforts requires the input and participation of other government ministries, development partners, and civil society. Parliaments or parliamentary bodies have a potentially crucial part to play here too. Parliaments are a core part of national accountability structures, and they also raise public awareness. Human rights principles of participation, equality, and non-discrimination are important. Accountability also means building local capacity to understand and use the available data. Civil society must be actively supported in its work of independent scrutiny. We cannot stress the role of civil society too highly. The evidence is clear: activists have a crucial role in holding governments,

policymakers, and those responsible for health services accountable for the quality of care provided to women and children. Often the debate over accountability rightly focuses on monitoring, data, and information. But there has been a relative neglect of the "review" aspect of our accountability model. We call for a revolution in accountability, putting participatory, democratic review on an equal basis with monitoring in national accountability processes. This refocusing of accountability must be evaluated to ensure that whatever community based accountability systems are implemented actually deliver benefits for women and children. We propose that the newly established RMNCH Steering Committee, together with the H4+, other development partners, and global health initiatives, take explicit steps to make national accountability a priority between now and 2015, reporting back on progress in countries to the iERG in 2014. One way to do so would be for PMNCH to convene a Partners' Forum in 2014 focused on accountability.

### **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**

Although the Commission on Information and Accountability for Women's and Children's Health emphasised the importance of independent accountability, there is only lukewarm interest in independent accountability for the post-2015 development era. The iERG provides one model for the future of independent accountability. It is likely not

the only model available. We call on our partners in the *Every Woman, Every Child* movement—countries, UN agencies, development partners, academia, civil society, foundations, and the private sector—to advocate for independent accountability post-2015. We have specific proposals to make to ensure that these lessons are translated into action. First, we request

a technical consultation on post-2015 accountability mechanisms to take place between the launch of our report in September, 2013, and the end of the year. That technical consultation should not only aim to devise a framework for independent accountability for women's and children's health, but also seek ways to incorporate other dimensions of global health within that accountability framework (such as AIDS, tuberculosis, and malaria; non-communicable diseases, including mental health; and neglected tropical diseases).

A final framework should be completed by the end of 2013, to be presented first to the Executive Board of WHO in January, 2014, and subsequently to the World Health Assembly in May, 2014. During this consultation process and presentations to WHO's governing bodies, WHO should also reach out to those responsible for devising the post-2015 development agenda to ensure that this proposal on accountability receives full and proper consideration.

### **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**

We have reviewed powerful evidence showing that adolescents are not only a neglected dimension of *Every Woman, Every Child*, but also that adolescents and young people have a key part to play in accountability—nationally, regionally, and globally. Inclusion of youth organisations and representatives should be an explicit component of efforts to embrace civil society organisations in consultations at all levels. On the iERG, we can and should do better to include younger voices in our evidence gathering and deliberations. We recommend that a young (under-25) person with proven interest and experience in women's, adolescents', or children's health be recruited, during an international selection process, to join the iERG as soon as possible. But we want to go further than simply recommending that adolescent voices be a routine part of policymaking. We want to introduce adolescent

health as an explicit part of monitoring progress towards the goals of *Every Woman, Every Child*. To embed adolescent health in routine monitoring means we need to identify an appropriate indicator. We have consulted colleagues in WHO and elsewhere, and two stand out: HIV prevalence and adolescent pregnancy. After considerable deliberation, we recommend that adolescent pregnancy (the proportion of women aged 20-24 years who report having had a baby by the age of 18 years) be included in the Commission's indicator framework, and we invite Countdown to include this indicator in their annual accountability report. We believe the inclusion of this indicator will help strengthen the commitment of donors and multilaterals to adolescent health.

### **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**

Human rights and women's and children's health have much to contribute to one another. Where might the bridge between the two lie? There are many points of connection—on participation, equality, and non-discrimination in accountability review procedures, and in the availability and accessibility of services. But quality—defined as the effectiveness, safety, and experience of care—might be the most fruitful point of contact. Every visitor to facilities for women's and children's health in countries will have experienced a range of scenarios that testify to an unacceptable variability in the quality of services. Too often women and children receive care that violates principles of dignity and equity. So far, the global community has paid too little attention to these issues. It is time to change that situation of neglect. Although an important movement around patient safety has been established, attention to quality in women's and children's health has stalled. We wanted to propose an indicator for quality

to be added to the 11—now 12, with the inclusion of an adolescent indicator—we are currently using to monitor progress of *Every Woman, Every Child*. But we were surprised to discover that there is no reliable evidence base from which to select a reliable and easily measurable indicator for quality of care. We therefore invite WHO, UNICEF, and UNFPA to establish a Task Force on Quality of Care for Women's and Children's Health, under the auspices of PMNCH, as part of the follow up to the Commission on Information and Accountability. We would hope that a new Task Force on Quality of Care would not only put quality at the centre of women's and children's health, but also help the iERG in defining the best measures of quality to ensure proper accountability in countries and globally. We hope the Task Force can work to a rapid timeline, as did the original Commission on Information and Accountability, delivering a first report, with recommendations, to the iERG by the end of May, 2014.

## **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**

One essential element of a quality revolution is the availability of educated health professionals to deliver high-quality care. In the evidence submitted to the iERG, a repeated theme has been the importance of human resources for health. According to the 2013 PMNCH report, Global Strategy commitments have resulted in approximately 870 000 additional health workers being trained—doctors, midwives, nurses, skilled birth attendants, and community health workers. PMNCH concludes that this increase is “an important step in closing the estimated global health worker gap of 2.5-3.5 million. This achievement is accompanied by supporting efforts to improve the quality of the existing health workforce and establishing or improving training facilities.” Although we commend the commitment of partners for their investments so far, we underline the fact that the Global Strategy estimated that up to 3.5 million additional health workers would need to be trained and deployed in 49 countries by 2015. (The iERG’s remit is wider—75 countries.) Clearly, the human resource requirements will be considerably greater when one adds in these additional 26 countries.

Moreover, for the 210 000 new health workers that PMNCH can locate geographically, only 18 000 are in sub-Saharan Africa, where the biggest workforce gap exists. The fact is that there is a growing inequity in distribution of health professionals dedicated to women’s and children’s health. While many parts of the world are seeing rapid expansions in health worker numbers, sub-Saharan Africa is being left behind. In November, 2013, the Third Global Forum on Human Resources for Health takes place in Recife, Brazil. The objective of the meeting is to focus on the health workforce dimensions of universal health coverage, including “greater accountability to track, monitor, and report on commitments.” We call on the organisers of the Global Forum in 2013 to give separate and specific attention to human resources for women’s and children’s health. The goal we would hope for is to identify new strategies in countries for the education of health professionals to meet the health needs of women and children. The meeting in Brazil must kick start a decade of action for human resources for health.

## **6. Launch a new movement for better data: Make universal and effective Civil Registration and Vital Statistics systems a post-2015 development target**

The time is right for the international community to seize the current momentum generated by country and regional action in order to achieve universal and effective CRVS systems in countries. CRVS systems matter to individuals, communities, countries, and globally. The official registration of important life events, including births, deaths, and causes of death, is crucial for individuals to establish legal identity, family relationships, and civil rights. Vital statistics generated through civil registration provide indispensable information about the demographics and health of the population, making policies more effective and responsive to the needs of women and children. CRVS is a broad development agenda and needs to be strongly prioritised in the post-2015 era. CRVS systems are essential to governance because they express the relationship between an individual and the state, thereby promoting democratic participation in debates about access to health services. For partners and donors, CRVS systems provide critical information for development, identifying individuals and populations at risk, as well as actions that must be taken. CRVS systems are

absolutely necessary for reliable monitoring as part of a comprehensive system of accountability for women’s and children’s health. International institutions have still not made adequate information about births, deaths, and causes of death the priority it should be. The iERG calls for increased advocacy and investment in CRVS systems, aligning partner actions with country and regional leadership, placing CRVS improvements at the forefront of partner activities, and including CRVS as an explicit goal in the post-2015 development framework. We support efforts to create a new global alliance to strengthen CRVS systems in countries. That global alliance needs to be in place by the end of 2013, with a global target on CRVS systems identified and agreed in 2014. We propose that the UN Secretary-General and President of the World Bank jointly convene a High-Level Working Group to establish the mandate and terms of reference of a new global alliance for better information—an entity with specific leadership, advocacy, norm-setting, and technical assistance roles to make stronger and more reliable country information systems (for health and other sectors) a reality.





# INTRODUCTION

**1.** Writing at the beginning of a new year, and having looked back on a successful 2012 for women's and children's health, one global health leader asked with some concern: "will this momentum carry into 2013?" (1). The answer to that question is an unequivocal "yes." In this second report of the independent Expert Review Group on Information and Accountability for Women's and Children's Health (iERG), we review progress towards the health-related Millennium Development Goals (MDGs) as they apply to adolescents, women, and children (encompassed under the umbrella of the UN Secretary-General's *Every Woman, Every Child* initiative [2]). We also review progress made on delivering the 10 recommendations of the Commission on Information and Accountability. In 2013, one specific recommendation of that Commission was expected to be fulfilled—Recommendation 8 on transparency ("By 2013, all stakeholders are publicly sharing information on commitments, resources provided, and results achieved annually, at both national and international levels"). We highlight two additional aspects of women's and children's health in this report, which we believe deserve special attention—namely, accountability in countries and adolescent health, which is emerging as a major yet hitherto neglected area in the continuum of care. We will make further recommendations, in addition to those we made in 2012, to help identify opportunities to strengthen prospects for women's and children's health in general, and to accountability mechanisms in particular. Throughout our second report, we will use country case studies to draw attention to themes we conclude deserve deeper consideration during these final two years of accelerated efforts to reach the Millennium Development Goals.

**2.** Ban Ki-moon set out the challenge facing the future for women's and children's health in early 2013 (3):

*"We have made much progress. But time is passing and we must urgently accelerate our work...much more remains to be done. Every two minutes a woman dies in pregnancy or childbirth and 200 million women and girls do not have access to the family planning services they need; 19 000 children under 5 still die every day from largely preventable causes; malnutrition is the underlying cause of 3 million child deaths. Around the world, millions of people are dying as a result of infectious diseases. If we want to see women and children survive and thrive, we must address inequalities and reach the most vulnerable in poor and underserved areas. We have the technology and know-how to save and improve women's and children's lives—and we need to join our good ideas and efforts [to do so]."*

**3.** The Commission on Information and Accountability for Women's and Children's Health published its final report in 2011 (4), the year after the launch of *Every*

*Woman, Every Child*. The Commission's purpose was to "determine the most effective international institutional arrangements for global reporting, oversight, and accountability on women's and children's health." Why was a Commission needed? Because, as the UN Secretary-General implied in his speech earlier this year, there was a sense that more could be done to deliver on the promises and commitments global and country actors were making to adolescents, women, and children. At a time of financial austerity, it was vital that every sum of money or in-kind commitment was used in the most effective and efficient way to deliver results. And, among the Commission's ten recommendations (Appendix 1), a gap was identified. There was no independent mechanism to monitor, review, and propose appropriate actions to advance progress towards internationally agreed goals and targets for adolescents', women's, and children's health. The iERG was created as a time-bound mechanism to fill that gap (see Appendix 2 for the iERG's terms of reference and the 75 countries within our sphere of concern). In our first report, we reviewed progress on *Every Woman, Every Child*, the Commission's recommendations, the successes and obstacles facing *Every Woman, Every Child* and the Commission, and we made recommendations for strengthening accountability (5). Our six recommendations are shown in Table 1.

**4.** We made a further 25 proposals or "imperatives" in our report. These imperatives are summarised in our final chapter, where we will review their progress in more detail.

**5.** The most important change the iERG has accommodated in 2013 is the addition of the Commission on Life-Saving Commodities for Women and Children into our portfolio (6). This responsibility was agreed by WHO's Executive Board in January, 2013:

*"The Executive Board...requests the Director-General: to provide support to the independent Expert Review Group in its work of assessing progress in the United Nations Secretary-General's Global Strategy for Women's and Children's Health and implementation of the recommendations of the United Nations Commission on Life-Saving Commodities for Women and Children."*

**6.** What is the Commission on Life-Saving Commodities? In the words of Goodluck Jonathan (President of the Federal Republic of Nigeria) and Jens Stoltenberg (Prime Minister of Norway),

*"...the Commission was convened in response to the current unacceptable situation where millions of women and children die from medical conditions that could have been cheaply and easily prevented and*

*treated through access to existing medicines and other health commodities. The Commission set out to define a priority list of 13 overlooked life-saving commodities for women and children and, through identifying key barriers preventing access to and use of these commodities, recommend innovative actions to rapidly increase both access and use. Scaling up usage of these 13 commodities alone will save more than 6 million lives by 2015."*

The 13 commodities are shown in Table 2. The specific recommendations of the Commission are set out in Appendix 3. As with the Commission on Information on Accountability, there are 10 recommendations, with specified years by which those recommendations are to be achieved. For this year's iERG report, we are expected to judge progress on 3 of those 10 recommendations, which are to be delivered this year:

*Recommendation 1: Shaping global markets. By 2013, effective global mechanisms such as pooled procurement and aggregated demand are in place to increase the availability of quality, life-saving commodities at an optimal price and volume.*

*Recommendation 3: Innovative financing. By the end of 2013, innovative, results-based financing is in place to rapidly increase access to the 13 commodities by those most in need and foster innovations.*

*Recommendation 9: Performance and accountability. By end 2013, all EWEC countries have proven mechanisms such as checklists in place to ensure that health-care providers are knowledgeable about the latest national guidelines.*

**7.** On this background of enhanced commitment towards achieving the MDGs by 2015, intensive work continues to define the shape of the post-2015 development agenda. The precise details of what will succeed the MDGs remain unclear, although various parallel processes are now beginning to converge and give clues to the future. For example, the High-Level Panel of Eminent Persons on the Post-2015 Development Agenda reported in May, 2013. It embraced two overarching ideas—"to tackle the challenges to people and planet so that we can **end extreme poverty** in all its forms *irreversibly* in the context of **sustainable development**" (7). Women and children are an important part of this draft for post-2015 (Appendix 4). For the specific health goal proposed by the High-Level Panel—"Ensure healthy lives"—the route identified to achieve improved health outcomes is "universal access to basic healthcare." Indeed, progress in establishing universal health coverage as the overriding objective of the health and development sector has been rapid. In December, 2012, the UN General Assembly acknowledged the importance of universal health coverage for national health systems and especially emphasised the contribution universal

health coverage could make to achieving the MDGs (8). The General Assembly recognised the responsibility of its member states "to urgently and significantly scale up efforts to accelerate the transition towards universal access to affordable and quality health-care services." And it underlined the importance of universal health coverage to the post-2015 development agenda.

**8.** New leadership at the World Bank has also brought energetic and welcome new attention to health as a dimension of international development policy, and the health of women and children in particular. In September, 2012, the new President of the World Bank, Jim Yong Kim, said (9):

*"Too many women and children continue to die needlessly, lacking access to the basic, quality, affordable health care they need and deserve. That's why I am announcing that the World Bank will establish a special funding mechanism to enable donors to scale up their funding to meet the urgent needs related to MDGs 4 and 5."*

And at the World Health Assembly in May, 2013, he continued to deepen his reflections on this idea (10):

*"We will support countries in an all-out effort to reach MDGs 4 and 5 on maternal mortality and child mortality. Reaching these two MDGs is a critical test of our commitment to health equity... We have been expanding our results-based financing for health, focusing on the maternal and child health goals. Our results-based financing fund has leveraged substantial additional resources from the International Development Association, IDA, the World Bank Group's fund for the poorest countries. This has been an unquestioned success: the trust fund has multiplied resources for maternal and child health. Over the past five years, we have leveraged \$1.2 billion of IDA in 28 countries, including \$558 million for 17 countries since last September alone. Now we are working with Norway, the United Kingdom, and other partners to expand this effort."*

The World Bank seems to be emerging as a powerful new force on behalf of women and children worldwide. However, the reality of the World Bank's engagement and effectiveness in countries is questioned by the evidence we have received from the H4+, which we will discuss in more detail in the next chapter.

**9.** Intergovernmental action for women's and children's health has also continued to advance. In 2011, the financial replenishment of GAVI gave an additional US\$4.3 billion towards vaccine coverage. In 2012, new commitments to family planning delivered US\$2.6 billion to provide 120 million women with access to modern contraceptives by 2020. And in June, 2013, US\$4.15 billion was pledged to save 1.7 million lives from undernutrition. These annual global campaigns,

together with initiatives such as the Commodities Commission, are an important means to bring international attention to specific, and often neglected, dimensions of women's and children's health. They are essential public displays of, and material contributions to, political commitment that bring new resources to bear on achieving MDGs 4, 5, and 1c.

**10.** Action has not only been taking place globally. In countries too, there has been a substantial recommitment to women's and children's health. To take just two examples: in January, 2013, Ministers of Health and high-level representatives met in Dubai to agree approaches to saving the lives of women and children in the Eastern Mediterranean Region of WHO. A regional commission on women's, adolescents', and children's health was promised—to accelerate and track progress on MDGs 4 and 5; meanwhile, in February, 2013, India held a National Summit on a Call to Action for Child Survival and Development. India accounts for the highest absolute number of under-5 deaths worldwide. But India's under-5 mortality rate has declined faster than the global average since 1990. As part of the 2012 Global Call to Action for Child Survival: A Promise Renewed, India has made a commitment to accelerate the gains it has made in recent years in order to reduce child mortality to 20 or fewer under-5 deaths per 1000 live births by 2035.

**11.** As political commitment globally and in countries continues to strengthen, so the knowledge base on which to build national programmes to improve women's and children's health strengthens too. Three examples stand out in 2013: a Global Maternal Health Conference held in Arusha in January, 2013; a Global Newborn Health Conference, held in Johannesburg in April, 2013; and the third Women Deliver conference, held in Kuala Lumpur in May, 2013. The Arusha meeting produced a powerful manifesto for maternal health (Panel 1) (11). The mobilisation of an influential alliance between the scientific community and civil society at both events, among many others, is creating the conditions for more rapid translation of new and robust scientific findings into policy and practice.

**12.** Since publication of our 2012 report, partners working together to deliver the Secretary-General's Global Strategy have moved quickly to address some of the gaps we identified. In November, 2012, WHO convened a stakeholder's meeting to critically review progress on implementation of the Global Strategy and the 10 recommendations of the Commission on Information and Accountability; to provide strategic direction on implementing the iERG recommendations; and to explore synergies in the implementation of the different initiatives under the Global Strategy. A new

RMNCH Steering Committee has now been established, whose first substantive meeting was held in April, 2013. And a global investment framework for women's and children's health is in the final stages of preparation. We will explore both innovations later in this report.

**13.** What this landscape indicates is the immense and increasing complexity of initiatives for adolescents', women's, and children's health. This complexity exists on a background of considerable political uncertainty as the era of the MDGs evolves into a new epoch of sustainable development. Critical transitions such as the one pivoting around 2015 can be moments of extreme fragility, where the risk of unanticipated adverse events or even failure is high. As one senior member within WHO put it this year, the global system is "struggling" to address the fragmentation that afflicts women's and children's health, a fragmentation that also leaves countries "struggling to understand" the new initiatives that seem to arise with a frequency that is often hard to absorb. And in a speech delivered in New Zealand in November, 2012, Helen Clark, UNDP's Administrator, noted the "paralysis, minimal outcomes, or failure" that too often characterise the way some of our most important predicaments are addressed by global institutions (12). But transitions can also represent opportunities for positive change. Our view and the views of those we have consulted (eg, during an open consultation with delegates at the Women Deliver conference in Kuala Lumpur) are that escalating activity across multiple sectors on behalf of women and children, global and country actions that this activity is catalysing, new leadership that is being brought to bear on adolescents', women's, and children's health, and already hopeful prospects for the post-2015 period should encourage us to be provisionally optimistic about what might be achieved. Our report aims to describe those opportunities for positive change.

**14.** To do so, we have adopted five principles that guide our evaluation of evidence and thinking. First, our common objective is to strengthen not only health but also **the dignity of, and equity between, women and children** in communities. Second, that the means by which we can do so involves a **person-centred**, not an intervention-centred, approach to health and human dignity. Third, that we can better understand the challenges and opportunities open to us by taking **a life-course approach** to adolescents', women's, and children's health. Fourth, that our work on behalf of women and children must substantively be set in the context of equitable and **sustainable development**. And finally, that none of these principles can be fully realised without a commitment to **independent accountability**, based on the tripartite model of monitor, review, and action or remedy.

**Table 1: The iERG's six recommendations from its 2012 report**

Recommendation 1	Strengthen the global governance framework for women's and children's health
Recommendation 2	Devise a global investment framework for women's and children's health
Recommendation 3	Set clearer country-specific strategic priorities for implementing the Global Strategy and test innovative mechanisms for delivering those priorities
Recommendation 4	Accelerate the uptake and evaluation of eHealth and mHealth technologies
Recommendation 5	Strengthen human rights tools and frameworks to achieve better health and accountability for women and children
Recommendation 6	Expand the commitment and capacity to evaluate initiatives for women's and children's health

**Table 2: 13 commodities prioritised by the UN Commission on Life-Saving Commodities for Women and Children**

<b>Maternal health commodities</b>	
1.	Oxytocin (for post-partum haemorrhage)
2.	Misoprostol (for post-partum haemorrhage)
3.	Magnesium sulphate (for eclampsia and severe pre-eclampsia)
<b>Newborn health commodities</b>	
4.	Injectable antibiotics (for newborn sepsis)
5.	Antenatal corticosteroids (for preterm respiratory distress syndrome)
6.	Chlorhexidine (for newborn cord care)
7.	Resuscitation devices (for newborn asphyxia)
<b>Child health commodities</b>	
8.	Amoxicillin (for pneumonia)
9.	Oral rehydration salts (for diarrhoea)
10.	Zinc (for diarrhoea)
<b>Reproductive health commodities</b>	
11.	Female condoms
12.	Contraceptive implants (for family planning/contraception)
13.	Emergency contraception (for family planning/contraception)

### Panel 1: A manifesto for maternal health (11)

- The global health community must build on past successes and accelerate progress towards eliminating all preventable maternal mortality within a time-bound period. To this end, a new and challenging goal for maternal mortality reduction is needed within the development goal framework for the post-2015 era, one that is led and owned by countries not donors.
- This maternal mortality goal must be broadened to embrace the progressive realisation of political, economic, and social rights for women. One critical lesson from the history of women's health is that maternal health will not be improved to its full potential by focusing on maternal health alone.
- As maternal mortality declines, the world must now focus on both prevention and treatment of maternal morbidities, the measurement of which is challenging but critical to tackle for the health, productivity, and dignity of the women involved.
- The successful framework of the continuum of care must be redefined to make women more central to our notions of reproductive, maternal, newborn, and child health. The continuum needs to be more inclusive of frequently neglected elements—eg, quality of care, integration with HIV and malaria programmes, non-communicable diseases, and the social determinants of health, such as poverty, gender disparities, sexual and gender-based violence, water and sanitation, nutrition, and transportation.
- The global health community must devise a responsive financing mechanism to support countries in implementing their plans to reduce maternal mortality and improve sexual and reproductive health.
- A much greater emphasis must be put on reaching the unseen women who are socially excluded because of culture, geography, education, disabilities, and other driving forces of invisibility. If we are serious about redressing gender and access inequities, we have to ask fundamental and difficult questions about the nature of our societies and the value, or sometimes lack of value, we ascribe to individuals, especially women, in those societies.
- One critically important element to address women's health and needs is attention to improving comprehensive quality of care. Respectful maternal health care for all women is an ethical imperative, not an option.
- The maternal health community must invite, include, and incorporate the voices of women themselves into writing the future of maternal health. Too often, women's voices are silenced, ignored, or reported only second hand. Women must be given the platform and power to shape their own futures in the way they wish.
- For the mother, her newborn child is a precious and indissoluble part of her life and her future. Maternal health outcomes cannot be fully addressed without attacking the appalling global toll of preterm births, preventable stillbirths, and newborn deaths.
- A critical gap that threatens the future health of women and mothers is the catastrophic failure to have reliable information on maternal deaths and health outcomes within and across countries. This gap in measurement, information, and accountability must be a priority now and post-2015.
- A tremendous opportunity lies in technology. Mobile and electronic health technologies must ensure that women are effectively and safely connected to the health system, from education to emergencies, referral for routine antenatal care to skilled birth attendance. Putting the right technologies in the hands of women offers one compelling opportunity to make empowerment of those women a reality.
- Finally, we must fulfil all of these actions sustainably, which means universal access to services free at the point of demand within a strong health system—to family planning, to emergency obstetric care, to safe abortion, to properly trained health workers, especially midwives and those providing midwifery services.



**1. *EVERY WOMAN, EVERY CHILD:*  
A MID-TERM PROGRESS REPORT**

**15.** The MDG-4 target is to reduce by two-thirds, between 1990 and 2015, the under-5 mortality rate. Despite an often extraordinary acceleration in the rate of reduction of under-5 mortality in sub-Saharan Africa and parts of Asia between 2000 and 2011, progress in improving child survival is still too slow for 58 of our 75 priority countries to achieve the MDG goal (Fig 1). Put another way, according to the Countdown to 2015 2013 update report, the only countries, based on current projections, that will reach MDG-4 by 2015 are (13):

Liberia	Guatemala
Rwanda	Bangladesh
Malawi	Indonesia
Ethiopia	Nepal
Niger	Egypt
Madagascar	Lao
Peru	China
Brazil	Cambodia
Mexico	

According to UN figures, 6.91 million children under 5 died in 2011 compared with 11.97 million in 1990, a stunning 42% fall in the total number of under-5 deaths.

Over 5 million more children are surviving today than 20 years ago. This achievement is remarkable by any standard, although a word of caution is necessary. 49% of the 5 054 000 fewer under-5 deaths in 2011 compared with 1990 come from India (1 406 000 fewer under-5 deaths) and China (1 047 000). The result of this trend is that under-5 deaths are now concentrated in sub-Saharan Africa (3.37 million) and South Asia (2.34 million)—83% of total under-5 deaths (Figs 2 and 3). One in 9 children in sub-Saharan Africa dies before the age of 5. The comparable figure for South Asia is 1 in 16. The commonest causes of death among children under-5 are shown in Fig 4. After neonatal causes, pneumonia remains the largest single cause of death. In some countries, and in some instances because of demographic change, total numbers of under-5 deaths are actually static or rising, despite falls in mortality rates. These countries are shown in Table 3. If we value the life of every child, as the global community says that it does, the toxic interaction between demographic change and child mortality should be a cause for extreme concern and concerted action.

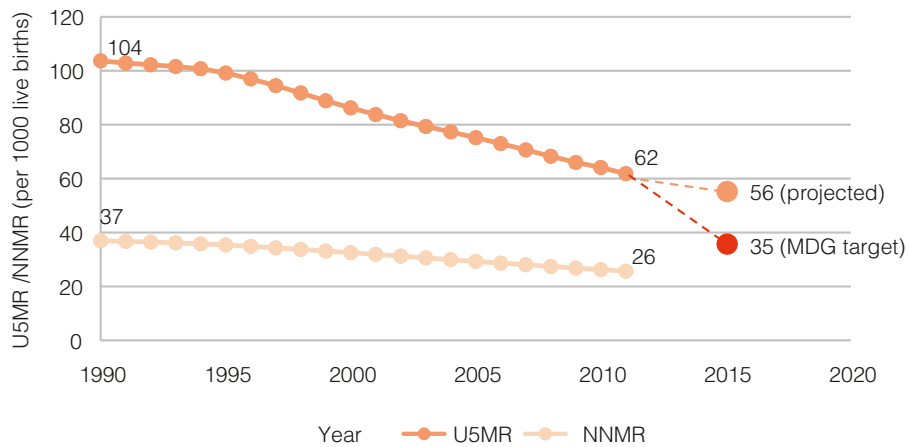
**Table 3: 19 iERG countries that have seen no reduction or increases in total under-5 deaths between 1990 and 2011 (14)**

Country	1990	2011
Afghanistan	117 000	128 000
Burkina Faso	87 000	101 000
Cameroon	71 000	88 000
Central African Republic	20 000	25 000
Chad	55 000	79 000
Comoros	2000	2000
Congo	10 000	14 000
DRC	312 000	465 000
Equatorial Guinea	3000	3000
Gabon	3000	3000
Guinea-Bissau	9000	9000
Iraq	30 000	42 000
Kenya	95 000	107 000
Lesotho	5000	5000
Mali	103 000	121 000
Mauritania	10 000	13 000
Papua New Guinea	12 000	12 000
Somalia	52 000	71 000
Swaziland	3000	4000

Source: Levels and trends in child mortality. Report 2012. UNICEF, 2012.

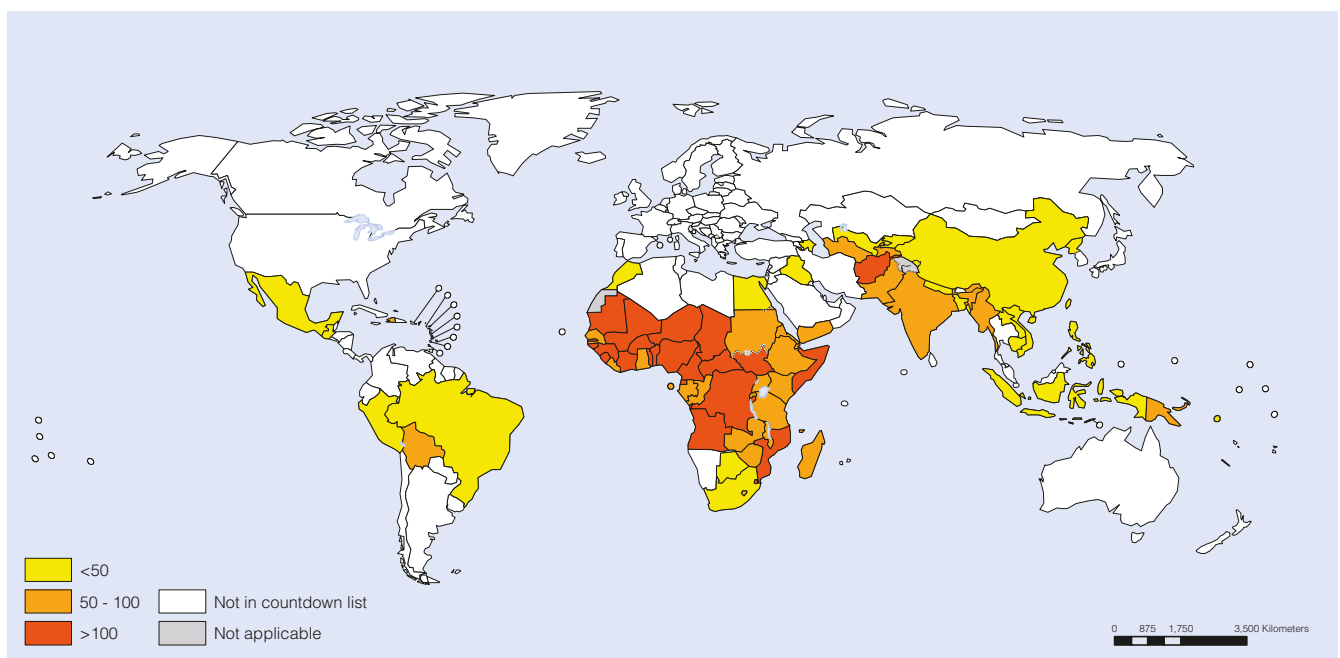


**Figure 1. Under-5 mortality and neonatal mortality in 75 iERG countries, 1990-2011**



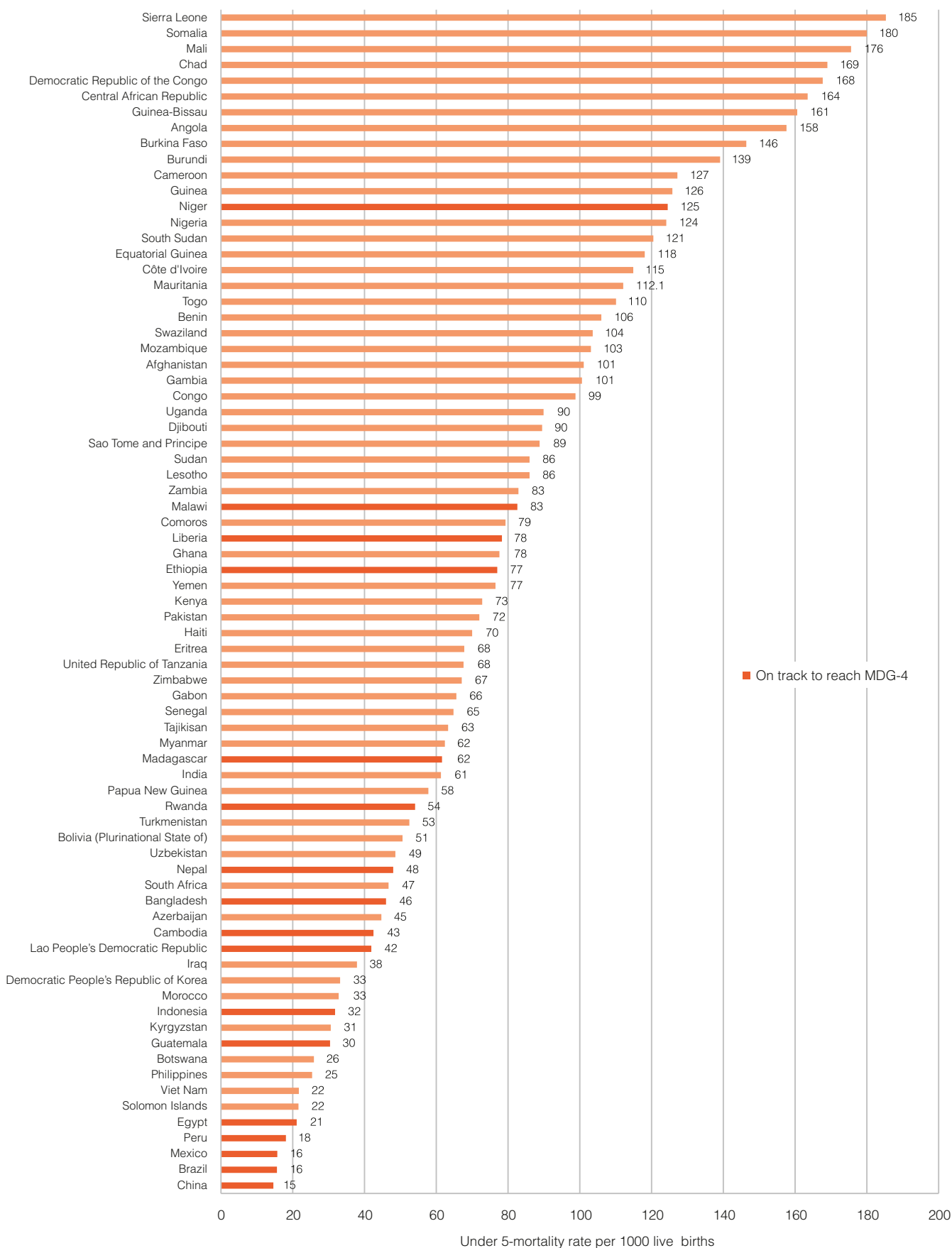
Source: UN-IGME, 2012

**Figure 2. Under-5 mortality rates (probability of dying by age 5 per 1000 live births) in 75 iERG countries, 2011**



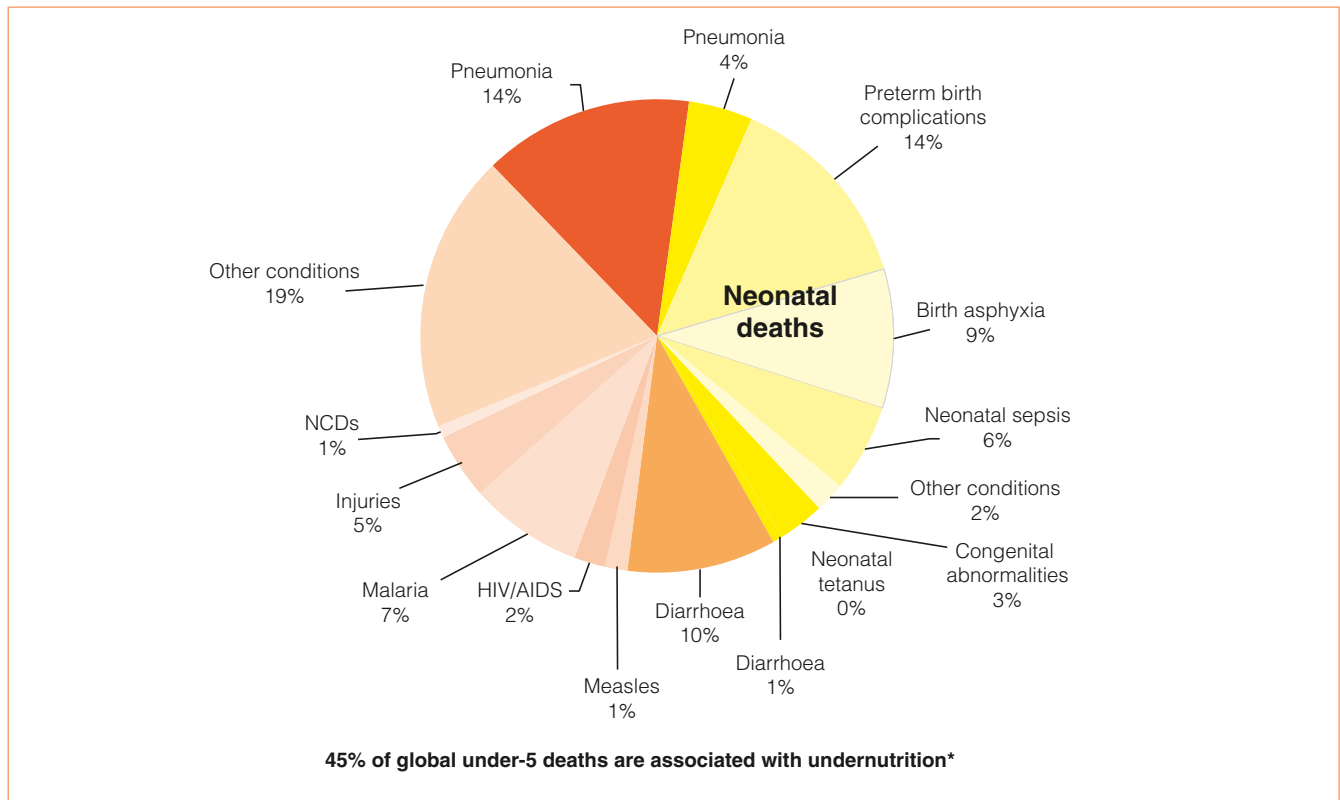
Source: UNICEF, WHO, The World Bank, UN DESA/Population Division. Levels and Trends in Child Mortality – Report 2012. UNICEF, 2012.

