



EVERY WOMAN
EVERY CHILD



COUNTRY DATA, UNIVERSAL ACCOUNTABILITY

MONITORING PRIORITIES FOR THE GLOBAL STRATEGY FOR
WOMEN'S, CHILDREN'S AND ADOLESCENTS' HEALTH (2016-2030)



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EXECUTIVE SUMMARY

The *Global Strategy for Women's, Children's and Adolescents' Health (2016-2030)* came into effect alongside the Sustainable Development Goals (SDGs) in January 2016. Its vision is to advance the 2030 Agenda for Sustainable Development by guiding transformative change that enables every woman, child and adolescent – in every setting – to realize their full potential and their human right to the highest-attainable standard of health. It is put into action by the Every Woman Every Child (EWEC) movement, which supports country-led implementation through aligned multistakeholder commitments, technical support, financing and a Unified Accountability Framework.

The EWEC Global Strategy targets are fully aligned with the SDGs along three axes: 1) **Survive** (end preventable deaths); 2) **Thrive** (ensure health and well-being); and 3) **Transform** (expand enabling environments). This report assesses the worldwide state of readiness to begin monitoring of progress using the Indicator and Monitoring Framework of the Global Strategy.

CHAPTER 1. COUNTRY DATA

Effective monitoring of progress on women's, children's and adolescents' health relies on well-functioning country health information systems that draw data from sources such as civil registration and vital statistics (CRVS) systems, health facilities, administrative sources, surveillance systems and household surveys. However, health information systems in many countries do not currently draw data from preferred sources (Table 1).

In low- and middle-income countries, CRVS and health information systems need substantial strengthening, with much greater emphasis on domestic organization, analytic capability and use of data. Country health information systems also can be supported by use of information and communication technologies (including eHealth and mHealth). Meanwhile, household surveys such as Demographic and Health Surveys and Multiple Indicator Cluster Surveys continue to be an important source of data.

TABLE 1. Preferred and current data sources for the 16 key indicators (a subset of 60) of the Global Strategy in low- and middle-income countries.

Global Strategy 16 key indicators	Preferred data sources by 2030	Current sources in low- and middle-income countries
SURVIVE		
i. Maternal mortality ratio	CRVS	CRVS, surveys, and specialized studies
ii. Under-5 mortality rate	CRVS	CRVS and surveys
iii. Neonatal mortality rate	CRVS	CRVS and surveys
iv. Stillbirth rate	CRVS	CRVS, surveys, facility data
v. Adolescent mortality rate	CRVS	CRVS, surveys and census
THRIVE		
vi. Prevalence of stunting among children under 5 years of age	Facility data, surveys	Surveys
vii. Adolescent birth rate (10-14, 15-19) per 1000 women in that age group	CRVS	Surveys, CRVS, facility data
viii. Coverage index of essential RMNCAH interventions: family planning, antenatal care, skilled attendance at birth, breastfeeding, immunization, childhood illnesses treatment	Facility data and harmonized surveys	Range of surveys, facility data as available
ix. Out-of-pocket health expenditure as a percentage of total health expenditure	System of health accounts, surveys	System of health accounts as available, surveys
x. Current country health expenditure per capita (including specifically on RMNCAH) financed from domestic sources	System of health accounts, surveys	System of health accounts as available, surveys
xi. Number of countries with laws and regulations that guarantee women aged 15-49 access to sexual and reproductive health care, information and education	Document review and independent validation	Self reports and specialized studies
xii. Proportion of population with primary reliance on clean fuels and technologies	Harmonized surveys	Range of surveys
TRANSFORM		
xiii. Proportion of children under 5 years of age whose births have been registered with a civil authority	CRVS, census	CRVS and surveys
xiv. Proportion of children and young people in schools with proficiency in reading and mathematics	Harmonized school assessments	Range of school assessments
xv. Proportion of women, children and adolescents subjected to violence	Surveys, incident reports	Surveys and specialized studies
xvi. Percentage of population using safely managed sanitation services including a hand-washing facility with soap and water	Sanitation systems reports, harmonized surveys	Sanitation systems reports, range of surveys

Currently, only a handful of the 60 core Global Strategy indicators are measured routinely, at scale and with high quality, adequate frequency and full disaggregation in all countries. Some indicators have been used for quite some time and have established monitoring systems in many countries that can be strengthened.

Others are new and hard to measure and require further investment and development before much country-level data are available. Countries will need strong health information systems that use multiple data sources to generate the relevant statistics for decision-making and tracking of progress towards national, Global Strategy and SDG targets.

CHAPTER 2. GLOBAL HEALTH ESTIMATES

Global health estimates, drawing on data collected at different times with different methods, are regularly produced by UN agencies and academic groups. These estimates can inform priority setting and promote investment in routine collection of primary data, but may have limited value for periodic monitoring. The demand for health estimates often is more from global partners than from countries. Whether for global or local use, health estimates are only as good as their underlying country data sources. Investment in the collection of routine, high-quality country data is essential for meaningful monitoring and actionable information at all levels.

CHAPTER 3. LEAVE NO ONE BEHIND

“Leave no one behind” is a core tenet of the SDGs. To this end, disaggregation of data by age, sex, wealth, education, gender and other equity and human rights considerations, across all populations and settings, is essential to identify underserved and marginalized groups.

The reproductive, maternal, newborn, child and adolescent health (RMNCAH) community is better placed to monitor equity than most other health areas due to the large volume of data collected through household surveys with standardized methods. New methodologies and tools are available for disaggregation of country data, and to communicate the findings. Much greater generation and use of national and subnational data is needed to understand, and act upon, inequalities in country-specific contexts.

Data in humanitarian settings

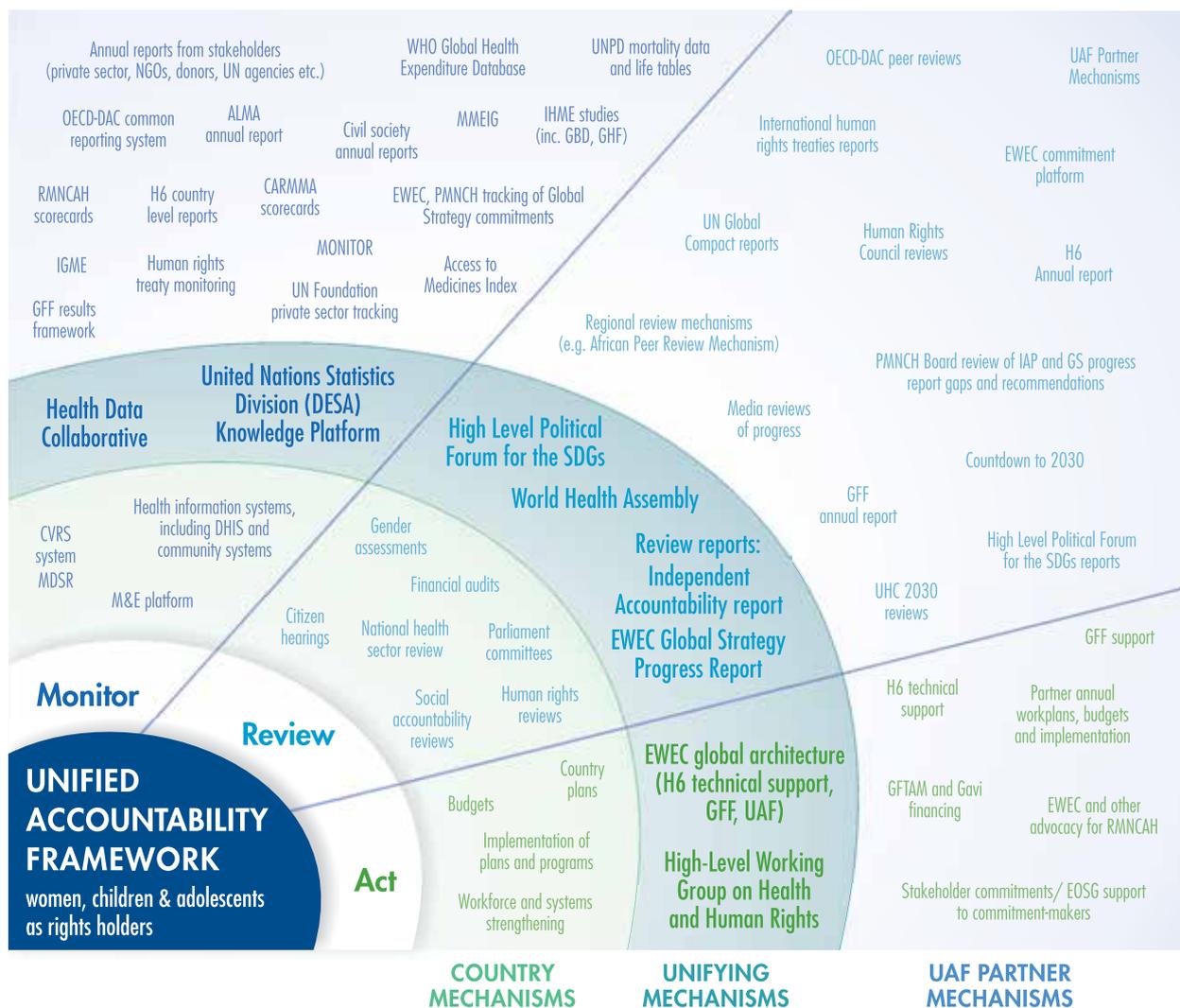
Global data systems largely under represent the health needs of women, children and adolescents living in humanitarian settings, who now account for more than 50% of the burden of preventable mortality. New systems of data collection are needed for these settings, as are new statistical instruments to generate usable estimates.

Monitoring data for humanitarian settings may come through: national institutional mechanisms; multilateral institutional mechanisms; nongovernmental organizations; and other sources such as think tanks and academic institutions. However, collection of data can be ad hoc and unsystematic, using different indicators than in development settings, so data availability and quality vary greatly.

CHAPTER 4. THE UNIFIED ACCOUNTABILITY FRAMEWORK

Chapter 4 considers the Unified Accountability Framework and other parts of the EWEC Global Architecture. The framework is supported by the Partnership for Maternal, Newborn & Child Health (PMNCH), and builds on the recommendations and work of the Commission on Information and Accountability. It aims to align multistakeholder partner support for country-led plans across three interconnected accountability processes: Monitor, Review and Act. Proposed unifying accountability mechanisms in each area are listed below.

FIGURE 1. Unified Accountability Framework.



Monitor: The Health Data Collaborative and the United Nations Statistics Division (a division of the Department of Economic and Social Affairs) Sustainable Development Knowledge Platform could be the main unifying mechanisms in this area. Technical support and inputs also would be provided from the H6 agencies and other regional and global partners. EWECC and PMNCH would track partner commitments to the Global Strategy.

Review: The World Health Assembly member state review of progress on women’s, children’s and adolescents’ health, supported by the collaboratively produced Global Strategy Progress report, would be a key unifying mechanism.

The Independent Accountability Panel’s report, the High-Level Political Forum for the SDGs (see Figure 1) and other political and multistakeholder reviews are also central.

Act: The EWECC Global Architecture aims to promote unified partner action, with technical support from the H6 agencies and other partners, financing through the Global Financing Facility and other financing mechanisms such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and Gavi the Vaccine Alliance, and accountability through the Unified Accountability Framework. The High-Level Health and Human Rights Working Group would help advance the shared health and human rights agenda in countries.

While some mechanisms are clearly strong candidates for the potential to unify partner action, they must be agreed and used by all key stakeholders to support country-led efforts in a harmonized way. Options will be reviewed in a process led by EWEC and PMNCH and the logistics and functioning of the Unified Accountability Framework further defined.

CHAPTER 5. RECOMMENDATIONS

1. **Strengthen country data:** improve data quality, harmonize data sources and strengthen country information systems

- Strengthen CRVS and country health information systems to advance analysis, action and accountability. The State of the World's Health Information Systems 2017 report from WHO and the Health Data Collaborative will provide guidance on key requirements and investments;
- Harmonize and streamline data collection methods, including to standardize indicators and improve data quality at all levels;
- Develop local capacities to utilize data for local decision-making and also contribute to global reporting and knowledge sharing.

2. **Leave no one behind:** emphasize equity and human rights and focus on humanitarian settings

- Strengthen capacities to monitor equity, human rights and gender;
- Use disaggregation of data to identify gaps and needs and to serve marginalized groups;
- Target data collection and analysis in humanitarian settings.

3. **Sharpen the focus:** refine the Global Strategy indicators and monitoring framework

- Ensure alignment with the SDG indicators now being finalized and with updates to national and global reporting mechanisms (e.g. on immunization and nutrition);
- Invest in research on newer indicators and implications for country monitoring efforts (e.g. on quality of care, cause of death, early childhood development, adolescent health and health in humanitarian settings);
- Prioritize key indicators required to inform country-specific planning, investment, implementation and accountability efforts.

4. Harmonize the global partnership: use the Unified Accountability Framework

- Partners should use existing unifying mechanisms to harmonize and align support for country-led accountability across Monitor, Review and Act (see Chapter 4 summary above);
- EWEC stakeholders should ensure their commitments to the Global Strategy support country-led plans, fill identified gaps and are subject to individual and mutual accountability.

5. Galvanize political support: for resources, advocacy and accountability

- Maintain the highest level of political attention and investment in women's, children's and adolescents' health;
- Build links to political bodies at all levels, including parliamentarians and local leaders, and to the media and other potential advocates and champions;
- Hold stakeholders and commitment-makers to account;
- Ensure women, children and adolescents have the ultimate say in accountability.

CONCLUSION

To ensure that Global Strategy monitoring will be meaningful with actionable data from the outset, significant early investments are required to strengthen country CRVS and health information systems and local capabilities to compile, validate, analyse, disaggregate, synthesize, communicate and use data. A special focus is required to improve data in humanitarian settings.

Sustained effort is required through the Unified Accountability Framework to align country, regional and global monitoring in ways that maximize the value of the data collected, minimize the reporting burden on countries and ensure accountability for resources, results and rights at all levels. Ultimately, our universal accountability is to women, children and adolescents everywhere and for the "World We Want in 2030".

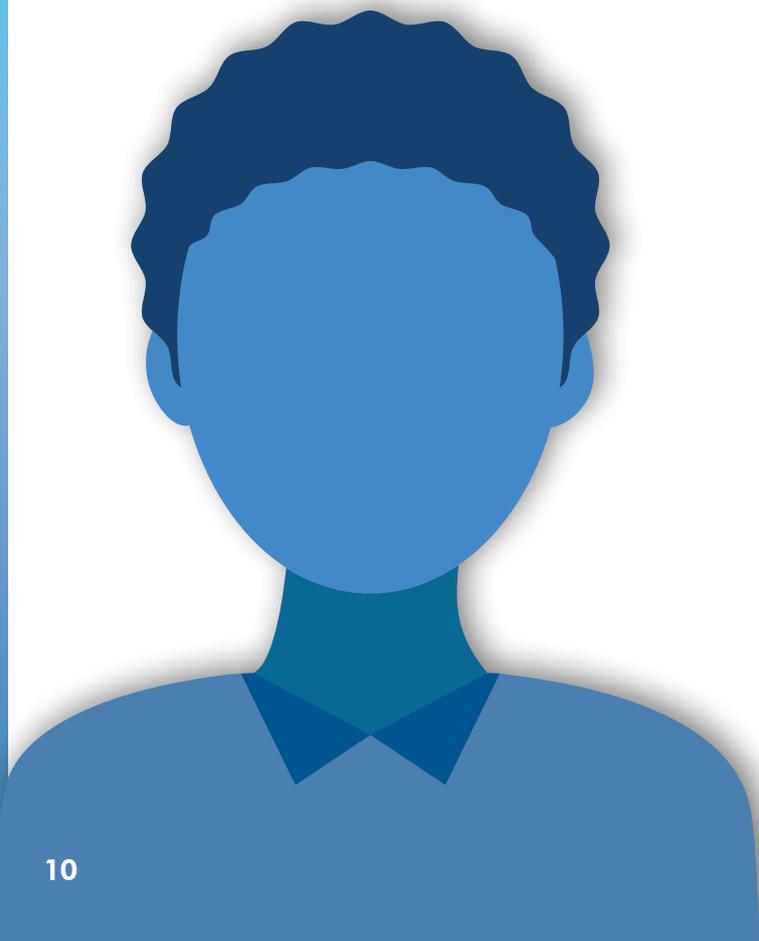
INTRODUCTION

In setting out the Sustainable Development Goals (SDGs) for all countries to achieve by 2030, world leaders pledged that “no one will be left behind” and that those furthest behind would be reached first.¹ The SDGs are grounded in international human rights standards and represent the universality of human aspiration. Their goals, targets and indicators are equally relevant for high-income countries as for those constrained by multiple forms of poverty.

Women, children and adolescents, especially those in humanitarian crises and fragile settings, are often the ones left furthest behind or hit hardest by poverty, conflict, environmental risks and ill health. By focusing on these populations and settings, the *Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030)* is central to the post-2015 transformative agenda that aims to leave no one behind.²

The Global Strategy is put into action by the Every Woman Every Child (EWEC) movement. It came into effect alongside the SDGs in January 2016 and is fully aligned with them along three axes: 1) Survive (end preventable deaths); 2) Thrive (ensure health and well-being); and 3) Transform (expand enabling environments).² Each objective supports specific targets, together covering nine SDGs and 20 SDG targets. For example: reducing maternal and newborn mortality and preventing epidemics (Survive); ending all forms of malnutrition and providing universal access to family planning and early childhood development strategies (Thrive); and eradicating extreme poverty and providing legal identity for all (Transform). Target 6 of SDG 16 (promote peaceful and inclusive societies) calls for “effective, accountable and transparent institutions at all levels”. It enshrines the tenet that substantive progress towards the SDGs is only possible if states, organizations and leaders commit to a world founded on sustainability, well-being and equity.

The same foundation of accountability underpins the EWEC Global Strategy. The world cannot realize the human right of every woman, child and adolescent to the highest attainable standard of health and well-being unless all stakeholders commit to an open and inclusive accountability agenda that systematically monitors progress and continually highlights areas for improvement. A rigorous system of accountability is needed to track progress towards these targets, and to provide decision-makers with the information they need to inform planning and investment for women’s, children’s and adolescents’ health.



Accountability is central to ensuring that health and human rights standards are respected, protected and fulfilled, and is a mechanism by which governments can explain and justify the steps they have taken. It also demonstrates to individuals and communities that their interests are taken into account and respected.

The first Global Strategy (2010-2015)³ led to the setting up of the landmark Commission on Information and Accountability (CoIA) for Women's and Children's Health, which defined accountability as a continuous process of learning and improvement comprising three interconnected stages – Monitor, Review and Act.⁴ The CoIA made 10 recommendations to strengthen accountability and to improve outcomes for women's and children's health by ensuring: *Better information for better results; Better tracking of resources for women's and children's health; and Better oversight of results and resources: nationally and globally.* It concluded that while partners and stakeholders at all levels should focus on accountability and commit to mutual accountability, the primary leadership and responsibility for progress lies with countries.