Figure 3. Under-5 mortality rates in 75 iERG countries, 2011



Source: UN-IGME, 2012

Figure 4. Major causes of under-5 deaths, including neonates, in 75 iERG countries, 2010

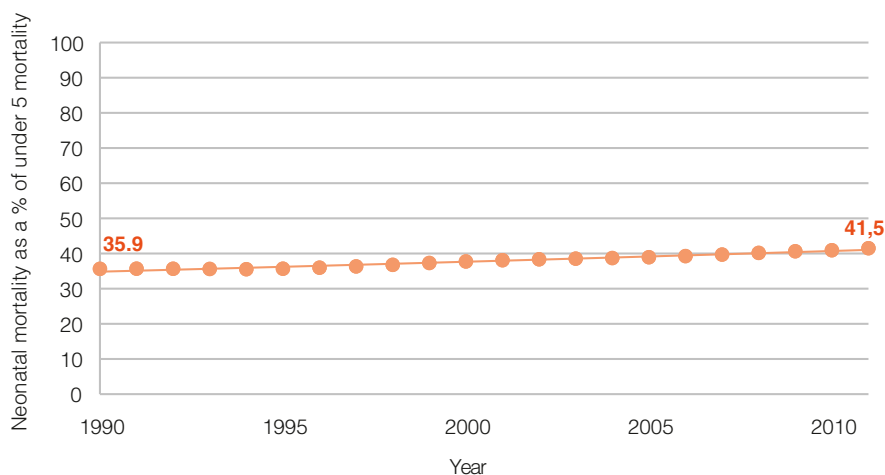


Source: 1. Based on data from WHO-CHERG joint estimates of child deaths by cause for 2000-2010  
 2. \* For under nutrition: Black et al. Maternal and child undernutrition and overweight in low-income and middle-income countries. *Lancet*; 2013.

16. A particular priority is the newborn period. The proportion of under-5 deaths that take place in the neonatal period is increasing, which is to be expected where progress in reducing post-neonatal mortality is being achieved (Fig 5). Declines in newborn mortality have been slower than declines in overall under-5

mortality. Moreover, in 36 countries, there has been either no change or an increase in total numbers of newborn deaths, again signalling the pressure that demographic change, among other factors, puts on the capacity of health systems to protect the lives of newborns (Table 4).

Figure 5. Neonatal mortality as a percentage of under-5 mortality in 75 iERG countries, 1990-2011



Source: UN-IGME, 2012

**Table 4: 36 iERG countries that have seen no reduction or increases in total newborn deaths between 1990 and 2011**

Country	1990	2011
Afghanistan	38 000	51 000
Angola	29 000	35 000
Benin	9 000	11 000
Botswana	1 000	1 000
Burkina Faso	18 000	25 000
Cameroon	19 000	24 000
Central African Republic	6 000	7 000
Chad	13 000	22 000
Comoros	1 000	1 000
Congo	3 000	5 000
Côte d'Ivoire	25 000	28 000
DRC	91 000	137 000
Djibouti	1 000	1 000
Equatorial Guinea	1 000	1 000
Eritrea	4 000	4 000
Gabon	1 000	1 000
Gambia	2 000	2 000
Ghana	22 000	23 000
Guinea	15 000	15 000
Guinea-Bissau	2 000	3 000
Iraq	15 000	23 000
Kenya	32 000	42 000
Mali	25 000	36 000
Mauritania	3 000	5 000
Niger	21 000	25 000
Nigeria	220 000	254 000
Sierra Leone	10 000	11 000
Somalia	15 000	21 000
South Sudan	13 000	13 000
Sudan	32 000	35 000
Swaziland	1 000	1 000
Togo	6 000	7 000
Uganda	35 000	43 000
Tanzania	47 000	48 000
Yemen	27 000	30 000
Zambia	15 000	17 000

Source: Levels and trends in child mortality. Report 2012. UNICEF, 2012.

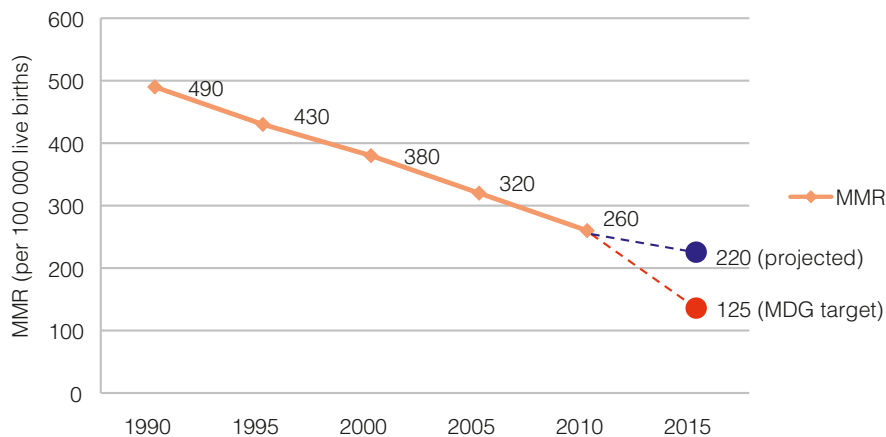
**17.** The MDG-5 target is to reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio and to achieve, by 2015, universal access to reproductive health. On maternal mortality, of 75 *Every Woman, Every Child* countries, only the following 9 countries are projected to reach the MDG-5 goal by 2015 (15):

Equatorial Guinea	Viet Nam
Eritrea	Lao
Nepal	China
Bangladesh	Cambodia
Egypt	

The trend for the maternal mortality ratio for our 75 countries of concern is shown in Fig 6. The rates by country are shown in Figs 7 and 8. The conclusion from these data is not new, but needs to be emphasised again and again: MDG-5 is the most off track Millennium Development Goal of all. The failure to make more rapid progress on reducing maternal mortality is the

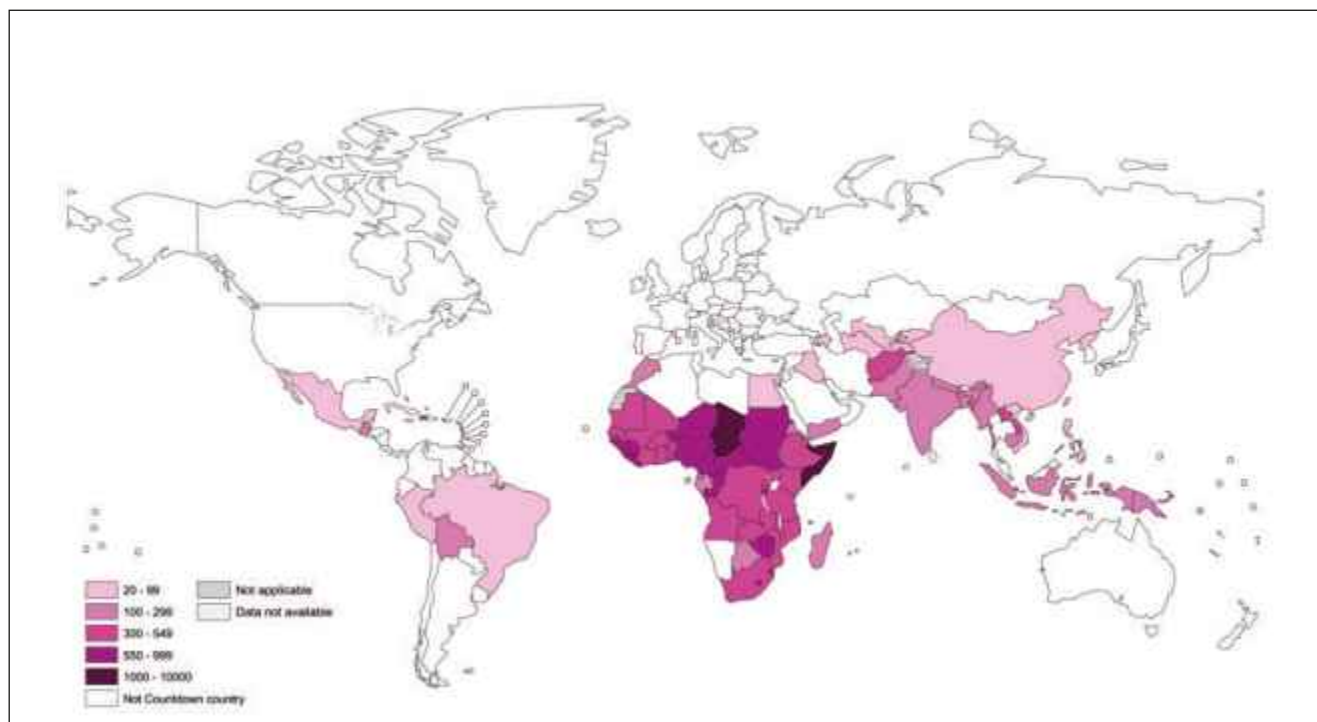
most serious wound on the body of global health. This failure indicates that, whatever the rhetoric of reports and speeches, the international community has failed women, and failed them badly. Many reasons will be given in mitigation. But the underlying cause of failure is that development partners have simply not been sufficiently interested in strengthening the systems of health care that women need during pregnancy and childbirth. Those development partners need to be asked: why have you let women down so badly? And what will they do now, and differently, to make up for these mistakes? On universal access to reproductive health, again our 75 countries of concern are a long way from reaching their target, despite increased political attention to family planning in recent years. Most countries are a considerable distance from reaching zero % unmet need (Fig 9). We shall return to family planning initiatives later in this chapter, but the inattention to reproductive health is symptomatic of a larger inattention to women more generally.

**Figure 6. Maternal mortality ratio in 75 iERG countries, 1990-2010**



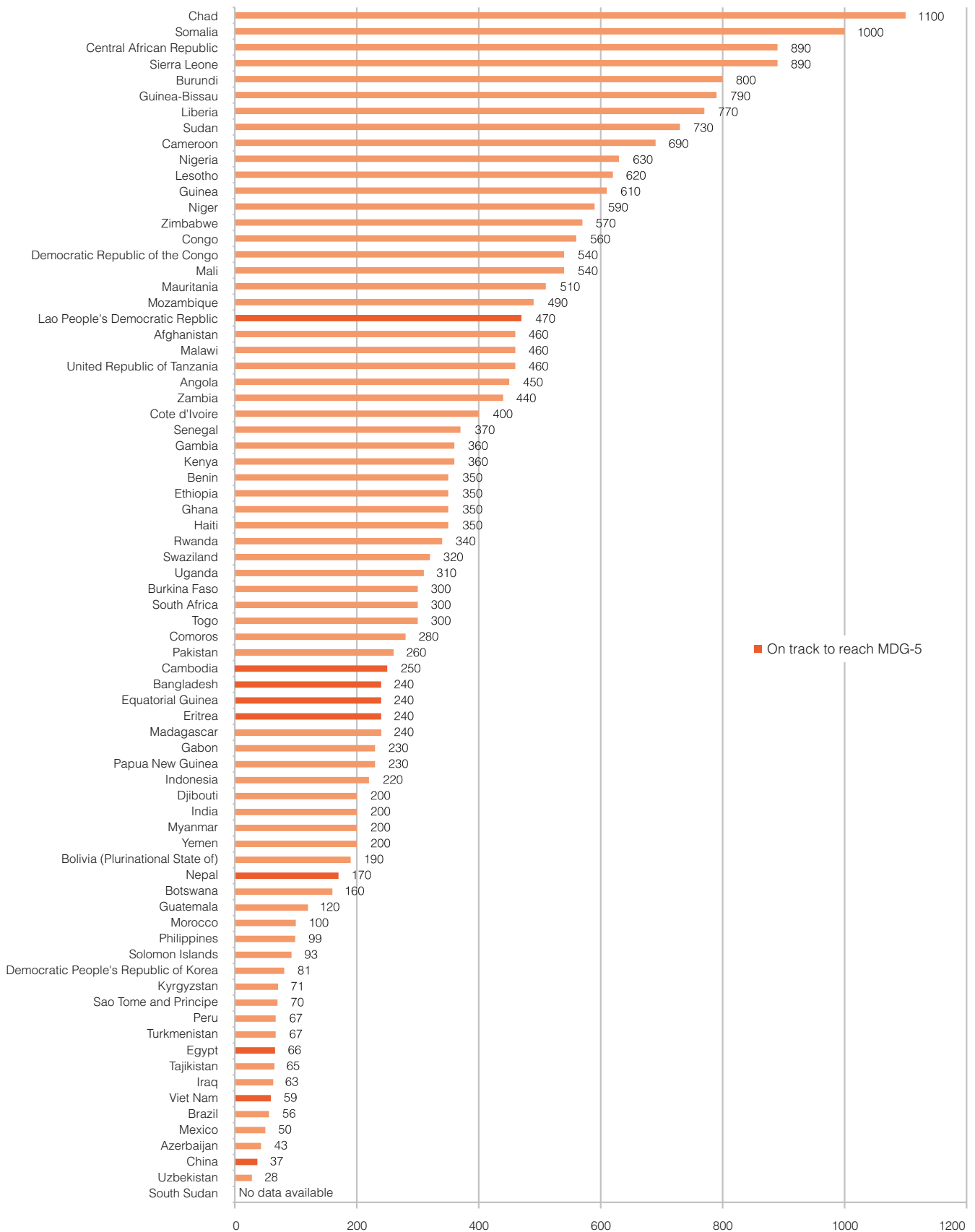
Source: WHO/UNICEF/UNFPA/World Bank. Trends in maternal mortality: 1990 to 2010. WHO, UNICEF, UNFPA, and The World Bank estimates. Geneva, World Health Organization, 2012.

Figure 7. Maternal mortality ratio (per 100 000 live births) in 75 iERG countries, 2010



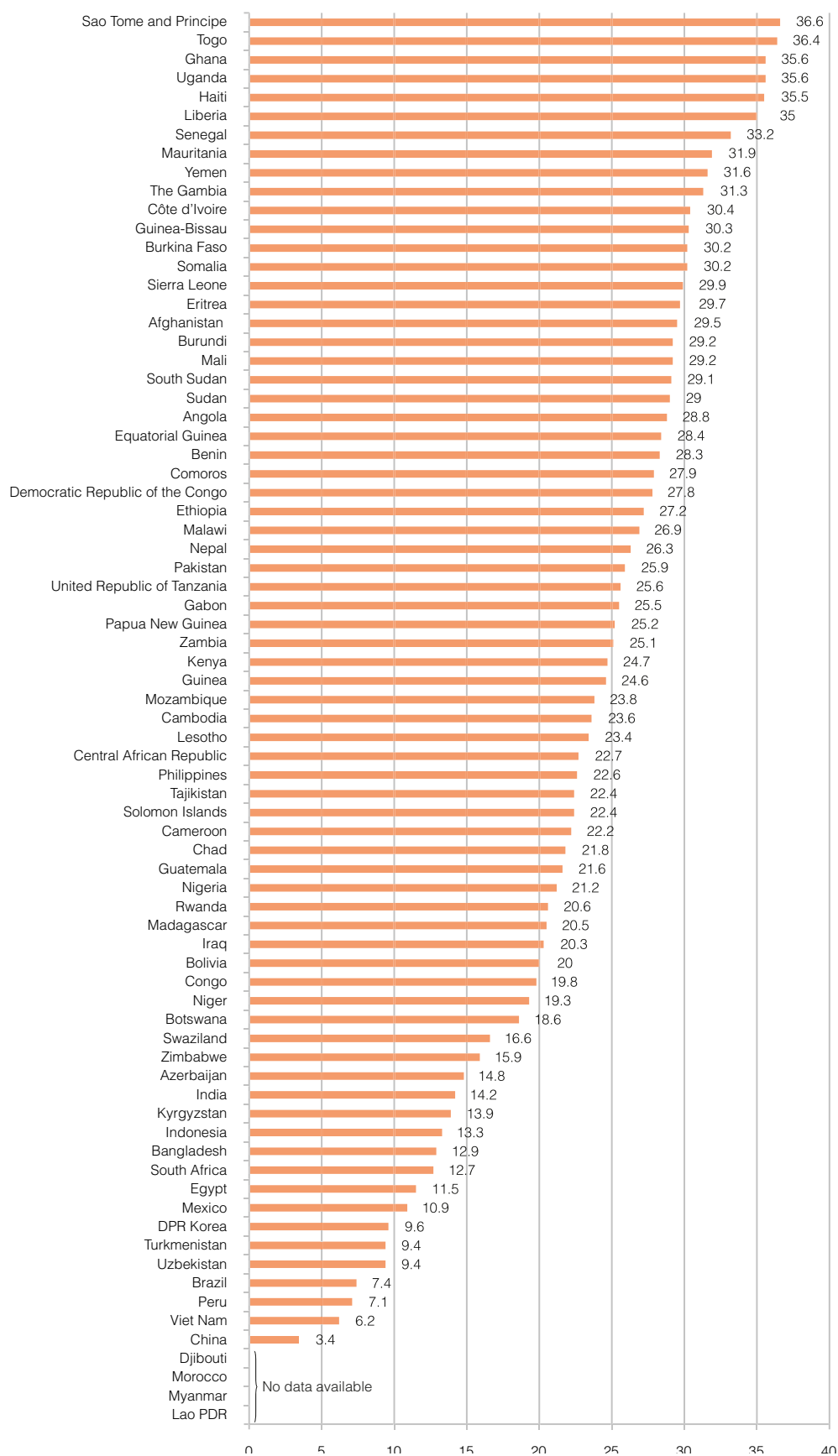
Source: Trends in maternal mortality: 1990 to 2010. WHO, UNICEF, UNFPA, and The World Bank estimates. Geneva, World Health Organization, 2012.

Figure 8. Maternal mortality ratios (per 100 000 live births), 2010



Source: Trends in maternal mortality: 1990 to 2010. WHO, UNICEF, UNFPA, and The World Bank estimates. Geneva, World Health Organization, 2012.

Figure 9. Estimates (%) of unmet need for family planning, 2010



Source: Alkema L, Kantorova V, Menozzi C, Biddlecom A., National, regional, and global rates and trends in contraceptive prevalence and unmet need for family planning between 1990 and 2015: a systematic and comprehensive analysis, *Lancet* 2013; 81: 1642-52



**18.** An additional critical goal for maternal and child health is nutrition. This objective is expressed as MDG-1c—to halve, between 1990 and 2015, the proportion of people who suffer from hunger. One indicator for this goal is the prevalence of underweight children under-5 years of age. According to the latest available data published in 2013, there are estimated to be 165 million children younger than 5 years who were stunted in 2011 (16). 52 million children are wasted. Undernutrition has an astonishing impact on child mortality: the combined effects of fetal growth restriction, sub-optimum breast feeding, stunting, wasting, and vitamin A and zinc deficiencies cause 3.1 million under-5 deaths worldwide, or 45% of total under-5 child mortality. The effects of nutrition on child mortality have been grossly underestimated, especially the contribution of maternal undernutrition and small-for-gestation births on under-5 mortality. The impact of interventions has also been neglected. The delivery of 10 interventions (folic acid, multiple micronutrient, calcium, and balanced energy protein supplementation; exclusive breastfeeding; complementary feeding; vitamin A and preventive zinc supplementation; and management of severe and moderate acute malnutrition)—with 90% coverage to 34 priority countries would save an additional 1 million lives annually (17). These interventions could be most effectively and efficiently delivered through community platforms, such as community health workers, women's groups, or schools. Thanks to these new data, together with strong political and technical advocacy from UN agencies and civil society (18-20), the Nutrition for Growth summit held in June, 2013, prior to the G8 meeting, was able to secure new commitments of US\$4.2 billion out to 2020. This new money could save 1.7 million lives and prevent 20 million children from becoming stunted. Although the MDG-1 target for nutrition may not be achieved, the scaling up of political commitment around nutrition has created an unprecedented opportunity to turn that momentum into results.

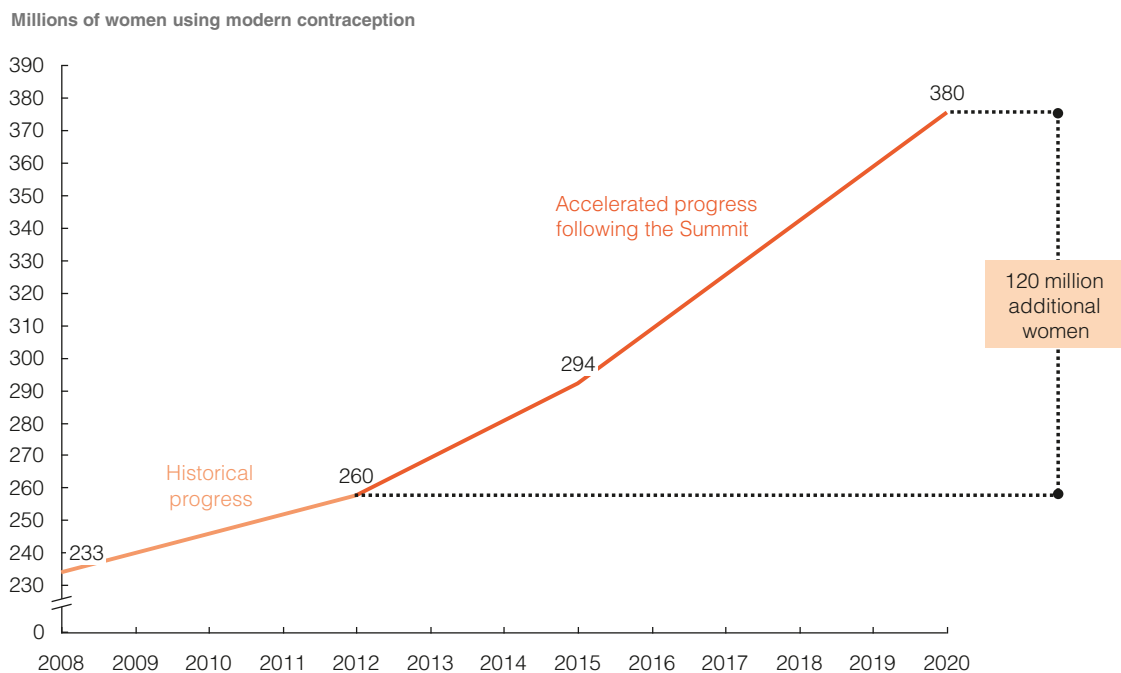
**19.** The programme of work for *Every Woman, Every Child* in 2013 has focused on strengthening strategic partnerships to ensure sustained investment, continued prioritisation of women and children for development, and coordination between new initiatives, such as family planning, life-saving commodities, and child survival. Regional and country leadership has been critical to these tasks—the Campaign on Accelerated Reduction in Maternal Mortality in Africa (CARMMA), Nigeria's Saving One Million Lives initiative, an Indian public-private partnership to end child diarrhoeal deaths, and Malawi's Presidential Initiative for Maternal Health and Safe Motherhood. The UN Secretary-General, Ban Ki-moon, continues to be at the forefront of these activities.

**20.** An independent assessment of progress towards delivering the commitments made to *Every Woman, Every Child* is provided annually by the Partnership for Maternal, Newborn, and Child Health (PMNCH) (21). In its 2013 report, PMNCH describes how commitments to the Global Strategy continue to rise, from 111 in 2010 to 293 by June, 2013. 73 new commitments have been made by stakeholders since April, 2012, mostly thanks to the London Summit on Family Planning and the Born Too Soon initiative. The largest number of commitments have come from NGOs. However, the speed of growth of commitments to *Every Woman, Every Child* is slowing—only 10 new commitments have been made between January and June, 2013. Some countries are also favoured more than others in terms of the commitments they receive: the top five countries in receipt of commitments are Tanzania (31, or 28%, of total commitments), India (30, 27%), Bangladesh (27, 24%), Kenya (27, 24%), and Ethiopia (26, 23%). The funding needed to support the Global Strategy—to save 16 million lives by 2015 in the 49 poorest countries—is US\$88 billion. The total funding PMNCH estimates has been committed as a result of the Global Strategy since 2010 is US\$40-45 billion. But more careful analysis shows that only US\$18-22 billion are new and additional financial commitments. Despite welcome money currently being disbursed to areas such as HIV, infectious disease control, and reproductive health, a huge funding gap remains (US\$25 billion has been disbursed since the launch of the Global Strategy to June, 2013). Furthermore, if one looks at domestic RMNCH expenditures, one discovers alarming variations and disparities. Countries with the lowest per capita spending on RMNCH in 2011 were: Myanmar, Eritrea, DRC, Afghanistan, Pakistan, Chad, Central African Republic, Madagascar, Nepal, and Bangladesh—their expenditure is substantially below the average for the 49 countries prioritised by the Global Strategy, and, for most, has been for some years. Although this variability does not necessarily correlate precisely with the coverage or quality of services, it is a contributory factor. Non-financial commitments went mainly to service delivery, advocacy, policymaking, and research. More than 873 000 new health workers have been trained, but given that the goal of the Global Strategy was to train an additional 2.5-3.5 million health workers, one can see that progress still lags behind expectations. On health facilities too, the Global Strategy's goal was 85 000 additional quality health facilities. But only 4450 new facilities have been provided since 2010. As PMNCH concludes, in something of an understatement: "much more needs to be done." The main obstacles to further progress, PMNCH argues, are clear: the failure to expand the health workforce sufficiently, lack of money, poor infrastructure, and too little attention to the determinants of health, such as nutrition, clean water and sanitation, and education. And one final warning in the PMNCH analysis: for policy investments, information and accountability were the least prioritised areas of all.

**21. Committing to Child Survival: A Promise Renewed** was launched in June, 2012, by USAID and UNICEF, in collaboration with the Governments of Ethiopia and India, as a global movement to end preventable child deaths. The goal is 20 by 35—reducing child mortality to 20 or fewer deaths per 1000 live births by 2035 (22). 174 governments have signed the pledge (including all of the iERG’s countries of concern, except for Angola, Azerbaijan, Guinea-Bissau, and Iraq). The main purpose of *A Promise Renewed* is to stimulate and expand the movement for child survival. A secretariat has been created within UNICEF to track and monitor national strategies in support of *A Promise Renewed*, and a report will be published in 2013. The initiative works partly through PMNCH, and will have its advisory group meetings in the margins of the PMNCH Board. Currently (at the time of writing in August, 2013), the administration of *A Promise Renewed* is largely driven by UNICEF and USAID. This has led to concerns

among other partners, notably WHO, that *A Promise Renewed* is failing to take an inclusive approach with respect to other important parties concerned with children’s health. *A Promise Renewed* risks becoming a single-donor (ie, US) driven initiative, with disabled coordination between relevant multilaterals. This danger requires urgent mitigation. The iERG was initially also concerned that the exclusive focus on children may harm efforts to promote the continuum of care around reproductive, maternal, newborn, and child health. That concern still exists, although a parallel goal is being devised for maternal mortality reduction, perhaps to as low as 50 or fewer deaths per 100 000 live births, which is likely to be launched in 2013. If the challenges in setting up and possibly extending *A Promise Renewed* can be resolved, these efforts have the potential to further support and secure the future of child and maternal mortality goals in the post-2015 development agenda.

**Figure 10. Family Planning 2020’s goal of making information, services, and supplies available to more women and girls in the world’s poorest countries**



Source: Futures Institute, FPS working team analysis, Guttmacher Institute for base line 2012 estimates; All estimates based on data from UN Population Division, DHS and other surveys and other sources

**22.** In July, 2012, in London, the UK Government and the Bill and Melinda Gates Foundation, in partnership with others, launched another new initiative—Family Planning 2020—to make available affordable, life-saving contraceptive information, services, and supplies to an additional 120 million women and girls in the world's poorest countries by 2020. Contraceptives are one of the most cost-effective investments a country can make for its future. When women and girls have access to family planning services, maternal and child mortality falls and wider health benefits accrue. Girls are more likely to complete their education and create better opportunities for their futures. Women and their families become healthier, wealthier, and better educated. The objective of FP2020 is shown in Figure 10. As can be seen from this graph, by the end of 2013 there should already be progress towards reaching the 120 million additional women targeted by the sponsors of the London summit. The task team supporting a newly created Reference Group (chaired by Babatunde Osotimehin, Executive Director of UNFPA, and Chris Elias, from the Bill and Melinda Gates Foundation, and whose responsibility it is to deliver the goal of the summit) followed up commitments made in London by creating working groups to advise on country engagement, rights and empowerment, market dynamics for contraceptives, and performance monitoring and accountability. There is also to be a Champions Group. The task team noted that the accountability working group would “ensure results are submitted to the FP2020 Reference Group and also inform EWEC’s annual reporting process including the independent Expert Review Group.” That commitment to report to the iERG was confirmed in the minutes of the December, 2012, Reference Group meeting. We were therefore disappointed that the FP2020 leadership team has not been able to submit a summary of progress to the iERG. We are aware that meetings of the Reference Group to plan further work around FP2020 have taken place. But we are not in a position to say anything about advances made during this first year after the summit, despite an expectation that measurable progress would have been made. This failure of FP2020 to deliver on its promise of accountability is a serious concern to us. FP2020 has created a complex vertical bureaucracy, one that all informed partners we have consulted are deeply anxious about. What countries do not need today is what seems to be another vertical initiative to grapple with. Yet partners involved in creating and now leading FP2020 seem intent on adding to the administrative complexity for already overburdened country and global health systems. This attitude seems inexplicable.

**23.** The PMNCH report selected family planning as one of its major thematic areas in 2013. Its key conclusions, based on an analysis of commitments, together with key informant interviews, shed important new light on the attention family planning is receiving globally. 40%

of all commitments made to the Global Strategy include support for family planning. The FP2020 summit, held in 2012, was an important catalyst for these commitments. Most of these promises—46%—come from low- and middle-income countries themselves (half of all commitments relate to sub-Saharan Africa). The second most important contributor was the NGO sector. Disappointingly, there were few commitments from the private sector. The main areas of attention within the sphere of family planning were: health system strengthening to improve delivery of services; awareness-raising campaigns to promote demand; addressing the security of commodities; embedding family planning within the larger context of integrated care for women; and mobilising community and political commitments. Spending on family planning by high-income countries and the Gates Foundation, according to the PMNCH analysis, was 9% of their total expenditure on RMNCH interventions in 2011—US\$0.8 billion. This is an increase from 7% in 2008 (US\$0.4 billion). PMNCH reports several examples of tangible progress in countries, such as in Senegal, Viet Nam, Cambodia, Sudan, and Liberia. Their report also highlights key obstacles—namely, lack of human resources, insufficient funding, poor infrastructure, and adverse sociocultural factors. Combine these data with new findings that the unmet need for modern contraceptives remains high, especially among poorer communities—83 million women in South Asia, 53 million women in sub-Saharan Africa, and 14 million women in Western Asia—and one can immediately see that it is of the utmost importance that FP2020 delivers on its own so far unmet promise to provide proper reporting on the commitments of partners to the agreements made in London in 2012 (23).

**24.** Several extraordinary new opportunities have been created this past year to accelerate progress in several dimensions of women’s and children’s health. First, new evidence around the global burden of childhood pneumonia and diarrhoea indicates not only the immense toll these two conditions exert on young lives (1.3 million under-5 deaths annually from pneumonia and 700 000 deaths from diarrhoea), but also the tremendous opportunity that exists to prevent the majority of those deaths (24-27). It is worth underlining that PMNCH found pneumonia to be a seriously neglected area among commitments from *Every Woman, Every Child* partners. Yet if interventions (Table 5) were scaled up to 80% coverage in our 75 priority countries, 95% of diarrhoeal and 67% of pneumonia deaths could be prevented by 2025. The goal of ending preventable childhood deaths from pneumonia and diarrhoea is real, yet strangely overlooked (and is perhaps not helped by the fact that no indicator exists for diarrhoea in the framework established by the Commission).

**Table 5: 16 interventions that could end preventable childhood deaths**

<b>Preventive interventions for pneumonia</b>
1. Measles vaccine
2. Hib vaccine
3. Pneumococcal conjugate vaccine
<b>Therapeutic interventions for pneumonia</b>
4. Antibiotics for the treatment and management of neonatal pneumonia
5. Oxygen systems
<b>Preventive interventions for diarrhoea</b>
6. Rotavirus vaccine
7. Cholera vaccine
<b>Therapeutic interventions for diarrhoea</b>
8. Oral rehydration solution and recommended home fluids
9. Zinc
10. Feeding strategies and improved dietary management of diarrhoea
11. Antibiotics for treatment of shigella
12. Antibiotics for treatment of cholera
13. Antibiotics for treatment of cryptosporidiosis
<b>Interventions common to both childhood pneumonia and diarrhoea</b>
14. Breastfeeding
15. Water, sanitation, and hygiene interventions
16. Preventive zinc supplementation

**25.** The GAVI Alliance submitted a comprehensive and detailed report to the iERG summarising progress on vaccination coverage in 60 out of our 75 priority countries. GAVI supports the poorest countries of the world to expand access to life-saving vaccines. By the end of 2012, WHO estimated that GAVI's support to over 70 countries had prevented 5 million future deaths since 2000. Over 370 million children had received GAVI-supported vaccines by the end of 2012. With the additional US\$4.3 billion pledged in London in 2011, GAVI has been able to accelerate the roll out of vaccination programmes worldwide. For example, by the end of 2012, pneumococcal vaccine had been added to the routine immunisation systems of 24 countries (and rotavirus vaccine in 12 countries). In 2012, Ghana and Tanzania simultaneously launched both vaccines, as the GAVI report says, "establishing Africa's leadership in fighting vaccine-preventable deaths." A new funding window was also opened to provide access to the HPV vaccine. Over 85% of deaths from cervical cancer occur in low- and middle-income countries. In 2013, the first GAVI-supported HPV vaccines were delivered to Kenya, Ghana, Madagascar, Malawi, Niger, Rwanda, Sierra Leone, Tanzania, and Lao PDR are additional demonstration countries. By 2015, one million girls will have received the HPV vaccine in over 20 countries. By 2020, over 30 million girls in more than 40 countries will have been vaccinated against HPV with GAVI support. GAVI also makes an important contribution to distributing the

measles-rubella vaccine, pentavalent vaccine (against diphtheria, tetanus, pertussis, Hib, and hepatitis B), and yellow fever vaccine. GAVI consistently performs well in independent assessments of its performance—eg, by the Australian, Swedish, and UK governments, and by the Multilateral Organisation Performance Assessment Network. Nevertheless, GAVI does anticipate challenges in the near term. The acceleration of GAVI's activity during the past two years inevitably stretches the resources and capacity of the organisation to the full. In some instances, there have been vaccine supply constraints. Vaccine coverage has improved substantially, but still remains insufficient in some countries. GAVI acknowledges that it could also have done more to support health-system strengthening. Its health system disbursements have fallen below the target set by GAVI's Board. This weakness is currently being corrected through a complete revision of its health system strengthening support model. But GAVI could go further. With new initiatives launched this year on pneumonia and diarrhoea, for example, we see great opportunities for GAVI to integrate more of its work with related projects that will reinforce, support, and sustain its core activities on vaccines. For example, over a quarter of childhood diarrhoea and pneumonia deaths can be prevented with 3 vaccines—Hib type b, pneumococcal conjugate, and rotavirus vaccines. But almost the same number of deaths could be prevented with water, sanitation, and hygiene interventions (17). It seems to us a missed opportunity not to seek ways to

connect investments in vaccines with investments with other related interventions that share a common goal. Data quality is also being upgraded by GAVI, using a revised data quality assessment tool. And fragile settings are being addressed through a new country-by-country approach agreed in 2012. The iERG also invited a submission on the progress of the Global Vaccine Action Plan. The first substantive progress report on this plan will be ready in 2014.

**26.** The iERG believes it is important to engage with all global actors that support women's and children's health. Those working in HIV are no exception. We invited the Global Fund, which makes substantial financial contributions to reproductive health (28), to submit evidence about progress in implementation of its health programmes, which cover a range of interventions for women and children. We received one brief (less than one page) summary of a Global Fund project linking HIV to gender and RMNCH programmes in Cambodia. We are not able to make any substantive comments about the contribution of the Global Fund to the Secretary-General's Global Strategy based on this sparse submission.

**27.** We highlighted the importance of non-communicable diseases to women's and children's health in our 2012 report (5). With the intensive debate around the post-2015 development agenda, the place of NCDs within that framework has become increasingly heard (29). To take one example—maternal obesity. Examination of Demographic Health Surveys from 27 sub-Saharan African countries shows that maternal obesity is associated with a significantly increased risk of neonatal death (30). There is now a global goal for reducing deaths from NCDs—a 25% reduction in mortality by 2025. And NCDs have been included in the High-Level Panel's provisional targets for their health goal (Ensure Healthy Lives). Organisations responsible for advocating on behalf of NCDs are now giving serious attention to diseases specific to women and

children (31). As the detail of the post-2015 goals and targets comes into sharper focus, it is essential that those responsible for drafting new objectives for health and development consider the evidence about NCDs as it pertains to women and children.

**28.** As discussed in our Introduction, the remit of the iERG has now extended to include the UN Commission on Life-Saving Commodities for Women and Children. It is early days in the post-Commission implementation process. So far, working groups have been set up for each commodity (13 in total) and each recommendation (another 10). Workplans and budgets are being prepared, together with guidelines and expertise to support country plans. The secretariat of the post-Commission process reported to the iERG that "it is too early to comment on the progress of these groups." A review is apparently planned for later in 2013. Meanwhile, 8 "pathfinder" countries have moved ahead to develop early plans—DRC, Ethiopia, Malawi, Nigeria, Senegal, Sierra Leone, Tanzania, and Uganda. A multi-country workshop was held in Senegal in July, 2013, to bring these 8 countries together to finalise their plans. However, the original Commission report was exceptionally ambitious, requiring 3 of its recommendations—on shaping global markets, innovative financing, and performance and accountability—to be fulfilled by the end of 2013. These recommendations cannot be met within the original time frame specified. The goal for Recommendation 1, for example, was to conduct a situational analysis for each commodity, to create a market outlook for that commodity, and to scope potential commodity interventions. This work is enormous in depth and range. The same challenge faces Recommendation 3 (innovative financing) and Recommendation 9 (performance and accountability). We admire the ambition of the Commission, but its feasibility within the timescale proposed was, as its inability to provide a progress report on these 3 recommendations shows, an ambition too far.

## Syria: The devastating impact of civil conflict on health services for women and children

The events that started in the Syrian Arab Republic in March, 2011, have led to widespread conflict affecting all 14 of its Governorates, including in heavily-populated areas. The humanitarian impact of the crisis exceeds almost all of the emergencies of the past two decades in scale and complexity with 6.8 million people in need, including 4.25 million internally displaced, and the number of children in need estimated at 3.1 million (1). An additional 1.75 million refugees have fled to Lebanon, Jordan, Turkey, Iraq, and Egypt (2). Unofficial refugee numbers may be considerably higher. The majority of the refugee population (75%) is women and children (3). The impact of the crisis on Syrian women and children has been significant.

The health system in Syria has been severely disrupted, compromising the provision of primary and secondary health care, the referral of patients, treatment of chronic diseases, maternal and child health services, vaccinations, and nutrition programmes.

Access to services for women and children has been significantly reduced as a large proportion of health facilities has been directly affected or damaged by the conflict and those that remain functional are overburdened. 60% of the Public Hospitals are damaged, out of which 22% are partially damaged and 38% are out of service (4). 34% of the Primary Health Care Centres are damaged, of which 2% are partially damaged and 32% are out of service. In addition 169 (32%) ambulances out of 520 are out of service and 138 (27%) are partially damaged, making referral for obstetric emergencies very difficult (4).

There are severe shortages of medicines and supplies, including for obstetric and reproductive health care, owing to damaged pharmaceutical infrastructure and the combined effects of economic sanctions, currency fluctuations, scarcity of hard currency, and fuel shortages. It is estimated that local production of medicines has fallen by 70% compared with before the crisis.

In addition, shortages of health staff, including for reproductive, maternal, newborn and paediatric care, are particularly acute in areas experiencing high levels of violence. Systematic targeting of health workers, facilities, and patients by armed groups continue (5). Up to 70% of the health workforce have fled resulting in severe shortages in qualified health personnel.

Access to quality reproductive healthcare services, especially emergency obstetric care and family planning has fallen as a result of damage to health facilities, depleted stocks and lack of qualified health personnel. Recent trends point towards reversal of positive reproductive health indicators that the country had been recording, which could adversely affect the reproductive health status of women across Syria.

Currently, a significant part of maternal health care has broken down. According to the 2009 family health survey, 96.7% deliveries were assisted by trained birth attendants. In Homs the community has reported an increased number of deliveries at home without any skilled trained birth attendant (4). At the other extreme, an increasing number of pregnant women are opting for caesarean sections in order to avoid the risk of not reaching health facilities in time or to avoid the risk of injury or violence (1). WHO reports that hospitals in the five most affected governorates are reporting an increasing number of elective caesarean sections as women are worried they may not reach hospitals in time, especially at night when movement is restricted with checkpoints, as well as the fact that security is unpredictable. Aleppo and Homs governorate have reported to WHO that emergency caesarean sections are being performed without anaesthesia. In one hospital in Homs 75% of babies were reported to be delivered by caesarean section (6).

Price escalations on basic food and fuel have adversely affected the ability of many Syrians to access food. Nutritional status of children is of concern and needs to be monitored.

A mid-upper arm circumference (MUAC) rapid assessment, undertaken by the Syrian Arab Red Crescent (SARC) in their Damascus clinics (235 children under 5 years), indicated that was 14% of these children were malnourished (of which 8% were moderately and 6% severely malnourished) (7). According to WHO, unsystematic detection of severe acute malnutrition cases coming from affected areas such as Rural Damascus and Aleppo is taking place. These are alarming indicators of the deteriorating nutritional status of children. Information gaps in nutritional status remain the biggest challenge. The MOH is currently conducting a MUAC screening on a national level to provide a better picture of the nutritional status of 6-59 months old children.

The devaluation of the Syrian Pound is certainly affecting the ability of Syrian families to pay for health services. The most vulnerable groups are internally displaced populations (IDPs) and the families in hard-to-reach areas. The high increase in the price of medications (25%-50%) that was announced recently by the pharmacist syndicate is also adding to the vulnerability of those families (8).

The unrest has also disrupted the national immunization programme. The shipment of vaccines to targeted areas has been complicated due to blocked roads and security issues. Numbers from previous years (2008-2011) showed an average coverage of 81.5% for all vaccination antigens which fell to 70.4% for 201 (9). There is a need to ensure access to vaccines for children against the risks of measles outbreaks particularly among under five children in crowded IDP locations, who are especially vulnerable, with sporadic outbreaks reported from a number of locations. There is also a need to reach an estimated 700 000 children under five, who missed their measles doses during last year's campaign. Numerous measles outbreaks have been reported, with the largest in northern Syria with up to 7000 cases (10), as well as in Syrian refugees in Turkey, Lebanon, Jordan, Iraq, and Egypt.

An increasing number of people are seeking psychological assistance for affected family members, including women suffering from post-partum depression (11). Studies have shown mental disorders in more than one third of the children affected by war (12), and it is likely that the Syrian crisis will have no less impact on Syrian children.

With overcrowding in public shelters, damage to water and sanitation infrastructure, and lack of waste management, diarrhoeal diseases, which overwhelmingly affect children, have significantly

increased as reported through the Early Warning Surveillance and Response Network (EWARN) within Syria (13).

There are also serious concerns about the protection of women and children and the occurrence of gender-based and sexual violence. A UNICEF Crisis Report from March 2013 reports killing and maiming, torture, arbitrary detention, sexual violence, recruitment and use of children by armed forces and armed groups. A report by the International Rescue Committee (IRC) details the prevalence of sexual violence. In the course of three IRC assessments in Lebanon and Jordan, rape was identified as a primary reason why Syrian refugees had fled the country (14).

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- 13 WHO. WHO warns of increased risk of disease epidemics in Syria and in neighbouring countries as summer approaches, 3 June 2013. Accessed 10 July at <http://www.emro.who.int/press-releases/2013/disease-epidemics-syria.html>
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IRIN/Jodi Hilton

**29.** In our 2012 report, we set a priority list of obstacles that were barriers to progress in achieving the hopes of *Every Woman, Every Child*. These obstacles are shown in Table 6. We have reviewed these predicaments and tried to construct a better framework to think operationally about their relation to women and children, and to one another.

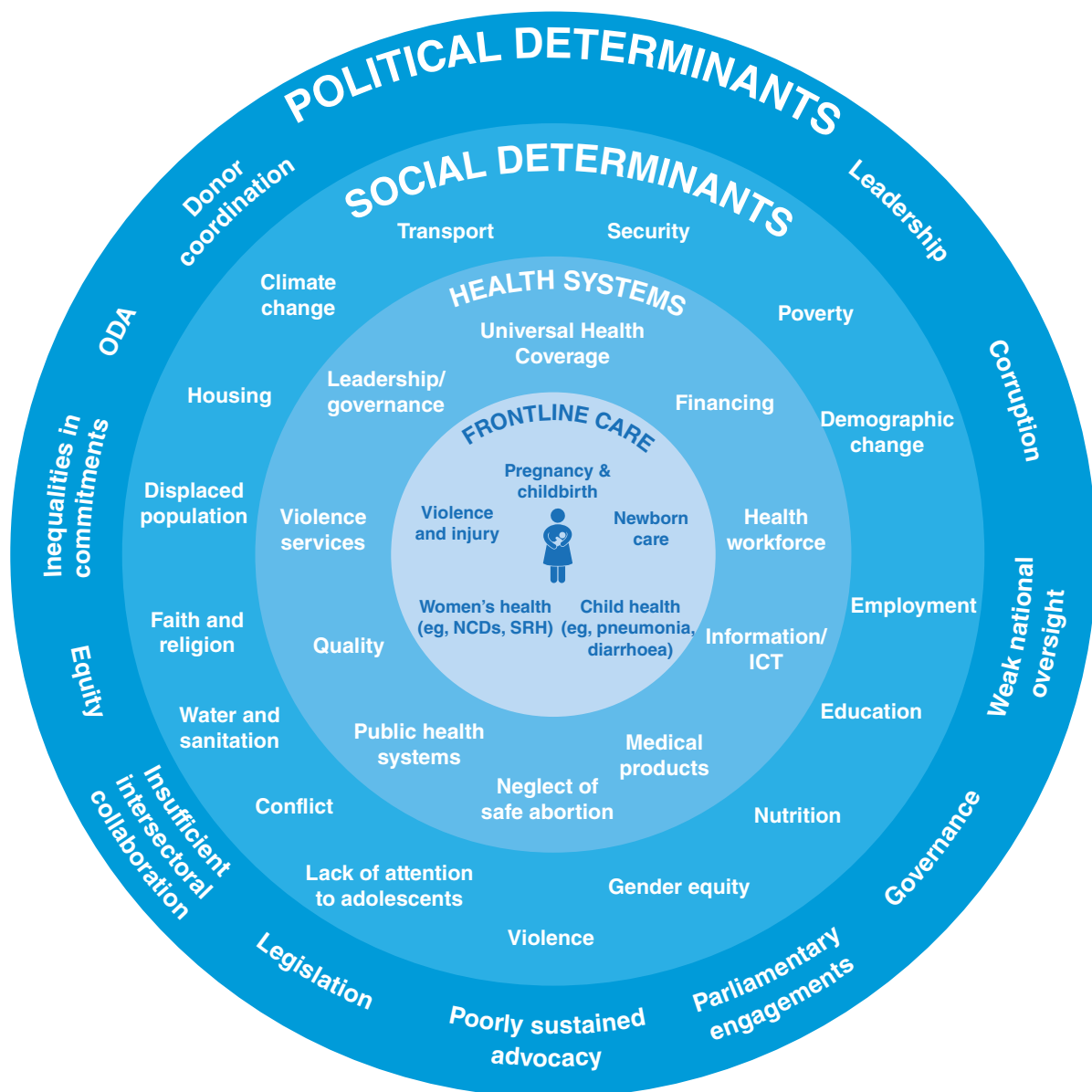
We see these challenges as forming four distinct categories of barrier to the woman and child. These categories are illustrated in Figure 11. The groupings provide a way for Global Strategy partners to think through the balance of their commitments to ensure that all determinants of women’s and children’s health are given proper attention.

**Table 6: Obstacles to achieving the goals of *Every Woman, Every Child* identified in IERG’s 2012 report**

Insufficient high-level political leadership
Inadequate financing
Lack of skilled workers
Weak health systems
Variations in coverage and coverage gaps
Weak national governance
Insufficient use of national parliaments
Inequalities in commitments
Inadequate attention to nutrition
Persistent inequity
Lack of attention to adolescent girls and gender discrimination
Pervasive neglect of safe abortion services
Inattention to conflict-affected and displaced populations
Insufficient intersectoral collaboration
Weak information technology platforms
Overburdened national oversight capacity
Poorly sustained advocacy



Figure 11. Country barriers to progress on women's and children's health



**30.** Let us conclude by returning to the principles we wish to use as our coordinates for judging progress towards MDGs 4 and 5—the inherent dignity of the woman and child and the importance of equity to their futures; respectful person-driven models of delivering care; sustainability; a life-course approach; and accountability. The available evidence supports these principles. In a recent paper, the President of the World Bank, Jim Kim, together with Paul Farmer and Michael Porter, argued that global health has been too fixated on interventions as a unit of analysis and concern (32). On the contrary, the global health community's overriding focus, they argued, should be the person, the individual for whom the health system is trying to create value in response to a particular health

predicament. The correct concern is not the commodity itself. It is the individual in a particular health, social, economic, and political context. This theoretical view has strong empirical support. Even when high coverage with essential maternal interventions is achieved, this success does not guarantee reductions in maternal mortality (33). Coverage with, and access to, life-saving commodities must run hand-in-hand with overall improvements in the quality of maternal care. This important observation is perhaps an alert to those who see the Commission on Life-Saving Commodities as offering a fast-track mechanism to improvements in women's and children's health. The evidence suggests that this may not be the case.

## Democratic Republic of the Congo: The urgent need for greater political leadership

Although classified as a post-conflict country, the Democratic Republic of the Congo (DRC) still suffers persistent civil unrest and insecurity in the east of the country. Despite an abundance of natural resources, more than 75% of its 70 million people live on just US\$ 1 per day or less (1,2). There are 0.64 health workers (doctors, nurses, midwives) per 1000 population compared with WHO's recommended minimum density of 2.28 health workers per 1000 population (3). DRC is among the 11 countries that together account for 65% of maternal deaths worldwide, with an estimated 19 000 maternal deaths in 2010 (4). DRC is making insufficient progress towards achieving MDG-5, with a maternal mortality ratio of 540 in 2010 (95% CI: 300-1100), down from 930 deaths per 100 000 live births in 1990 (average annual reduction rate 2.7%). 74% of deliveries are said to be assisted by a skilled birth attendant (5), but this indicator is probably misleading because it is based on women's perceptions rather than on competency assessment. There is a large unmet need for contraception (24%), a very high fertility rate (6.3), and the contraceptive prevalence rate dropped from 15% in 1990 to 5.4% in 2010 (5,6). The adolescent pregnancy rate is 135 per 1000 women aged 15-19 (5). Although contraceptives are widely available in a few provinces, a nationwide survey in 2012 found they were offered in only 124 out of 515 health zones (7). Obstetric services were only available in 30% of the surveyed health centres in the 124 health zones that provided family planning. DRC has committed to increasing the proportion of deliveries assisted by a skilled birth attendant to 80%, and to increasing emergency obstetric care and the availability of contraceptive services by 2015. Reducing maternal and neonatal mortality has been prioritized in national policy agendas (8,9). Improved collaboration and coordination mechanisms are in place between the Ministry of Public Health and development partners to improve essential and emergency obstetric and neonatal care (EmONC) services, and human resources for health, with a focus on midwives and family planning.

A baseline survey on EmONC services was conducted in 2012, which is allowing more effective district planning for maternal health service strengthening. There is a clear focus on increasing access to competent birth attendants. A national committee charged with revising the midwifery training curriculum is in place, and a new competency framework for midwives has been adopted. A strategic choice was made to train fully competent

midwives (Ministry of Education) and provincial midwifery schools (in 3 provinces) are now better supported. A new training programme for licensing midwives is under development. More effective in-service training strategies have been adopted and implemented, allowing nurse-midwives to become fully competent midwives. An ongoing midwifery workforce assessment, led by the MoH and the H4+, should lead to strategies to improve the selection, deployment, and retention of this workforce. The focus on family planning includes advocacy, a national conference and parliamentary debate, the revision of the reproductive health law to allow the promotion of contraceptives, and the development of a strategic plan for reproductive health commodity security. Despite the efforts invested in MDG-5, significant challenges have impeded progress including: inadequate government leadership, insufficient domestic spending on health (especially reproductive health and family planning), and lack of support from external donors (less than 5% of financial resources came from external donors in 2010) (1, 5). Other major challenges include: large insecure geographical areas; lack of essential medicines and contraceptives; insufficient and unevenly distributed health workers (especially midwives); substandard quality of care; and financial, geographical, and socio-cultural barriers (1, 5, 10).

Government leadership and continued strengthening of the health system are needed to improve the availability, accessibility, acceptability, quality, and use of reproductive health services, especially emergency obstetric care, neonatal care, and family planning. This includes improving the quality of midwives' and nurses' training, priority setting at provincial and district levels, ensuring the availability of medicines and vaccines, and improving referral systems.

1. Ministère de la Santé Publique. Cadre d'accélération de la réduction de la mortalité de la mère et de l'enfant en République Démocratique du Congo. Kinshasa: Ministère de la Santé Publique, 2012.
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3. WHO. *World Health Report 2006: working together for health*. Geneva: WHO, 2006.
4. WHO. Trends in maternal mortality: 1990-2008. Estimates developed by WHO, UNICEF, UNFPA and The World Bank. Geneva: WHO, 2010.
5. WHO. *From whom to whom? Official Development Assistance for Health*. 2nd edition 2000-2010. (WHO/HSS/HPW/2012.1). WHO, 2012.
6. Ministère du Plan, Institut National de la Statistique. Enquête par grappes à Indicateurs Multiples MICS 2010. Kinshasa: UNICEF, 2010.
7. UNFPA. Cartographie des intervenants et des interventions en planification familiale en RDC. Kinshasa: UNFPA, 2011.
8. Ministère du Plan. Enquête Démocratique et de Santé DRC 2007. Calverton Maryland: Macro International Inc, 2008.
9. Ministère de la Santé Publique. Plan National de Développement Sanitaire PNDS 2011-2015. Kinshasa: Ministère de la Santé Publique, 2010.
10. République Démocratique du Congo. Document de la stratégie de Croissance et de réduction de la pauvreté (seconde génération). Kinshasa: République Démocratique du Congo, 2011.

**31.** We conclude that there is a substantial gap between our principles and evidence about the reality of care for woman and children in countries. The way care is currently delivered frequently violates our principles. To bridge this gap, we need stronger integration and coordination of care services for women and children, including interventions that give women space to find their own voice and empower themselves, rather than make them the objects of healthcare delivery (34, 35). This is surely the essence of the meaning of sustainability. Here, the report to the iERG from the H4+ contains vitally important evidence. The H4+ comprises 6 institutions—WHO, UNICEF, UNFPA, UNAIDS, UN Women, and the World Bank. They completed a survey of 58 partner countries in 2013, of which 46 responded. Although the H4+ judged that “2012 has been a productive year for the H4+ support”, especially on improved coordination, technical assistance, and increased financing, they were candid about current predicaments and challenges. First, “the ever increasing number of initiatives and targeted efforts to improve RMNCH results while maintaining country ownership and leadership.” We drew attention to this issue in our 2012 report and made a specific recommendation to address it (about which we have more to add in our conclusions and recommendations). Second, “lack of sufficient funding to implement some of the activities included in the joint work plan.” Additional financing is seen as crucial to ensure the H4+ can deliver on its promises, as well as achieve the level of coordination sought by countries. Third, “limited human resource capacity.” Fourth, “low ownership by implementing agencies.” Fifth, “fragmentation at the H4+ agencies and government levels.” Sixth, “the need for more support for improving monitoring and evaluation systems”, a challenge that supports the finding by PMNCH that information and accountability are low priorities in commitments to the Global Strategy. And finally, “better integration of RMNCH services with HIV and malaria”, a point that makes engagement with the Global Fund all the more urgent. The H4+ makes two further revelations. One is that almost a third of countries (10 in all) rated the contribution of H4+ country teams “poorly.” Only 4 countries rated the H4+ contribution as “very satisfactory”, by which was meant that it had overachieved expectations. This is a disappointing report card for these largely UN-led teams. A second revelation

is the apparent disengagement of the World Bank, a finding that seems at odds with the Bank President’s own statements. But the evidence given to the iERG by the H4+ is that: “while generally H4+ has been applauded for its coordination role, a few countries have highlighted some room for improvement, particularly in engaging more the World Bank.” The lesson the H4+ has sent to the iERG is that they must “improve coordination in certain areas by more actively engaging other UN partners in health including the World Bank.”

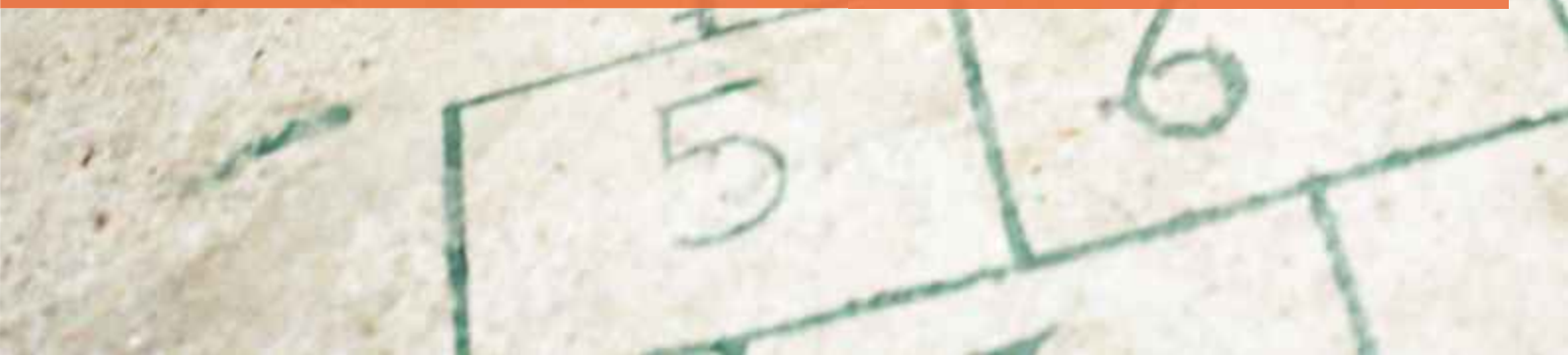
**32.** We have called this chapter a “mid-term progress report”: it is just 27 months between now (September, 2013) and the end of 2015. But what plans are in place for adolescents’, women’s, and children’s health for the post-2015 period? We have already underlined the encouragingly broad vision for women and children in the High-Level Panel’s final report on post-2015 development (7). But what does the experience of *Every Woman, Every Child* teach us about the principles that should apply in a new era of sustainable development?

- *First*, strong leadership and good governance are essential. Leadership means country ownership and strategic planning, as well as consistent commitments by development partners. Governance means effective coordination and stewardship—alignment of partners with country strategies and objectives, and harmonization between partners.
- *Second*, integration must become a much more prominent feature—delivered, not merely talked about—for global health initiatives. The creation of parallel bureaucracies that put extreme burdens on countries continues.
- *Third*, programmes and policies must be rights-based and universal, applying to everyone in all societies, with a particular focus on equity and dignity.
- *Fourth*, knowledge translation must improve. An enormous amount of new scientific evidence is generated each year, yet there are weak and inefficient mechanisms for synthesising that evidence into programmes and policies.
- *Finally*, the post-2015 era needs a better system of inclusive, independent accountability. We will return to this issue in our final chapter.





## 2. THE COMMISSION ON INFORMATION AND ACCOUNTABILITY FOR WOMEN'S AND CHILDREN'S HEALTH: DELIVERING ACCOUNTABILITY



**33.** “International aid projects come under the microscope.” This headline ran in *Nature* at the beginning of 2012 (36). It was indicative of growing political concerns that without evidence of impact the public’s support for international aid at a time of domestic financial constraint, even austerity, might diminish. Accountability for how aid money is spent is now a paramount concern among donors. Superficially, this awareness seems to be growing, despite the findings by both PMNCH and the H4+ that information, accountability, monitoring, and evaluation are being left behind by those making pledges to the Global Strategy. Formidable and seemingly bureaucratic performance and accountability mechanisms are being devised for almost every new global health initiative. But it is important to be clear about the purpose of these steps to improve monitoring, review, and action around a particular development goal. We believe that our person-centred principles offer a potentially useful ethical framework to bring performance evaluation back to its overriding purpose—namely, to improve the health and wellbeing of women and children themselves. To reiterate: those principles are—

- Delivering and protecting **equity** and **dignity** for every woman and every child
- Devising a **person-centred** approach to universal health access
- Integrating this person-centred approach into the **life-course** of women, adolescents, and children
- Ensuring that practices, programmes, and policies are equitable and **sustainable**
- Creating the appropriate **accountability** mechanisms to support these principles

**34.** The context for this framework of principles is that many organisations are now using data to hold different agencies, countries, and donors accountable for their promises and commitments. In the context of the *Every Woman, Every Child* initiative, for example, the annual report on commitments in support of the Global Strategy for Women’s and Children’s Health (37) has become an important mechanism to monitor efforts to accelerate progress towards MDGs 4, 5, and 1c. This culture change to make accountability a litmus test of any responsible organisation has been adopted by others. The Director-General of WHO, Margaret Chan, published an accountability report of her first term in 2012, entitled *Keeping Promises* (38). She wrote, “I promised results and am holding myself accountable.” The Institute of Health Metrics and Evaluation publishes an annual report on global health expenditures (39). This tracking of resources for both development assistance for health and government health expenditure is the most authoritative guide available on financing global health. And civil society organisations are joining the movement for accountability too. World Vision has now published two independent assessments of its commitments to

*Every Woman, Every Child* (40, 41). These developments are extremely encouraging. They indicate a growing public commitment to accountability. However, they might all benefit from applying two further tests. First, to what extent do these accountability tools adhere to the iERG framework of independent monitoring, review, and action? The WHO accountability report, for example, was not an independent analysis of the agency’s progress on commitments. And IHME’s independent resource tracking tool has not led to review or action by those it is monitoring. Second, to what extent do these mechanisms embed the 5 ethical principles we have set out above? We fear that without a strong moral basis, accountability may become a matter of ticking boxes on a checklist without fully appreciating that accountability means measuring tangible progress for real people in real communities. As one contributor to our call for evidence noted, “Accountability should have a human being at its heart.”