The Unified Accountability Framework (UAF) of the EWEC Global Strategy² builds on the CoIA principles, framework and recommendations. Supported by the Partnership for Maternal, Newborn & Child Health (PMNCH), the UAF represents the accountability element of the EWEC Global Architecture in support of country-led plans to implement the Global Strategy.

Its purpose is to promote and align multistakeholder engagement to support countries, as required, to fulfil their responsibilities for accountability, including by strengthening country health information systems and national monitoring platforms. The UAF also should help ensure that global and regional processes are synchronized with country planning and review cycles, and have a streamlining effect that minimizes the reporting burden on countries.

An effective and consistent approach to monitoring progress is part of the UAF. An Indicator and Monitoring Framework has been developed, including indicators for all targets of Survive, Thrive and Transform.⁵ During the Millennium Development Goals (MDGs), countries made considerable progress in monitoring reproductive, maternal, newborn, child and adolescent health (RMNCAH) indicators, particularly through the scaling up of international household survey programmes. But the post-2015 agenda is much more ambitious and presents both challenges and opportunities to enhance country, regional and global systems of accountability with a focus on equity and human rights. This report assesses the worldwide readiness to address these challenges and opportunities and strengthen accountability at all levels for women's, children's and adolescents' health.

REPORT OUTLINE

Chapter 1 looks at the state of the main country data sources for the indicators of the Global Strategy Indicator and Monitoring Framework, and how countries might strengthen their data sources and capacities to monitor progress towards achieving the Global Strategy objectives and the SDGs overall.

Chapter 2 considers the role and limitations of health estimates in assessing progress on women's, children's and adolescents' health.

Chapter 3 discusses data disaggregation as a tool for monitoring equity, human rights and gender equality. It assesses current country capacities for disaggregation and potential improvements to support monitoring.

Chapter 4 outlines the functions of the Unified Accountability Framework (UAF) and identifies current gaps. It highlights some of the main actors and mechanisms engaged with the UAF and their potential roles.

Chapter 5 offers recommendations for addressing the identified gaps, investing in country data collection and analysis, and strengthening the global partnership around monitoring of the Global Strategy indicators.

Annexes provide more detailed information on data sources, frequency of data collection and potential for disaggregated data for the Global Strategy indicators.

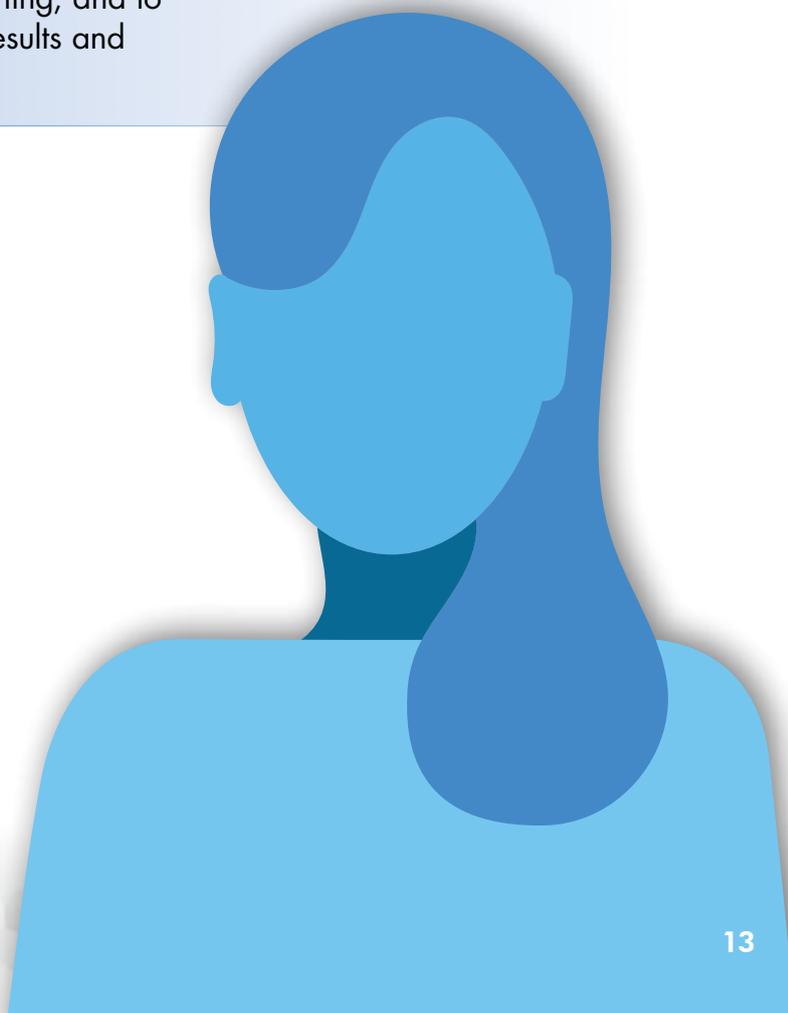
CHAPTER 1.

COUNTRY DATA FOR ACTION AND ACCOUNTABILITY

MAIN POINTS

- Currently, only a handful of the 60 Global Strategy indicators are measured routinely at scale and with adequate frequency and disaggregation in all countries.
- International household surveys are the main data source for most health-related coverage indicators and equity analyses, and often also for mortality indicators. These are conducted in selected low- and middle-income countries every three to five years.
- Strengthening the data sources of country health information systems is essential to address country data gaps and improve monitoring. This should include: CRVS systems to generate better data on mortality and causes of death; improved health facility information for national and local monitoring of several health system and coverage indicators; national health accounts with subaccounts on RMNCAH and health work accounts; and good linkages with data generated by other sectors, such as education.
- Country health information systems also require a workforce with capacities to compile, validate, analyse, synthesize and communicate results to provide actionable information for national planning and implementation, for regional peer reviews and global reporting, and to promote accountability for resources, results and rights at all levels.

The Sustainable Development Goals (SDGs)¹ and the Every Woman Every Child (EWEC) Global Strategy for Women's, Children's and Adolescents' Health (2016-2030)² represent an ambitious agenda with a large number of accompanying targets and indicators. There is little doubt that country civil registration and vital statistics (CRVS) and health information systems improved tremendously during the MDGs and through the Commission on Information and Accountability (CoIA) for Women's and Children's Health (see Annex 1).³



Monitoring progress of a small set of indicators for women's and children's health became the backbone of regular reviews of progress in and across countries, but there were major gaps in country health information systems. These gaps are now even more exposed because of the increased demand for high-quality data on a much wider range of health and SDG indicators and targets.

COUNTRY HEALTH INFORMATION SYSTEMS

Country health information systems provide the underpinnings for decision-making in countries and for country and global statistics. They have four key functions: data generation; compilation; analysis and synthesis; and communication and use. The health information system collects data from the health sector (and, to a lesser extent, other relevant sectors), analyses the data and ensures their overall quality, relevance and timeliness, and converts them into information for health-related decision-making and monitoring of progress.⁴

Since 2010, the work of CoIA has done much to stimulate efforts to strengthen country CRVS and health information systems, improve data collection and analysis and promote accountability efforts at all levels.³ For example, in response to CoIA recommendations, 65 countries have conducted an assessment of their CRVS systems, or have a CRVS assessment underway, and 52 have a national maternal death review committee in place (Annex 1). The monitoring and accountability frameworks for the Global Strategy owe a clear debt to CoIA and will continue to build on its work.

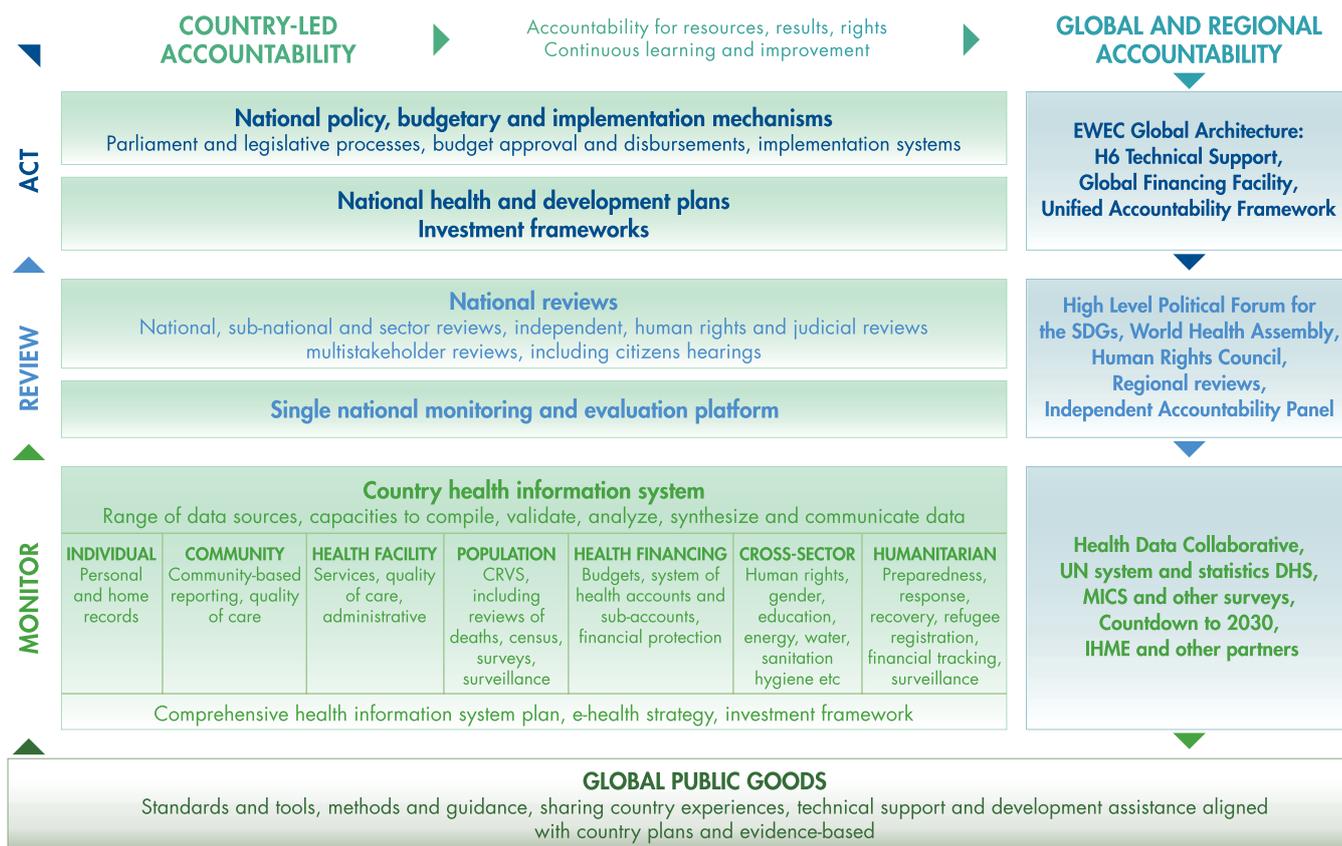
Innovations in technology, especially around the internet, information and communication technologies and mobile telecommunications, have great potential to strengthen and speed up the transfer, compilation, analysis and dissemination of data from country health information systems. In response to the CoIA recommendations, 27 countries have developed and are implementing national eHealth strategies linked to reproductive, maternal, newborn, child and adolescent health (RMNCAH), and 44 are using web-based facility reporting, primarily the District Health Information System 2 (DHIS 2).⁵

This chapter focuses on the country data sources that serve as a basis for monitoring the Global Strategy indicators. Selected other aspects of the health information system, such as use of data and statistics for review and remedial action, are addressed in Chapter 4 under the Unified Accountability Framework. The key data sources for effective country health information systems are outlined in Figure 1.1, and provide the inputs to inform action and promote accountability at all levels.

COUNTRY DATA SOURCES FOR GLOBAL STRATEGY INDICATORS

The Indicator and Monitoring Framework for the Global Strategy includes a set of indicators and a measurement agenda for assessing progress towards the Survive, Thrive and Transform objectives of the Global Strategy and the SDGs. Based on technical reviews and an open consultative process, 60 indicators were selected.⁶ The framework aims to minimize the burden of country-to-global reporting by aligning with the SDGs (34 of the 60 indicators). The remaining 26 indicators were drawn from established global initiatives for RMNCAH and considered the Global Reference List of 100 Core Health Indicators.⁷

FIGURE 1.1. Effective country-led action and accountability is based on strong country data.



Together, these 60 indicators provide sufficient depth and breadth for tracking progress, evidence-informed advocacy and decision-making, and accountability for resources, results and rights. From the 60, a subset of 16 key indicators was selected to provide a snapshot of the status of women’s, children’s and adolescents’ health (see Executive Summary and Table 1.1).⁷

The main sources for country-level health data include the following: CRVS systems; household and other population-based surveys; routine health facility reporting systems (including community-based services) and health facility surveys; and administrative data systems relating to health systems resources such as health workforce and financing. Some indicators also rely on non-health-sector data sources such as those coming from the education and humanitarian sectors. In addition, the population census is an important source of data.

Tables 1.1 and 1.2 show the potential data sources for the 24 Survive, 18 Thrive and 18 Transform indicators. While CRVS, surveys and facility data are the three main sources of data, other sources, such as those outlined in Figure 1.1, may be relevant. For several indicators, multiple data sources are possible. In countries without a well-functioning CRVS system to record births, marriages, deaths, and causes of death, household surveys (and sometimes facility data) can be used to obtain some of these data. There are also five indicators which are measured through key-informants or country self-assessments, e.g. the presence of a policy or legal framework. For these indicators to have value for monitoring progress, some independent validation of reported information will probably be required. More details are provided in Annex 2.

TABLE 1.1. Mapping the Global Strategy indicators to potential country data sources.

Indicator	CRVS system	Survey	Facility	Other
SURVIVE				
Maternal mortality ratio [3.1.1]	x	x		x
<i>Skilled attendance at birth [3.1.2]</i>		x	x	
<i>Four or more ANC visits</i>		x	x	
<i>Postpartum care for mothers</i>		x	x	
Neonatal mortality rate [3.2.2]	x	x		
Stillbirth rate	x	x	x	
<i>Early breastfeeding initiation</i>		x		
<i>Postnatal care for newborns</i>		x	x	
<i>ANC syphilis screening</i>		x	x	
Under-five mortality rate [3.2.1]	x	x		
<i>ORS treatment for children with diarrhoea</i>		x		
<i>Care seeking for suspected pneumonia</i>		x		
<i>Exclusive breastfeeding 0-6 months</i>		x		
<i>Full immunization coverage</i>		x	x	
<i>HIV incidence [3.3.1]</i>		x	x	
<i>ART coverage</i>			x	
<i>Malaria incidence [3.3.3]</i>		x	x	
<i>ITN coverage among children</i>		x		x
<i>Household ownership of ITN</i>		x		
<i>Tobacco use [3.a.1]</i>		x		
<i>NCD mortality (between ages 30 and 70 years) [3.4.1]</i>	x	x		
<i>Suicide mortality rate [3.4.2]</i>	x			
<i>Cervical cancer screening among women 30-49 years</i>		x	x	
Adolescent mortality rate	x	x		x
THRIVE				
Child stunting [2.2.1]		x		
<i>Child wasting and underweight [2.2.2]</i>		x		
<i>Adolescent insufficient physical activity</i>		x		
<i>Anaemia prevalence in women</i>		x		
<i>Children with minimum acceptable diet</i>		x		
<i>Family planning need satisfied among women [3.7.1]</i>		x	x	
Adolescent birth rate [3.7.2]	x	x		x
<i>Informed decisions by women on sexual and reproductive health [5.6.1]</i>		x		
<i>Country laws and regulations for access to sexual and reproductive health [5.6.2]</i>				x
<i>Sexual and reproductive health knowledge at ages 15-24 years</i>		x		
<i>Children under five years developmentally on track [4.2.1]</i>		x		x
<i>Participation in organized learning 1 year before primary school entry [4.2.2]</i>		x		x
<i>Mortality attributed to air pollution [3.9.1]</i>	x	x		
Population relying on clean fuels and technology [7.1.2]		x		x
Coverage of essential services [3.8.1]		x	x	
<i>Financial protection against catastrophic health spending [3.8.2]</i>		x		x
Country health, and RMNCAH, expenditure per capita				x
Out-of-pocket health expenditure as % of total health expenditure				x

Indicator	CRVS system	Survey	Facility	Other
TRANSFORM				
<i>Population living below the poverty line [1.1.1]</i>		x		x
Child reading and math proficiency [4.1.1]		x		x
Sexual violence against women by intimate partners [5.2.1]		x		
<i>Early marriage (before 15 and before 18 years) [5.3.1]</i>	x	x		x
<i>Female genital mutilation [5.3.2]</i>		x		
<i>Legal frameworks for equality and non-discrimination on basis of sex [5.1.1]</i>				x
Sexual violence experienced as a child or adolescent [16.2.3]		x		
<i>HIV post-exposure prophylaxis (PEP) for rape survivors</i>			x	x
<i>Safe drinking water [6.1.1]</i>		x		x
Safely managed sanitation services [6.2.1]		x		x
<i>R&D expenditure as proportion of GDP (health/RMNCAH) [9.5.1]</i>				x
Birth registration coverage [16.9.1]	x	x		x
<i>Census and coverage of CRVS system [17.19.2]</i>				x
<i>Progress in multistakeholder development effectiveness frameworks [17.16.1]</i>				x
<i>World Governance Indicators</i>				x
<i>Indicators with full disaggregation when relevant [17.18.1]</i>				x
<i>National ratification of human rights treaties</i>				x
<i>Humanitarian Response Index</i>				x

Notes:

Numbers in brackets denote SDG indicator number. Indicators with names in bold are the 16 key indicators. When there are multiple data sources for a single indicator the preferred data sources has an "x" in bold. "Other" includes census, administrative data, key informants, document reviews and other sources of information. For acronyms, please see the list at the end of this report.

Table 1.2 shows that household surveys are currently the predominant source of information, potentially contributing data to 46 indicators, including 22 of the 24 Survive indicators. Household surveys,

in particular demographic and health surveys (DHS)⁸ and multiple indicator cluster surveys (MICS),⁹ are conducted in selected countries every three to five years with a typical sample size of 6000 households.

TABLE 1.2. Summary of the country data sources for the 60 indicators.

	Indicators	CRVS system	Household surveys	Health facility data	Other data sources	Key informant
SURVIVE	24	7	22	11	3	0
THRIVE	18	2	15	2	7	1
TRANSFORM	18	2	9	1	11	4
TOTAL	60	11	46	14	21	5

Health facility sources can provide important additional data and, as their quality improves, will increasingly become an important source of subnational data. Eleven indicators should be measured through CRVS systems and 26, including most Transform indicators, rely on data from other sources, often outside the health sector. All of these data sources will need to be strengthened and expanded in most countries to meet the full monitoring requirements for the Global Strategy. They range across a variety of sectors and categories, as described in the following sections.