**35.** An example of the need for a rigorous approach to accountability is shown by the High-Level Panel’s strong commitment to, and interpretation of, accountability (7). The High-Level Panel saw accountability as being central to the post-2015 development era. It made several specific recommendations. First, that there needed to be a data revolution for sustainable development—more reliable data available to people and governments. They suggested a “Global Partnership on Development Data”, bringing together all interested stakeholders to develop a new global strategy “to fill critical gaps, expand data accessibility, and galvanise international efforts to ensure a baseline for post-2015 targets is in place by January, 2016.” For global monitoring and peer review, the Panel made three proposals. First, that the UN establishes a “single locus” within the UN itself to be the accountability mechanism for the post-2015 development agenda. Second, that an independent and inclusive advisory committee should be convened periodically “to comment in a blunt and unvarnished way” on progress. And third, that regional peer review could complement this global monitoring process. We fully concur with the idea of improving the quality of available data to guide policies on post-2015 development, subject to the caveats we set out below. But we disagree strongly with the idea that the UN should create the single global locus of accountability within its own institutions. This is not in the spirit or reality of independent accountability. As we described in our first report, there is an understandable tendency among intergovernmental bodies to draw positive conclusions from weak or absent data, more in the hope that progress is being made than based on any reliable evidence that this is so. We urge those who are designing the post-2015 accountability mechanisms to look again. Only a properly constituted and resourced independent

accountability mechanism can truly deliver the kind of monitoring, review, and proposals for remedy that the High-Level Panel is rightly seeking.

**36. Transparency.** The Commission on Information and Accountability set a clear goal for this year: “By 2013, all stakeholders are publicly sharing information on commitments, resources provided, and results achieved annually, at both national and international levels.” Before turning to look at the evidence for whether this goal has been achieved, it is worth reflecting briefly on the meaning of transparency. Sharing information is a necessary, but not a sufficient, condition for transparency. Transparency means little unless the data being made transparent can be used for understanding and action. Too often a pledge to be transparent can be used to obscure. Simply publishing, posting online, or providing access to large volumes of data is not being transparent. Overwhelming the user with technical information can be more disabling than enabling, a barrier rather than an aid to understanding. For our purposes, transparency must be linked to country-level accountability, including the accountability of international partners in countries—the use of information in an open, inclusive, and participatory mechanism that allows freedom to express opinions and to have those opinions listened to respectfully and taken into consideration when formulating remedies to improve the health of women and children. Essential elements of transparency include clarity and communication. Placing a premium on communication means having some consideration for the user of that information. Who is the user? And will the information provided be useful to her? If we are taking transparency in the context of women's and children's health seriously it must include being able to communicate life-saving information to an illiterate woman in a rural setting. Therefore, transparency implies a concern with building capacities to understand and use information. For the iERG, we believe that establishing arbitrary targets—eg, the number or percentage of countries that will have achieved some measure of transparency—will not help illuminate the more complex meaning of transparency we have set out here. Instead, what we are looking for is a detailed analysis country-by-country of the ways in which transparency is being achieved—access to information, but also an understanding of who the user is, the efforts made to communicate information in an understandable and usable form for women and, where necessary, children (including ways in which capacity is being built to do so), together with evidence that this communication is part of a national accountability process leading to action.

**37.** In WHO's report to the iERG, the agency concludes that although “momentum is strong”, transparency (Recommendation 8) is one of several areas where

progress needs to be accelerated. WHO identifies transparency as one of only two Commission recommendations (the other being national country Countdown events) that are labelled with the traffic signal red—that is, “this target will be difficult to achieve, or the deadline has passed without the target being fully achieved.” It is worth quoting the WHO summary in full:

*“Transparency includes several components and gradual progress is being made on each. Better monitoring of results and tracking of resources... provide the necessary data for transparency. This results in, for instance, better data on the 11 health indicators, better data and analyses to inform reviews of progress and performance, and better dissemination of information through the introduction of web-based health information systems... in over 20 countries and through the launch of regional initiatives such as the African Health Observatory. Improvements in review processes with participation of civil society, parliamentarians, and media are being made, albeit slowly. The work with the Inter-Parliamentary Union (IPU) has already led to greater involvement of parliamentarians in women's and children's health issues, but many countries lack strong civil society and media that can play a role in regular reviews and accountability processes that should lead to greater transparency and effective action following reviews.”*

This conclusion is helpful, since it goes beyond WHO's previously narrow and arbitrary targets of having 50 countries with mechanisms for sharing and disseminating data, and global partners with databases on women's and children's health. WHO reports that data on 11 key indicators for women's and children's health are available for all 75 countries through Countdown to 2015 (13). But as WHO indicates in its summary, transparency is much more than simply making data available. Data access needs to be linked with inclusive and participatory country review mechanisms that lead to action. Based on data from WHO, a total budget expenditure on Commission follow-up activities of US\$24.27 million, US\$1.08 million (4.4%) had been allocated to Recommendation 8 as of May 22, 2013 (Table 7).

**38.** WHO identifies two particular areas of weakness in efforts to improve transparency. First, activating media networks. Although PMNCH has mobilised global media across the internet, social media, television, radio, and print, too little has been done to partner with media to enhance accountability processes in countries. PMNCH has now made country media engagement a priority, beginning in Africa. The goal is to engage media to increase reporting on women's and children's health. The second area of weakness identified by WHO is lack of collaboration with civil society. PMNCH has already begun to reach out to civil society coalitions

**Table 7: Financial expenditures by work area of the Commission for Information and Accountability**

Recommendations and work streams	Total disbursements as of 22 May 2013
0.2 Country accountability self-assessment and roadmaps	3 070 961
<b>Recommendation 1: Vital Events and Health Information Systems</b>	
1.1 CRVS	2 033 264
1.2 MDSR and quality of care	2 449 277
1.3 Monitoring of results (health information systems and data quality)	2 977 827
<b>Recommendation 2: Health Indicators</b>	
2.1 Global monitoring of results	671 604
<b>Recommendation 3: Innovation and eHealth</b>	
3.1 eHealth and innovation	1 163 325
<b>Recommendation 4: Resource Tracking</b>	
4.1 Resource tracking with main indicators	2 206 167
<b>Recommendation 5: Country Compacts</b>	
5.1 Compacts in place	396 152
<b>Recommendation 6: Reaching Women and Children: Capacity to Review Spending</b>	
6.1 Capacity to review health spending	653 664
<b>Recommendation 7: National Oversight</b>	
7.1 Health sector reviews	1 099 007
7.2 Advocacy and outreach (Parliamentarians, Countdown, civil society)	1 714 706
7.3 Country Countdowns (dissemination, interpretation use)	388 900
<b>Recommendation 8: Transparency (linked to advocacy, Countdown, monitoring resources)</b>	
8.1 Transparency	1 078 899
<b>Recommendation 9: Reporting aid for Women's and Children's Health</b>	
<b>Recommendation 10: Global Oversight</b>	
10.1 independent Expert Review Group	2 470 000
<b>Overall</b>	
11.1 Project management/Secondments	1 896 000
PSC (13%)	2 483 031
<b>Grand Total (net of programme support cost)</b>	<b>24 269 753</b>

in 11 countries, including India, Nigeria, Ethiopia, and Indonesia. Three streams of work are in progress: building a public-private alliance to scale up national information campaigns for behavioural change, especially around newborn health; mobilising PMNCH's professional and civil society members to scale up advocacy and education in selected African countries; and building media capacity in budget tracking.

**39.** The evidence provided by WHO raises an important warning signal, not only that Recommendation 8 will clearly not be achieved by the target date (2013), but also that the logistical barriers to further progress on our broader definition of transparency are formidable and demand long-term engagement and investment by partners. The work of PMNCH is critically important to maintain this longer term focus. We believe that further opportunities exist to embrace and engage global and national health professional associations, local research

communities, national professional and research journals, global and national research funders, and local universities, in addition to media and civil society groups. Although creating such coordinated networks is ambitious, we believe it is an essential component of building demand for accountability in countries. We ask those partners responsible for disbursing the budget spent on Commission work to look again at the relatively small proportion dedicated to transparency. The amount being invested does not match the importance of the need.

**40.** In the iERG's first report, we had to judge progress on 5 Commission recommendations that were supposed to be delivered by the end of 2012—on health indicators (Recommendation 2), country compacts (Recommendation 5), national oversight (Recommendation 7), reporting aid (Recommendation 9), and the iERG itself (Recommendation 10). We will



### Pakistan: Conflict, disaster, and protecting maternal and child health

The United Nations High Commissioner for Refugees (UNHCR) determined that 42.5 million people were forcibly displaced worldwide in 2011, half of them being women and girls (1). Pakistan stands out among affected countries: it has about 1.5 million Afghan refugees in addition to dramatically increased internally displaced populations (IDPs) as a result of armed conflict or natural disasters during the past decade. About 0.8 million people are now registered as conflict affected IDPs; another 1.9 million were recorded as flood affected IDPs in 2012 (2). Most refugees are living in camps or specific urban settlements, whereas a significant proportion have been absorbed into local communities (3). As a result, not only are MNCH health services needed in camps, but the local healthcare system is also over-burdened.

Pakistan's health indicators for women and children are already poor. The national maternal mortality ratio (MMR) is 260 per 100 000 live births and the infant mortality rate (IMR) is 78 per 1000 live births (4). The indicators in Khyber Pakhtunkhwa, FATA, and Baluchistan, which have borne the brunt of conflict and IDPs, have worsened: Baluchistan's MMR is 785, and FATA's IMR is 86 (5).

Violent conflict has reduced healthcare utilization. The destruction of health infrastructure, and the intimidation and even killing of medical personnel, have compromised human resources (6) and discouraged people from travelling. These factors have had a glaring negative impact, for example on the polio campaign in Pakistan, leading to over 0.2 million children being persistently missed in FATA alone during each immunization campaign since 2012 (7).

Evidence from local studies show some promising results. Training local informal health workers in cultural context and providing comprehensive reproductive health services at mobile or fixed centres in refugee camps are two examples (8, 9). An innovative project integrated primary and secondary healthcare services with established tertiary care services, ensuring mobility by providing transport to the sick, in a population of about 150 000 Afghan refugees over a period of 4 years: this resulted in improved services for mothers and children, at a minimal additional cost of US\$ 0.15 per person per day (10). Another ground-

breaking scheme gave pregnant women access to healthcare facilities through an output-based aid voucher scheme in 17 IDP camps in flood-affected districts in Sindh, benefiting about 2000 women; it has emerged as a model of public-private partnership in such situations (11). On a larger scale, an entire district health system was revitalized by the PRIDE project, using primary healthcare standards, after the near complete destruction of Bagh district by the 2005 earthquake. The end-line survey showed that the infant mortality rate in the intervention area was about 40 per 1000 live births, approximately half the national average (12). These innovations, both small scale pilots and larger implementation strategies, have allowed Pakistan to overcome some of the acute strains placed upon limited resources in the wake of conflict and natural disasters.

Better understanding is needed of how best to address women's and children's health needs in Pakistan's conflict areas, with tailored and sustained approaches. The fundamental issues are: choosing the right delivery models, selecting the right aid instruments, and selecting appropriate delivery channels. The development of RMNCH programmes should involve consideration, not only of the medical and public health perspectives, but also of the underlying social and cultural determinants. A multi-sectoral approach, preparedness, locally effective innovations, and long-term commitment including efforts for rehabilitation are all needed in order to improve the health of women and children in conflict-affected areas.

1. UNHCR. *A year of crises: Global trends, 2011*. UNHCR, 2012.
2. Lennard J (ed.) *Global Overview 2012. People internally displaced by conflict and violence*. Internal Displacement Monitoring Centre, Norwegian Refugee Council, 2013.
3. Bile KM, Hafeez A. crisis in the Swat Valley of Pakistan: need for international action. *Lancet* 2009; 374: 23-24.
4. National Institute of Population Studies NP, Macro International Inc. Pakistan Demographic and Health Survey 2006-07. Islamabad, Pakistan: National Institute of Population Studies and Macro International Inc, 2008.
5. FATA multiple indicator cluster survey (MICS FATA). Government of Pakistan, 2009.
6. Another attack on polio workers. Editorial, *Express Tribune*, 12 April 2013.
7. WHO Pakistan briefs on vaccination activity Nov 2012 to March 2013. Prime Minister's Polio Monitoring and Coordination Cell, Prime Minister's Secretariat, Islamabad.
8. Miller LD, Fahima Jami-Imam MT, Wijnker J. Safe motherhood trained traditional birth attendants as educators of refugee mothers. *World Health Forum* 1995; 16: 151-56.
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10. Hafeez A et al. Integrating health care for mothers and children in refugee camps and at district level. *BMJ* April 2004; 328(3): 834-36.
11. New approaches for reproductive health initiatives: <http://www.hands.org.pk/2012/health-models/Nari%20Health%20Model>.
12. Zaman RU, Zulfiqar T et al. Evaluating primary healthcare service revitalization interventions through a knowledge, practice and coverage survey in earthquake-affected areas in Pakistan. *J Public Health Epidemiology* May 2013; 5(5): 228-36.

discuss national oversight in the next chapter. The recommendation on reporting aid was delivered in 2012: OECD-DAC will initiate a new marker for RMNCH resource tracking, starting in 2014. We will discuss the role of the iERG in our concluding chapter.

**41. Health indicators.** The 11 tracer indicators to monitor progress on women’s and children’s health are shown in Table 8. In 2012, WHO judged countries to be “on-track” to meet this goal. However, we concluded, based on the data provided to the iERG, that this recommendation would not be met. This year, WHO gives this recommendation a yellow signal light—“Progress is made to achieve the target, but a continued effort must be made to achieve it.” This conclusion is again generous. If one studies the 2013 Countdown report, one will find that only 29 of 75 countries with the highest burden of maternal and child mortality are using all 11 indicators to monitor progress. The majority of countries not fully using, or not able to fully use, the 11 indicators are in sub-Saharan Africa (23 countries). The most common indicator not being tracked is post-natal care (41 of 75 countries), followed by antenatal care (18/75), prevention of mother-to-child transmission of HIV (8/75), and met need for contraception (7/75). Data disaggregated according to socioeconomic status were not available in 17 countries. 28 countries have two or more indicators they do not track. These findings present a worrying concern that countries are unable to fully monitor, let alone review and act upon, their progress towards MDGs 4, 5, and 1c.

**42. Country compacts.** In 2012, WHO reported that countries were “making progress” towards achieving this goal, although we concluded that, judged by the original time target set by the Commission,

this recommendation had not been fulfilled. (It is important to note here that the Commission’s intended target date of 2012 was changed by stakeholders after the Commission published its final report. This change was not communicated to the iERG as an instruction to revise our terms of reference or method of evaluating the Commission’s work. The alteration in target date simply appears as a footnote in WHO’s submission to the iERG. Given the lack of substantive dialogue over this important change, we have not incorporated it into our monitoring framework.) In WHO’s 2013 submission to the iERG, they report that only 29 of 75 countries have compacts or partnership agreements between country governments and all major development partners. WHO judges progress on compacts to be yellow—progress is being made, but a continued effort is needed. Again, this is an optimistic view. There is clearly a very long way to go before most high-burden countries will be ready to sign a country compact with development partners. Encouragingly, for those that do, WHO reports that civil society groups are increasingly signing up and including specific indicators to track commitments. In a review of 9 country compacts by the International Health Partnership (IHP+), it was clear that compacts improved coordination and the quality of dialogue between partners: “Compacts can bring international legitimacy and moral strength to national aid coordination efforts.” As WHO notes, compacts are not magic bullets that act as a panacea for all partnership ills. But they can help embed accountability in country processes and planning. And with regard to the importance of compacts, one could argue that without effective country compacts in place, progress on several other Commission recommendations will be hampered.

**Table 8: 11 health indicators for women and children adopted by the Commission on Information and Accountability**

Health status indicators	
1.	Maternal mortality ratio (deaths per 100 000 live births)
2.	Under-5 child mortality, with the proportion of newborn deaths (deaths per 1000 live births)
3.	Children under 5 who are stunted (percentage of children under 5 years of age whose height-for-age is below minus two standard deviations from the median of the WHO Child Growth Standards)
Coverage indicators	
4.	Met need for contraception (proportion of women aged 15-49 years who are married or in union and who have met their need for family planning—ie, who do not want any more children or want to wait at least two years before having a baby, and are using contraception)
5.	Antenatal care coverage (percentage of women aged 15–49 years with a live birth who received antenatal care by a skilled health provider at least four times during pregnancy)
6.	Antiretroviral prophylaxis among HIV-positive pregnant women to prevent vertical transmission of HIV, and antiretroviral therapy for women who are treatment-eligible
7.	Skilled attendant at birth (percentage of live births attended by skilled health personnel)
8.	Postnatal care for mothers and babies (percentage of mothers and babies who received a postnatal care visit within two days of childbirth)
9.	Exclusive breastfeeding for six months (percentage of infants aged 0–5 months who are exclusively breastfed)
10.	Three doses of the combined diphtheria, pertussis and tetanus vaccine (percentage of infants aged 12–23 months who received three doses of diphtheria/pertussis/tetanus vaccine)
11.	Antibiotic treatment for pneumonia (percentage of children aged 0–59 months with suspected pneumonia receiving antibiotics)

**43.** The remaining four Commission recommendations do not have to be fulfilled until 2015—on vital events (Recommendation 1), innovation (Recommendation 3), resource tracking (Recommendation 4), and reaching women and children (Recommendation 6). We will summarise WHO's assessment of all four recommendations and offer our brief views to date.

**44. Vital events.** In 2012, WHO reported that countries were “on track” to meet this goal—namely, that all 75 countries had taken “significant steps” to establish civil registration and vital statistics (CRVS) systems as part of “well-functioning health information systems.” We disagreed strongly, seeing little reliable evidence that countries would meet this goal by 2015. In 2013, WHO has revised its assessment to “making progress”. However, based on the evidence WHO has provided to us, we still see this judgment as overly optimistic. Only 2 countries have so far taken “significant steps” to begin implementation of a CRVS system—Egypt and the Philippines. Commitments made in accountability roadmaps, or rapid or comprehensive assessments of existing CRVS systems, are insufficient to deliver the time-bound promise countries agreed to when they endorsed the Commission's report. This lack of progress was reflected in the concluding statement of the first Global Summit on CRVS, held in Bangkok in April, 2013: “With fewer than 1000 days until the 2015 target date for the world's MDGs, progress towards the MDGs cannot be measured without adequate information about births, deaths, and causes of death.” Although considerable regional activity has taken, and is taking, place—eg, through the UN Economic and Social Commission for Asia and the Pacific (UNESCAP), the UN Economic Commission for Africa (UNECA), and the Eastern Mediterranean Regional Office of WHO—this political will is still a long way from being turned into substantive and lasting national action. Furthermore, with the demise of the Health Metrics Network (HMN), there is now no single advocacy, coordination, monitoring, or funding body to lead global efforts on CRVS strengthening. This uncertainty could not come at a worse time. In a case study submitted to us by WHO—originally commissioned by HMN—the costs of a CRVS system in South Africa were analysed. The initial results showed the efficiency of the CRVS system: the direct cost per birth and death was only US\$3.21. A new global alliance to strengthen CRVS systems is under discussion, but, as yet, no concrete proposal has been either made or funded. There is a real danger that progress on CRVS will stall unless new leadership and financing is urgently put in place.

**45. Innovation.** In 2012, WHO reported that progress was being made to deliver this recommendation—namely, that “By 2015, all countries have integrated the use of Information and Communication Technologies in their national health information systems and health infrastructure.” By contrast, we concluded that there was insufficient evidence available to draw such an optimistic conclusion. In WHO's 2013 report, progress is again judged to have been made, although WHO acknowledges that continued efforts are needed to reach this goal. Only 6 countries have so far completed a national eHealth strategy with an RMNCH component. A Technical and Evidence Review Group on mHealth has been established to support the gathering of evidence on the role of mHealth for women and children. We were also encouraged by the commitment made and underlined in our report last year that “WHO and ITU [International Telecommunications Union] will be submitting a full report of progress, including results of their global eHealth survey.” This survey is to make use of WHO's Global Observatory for eHealth. Unfortunately, data collection for this work has been delayed. However, ITU has submitted an excellent interim report to the iERG, which sets out how ICT can help deliver the Commission's recommendations. Briefly, we will summarise their evidence. In 49 countries within the purview of the iERG, annual rates of growth of mobile-cellular subscriptions have been around 30% for the past 6 years. eHealth applications therefore provide the iERG's 75 priority countries with “an unprecedented opportunity to meet the goals set by the Commission... and, consequently, make progress towards meeting MDGs 4 and 5.” The ITU report takes each Commission recommendation and reviews the potential of e or m Health technologies, with examples, to accelerate action in countries. On vital events, health indicators, innovation, resource tracking, country compacts, reaching women and children, national oversight, transparency, reporting aid, and the work of the iERG itself, the ITU sees many opportunities for collaborative solutions. A national eHealth strategy is critical to delivering these opportunities, including attention to leadership and governance, policy and legal frameworks, and human resources capacity building and incentives. Technical considerations matter too—health information management models (centralised, decentralised, or both), IT architecture, interoperability and standards, and implementation strategy. The ITU report makes several recommendations.

- Accelerate the rate of mobile-cellular and broadband infrastructure deployment in CoIA countries
- Facilitate access to mobile-cellular and broadband services among low-income and rural populations
- Develop and adopt national eHealth policies and strategies

- Ensure the inclusion of an mHealth component in eHealth policies and strategies
- Encourage the harmonisation of eHealth standards
- Take security concerns into consideration
- Improve measurement of the impact of eHealth applications and services, particularly at the community level
- Target financial resources specifically for eHealth services
- Develop human capacity in eHealth

Despite this justifiable enthusiasm for e and m Health, we remain concerned that the lack of sustained funding, the project nature of most e and m Health programmes, and the failure to build a strong evidence base around e and m Health all hinder what should be one of the most exciting possibilities for accelerating progress for women's and children's health (42). At the Arusha Maternal Health Conference, for example, work was presented showing how mobile phone technologies could be used for health information, education, diagnosis and treatment, and improved access to services. Mobile technology enables women to be connected to the health system often for the first time, strengthening opportunities for antenatal and postnatal care, skilled birth attendance, referral, data collection, and even emergency obstetric care. The key challenge for programmes such as these is sustainability. When funding for a research study ends, so does the mHealth programme.

**46. Resource tracking and reaching women and children.** These two recommendations are linked since both are concerned with better tracking of resources for women's and children's health. The first (Recommendation 4 on resource tracking) relates to monitoring total health and RMNCH health expenditures by source and per capita. The second (Recommendation 6 on reaching women and children) is concerned with reviewing those data and linking spending to needs, results, commitments, equity, human rights, and gender. In 2012, WHO judged that progress was being made towards both goals. At that time, it was too early for the iERG to make its own judgements about progress. In WHO's 2013 report, resource tracking is judged to be "on track", while reaching women and children, although making progress, is identified as requiring continued effort. 21 countries are currently tracking RMNCH expenditures, and a further 21 countries are beginning work on health accounts. We will discuss the issue of tracking resources further in the next chapter when we take up the issue of national oversight.

**47. What can we conclude from this review of progress on the Commission's recommendations?** First, there is tangible progress in many areas of the Commission's work. But as we concluded last year, WHO and its partners need to adopt a more critical and evaluative perspective when working together to monitor progress towards the Commission's recommendations. There is a tendency to interpret activity as progress, to emphasise the positive without fully taking account of the threats and risks to sustaining what progress has been made. There is also a reticence about being a stronger advocate for areas where there is a clear country and global need, such as strengthening CRVS systems. Second, we need much more country-level detail about how the Commission's recommendations are leading to change and action. What changes are being made? How are these changes being implemented? And by whom? This descriptive detail is important. Without it, we cannot properly assess WHO's work in countries (as opposed to its assessments). In next year's report from WHO, we hope for much greater analysis of accountability processes in countries—and how the Commission's recommendations are contributing to these processes. The iERG also realises that we will need to engage more deeply with countries ourselves if we are to answer these questions fully.

**48. A further concern is equity.** Amid technical discussions about reaching the Commission's goals in the required timeframe, it is easy to lose sight of the ethical framework we have tried to construct around accountability. Equity is a crucial dimension of that ethical framework. Time and again, we learn that even when health system usage increases, there can be unanticipated adverse effects, such as increases in inequity (43, 44). The risk of social exclusion and inattention to vulnerable populations is ever present. The omission of equity considerations is not only bad for women's and children's health. It also misses an important opportunity to accelerate progress. Equity-focused initiatives themselves could lead to faster decreases in mortality, enhanced cost-effectiveness, and reduced inequality (45, 46). The evidence to support strategies for reducing inequities is growing. Several approaches have been proposed, including removal of financial barriers, targeting, and community-based initiatives to reach those in greatest need. Equity must not be an afterthought of programme implementation. It must be central to it. Recent exercises to model the effects of community-based strategies to address childhood diarrhoea, pneumonia, and undernutrition suggest important benefits for reducing deaths among the poorest population quintiles (17, 25).

**49.** This move to strengthen the ethical context in which women's and children's health is advanced has at least one further neglected dimension—quality. Much of the movement for improved women's and children's health has understandably focused on coverage, financing, and policy. The contemporary context for much of these discussions is universal health coverage or access. While the availability, accessibility, and acceptability of services for women and children is justifiably underlined, quality must be brought back to the centre of these discussions. Too often, quality is either ignored or sits at the margins of our discussions. Quality needs to be an indispensable part of our accountability framework for women's and children's health. Quality of care cannot be taken for granted. Medical mistakes can kill and harm women and children. As health systems become more complex, the risk of harm increases, making a concern for quality even more important. Quality comprises at least three dimensions—clinical effectiveness, patient safety, and the person's experience of care. These elements must underpin all actions to strengthen the health of women and children. This concern for quality also needs to be an essential part of the governance of health systems—so-called “quality-led governance.” The safety of pregnant women and newborns has been an important part of WHO's successful initiative on patient safety (47). But a major challenge has been, and remains, the lack of knowledge about the role of poor-quality, unsafe care for women and children. WHO has published protocols for measuring patient harm (48) but clearly we are still at the data gathering

stage. We simply don't have an accurate estimate of the quality of care being offered to women and children in our 75 countries of concern, at least from conventional epidemiology. To its credit, PMNCH has produced a knowledge summary drawing attention to the importance of quality issues in reproductive, maternal, newborn, and child health (49). But as yet, there is no universally accepted definition of, or indicators for, quality of care for women and children (50-53). Intervention trials show that maternal death reviews, together with education about best clinical practices, can reduce hospital mortality among women (54). Attention to quality saves lives. This important message needs to be amplified through the iERG and others to all providers of care to women and children. Quality continues to have its advocates (55), but what is now needed is something more—a technical process to embed quality (and its indicators) into reproductive, maternal, newborn, and child health programmes and accountability mechanisms. This work began in 2010 at WHO with a meeting on indicators of quality of maternal health care. But the momentum behind this effort seems to have waned. It is time to put quality back to the top of the agenda for women's and children's health among all health agencies, civil society organisations, and scientific collaborations. To help to do so, we have worked with Professor Wendy Graham from the University of Aberdeen to show how alternative forms of evidence can be used to illustrate the importance of quality for delivering health services for women and children. An introduction to this collaboration is shown in Panel 2.

## Panel 2: Quality of care: the image of accountability

*“Improving and assuring the quality of care received by all women and children in low-income countries is crucial to achieving health, equity, and human rights goals. Now is the time to seize this opportunity and to reposition quality at the centre of debates on universal health coverage and in the post-2015 development priorities. ‘Effective coverage’ should be the new narrative in these debates, meaning high and equitable coverage of quality care. This repositioning requires a fundamental shift in policy and programme mindsets to accept quality care as essential to protecting lives, wellbeing and scarce health resources.” Wendy Graham et al (55)*

Universal coverage of care for women and children is the foundation stone of the Ban Ki-moon’s Global Strategy. It is central to the emerging targets and plans for the post-2015 era. The extent to which this strategy translates into improved health and survival for women and children fundamentally depends on the quality of the care provided. Whilst universal coverage of poor quality care is clearly not the intention, assuring acceptable standards are met for all women and children requires the continuous process of monitoring, review, and action which lies at the very heart of accountability for health. Quality of care was recognized in the second recommendation of the Commission for Information and Accountability as being a crucial addition to tracking coverage. Quality of care is a multidimensional and multi-faceted component of all health systems. Capturing quality continues, however, to prove one of the greatest obstacles to ensuring attention and action remain high on agenda at all levels—from local to global.

The conventional approaches to measuring quality of care, either as an intervention to improve health or as an outcome of service inputs, have created an evidence base comprised predominantly of words, statistics, graphs, and tables. These will always be needed. But some aspects of quality are also amenable to representation through what might be called “visual evidence.” Harnessing the power of the image whilst also respecting a code of conduct on the ethics of image also presents challenges. In this 2013 iERG report, we hope to begin a conversation on the constructive use of image evidence as one of an armory of tools for accountability and action around quality of care. Here we start by using images to ask questions about the visual state of readiness of health care facilities to provide quality care at the time of childbirth — care which is effective, safe, and a good experience for care-seekers. The images used have all been taken, with consent, over the last 1-2 years in some of the 75 high-burden countries. They highlight the unacceptable realities faced by those attending for care and those working to provide care. These are also some contrasting images taken in essentially the same context to emphasize that “it does not need to be like this”. The order of the images attempts to reflect aspects of the care journey undertaken by women on reaching a health facility. We invite your reactions to these images. Please submit your comments online via [iERG\\_secretariat@who.int](mailto:iERG_secretariat@who.int). The ultimate aim is to create a movement for change using images for accountability.





Urban clinic patients' toilets—locked for the past 10 years



A broken and blocked shower



A broken sink



Lack of space in a hospital pharmacy



A dilapidated (and dangerous) hospital ward



A broken toilet

50. Finally, what has the Commission on Information and Accountability added to progress on women's and children's health? First, we can summarise that progress from the point of view of the Commission's recommendations (Panel 3). The conclusion we draw from this summary is that progress is slow and inconsistent across the recommendations. Beyond the recommendations themselves, the Commission has served to increase the overall attention paid to accountability in global health. The continued interest of the G8 and its individual members, for example,

together with new interest from the development banks, shows that accountability is a priority international concern as we move from the era of the MDGs to sustainable development. The scientific community is also investing more time and resources into better tracking (eg, coverage of interventions) in order to strengthen the first level of accountability—namely, monitoring. While this trend is welcome, it raises important questions about the nature of accountability mechanisms post-2015, questions we return to in the final chapter.

**Panel 3: Summary of global progress on implementation of the recommendations from the Commission on Information and Accountability**

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

- 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





### 3. ACCOUNTABILITY IN COUNTRIES: ENHANCING NATIONAL OVERSIGHT OF WOMEN'S AND CHILDREN'S HEALTH



**51.** Many countries have examples of success to share. In October, 2012, Nigerian President Goodluck Jonathan launched an ambitious and far-reaching new campaign, “Saving One Million Lives.” His goal is to scale up access to essential services for women and children, building on the momentum of *Every Woman, Every Child*, and the President’s own leadership of the Commission on Life-Saving Commodities. Currently, the rate of decline in under-5 mortality in Nigeria (2.6% overall between 1990 and 2011, but faster at 3.8% between 2000 and 2011) is insufficient to meet MDG-4. Similarly, Nigeria’s fall in maternal mortality ratio (2.6% overall between 1990 and 2011, although 4.3% between 2000 and 2010) will also mean the country will fail to reach MDG-5. But President Jonathan has made saving lives of women and children the “yardstick for measuring...one of the dividends of democracy.” In June, 2013, his government committed to recruiting and training an additional 2000 midwives to be deployed in rural areas. Brazil is on track to meet its MDG-4 goal. It has succeeded thanks to effective leadership and policies (creating a national health system, implementing powerful vertical programmes such as immunisations and oral rehydration, and non-health-sector programmes such as improved water and sanitation and conditional cash transfer schemes), expanded delivery (a Family Health Programme, larger health workforce, all with a commitment to equity), and strengthened accountability. Through targeted investments to strengthen its health system, Zambia has improved access to contraception, increased availability of antiretroviral drugs for pregnant women living with HIV, and reduced maternal mortality. And Ethiopia has reduced rates of childhood underweight, stunting, and wasting through an effective health sector development plan focused especially on child survival and reproductive health, a school health and nutrition strategy, improved water and sanitation, and a food security and agricultural growth programme. These successes must be studied, their lessons learned and disseminated, and the gains secured and built

upon for future generations. This is the essence of accountability—monitoring, reviewing, and remedying. It matters because success can bring unanticipated adverse effects. For example, poorly structured socioeconomic development can worsen equity (56).

**52.** Recommendation 7 of the Commission on Information and Accountability concerns 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.” As Family Care International argues in its submission to the iERG, “national oversight is key to achieving all of the CoIA recommendations on accountability for commitments to women’s and children’s health.” In 2012, WHO judged countries to be “on target” for achieving this goal. The iERG disagreed. We thought there was little reliable evidence on which to draw such an optimistic conclusion. We had seen no detailed evidence about what national oversight looked like in any of the 75 countries within our sphere of concern.

**53.** In 2013, WHO reports that 53 of 75 countries do have regular health-sector review mechanisms, and 4 more countries have reviews planned. Those countries that have not had or are not planning in 2013 to have health-sector reviews are shown in Table 9. In addition, parliaments from 50 countries are said to be engaged around issues of reproductive, maternal, newborn, and child health thanks to the work of the Inter-Parliamentary Union (about which more will be said later). But WHO does concede that its hopes for 50 countries to have held Countdown events to review progress were over-ambitious. At the time the final WHO report was submitted to the iERG (July, 2013), no country had conducted a national Countdown event. Only 10 countries are planning a Countdown event in 2013. For four of these countries, detailed case studies will be undertaken.

**Table 9: Countries that have not undertaken or have not planned to undertake in 2013 a health-sector review (based on WHO’s submission to the iERG)**

AFRO		EMRO	PAHO
Botswana		Djibouti	Guatemala
Central African Republic		Egypt	Haiti
Congo		Pakistan	Mexico
São Tomé and Príncipe		Yemen	
Somalia			
Swaziland			
EURO		SEARO	WPRO
Azerbaijan		Myanmar	-
Turkmenistan			
Uzbekistan			

**54.** A further aspect of national accountability should be resources. The iERG received important evidence from the International Budget Partnership showing that the level of budget transparency, and so accountability, in countries, including iERG countries, is poor. In some cases, such as Zambia and Nigeria, budget transparency between 2010 and 2012 has actually declined, according to the Open Budget Index. One might worry that calling for greater accountability around resources would require countries to produce new information or design new systems. The International Budget Partnership argues that this is not so. More could be done, they say, to make information already available publicly accessible online. There is also a minimum set of budget documents that should be provided:

- Executive budget proposal
- Enacted budget
- Audit report
- Citizen's budget

Over time this information should be made more comprehensive and more disaggregated. There should also be ways for the public to take part in consultations about the budget—for example, through public hearings, innovative uses of communication technologies for feedback, and surveys.

**55.** What is the nature of an annual health-sector review? There is no fixed model. Each country has a slightly different process. The WHO submission to the iERG gives examples. Burundi includes field visits with the Ministry of Health and national and international partners. Mozambique feeds data from its provinces into a national review, also involving partners and incorporating field visits. Nepal includes government departments, development partners, civil society and professional bodies, and service providers. Joint annual reviews, although sometimes of variable quality, are considered useful, especially for strengthening policy dialogue and implementation. They are based on mutual rather than truly independent accountability. But they do have the potential to improve plans and stimulate further investment in the health sector. The keys to success are strong government leadership, wide participation, a sense of openness in the discussion, and access to reliable data. Based on the evidence provided to us, although practices will differ from country-to-country, we think there are some fundamental principles that should underpin joint annual health-sector reviews. These include:

- Independence
- Political legitimacy
- Access to high-quality data
- Inclusivity (eg, of government departments, development partners, civil society organisations,

health professionals, scientists, media, private sector, and marginalised populations)

- Transparency
- Public reporting of outcomes
- Action oriented—programmatically and politically
- Audited

**56.** Work by WHO and partners on country accountability frameworks is, according to WHO, proceeding well. By May, 2013, 58 countries had completed national stakeholder consultations with the development of roadmaps for strengthening accountability. Those countries that have not yet done so are: Burundi, Chad, China, Côte d'Ivoire, Equatorial Guinea, Eritrea, Gabon, Guinea-Bissau, India, Mali, Mexico, Mozambique, Niger, São Tomé and Príncipe, South Africa, Swaziland, and Turkmenistan. (We note that roadmaps are not themselves indicators of progress. Often multiple country roadmaps exist, but are never implemented.) Despite these omissions, WHO reports higher than expected demand from countries for funding to begin the process of strengthening accountability. This higher demand is straining the resources WHO has available to meet country expectations. More financing for accountability is urgently needed. But there is an alternative view to the one offered to the iERG by WHO. Here we draw on evidence from Family Care International (FCI), one of the few active civil society organisations involved in Commission accountability activities. FCI points out that civil society was significantly under-represented at multi-country Commission's workshops held in Mali, Tanzania, Burkina Faso, and Guatemala. This absence is especially striking given the prominent part civil society organisations, and women's groups in particular, have played globally in shaping the health agenda, notably around reproductive health. The impression this leaves us is that opportunities for civil society participation are curtailed by governments and WHO. As FCI observed: "the [Country Accountability Framework] for some countries was completed by WHO and the Ministry of Health prior to the COIA workshop, effectively eliminating opportunities for [civil society organisation] participation in identifying priorities for national action... We encourage the iERG to clarify with all partners—and specifically with WHO, Ministries of Health, and other H4+ partners—that all COIA accountability processes, including identification of priorities...and finalisation and implementation of the national roadmap, are intersectoral and should include civil society partners." This exclusion matters since FCI has also observed limited awareness in countries about the Commission and the iERG. Stronger civil society engagement could overcome this invisibility. FCI makes several specific proposals

## Niger: Better data = better programmes

Niger's success in improving child survival was documented in 2012, showing a 43% decline in under-5 mortality between 1998 and 2009 (1). The Ministry of Health achieved this by: increasing geographic and financial access to health services, mass campaigns for vaccination, vitamin A supplementation and insecticide-treated nets (ITNs) for the prevention of malaria, and the expansion of nutrition programmes. There were no major changes in levels of mothers' education or GDP, suggesting that the mortality declines resulted from rapid and sustained increases in coverage of high-impact interventions.

Niger was able to document its success because the National Institute of Statistics (INS) conducted high-quality household surveys at frequent intervals throughout this period. INS has continued this work, moving beyond national-level analyses to understand and explain regional patterns. Sample sizes are too small to support interpretation in three of the country's eight regions; however, the results from the remaining five regions, representing over 85% of the country's population, raise important questions.

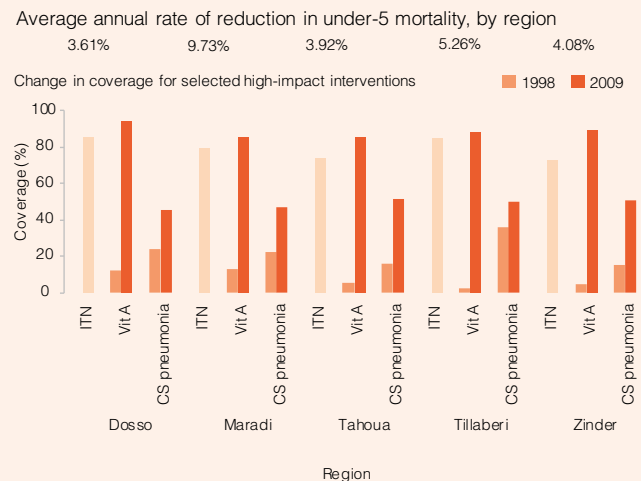
Figure 1 shows the average annual rates of decline in under-5 mortality, and changes in coverage for three selected high-impact interventions between 1998 and 2009 for the five regions. Rates of mortality decline varied widely by region, from 9.73% per year in the Maradi region (reflecting a decline from 304 under-5 deaths per 1000 in 1998 to 99 under-5 deaths per 1000 in 2009) to 3.61% per year in the Dosso region (from 229 in 1998 to 153 in 2009). Coverage rates for the three interventions shown in the figure, as well as other high-impact interventions addressing main causes of child deaths, showed considerable variation in 1998, and were not substantially different by 2009. The INS team is working to test alternative explanations for this finding. One hypothesis is that the higher baseline mortality due to causes addressed by the interventions in Maradi region rendered the interventions more effective in achieving population impact, lending support to calls for greater attention to population subgroups with higher burden and lower access to services (2). Another is that the quality of services was particularly high in the Maradi region. An important concern is that recent instability in West Africa may reduce financial inflows to health programmes for women and children, thereby slowing survival gains.

Countries need more and better data, particularly at subnational level, to understand and improve

their programmes. The global public health community needs more and better data to unravel the relationships between coverage and quality, using measurement strategies that link population-level coverage, measured by household surveys, to data on service quality generated from observation-based assessments of service provision (3). The accountability agenda is focusing new attention on measurement and data use, especially by scientists living and working in countries, like Niger, where understanding the dynamics of effective programming is a matter of life and death.

The publication of the Niger case study in *The Lancet* (1) generated enormous interest from countries and their development partners. Countdown to 2015 for Maternal, Newborn and Child Health has established a programme of similar case studies focused on a broader range of country successes and challenges across the RMNCH continuum (4). A prerequisite for being selected is the availability of adequate data, and Niger provides an important object lesson in the need to establish and maintain high-quality data generation activities as an integral part of public health programmes.

## Changes in under-5 mortality and coverage of high-impact interventions, 5 regions in Niger, 1998-2009



1. Amouzou A, Habi O, Bensaid K and the Niger Countdown Case Study Working Group. Reduction in child mortality in Niger: a Countdown to 2015 country case study. *Lancet* 2012; 380: 1169-78.
2. Chopra M, Sharkey A, Dalmiya N, et al. Strategies to improve health coverage and narrow the equity gap in child survival, health, and nutrition. *Lancet* 2012; 380: 1331-40.
3. Bryce J, Arnold F, Hancioglu A, et al. and the CHERG Working Group on improving Coverage Measurement. Measuring coverage in Maternal, Newborn and Child Health: New findings, new strategies and recommendations for action. *PLoS Med* 2013; doi/10.1371/journal.pmed.1001423.
4. Requejo J, Bryce J, Victora C, Deixel A on behalf of Countdown to 2015 for Maternal, Newborn and Child Survival. Accountability for Maternal, Newborn & Child Survival: The 2013 Update. WHO and UNICEF, 2013.

regarding national accountability processes and the development of country accountability frameworks:

- Make accountability mechanisms more inclusive: all Commission accountability processes should involve civil society partners
- Ensure a focus on human rights and equity: civil society can make sure vulnerable and traditionally excluded groups are included or represented
- Build the evidence base: evidence to support advocacy is essential
- Ensure visibility and transparency of national accountability processes: civil society organisations see their primary role as monitoring implementation

**57.** A critical partner in work on national accountability is the Countdown to 2015 group. Countdown is a global movement launched in 2003, involving scientists, policymakers, public health workers, parliamentarians, UN agencies, donors, and civil society. Countdown aims to make available annually the best evidence on reproductive, maternal, newborn, and child health intervention coverage and equity, together with related policy, health systems, and financial determinants, for each of the 75 Countdown countries. Countdown also aims to build capacity within these countries for the collection, quality assessment, and use of data related to maternal and child health policies and programmes. This objective includes increasing participation of in-country researchers on products and technical support. Although Countdown is highly visible globally, it recognises that real change relies on country level use of data for policy and programme action, perhaps especially through national oversight and accountability mechanisms. One way of achieving this objective is through country Countdowns: to promote the use of evidence for national and subnational decision making, to increase political awareness of the needs of women and children, to strengthen data gathering, to monitor resource flows for women's, adolescents', and children's health, to increase advocacy for women and children, and to encourage rigorous accountability processes. Country Countdowns have so far taken place in Senegal (2006), Zambia (2008), and Nigeria (2011). One detailed Countdown case study of Niger was published in 2012 (57). Involvement of the country's Ministry of Health is critical to success, and subsequent action.

**58.** Although no country Countdowns have taken place in 2012 or the first half of 2013, several countries are well advanced in planning their own Countdown event—Kenya, Bangladesh (on maternal mortality), Rwanda, Uganda, Zambia, Burkina Faso, and Sierra Leone. Several in-depth case studies are in process or planned in follow up to Niger—

Afghanistan/Pakistan, Ethiopia, Malawi, Peru, and Tanzania. Although we recognise that country Countdowns are ambitious activities, absorbing considerable time and resource, we believe they can play a catalytic part in promoting national accountability mechanisms for women's and children's health. They deserve wide support and investment, and greater attention by Countdown.

**59.** A further important partner in strengthening national oversight is the Inter-Parliamentary Union (IPU). The IPU submitted evidence of its work to the iERG and we briefly summarise it here. In 2012, the IPU passed a resolution entitled: "Access to health as a basic right: the role of parliaments in addressing key challenges to securing the health of women and children." The resolution committed the IPU to annual reporting of the progress being made by parliaments on their country's performance on women's and children's health. Their first accountability report is published in 2013. For this initial study, selected parliaments were surveyed, and encouraging findings were reported: political awareness and commitment to women's and children's health was high. The IPU resolution seemed to have played at least some part in strengthening that awareness. In Bangladesh, a new parliamentary caucus around reproductive, maternal, and child health has been created. Mauritania has established a commission of parliamentarians working for the health of mothers and children. But the report also points to much more that parliaments can do—using laws to protect women and children from violence, ensuring more effective national oversight of women's and children's health, and making sure neglected issues (health information systems, universal health access, reproductive health services) are addressed. The IPU will publish a handbook on women's and children's health for parliamentarians in late 2013. We commend their advocacy and work on behalf of women and children worldwide.

**60.** So far, we have been discussing national oversight and accountability without any explicit reference to human rights. This omission needs to be corrected. In 2013, an important report was published examining whether human rights tools had any impact on women's and children's health (58). What is a human-rights-based approach to health? The goal of a rights-based approach is the achievement of the highest attainable standard of health, which includes not only the right to health care but also the right to expect action on the underlying determinants of health. Seven principles underpin a rights-based approach to health: the **availability, accessibility, acceptability, and quality** of services; **participation; equality and non-discrimination**; and **accountability**. A human

## Guatemala: Resources for maternal health—Rights or privileges?

In 2009, the Center for Economic and Social Rights (CESR) and the Instituto Centroamericano de Estudios Fiscales (ICEFI) published a report that focused, *inter alia*, on realising the right to maternal health in Guatemala (1). The report incorporated different techniques for measuring compliance with the principles and standards related to the right to health, framing them around four levels of analysis: outcomes, policy efforts, resources, and assessment (2).

The report found that Guatemala had some of the worst and most unequal maternal mortality outcomes in Latin America, with indigenous women three times more likely to die during childbirth or pregnancy than non-indigenous women. Over 50% of deaths were caused by post-partum haemorrhaging (largely preventable with skilled care). In terms of policy efforts, despite an exemplary legal framework, as well as strong, normatively grounded policies for maternal health on paper, the report found serious issues in practice with the availability, accessibility, cultural acceptability, and quality of services, such as emergency obstetric care and adolescent contraceptive services.

These problems related to inadequate financial investment in the health sector: allocations to health had remained at about 1% of GDP since the end of the war in 1996. Distribution of per capita health spending was also highly inequitable, with three times more money going to the capital city than to Quiché, the poorest region. Low social spending was directly linked to the country's low tax base, which was mostly generated through regressive indirect taxes that disproportionately affect the poor, while the country's business sectors enjoyed unparalleled tax privileges and incentives. The report concluded that by not doing all it reasonably could to generate the resources potentially available to improve maternal health, the state was in effect discriminating against poorer indigenous women.

Framing maternal mortality as a human rights issue, and linking it explicitly to fiscal policy, gave renewed force to civil society demands for both health and fiscal reforms. The Government welcomed the findings and pledged to introduce

progressive tax and budget reforms, but these were thwarted following opposition from conservative business sectors (3). Nevertheless, the approach taken in the report was embraced by other bodies, including the Observatorio de Salud Reproductiva (OSAR), a network of 21 supervisory bodies set up by Congress in association with civil society organisations that monitor maternal health at the departmental level (4).

Members of Congress linked to OSAR presented a new maternal health law, which was adopted in September, 2010 (5). The law affirms the right to health without discrimination, and prioritises efforts to reduce maternal mortality among indigenous women living in rural areas. Importantly, it mandates that necessary resources be provided, including through earmarked funding for reproductive health generated from specific direct taxes. The law also established a multi-sectoral commission, made up of civil society and governmental agencies, to monitor the law's implementation (6). The commission convened its first meeting in early 2013.

Rights-based efforts to monitor comprehensive, timely data, and to review both resources and results, have the potential to greatly improve transparency and accountability in the implementation of maternal health policy. However, they must lead to action. Competing issues on the political agenda have slowed progress in implementing the 2010 law, and OSAR has had to focus much of its efforts on raising awareness. In particular, the comprehensive fiscal reforms that would enable the government to invest adequately in maternal health are still needed; ICEFI continues its advocacy efforts to this end (7).

1. CESR and ICEFI. ¿Derechos o privilegios? El compromiso fiscal con la salud, la educación y la alimentación en Guatemala. CESR and ICEFI, 2009. Available at: <http://cesr.org/downloads/Derechos%20o%20Privilegios%20Final.pdf>.
2. CESR. The OPERA Framework: assessing compliance with the obligation to fulfil economic, social and cultural rights. CESR, 2012. Available at: <http://www.cesr.org/downloads/the.opera.framework.pdf>.
3. Fuentes Knight JA. Rendición de Cuentas. Guatemala, F&G Editores, 2011.
4. See <http://www.osarguatemala.org/>.
5. Congreso de La República de Guatemala. Ley para la Maternidad Saludable, Decreto Número 32-2010. Available at: <http://www.oj.gob.gt/es/QueEsOJ/EstructuraOJ/UnidadesAdministrativas/CentroAnálisisDocumentaciónJudicial/cds/CDs%20leyes/2010/pdfs/decretos/D032-2010.pdf>.
6. Ministerio de Salud Pública y Asistencia Social. Reglamento de la Ley para la Maternidad Saludable, Acuerdo Gubernativo 65-2012. Available at: <http://www.osarguatemala.org/userfiles/acuerdo%20gubernativo%2065-2012.pdf>.
7. ICEFI and UNICEF. Boletín No. 9 ¡Quiero crecer con mamá! Estudio sobre los mecanismos, costos y formas de financiamiento para disminuir la mortalidad materna en Guatemala, 2013-2022. ICEFI and UNICEF, 2012. Available at: [http://www.unicef.org/guatemala/spanish/recursos\\_20207.htm](http://www.unicef.org/guatemala/spanish/recursos_20207.htm).

rights perspective emphasises the importance of the process adopted in achieving a certain outcome, as well as the outcome itself. In the recent and powerful report, four countries were used as exemplars for what human rights might achieve for women and children—3 of these countries are relevant to the iERG: Nepal, Brazil, and Malawi (the fourth country studied was Italy). Two questions were asked. First, has a rights-based approach explicitly shaped the laws, policies, and programmes related to women's and children's health? Second, if so, what is the evidence that these explicitly human-rights-based interventions have contributed to women's, adolescents', and children's health?

**61.** The conclusion these authors draw from the data available to them is that human rights have shaped laws, policies, and programmes in women's and children's health. While it is impossible to prove direct cause and effect, the authors of the report argue that there is "plausible evidence" that human rights tools have contributed to improvements in health for women and children. They highlight one critical element of this success: participation. There was evidence of an association between women's participation and positive health outcomes. An enabling environment is also important. High-level political leadership and advocacy and an active and engaged civil society are both important. Governments have a crucial part to play by ratifying international human rights treaties, recognising the right to health in national constitutions, and forming rights-driven national oversight bodies.

**62.** The health and human rights communities have much to learn from one another, a collaboration that so far remains largely neglected. Human rights instruments are powerful and legally binding moral statements signed by governments worldwide. The Convention on the Rights of the Child (59) recognises (in Article 24) "the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health." General Comment 14 on the International Covenant on Economic, Social, and Cultural Rights not only sets out the commitment to availability, accessibility, acceptability, and quality of services, but also explicitly refers to the right to improvements in child and maternal health, and sexual and reproductive health services (60). In addition, human rights tools can have great practical value—eg, the technical guidance provided on application of a human-rights-based approach towards reducing preventable maternal morbidity and mortality, which was adopted by the Human Rights Council in September, 2012 (61). Rights-based frameworks have been applied in many related areas too—eg, around the right to food and nutrition (62). The legal

architecture that human rights provides to health could contribute to efforts to scale up action on behalf of women and children. Slowly, the health community is becoming aware of these opportunities, although they remain incompletely realised (63-65).

**63.** In 2013, a further opportunity arose to continue to link health with human rights—an annual day discussion on the rights of the child at the Human Rights Council in March. The Office of the High Commissioner for Human Rights set out the priorities for children worldwide within a framework of human rights (66). The Human Rights Council, led by Uruguay, Austria, and Ireland, debated their report and adopted a resolution on a child's right to health. WHO has been asked to prepare a study on under-5 mortality as a human rights concern. That report will be published in September, 2013, hopefully precipitating further action by the Human Rights Council and its member states. In February, 2013, the UN Committee on the Rights of the Child adopted a General Comment describing the meaning of the child's right to the highest attainable standard of health. This General Comment sets out the core obligations of governments and others to ensure that all children receive the care they need to survive and enjoy health. A Group of Partners—comprising WHO, UNICEF, World Vision, and Save the Children—now have the responsibility to disseminate the General Comment and ensure that governments apply the document in their child health strategic planning. A workplan and funding proposal are in preparation to do so.

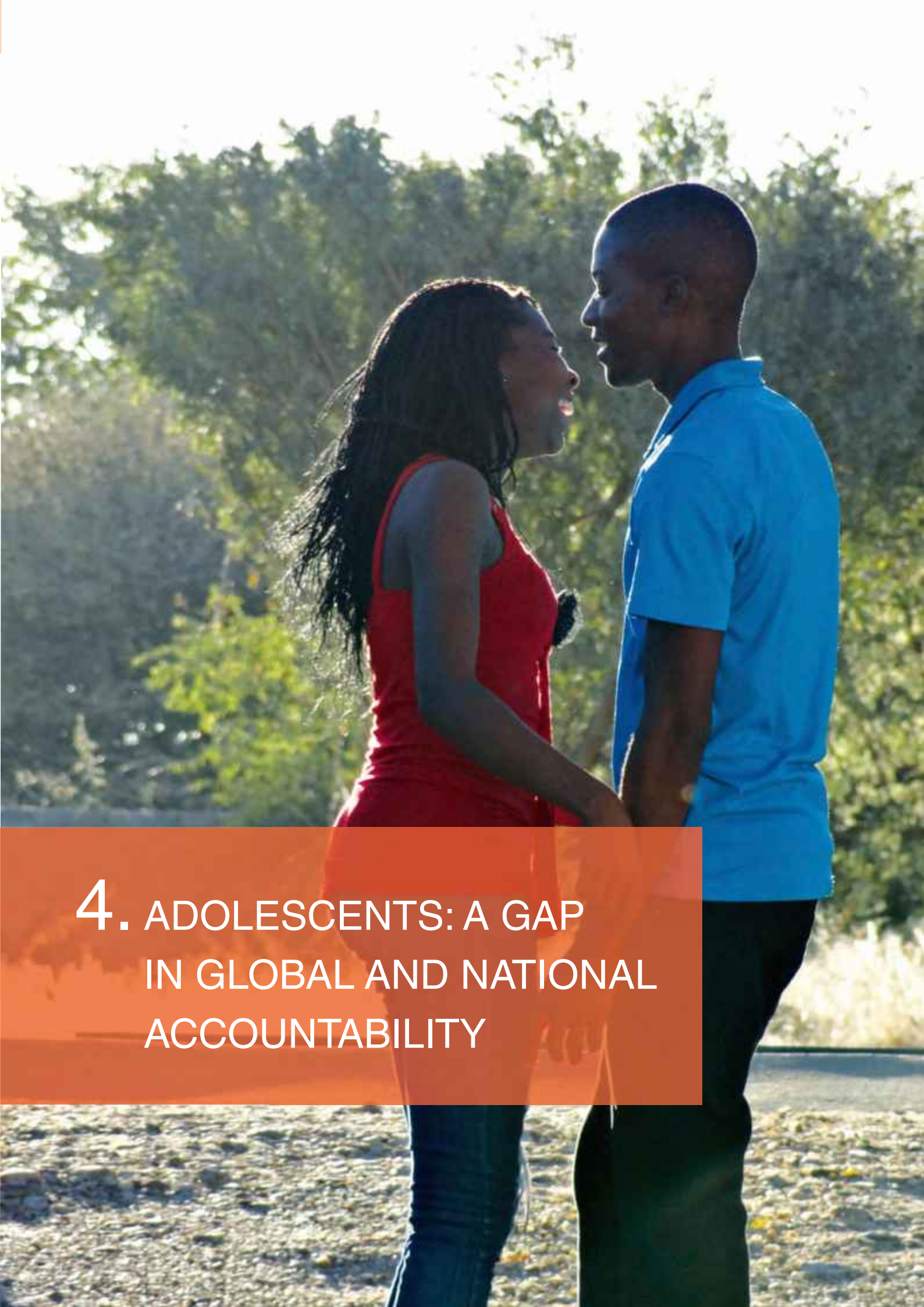
**64.** The iERG was born out of human-rights-based approach to health. Our independent accountability framework of monitor-review-remedy is taken explicitly from the human rights community within the UN system. We believe the reproductive, maternal, newborn, and child health community could do a great deal more to bridge the gap between its work and that of the human rights community. The recent work by WHO shows that a convergence of these communities has the potential to produce tangible progress for women's and children's health.

**65.** We conclude this chapter with a summary of what the evidence presented here suggests to us about the future of national oversight mechanisms. It is clear that although work is progressing on strengthening national oversight and accountability mechanisms, that work needs to be accelerated, not only for the purpose of moving faster towards MDG goals and targets, but also for preparing countries and partners for what follows the MDGs, which will almost certainly continue to include ambitious commitments to women and children. Our assessment is that

national oversight has been insufficiently prioritised by countries and partners in work to accelerate progress for women's and children's health. We have set out several crucial methods that could help—joint annual health sector reviews, greater engagement by civil society and parliaments, country Countdowns, and the application of human-rights-based approaches to women's and children's health. We believe we need further analyses to understand better how oversight mechanisms lead to change and action in countries. Currently, this evidence is largely lacking. The Countdown country case studies provide potentially the most powerful means to examine the links

between accountability and outcomes. We also want to see ways in which country oversight processes can be better connected to global tracking of results and resources. Currently, there is often a disconnect between global impressions about progress on accountability and the reality in countries. In an iERG consultation with NGOs in Geneva in May, 2013, and during a stakeholder meeting in Kuala Lumpur, also in May, 2013, we were encouraged to focus on national oversight as a potential recommendation, taking special account of the role of civil society. The zone between the technical and the political is always fraught with difficulty. But we shall return to this issue in our concluding chapter.





**4. ADOLESCENTS: A GAP  
IN GLOBAL AND NATIONAL  
ACCOUNTABILITY**

**66.** The immense vulnerability of adolescent girls was brought into sharp relief in 2013 with two horrific episodes of violence, separated by geography but united in meaning. Malala Yousafzai, aged 15, was shot and almost killed when a Taliban gunman boarded the bus she travelled on to school and attacked her and two other girls. The reason for this brutal attempted murder, the Taliban said later, was to teach her a “lesson”—the lesson being that they would not tolerate a young woman seeking education, independence, and freedom. Thanks to her bravery and determination, together with heroic surgery, she lived and is now writing a book about the 57 million children in the world not at school. Meanwhile, the gang rape, beating, and murder of a 23-year-old student in Delhi by 6 men in December, 2012, not only shocked a nation but also mobilised a world, at least temporarily, to protest against the violence women suffer every day in all societies. Stories of violence against adolescent girls and young women scar news bulletins daily. Often the experience of violence against women is emphasised in zones of conflict (67-68). While conflict does substantially increase the risk of rape, sexual exploitation, and violence, it would be a mistake to think that such acts are confined to areas of war. As the cases of both Malala and the young Indian woman show, the threat of sexual violence is always present (69). The Human Rights Council has drawn attention to the widespread failure of governments to take violence against women seriously (70). But this failure is symptomatic of a wider problem—the omission of adolescents from almost all discussions of women’s and children’s health and rights. In December, 2012, UNFPA and the Indonesian government convened the Global Youth Forum as a follow up to the programme of action of the International Conference on Population and Development. The goal was to generate ideas for key areas of investment for young people’s health and rights post-2015. Over 3000 young people and others took part. They produced a historic set of recommendations: programmes and policies to ensure access to sexual and reproductive health and rights; gender equality; safe, legal, and accessible abortion; and support for meaningful youth participation in programme and policy design and development. But as the PMNCH report to the iERG points out, priorities for adolescents are invisible in both the Secretary-General’s Global Strategy and the Commission on Information and Accountability. Adolescents are marginalised, frequently living in poverty, and with fewer opportunities than many groups in society. They have unmet health needs, and yet must often endure health systems that are unfriendly to their expectations, do not fully meet their needs, or do not recognise them as holding particular rights. Changing this reality is especially crucial given the fact that pregnancy and childbirth related

complications are the leading causes of death among girls aged 15-19 years. Adolescents could perhaps benefit most from our principles of dignity, equity, a person-centred and life-course approach to their care, sustainability, and accountability.

**67.** What do we mean by adolescents? The official UN definition is that adolescence extends from 10 to 19 years of age, overlapping with a period designated “youth” (15 to 24 years). Adolescents possess special features and endure distinct risks:

- There are 1.2 billion adolescents in the world, more than double the number in 1950, and the largest number the world has ever known
- Almost 90% of adolescents live in low- and middle-income countries
- 16 million girls aged 15-19 years become pregnant every year (accounting for 11% of all births worldwide)
- Girls are more likely to have engaged in early sex in adolescence but also less likely to have used contraception
- Unsafe abortions pose high risks for adolescent girls
- Children born to adolescent girls have a greater risk of morbidity and mortality than children born to older parents
- Young people account for about 40% of new HIV infections, with adolescent girls especially vulnerable
- Tobacco consumption and drug and alcohol use are growing health risks for adolescents
- Adolescent girls are more prone to undernutrition than adolescent boys
- Across low-income countries, girls still lag behind boys in secondary school attendance
- In 2009, around 50% of the world’s adolescents lived in urban areas; that proportion will grow to 80% by 2050
- 14 million girls under age 18—or one girl every 2 seconds—are married each year
- The prevalence of female genital mutilation (FGM), although declining, is still widespread in 29 countries
- Child labour is declining, but still affects a large number of adolescents
- Adolescents are victims of trafficking into forced labour, marriage, and sex work
- Adolescent health has improved at a much slower pace than that of younger children
- Fertility among adolescents has shown little decline even in countries where steep declines have occurred among adult women
- Worldwide, up to 50% of sexual assaults are committed against girls under 16 years

**68.** PMNCH reports that over a quarter (26%) of commitments to the Global Strategy relate to adolescent health (to 69 countries in all). Low- and middle-income countries make the largest contributions to these commitments (37%), with the NGO sector adding a further 32%. There is a disappointing direct commitment from many multilateral organisations, foundations, and the private sector. Incredibly, adolescents are simply not on the political radar of donors. The major areas where commitments are made include:

- Adolescent sexual and reproductive health policies
- Health services sensitive to adolescent needs
- Reducing early and forced marriage
- Improved access to education
- Reducing violence against girls
- Increasing youth empowerment

Geographically, these commitments are focused on sub-Saharan Africa and Asia-Pacific, even though Latin America also has persistently high rates of adolescent pregnancies and unsafe abortions. The countries with the most and least commitments to adolescent health are shown in Table 10. PMNCH points out that these commitments largely omit reducing unsafe abortion or coerced sex. There is also a surprising inattention to skilled antenatal, childbirth, and postnatal care. Overall, there seems to be a much greater number of commitments dedicated to prevention rather than treatment.

**69.** Positively, since the London Family Planning Summit in 2012, more commitments on access to contraception seem to have been made to adolescents. Examples of commitments include:

- Benin: development of adolescent sexual health policies
- Malawi: development of a comprehensive sexual and reproductive health programme
- Mali: implementation of a national strategic plan for improving adolescent reproductive health
- Bangladesh, Ethiopia, Kyrgyzstan, Madagascar, and Tajikistan: provision of youth-friendly services
- Niger, Bangladesh: implementation of a minimum legal age for marriage
- Burkina Faso: enforcing laws against early and forced marriage
- Sudan: advocacy to eliminate early marriage
- Liberia: increased girls' education
- Burkina Faso: enforcing laws against FGM
- Sudan: advocacy against FGM
- Senegal: community mobilisation to increase involvement of young people in family planning

**70.** PMNCH identifies 3 key enablers to improve adolescent health.

- First, meaningfully engaging with young people in the development policies and programmes that affect their lives. Adolescents themselves have an overlooked, yet powerful, part to play in determining their own health outcomes. Only by engaging adolescents can one get a better insight into the issues they value most. One example of how this idea is operationalised is shown by IPPF, which requires 20% of its governing board members to be under 25 at global, regional, and national levels in 150 countries. There are different levels of engagement to take into account too—information providing, consulting, shared decision-making and co-management, and full autonomy.