Other data sources include record reviews, international assessments, and data from other sectors.

DATA SOURCES FOR MORTALITY AND RELATED INDICATORS

Although CRVS systems are the preferred source of mortality data, census and household surveys are the main sources in most low- and middle-income countries (LMICs) today. The census can provide data on levels of mortality by age and sex, and by subnational unit, particularly if it includes specific mortality questions. Household surveys, in particular DHS and MICS, are an important source of mortality data for children and mothers (and to some extent adults and adolescents) through birth and sibling survival histories. Some surveys have included a pregnancy history, which allows an assessment of stillbirth rates in the population. Some mortality information is also collected through hospital data in LMICs. However, data quality and timeliness from these sources are a challenge, often because the global standard International Classification of Diseases is not used consistently to assign cause of death, and because many deaths occur outside of hospitals.

Cause-specific mortality (e.g. due to noncommunicable diseases) could be obtained from household surveys through verbal autopsy, but again quality is a major problem. Data quality is even more problematic for some causes, such as suicide, which tend to be poorly reported. In general, verbal autopsy modules in national surveys can provide a general idea of cause-specific mortality but are not precise enough to allow monitoring of trends over time. Additionally, the majority of existing verbal autopsy studies are not nationally representative.

Given the limitations of surveys and censuses, well-functioning CRVS systems are ultimately needed to monitor mortality and related indicators well. However, in almost all low-income countries, and some middle-income ones, CRVS systems do not function well enough to produce data for reliable vital statistics. Efforts to strengthen CRVS systems are therefore critical but are unlikely to improve statistics in the short term as it takes time to implement a fully functioning system. Developing sample registration systems, with verbal autopsy for community deaths, in conjunction with CRVS strengthening, is therefore essential to bridge that gap. Countries such as Indonesia, Malawi, Mozambique, Tanzania and Zambia are implementing or working towards such sample registration systems, while India and China have long-term positive experience with sample registration systems.

DATA SOURCES FOR HEALTH SERVICE COVERAGE INDICATORS

Countries have considerable experience in monitoring the coverage of RMNCAH services, such as family planning, pregnancy care, syphilis screening and childhood illness treatment through household surveys. In general, the quality of information is better for preventive interventions than for treatment interventions where the target population is difficult to measure (e.g. children in need of pneumonia treatment, or oral rehydration solution [ORS] for severe diarrhoea). Some indicators such as coverage of cervical cancer screening are not yet included in most surveys, so data availability is poor.

Household surveys are generally conducted every three to five years in many countries, which determines the frequency of underlying data availability. Health-facility data are rarely used for monitoring coverage rates with a few exceptions such as immunization coverage, where special efforts have been made to ensure good-quality data. With improvements in health-facility information systems (mainly due to the implementation of DHIS 2) and strong demand for subnational coverage indicators and targets, facility data are likely to provide more information on service coverage and related statistics in the future, especially when used in combination with survey data. Issues related to complete reporting and denominators to assess coverage will have to be addressed to develop credible estimates for national and subnational levels. For some indicators, such as post-exposure prophylaxis for rape survivors, surveys are unlikely to generate representative information, given major reporting biases and the relative rarity of the event.

In high-income countries, coverage of many interventions included in the Global Strategy is assumed to be close to 100%, and they are not routinely monitored through national surveys. These indicators may be monitored through administrative data (e.g. skilled attendance at birth). However, it is hard to monitor coverage in disadvantaged populations in high-income countries that may have lower coverage rates, because information on stratifying variables is not collected. Some indicators are not measured in high-income countries because the burden is so low, e.g. use of ORS.

The Global Strategy also includes a summary measure of service coverage, in relation to universal health coverage (UHC).¹⁰ The proposed index for UHC includes four major domains, of which RMNCAH is one – currently with four proposed indicators (family planning, four or more antenatal visits, full child immunization coverage and care-seeking behaviour for pneumonia). In RMNCAH the most commonly used index is the Countdown coverage index, which includes four intervention areas – antenatal and delivery care, family planning, immunization, and treatment of sick children – and eight indicators. This index is regularly computed from DHS and MICS data. Countries can easily expand or reduce the UHC and RMNCAH coverage index to include their national priority indicators for which good data are available.

DATA SOURCES FOR NUTRITION AND HEALTH RISK FACTOR INDICATORS

Household surveys are also the main (often sole) data source for data on anthropometry and feeding practices, such as breastfeeding and supplementary feeding patterns. The new indicator of children with minimally acceptable diets is a composite indicator that requires survey data. DHS, MICS and nutrition surveys are the predominant sources, but some socioeconomic surveys may also include anthropometry or nutrition-related questions.

Data on risk factors for health play an important role in the design of preventative health programmes and interventions, particularly for water, sanitation and hygiene (WASH). Many health and socioeconomic surveys include questions on sources of water supply and sanitation facilities, which allowed monitoring of trends for the MDGs. The expanded quality component for WASH indicators in the SDGs will require additional information collected through other sources. Tobacco use is typically monitored through a module in the DHS, or through special tobacco surveys, often as part of global programmes. Past exposure to violence (two indicators) can also be measured through surveys, although the quality of reporting is a major issue.

DATA SOURCES FOR FINANCIAL PROTECTION AND HEALTH-EXPENDITURE INDICATORS

While the UN Statistical Commission is still debating the exact definition of an indicator of financial protection for the SDGs, the experts agree that the incidence of catastrophic expenses (and impoverishing expenses) due to out-of-pocket health spending is a key indicator.

This is measured through household budget and expenditure surveys, with some data from health surveys. National health accounts draw upon a wide range of financial data from multiple sources to provide data on macro-level health financing indicators, such as the proportion of health expenditure that comes from out-of-pocket spending, and the proportion of health expenditure allocated to RMNCAH. The latter requires subaccounts.

DATA SOURCES ON INDICATORS LINKED TO OTHER SECTORS

Education

The Global Strategy includes two outcome-level education indicators: children and young people's learning status and young children's developmental status. Many countries now measure learning outcomes among primary and secondary school students using international and regional assessments such as the Programme for International Student Assessment (PISA),¹¹ Trends in International Mathematics and Science Study (TIMSS),¹² Health Behaviour in School-Aged Children (HBSC),¹³ and the Global school-based student health survey (GSHS).¹⁴ While a growing number of countries have participated in these international and regional assessments, they do not provide comparable data across assessments, due to differences in their methodologies, targets and content. Data on young children's developmental status in LMICs are being collected through MICS, and are summarized with the UNICEF Early Childhood Development Index.¹⁵

Poverty

The data sources for the indicator of extreme poverty (defined as \$1.90 per person per day)¹⁶ are national household surveys, often conducted by National Statistical Offices, including household income and expenditure surveys, living standards measurement surveys, and labour force surveys. On this and other topics, the International Household Survey Network (IHSN) aims to improve the availability, accessibility, and quality of survey data and to encourage its analysis and use by national and international development decision makers and other stakeholders.¹⁷

Governance

In the Global Strategy, governance is assessed by the World Governance Indicators, which has six dimensions of governance: Voice and Accountability; Political Stability and Absence of Violence; Government Effectiveness; Regulatory Quality; Rule of Law; and Control of Corruption.¹⁸ The Global Strategy Indicator and Monitoring Framework relates this indicator to SDG 17.6: “Enhance the global partnership for sustainable development”. Global development of governance indicators in recent years has been led by UN agencies, nongovernmental organizations, or the private sector, with few inputs from countries themselves. The indicators vary across partners, reflecting their individual needs and interests, with little or no coordination across them. While less frequently used for monitoring health programmes, they are powerful tools for assessing the legal, political, economic, institutional and administrative structures and environment in countries.

Human rights and health

The Human Rights Treaty Body Database provides the ratification status of countries for each treaty.¹⁹ Beyond this, despite international commitment to health policies and programmes that are grounded in human rights principles, monitoring human rights based approaches and their impact remains fairly novel.²⁰ While human rights indicators have been used to monitor some specific issues related to health, and health indicators have been used to draw attention to some human rights issues, there are not yet shared indicators and monitoring systems to systematically link human rights and health monitoring. From 2016, the High-Level Health and Human Rights Working Group, supported by the World Health Organization and the Office of the High Commissioner for Human Rights, will help advance the shared health and human rights agenda in countries.

THE CHALLENGE OF MONITORING IN HUMANITARIAN AND FRAGILE SETTINGS

The Global Strategy explicitly calls for a stronger focus on health in humanitarian settings. These settings are typically characterized by poor health-service access and health outcomes, while at the same time lacking data systems for monitoring and accountability. Monitoring of progress in this context will be extremely challenging due to the difficulty of setting up and sustaining monitoring systems in highly fluid and often resource-constrained scenarios. Monitoring data for humanitarian settings may come through national institutional mechanisms, multilateral institutional mechanisms, nongovernmental organizations, and other sources, including think tanks, academic institutions, and non-operational entities.²¹

Innovative approaches are needed to improve the quality and timeliness of data. Conventional household surveys may not work due to security issues, and their sampling frames are unlikely to be complete. In many higher-income countries, CRVS systems do not include migrants or internationally displaced persons, leaving them uncounted.

CONCLUSION

Currently, only a handful of the 60 core Global Strategy indicators are measured routinely, at scale and with high quality, adequate frequency and full disaggregation in all countries (including family planning, immunization and clean household energy). Some indicators have been used for some time and have well-established monitoring systems in many countries. Others are new and hard to measure and require further investment and development before much country-level data are available. Countries will need strong health information systems that use multiple data sources to generate the relevant statistics for decision-making and tracking progress towards Global Strategy targets. Such a system will include a well-functioning CRVS system, regular health surveys with flexible contents using international standards, a high-quality facility-reporting system, and good linkages with data generated by other sectors, such as the economy or education.

In the near term in LMICs, regular household surveys will be an important source of data for many Global Strategy indicators as other components of the health information system are strengthened. Two household surveys on RMNCAH, with variable contents according to country needs, within a five-year period, will allow sound monitoring of progress on many indicators, including those for all-cause mortality rates and for a wide range of coverage and risk-factor-related indicators. It is often sufficient for a household survey to collect mortality data once every five years, as sampling errors are large and change is gradual. However, more frequent data collection for indicators of coverage and quality of services is important. Changes may occur quickly, and when measured can immediately influence policies and programmes. Surveys are also essential for disaggregation by socioeconomic position and related stratifiers for monitoring equity (as discussed in Chapter 3). Finally, regular survey data are needed to verify and enhance facility data-based estimates for health indicators. Over time, more robust facility data systems have the potential to provide real time monitoring and allow monitoring at the local level.

Across all of these indicators and data sources there is a need to improve standardization and data quality and to harmonize methods for data collection and analyses. Global monitoring has a role to play in such efforts (as discussed in Chapter 2). These methods should also synchronize with national and subnational planning and review cycles to provide meaningful and actionable data. Significant investments also are required to strengthen information systems in humanitarian and fragile settings.

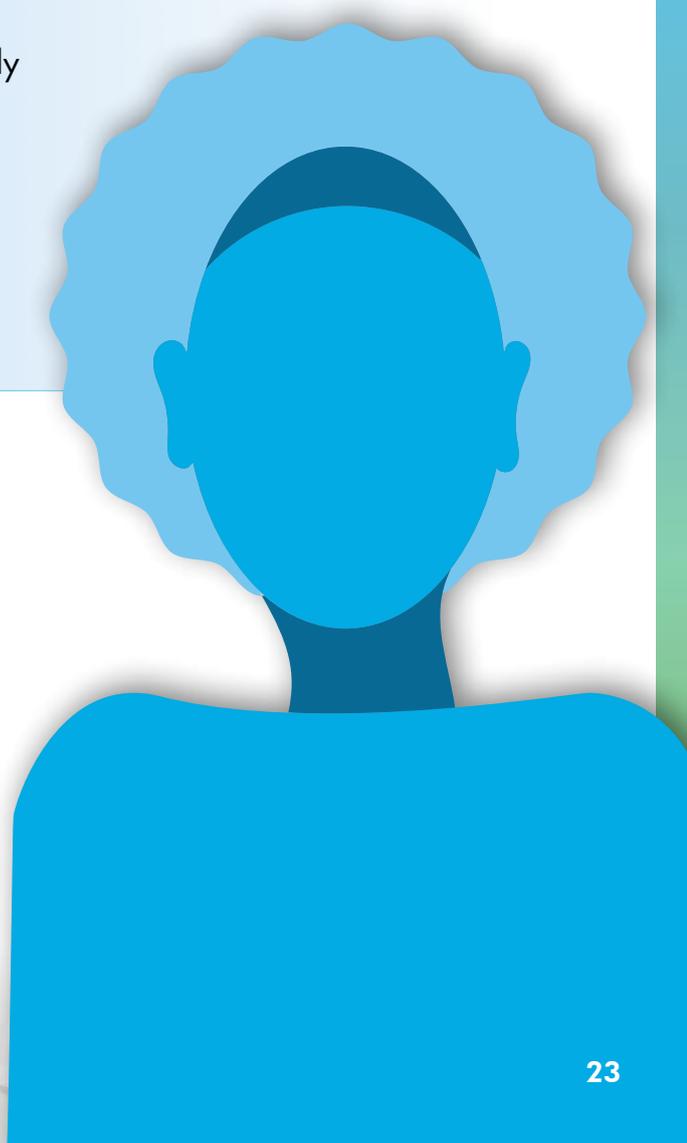
CHAPTER 2.

GLOBAL MONITORING OF THE EWEC GLOBAL STRATEGY: THE ROLE OF HEALTH ESTIMATES

MAIN POINTS

- The Global Strategy includes multiple indicators for which well-established global monitoring procedures are in place, including methods, expert groups and databases. There are, however, also a substantial number of indicators with fundamental measurement problems, weak underlying country data and no established global estimation procedures; these require considerable investments in the coming years.
- The main demand for health estimates comes from global partners – multilateral agencies, donors, NGOs, researchers and journals; much less so from implementing governments. Generally, global demand is for the current or just completed calendar year. To obtain comparable data for countries and fill major data gaps, global estimates are based on predictions from past trends using statistical models. Predicted estimates can inform priority setting exercises, but should not be used to monitor recent changes in response to policies or interventions.
- Ultimately, health estimates produced globally or locally for monitoring the Global Strategy are only as good as their underlying data sources. Therefore, the collection of timely, high-quality data to measure the 60 indicators is needed. Continued investments in global estimation processes should, however, be only a small proportion of overall investments in country health information systems.

Global monitoring of health indicators has expanded greatly over the past 15 years. Following the adoption of the Millennium Development Goals (MDGs), international agencies and academic groups began working to construct global and regional estimates of trends in indicators for family planning, maternal and child health, HIV/AIDS, tuberculosis and malaria, and water and sanitation.



Over time, these groups began publishing the country-level estimates that made up the regional and global figures. Now, UN agencies and academic groups publish estimates of country-level trends in MDG and other health-related indicators every year or two. This rise in the production of global health estimates has mainly occurred to meet demand by global partners – multilateral agencies, donors, NGOs, researchers and journals – for measures of progress towards global targets. However, as the Commission on Information and Accountability emphasized, the primary focus of accountability efforts needs to be in countries where investments and implementation occur.¹ If global statistics are not also useful at country level, they need to be reconsidered.

The main focus of global monitoring has been to generate estimates of indicators that are comparable across countries and time. Ideally, every country in the world would collect annual data using consistent definitions and measurement techniques for each indicator. However, this does not happen, so global health estimates are derived from data collected at different intervals using different methods. The analysis techniques then focus on computing comparable country values across time. In cases where data availability is reasonably good, this may involve adjusting data to use a consistent definition. For example, estimates of under-five mortality rates are sensitive to the definitions used to differentiate stillbirths from neonatal deaths.² When data are not available, global health estimates may also involve the imputation of missing data, with the aim of providing a “best guess” value for the country, region or world – ideally with clear communication about uncertainty.

The proliferation of global health estimates has been a double-edged sword. On the positive side, they have contributed to international discussions on prioritizing and monitoring progress, and arguably have provided evidence to help rally additional resources. They have also fostered scientific and methodological advances, for example in assessing biases in common data sources and standardizing indicator definitions. When done well, they can also be useful for stakeholders to hold leaders to account for less than satisfactory progress.

On the negative side, the generation of global health estimates may give the false impression of complete “data” across countries and time, which can lead to misinterpretation and potentially disincentivize investments in strengthening country health information systems and data collection. For some indicators the underlying data are poor in many countries, and statistical modelling has been used to fill these gaps. Such models may involve complex methodologies aimed at improving accuracy and comparability, but may yield estimates that differ from country data and are not replicable by country analysts. Another common challenge for global health estimates is that methodological revisions can lead to changing values for estimates even in the absence of new data, which can cause confusion when assessing trends.

GLOBAL MONITORING OF GLOBAL STRATEGY INDICATORS

Global monitoring activities vary widely across the 60 Global Strategy indicators. In the 1990s, competing estimates for high-profile mortality indicators like those for child and maternal mortality were produced independently by different UN agencies.

These processes have been streamlined under inter-agency estimation groups, such as the UN Inter-agency Group for Child Mortality Estimation (IGME) and the Maternal Mortality Estimation Inter-agency Group (MMEIG). These groups are supported by independent technical advisory or expert reference groups that include academic experts – such as the UNAIDS Reference Group on Estimates, Modelling and Projections, which advises on HIV estimates. This process for producing estimates – where UN agencies collaborate to produce one set of estimates, with guidance from outside experts – has become increasingly common over time and is likely to continue. However, many indicators in the Global Strategy do not currently receive this level of attention.

Revisiting the categories discussed in Chapter 1, the mortality and related indicators have the longest tradition of global health estimation work. The data backbone of these indicators are civil registration and vital statistics (CRVS) systems, which record births and deaths. Demographers in the UN Population Division produce life tables for all countries every two years, which synthesize CRVS data along with census and survey data. Their analyses for World Population Prospects (the official UN population estimates and projections) allow for the computation of all-cause mortality rates, and adolescent birth rates.³ Child mortality rates and maternal mortality ratios are estimated by UN inter-agency groups using sophisticated statistical models to smooth and reconcile multiple data sources.^{4,5}

Estimates of HIV/AIDS and malaria incidence and intervention coverage also rely on sophisticated modelling techniques.^{6,7} In general, with the partial exception of survey data on pregnancy-related deaths to inform maternal mortality estimates, there are very few directly observed, complete, nationally representative data on cause-specific mortality and disease incidence in low- and middle-income countries. For these indicators, statistical modelling plays an important role in filling data gaps to create global health estimates.

Global estimates of health service coverage are less common, with family planning coverage and child immunization coverage notable exceptions.^{8,9} This may be due, somewhat unintuitively, to the greater data availability for many of these indicators as measured through household surveys and routine health information sources for immunization coverage, but also to the demand from agencies and donors to have estimates of ultimate impact (i.e. death) as opposed to intermediate measures of service availability and use. Comparability is still an important component of global monitoring, even without statistical modelling. For example, WHO, UNICEF and UNFPA are currently working to arrive at a global consensus on how to operationally define skilled attendance at birth, as countries rely on a wide variety of cadres to provide care. For global monitoring, DHS/MICS point estimates for these indicators are often presented for the most recent year available (see Table 2.1).