**Table 10: Countries with most and least commitments to adolescent health**

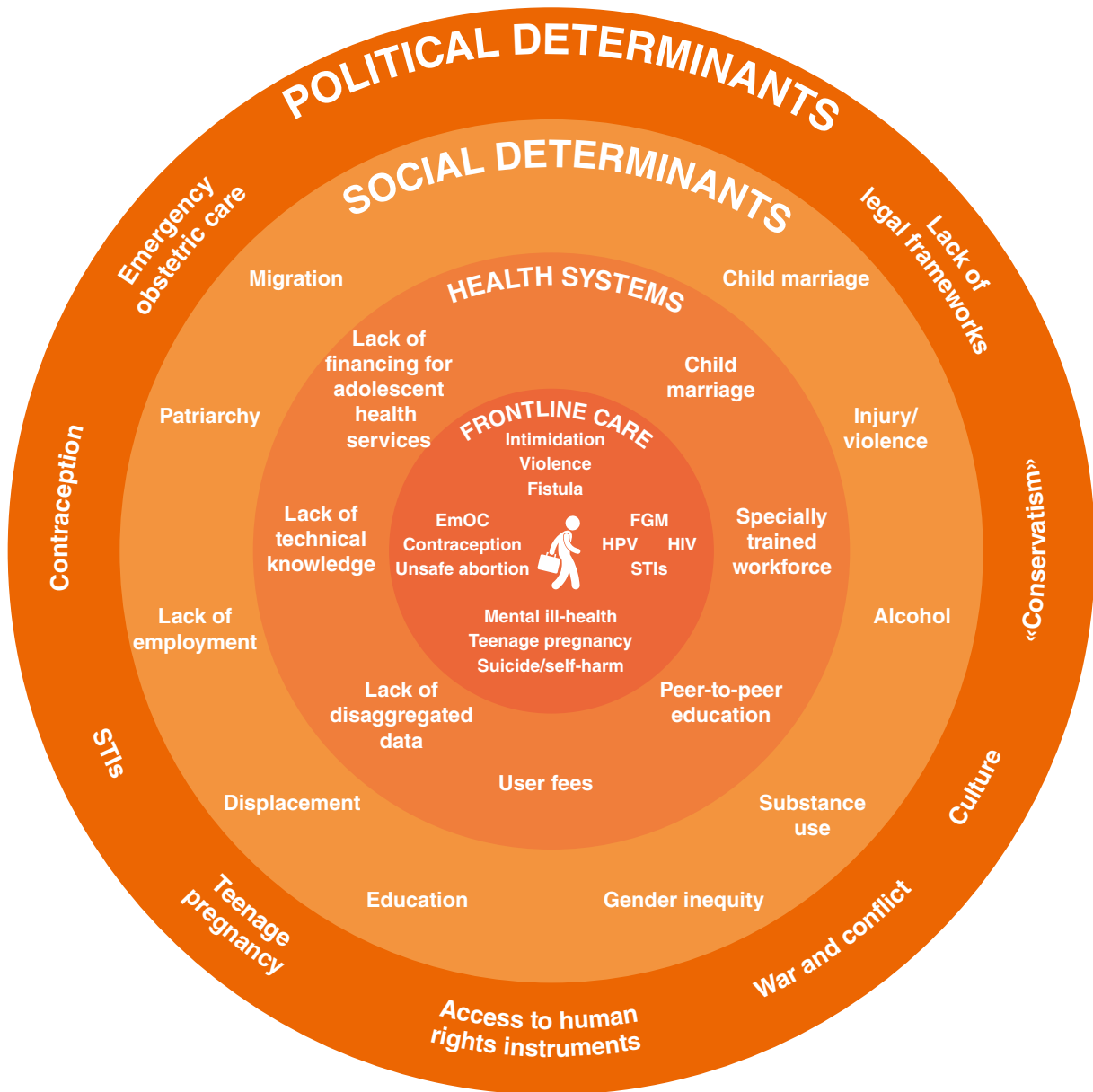
Country	Number of commitments	Population of adolescents aged 10-19 years (thousands), and as % of total population (2010)	Adolescent birth rate per 1000 females aged 15-19 years (2000-10)
<b>Top</b>			
<b>Tanzania</b>	11	10,198 (23%)	116
<b>Uganda</b>	10	8,063 (24%)	159
<b>India</b>	10	242,991 (20%)	45
<b>Nigeria</b>	9	35,326 (22%)	123
<b>Kenya</b>	9	9,135 (23%)	106
<b>Bangladesh</b>	9	31,514 (21%)	133
<b>Bottom</b>			
<b>Azerbaijan</b>	0	1,477 (16%)	41
<b>Turkmenistan</b>	0	1,031 (20%)	21
<b>Iraq</b>	0	7,262 (23%)	68
<b>Equatorial Guinea</b>	0	151 (22%)	128
<b>Gabon</b>	0	344 (23%)	144
<b>Congo</b>	0	888 (22%)	132

Source: The PMNCH 2013 Report—analysing progress on commitments to the Global Strategy for Women's and Children's Health. PMNCH, 2013.

- Second, using ICT and digital and social media tools. These tools are a highly effective channel to reach adolescents. But they also provide a means for adolescents to engage with one another. Social media have the potential to accelerate change among communities, whether in knowledge or behaviour.
- Third, linking adolescent health to other important issues of concern, such as maternal and newborn health, family planning, and access to key protective technologies, such as the HPV vaccine.

**71.** Taking this evidence into account, it is clear that adolescents face a unique set of challenges in terms of their health. We have used the framework we developed earlier for women and children to try to capture these challenges and threats (Fig 12). Linking with our analysis of the benefits of a human-rights-based approach to women’s and children’s health and to accountability in Chapter 3, we see adolescents as a group where the intersection of human rights and health principles could have special value—eg, preventing early and forced marriage and forced sex, addressing violence against young women, recognising their right to information and comprehensive sexuality education, and removing barriers to access contraception.

**Figure 12. Country barriers to progress on adolescent health**



**72.** The omission of adolescents from the reproductive, maternal, newborn, and child health continuum of care is perplexing and mysterious. Recognising the importance of adolescent health is not new—one can trace it back to the 1994 International Conference on Population and Development and the resulting Programme of Action (“To promote to the fullest extent the health, wellbeing, and potential of all children, adolescents, and youth as representing the world’s future human resources”). But interest in adolescent health is now making its mark, at long last. In 2007, for example, the neglect of adolescent sexual and reproductive health was signalled out as cause of serious and urgent contemporary concern (Panel 4) (71). But still these pleas for action have been too often ignored by politicians and policymakers.

**73.** The global effort to put adolescents at the center of women’s and adolescents’ health was led by UNFPA after the 1994 Cairo conference. More recently, UNICEF has led work to put adolescents at the centre of the continuum of care (72). In its *State of the World’s Children 2011* report, UNICEF described adolescence as an “age of opportunity.” The report included adolescent voices and framed a new global campaign for adolescent health around human rights. UNICEF followed up this ground-breaking report with an updated report card on adolescent health in 2012 (73). The report highlighted risks of death, disease, mental ill-health, undernutrition, tobacco consumption, alcohol and drug use, sexual behaviour, childbearing, maternal health, HIV, and sexual violence. UNICEF set out an ambitious way forward in all these aspects

of health. But, in truth, these wise messages have not been adopted widely, either globally or in country women’s and children’s health strategies. It is almost as if adolescents are somehow stigmatised as a group, not so vulnerable as to merit the attention that children under-5 receive and less well-organised and vocal to capture the audience that maternal health advocates succeed in winning. Part of the reason for this situation may lie in the generational conflict played out in this period of life, especially when adolescents become sexually aware.

**74.** Why, despite the best efforts of some agencies, is adolescent health neglected? Part of the reason is that the global community does not monitor adolescent health. And part of the reason for that monitoring failure is that we don’t know what to monitor (74). Few indicators are measured well for adolescents, even in adolescent sexual and reproductive health, which has won the greatest policy attention. In 2012, after wide consultation, a new set of indicators was proposed for monitoring adolescent health (Table 11), and recommendations were made for measurement of adolescent health, on data gathering and coverage, and on leadership and coordination (74). As can be seen from the table, many of these indicators are relevant to the broad remit of women’s and children’s health in our 75 priority countries. This work offers a renewed opportunity to include at least one adolescent health indicator to the 11 we have been asked to monitor on behalf of the Commission on Information and Accountability.

#### Panel 4: A call to action on adolescent sexual and reproductive health (71)

“Worldwide, societal shifts and behavioural patterns exacerbated by unique developmental vulnerabilities create a confluence of factors that place today’s adolescents at heightened risks for poor health outcomes... All strategies designed for adolescents must be tailored to the unique developmental needs of young people and to the contexts and cultures in which they live. Health providers, teachers, and programme leaders all need specific knowledge and skills to assess and respond to the unique needs of this age group. Young people need access to quality clinical services that offer effective treatments and vaccines, coupled with sex education that gives medically accurate information and teaches skills for negotiating sexual choices. Along with these two critical components, youth development programmes should connect adolescents with supportive adults and with educational and economic opportunities. And, for all cultures, communities, and countries, multifaceted approaches connecting multiple sectors show the greatest promise for success.”

“We should balance these individual-focused interventions with equal emphasis on broader initiatives that address structural determinants of health in populations, and work to create supportive environments with policies and priorities that pay heed to the social contexts in which adolescents live. Advocates for systems change need to work with health providers to meet the goals set by the 1994 Cairo Conference, the MDGs, the Bali Youth Declaration, and worldwide aspirations for the healthy development of adolescents.”

**Table 11: Proposed set of 25 indicators for adolescent health worldwide**

<b>1. All-cause mortality</b> (by sex 10-14, 15-19, 20-24 years)
<b>2. Road traffic deaths</b> (by sex 10-14, 15-19, 20-24 years)
<b>3. Death due to suicide</b> (by sex 10-14, 15-19, 20-24 years)
<b>4. Deaths due to violence</b> (by sex 10-14, 15-19, 20-24 years)
<b>5. Maternal mortality</b> (15-19 years)
<b>6. HIV prevalence</b> (15-24 years)
<b>7. Mental health disorder</b> (10-14, 15-19, 20-24 years)
<b>8. Tobacco use in past 30 days</b> (10-14, 15-19, 20-24 years)
<b>9. Alcohol binge drinking in past 30 days</b> (10-14, 15-19, 20-24 years)
<b>10. Cannabis use in past 30 days</b> (10-14, 15-19, 20-24 years)
<b>11. Underweight</b> (10-14 years)
<b>12. Overweight</b> (10-14, 15-19, 20-24 years)
<b>13. Physical activity for more than 60 min each day per week</b> (10-14, 15-19, 20-24 years)
<b>14. Parents or guardians understood worries most of the time</b> (13-15 years)
<b>15. Self-rated health as fair or poor</b> (10-14, 15-19, 20-24 years)
<b>16. Sexual activity by age 15 years</b>
<b>17. Youth unemployment</b> (15-24 years)
<b>18. Early marriage</b> (females < 18 years)
<b>19. Childbirth by 18 years</b> (< 18 years)
<b>20. Gross enrolment ratio in early secondary education</b>
<b>21. Comprehensive and correct knowledge about HIV</b> (15-24 years)
<b>22. Condom use at last high-risk sex</b> (15-24 years)
<b>23. HPV vaccination rate</b> (females 15-19 years)
<b>24. Unmet need for treatment of mental health disorder</b> (10-24 years)
<b>25. Use of health services in past 12 months</b> (10-24 years)

Source: Patton GC, Coffey C, Cappa C et al. Health of the world's adolescents: a synthesis of internationally comparable data. *Lancet* 2012; 379:1665-1675

**75.** Similarly, national and regional commitments to the health and rights of adolescents need careful monitoring and review to ensure adequate funding and implementation. In August, 2008, at the International AIDS Conference in Mexico City, health and education ministers from Latin America and the Caribbean signed a historic Declaration—"Preventing through Education"—to increase dramatically young people's access to comprehensive sexuality education and sexual and reproductive health services by 2015. While some progress has been made, an evaluation completed by the Mesoamerica Coalition found that much remains to be done to fulfil the promises of the Declaration. With fewer than two years left to ensure youth access to sexual and reproductive health and information, more investments in monitoring progress and holding governments accountable are needed.

**76.** As Figure 12 suggests, the overall political and social context is critical to advance adolescent health. Perhaps the most important aspect of this constellation of political and social factors is a high-level commitment to gender equity, for without that commitment almost nothing of lasting value can be sustained (75). But there are other important

determinants too. Child marriage—defined as marriage before the age of 18—is an especially important and neglected factor adversely shaping the lives and health of young women (one that is closely linked to the absence of reliable CRVS systems that prove the age of the young girl). According to UNFPA, there are 39 000 child marriages every day—that is 140 million girls marrying between 2011 and 2020 (76). Of this 140 million, 50 million will be under the age of 15. The 10 countries with the highest rates of child marriage (defined as the proportion of girls aged 20-24 years who were married or in union before the age of 18) are all part of the iERG's 75 countries of concern.

- Niger 75%
- Chad 68%
- Central African Republic 68%
- Bangladesh 66%
- Guinea 63%
- Mozambique 56%
- Mali 55%
- Burkina Faso 52%
- South Sudan 52%
- Malawi 50%

In absolute numbers, India, also one of the iERG's countries, has the most child marriages (47% of 20-24-year-old women who were married before the age of 18 years). Again, a human rights lens provides a useful means to address child marriage—it means the end of a young person's right to an education, exposes that person to life-threatening health risks of early pregnancy and childbearing, and increases their risk of sexual violence and infection with HIV. As the Executive Director of UNFPA, Babatunde Osotimehin states:

*“Child marriage is an appalling violation of human rights and robs girls of their education, health, and*

*long-term prospects. A girl who is married as a child is one whose potential will not be fulfilled.”*

**77.** In March, 2013, a special session of the UN Commission on the Status of Women focused on child marriage as part of *Every Woman, Every Child*. Although 158 countries have set the legal age for marriage at 18, these laws are often not enforced. Child marriage is frequently rooted in tradition, poverty, and gender inequality. Some cultures believe that early marriage is protective. The most effective means to end child marriage lie in a mix of policies—enforcing already existing laws, providing access to education equally for girls and boys, mobilising political and

### Bolivia: Young people lead efforts to improve adolescent sexual and reproductive health

Advocacy by youth organisations and activists is largely responsible for a comprehensive youth bill with strong provisions concerning adolescent sexual and reproductive health (always controversial for that age group) becoming law in Bolivia on 5 February 2013.

The Youth Law grew out of a national youth organisation meeting, at which model legislative proposals that had been developed by young people were discussed and debated as the basis for a proposed bill. A leading role was played by the *Tu Decides* youth network and the Committee of Adolescents and Youth for the Prevention of Unplanned Pregnancy, with the Centro de Investigacion, Educacion y Servicios (CIES) providing funding, technical assistance, and convening authority (1).

The close link between the provision of youth-friendly services and consequent youth-centred advocacy was evident in the final text of the Youth Law, especially in: article 7 with its robust definitions of quality youth-differentiated health services; the right to sexual and reproductive information and services in article 11; and the right to comprehensive sexuality education in article 38 (2). This result was no accident. Since 2007, CIES (an International Planned Parenthood Federation Member Association since 1995) has trained 2594 young people as leaders, and 465 public officials and politicians have been sensitised to their needs (3).

The Youth Law is critically important for Bolivia where adolescents (aged 10-19) represent 23% of the population. 18% of young women become pregnant before age 20, half of these pregnancies being unplanned. The fertility rate among adolescents increased from 83 per 1000 women in 2003 to

88 in 2008. Among adolescent girls engaging in sexual activity, 60% became pregnant, 9% of them under age 15. There is a marked difference in the rate of adolescent pregnancy between rural (25%) and urban (14%) communities, and an even greater difference between the poorest (32%) and the wealthiest (7.8%) population quintiles (4). Adolescents are a key target group for HIV/AIDS prevention: only 26% having comprehensive knowledge (5).

The CIES Youth Programme is responding to this crisis in adolescent health by providing both sexual health services and education. CIES has 13 permanent clinics spread across the country, and 3 mobile facilities. Each clinic has a youth services space where young people meet, receive leadership training, participate in workshops, and access sexual and reproductive health services. The training allows young people to become advocates and peer-educators. It not only provides young people with the tools to share information about sexual and reproductive health and rights, but also builds their self-esteem, as well as political and overall life planning skills (6). Potential leaders who are part of the CIES *Tu Decides* youth programmes benefit by attending national meetings, networking with other peer-educators throughout Bolivia, and participating in CIES' governance structure. Many become active in the independent *Tu Decides* national youth network which originally arose from these programmes.

1. Advocacy Report, CIES-Bolivia, "Informe Narrativo de la Ley No. 342 – De Juventudes".
2. Ley No. 342, Ley de 5 de Febrero de 2013, Ley de la Juventud, Gaceta Oficial del Estado Plurinacional de Bolivia.
3. IPPF Independent Progress Review 2012. Draft Report CIES-Bolivia, Georgia Taylor and Veronica Vargas, contribution to the DFID Programme Partnership Arrangement (PPA) independent mid-term review, p. 14.
4. Demographic and Health Survey, Bolivia, 2008.
5. Health in the Americas: Bolivia Pan American Health Organization. PAHO, 2012.
6. IPPF Independent Progress Review 2012, op. cit., p. 14.

civil society leadership to end child marriage, and addressing the causes of child marriage, including poverty, inequity, discrimination, and violence.

**78.** As the PMNCH report to the iERG emphasises, “there is no single agency or institution which has a mandate focused primarily on young people or adolescents.” However, there are powerful advocacy movements on behalf of adolescents. These civil society actors at the national level are taking action and seeing results. In Bolivia, for example, where three teenagers get pregnant every hour, the Centre for Investigation, Education, and Services (CIES) led a systematic effort to give young people a seat at the table. CIES organised conversations with youth groups in five regions, conversations that soon transformed into extensive youth networks. These young people

soon became an unstoppable force. 18 municipal and government department level policies have been enacted to guarantee sex education and access to health services for adolescents. And the Ministry of Health issued a resolution to implement youth participation in the nation’s health system. Another example is The Coalition for Adolescent Girls, founded in 2005 by the UN Foundation and Nike Foundation. The Coalition has an ambitious agenda, which includes health (Table 12). But, despite isolated pockets of advocacy for adolescents, there are no adolescent-specific outcomes in *Every Woman, Every Child* and there has been little focus on adolescent health in discussions about accountability, either globally or in countries. The iERG has an opportunity to redress that imbalance with our recommendations this year.

**Table 12: Adolescent girls: an agenda for global action from the Coalition for Adolescent Girls (modified from the original)**

<b>10 actions: enabling girls today to end poverty tomorrow</b>
1. Give adolescent girls an officially recognised identification
2. Collect data on adolescent girls and disaggregate it by age and gender to assess whether programmes are reaching adolescent girls
3. Increase funding for adolescent girls—and track what it achieves
4. Expand opportunities for girls to attend secondary school
5. Refocus HIV/AIDS prevention strategies to focus on adolescent girls
6. Reorient health delivery systems to work for adolescent girls
7. Economically empower adolescent girls by building and protecting their assets
8. Make the law work for adolescent girls
9. Equip adolescent girls to advocate for themselves and their communities
10. Mobilise communities, families, men, and boys to support adolescent girls
<b>Taking action for girls’ health</b>
1. Implement a comprehensive health agenda for adolescent girls in at least 3 countries
2. Eliminate marriage for girls younger than 18
3. Place adolescent girls at the centre of international and national action and investment on maternal health
4. Focus HIV prevention on adolescent girls
5. Make health-system strengthening and monitoring work for adolescent girls
6. Make secondary school completion a priority for adolescent girls
7. Create an innovation fund for girls’ health
8. Increase donor support for adolescent girls’ health





## 5. CONCLUSIONS AND RECOMMENDATIONS

## CONCLUSIONS

**79.** Global health is entering a critical transition—from a stable era built around a poverty-focused agenda (the MDGs), to one that will embrace considerably more uncertainty (environmental damage, climate change) and so will require a broader and more adaptable framework that can accommodate “unknown unknowns.” There are, however, some certainties to this future. One is demographic change. The share and number of children living in the world’s most resource-poor regions will grow rapidly. By 2050, 1 in every 3 births will be African. Under-5 deaths will continue to concentrate in Africa. Within countries, those deaths are likely to be concentrated still further among the poorest populations. With a growing old-age dependency ratio, children face the risk of resources being transferred from their needs to those of older generations.

These demographic shifts will come at a moment of unprecedented environmental pressure. These pressures are already having an effect on women’s and children’s health (77). The toxic mix of demography and climate is likely to intensify (78). We are in serious danger of failing to measure the consequences for the future of what we do today (79). When one examines the intersection of population, human consumption, and the environment, one quickly sees that the way we live now is unsustainable. All societies have to break the cycle of unsustainable consumption and one of the most powerful groups to do so is women. As Partha Dasgupta and Paul Ehrlich argue, “women are the tradition-breakers” (79). It is they who can often make the first move to a different societal or development trajectory—by resetting the norms (eg, around fertility rate or consumption patterns).

**80.** Our diverse societies understand that we must improve the way we manage the limited resources we have to ensure better results. That means measurement, the first step towards accountability. Many different models of accountability have emerged in recent years. The UN system has an advanced reporting process for different dimensions of human development. WHO’s *World Health Statistics*, for example, tracks progress for the health-related MDGs, life expectancy, mortality, causes of death, health-service coverage, risk factors, and health systems. UNICEF, UNAIDS, and UNFPA publish their own statistical reports, which have the same monitoring (although no review or remedy) function. Specific disease or intervention partnerships track progress towards control, elimination, or even eradication of particular diseases (80, 81). Development partners are now much more concerned about the impact of their investments in countries. The IHP+ is probably the most advanced and successful accountability tool for partners (82). Civil society is assuming a far more important role in accountability

too (83, 84). Human rights tools are under active development so that countries can conduct rapid rights-based assessments of RMNCH laws, regulations, and policies (these tools will be available in 2014). The Multilateral Organisation Performance Assessment Network assesses organisational effectiveness of key institutions relevant to women’s and children’s health—eg, UNDP, the World Bank, UNICEF, UNAIDS, and GAVI. And in indirect ways, other accountability instruments add to our view of the environment in which women’s and children’s health is delivered—the Open Budget Survey (85), the International Aid Transparency Initiative (86), and the Ibrahim Index of African Governance, from the Mo Ibrahim Foundation (87).

**81.** It is within this complex arena of accountability that the iERG exists. The response to our 2012 report was engaged and constructive. We found partners highly responsive to our concerns and suggestions. The UN system (including the H4+), PMNCH, Countdown to 2015, the IPU, ITU, civil society (eg, World Vision, Save the Children, and many others), and the human rights community have continued to engage fully as we have developed our 2013 report. A special mention should be made of WHO’s Regional Offices. We found interaction with Regional Directors of WHO extremely productive. Their offices actively participated over the substance of our report after publication. They raised various issues—quality of care, the importance of early child development, the post-2015 development agenda, progress on multi-country workshops for accountability, the value of restarting a movement on health information systems, the importance of inequity, issues around coordination and governance, the use of human rights tools, their role in technical assistance to countries, and universal health coverage and health system strengthening. Although the iERG cannot easily visit each of 75 countries within our sphere of concern, we can offer the opportunity for joint regional office-iERG meetings to report to member states in those regions. We have written to Regional Directors to propose such collaborative events with this 2013 report.

**82.** In future years we hope for stronger, substantive, and more timely engagement with WHO country representatives, UNAIDS, the World Bank, the Global Fund to Fight AIDS, TB, and Malaria, A Promise Renewed, Family Planning 2020, the Decade of Vaccines, the Commodities Commission, and the private sector.

**83.** Here we give a brief update on progress regarding our 6 recommendations from 2012. A stakeholder meeting was convened in November, 2012, where over 70 partners gathered to discuss future actions. Our

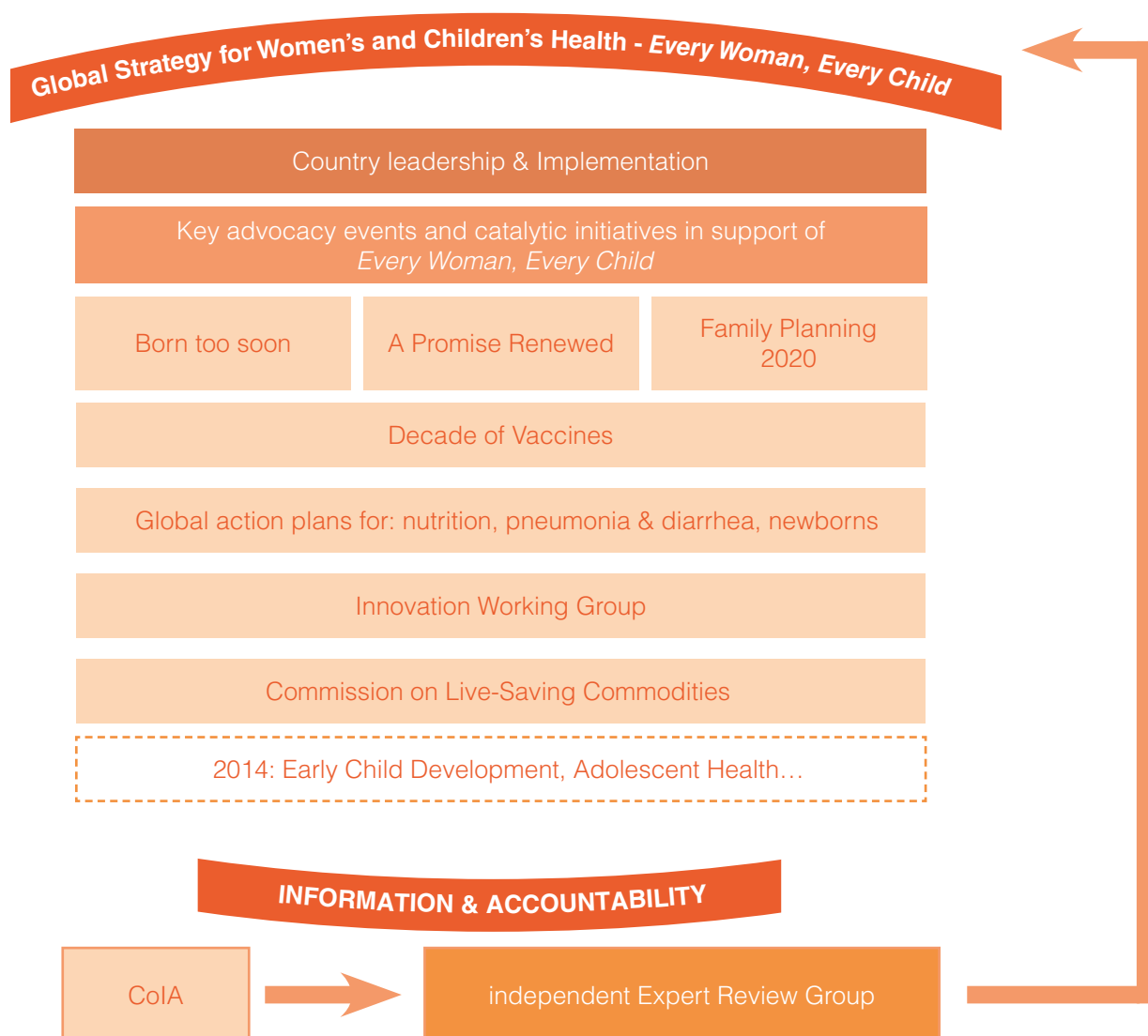
proposals were prioritised by the group and we report back now according to their prioritisation.

- *Devise a global investment framework for women's and children's health.* An investment framework will be published in 2013. In collaboration with the University of Washington and PMNCH, WHO is currently overseeing the development of an investment framework as part of a larger project on investing in health, also to be published in 2013, in the twentieth anniversary year of the 1993 World Development Report on Investing in Health. The first meeting of the working group to devise an investment framework for women's and children's health took place in February, 2013. A further meeting was held in Venice in June, 2013. The main objectives of this work are to: develop a strategic and aligned approach for prioritisation and resource allocation for women's and children's health; to strengthen accountability for results and resources;

and to position remaining challenges for the post-2015 development agenda. This investment framework will be a critical document for mobilising future action and commitment globally and in countries, especially given recent slowdowns in donor aid for maternal, newborn, and child health (88).

- *Strengthen the global governance framework for women's and children's health.* Here progress has been less positive than we would have hoped for, despite general agreement that "unregulated energy can lead to chaos." On accountability, the hope was that important parallel initiatives in women's and children's health could have used the iERG as a mechanism to identify a single global locus of independent accountability. Although there were expressions of strong interest from some partners—eg, A Promise Renewed, Family Planning 2020, the Commission on Life-Saving Commodities—the

Figure 13. Coordination of initiatives under *Every Woman, Every Child*



## Afghanistan: Improving maternal and child health in areas of conflict

Decades of political instability severely damaged Afghanistan's health infrastructure (1). In 2002, the maternal mortality ratio was among the highest worldwide (1600 per 100 000 live births) (2) and, at 257 per 1000 live births, the under-5 mortality rate was the third highest globally (after Sierra Leone and Angola) (2). In this fragile post-conflict country, the health sector lacked capacity and human resources to reach people living in rural areas, which meant that 70% of the population was underserved (3). Therefore, in close coordination with development partners, a basic package of health services was developed and contracted out to national and international NGOs between 2002 and 2003. In order to address the two main barriers to the training of female staff outside their own communities (security concerns and cultural norms), the government also initiated a community midwifery education programme in 2002. By 2006, the programme was running in 21 out of 34 provinces, with 640 enrolled students. This initiative aimed particularly to increase the number of female midwives, essential for lowering maternal and child mortality. Currently, community midwifery education programmes have expanded and are operating in 31 provinces (4).

These new health initiatives have substantially increased the number of trained health staff and coverage of key interventions. Recent data reveal that by 2012 the number of midwifery programmes had increased from 1 to 30, over 3000 midwives had graduated, and 86% of them had been employed. As a result, the number of births at health facilities increased from 6% in 2003 to 19% in 2005 and 32% in 2011. The percentage of facilities employing female health professionals (doctors, nurses, or midwives) increased from 39% in 2004 to 76% in 2006. Likewise, skilled antenatal care (at least one visit) increased from 4.6% in 2003 to 32.3% in 2006 and 48% in 2008.

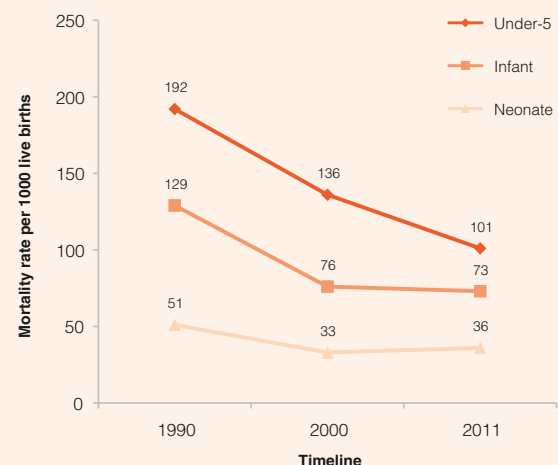
Contracting out has also resulted in a very rapid expansion of health services coverage (82% in 2006 (3)), increasing the number of trained personnel, and lowering mortality rates (1). In 2010, the maternal mortality ratio was estimated at 460 per 100 000 live births (5), well on the way to the target of 400 by 2015. Progress towards achieving MDG-4 has also been tremendous. Between 1990 and 2011 the under-5, infant, and neonatal mortality rates all decreased substantially (figure 1). The under-5 mortality rates in 1990, 2000, and 2011 were 192 (95% CI: 160-210), 136 (95% CI: 125-151), and 101

(95% CI: 84-126) per 1000 live births respectively; Afghanistan aims to reduce this to 64 by 2015.

Ongoing conflict and population displacement have slowed progress in some areas. Measles-containing vaccine (MCV) coverage was 35% in 2000 and 68% in 2006, but decreased to 55.9% in 2010. DPT coverage was 31% in 2002 and 43% in 2007. Recently, 31% of 12 246 children under-5 were underweight (moderate or severe). Moreover, 54% of these children had chronic malnutrition (moderate or severe) and almost 18% had moderate or severe wasting. However, the quality of the data from the Afghan Multiple Indicator Cluster Survey 2011, used for the nutrition analysis, is yet to be confirmed.

The biggest challenge is sustaining the current level of health services. Financial sustainability is a major concern because while the cost of contracting out is currently met by international donors, this model is known to increase transactional and overall costs. Insecurity and ongoing conflict are additional barriers to maintaining and expanding the scope of health services and cannot be underestimated. Nevertheless, Afghanistan's health achievements have been impressive, and the current quality and range of services should be maintained until a more stable and effective administration can undertake further interventions.

### Under-5, infant, and neonatal mortality rates from 1992 to 2011 in Afghanistan



1. WHO. Mission report. Health system review in Afghanistan: Challenges and the way forward. WHO, 9-18 July 2006.
2. MoPH Afghanistan. Afghanistan Health Survey 2006. Estimates of priority health indicators.
3. Sabri B et al. Towards sustainable delivery of health services in Afghanistan: options for the future. *Bull World Health Organ*, 2007; 85(9): 712-18.
4. GIHS. Community and hospital midwifery education information update sheet: updated 20 February 2013.
5. WHO. Trends in maternal mortality: 1990 to 2010. WHO, UNICEF, UNFPA and World Bank estimates. WHO, 2012.

tangible contributions from these initiatives to the iERG have so far been small. More encouragingly, a step towards enhanced global governance has been taken with the creation of an RMNCH Steering Committee to more closely harmonise and coordinate activities and funding. The concept behind this greater effort on coordination is captured in Figure 13. The first meeting of the Steering Committee took place in Washington, DC, in April, 2013. Although membership is still fluid, the composition of the Committee includes representatives from the Gates Foundation, USAID, World Bank, Clinton Health Access Initiative, PMNCH, WHO, UNICEF, UNFPA, the UNSG's Office, UN Foundation, UK, France, Norway, Sweden, Canada, Nigeria, Ethiopia, Tanzania, Senegal, and Indonesia. Among the key areas of consensus were the following:

1. Countries and donors will work together to transparently map available and potential financial resources (both domestic and external) as well as gaps.
2. Alignment around monitoring and reporting of results—one plan, one budget, one report—will enhance mutual accountability and country ownership.
3. Both from a country perspective and a global perspective, the Steering Committee is filling a gap in the RMNCH space. It must be used to take the IHP+ principles and make it work in a few countries.

The Steering Committee noted that countries still suffer “unnecessary distraction, inefficiencies, and high transaction costs” because of the multiple global initiatives they must absorb. Often lip-service is paid to the umbrella of *Every Woman, Every Child* under which multiple initiatives are supposed to sit. But, as we have described, frequently these initiatives are flagship projects for donors, with burgeoning governing bodies, secretariats and working groups underpinning their work. We must therefore hold donors accountable too. In June, 2013, the FP2020 initiative announced the chairs and membership lists of four and three working groups, respectively, all created to provide technical guidance on accelerating implementation of family planning commitments. Each working group—on country engagement, performance monitoring and accountability, rights and empowerment, and market dynamics—has two co-chairs. For three working groups a total of 49 people have been appointed. We continue to question the value of these parallel bureaucracies, dividing family planning from other initiatives in women's and children's health and introducing a large and administratively complex enterprise that will inevitably add further duplication and fragmentation to global efforts for reproductive health. The work of the Steering Committee is therefore of the utmost importance and we commend partners for taking this important step towards alignment and harmonisation. At the time of

writing, we have been advised that there is no civil society representation on this Steering Committee, a surprising omission by partners. We hope this omission will be rapidly corrected.