Global monitoring activity around indicators on nutrition and risk factors fall somewhere in-between indicators for mortality and health service coverage. Data are often more available than for mortality, and modelling is used for several indicators to generate estimates.

This includes indicators for anaemia prevalence, child anthropometry, water and sanitation, and tobacco use. Given the richer data, the modelling is often used more modestly to reconcile multiple data points from a country, or to interpolate or extrapolate estimates beyond years with observed data, as opposed to projecting values where no country data exist.

IMPROVING LINKS BETWEEN GLOBAL AND COUNTRY MONITORING

Making sensible use of global health estimates requires an understanding of how the estimates relate to underlying country data. Table 2.1 provides a summary of underlying data and availability of estimates for selected SDG indicators.

TABLE 2.1. Summary of the availability and degree of disaggregation of country data on selected health-related SDG indicators included in the Global Strategy.

Indicator topic	Country data availability	Disaggregation	Comparable estimates	Source estimates
3.1.1 Maternal mortality	Fair	Poor	Annual	UN MMEIG
3.1.2 Skilled birth attendance	Good	Fair	In preparation	UNICEF, WHO
3.2.1 Under-five mortality rate	Good	Fair	Annual	UN IGME
3.2.2 Neonatal mortality rate	Good	Fair	Annual	UN IGME
3.3.1 HIV incidence	Fair	Fair	Annual	UNAIDS
3.3.3 Malaria incidence	Fair	Fair	Annual	WHO
3.4.1 Mortality due to NCDs	Fair	Poor	Every 2–3 years	WHO
3.4.2 Suicide mortality rate	Fair	Poor	Every 2–3 years	WHO
3.7.1 Family planning	Fair	Fair	Annual	UNPD
3.7.2 Adolescent birth rate	Good	Fair	Annual	UNPD
3.8.1 Coverage index UHC	Fair	Poor	In preparation	WHO, World Bank
3.8.2 Financial protection	Poor	Poor	In preparation	WHO, World Bank
3.9.1 Mortality due to air pollution	Fair	Poor	Every 2–3 years	WHO
3.a.1 Tobacco use	Good	Fair	Every 2–3 years	WHO
2.2.1 Stunting among children	Good	Good	Annual	UNICEF, WHO, World Bank
2.2.2 Wasting and overweight among children	Fair	Fair	Annual	UNICEF, WHO, World Bank
6.1.1 Drinking-water services	Good	Good	Annual	UNICEF, WHO
6.2.1 Sanitation services	Good	Good	Annual	UNICEF, WHO
7.1.1 Clean household energy	Good	Good	Every 2-3 years	WHO

Source: World Health Statistics 2016. Country data availability and disaggregation were assessed based on the data available to WHO or other international agencies producing estimates for global monitoring. An indicator is classified as having “good” data availability/disaggregation if data were available for more than 75% of countries where the indicator is relevant (2010 or later); “fair” if data were available for 40 to 74% of countries; and “poor” if data were available for less than 40% of countries.

FIGURE 2.1. Interpreting health indicators in relation to availability of data and health estimates.

		EXISTENCE OF GLOBAL HEALTH ESTIMATES	
		Yes	No
COUNTRY DATA AVAILABILITY	High	<p>Best-case scenario. Estimates can be used for cross-country comparisons, priority setting and monitoring long-term progress.</p> <p><i>Examples: Under-five mortality rate, access to improved water and sanitation.</i></p>	<p>Data can be used for priority setting and monitoring progress within countries, but lack of comparability may limit cross-country comparisons.</p> <p><i>Example: Skilled attendance at birth.</i></p>
	Low	<p>Estimates prone to misinterpretation. If a country has no data, cross-country comparisons and monitoring long-term progress have no meaning. Can potentially be used as "best guess" values for priority setting.</p> <p><i>Examples: Suicide mortality rate, adolescent mortality rate.</i></p>	<p>Hardly any information exists.</p> <p><i>Examples: cervical cancer screening, HIV post exposure prophylaxis (PEP) for rape survivors.</i></p>

An ideal situation is one in which global health estimates are derived from a rich set of underlying data across countries (Figure 2.1). In these cases, the estimates will likely be similar to the underlying data, but will also have been scrutinized to ensure comparability. However, in almost all cases, global health estimates will involve some degree of prediction of unobserved data – sometimes massively so.

Global health estimates may involve predicting current values based on past levels and trends within a country, or predicting entire time series based on covariates that explain variation in a limited set of observed data from other, often high-income, countries. Predicting to the current time period can help facilitate the use of estimates in policy discussions, but can cause confusion when countries are deemed to have met, or failed to have met, targets before recent data become available. It should also be noted that data-rich estimates, such as for the under-five mortality rate, typically involve smoothing of data. This better reflects long-term trends in noisy data.

However, it prevents the detection of recent, sharp changes in a health indicator due to particular interventions or policies.

Global health estimates have also tended to focus on national, regional and global averages. In the SDG era, global monitoring should aim to characterize the health of disadvantaged populations within countries as part of the equity agenda and leaving no one behind. This work can build on the experience of the Countdown to 2015 initiative, which began monitoring inequalities in maternal and child health-service coverage in 2005 (see Chapter 3).¹⁰ Global monitoring has also largely failed to reflect the health of internationally displaced people and others living in humanitarian settings, either as part of national averages or as explicit subgroups. Addressing this gap is critical, but the gap should be filled through data collection as opposed to statistical predictions.

Given these limitations, it is fair to ask whether or not countries should be assessing their own progress towards Global Strategy targets with global health estimates. The answer to this question likely varies across indicators, data availability, the analytical capacity of countries and the process used to derive estimates. When country data do not exist, estimates can provide valuable information to inform priority setting. However, it makes little sense to interpret trends in predicted estimates as measures of progress towards targets. When country data are available, global health estimates provide countries with a benchmark to assess their own statistics. To facilitate this, global estimation processes should involve support to countries to analyse their data and to interpret the estimates in the context of country-level information.

Some current global processes go further by providing methods and a framework for national technical staff to produce estimates, such as the estimation process for HIV/AIDS indicators led by UNAIDS. The WHO country consultation process – through which WHO sends draft estimates and methodological documentation to focal points nominated by Member States for review and comment – is a key means to share data, methods and estimates with countries, but more efforts are needed to enhance communication. The recently published Guidelines for Accurate and Transparent Health Estimates Reporting (GATHER) should also help improve understanding of methods used to produce global health estimates, by requiring sharing of input data sources and statistical code.¹¹

CONCLUSION

Ultimately, health estimates produced globally or locally for monitoring the Global Strategy are only as good as their underlying data sources. This means that the collection of timely, high-quality data to measure the 60 indicators is needed. Global support for strengthening CRVS and country health information systems, as well as standardized multi-country surveys and measurement standards and resources for monitoring indicators in humanitarian settings, will ultimately reduce gaps between global and country monitoring. It will also ensure accurate information on progress towards Global Strategy targets, and how this makes a tangible difference to the lives of women, children and adolescents, and their families and communities.

CHAPTER 3.

LEAVE NO ONE BEHIND: DISAGGREGATED DATA FOR THE EWEC GLOBAL STRATEGY INDICATORS

MAIN POINTS

- The SDGs and the Global Strategy have put equity at the centre, and require a major effort in all countries to collect, analyse and use disaggregated data (e.g. by wealth, age, geographic location, education and other stratifiers).
- Equity analyses carried out in support of the SDGs and Global Strategy will complement the substantial work in the fields of human rights, law and gender on addressing inequalities and discrimination.
- Within health, RMNCAH has relatively good availability of disaggregated data due to the frequency of household surveys with standardized methods – although data are not generally reported disaggregated by age.
- Improved routine health-facility information systems are critically needed to generate continuous data on subnational areas. Other non-survey data sources and special studies are also needed to assess the situation and trends among minorities, recent migrants, people living with disabilities, and other disadvantaged groups.
- Monitoring of equity in humanitarian settings is currently unsystematic and ad hoc, so new tools and methodologies are needed as a priority.
- To establish national health inequality monitoring, not only should data collection processes be equity oriented, but technical capacities should be strengthened for analysis and reporting on health inequality, as well as using disaggregated data in policy-making and effective targeting of interventions.



The Millennium Development Goals (MDGs) sought to reduce the gaps between high-income and low- and middle-income countries (LMICs) and country progress towards the MDGs was assessed solely at the national level.^{1,2} Equality and non-discrimination are foundational principles of the international human rights framework, and related violations primarily have been addressed through the legal system. The Countdown to 2015 for Maternal, Newborn and Child Survival pioneered methods for monitoring of inequalities in health within countries using survey data. Its first report in 2005 stratified coverage of essential interventions for the health of mothers and children by wealth quintiles.³ Starting with the World Bank,⁴ equity analyses have also permeated the reports and websites of international organizations. The World Health Organization (WHO),^{5,6} UNICEF,^{7,8} the independent Expert Review Group of the Commission on Information and Accountability (CoIA) for Women's and Children's Health⁹ and USAID¹⁰ have all helped to bring equity considerations into the mainstream of reproductive, maternal, newborn, child and adolescent health (RMNCAH).

The Sustainable Development Goals (SDGs) have made "leave no one behind" a centrepiece of the 2030 Agenda for Sustainable Development. For many goals and targets there is explicit language to highlight the importance of reaching everyone. The SDGs are also quite specific about the importance of disaggregated statistics. SDG 17.18 proposes a specific target: *"By 2020, enhance capacity building support to developing countries, including for least developed countries and small island developing states, to increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts."*¹¹

Inequities are defined as inequalities that are unfair, unjust and avoidable. Equity monitoring will therefore have a much greater focus in the SDG era, and will help guide programme implementation and assessments of progress. While the practical relevance and feasibility of disaggregation need to be appropriately addressed, disaggregation of data helps countries design, adapt, implement and monitor measures to advance equity, human rights and gender equality, and contributes to the detection of related problems, such as direct or indirect discrimination. However, data disaggregation is often only the starting point for understanding health and related inequalities in countries. Diverse types of evidence are needed to understand how, for instance, gender operates as a determinant of health and intersects with other health determinants such as education and ethnicity.

AVAILABILITY OF DISAGGREGATED DATA

An assessment of current monitoring arrangements indicates that it will be possible to conduct meaningful monitoring of most Global Strategy indicators with an equity lens, although substantial improvements will be required in most countries. In terms of equity monitoring, RMNCAH is in a better position than most other health areas due to the large amount of data collected through household surveys with standardized methods.

Among the 60 indicators, 11 are macro level and disaggregation is either not possible or not meaningful (e.g. countries having a certain law or policy in place). Of the remaining 49 indicators, 32 are often well disaggregated by selected socioeconomic status, geographic and demographic characteristics, mostly from household survey data. Demographic and household surveys (DHS)¹² and multiple indicator cluster survey (MICS)¹³ reports and further analyses are presented by the Countdown to 2015 (now Countdown to 2030), the WHO Health Equity Monitor, UNICEF special reports and others.^{3,5-8} While available data can be disaggregated by age and marital status, which is essential for monitoring adolescent populations, these data are often not reported in standard reports such as the DHS. Several surveys only collect information on girls and women who are married or in a union, thus leaving out important subgroups of girls and women, and other population groups as well.

Another five indicators can be disaggregated more extensively by key stratifiers using existing data, as better and more data are collected through surveys or facility information systems about specific issues, such as immunization. The three education-related indicators can also be presented using disaggregated data, provided they are derived from household surveys. For seven indicators, mostly on cause-specific mortality, disaggregation is limited because in high-income countries they are typically measured through civil registration and vital statistics (CRVS) systems, which collect age, sex and region but not socioeconomic information, or in lower-income countries through household surveys. The latter do not provide large enough sample sizes to support disaggregation for most mortality indicators (e.g. on maternal mortality, cause-specific child mortality or suicide mortality, in contrast to under-five mortality for which disaggregation is possible). Also, disaggregation of the indicator on post-exposure prophylaxis (PEP) for rape survivors is likely to be limited. But in general, even in the absence of new survey or other data initiatives, it is possible to ensure that most indicators are monitored with an equity lens.

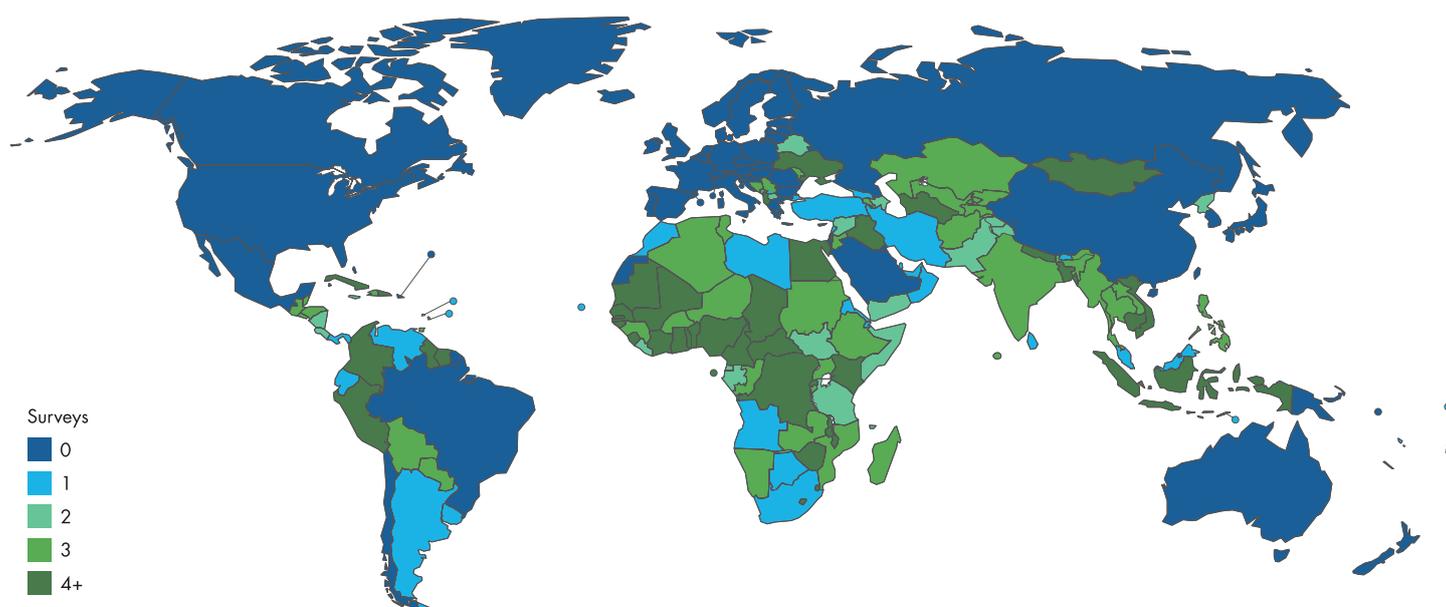
The proposed essential services coverage index for universal health coverage has multiple components and it will be challenging to achieve the same disaggregations for all indicators of the composite measure.

For the RMNCAH component of universal health coverage, however, it is possible to disaggregate by key stratifiers. The most established measure is the Countdown to 2015 summary measure, known as the composite coverage index (CCI), which is a weighted average of eight intervention coverage indicators, based on aggregate estimates,¹⁴ encompassing family planning, pregnancy and delivery care, immunization and management of child illness. The CCI is a proxy for intervention coverage along the RMNCAH continuum, being strongly correlated with child mortality and undernutrition.¹⁴ The set of indicators may be expanded to include other coverage indicators as data on additional population groups (such as male adolescents and adults) become available. Summary indices are useful for providing an overall assessment of inequalities, but do not replace the need to also examine coverage levels and trends of individual coverage indicators for programmatic purposes.

SURVEYS AND EQUITY

Household surveys have been the cornerstone of equity analyses in low- and middle-income countries (LMICs), because most questionnaires provide information both on stratification variables, such as wealth or education, and on health-related indicators. The marked increase in national surveys in developing countries during the MDG era, as well as methodological developments regarding the measurement of wealth and the assessment of the magnitude of inequalities, have contributed to the mainstreaming of equity analyses in RMNCAH. Figure 3.1 shows the number of standardized RMNCAH surveys (checked for quality carried out in countries since 2000) that provide the necessary information for detailed equity analyses.

FIGURE 3.1. Map showing number of standardized surveys per country allowing disaggregated analyses related to women's, children's and adolescents' health (2000-2017).



Disclaimer

The boundaries shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Among 127 countries with surveys, 100 countries have had more than one, allowing time-trend analyses. Peru had the largest number of surveys, as DHS were carried out annually for several years. In fact, RMNCAH is currently the health area with the best availability of disaggregated data; better than for control of noncommunicable diseases or control of infectious diseases.

High-income countries often do not conduct surveys on RMNCAH. These countries use other sources such as facility data to assess coverage of interventions. Upper-middle-income countries with large populations, such as China, Brazil, Mexico and South Africa, are implementing national household surveys that include RMNCAH questions and measurements. Unfortunately, the measurement of several RMNCAH indicators is not based on standard international indicator definitions. As long as the countries use the same measurement approaches over time, country trends in equity can be monitored. However, inconsistent definitions will pose a challenge to conducting comparative global analyses.

STRATIFIERS FOR DATA DISAGGREGATION

The most commonly used stratifiers are socioeconomic status (education, wealth), geographic (urban-rural, place of residence) and demographic characteristics (sex, age). For RMNCAH, the International Center for Equity in Health at the Federal University of Pelotas, Brazil,¹⁵ routinely carries out disaggregated analyses that are disseminated by the WHO Health Equity Monitor⁵ and the Countdown to 2015 (now Countdown to 2030),³ and UNICEF produces analyses that are disaggregated by wealth, sex of the child and place of residence.¹⁶

Sample sizes in RMNCAH surveys carried out since 2010 are typically about 6000 households, which are usually sufficient for disaggregating most indicators by wealth quintiles, sex of the child and urban-rural residence. Such samples are often too small for studying women in a narrow age range, such as young adolescents, and may also be too small for some ethnic groups, as will be discussed below. Small sample sizes may also hamper disaggregated analyses of health outcomes measured on a subgroup of the population, for example treatment for diarrhoea which is restricted to children with symptoms in the two weeks preceding the survey. Disaggregation by subnational regions is only possible for regions treated as sampling domains in the survey, often between five and 10 regions per country, whereas finer disaggregation is usually required by policy-makers and managers, a point that is further discussed below.

In addition to the above-listed stratifiers, SDG 17.18 calls for disaggregation by race, ethnicity, migratory status and disability. Stratifications by migratory status, disability and ethnicity require that these variables are included in the survey, measurement of the minority status (e.g. disability status) is specific and numbers are adequate. Until now, this has been the case only in some countries and surveys. For race or ethnicity, analyses may be hampered by the sample sizes (large number of ethnicities) and in some contexts by political sensitivities. Similar political sensitivities hinder rigorous analyses on religion. There are important exceptions, such as race in the USA or large ethnic minorities or indigenous populations in some countries. In such cases, national surveys can capture the required data for disaggregated statistics. In other situations special data collection efforts are required. The marital status of adolescent girls is another important indicator to be added to routine analyses.

On the positive side, recent developments will contribute to a better understanding of health inequalities and how best to tackle them. Use of wealth deciles instead of quintiles is increasingly possible as larger survey samples are recruited. It effectively doubles the granularity of disaggregation and so may help pinpoint groups at particularly high risk. If sample sizes permit, double disaggregation – for example by two stratifiers such as urban-rural residence and wealth quintile – may identify subpopulations such as the urban poor in many countries who deserve special attention. Lastly, fine geographical disaggregation, by coupling survey data with other data sources such as censuses, will be of particular interest to policy-makers and managers by identifying specific communities that need to be prioritized.

SUBNATIONAL DATA AND EQUITY

While household surveys also include geographic variables such as urban-rural residence and province or region of residence, the sample sizes are generally not adequate to provide reliable data for lower-level administrative units in countries. The SDGs and the Global Strategy, however, emphasize the need for local action based on local evidence. National demand for such data has increased considerably, particularly in countries with large populations or with active policies for decentralization or devolution.

The main potential sources for local data are CRVS and health facility data systems. CRVS systems may provide information on geographic and gender inequalities, for mortality and causes of death. High-income countries have an explicit interest in subnational data for planning and monitoring purposes. Middle-income countries like South Africa, Brazil and Thailand have also developed local maps with cause-of-death information, derived from the CRVS system after adjustment for various reporting biases. In general, however, reliable information is scant at present for most LMICs.

More than 50 LMICs now use electronic health facility data reporting systems, mostly based on DHIS 2. These systems hold great promise in improving the timely availability, quality and analyses of health-facility data on service delivery and facility-based cause-specific mortality, as is increasingly proven in some countries (e.g. Rwanda, Kenya). These systems should lead to improved subnational analyses conducted at the national level, which eventually lead to better allocation of resources within the country. In the future, the ability to analyse individual medical records, while ensuring anonymity, may provide even finer levels of disaggregation. This should also lead to more efficient and effective resource allocation within the subnational units, enabling them to monitor progress and target those who are left behind.

Current approaches to equity monitoring are mainly based on household health surveys providing data at the individual or household level. The wider use of an area-based unit of analysis (e.g. linking different data sources including censuses, CRVS, surveys and facility data using a small-area identifier like a postcode) as a complementary way to analyse data at the individual or household level has certain practical advantages, as mentioned earlier, and this is applicable to low- and middle-income countries as well as high-income countries.

EQUITY MONITORING IN HUMANITARIAN SETTINGS

Chapter 1 discusses the challenges of monitoring in humanitarian and fragile settings. Global data systems largely under represent the health needs of women, children and adolescents living in humanitarian settings, who now account for more than 50% of the burden of preventable mortality. Data collection is often ad hoc and unsystematic, using different indicators than in development settings, so data availability and quality vary greatly. New systems of data collection are needed for these settings, as are new statistical instruments to generate usable estimates.

DISAGGREGATED ANALYSES AND REPORTING

The increased interest in equity analyses has led to important methodological advances. As mentioned above, assessment of socioeconomic position through asset indices has become widespread. The magnitude of inequalities, which in the past was primarily assessed by comparing extreme subgroups – e.g. the poorest and the richest quintiles – can now be compared through summary measures such as the slope index of inequality, the relative index of inequality and the concentration index, all of which take the whole distribution of wealth into account.¹⁷

The importance of presenting both absolute measures of inequality (e.g. the coverage difference between urban and rural children, or between the best and poorest performing districts) and relative measures (e.g. the corresponding ratio of coverages) has become evident, as each type of comparison may lead to different interpretations and programmatic responses. This is particularly so in time-trend analyses assessing whether equity is improving or getting worse. Also, several methods became available for assessing the overall magnitude of inequalities when the stratifier is a nominal variable, as is the case for subnational regions.¹⁸

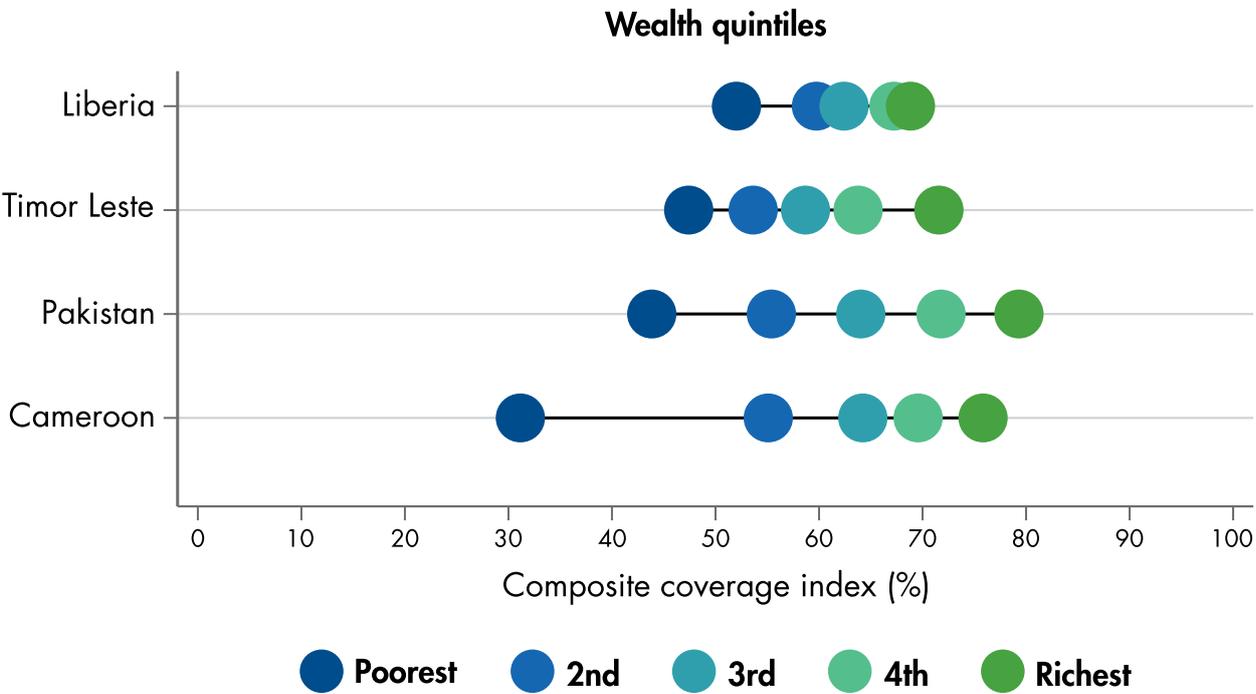
Disaggregated analyses have shown that countries with similar national average values for an indicator may have markedly different degrees of inequality across population subgroups. The magnitude of inequalities becomes evident through graphic displays such as the equiplot. An example is shown in Figure 2, with five circles plotted on the same horizontal line, each showing the composite coverage index in a quintile for four countries with national coverage around 60%.¹⁹ It is important to note that a similar gap between the richest and poorest, for example, may be due to different patterns: in one country, inequality in intervention coverage may be due to the wealthiest quintile being well above the rest,

whereas in another the same degree of inequality between the two extreme income groups may be due to the poorest quintile being well below the rest – as is the case for Cameroon in Figure 2. Understanding inequality patterns is essential for designing programmes aimed at reaching the underserved.

In addition, reporting the state of health inequality should be aligned with the needs and expertise of the target audience. The Health Equity Monitor team at WHO has developed a series of materials and tools for building capacity in the methods, analyses, visualization and presentation of inequalities, and the incorporation of results into priority setting.^{5,20}

FIGURE 3.2. Composite coverage index (CCI) by wealth quintile for four countries with national levels around 60%.

These *equiplots* show that countries with similar national coverage may differ substantially in terms of the degree of inequality.



CONCLUSION

The SDGs' requirement for disaggregated analyses represents an important change from the MDGs, in which equity, human rights and gender concerns were not evident. The growing involvement of several major institutions with equity, human rights and gender analyses and impact assessments for women's, children's and adolescents' health analyses for RMNCAH indicators in recent years has led to a number of developments in data collection and analysis. These will contribute to SDG 17.18, the Survive, Thrive and Transform agenda of the Global Strategy, and to the routine reporting of disaggregated statistics. With the addition of adolescents as part of the Global Strategy, age disaggregation has become increasingly important. Important challenges still remain, however, and include the continued need for regular surveys in all countries – particularly in high- and upper-middle-income countries – and difficulties inherent to measuring important stratifiers such as ethnicity.

As noted above, RMNCAH is in a better position than most other health areas due to the large number of indicators collected through household surveys. Even though national surveys will remain the main source of disaggregated statistics, other sources will also play an increasingly important role. As country health information systems are being strengthened, health facility and community-level data are particularly relevant. They present continuous data and are first and foremost useful for disaggregation by geographic or administrative areas. This permits much greater local use for targeting populations. In addition, it will be essential to invest in strengthening CRVS systems, which ultimately should lead to much greater insights into subnational mortality and cause of death patterns. Investments are also needed in new tools and methodologies to track equity in humanitarian settings.

CHAPTER 4.

THE UNIFIED ACCOUNTABILITY FRAMEWORK FOR THE EWEC GLOBAL STRATEGY

MAIN POINTS

- Many countries have already strengthened, or are strengthening, their accountability efforts around women's, children's and adolescents' health, including in response to CoIA recommendations;
- The sheer number of global and regional accountability mechanisms related to the Global Strategy makes alignment with country-led efforts difficult.
- A key function of the Unified Accountability Framework (UAF) is to align partner support for country-led plans and evidence-based priorities, and to synchronize with country accountability processes.
- Proposed unifying mechanisms within the UAF have been identified to strengthen partner alignment, support voluntary commitments and promote harmonization across the interconnected accountability processes of Monitor, Review and Act.
 - Options will be reviewed in a process led by EWEC and PMNCH and the UAF functions further defined.
 - The UAF will provide a supportive global architecture to enable countries and development partners to adopt a harmonized approach to fulfilling their commitments to the Global Strategy, in alignment with country-led plans, with individual and mutual accountability for resources, results and rights at all levels.
 - Ultimately, universal accountability is to rights holders – women, children and adolescents everywhere – and for the "World We Want in 2030".

The *Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030)* was launched alongside the Sustainable Development Goals (SDGs) in September 2015 by the UN Secretary-General and world leaders as a “front-runner implementation platform” to help countries achieve the SDGs.¹ The preceding *Global Strategy for Women’s and Children’s Health (2010-2015)* catalysed high-level political attention, in-country action and more than 400 multistakeholder commitments, including financial commitments totalling almost US\$ 60 billion.² During development of the updated EWEC Global Strategy, more than 7000 organizations and individuals contributed through consultations, inputs and reviews.¹ It has already attracted around 180 commitments to date (September 2016). Around a third have been made by implementing governments, and the rest by donors, the private sector, nongovernmental organizations, health-care professional associations and research institutions – as financial, policy or practice commitments.¹

The EWEC Global Strategy calls for harmonization of monitoring and reporting, to: “minimize the reporting burden on countries by harnessing existing data sources disaggregated by gender, geography and income to track progress on implementing the Global Strategy...”¹ This chapter looks at the role of the Unified Accountability Framework (UAF) in achieving these objectives by reviewing, selecting and supporting a series of unifying mechanisms for multistakeholder partners to engage in accountability processes. It also outlines current gaps and challenges. Figure 4.1 summarizes key elements of the UAF within the Global Strategy.

As Figure 4.1 shows, countries are key drivers of accountability for RMNCAH. Their monitoring and reporting activity is essential for national accountability and feeds directly into regional and global processes.

FIGURE 4.1. The Unified Accountability Framework and the Global Strategy.



In response to the recommendations of the Commission on Information and Accountability (CoIA), many countries have already strengthened, or are strengthening, their monitoring and reporting efforts around RMNCAH. Annex 1 provides a snapshot of countries' progress towards implementing the 10 CoIA recommendations.³ Figure 4.2 summarizes some of the numerous country mechanisms that are already in place. A central purpose of the UAF is to support country monitoring and reporting by harmonizing the activity of partner organizations at all levels.

Through multistakeholder alignment and action, it also aims to address new challenges and opportunities in the SDG era for country, regional and global accountability.

Accountability comprises three interconnected processes – Monitor, Review and Act – which support learning and continuous improvement.³ Across these processes, Figure 4.2 summarizes the wide range of accountability mechanisms that currently exist for women's, children's and adolescents' health.

FIGURE 4.2. Unified Accountability Framework: Unifying Mechanisms.



Note: for abbreviations, please see the list at the end of the report.

The complex and fragmented landscape it depicts is unwieldy and inefficient, and places an unacceptable reporting burden on countries and partners. However, key unifying mechanisms are already emerging to streamline accountability processes and reduce the reporting burden.

To advance the objectives of the UAF, and specifically to harmonize multistakeholder partner action in support of country-led efforts, proposed unifying mechanisms are discussed below. While some mechanisms are clearly strong candidates for UAF selection, they must be agreed and used by all key stakeholders to align support for country-led efforts. Options will be reviewed and agreed upon in a process led by Every Woman Every Child (EWEC) and the Partnership for Maternal, Newborn & Child Health (PMNCH), and the related roles and functions defined.

MONITOR: STRENGTHEN COUNTRY HEALTH INFORMATION SYSTEMS

Building on the work already being undertaken by countries to improve RMNCAH monitoring (Figure 4.2), the UAF will help countries and their partners to align efforts to strengthen country civil registration and vital statistics (CRVS) and health information systems. A guiding principle is to implement Global Strategy monitoring in line with country-led plans and evidence-based priorities.

An array of monitoring mechanisms evolved during the era of the Millennium Development Goals (MDGs), but operate in a fragmented way. This is exemplified in the network of mechanisms under “monitor” in Figure 4.1, while the gaps and challenges that exist in country data and data systems are described in Chapter 1.

Partners need to further align their investments and action on these issues to fill in the gaps, and maintain the continuity of established systems for indicator monitoring. Across all countries, it will be important to take account of equity and human rights considerations and the determinants of women’s, children’s and adolescents’ health – including specifically in humanitarian and fragile settings.

Indicators for monitoring human rights in health remain fairly novel – despite international commitment to health policies and programmes that are grounded in human rights principles. While human rights indicators have been used to monitor some specific issues related to health, and health indicators have been used to draw attention to some rights issues, a systematic, transparent system does not yet exist to explicitly link human rights and health concerns, nor to determine their combined impact on the effectiveness and outcomes of health policies and programmes.

A number of established mechanisms and partnerships already exist to strengthen country health information systems and monitoring.

The Health Data Collaborative (HDC)⁴ is a proposed unifying mechanism to align partner support for national plans and streamline efforts to strengthen country CRVS and health information systems. The HDC works to improve the availability, quality and use of health data for local decision-making through an inclusive partnership of international agencies, governments, philanthropies, donors and academics. As well as supporting a common monitoring agenda, the HDC will support countries and health partners with data standards, measurement methods, health indicators and other resources.⁴

This work will include the harmonization of indicators and monitoring systems to reduce the reporting burden on countries.

The United Nations Statistics Division (a division of the Department of Economic and Social Affairs) Sustainable Development Knowledge Platform⁵ is another potential unifying mechanism to ensure consistent approaches to the collection and analysis of data, especially as related to the SDGs. The UAF will depend on other UN and multilateral agencies to support countries in monitoring progress and collating and analysing data through a variety of mechanisms. These include the interagency groups for the estimation of maternal and child mortality,^{6,7} the WHO Global Health Observatory and World Health Statistics reports,^{8,9} the World Bank Group's World Development Indicators and World Development Report,^{10,11} the UNFPA State of World Population¹² and UNICEF's State of the World's Children,¹³ among others.

Other mechanisms, shown in Figure 4.1, also cover different aspects of monitoring that may directly or indirectly contribute to the strengthening of country health information systems. The Countdown to 2030 tracks coverage for reproductive, maternal, newborn, child and adolescent health (RMNCAH) interventions and conducts equity analyses.¹⁴ The Institute for Health Metrics and Evaluation (IHME) publishes estimates on mortality, as well as an annual global financing for health report that explores patterns of worldwide health financing flows from 1990 onwards.¹⁵ Reviews and audits of companies and corporations are another underused potential source of data.

REVIEW: SUPPORT MULTISTAKEHOLDER REVIEW AND INDEPENDENT VERIFICATION

"Review" refers to the process of checks and balances that assess whether governments have met their obligations related to women's, children's and adolescents' health, and that all stakeholders have kept to their proposed commitments in response to the Global Strategy. It also involves the verification and synthesis of progress data to ensure they are credible, accessible and widely comprehensible. As such, review activity is a priority for countries. Some are already making significant progress in areas such as maternal death review, social accountability reviews and human rights reviews (Figure 4.2).

Review is also an essential task for the UAF at global level, which entails both monitoring the Global Strategy indicators and supporting a critical independent review function. For independent review, the newly appointed Independent Accountability Panel (IAP),¹⁶ following the independent Expert Review Group (iERG),¹⁷ will scrutinize the monitoring data on the implementation of the Global Strategy and make recommendations on remedial action required.

Although important for driving action, the emergence of multiple accountability initiatives for the 2010 Global Strategy – and for women's children's and adolescents' health generally – created a fragmented accountability landscape (Figure 4.2). The accountability picture has also been clouded by over-reliance on aggregated figures and self-reporting on Global Strategy commitments. There is a need to hold individual commitment-makers more clearly to account by reviewing their performance against their own commitments, with increased capacity to analyse and verify progress reporting.

The proposed unifying review mechanism for the Global Strategy is the collaboratively developed Global Strategy progress report. The progress report is scheduled for publication every April in advance of the World Health Assembly in May and the July United Nations High-Level Political Forum on Sustainable Development (HLPF).¹⁸ The Global Strategy progress report provides a way of organizing and bringing together diverse stakeholders, including critical elements, to streamline the review of accountability across all areas of the Global Strategy. It will feature assessments of progress using the indicator and monitoring framework,¹⁹ as well as thematic analyses of the Global Strategy action areas and guiding principles and focusing on country-specific progress. As certain data are only collected every three to five years, it may not be appropriate to report annually on progress against the Global Strategy targets or outcome indicators. In the interim, the Global Strategy progress report will provide thematic updates on emerging issues, including linkages to the annual themes and priorities of the HLPF and the World Health Assembly.