- *Strengthen human rights tools and frameworks to achieve better health and accountability for women and children.* We have discussed progress at the intersection of the health and human rights communities elsewhere in this report. In direct response to our recommendation, WHO, PMNCH, and the Office of the UN High Commissioner for Human Rights joined together to incorporate human rights more fully into accountability mechanisms for women's and children's health. The 2013 accountability workplan now includes a human rights component where partners will support a series of rights-based reviews in Malawi, Tanzania, Uganda, and Nepal to analyse laws and policies bearing on maternal and child health. The case studies and recommendations that result from these reviews will be shared in late 2013. Two important advances in the field of human rights and women's and children's health took place this year. First, the adoption by the Human Rights Council of a resolution on the child's right to health. This resolution asks for a study of child mortality as a human rights concern to be completed. The results of this study will be presented to the Human Rights Council in September, 2013. Second, a two-year process concluded in 2013 with the adoption of General Comment 15 on the Child's Right to Health.
- *Set clearer country-specific strategic priorities for implementing the Global Strategy and test innovative mechanisms for delivering those priorities.* WHO judges that country-specific strategic priorities are being set through Country Accountability Frameworks. But as we have noted elsewhere, national oversight mechanisms in countries are weak, poorly understood, and in some cases entirely missing. It is true that 54 countries have accelerated their progress towards MDG-4 from 2000-10 compared with 1990-2000; and 53 countries have done the same for MDG-5. But we cannot be sure that an inclusive, transparent, and participatory process is in place in countries to ensure further progress towards the MDGs.
- *Accelerate the uptake and evaluation of eHealth and mHealth technologies.* WHO argues that eHealth is addressed in Commission Recommendation 3. While this is true, our intent was to see evidence of acceleration of action rather than merely adhering to a goal that we had previously indicated seemed some way off. We have not seen that accelerated action over the past year. We believe that the survey to be completed this year by ITU will greatly help to set priorities for developing and strengthening national eHealth plans.

- *Expand the commitment and capacity to evaluate initiatives for women’s and children’s health.* On this recommendation, our hopes have been amply fulfilled. The scientific community has continued to generate extraordinarily large volumes of high-quality original and synthesised knowledge that should have a profound effect on policymaking. We draw attention to two large research projects of relevance to women’s and children’s health, both of which have been published in the past year. First, a unique collaboration of researchers published two collections of reports in *PLoS Medicine* (89): on child mortality estimation methods and on measuring coverage in maternal, newborn, and child health. These collections explain how estimation techniques are revealing accelerated progress in reducing global child mortality. They also illustrate how better coverage measurements of interventions can assist policymakers make better decisions about where to invest scarce resources. Second, the Global Burden of Disease (GBD) (90) provided a mechanism to compare all countries and all outcomes on an equal basis. This comprehensive assessment of the world’s health confirmed the rapid declines in child mortality, but also showed the considerable years of life lost despite these improvements in child survival. Mortality estimates alone are not necessarily the best way to describe the loss to society of children under 5. The GBD also revealed the neglected toll of mortality and morbidity among middle-aged adults: emphasising that a

greater attention to women and their health is needed in global health today. We should not be viewing women’s health only through the lens of reproductive and maternal health. The emergence of an epidemic of non-communicable disease should encourage us to broaden our vision for the future health of women. In PMNCH’s assessment of commitments made to evaluation, most were dedicated to operational research, followed by policy research, biomedical science, and intervention impact studies. There were worrying gaps in this support—capacity building and financing for research received much less attention, a trend that PMNCH suggests might adversely effect the quality and quantity of research (and knowledge production) in the long term. We again stress the importance of research as an accountability tool in its own right. Research can show, for example, whether and how government policies to train health extension workers enhance maternal health services (91). Research can monitor the expansion of emergency obstetric care services in many of our 75 countries of concern (92). Research is the most rigorous accountability tool available to the global community. It plays a vital part in bringing evidence together to inform policies and programmes. Take the example of interventions to address pneumonia, diarrhoea, and undernutrition. Rather than think of these health priorities separately, evidence on effective interventions allows policymakers to identify synergies and complementarities (Table 13).

**Table 13: Synergies and complementarities between interventions to address pneumonia, diarrhoea, and undernutrition**

DIARRHOEA	PNEUMONIA	UNDERNUTRITION
<b>Breastfeeding promotion</b>	<b>Breastfeeding promotion</b>	<b>Breastfeeding promotion</b>
<b>Improved water source, sanitation, and hygiene</b>	<b>Improved water source, sanitation, and hygiene</b>	<b>Improved water source, sanitation, and hygiene</b>
<b>Preventive Vitamin A supplementation</b>	<b>Preventive Vitamin A supplementation</b>	<b>Preventive Vitamin A supplementation</b>
<b>Preventive Zinc supplementation</b>	<b>Preventive Zinc supplementation</b>	<b>Preventive Zinc supplementation</b>
Rotavirus vaccine	Hib vaccine	Periconceptional folic acid supplementation or fortification
ORS	Pneumococcal vaccine	Appropriate complementary feeding
Zinc - for treatment of diarrhea	Case management of neonatal infections	Maternal balanced energy protein supplementation
Antibiotics for dysentery	Oral antibiotics : case management of pneumonia in children	Maternal calcium supplementation
		Multiple micronutrient supplementation in pregnancy
		Management of Moderate Acute Malnutrition
		Management of Severe Acute Malnutrition

Source: Bhutta ZA, Das JK, Rizvi A et al. Evidence-based interventions for improvement of maternal and child nutrition: what can be done and at what cost? *Lancet* 2013; ISSN 0140-6736. Bhutta ZA, Das JK, Walker N et al. Interventions to address deaths from childhood pneumonia and diarrhoea equitably: what works and at what cost? *Lancet* 2013; 381: 1417-29

### Malawi: Focusing on human resources for health

In the early 2000s, the Government of Malawi and its partner, the Christian Health Association of Malawi (CHAM), were facing severe challenges in the health sector: a dire shortage of health workers, exacerbated by staff migration, and compounded by inefficient skills mix, inadequate incentives, and poor management practices, contributed to imbalances in geographical distribution and poor motivation, creating gaps in service coverage (1, 2).

In 2004, the Government launched the Emergency Human Resource Programme (EHRP), comprising:

- improved incentives for recruitment and retention through a 52% salary top-up for 11 cadres;
- expansion of domestic training capacity for priority cadres by over 50%, accompanied by a 115% scale-up of health surveillance assistants (community health workers), which increased from 4886 in 2004 to 10 507 in 2009, to improve community case management of childhood illnesses;
- use of international volunteers as a stop-gap measure;
- provision of technical assistance to build capacity in management, monitoring, and evaluation in the Ministry of Health.

The EHRP, part of the health sector-wide approach, was supported by development partners, including DFID and the Global Fund.

An independent evaluation (2) concluded that, between 2004 and 2009, the EHRP increased the number of health workers by 53%, raising their density from 0.87 to 1.44 per 1000 population, and contributed to saving 13 187 lives (3) through increased coverage of skilled birth attendance (+15%), antenatal care (+7%), immunisation (+10%), and PMTCT (+10%), at a cost of US\$ 95 million. There has also been a renewed focus on quality of care, with mandatory continuing medical education initiatives introduced for doctors, nurses, and midwives, and on postgraduate training opportunities, now offered by the College of Medicine and the Kamuzu College of Nursing. Government leadership of the EHRP and the multi-constituency collaboration mechanisms adopted in its design and implementation were key determinants of success. Malawi is on track to meet MDG-4, and is advancing towards MDG-5 targets.

Significant challenges nevertheless persist, as in most countries with a weak health labour market: high burn-out is reported, particularly among maternity health personnel; almost half of medical students plan to leave the country after graduation, even though the incentives introduced have mitigated the problem; salary increments, while significant, are perceived to be insufficient, and may be outpaced by inflation and currency devaluation; and frequent absences of staff from their posts are reported, mostly due to in-service training initiatives.

In addition, there are concerns about a possible mismatch between the increased student input and graduation output on the one hand, and the capacity of training institutions on the other hand. Following the end of the EHRP in 2010-11 and the discontinuation of some external funding, the financial sustainability of some of its policies has been questioned. Bridging mechanisms to transition to regular Government funding have not been fully operationalised, causing challenges for pre-service training programmes (for instance, some schools had to reintroduce student fees, negatively affecting enrolment). Also, management capacity has not been strengthened to the level initially envisaged.

Sustaining the EHRP's achievements will require: further improvements in the governance and capacity of the Ministry of Health and CHAM; continued financial investment in the health workforce, including support for potential students who cannot afford tuition; creating opportunities for career progression (4); shaping labour market forces by creating a conducive environment for new and existing health workers; diversifying the skills mix, including the introduction of general practice as a specialty; and corresponding investment in training infrastructure.

1. Task Force on Scaling Up Education and Training for Health Workers. Malawi's emergency human resources programme. In *Scaling Up, Saving Lives*. Geneva: WHO and Global Health Workforce Alliance, 2008. Available from: [http://www.who.int/workforcealliance/knowledge/resources/casestudy\\_malawi/en/](http://www.who.int/workforcealliance/knowledge/resources/casestudy_malawi/en/), accessed 10 May 2013.
2. Management Sciences for Health. Evaluation of Malawi's Emergency Human Resources Programme. Management Sciences for Health, 2010. Available from: <http://www.msh.org/news-bureau/msh-publishes-evaluation-of-malawi-human-resource-program.cfm>, accessed 10 May 2013.
3. Estimated with the Lives Saved Tool; see Fox M et al. Assumptions and methods in the Lives Saved Tool (LIST). *BMC Public Health* 2011; 11 (Suppl 3):1.
4. Manafa O, McAuliffe E, Maseko F, et al. Retention of health workers in Malawi: perspectives of health workers and district management. *Human Resources for Health* 2009, 7:65.

**84.** In addition to these 6 recommendations, we made several statements in our 2012 report that might be characterised as “imperatives.” These are summarised

in Panel 5, with an assessment of progress during the past year.

### **Panel 5: 25 additional imperatives proposed by the iERG**

1: “We urge those responsible for these different estimates to agree on the broad progress countries are making towards internationally agreed goals.” (para 12)

*In February, 2013, WHO hosted a meeting to offer recommendations for a way forward on global health estimates. The concluding statement of this meeting is shown in Appendix 6.*

2: “By any standard, Africa must be a greater global policy priority for all partners concerned with achieving the highest level of health for women and children.” (para 16)

*Although we have not been able to monitor commitments from all partners regarding Africa, we do note and welcome WHO’s increased attention to sub-Saharan Africa, as reflected in the 2.5% increase in its 2014-15 programme budget for WHO’s African Regional Office.*

3: “What we hope to see in the future is an assessment of what each commitment to or within a particular country has achieved for women and children. As part of the causal chain from commitment to end result, we need to know what the commitment is, how much resource has been allocated and delivered, what has been done with that resource, and finally what has been achieved by that commitment.” (para 21)

*No progress has been made.*

4: “Dr Margaret Chan inaugurated her second term of office by saying that ‘Universal health coverage is the single most powerful concept that public health has to offer.’ The iERG will monitor the evolution and implementation of WHO’s newly stated priority strategic initiative.” (para 31)

*WHO continues to lead the global dialogue around Universal Health Coverage. The inclusion of universal coverage as a major idea in the health thematic group of the High Level Panel, as well as the final report of the High-Level Panel itself, is in no small part because of WHO’s continued and vocal leadership in this area. The next 12 months need to see WHO convert this political momentum into results in countries.*

5: “Women’s and children’s health must be at the centre of sustainable development—eg, through the social pillar of sustainable development, where issues such as women’s empowerment, girls’ education, and reproductive health, including family planning, are vital elements.” (para 34)

*As we show in Appendix 4, women and children are a core component of current post-2015 thinking.*

6: “The case must be argued much more strenuously—women have an indispensable role as agents of sustainable development. The gains made in women’s and children’s health during the past two decades need to be protected and augmented.... This priority must become a foundation for the next decade of development.” (para 37)

*See Appendix 4.*

7: “We plan a deeper analysis of equity in subsequent reports. Disaggregation by sex and age is especially important because poor young women have the largest unmet needs.” (para 43)

*We have not yet been able to fulfil this hope, mainly because of lack of data.*

8: “Plans need to be put in place urgently not only to fill this gap, but also to secure the additional US\$44 million needed for 2014-15.” (para 54)

*We discuss this issue later in this section of our 2013 report.*

9: “We hope to bring more quantitative measures to our analysis in future years to understand better how countries are performing relative to themselves and to one another... We would like to quantify those



commitments further, a crucial part of tracking resources for accountability, especially since there are concerns and signals that donor funding may have fallen more recently. We believe that a more precise report card will foster opportunities to accelerate the sharing of innovations and best practices, including in policy and service delivery, and more quickly identify obstacles to implementing both the Global Strategy and the Commission's recommendations." (para 56)

*We still hope to fulfil this wish in subsequent reports.*

10: "Intensified efforts are needed to raise the profile of the Commission's work and its ongoing implementation." (para 58)

*Much more could be done to meet this imperative. Too often we find that the Commission and its recommendations are little known in countries. We hope to correct this deficit by reporting to WHO Regional Committees in 2013.*

11: "We urge all partners who have committed to the Global Strategy to consider carefully opportunities for aligning and harmonising their own programmes with *Every Woman, Every Child*." (para 58)

*In words, this request is being fulfilled. In deeds, progress is much less evident.*

12: "The correct investments and incentives therefore need to be put in place now to ensure the equitable distribution of health workers where need is greatest." (para 60)

*We look forward to this issue being addressed in the global investment framework for women and children.*

13: "A particular challenge will be to address inequalities in countries with rapidly rising populations." (para 62)

*As far as we are aware, this issue is receiving insufficient attention globally and in countries.*

14: "Individual parliamentarians must therefore have access to current, reliable, and user-friendly information, a need that remains a substantial challenge in many settings. Parliamentarians must also be routinely included in decision-making processes and platforms about women's and children's health." (para 64)

*See Chapter 3 of this report.*

15: "Nutrition is an urgent priority for women and children. All partners to the Global Strategy have to do more...The iERG will monitor progress on nutrition closely in its subsequent reports." (para 66)

*See Chapter 1 of this report.*

16: "We believe that this goal [on inequity], or one similar to it, should be an essential component of any country-based or global oversight mechanism for the Global Strategy." (para 67)

*See Chapter 3 of this report.*

17: Pervasive neglect of safe abortion services: "Indeed, if countries and partners are serious about delivering *Every Woman, Every Child*, they must embrace such evidence-informed policies to reduce the large and preventable toll of mortality and morbidity associated from unsafe abortion." (para 69)

*We have seen zero progress on international efforts to address safe abortion.*

18: "We need to build a mechanism to include displaced women and children into our accountability assessment, including those who do not fall within our 75 country remit." (para 70)

*We have seen no new initiatives for displaced women and children, despite a growing need.*

19: "The health of women and children amid these conflagrations should be a higher priority concern for the global community." (para 70)

*Progress has been uneven. There have been isolated efforts in particular conflicts, but overall there have been no new, sustained initiatives for women and children in conflict settings, such as Syria and Afghanistan.*

20: “Robust and cohesive RMNCH advocacy needs to be established through national and sub-national civil society coalitions.” (para 74)

*See Chapter 3.*

21: “Adolescents need to be brought into the mainstream of women’s and children’s health.” (para 91)

*See Chapter 4.*

22: “All partners supporting *Every Woman, Every Child* need to do more to make policymakers, parliamentarians, and political leaders aware of the Commission’s work.” (para 92)

*This work remains to be done.*

23: “Financial donors need to be clear about the extent to which stated financial commitments are being met... We plan to return to this subject more fully in subsequent years.” (para 94)

*We hope to examine this question in next year’s iERG report.*

24: “We hope to bring more precise and quantitative measures to our analysis in future years to understand better how countries are performing relative to themselves and to one another.” (para 56)

*We hope to bring greater quantification to our approach in subsequent reports.*

25: “A mechanism is needed to continuously update the Global Strategy—to take account of the shifting burden of disease and disability facing women and children, as well as to integrate new policies shaping the global and country responses to those burdens.” (point 12, Executive Summary)

*Disappointingly, this rolling revision of the Global Strategy has not taken place.*

## RECOMMENDATIONS

**85.** We now turn to our six 2013 recommendations to strengthen accountability and accelerate progress towards the goals of *Every Woman, Every Child* and the Commission on Information and Accountability for Women’s and Children’s Health.

**86. 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.** The most consistent message we received in our evidence gathering was the importance of strengthening accountability mechanisms within countries, and ensuring meaningful civil society participation in those mechanisms. Ministers of Health often have overall responsibility for leading accountability efforts in health, but implementation of these efforts requires the input and participation of other government ministries, development partners, as well as civil society. Parliaments or parliamentary bodies have a potentially crucial part to play here. Parliaments are a core part of national accountability structures, and they also raise awareness. A major limitation to accountability is the lack of appropriate

data on national and subnational mortality, causes of death, intervention coverage, equity, and the impact of services and policies. These accountability mechanisms also often lack data on quality of care—especially data on safety and the experience for the person, family, or community. There are several successful models of community accountability that countries could draw on to ensure full community participation in their accountability process. Human rights principles of participation, equality, and non-discrimination are important here. As we noted in our discussion about transparency, accountability also means building local capacity to understand and use the data available. Civil society must be actively supported in its work of independent scrutiny. We cannot stress the role of civil society too highly. The evidence is clear: activists have a crucial role in holding governments, policymakers, and health services accountable for the quality of care provided to women and children (93). We have received powerful evidence from several settings in support of this view—India (94), Uganda (World Vision and White Ribbon Alliance evidence to the iERG), Indonesia (World Vision), Tanzania (White Ribbon Alliance), together with Ghana, Burkina Faso, Nigeria, Yemen,

Nepal, Bangladesh, and Malawi (evidence from the White Ribbon Alliance). Often the debate over accountability rightly focuses on monitoring, data, and information. But there has been a relative neglect of the “review” aspect of our accountability model. We call for a revolution in accountability, putting participatory, democratic review on an equal basis with monitoring in national accountability processes. This refocusing of accountability must be evaluated to ensure that whatever community based accountability systems are implemented actually deliver benefits for women and children (95). We would like to see the RMNCH Steering Committee, together with the H4+, other development partners, and global health initiatives (eg, FP2020), take explicit steps to make national accountability a priority between now and 2015, reporting back on progress in countries to the iERG in 2014. To that end, we recommend that Ministers of Health, the ultimate stewards of the health system, together with partners, demonstrably prioritise and evaluate country-led, inclusive, transparent, and participatory national oversight mechanisms for women’s and children’s health. One way to do so would be for PMNCH to convene a Partners’ Forum in 2014 focused on accountability.

**87. Demand global accountability for women and children: Advocate for and win an independent accountability mechanism to monitor, review, and continuously improve actions towards delivering the post-2015 sustainable development agenda.** We have specific proposals to make to ensure that these lessons are translated into action. First, we request a technical consultation on post-2015 accountability mechanisms to take place between the launch of our report in September, 2013, and the end of the year. That technical consultation should not only aim to devise a framework for independent accountability for women’s and children’s health, but also seek ways to incorporate other dimensions of global health within that accountability framework (such as AIDS, tuberculosis, and malaria; non-communicable diseases, including mental health; and neglected tropical diseases). A final framework should be completed by the end of 2013, to be presented first to the Executive Board of WHO in January, 2014, and subsequently to the World Health Assembly in May, 2014. During this consultation process and the presentations to governing bodies of WHO, WHO should also reach out to those responsible for devising the post-2015 development agenda to ensure that this proposal on accountability receives full and proper consideration. We are often asked: what is the role of the iERG post-2015? The answer is that we have no role: our remit ends in 2015. But we hope we can prove the value of an independent accountability mechanism so that those who follow us can learn

from our experience. It is not for us to say whether our work is making a difference for women and children. What we hope we can say is that, working with many partners, we have a role in helping to shape the evolution of progress for women and children. But, at present, there is only lukewarm interest in independent accountability post-2015. We could certainly do better at reaching out to countries to promote the idea of independent accountability for women’s and children’s health. We hope to begin to do so through the Regional Offices of WHO. But in the meantime, we call on our partners in the *Every Woman, Every Child* movement—countries, UN agencies, development partners, academia, civil society, foundations, and the private sector—to evaluate the work of the iERG and, if they see merit to it, to advocate for independent accountability post-2015.

**88. 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.** We have reviewed powerful evidence showing that adolescents are not only a neglected dimension of *Every Woman, Every Child*, but also that adolescents have a key part to play in accountability—nationally, regionally, and globally. Inclusion of youth organisations and representatives should be an explicit component of efforts to embrace civil society organisations in consultations at all levels. On the iERG, we can and should do better to include younger voices in our evidence gathering and deliberations. We recommend that a young (under-25) person with proven interest or experience in women’s, adolescents’, and children’s health be recruited from an international selection process to join the iERG as soon as possible. But we want to go further than simply recommending that adolescent voices be a routine part of policymaking. We want to introduce adolescent health as an explicit part of monitoring progress towards the goals of *Every Woman, Every Child*. To embed adolescent health in routine monitoring means we need to identify an appropriate indicator. We have summarised the most recent evidence on global indicators for adolescent health (Table 11). Which of these indicators is best suited for monitoring progress on adolescent health for our purposes? We have consulted colleagues in WHO and elsewhere, and two stand out: HIV prevalence and adolescent pregnancy. After considerable deliberation, we recommend that adolescent pregnancy (the proportion of women aged 20-24 years who report having had a baby by the age of 18 years) be included in the Commission’s indicator framework, and we invite Countdown to include this indicator in their annual accountability report.

We believe the inclusion of this indicator will help strengthen the commitment of donors and multilaterals to adolescent health.

**89. 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.**

Human rights and women's and children's health have much to contribute to one another. Where might the bridge between the two disciplines lie? There are many points of connection that we have so far outlined in this report—on participation, equality, and non-discrimination in accountability review procedures, and in the availability and accessibility of services. But quality—defined as the effectiveness, safety, and experience of care—might be the most fruitful point of connection. Every visitor to facilities for women's and children's health in countries will have experienced a range of scenarios that testify to an unacceptable variability in the quality of services. Too often women and children receive care that violates principles of dignity and equity. So far, the global community has paid too little attention to these issues. It is time to change that situation of neglect. Indeed, without prioritising quality, current initiatives may actually cause harm. Key commodities for women's health can have powerful beneficial effects. But if, to take one example, oxytocin is used at the wrong time and in the wrong way, it will cause harm. Although an important movement around patient safety has been established, attention to quality in women's and children's health has stalled. We wanted to propose an indicator for quality to be added to the 11—now 12, with the inclusion of an adolescent indicator—we are currently using to monitor progress of *Every Woman, Every Child*. But we were surprised to discover that there is no reliable evidence base from which to select a reliable and easily measurable indicator for quality of care. We now urge WHO, UNICEF, and UNFPA to establish a Task Force on Quality of Care for Women's and Children's Health, under the auspices of PMNCH, as part of the follow-up to the Commission on Information and Accountability. We would hope that a new Task Force on Quality of Care would not only put quality at the centre of women's and children's health, but also help the iERG in defining the best measures of quality to ensure proper accountability in countries and globally. We hope the Task Force can work to a rapid timeline, as did the original Commission on Information and Accountability, delivering a first report, with recommendations, to the iERG by the end of May, 2014.

**90. Make health professionals count: Deliver an expanded and skilled health workforce, especially in sub-Saharan Africa, which serves women and children with measurable impact.** One essential element of a quality revolution is the availability of educated health professionals to deliver high-quality care. "High-quality" includes knowledge, skills, and sensitivities of health workers, and those of the adolescent patient. In the evidence submitted to the iERG, a repeated theme has been the importance of human resources to health. As Lincoln Chen has said, "The only route to achieve the health MDGs is through the health worker: there are no short cuts" (96). According to the 2013 PMNCH report, Global Strategy commitments will have resulted in up to 1.7 million additional health workers being trained—doctors, midwives, nurses, skilled birth attendants, community health workers. PMNCH concludes that this increase is "an important step in closing the estimated global health worker gap of 2.5-3.5 million. This achievement is accompanied by supporting efforts to improve the quality of the existing health workforce and establishing or improving training facilities." Although we commend the commitment of partners in their investments so far, we underline the fact that the Global Strategy estimated that up to 3.5 million additional health workers would need to be trained and deployed in 49 countries by 2015. The iERG's remit is wider—the 75 countries where over 95% of all maternal and child deaths take place. Clearly, the human resource requirements will be considerably greater when one adds in these additional 26 countries. Moreover, for the 210 000 new health workers that PMNCH can locate geographically, only 18 000 are in sub-Saharan Africa, where the biggest workforce gap exists. The fact is that there is a growing inequity in distribution of health professionals dedicated to women's and children's health. In addition, there is growing inequity in countries, and between public and private sectors. An increase in the health workforce does not necessarily lead to greater access to health professionals, especially for the rural poor. While many parts of the world are seeing rapid expansions in health worker numbers, sub-Saharan Africa is being left behind. As evidence submitted to the iERG reported (97):

*"Surprisingly, the EWEC campaign has yet to grasp the centrality of the HRH workforce in accelerating progress. Commissions have been formed on information and accountability and life-saving commodities, raising global awareness of these care components of the Global Strategy. Meanwhile, the priorities of low-income countries to address the service providers themselves—the essential health workers who save the lives of women and children through their daily action—have not been afforded the same international attention."*

In November, 2013, the Third Global Forum on Human Resources for Health takes place in Recife, Brazil. The objective of the meeting is to focus on the health workforce dimensions of universal health coverage. The first Global Forum in 2008 led to the Kampala Declaration, and the second Forum was held in Thailand in 2011. In Brazil, the aim is to release an updated Declaration, together with a new agenda for global action. Part of that new agenda will be “greater accountability to track, monitor, and report on commitments.” Clearer links will also be sought between human resources and the MDGs, social determinants of health, and the post-2015 development agenda. We call on the organisers of the Global Forum in 2013 to give separate and specific attention to human resources for women’s and children’s health. The goal we would hope for is to identify new strategies in countries for the education of health professionals to meet the health and productive needs of women and children. There also needs to be a better way to measure human resources for health, to identify gaps, and to create responsive mechanisms to address those gaps. There are new opportunities to exploit (98). It is a moment to be innovative. The meeting in Brazil could and must kick start a decade of action for human resources for health.

**91. Launch a new movement for better data: Make universal and effective Civil Registration and Vital Statistics systems a post-2015 development target.**

The time is right for the international community to seize the current momentum generated by country and regional action in order to achieve universal and effective CRVS systems in countries. CRVS systems matter to individuals, communities, countries, and globally. The official registration of important life events, including births, deaths, and causes of death, is crucial for individuals to establish legal identity, family relationships, and civil rights. Vital statistics generated through civil registration provide indispensable information about the demographics and health of the population, making policies more effective and responsive to the needs of women and children. CRVS is a broad development agenda and needs to be strongly prioritised in the post-2015 era. CRVS systems are essential to governance because they express the relationship between an individual and the state, thereby promoting democratic participation in debates about access to health services. For partners and donors, CRVS systems provide critical information for development, identifying individuals and populations at risk, as well as actions that must be taken. CRVS systems are absolutely necessary for reliable monitoring as part of a comprehensive system of accountability for women’s and children’s health. Some progress has been made

in recent years. eCRVS and mCRVS interventions have the potential to accelerate that progress still further (99). But today, international institutions have still not made adequate information about births, deaths, and causes of death the priority it should be. The iERG calls for increased advocacy and investment in CRVS systems, aligning partner actions with country and regional leadership, placing CRVS improvements at the forefront of partner activities, and including CRVS as an explicit goal in the post-2015 development framework. We support efforts to create a new global alliance to strengthen CRVS systems in countries, and we are keen to play any part we can to assist this process. That global alliance needs to be in place by the end of 2013, with a global target on CRVS systems identified and agreed in 2014. We propose that the UN Secretary-General and the President of World Bank jointly convene a High-Level Working Group to establish the mandate and terms of reference of a new global alliance for better information—an entity with specific leadership, advocacy, norm-setting, and technical assistance roles to make stronger and more reliable country information systems (for health and other sectors) a reality. We also ask that the RMNCH Steering Committee, H4+, and development partners work with the newly emerging global alliance to ensure that it secures resources and technical capacity to deliver on its objectives, which are crucial for the future of women’s and children’s health.

**92.** These recommendations come at a time of enormous change in women’s and children’s health. Over the next 12 months, for example, we will see new energy being brought to bear on newborn health, still a massively neglected aspect of women’s and children’s health. Even in countries with reductions in under-5 mortality rates, newborn mortality has remained stubbornly resistant to change. As the PMNCH report underlines, the rate of progress in reducing newborn mortality is 40% slower than for children under 5, and is incredibly 30% slower than for reductions in maternal mortality. No statistically significant change in neonatal mortality has taken place in sub-Saharan Africa for a decade. One submission to the iERG called the inattention to newborn health a “global level vacuum.” There have been efforts to improve the global response to newborn deaths—the *Lancet* Neonatal Survival Series in 2005, the Global Strategy itself in 2010, and the Born too Soon initiative in 2012. Research is drawing attention to the importance of preventable newborn deaths (100). And funders and civil society groups are beginning to fill gaps left by international agencies (101). PMNCH reports that 26% of all commitments to the Global Strategy are focused on newborn health. But these commitments are not being translated into new money for neonatal programmes

and policies. Most commitments are from civil society organisations, low-income countries, middle-income countries and academic and research institutions. Disappointingly, many fewer commitments are coming from foundations and multilateral agencies. Even where there are commitments, PMNCH describes uneven and inconsistent expectations about whether those commitments will be fulfilled. Worse still, there are very few reliable data to inform judgements about progress. The major constraints for the future remain lack of financial resources, and human resources too. Lack of awareness and lack of demand play their part also, as well as inadequate coverage of essential interventions for newborn care. Every Newborn (the Global Newborn Action Plan), to be published and launched in 2014, will present a roadmap for change. It will set out a vision with targets, strategic objectives, and actions. It will be supported by new data on mortality trends, interventions, and costs and impact of scaling up. There are already important emerging themes that should be informing policy dialogue now. Actions for newborns should be prioritised during labour, the day of birth, and the first week. Effective interventions exist and must be scaled up. Integrating maternal and newborn interventions is critical. Quality of care matters as much as coverage. Stronger health systems are key. And communities, families, and women have an important role. In all the attention rightly paid to newborns, it is also critical that stillbirths are not excluded. At least 2.7 million stillbirths are estimated to occur every year, 98% in low- and middle-income countries (102). But policies, programmes, and resources fail to meet the demand of this even more invisible and preventable tragedy (103).

**93.** One aspect of women's health that has recently received important new attention, although it is not yet fully integrated into *Every Woman, Every Child*, is violence against women, "a global health problem of epidemic proportions" according to research published in 2013 (104, 105). Globally, 39% of women who are murdered are killed by an intimate partner. Violence that leads to murder commonly represents the culmination of a long history of abuse. 42% of women who have experienced physical or sexual violence by a partner had been injured as a result. Violence is a major contributor to mental health problems among women. Women who experience partner violence are almost twice as likely to experience depression or have alcohol-use problems compared with women who have not experienced any violence. Violence against women also increases the risk of sexually-transmitted infections, unwanted pregnancies and abortion, and low-birth weight babies. New guidelines published by WHO emphasise the importance of training health

providers to ask about violence, ensuring privacy and confidentiality in their consultations, and offering effective referral systems so that women can safely and quickly access health services (106). We have previously recommended that the Global Strategy be updated regularly to take account of new research and policy guidance. There is no better example than these new findings about violence against women of why this rolling approach to continuously improve *Every Woman, Every Child* is so important.

**94.** There are even more intractable determinants of women's and children's health that deserve greater attention. Who speaks for the stateless, those women and children who are displaced from their homes because of conflict or humanitarian disaster (107)? Or for adolescents seeking better opportunities through migration in pursuit of education and work (108)? Although the iERG has no additional new information to bring to bear on women, adolescents, and children who are enduring displacement, we wish to draw the particular attention of partners to the importance of this issue. In June, 2013, on the occasion of World Refugee Day, the UN's High Commissioner for Refugees, António Guterres, spoke from Jordan about his concerns for the people of Syria. He said: "In all the years I have worked on behalf of refugees, this is the most worrying I have ever witnessed. The needs of these people are overwhelming; their anguish is unbearable. Today, there are over 1.6 million registered Syrian refugees...thousands come every day, seeking places to stay, sustenance, someone who will listen and help them heal." Guterres emphasised the plight of children: "Nightmares define their waking lives as much as they haunt their sleep. School is a distant memory." In addition to the suffering of children, there are increasing numbers of reports of sexual violence against women, including rape (109). It is essential that all partners to the Global Strategy mobilise in support of the women, adolescents, and children displaced by the Syrian conflict. The country case study on Syria that we have commissioned for this report (see p. 32) describes these predicaments for women and children further.

**95.** Advocacy is critical to maintain and increase momentum for women's, adolescents' and children's health. The UN definition of advocacy is "the process of managing information and knowledge strategically to change and/or influence policies and practices that affect the lives of people—particularly the disadvantaged." In other words, advocacy is about people, values, and power. 46% of commitments to the Global Strategy contain specific advocacy content, while up to 80% of survey respondents to PMNCH state that their commitments are contributing to advocacy for the goals of the Global Strategy. The

main categories of commitment are advocacy for service delivery, investment, policy, accountability, social determinants, human rights, equity, and improved coordination. Most commitments relate to policy development and political support, with the greatest attention being on sub-Saharan Africa. And most of the commitments are so far being implemented by NGOs. However, the expectation that commitments would be completed by 2015 was less than 50%. The key enablers to drive success will be initiatives and events, innovative uses of media, and parliaments. There are efforts to keep an advocacy focus on specific issues pertaining to women's and children's health through specially designated health days or weeks (Table 14). But these opportunities are poorly coordinated and it is not fully clear what they achieve. The main constraints to successful advocacy are lack of people and lack of money.

**96.** The iERG cannot speak about, let alone solve, all problems for women's and children's health. One fair criticism of our first report was that we should have been more specific in our recommendations (a criticism we have tried to address this year). But we are also part of a process—the Commission on Information and Accountability—that is, we must acknowledge, fragile. The 2012-15 budget for the post-Commission work is US\$96.5 million. In 2013, there is, at the time of writing, a US\$5 million funding gap. Over the next 2 years that funding gap is US\$56 million. The additional resources are largely needed to support countries. Our recommendations in this 2013 report will not be fulfilled without the commitment of partners to the process they initiated in 2011. WHO identifies the lack of funding as “a significant risk.” They go on: “the overall funding required to support country implementation significantly exceeds the work plan funding estimate.” What is needed urgently is a replenishment exercise to ensure that what has been started can be continued. The iERG has heard no-one say that this agenda is not important. All partners support *Every Woman, Every Child* and the recommendations of the Commission on Information and Accountability. But when it comes to financial support, there seems to be a worrying gulf between words and deeds.