Annual progress reporting will build on existing review activity for RMNCAH. For example, PMNCH has published five annual accountability reports since 2010, which review multistakeholder commitments to Every Woman Every Child. This PMNCH tracking activity aligns with other key accountability efforts, including CoLA and the iERG. Other specific initiatives that helped drive accountability pre-2015 include the Countdown to 2015, which tracked progress towards MDGs 4 and 5 between 2003 and 2015.¹⁴ Human Rights review mechanisms – including the Universal Periodic Review,²¹ Human Rights Council and Treaty Body Mechanisms – can supplement the data on women’s, children’s and adolescents’ health.²²

It is crucial to align Global Strategy review processes with country-level review processes for the SDGs, and with regional efforts. Various regional mechanisms, such as the African Union Peer Review Mechanism,²⁰ reflect the need for national and subnational accountability in comparison with other countries and highlight the shared priorities and experiences of countries, as well as opportunities for collaboration in the region to effect remedial action.

Scorecards are potentially a powerful tool for reviewing Global Strategy progress within countries by communicating key findings to multiple stakeholders using simple graphics and dashboards. They are supported by a range of country data sources. The approach was developed by, and has been mostly supported by, the African Leader’s Malaria Alliance (ALMA), which has published guidance for developing an RMNCAH scorecard.²³ Objectives of using the scorecard include: 1) enabling better profiling and monitoring of high-impact RMNCH interventions to help decision-makers identify and prioritise gaps; 2) facilitating and strengthening evidence-based action plans to improve internal management of programmes and policies; 3) serving as an advocacy tool for external partners and civil society; 4) aligning with existing national review processes and timings; and 5) validating and triangulating the implementation of actions intended to improve the health of women, children and adolescents.

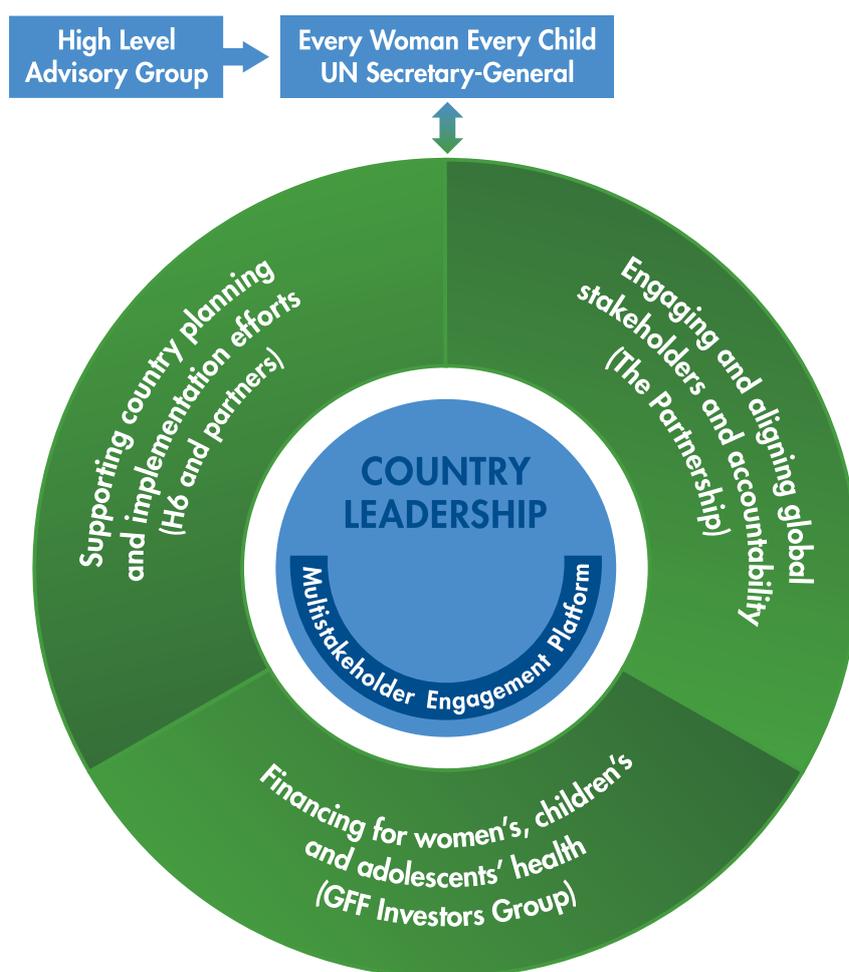
ACT: IMPLEMENTATION OF COMMITMENTS THROUGH REMEDIAL ACTION AND ACCOUNTABILITY

In the context of accountability, “acting” refers to making strong commitments and supporting remedial action, based on identified gaps and challenges through monitor and review processes. Country activity in these areas has strengthened in recent years in response to the CoLA recommendations of 2011, which called for “national accountability mechanisms that... recommend remedial action, as required”.

Figure 4.2 shows the importance in this area of central mechanisms to create and implement health plans, set budgets and strengthen the health system and workforce.

The unifying mechanism for the Act element of the UAF is the EWEC Global Architecture (Figure 4.3). The EWEC movement works to mobilize and intensify international and national action by governments, the UN, multilaterals, the private sector and civil society to address the major health challenges facing women, children and adolescents.

FIGURE 4.3. EWEC Global Architecture in support of country-led activity to implement the Global Strategy.



The movement is led by the UN Secretary-General, supported by the High-level Advisory Group (HLAG),²⁴ to inspire ambitious action for women's, children's and adolescents' health in countries. The EWEC Global Architecture also plays a critical function in supporting voluntary commitments towards the implementation of SDGs, as well as engaging with subnational bodies and civil society to ensure accountability to women, children and adolescents as rights-holders.

Within the EWEC Global Architecture, the H6 agencies²⁴ – UNAIDS, UNFPA, UNICEF, WHO, UN Women and the World Bank – will provide technical support for country-led plans, systems strengthening and implementation, while also strengthening commitments and ensuring remedial action for women's, children's and adolescents' health.

The Global Financing Facility (GFF) will facilitate financing from multiple sources for country investments in RMNCAH, coordinated by the World Bank and multistakeholder partners in the GFF Investors Group.²⁵ Embedded in the work of the GFF is an annual review of gaps in commitments, and of progress towards goals and targets, to provide additional support to help countries make targeted adjustments on investment cases and implementation plans. Other key financing mechanisms include the Global Fund to Fight AIDS, Tuberculosis and Malaria and Gavi, the Vaccine Alliance.^{26,27}

The UAF is the accountability pillar of the EWEC Global Architecture, supported by PMNCH. Through the PMNCH Board and annual workplan, stakeholders also will consider how commitments can be better targeted to fill identified gaps and implement the Global Strategy and how better to hold themselves individually and mutually accountable for fulfilling their commitments.

Commitment-makers need to focus their attention on the gaps and challenges that specifically prevent countries from achieving their objectives for women's, children's and adolescents' health. All stakeholders should consider how their commitments fill identified accountability gaps – such as the need to strengthen country health information systems and to promote knowledge sharing and integrated action to address identified gaps and needs.

Another important unifying mechanism for action is the High-Level Working Group on Health and Human Rights.²⁸ Convened by WHO and OHCHR, the working group will provide guidance on how human rights can be integrated in health policies and programming. It also will enhance accountability for rights by the re-purposing of health indicators and data sources in collaboration with other UN agencies and partners (e.g. through treaty-monitoring bodies, national human rights institutions, the IAP, professional associations). The working group will provide an opportunity for human rights mainstreaming at different levels through the work of UN agencies, governments and partners, and provide guidance on operationalization of recommendations made by UN treaty monitoring bodies.

CONCLUSION

The UAF has been created to promote harmonization in multistakeholder accountability efforts at all levels for women's, children's and adolescents' health. It will provide an overarching structure for tools, mechanisms and partnerships that support countries in their monitoring of national progress related to the Global Strategy, and will do so in a way that aims to streamline global processes, align with regional efforts and reduce the reporting burden on countries. A key objective of the UAF is to give countries, commitment-makers and other stakeholders the information and support they need to target their efforts at priority gaps in RMNCAH coverage.

An organizing principle for all actors and activity overseen by the UAF is the CoIA definition of the accountability process: Monitor, Review and Act.

Currently, the monitoring and accountability landscape for RMNCAH is fragmented and lacks coherence (Figure 4.2). A priority task for EWEC, PMNCH and other partners is to review this scene and select those UAF unifying mechanisms that can best deliver accountability for implementation of the Global Strategy, and ensure that the UAF itself operates effectively. A number of potential unifying mechanisms are detailed in this chapter. However, they must be agreed and used by all key stakeholders to align support for country-led efforts. At time of publication of this report these decisions were pending.

The UAF will operate as a facilitator of accountability, and as such will be largely invisible to countries and their partners. It will work in the background to promote harmonized partner accountability efforts in support of country-led plans. However, the ultimate, universal accountability is to women, children and adolescents everywhere, to whom commitment makers to the Global Strategy and the SDGs have promised so much.

CHAPTER 5.

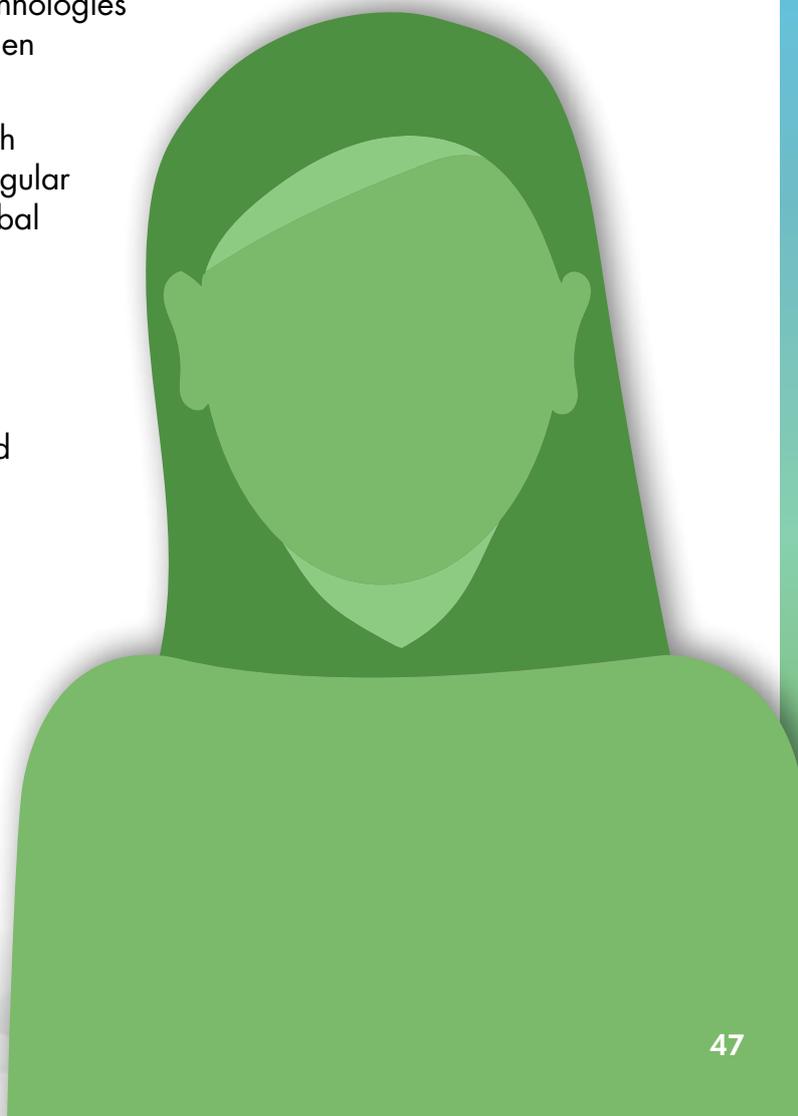
RECOMMENDATIONS

This chapter offers a series of recommendations to strengthen monitoring of the Global Strategy indicators. They will not *all* be relevant or useful to *all* countries and partners, so discretion will be needed to identify those that do apply, and to adapt them to specific country and programmatic circumstances. As an overarching principle, countries and their partners should attempt to dovetail their monitoring efforts for the Global Strategy with national health plans, investments and priorities.

1. STRENGTHEN COUNTRY DATA:

improve and harmonize data sources and information systems

- Strengthen CRVS and country health information systems to advance analysis, action and accountability (the State of the World's Health Information Systems 2017 report from WHO and the Health Data Collaborative will provide guidance on key strategies and investments to strengthen country health information systems);
- Work towards standardization and harmonization of data collection methods and data quality improvement;
- Deploy information and communication technologies (including eHealth and mHealth) to strengthen country health information systems;
- Supplement routine data from country health information systems with sample surveys, regular facility surveys, specialized studies and global estimates as relevant;
- Whenever possible, ensure that global statistics are also of use to countries;
- Harmonize and streamline data collection methods with national country planning and review cycles to maximize synergies between monitoring efforts;
- Develop local capacities to utilize data for local decision-making and contribute to global reporting as relevant.



2. LEAVE NO ONE BEHIND:

put equity at the heart of monitoring, and focus on humanitarian settings

- Strengthen capacities to monitor equity, human rights and gender;
- Use disaggregation of data to identify and serve marginalized groups;
- Include migratory status, disability and ethnicity as variables in surveys to allow disaggregated analyses;
- Target data collection and analysis in humanitarian settings;
- Use standard international indicator definitions and measurement approaches to allow monitoring of country trends according to population subgroups defined by socioeconomic position, gender, ethnicity, place of residence and other stratifiers proposed by the SDGs;
- Include a range of variables in analyses of gender inequalities in addition to sex, such as reproductive status, income, education, religion, family configuration and others;
- Use stratification by more than one dimension – such as wealth and urban-rural residence, or sex and ethnicity or wealth – in order to identify the most vulnerable groups;
- Take advantage of methodological advances in equity analyses, such as summary indices of inequality, to explore inequity patterns;
- Invest in health-facility information systems to allow them to produce data on mortality, morbidity and utilization that may be disaggregated by key dimensions of inequality.

3. SHARPEN THE FOCUS:

update the Global Strategy indicators and monitoring framework

- Ensure alignment with the finalized SDG indicators and with established national and global reporting mechanisms (e.g. on immunization, nutrition);
- Invest in research on new and poorly measured indicators and implications for country monitoring efforts (e.g. on quality of care, cause of death, early childhood development, adolescent health and health in humanitarian settings);
- Prioritize key indicators required to inform country-specific planning, investment, implementation and accountability efforts.

4. BUILD THE GLOBAL PARTNERSHIP: the Unified Accountability Framework

- Identify, agree on and use key mechanisms to unify partner support for country-led accountability across Monitor, Review and Act processes;
- Build on existing unifying mechanisms. Mechanisms to help unify multistakeholder support for country-led plans include: [for Monitor] the Health Data Collaborative, UN-DESA Sustainable Development Knowledge Platform and the WHO/OHCHR high-level working group on health and human rights of women, children and adolescents; [for Review] the Independent Accountability Panel report and the EWEC Global Strategy progress report for the WHA, HLPF and other review processes; [for Act] the EWEC Global Architecture with H6 technical support; Global Financing Facility; and the Unified Accountability Framework;

- Partners should adopt a harmonized approach to fulfilling their commitments to the Global Strategy, in alignment with country-led plans, with individual and mutual accountability for resources, results and rights at all levels.

5. GALVANIZE POLITICAL SUPPORT: for resources, advocacy and accountability

- Maintain the highest level of political attention and investment in women's, children's and adolescents' health;
- Build links to political bodies at all levels, including parliamentarians and local leaders, and to the media and other potential advocates and champions;
- Work closely with existing civil society organizations and their links with communities;
- Hold stakeholders and commitment-makers to account for fulfilling their commitments to the Global Strategy and for resources, results and rights at all levels;
- Ensure women, children and adolescents have the ultimate say in accountability.

CONCLUSION

To ensure that Global Strategy monitoring will be meaningful with actionable data from the outset, significant early investments are required to strengthen country CRVS and health information systems and local capabilities to compile, validate, analyse, disaggregate, synthesize, communicate and use data. A special focus is required to improve data in humanitarian settings. At the global level, the widespread availability of survey data on RMNCAH – augmented by CRVS data and judicious use of estimates – are useful supplementary sources if limited on some indicators. Sustained focus is required through the Unified Accountability Framework and other partners to align country, regional and global monitoring in ways that maximize the value of the data collected, minimize the reporting burden on countries and ensure accountability for resources, results and rights at all levels and ultimately to women, children and adolescents everywhere and for the “World We Want in 2030”.

ANNEXES

ANNEX 1.

SNAPSHOTS OF COUNTRIES' PROGRESS TOWARDS THE COMMISSION ON INFORMATION AND ACCOUNTABILITY'S (COIA) 10 RECOMMENDATIONS

Work Area	Recommendation	Target	Result August 2016
Country Accountability Frameworks (CAFs)	Countries have plans for strengthening national accountability processes.	50 countries with CAFs by 2013.	68 countries with CAFs; 17 countries received additional catalytic funding to expand upon their CAFs.
BETTER INFORMATION FOR BETTER RESULTS			
1 Vital events and Maternal Death Surveillance and Response (MDSR)	By 2015, countries improve systems for registration of births, deaths and causes of death and health information systems.	50 countries with civil registration and vital statistics (CRVS) assessments and plans by 2015. 50 countries making improvements in MDSR by 2015.	65 countries have conducted an assessment of their CRVS system, or have a CRVS assessment underway; many have CRVS improvements underway as part of regional CRVS programmes. 68 countries have a national policy requiring all maternal deaths to be notified; 63 countries have a policy requiring all maternal deaths to be reviewed; 52 countries have a national maternal death review committee in place; 29 countries have a national maternal death review committee that meets at least biannually (as recommended).
2 Health Indicators	By 2012, countries using the same 11 indicators on reproductive, maternal, newborn and child health (RMNCH), disaggregated for gender and other equity considerations.	50 countries use and have accurate data on the core indicators. Global partners have streamlined reporting systems.	44 countries using web-based facility reporting, primarily the District Health Information System 2.0 (DHIS 2.0); countries conduct regular household surveys, and 20 countries have introduced data quality improvement mechanisms Global partners are streamlining reporting systems.
3 eHealth and Innovation	By 2015, countries integrating information and communication technologies in national health information systems and health infrastructure.	By 2015, 50 countries developed and implementing national eHealth strategies.	27 countries developed and implementing national eHealth strategies linked to RMNCH.