**97.** We have noted that our remit and work doubled this year with the incorporation of the UN Commission on Life-Saving Commodities for Women and Children into our terms of reference. We welcome this attempt to integrate rather than duplicate accountability arrangements for women's and children's health. We also note that in 2014 four of the Commission's recommendations are expected to be fulfilled: on shaping local delivery markets, on demand and

utilisation, on reaching women and children, and on product innovation. We have already noted our disappointment that we did not receive a formal report on progress towards those recommendations that were supposed to have been met in 2013. At this point, we wish to signal our concern that the Commission on Life-Saving Commodities does not yet seem fully ready or able to deliver on its ambitious agenda. We urge all stakeholders responsible for this Commission to review urgently: the status of expected post-Commission work over the next two years; the resources needed to deliver that work and achieve the recommendations on time; and the implications of not doing so.

**98.** The message we wish to convey in our 2013 report is one of opportunity. Scientific evidence points unequivocally to what can be achieved if high rates of coverage with life-saving preventive and treatment interventions could reach women and children. We know the frontline care, health system, social, and political determinants that have to be addressed if we are to make sustained and sustainable progress. We better understand the dimensions of accountability that need to be fulfilled in countries and globally. Never has our knowledge and understanding about what we need to do for women and children been better. Of course, there is more to learn and to investigate. But the main limitation to progress today is not lack of knowledge. What will transform the lives of adolescents', women's, and children's health is our imagination and our conviction. Our imagination, because we have to envision a different future for the most vulnerable women and children in the world today. Our conviction, because once we have that image of their future, we must have the belief and will to deliver it. Independent accountability creates the opportunity for a vision to be agreed upon by all partners. It also provides a means to ensure that this vision is progressively realised—and quickly.

**99.** We also see great opportunities as the MDG era begins to draw to a close. Writing a new post-2015 development agenda allows partners to think differently and radically about how to end diseases that dominate the health landscape today. Is the end of AIDS truly in our sights and, if so, how do we make the possibility of an AIDS-free generation a reality? Can we envisage eliminating preventable child mortality by 2035? And can we expect the same for maternal mortality? Can movements that have accelerated progress in certain domains of global health—such as the AIDS movement—be revived, expanded, and redirected to a broader development vision? And if any of these seemingly wild hopes could conceivably come true, what are the institutions we need to deliver those hopes?

Should the present UN system stay largely the same? Or should it evolve? Should UNAIDS continue to focus only on AIDS? Should WHO reform enter a second phase that strengthens the agency's role in accountability? Should UNICEF, UNFPA, WHO, and UN Women find a mutually acceptable way to work more closely together as one integrated organisation for women, adolescents, and children? And can human rights tools be more effectively deployed to ensure that the goals and targets set post-2015 identify clear responsibilities for different development

actors, demand that those actors are answerable for those responsibilities, and insist on enforceable sanctions should those responsibilities not be fulfilled (110)? These questions need time and space to be asked, debated, and answered. In the rush to make as much progress as possible before 2015, it is perhaps understandable that these questions are sometimes put to one side. But we believe now is the right moment to think differently and to grasp new opportunities. The future for women and children depends upon us doing so.

**Table 14: Opportunities for attention through dedicated days of advocacy for women and children**

February 4	World Cancer Day
February 6	International Day of Zero Tolerance to Female Genital Mutilation
February 10-16	Pregnancy Awareness Week
March 8	International Women's Day
April 7	World Health Day
April 24-30	World Immunisation Week
April 25	World Malaria Day
May 5	International Day of the Midwife
May 23	International Day to End Obstetric Fistula
May 28	International Day of Action for Women's Health
June 20	World Refugee Day
August 1-7	World Breastfeeding Week
August 19	World Humanitarian Day
September 26	World Contraception Day
September 28	Global Day of Action for Access to Safe and Legal Abortion
October 11	International Day of the Girl Child
October 15	International Day of Rural Women
November 10	World Immunisation Day
November 12	World Pneumonia Day
November 17	World Prematurity Day
November 20	Universal Children's Day
November 25	International Day for the Elimination of Violence Against Women
December 1	World AIDS Day
December 10	Human Rights Day



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# APPENDICES

## APPENDIX 1: RECOMMENDATIONS OF THE COMMISSION ON INFORMATION AND ACCOUNTABILITY FOR WOMEN'S AND CHILDREN'S HEALTH

### **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 expenditure.
- *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: TERMS OF REFERENCE OF THE IERG AND ITS COUNTRIES OF CONCERN

The UN Commission on Information and Accountability for Women's and Children's Health was established by WHO at the request of the United Nations Secretary-General to accelerate progress on the Global Strategy for Women's and Children's Health. The Commission was chaired by H.E. Jakaya Kikwete, President of the United Republic of Tanzania and Rt. Hon. Stephen Harper, Prime Minister of Canada, with the Director-General of WHO and the Secretary-General of ITU as vice-chairs. The Final Report of the Commission proposed an accountability framework and ten recommendations. The full Report is available online at [www.everywomaneverychild.org/accountability\\_commission](http://www.everywomaneverychild.org/accountability_commission). On the issue of global reporting, the Commission proposed a time-limited independent Expert Review Group be established and operate until 2015:

*“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.”*

In response to Recommendation 10 (Global oversight), starting in 2012 and ending in 2015, the independent Expert Review Group (IERG) will serve as the principal global review group and report to the UN Secretary-General, through WHO Director General.

The independent ERG will:

- assess the extent to which all stakeholders honour their commitments to the Global Strategy and the Commission; including the US\$ 40 billion of commitments made in September, 2010;
- review progress in implementation of the recommendations of the Commission;
- assess progress towards greater transparency in the flow of resources and achieving results;
- identify obstacles to implementing both the Global Strategy and the Commission's recommendations;
- identify good practice, including in policy and service delivery, accountability arrangements and value-for-money approaches relating to the health of women and children;
- make recommendations to improve the effectiveness of the accountability framework developed by the Commission.

### Countries

The global oversight covers 75 low- and middle-income countries with 98% of the world's maternal and child mortality. 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)

Angola\*, Benin, Botswana\*, Burkina Faso, Burundi, Cameroon\*, Central African Republic, Chad, Comoros, Congo\*, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea\*, Eritrea, Ethiopia, Gabon\*, The Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho\*, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Africa\*, South Sudan\*, Swaziland\*, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe

#### 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

## APPENDIX 3: RECOMMENDATIONS OF THE COMMISSION ON LIFE-SAVING COMMODITIES

### **Improved markets for life-saving commodities**

1. *Shaping global markets:* By 2013, effective global mechanisms such as pooled procurement and aggregated demand are in place to increase the availability of quality, life-saving commodities at an optimal price and volume.
2. *Shaping local delivery markets:* By 2014, local health providers and private sector actors in all EWEC countries are incentivised to increase production, distribution and appropriate promotion of the 13 commodities.
3. *Innovative financing:* By the end of 2013, innovative, results-based financing is in place to rapidly increase access to the 13 commodities by those most in need and foster innovations.
4. *Quality strengthening:* By 2015, at least three manufacturers per commodity are manufacturing and marketing quality-certified and affordable products.
5. *Regulatory efficiency:* By 2015, all EWEC countries have standardized and streamlined their registration requirements and assessment processes for the 13 live-saving commodities with support from stringent regulatory authorities, the World Health Organization and regional collaboration.

### **Improved national delivery of life-saving commodities**

6. *Supply and awareness:* By 2015, all EWEC countries have improved the supply of life-saving commodities and build on information and communication technology (ICT) best practices for making these improvements.
7. *Demand and utilization:* By 2014, all EWEC countries in conjunction with the private sector and civil society have developed plans to implement at scale appropriate interventions to increase demand for and utilization of health services and products, particularly among under-served populations.
8. *Reaching women and children:* By 2014, all EWEC countries are addressing financial barriers to ensure the poorest members of society have access to the life-saving commodities.
9. *Performance and accountability:* By end 2013, all EWEC countries have proven mechanisms such as checklists in place to ensure that health-care providers are knowledgeable about the latest national guidelines.

### **Improved integration of private sector and consumer needs**

10. *Product innovation:* By 2014, research and development for improved life-saving commodities has been prioritized, funded and commenced.

## APPENDIX 4: HIGH-LEVEL PANEL—UNIVERSAL GOALS AND NATIONAL TARGETS FOR WOMEN AND CHILDREN

### 1. End Poverty

- 1b. Increase by x% the share of women and men, communities, and businesses with secure rights to land, property, and other assets

### 2. Empower Girls and Women and Achieve Gender Equality

- 2a. Prevent and eliminate all forms of violence against girls and women
- 2b. End child marriage
- 2c. Ensure equal rights of women to own and inherit property, sign a contract, register a business and open a bank account
- 2d. Eliminate discrimination against women in political, economic, and public life

### 3. Provide Quality Education and Lifelong Learning

- 3a. Increase by x% the proportion of children able to access and complete pre-primary education
- 3b. Ensure every child, regardless of circumstance, completes primary education able to read, write and count well enough to meet minimum learning standards
- 3c. Ensure every child, regardless of circumstance, has access to lower secondary education and increase the proportion of adolescents who achieve recognised and measurable learning outcomes to x%
- 3d. Increase the number of young and adult women and men with the skills, including technical and vocational, needed for work by x%

### 4. Ensure Healthy Lives

- 4a. End preventable infant and under-5 deaths
- 4b. Increase by x% the proportion of children, adolescents, at-risk adults and older people that are fully vaccinated
- 4c. Decrease the maternal mortality ratio to no more than x per 100,000

- 4d. Ensure universal sexual and reproductive health and rights

- 4e. Reduce the burden of disease from HIV/AIDS, tuberculosis, malaria, neglected tropical diseases and priority non-communicable diseases

### 5. Ensure Food Security and Good Nutrition

- 5a. End hunger and protect the right of everyone to have access to sufficient, safe, affordable, and nutritious food
- 5b. Reduce stunting by x%, wasting by y%, and anaemia by z% for all children under five

### 6. Achieve Universal Access to Water and Sanitation

- 6a. Provide universal access to safe drinking water at home, and in schools, health centres, and refugee camps
- 6b. End open defecation and ensure universal access to sanitation at school and work, and increase access to sanitation at home by x%

### 8. Create Jobs, Sustainable Livelihoods, and Equitable Growth

- 8b. Decrease the number of young people not in education, employment or training by x%

### 10. Ensure Good Governance and Effective Institutions

- 10a. Provide free and universal legal identity, such as birth registrations
- 10c. Increase public participation in political processes and civic engagement at all levels
- 10d. Guarantee the public's right to information and access to government data

### 11. Ensure Stable and Peaceful Societies

- 11a. Reduce violent deaths per 100,000 by x and eliminate all forms of violence against children

## APPENDIX 5: EVIDENCE COMMISSIONED BY, AND SUBMITTED TO, THE IERG

### Evidence submitted to the iERG (in alphabetical order)

1. *Aahung, WPF, WHO (Sheena Hadi, Qadeer Baig, Syeda Ayesha Ali, Aisha Ijaz and with support from Venkatraman Chandra-Mouli)*  
Implementing Comprehensive Sexuality Education, in a climate of growing conservatism: The case of Pakistan
2. *Asian-Pacific Resource and Research Centre for Women - ARROW (Nalini Singh)*  
Rights Based Continuum of Quality Care for Women's Reproductive Health in south Asia
3. *Bill & Melinda Gates Foundation (Susannah Canfield Hurd)*  
- Donor and Government accountability  
- Human rights and the role of private sector  
- Access to innovative contraceptive implant implanon/nxt in the developing world
4. *Family Care International (Amy Boldosser)*  
Mobilizing Advocates from Civil Society
5. *Family Care International (María Faget Montero and Ariadna Capasso) with support from (WHO) Venkatraman Chandra-Mouli*  
Communities mobilizing for adolescents' sexual and reproductive health: the case of Guatemala
6. *Health Partners International (Paula Quigley)*  
Mobilising Access to Maternal Health Services in Zambia (MAMaZ)
7. *International Alliance of Women - IAW (Gudrun Haupter)*  
NGO-Government cooperation improves adolescent sexual and reproductive health in Togo
8. *ICS Integrare (Jim Campbell)*  
Commitments for "Every Woman, Every Child": a Human Resources for Health perspective
9. *International Institute for Democracy and Electoral Assistance - International IDEA (Alberto Fernández Gibaja)*  
Why politics matter: aid effectiveness and domestic accountability in the health sector
10. *IIT Kanpur (Rohini Ghosh)*  
Female feticide: A case of financial autonomy in India
11. *International Organization of Physical Therapists*  
*in Women's Health - IOPTWH (Ruth Broom and Rebecca Stephenson)*  
New Zealand: Physical therapy and FGM: a globally displaced woman seeks optimal health
12. *IPPF (Laura Malajovich)*  
Funding youth policies in Mexico: a partner in the legislative branch
13. *Novo Nordisk A/S (Scott Dille)*  
Video documents:  
- "Now this child is your child" – Changing Diabetes in Children, Ethiopia  
- Safiatou Diallo – a young girl with diabetes in Guinea  
- Changing Diabetes in Children – Bangladesh
14. *Pathfinder, WHO(\*) (Gwyn Hainsworth, Callie Simon and V Chandra-Mouli(\*))*  
How a low-income country facing many health and social challenges, joined hands with partners to set up a programme that has endured, extended its reach and improved the sexual and reproductive health of young people: The case of Mozambique.
15. *Reproductive Health Matters (Louise Finer)*  
Information on adolescents, accountability mechanisms, human rights and transparency
16. *Results for Development (Christina Synowiec)*  
MNCH innovations in low- and middle-income country health markets
17. *Karin Ringheim*  
A question to the iERG
18. *Save the Children (Louise Holly)*  
Response to the iERG Call for Evidence
19. *Stop AIDS now (Miriam Groenhof)*  
- Working towards evidence and rights based SRHR and HIV prevention interventions for youth  
- Evaluation of the use of the workbook "Are you on the right track?" in Zimbabwe
20. *UNICEF (Tessa Wardlaw)*  
Household surveys, Interagency MDG Monitoring Groups, Birth Registration
21. *UCLA (Isabel K. Latz)*  
Measuring and Mapping Policy Progress: One of the Necessary Steps in Increasing Accountability
22. *UCL institute for Global Health (Anthony Costello)*  
- Women's groups practising participatory learning

and action to improve maternal and newborn health in low-resource settings: a systematic review and meta-analysis

- Participatory women's groups: ready for prime time?

23. *University of Limerick (Pieterella Pieterse)*  
Sierra Leone's Free Healthcare Initiative - How one NGO monitors and motivates at the same time
24. *University of Oslo (Petter Nielsen)*  
*Advancing Health Information Systems*  
Experiences from Implementing DHIS 2 in Africa
25. *The White Ribbon Alliance (Katy Woods)*  
National Accountability for Delivery Commitments
26. *WITS Reproductive Health & HIV Institute (Holly Fee)*
  - ART in limited resource setting
  - High prevalence of childhood multi-drug resistant tuberculosis in Johannesburg, SA: a cross sectional study
  - Frequency of stavudine substitution due to toxicity in children receiving ART in Soweto
  - ART outcomes in HIV-Infected children after adjusting protease inhibitor dosing during tuberculosis treatment
  - Cost and outcomes of paediatric ART in South Africa
27. *WHO (Krishna Bose)*  
A Rights-Based Approach to the Delivery of Youth-Friendly Health Services (YFHS) in Tajikistan
28. *WHO, University of Southampton(\*) (Doris Chou, Venkatraman Chandra-Mouli, Sarah E Neal\*)*  
Disaggregation of adolescent fertility data for improved programme planning and monitoring
29. *WHO (Venkatraman Chandra-Mouli)*  
Why have so few countries moved from sound policies and strategies to large scale and sustained programmes on Adolescent Sexual and Reproductive Health ? And what has enabled the few positive deviants to do so ?
30. *World Vision International (Emma Edwards)*
  - Uganda: impacting national health policy change through local-level accountability
  - Indonesia: working in coalition to promote national-level accountability for commitments to *Every Woman, Every Child*

### Work commissioned by the iERG<sup>1</sup>

1. *UN Commission on Life-Saving Commodities*  
A report on progress of assessment and monitoring framework of the Commodities Commission and assessment of the progress on Recommendations 1, 3 and 9 of the Commodities Commission due in 2013.  
**Note: no submission received**
2. *Countdown to 2015*  
Progress on the Commission indicators  
**Note: submission received**
3. *Family Planning 2020*  
A report on the progress made in monitoring the implementation of FP commitments by the 75 priority countries  
**Note: no submission received**
4. *GAVI*  
Progress report on the new vaccination agenda in the 75 countries, including the plans to scale up and strengthen routine immunization systems in these countries  
**Note: submission received**
5. *Global Fund*  
Evidence or case studies (both good and bad news) about the progress in implementation of health programmes supported by the Global Fund that cover a range of interventions for women and children across the continuum of pre-pregnancy, pregnancy, birth and infant and child care worldwide and in particular in 75 countries  
**Note: submission not specific to the iERG's request**
6. *Guttmacher Institute*  
Data reflecting progress in addressing unsafe abortion worldwide and in particular in the 75 priority countries  
**Note: submission received**
7. *H4+*  
Information on the progress made in monitoring the implementation of commitments made to the Global Strategy  
**Note: submission received**

<sup>1</sup> Responses were requested by specific dates

8. *IPU*  
Information on the progress achieved in parliamentary engagement and oversight for reproductive, maternal, newborn and child health in the 75 priority countries  
**Note: submission received**
9. *ITU*  
(1) A report on the baseline and progress made in using ICT to improving accountability (monitoring, reviewing, action) and women's and children's health  
(2) An overview of good country examples where ICT was used to enhance implementation of the first nine Commission's recommendations, in particular cases that have quantified specific impact that was resulted from use of ICT  
**Note: submission received**
10. *PMNCH*  
Report on the implementation of the GS commitments by stakeholders  
**Note: submission received**
11. *Promise Renewed*  
2012/2013 progress report on the implementation of A Promise Renewed commitments in 75 countries, highlighting both positive developments and challenges.  
**Note: submission received**
12. *SAGE / Decade of Vaccines*  
A report, that will be presented every year to the World Health Assembly (WHA) as well as any relevant update; information on the progress being made on immunization and the contribution it makes to children's and women's health  
**Note: no specific iERG-related submission received**
13. *UNAIDS*  
Information on the progress made in the Global Plan for Elimination of Mother and Child Transmission especially in the in the 75 priority countries  
**Note: no specific iERG-related submission received**
14. *UNECA*  
Information on the progress on strengthening health information systems in the African countries on annual basis  
**Note: submission received**
15. *World Vision*  
(1) Information on the progress achieved under the World Vision's commitment for Strategic Alignment, in particular in the implementation of the Health and Nutrition Strategy in the 75 priority countries  
(2) Information on the progress achieved under the World Vision's commitment for Social Accountability, in particular in tracking commitments and parliamentary engagement of the Inter-Parliamentary Union (IPU) in the 75 priority countries  
**Note: submission received**
- 16.a *World Health Organization – on behalf of implementing partners*  
(1) Information on the progress made in implementing the first nine CoIA recommendations in the 75 countries  
(2) Reporting of specific actions that were taken by WHO and the partners to address the iERG 2012 recommendations, and their outcomes.  
**Note: submission received**
- 16.b *World Health Organization – Assistants Director-General (ADGs)*  
(1) Review of the iERG 2012 report and identification of potential interaction between the iERG and their areas of responsibility  
(2) Evidence around RMNCH in the context of their area of work  
Requests sent to four ADGs for (1) Noncommunicable Diseases and Mental Health, (2) Polio, Emergencies and Country Collaboration; (3) HIV/AIDS, TB, Malaria and Neglected Tropical Diseases; (4) Health Security and Environment  
**Note: submissions received**
- 16.c *World Health Organization – Regional Directors (RDs)*  
(1) Review of the 2012 iERG report and identification of potential interactions between the iERG and their areas of responsibility  
(2) Evidence around RMNCH from their specific region  
Requests sent to six RDs for (1) African Region (AFRO), (2) Region of the Americas (AMRO/PAHO), (3) Eastern Mediterranean Region (EMRO), (4) European Region (EURO), (5) South-East Asia Region (SEARO), (6) Western Pacific Region (WPRO).  
**Note: submissions received**

## Feedback and evidence requested by the iERG<sup>2</sup>

1. *World Health Organization – Representatives of WHO country offices*
  - (1) Review of the iERG 2012 report from the WHO Representative position and identification of potential interactions between the iERG and their areas of responsibility;
  - (2) Material for case studies to be published in the next iERG reports;
  - (3) List of 4-5 key stakeholders at country level representing key health and non-health actors in the work related to ours and dissemination of the 4-5 hard copies of the iERG 2012 report to these stakeholders. These should include the Minister of Finance (or equivalent minister responsible for resources tracking) and the Minister responsible for Civil Registration and Vital Statistics (or equivalent minister)

Requests sent to the WHO Representatives of 75 countries of the iERG focus.

**Note: no submission received**

2. *Ministries of Health*  
Review of the iERG 2012 report from the leadership position, identification of weaknesses and deficiencies, suggestions for improvement .

Requests sent to the Ministers of Health of 75 countries of the iERG focus.

**Note: no submission received**

3. *Human Rights Treaty Bodies*  
Review of the *iERG Recommendation 5. Strengthening human rights tools and frameworks to achieve better health and accountability for women and children* and advice on how to operationalize it.

Requests sent to five HR treaty bodies: (1) The Committee on Economic, Social and Cultural Rights (CESCR), (2) The Committee on the Elimination of Discrimination against Women (CEDAW), (3) The Committee on the Elimination of Racial Discrimination (CERD), (4) The Committee on the Rights of the Child (CRC), (5) The Committee on the Right of Persons with Disabilities (CRPD)

Note: in response to these requests, the OHCHR and the iERG co-organized the iERG Human Rights workshop on 6 March 2013, participated by the representatives of five HR treaty bodies. The workshop had a two-fold purpose: (1) to enhance information exchange between the HR treaty bodies and the iERG, and (2) to discuss the concrete implications of further integration of human rights into the work of the iERG with a focus on human rights indicators.

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<sup>2</sup> Requests had no specific timeline for response

## APPENDIX 6: GLOBAL HEALTH ESTIMATES: PROPOSALS ON THE WAY FORWARD

*Summary of a Technical Meeting  
WHO, Geneva, 13-14 February, 2013*

Global, regional, and country statistics on population and health indicators are important for assessing development and health progress and for guiding resource allocation. The demand is growing for timely data to monitor progress in health outcomes such as age- and cause-specific mortality rates, prevalence of disease and risk factors, and measures that combine mortality and disability. Much of the current focus is on monitoring progress towards the targets of the (health-related) MDGs, including time series and country-level estimates that are regularly updated. But increasingly, the demand is for comprehensive estimates across the full spectrum, including noncommunicable diseases and injuries.

Because of the major data gaps and measurement issues for mortality and health statistics, adjustments and predictions are needed to transform raw or crude data to comprehensive and comparable estimates. Time series estimates for child and adult mortality and priority causes, including HIV, TB, malaria, maternal mortality and major causes of child deaths have been published by UN agencies. For many mortality and health indicators there are now at least two sets of estimates. The recently published Institute for Health Metrics and Evaluation (IHME) GBD 2010 comprises estimates of child and adult mortality by cause for three time periods based on a range of new methods.

More than 60 experts and UN agency staff met to take a broad view of estimation practices with the following objectives:

- To take stock of current and new approaches related to global health estimation
- To discuss and agree upon ways in which current estimation practices can be improved, including data availability, country capacity strengthening, model selection, data sharing, methods and tools development and sharing.

The meeting, chaired by Peter Piot and Hans Rosling, was organized according to a series of sessions that were introduced by a panel of speakers who presented different viewpoints on the topic. The session topics included current practices in global health estimates (general), country capacity for development and use of estimates, model selection and statistical issues, and sharing of data and methods. In the final session the participants discussed and agreed upon a series of proposals for the way forward.

### Proposals on the way forward

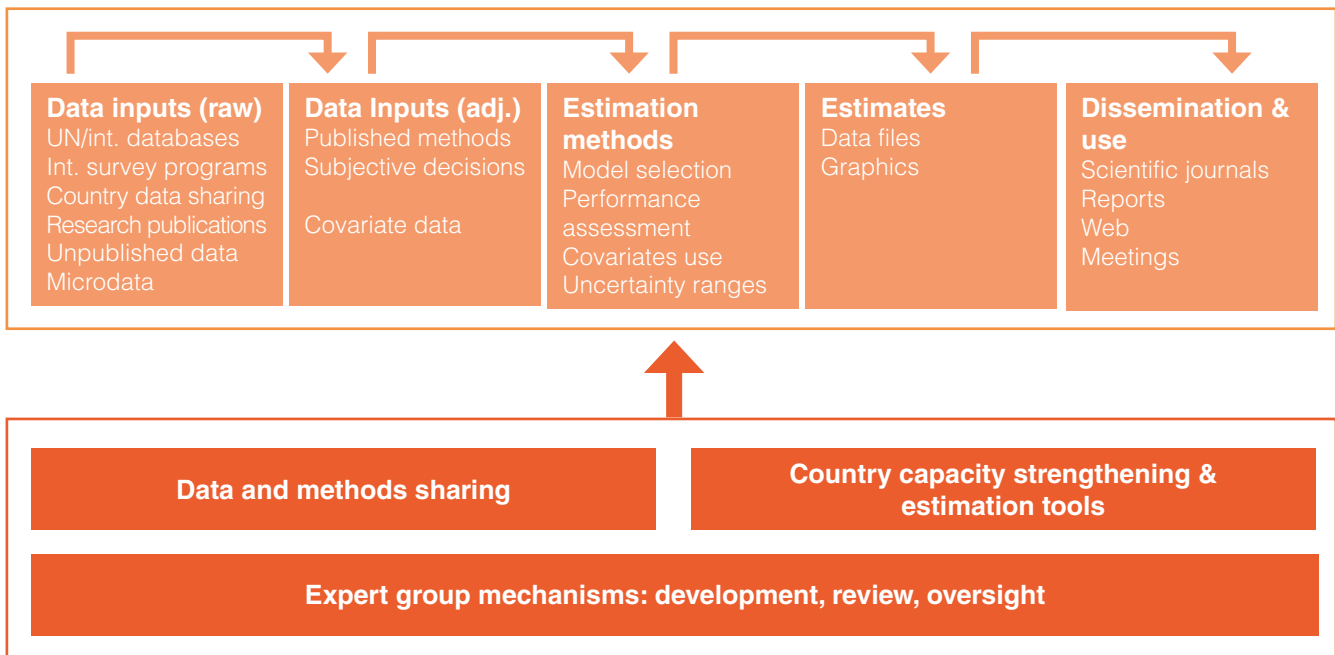
1. Global, regional, and country estimates of health indicators are needed to transform raw data to comprehensive and comparable estimates and to fill data gaps.
  - a. Considerable progress has been made in the field of global health estimation, but much work remains to be done to strengthen country data and capacity, improve transparency, and allow debate on methods.
  - b. The presence of multiple actors in the field of global health estimates can be a healthy basis for continuous improvement of estimates. The plurality of estimates will be most productive if accompanied by regular interaction and cooperation between major actors in order to share methods and identify and communicate reasons for differences in estimates.
  - c. We propose the establishment of an overall platform, with global representation, that focuses on overall mortality rates, causes of death, risk factors and burden, and facilitates interaction between multilateral development institutions, IHME and other independent academic groups, and WHO expert groups in specific subject areas.
2. Greater investment in **country health information systems**, as part of health systems strengthening, is necessary to improve health estimates, to reduce reliance on statistical models for prediction, and to provide a solid empirical basis for monitoring health trends. The focus should be on:
  - a. Birth and death registration, including medical certification and ICD coding of cause of death, with verbal autopsy as an interim strategy; We propose that a target on civil registration and vital statistics be included in the post-2015 development agenda.
  - b. Household health surveys that include mortality modules, as well as biological and clinical data collection, with sufficient sample size for subnational estimates.
  - c. Other sources of health information, including disease surveillance systems, health facility/hospital data, and disease registries.
3. Greater investment in **country capacity** in estimation work should be a priority, including data analysis and production, interpretation, and use of estimates:
  - a. Multilateral institutions, academia, donor agencies, and national governments all have an important role in strengthening capacity through



- substantial and sustained investments focusing on country institutions.
- b. Timely and responsive consultation with countries on estimates is an important quality control measure that can improve estimates, but also builds country capacity and facilitates data improvement and use for national policy formulation. Consultations should be technical in scope with a focus on appropriate use of data and methods.
  - c. When estimates are made for a specific country, the goal is to strive for strong participation of personnel at local institutions. This is often not feasible for estimates that are made for many countries at the same time.
4. Global health estimation work should meet agreed standards of **transparency**:
- a. All major global investments in systematically gathering data to inform estimates should lead to publicly accessible up-to-date databases and estimation tools, including input data, adjusted data, software and final estimates. Funding agencies should contribute by requiring data and methods sharing as part of their investment in health research. Users of shared data and software have the responsibility to appropriately attribute the data sources.
  - b. Better communication of estimation work is essential, including user-friendly estimation tools, commentaries in journals, and training materials.
  - c. Published data and estimates should be freely available (ideally with open access if published in peer-review journals) so there are no unnecessary barriers to access.
  - d. UN entities, research funders and scientific journals should advocate for the sharing of microdata and aggregated data by countries, researchers and others, building upon a code of conduct for research data sharing developed by researcher funders with WHO in 2010
  - e. Scientific journals should continue to strengthen requirements to share data and methods on publication, as well as making all materials available to peer reviewers.
  - f. A standard checklist for reporting global health estimates should be developed. All producers of global health estimates should aim to follow these reporting guidelines when publishing new estimates (see box below for elements that may be included in such a checklist).

#### Elements of documentation accompanying estimates

- a. A complete listing of data sources used in the analysis, with relevant metadata;
- b. Decision rules for inclusion of data points, including identification of outliers, use of quality-related weighting, and use of subnational data;
- c. Explanation and justification of adjustments to incomplete or inaccurate data, including mathematical formulae;
- d. Explanation of alternative models considered during the model selection process, including covariates evaluated;
- e. Description of the statistical model(s) finally used to impute missing values and predict estimates from multiple data points, including mathematical formulae;
- f. Systematic evaluation of model performance, including but not necessarily limited to out-of-sample predictive validity measures; and
- g. Specification of the precision of the estimates, ideally in the form of uncertainty ranges.



# independent Expert Review Group (iERG)

## Members



### **Professor Richard Horton** **iERG Co-Chair**

Richard Horton is Editor-in-Chief of *The Lancet*. He is an honorary professor at the London School of Hygiene and Tropical Medicine, University College London, and the University of Oslo; a Foreign Associate of the US Institute of Medicine and a Fellow of the UK's Academy of Medical Sciences.



### **Mrs Joy Phumaphi** **iERG Co-Chair**

Joy Phumaphi is the Executive Secretary of the African Leaders Malaria Alliance (ALMA). Joy Phumaphi is a distinguished African American Institute Fellow and has been Commissioner in the UN Secretary-General's Commission on HIV/AIDS and Governance in Africa. She held the position of Vice President & Head of the Human Development Network at the World Bank until the end of 2009.



### **Dr Carmen Barroso** **iERG Member**

Carmen Barroso is the Regional Director of International Planned Parenthood Federation, Western Hemisphere Region (IPPF/WHR). Among her responsibilities is the leadership of a comprehensive accreditation system to ensure accountability among member associations.



### **Professor Zulfiqar Bhutta** **iERG Member**

Zulfiqar Bhutta is the Noordin Noormahomed Sheriif Endowed Professor and Founding Chair of the Division of Women and Child Health, Aga Khan University, Karachi, Pakistan. He also holds adjunct professorships at several leading Universities globally including the Schools of Public Health at Johns Hopkins (Baltimore), Harvard and Tufts Universities (Boston), University of Alberta and the London School of Hygiene & Tropical Medicine.



### **Mrs Kathleen Ferrier** **iERG Member**

Kathleen Ferrier is strongly committed to global social change. She has been a member of the Dutch parliament for over ten years and is the founder of the Dutch All Party Initiative on SRHR and HIV/AIDS. She has lived in different countries and worked as an expert in sustainable development, population policies and migration.



### **Professor Dean Jamison** **iERG Member**

Dean Jamison is Professor in the Department of Global Health at the University of Washington. In 2006-2008 Prof. Jamison served as the T. & G. Angelopoulos Visiting Professor of Public Health and International Development in the Harvard Kennedy School and the Harvard School of Public Health. He concurrently served as a Professor in Global Health Sciences at the University of California, San Francisco.



### **Professor Tarek Meguid** **iERG Member**

Tarek Meguid is Associate Professor and Head of the Department of Obstetrics & Gynaecology at the University of Namibia School of Medicine. He is the former Head of the Department of Obstetrics & Gynaecology at Bwaila Hospital and Kamuzu Central Hospital in Lilongwe, Malawi.



### **Professor Miriam Were** **iERG Member**

Miriam Were's career path includes working for the University of Nairobi Faculty of Medicine, the Ministry of Health in Kenya, UNICEF as Chief of Health and Nutrition in Ethiopia, Representative of the World Health Organisation in Ethiopia and Director of the UNFPA for the Technical Advisory Team (Country Support Team) for East, Central and Anglophone West Africa from which she retired in 2000. Since retirement, she has continued to be professionally involved in the health sector.



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STRENGTHENING EQUITY AND DIGNITY THROUGH HEALTH