Work Area	Recommendation	Target	Result August 2016
BETTER TRACKING OF RESOURCES			
4 Resource Tracking	By 2015, countries are tracking and reporting: 1) total health expenditure by financing source, per capita; and 2) total RMNCH expenditure by financing source, per capita.	By 2013, 50 countries have and use accurate data on the two indicators, as part of their monitoring and evaluation systems.	New System of Health Accounts 2011 methodology accepted by countries and global partners (GAVI, Global Fund, USAID); 30 countries have data on RMNCH expenditure; of these, 16 countries have subsequent years of data and have institutionalized the methodology.
5 Country Compacts ¹	By 2012, "compacts" in place between governments and development partners.	By 2015, 50 countries have formal agreements with donors.	51 countries have compact or similar partnership agreements for the health sector in place; Since 2010, more than one in three of these compacts have been co-signed by civil society or non-state actors.
6 Reaching Women and Children	By 2015, governments have capacity to review health spending and relate spending to commitments, human rights, gender and equity goals and results.	Linked to Recommendations 2 and 4.	Partnership for Maternal, Newborn & Child Health (PMNCH) tracks implementation of commitments and spending; Budget advocacy workshops held for 16 country teams of media, civil society and parliaments to better understand national budget expenditures for RMNCH.
BETTER OVERSIGHT OF RESULTS AND RESOURCES NATIONALLY AND GLOBALLY			
7 National Oversight (Health Sector Reviews, Advocacy and Action)	By 2012, countries have transparent and inclusive national accountability mechanisms.	50 countries have regular national health sector review processes. 20 countries are engaging political leaders and financial decision-makers in health	54 countries have reported undertaking an annual, mid-term review, or a similar process (such as a health summit). Parliaments in 30 countries have engaged in legislation and/or budget allocation to improve the health of women and children.
		50 countries have held a Countdown event	Countdown to 2015 has been providing regular global and country assessments of progress towards the 11 core indicators.
8 Transparency	By 2013, stakeholders publicly sharing information on commitments, resources and results achieved annually, at both national and international levels.	50 countries with mechanisms for sharing and disseminating data Global partners with databases on women's and children's health, and dissemination on core indicators	Global partner databases for 11 core indicators are publicly available through Countdown to 2015; Web-based facility reporting systems (DHIS 2.0) makes information publicly available; 27 countries organizing civil society hearings on women's, children's, and adolescents' health; OECD-DAC reporting on aid flows for RMNCH.
9 Reporting Aid for Women's and Children's Health	By 2012, the Organization for Economic Co-operation and Development-Development Assistance Committee (OECD-DAC) to agree on improvements to Creditor Reporting System to capture RMNCH health spending by development partners.	By 2012, development partners agree on the method By 2013, OECD has developed guidance and instruction to support new method, and donors using new method	21 DAC member countries began reporting on the RMNCH policy marker; 1 non-DAC donor reported on the RMNCH policy marker; 6 multilateral organizations reported on the RMNCH policy marker.
10 Global Oversight	2012–2015, an independent Expert Review Group (iERG) reporting to the United Nations Secretary-General on the results and resources related to the Global Strategy and progress on CoIA recommendations.	Members appointed	4 reports delivered to the UN Secretary-General with recommendations to accelerate progress on the Global Strategy for women's and children's health; New Independent Accountability Panel established to provide an annual independent report to the UN Secretary-General on the State of Women's, Children's and Adolescents' Health.

LESSONS LEARNED AFTER FIVE YEARS OF IMPLEMENTING THE COMMISSION'S RECOMMENDATIONS

- By making accountability a central component of the RMNCH agenda at multiple levels (global, regional, and national), the CoIA recommendations initiated a process that will continue beyond the lifespan of the recommendations themselves. Facilitating development of country-level accountability frameworks and then providing catalytic funding were key steps in initiating this process and helped to institutionalize the practice of planning for accountability.
- The Commission's focus on accountability for RMNCH specifically served as an entry-point for what have turned out to be broad health systems strengthening initiatives. Particularly in the areas of CRVS and MDSR, efforts to implement the CoIA recommendations have garnered widespread support and collaboration from multiple partners, since the benefits are salient to multiple sectors beyond RMNCH.
- That said, establishing robust accountability mechanisms—such as comprehensive CRVS, MDSR and health management information systems—is a long-term process with no one-size-fits-all strategy. Countries require extensive and ongoing technical and financial support, and capacity building for data quality assurance, management, and analysis.
- Given the multiple CoIA recommendations, inevitably some were more highly prioritized than others, by both implementing countries and donors. Those workstreams with outputs that were less defined, less immediately translatable into actions for improving maternal and child health, or politically sensitive, tended to receive less focus from countries and donors.
- Obtaining and maintaining the engagement of diverse groups of stakeholders is a challenging and time-consuming, but very necessary, part of developing and implementing accountability mechanisms. Civil society organizations and parliamentarians in particular have a critical role to play in advocating for resource monitoring and transparent dissemination of data, and it is important to ensure that they are equipped with the resources and know-how to do this.
- Utilizing newly available data for advocacy and evidence-based policy making can initiate a positively-reinforcing cycle that prompts further demand for data, but there is a need to strengthen capacity for and institutionalize norms surrounding use of data in decision making.
- Ongoing efforts to align and streamline accountability work is also needed. Countries continue to experience significant challenges in dealing with the high volume of requests for reporting from multiple agency partners, fragmentation in data collection efforts, and uncoordinated efforts to strengthen country institutional analytical capacity that are causing unnecessary reporting burden and inefficiencies.

ANNEX 2.

COUNTRY DATA SOURCES AND COLLECTION FREQUENCY FOR THE EWEC GLOBAL STRATEGY INDICATORS

Global Strategy Indicator [SDG indicator number, if aligned]	Sources of Country Data Commonly in Use	Data Collection Frequency	Comparable country-level estimates*	References for further information
SURVIVE (END PREVENTABLE MORTALITY) - 24 INDICATORS				
Maternal mortality ratio [3.1.1]	CRVS, DHS, census and specialized surveillance systems	1-5 years	Yes	WHO Global Health Observatory
Proportion of births attended by skilled health personnel [3.1.2]	DHS, MICS, other national health surveys and administrative data	1-2 years	In preparation	UNICEF www.data.unicef.org WHO Global Health Observatory
Proportion of women aged 15-49 who received 4 or more antenatal care visits	DHS, MICS, other national health surveys and administrative data	3-5 years	In preparation	UNICEF www.data.unicef.org WHO Global Health Observatory
Proportion of women who have postpartum contact with a health provider within 2 days of delivery	DHS, MICS	3-5 years	No	WHO Global Health Observatory
Neonatal mortality rate [3.2.2]	CRVS, DHS, MICS	1-5 years	Yes	UN-IGME, CME Info www.childmortality.org
Stillbirth rate	CRVS, DHS, RHS, demographic surveillance sites, facility data	1-5 years	Yes	Blencowe et al. National, regional and worldwide estimates of stillbirth rates in 2015, with trends from 2000: a systematic analysis. The Lancet Global Health. 2016; 4(2): e98-e108
Proportion of infants who were breastfed within the first hour of birth	DHS, MICS	3-5 years	No	UNICEF Infant and Young Child Database WHO Global Data Bank on Infant and Young Child Feeding
Proportion of newborns who have postnatal contact with a health provider within 2 days of delivery	DHS, MICS	3-5 years	No	UNICEF www.data.unicef.org
Proportion of women in antenatal care (ANC) who were screened for syphilis during pregnancy	DHS, MICS and facility-based exit surveys	3-5 years	No	WHO Global Health Observatory
Under-5 mortality rate [3.2.1]	CRVS, DHS, MICS	1-3 years	Yes	UN-IGME, CME Info www.childmortality.org
Percentage of children with diarrhoea receiving oral rehydration salts (ORS)	DHS, MICS	3-5 years	No	UNICEF www.data.unicef.org
Proportion of children with suspected pneumonia taken to an appropriate health provider	DHS, MICS	3-5 years	No	WHO Global Health Observatory
Percentage of infants <6 months who are fed exclusively with breast milk	DHS, MICS	3-5 years	No	UNICEF Infant and Young Child Database WHO Global Data Bank on Infant and Young Child Feeding
Full child immunization	Administrative data calibrated with DHS, MICS	Annual	Yes	UNICEF www.data.unicef.org WHO Global Health Observatory
Use of insecticide-treated nets (ITNs) in children under 5 (% of children)	DHS, MICS and Malaria Indicator Surveys	3-5 years	Yes	WHO Global Health Observatory UNICEF www.data.unicef.org

Global Strategy Indicator <i>[SDG indicator number, if aligned]</i>	Sources of Country Data Commonly in Use	Data Collection Frequency	Comparable country-level estimates*	References for further information
SURVIVE (END PREVENTABLE MORTALITY) - 24 INDICATORS				
Number of new HIV infections per 1000 uninfected population, by age and sex [3.3.1]	Prevalence measured via DHS, AIDS Indicator Surveys and sentinel surveillance & facility data from antenatal clinics; converted to incidence with model	1-5 years	Yes (not all countries)	UNAIDS AIDSinfo
Malaria incident cases per 1000 persons per year [3.3.3]	Household surveys to measure parasite prevalence rates; model to convert to incidence. Country case reports for lower burden areas.	3-5 years	Yes	WHO Global Health Observatory
Percentage of people living with HIV who are currently receiving antiretroviral therapy (ART), by age and sex	Prevalence modeled from DHS, AIDS Indicator Surveys and sentinel surveillance & facility data from antenatal clinics. ART supply from administrative data	Annual	Yes (not all countries)	WHO Global Health Observatory UNAIDS AIDSinfo
Proportion of households with at least 1 ITN for every 2 people and/or sprayed by indoor residual spray (IRS) within the last 12 months	DHS, MICS and Malaria Indicator Surveys	3-5 years	Yes	WHO Global Health Observatory UNICEF www.data.unicef.org
Age-standardized prevalence of current tobacco use among persons 15 years and older, by age and sex [3.a.1]	Global Adult Tobacco Survey, STEPs, DHS and other household surveys	2-3 years	Yes (not all countries)	WHO Global Health Observatory
Mortality between ages 30 and 70 years from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases, by sex [3.4.1]	CRVS and verbal autopsy studies	Annual - rarely	Yes	WHO Global Health Observatory
Suicide mortality rate, by age and sex [3.4.2]	CRVS and verbal autopsy studies	Annual - rarely	Yes	WHO Global Health Observatory
Adolescent mortality rate, by sex	CRVS, census and surveys as data inputs to lifetables	1-5 years	Yes	UNPD World Population Prospects
Proportion of women aged 30-49 who report they were screened for cervical cancer	Nationally representative surveys or facility-based data	Rarely	No	WHO Global Health Observatory Globocan
THRIVE (PROMOTE HEALTH AND WELL-BEING) - 18 INDICATORS				
Prevalence of stunting (height for age <2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age [2.2.1]	DHS, MICS and other nationally representative surveys (National Nutrition Surveys, Living Standards Measurement Study, and Micronutrient Surveys)	3-5 years	In preparation	Joint Child Malnutrition Estimates (UNICEF/WHO/World Bank)
Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting and overweight) [2.2.2]	DHS, MICS and other nationally representative surveys (National Nutrition Surveys, Living Standards Measurement Study, and Micronutrient Surveys)	3-5 years	In preparation	Joint Child Malnutrition Estimates (UNICEF/WHO/World Bank)
Prevalence of insufficient physical activity among adolescents	Global School-based Health Survey, Health Behaviour in School-aged Children Survey	5 years	No	
Prevalence of anaemia in women aged 15-49, disaggregated by age and pregnancy status	DHS and other health examination and nutrition surveys	5 years	Yes	WHO Global Health Observatory
Proportion of children aged 6-23 months who receive a minimum acceptable diet	DHS, MICS	3-5 years	No	UNICEF Infant and Young Child Feeding database
Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods [3.7.1]	DHS, MICS and Reproductive Health Surveys	3-5 years	Yes	UNPD Family Planning website
Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group [3.7.2]	CRVS, census and household surveys	1-5 years	Yes	UNPD World Population Prospects

Global Strategy Indicator <i>[SDG indicator number, if aligned]</i>	Sources of Country Data Commonly in Use	Data Collection Frequency	Comparable country-level estimates*	References for further information
THRIVE (PROMOTE HEALTH AND WELL-BEING) - 18 INDICATORS				
Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care <i>[5.6.1]</i>	DHS and other national surveys	3-5 years	No	UNFPA and UN Women
Number of countries with laws and regulations that guarantee women aged 15-49 access to sexual and reproductive health care, information and education <i>[5.6.2]</i>	Self-reporting by governments	..	..	Measurement of indicator is under development by UNFPA, UN Women, and WHO
Proportion of men and women aged 15-24 with basic knowledge about sexual and reproductive health services and rights	..	..	No	Indicator under development by Guttmacher Institute, UNFPA
Percentage of children under 5 years of age who are developmentally on track in health, learning and psychosocial wellbeing, by sex <i>[4.2.1]</i>	MICS (Early Childhood Development Index)	3-5 years	No	UNICEF www.data.unicef.org
Participation rate in organized learning (one year before the official primary entry age), by sex <i>[4.2.2]</i>	Administrative data (Survey of Formal Education) and household surveys	1-5 years	Yes	UNESCO Institute for Statistics
Mortality rate attributed to household and ambient air pollution, by age and sex <i>[3.9.1]</i>	DHS, MICS, ground measurement and remote sensing (exposure to air pollution); CRVS and verbal autopsy studies (mortality)	2-5 years (exposure data); annually (mortality data)	Yes	WHO Global Health Observatory
Proportion of population with primary reliance on clean fuels and technology <i>[7.1.2]</i>	DHS, MICS, LSMS, and other national household surveys	3-5 years	Yes	WHO Global Health Observatory
Coverage of essential health services <i>[3.8.1]</i>	Various household surveys and administrative databases across indicators	1-5 years	In preparation	WHO Global Health Observatory
Current country health expenditure per capita (including specifically on RMNCAH) financed from domestic sources	Country reported data (Joint Health Accounts Questionnaire and National Accounts reports, including sub-accounts)	1-2 years (not all countries)	Yes (total health expenditure)	WHO Global Health Expenditure Database
Out of-pocket health expenses as percentage of total health expenditure	Country reported data (Joint Health Accounts Questionnaire and National Accounts reports), household surveys	1-2 years	Yes	WHO Global Health Expenditure Database
Lack of financial protection coverage <i>[3.8.2]</i>	Living Standards Measurement Surveys and Household Budget Surveys.	1-5 years	In preparation	WHO Global Health Observatory
TRANSFORM (EXPAND ENABLING ENVIRONMENTS) - 18 INDICATORS				
Proportion of population below the international poverty line, by sex, age, employment status and geographical location <i>[1.1.1]</i>	Household surveys (LFS, HIES, LSMS, Integrated Household surveys)	3-5 years	Yes	World Bank
Proportion of children and young people: (a) in grades 2/3; (b) at the end of primary; and (c) at the end of lower secondary achieving at least a minimum proficiency level in (i) reading and (ii) mathematics, by sex <i>[4.1.1]</i>	Various international and regional learning assessments	3-4 years	No	UNESCO
Percentage of women aged 20-24 years who were married or in a union before age 15 and (before age 18) <i>[5.3.1]</i>	DHS, MICS, other nationally representative surveys, and occasionally census	3-5 years	No	UNICEF www.data.unicef.org

Global Strategy Indicator <i>[SDG indicator number, if aligned]</i>	Sources of Country Data Commonly in Use	Data Collection Frequency	Comparable country-level estimates*	References for further information
TRANSFORM (EXPAND ENABLING ENVIRONMENTS) - 18 INDICATORS				
Proportion of ever-partnered women and girls aged 15 and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age [5.2.1]	DHS, RHS, other nationally representative surveys, and specialized violence surveys	5-8 years	No	UN Women, UNFPA, WHO, UNICEF
Proportion of girls and women aged 15-49 years who have undergone female genital mutilation/cutting, by age [5.3.2]	DHS, MICS, other nationally representative surveys	3-5 years	No	UNICEF www.data.unicef.org
Whether or not legal frameworks are in place to promote, enforce and monitor equality and non-discrimination on the basis of sex [5.1.1]	Women Business and the Law database (World Bank) and Social Institutions and Gender Index (OECD)	..	..	UN Women is developing this indicator
Proportion of young women and men aged 18-29 years who experienced sexual violence by age 18 [16.2.3]	DHS, other nationally representative surveys and specialized violence surveys	3-5 years	No	UNICEF www.data.unicef.org
Proportion of rape survivors who sought care within 72 hours who received HIV post-exposure prophylaxis (PEP)	Facility data	Annual-rarely	No	
Percentage of population using safely managed drinking water services [6.1.1]	Household surveys combined with information on national water delivery systems	2-3 years	In preparation	WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation
Percentage of population using safely managed sanitation services including a hand-washing facility with soap and water [6.2.1]	Household surveys combined with information on national sanitation systems	2-3 years	In preparation	WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation
Research and development expenditure as a proportion of GDP [9.5.1] (disaggregated by health/RMNCAL)	Country-conducted national R&D surveys	Annually (for all health)	No	UNESCO Institute of Statistics
Proportion of children under 5 years of age whose births have been registered with a civil authority, by age [16.9.1]	Census, civil registration and household surveys	1-5 years	No	UNICEF www.data.unicef.org
Proportion of countries that (a) have conducted at least one population and housing census in the last 10 years; and (b) have achieved 100% birth registration and 80% death registration [17.19.2]	Assessment of availability of civil registration and census	Annually	..	UNSD, WHO, UNICEF, UNFPA, the World Bank Group
Number of countries reporting progress in multistakeholder development effectiveness monitoring frameworks that support the achievement of the SDGs [17.16.1]	Country report	2-3 years	..	OECD, UNDP. See for example the Global Partnership for Effective Development Cooperation monitoring framework
Worldwide Governance Indicators (voice, accountability, political stability and absence of violence, government effectiveness, regulatory quality, rule of law, control of corruption)	Key informants	Annual	Yes	World Bank Group, Natural Resource Governance Institute and Brookings Institution
Proportion of indicators at the national level with full disaggregation when relevant to the target [17.18.1]	Assessments of SDG indicator metadata and reporting	..	..	UNDESA, UNDP and UNFPA
Proportion of countries that have ratified human rights treaties related to women's, children's, and adolescents' health	Country reporting and assessment by human rights bodies	..	..	OHCHR
Humanitarian Response Index	Key informants and government donor funding	Annual	Yes	WHO, DARA

* Comparable estimates across countries and time, which can be aggregated to compute regional and global totals.

ANNEX 3.

SDG INDICATORS IN THE EWEC GLOBAL STRATEGY ACCORDING TO CURRENT STATUS OF DISAGGREGATED ANALYSES

Based on disaggregated analyses (by sex, wealth, education, etc) in the Countdown and/or WHO Global Health Observatory. The SDG indicators are drawn from the core and additional lists in the Global Strategy framework. For indicators that are not already analysed, the table shows whether such analyses are feasible using data from existing RMNCAH surveys.

SDG targets	SDG indicators (number in parentheses)	Countdown and GHO equity analyses CURRENT STATUS	Additional indicators	Countdown and GHO equity analyses CURRENT STATUS
SURVIVE (END PREVENTABLE MORTALITY)				
Reduce global maternal mortality to less than 70 per 100 000 live births (SDG 3.1)	Maternal mortality ratio (3.1.1)	Not possible with currently available data sources	Proportion of women aged 15-49 who received 4 or more antenatal care visits	Already analysed
	Proportion of births attended by skilled health personnel (3.1.2)	Already analysed	Proportion of women who have postpartum contact with a health provider within 2 days of delivery	Already analysed
Reduce newborn mortality to at least as low as 12 per 1000 live births in every country (SDG 3.2)	Neonatal mortality rate (3.2.2)	Already analysed	Stillbirth rate	Possible
			Proportion of infants who were breastfed within the first hour of birth	Already analysed
			Proportion of newborns who have postnatal contact with a health provider within 2 days of delivery	Already analysed
			Proportion of women in antenatal care (ANC) who were screened for syphilis during pregnancy	Not possible with currently available data sources
Reduce under-5 mortality to at least as low as 25 per 1000 live births in every country (SDG 3.2)	Under-5 mortality rate (3.2.1)	Already analysed	Percentage of children with diarrhoea receiving oral rehydration salts (ORS)	Already analysed
			Proportion of children with suspected pneumonia taken to an appropriate health provider	Already analysed
			Percentage of infants <6 months who are fed exclusively with breast milk	Already analysed
			Percentage of children fully immunized	Already analysed
			Use of insecticide-treated nets (ITNs) in children under 5 (% of children)	Already analysed
End epidemics of HIV, tuberculosis, malaria, neglected tropical diseases and other communicable diseases (SDG 3.3)	Number of new HIV infections per 1000 uninfected population, by age and sex (3.3.1)	Not possible with currently available data sources	Percentage of people living with HIV who are currently receiving antiretroviral therapy (ART), by age and sex	Not possible with currently available data sources
	Malaria incident cases per 1000 persons per year (3.3.3)	Not possible with currently available data sources	Proportion of households with at least 1 ITN for every 2 people and/or sprayed by indoor residual spray (IRS) within the last 12 months	Possible
Reduce by 1/3 premature mortality from noncommunicable diseases and promote mental health and well-being (SDG 3.4)	Age-standardized prevalence of current tobacco use among persons 15 years and older, by age and sex (3.a.1)	Possible	Adolescent mortality rate, by sex	Not possible with currently available data sources
	Mortality between ages 30 and 70 years from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases, by sex (3.4.1)	Not possible with currently available data sources	Proportion of women aged 30-49 who report they were screened for cervical cancer	Not possible with currently available data sources
	Suicide mortality rate, by age and sex (3.4.2)	Not possible with currently available data sources		

SDG targets	SDG indicators (number in parentheses)	Countdown and GHO equity analyses CURRENT STATUS	Additional indicators	Countdown and GHO equity analyses CURRENT STATUS
THRIVE (PROMOTE HEALTH AND WELL-BEING)				
End all forms of malnutrition and address the nutritional needs of adolescent girls, pregnant and lactating women and children (SDG 2.2)	Prevalence of stunting (height for age <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age (2.2.1)	Already analysed	Prevalence of insufficient physical activity among adolescents	Not possible with currently available data sources
	Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age, by type wasting and overweight) (2.2.2)	Already analysed	Prevalence of anaemia in women aged 15-49, disaggregated by age and pregnancy status	Possible
			Proportion of children aged 6-23 months who receive a minimum acceptable diet	Possible
Ensure universal access to sexual and reproductive health-care services (including for family planning) and rights (SDG 3.7 and 5.6)	Percentage of women of reproductive age (15-49) who have their need for family planning satisfied with modern methods (3.7.1)	Possible	Proportion of men and women aged 15-24 with basic knowledge about sexual and reproductive health services and rights	Not possible with currently available data sources
	Adolescent birth rate (10-14, 15-19) per 1000 women in that age group (3.7.2)	Already analysed		
	Proportion of women aged 15-49 who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care (5.6.1)	Possible		
	Number of countries with laws and regulations that guarantee women aged 15-49 access to sexual and reproductive health care, information and education (5.6.2)	Not applicable		
Ensure that all girls and boys have access to good-quality early childhood development (SDG 4.2)	Percentage of children under 5 years of age who are developmentally on track in health, learning and psychosocial wellbeing, by sex (4.2.1)	Possible		
	Participation rate in organized learning (one year before the official primary entry age), by sex (4.2.2)	Possible (only for MICS)		
Substantially reduce pollution-related deaths and illnesses (SDG 3.9)	Mortality rate attributed to household and ambient air pollution, by age and sex (3.9.1)	Not possible with currently available data sources		
	Proportion of population with primary reliance on clean fuels and technology (7.1.2)	Possible (indoor pollution only)		
Achieve universal health coverage, including financial risk protection and access to quality essential services, medicines and vaccines (SDG 3.8)	Coverage of essential health services (index based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access) (3.8.1) (including RMNCAH: family planning; pregnancy and childbirth care; breastfeeding; immunization; childhood illnesses treatment) SDG 3.8.2 to be decided*	Already analysed for RMNCH indicators (the Countdown composite coverage index); not possible for other components	Current country health expenditure per capita (including specifically on RMNCAH) financed from domestic sources Out-of-pocket health expenses as percentage of total health expenditure	Not applicable

SDG targets	SDG indicators (number in parentheses)	Countdown and GHO equity analyses CURRENT STATUS	Additional indicators	Countdown and GHO equity analyses CURRENT STATUS
TRANSFORM (EXPAND ENABLING ENVIRONMENTS)				
Eradicate extreme poverty (SDG 1.1)	Proportion of population below the international poverty line, by sex, age, employment status and geographical location (1.1.1)	Not possible with currently available data sources		
Ensure that all girls and boys complete free, equitable and good-quality secondary education (SDG 4.1)	Proportion of children and young people: (a) in grades 2/3; (b) at the end of primary; and (c) at the end of lower secondary achieving at least a minimum proficiency level in (i) reading and (ii) mathematics, by sex (4.1.1)	Not possible with currently available data sources		
Eliminate all harmful practices and all discrimination and violence against women and girls (SDG 5.2 and 5.3)	Percentage of women aged 20-24 who were married or in a union before age 15 and before age 18 (5.3.1)	Possible	Proportion of young women and men aged 18-29 who experienced sexual violence by age 18 (16.2.3)	Possible
	Proportion of ever-partnered women and girls aged 15 and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age (5.2.1)	Possible	Proportion of rape survivors who received HIV post-exposure prophylaxis (PEP) within 72 hours of an incident occurring	Not possible with currently available data sources
	Proportion of women and girls aged 15-49 who have undergone female genital mutilation/cutting (FGM/C), by age (5.3.2)	Possible		
	Whether or not legal frameworks are in place to promote, enforce and monitor equality and nondiscrimination on the basis of sex (5.1.1)	Not applicable		
Achieve universal and equitable access to safe and affordable drinking water and to adequate sanitation and hygiene (SDG 6.1 and 6.2)	Percentage of population using safely managed drinking water services (6.1.1)	Already analysed		
	Percentage of population using safely managed sanitation services including a hand-washing facility with soap and water (6.2.1)	Already analysed		
Enhance scientific research, upgrade technological capabilities and encourage innovation (SDG 8.2)	Research and development expenditure as a proportion of GDP (9.5.1) (disaggregated by health/RMNCAH)	Not applicable		
Provide legal identity for all, including birth registration (SDG 16.9)	Proportion of children under 5 years of age whose births have been registered with a civil authority, by age (16.9.1)	Already analysed		
	Proportion of countries that (a) have conducted at least one population and housing census in the last 10 years; and (b) have achieved 100% birth registration and 80% death registration (17.19.2)	(a) Not applicable (b) Possible for births		
Enhance the global partnership for sustainable development (17.16)	Number of countries reporting progress in multistakeholder development effectiveness monitoring frameworks that support the achievement of the SDGs (17.16.1)	Not applicable	Governance index (voice, accountability, political stability and absence of violence government effectiveness, regulatory quality, rule of law, control of corruption)	Not applicable
Additional equity, humanitarian and human rights cross-cutting indicators	Proportion of indicators at the national level with full disaggregation when relevant to the target (17.18.1) (for indicators from the Global Strategy for Women's, Children's and Adolescents' Health, this indicator would be relevant at regional and global levels too)	Possible	Proportion of countries that have ratified human rights treaties related to women's, children's and adolescents' health	Not applicable
			Humanitarian Response Index	Not applicable

Matrix based on the report "Indicator and Monitoring Framework for the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030)"

REFERENCES

INTRODUCTION

1. United Nations General Assembly. Transforming our World: the 2030 Agenda for Sustainable Development. A/RES/70/1. New York, USA: United Nations; 2015.
2. Every Woman Every Child. Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). New York, USA: Every Woman Every Child, Executive Office of the United Nations Secretary-General; 2015.
3. United Nations Secretary-General. Global Strategy for Women's and Children's Health. New York, USA: United Nations; 2010.
4. Commission on Information and Accountability for Women's and Children's Health. Keeping promises, measuring results. Geneva, Switzerland: World Health Organization; 2011.
5. Every Woman Every Child. Global Strategy Indicator and Monitoring Framework. Geneva, Switzerland: World Health Organization; 2016.

CHAPTER 1

1. United Nations General Assembly. Transforming our World: the 2030 Agenda for Sustainable Development. A/RES/70/1. New York, USA: United Nations; 2015.
2. Every Woman Every Child. Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). New York, USA: Every Woman Every Child, Executive Office of the United Nations Secretary-General; 2015.
3. World Health Organization. Accountability for Women's and Children's Health: 2015 Progress Report. Geneva, Switzerland: World Health Organization; 2015.
4. World Health Organization. Health Information Systems. Geneva, Switzerland: World Health Organization; 2008.
5. DHIS2. District Health Information System, DHIS 2.24. 2016. <https://www.dhis2.org/>
6. Every Woman Every Child. Global Strategy Indicator and Monitoring Framework. Geneva, Switzerland: World Health Organization; 2016.
7. World Health Organization. Global Reference List of 100 Core Health Indicators. Geneva, Switzerland: World Health Organization; 2015.
8. Demographic and Health Surveys (DHS) Program. Demographic and Health Surveys (DHS) Program. 2016. <http://dhsprogram.com/>
9. UNICEF. Multiple Indicator Cluster Surveys (MICS). 2014. http://www.unicef.org/statistics/index_24302.html
10. World Health Organization. Monitoring Universal Health Coverage. 2016. <http://unstats.un.org/sdgs/files/meetings/iaeg-sdgs-meeting-03/3rd-IAEG-SDGs-presentation-WHO--3.8.1-and-3.8.2.pdf>
11. The Organisation for Economic Co-operation and Development (OECD). Programme for International Student Assessment (PISA). <https://www.oecd.org/pisa/>
12. Lynch School of Education–Boston College, International Association for the Evaluation of Educational Achievement. Trends in International Mathematics and Science Study (TIMSS) and the Progress in International Reading Literacy Study (PIRLS) International Study Center. 2016. <http://timssandpirls.bc.edu/about.html>
13. HBSC International Coordinating Centre. Child & Adolescent Health Research Unit, World Health Organization Regional Office for Europe. Health Behaviour in School-aged Children (HBSC). 2016.
14. World Health Organization. Global school-based student health survey (GSHS). 2016. <http://www.who.int/chp/gshs/en/>

15. UNICEF. Early Childhood Development Monitoring. http://www.unicef.org/earlychildhood/index_69846.html
16. World Bank Group. Poverty: Overview. 2016. <http://www.worldbank.org/en/topic/poverty/overview>
17. International Household Survey Network (IHSN). Survey catalogs. 2016. <http://www.ihsn.org/home/>
18. World Bank Group. Worldwide Governance Indicators. 2015. <http://data.worldbank.org/data-catalog/worldwide-governance-indicators>
19. Office of the United Nations High Commissioner for Human Rights (OHCHR). Treaty Body Database. 2015. http://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/Treaty.aspx
20. Bustreo F, Hunt P, Gruskin S, et al. Women's and Children's Health: Evidence of Impact of Human Rights: World Health Organization, 2013.
21. Columbia University School of International Public Affairs and the Women's Refugee Commission. Measuring Progress in Humanitarian Settings. New York, USA; 2010.

CHAPTER 2

1. Commission on Information and Accountability for Women's and Children's Health. Keeping promises, measuring results. Geneva, Switzerland: World Health Organization; 2011.
2. UN Inter-agency Group for Child Mortality Estimation. Levels and trends in child mortality. New York, USA: UNICEF; 2015.
3. United Nations Population Division. World Population Prospects. 2015. <https://esa.un.org/unpd/wpp/>
4. You D, Hug L, Ejdemyr S, et al. Global, regional, and national levels and trends in under-5 mortality between 1990 and 2015, with scenario-based projections to 2030: a systematic analysis by the UN Inter-agency Group for Child Mortality Estimation. *Lancet* 2015; **386**(10010): 2275-86.
5. Alkema L, Chou D, Hogan D, et al. Global, regional, and national levels and trends in maternal mortality between 1990 and 2015, with scenario-based projections to 2030: a systematic analysis by the UN Maternal Mortality Estimation Inter-Agency Group. *Lancet* 2016; **387**(10017): 462-74.
6. Stover J, Brown T, Marston M. Updates to the Spectrum/Estimation and Projection Package (EPP) model to estimate HIV trends for adults and children. *Sexually Transmitted Infections* 2012; **88 Suppl 2**: i11-6.
7. Bhatt S, Weiss DJ, Cameron E, et al. The effect of malaria control on *Plasmodium falciparum* in Africa between 2000 and 2015. *Nature* 2015; **526**(7572): 207-11.
8. 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; **381**(9878): 1642-52.
9. World Health Organization, UNICEF. Estimates of national immunization coverage. 2016. http://www.who.int/immunization/monitoring_surveillance/routine/coverage/en/index4.html
10. Victora CG, Requejo JH, Barros AJ, et al. Countdown to 2015: a decade of tracking progress for maternal, newborn, and child survival. *Lancet* 2016; **387**(10032): 2049-59.
11. Stevens GA, Alkema L, Black RE, et al. Guidelines for Accurate and Transparent Health Estimates Reporting: the GATHER statement. *Lancet*. Published online, June 28, 2016; [http://dx.doi.org/10.1016/S0140-6736\(16\)30388-9](http://dx.doi.org/10.1016/S0140-6736(16)30388-9)

CHAPTER 3

1. Victora C, Wagstaff A, Schellenberg J, Gwatkin D, Claeson M, Habicht J. Applying an equity lens to child health and mortality: more of the same is not enough. *Lancet* 2003; **362**(9379): 233-41.
2. Waage J, Banerji R, Campbell O, et al. The Millennium Development Goals: a cross-sectoral analysis and principles for goal setting after 2015 *Lancet* and London International Development Centre Commission. *Lancet* 2010; **376**(9745): 991-1023.

3. Countdown to 2015. A decade of tracking progress for maternal, newborn and child survival: the 2015 Report. Geneva, Switzerland: World Health Organization; 2015.
4. Gwatkin D, Rutstein S, Johnson K, Suliman E, Wagstaff A, Amouzou A. Socio-economic differences in health, nutrition, and population within developing countries: An overview. New York, USA: The World Bank Group; 2007.
5. World Health Organization. Global Health Observatory - Health Equity Monitor. 2016. http://www.who.int/gho/health_equity/en/
6. World Health Organization. State of Inequality: Reproductive, maternal, newborn and child health. Geneva: WHO, 2015.
7. United Nations Children's Fund. Narrowing the gaps to meet the goals. New York: Unicef, 2010.
8. United Nations Children's Fund. Progress for Children. Beyond averages: learning from the MDGs. New York: UNICEF, 2015.
9. Independent Expert Review Group (iERG). iERG final report: 2015 and beyond. Geneva, Switzerland: World Health Organization, 2015.
10. USAID. Acting on the call: ending preventable child and maternal deaths. Arlington, USA: United States Agency for International Development; 2016.
11. United Nations General Assembly. Transforming our World: the 2030 Agenda for Sustainable Development. A/RES/70/1. New York, USA: United Nations; 2015.
12. Demographic and Health Surveys (DHS) Program. Demographic and Health Surveys (DHS) Program. 2016. <http://dhsprogram.com/>
13. UNICEF. Multiple Indicator Cluster Surveys (MICS). 2014. http://www.unicef.org/statistics/index_24302.html
14. Wehrmeister F, Restrepo-Mendéz M, França G, Victora C, Barros A. Summary indices for monitoring universal health coverage: learning from the MDG experience in reproductive, maternal, newborn and child health. *Bull World Health Organ* 2016.
15. International Center for Equity in Health. 2016. <http://www.equidade.org/>
16. United Nations Children's Fund. The State of the World's Children reports. <http://www.unicef.org/sowc/>
17. Filmer D, Pritchett L. Estimating wealth effects without expenditure data--or tears: an application to educational enrollments in states of India. *Demography* 2001; **38**(1): 115-32.
18. Barros A, Victora C. Measuring Coverage in MNCH: Determining and Interpreting Inequalities in Coverage of Maternal, Newborn, and Child Health Interventions. *PLoS Medicine* 2013; **10**(5).
19. International Center for Equity in Health. The Equiplot. 2015. <http://www.equidade.org/equiplot> (accessed August 18, 2016).
20. Hosseinpoor A, Bergen N, Barros A, Wong K, Boerma T, Victora C. Monitoring subnational regional inequalities in health: measurement approaches and challenges. *Int J Equity Health* 2016; **15**(1): 18.

CHAPTER 4

1. Every Woman Every Child (EWEC). New York, USA: EWEC, Executive Office of the United Nations Secretary-General. 2015. <http://www.everywomaneverychild.org>
2. Partnership for Maternal Newborn & Child Health (PMNCH). Strengthening Accountability: Achievements and Perspectives for Women's, Children's and Adolescents' Health. Geneva, Switzerland: PMNCH; 2015. http://www.who.int/pmnch/knowledge/publications/2015_pmnch_report/en/
3. Commission on Information and Accountability for Women's and Children's Health. Keeping promises, measuring results. Geneva, Switzerland: World Health Organization; 2011.
4. Health Data Collaborative. Data for health and sustainable development. 2016. <http://www.healthdatacollaborative.org/>

5. United Nations Statistics Division (DESA). Sustainable Development Knowledge Platform. 2016. <https://sustainabledevelopment.un.org/index.php?page=view&type=6&nr=1081&menu=1442&template=375>
6. UN Inter-agency Group for Child Mortality Estimation. Levels and trends in child mortality. New York, USA: UNICEF; 2015.
7. World Health Organization, UNICEF, UNFPA, World Bank Group, United Nations Population Division. Trends in maternal mortality: 1990 to 2015. Geneva, Switzerland: World Health Organization; 2015.
8. World Health Organization. Global Health Observatory - Health Equity Monitor. 2016. http://www.who.int/gho/health_equity/en/
9. World Health Organization. World Health Statistics 2016: monitoring health for the SDGs. Geneva, Switzerland: World Health Organization, 2016.
10. World Bank Group. World Development Indicators. <http://data.worldbank.org/data-catalog/world-development-indicators>
11. World Bank Group. World Development Reports. 2016. <http://www.worldbank.org/en/publication/wdr/wdr-archive>
12. United Nations Population Fund. State of the World Population Reports. <http://www.unfpa.org/swop>
13. United Nations Children's Fund. The State of the World's Children reports. <http://www.unicef.org/sowc/>
14. Countdown to 2015. A decade of tracking progress for maternal, newborn and child survival: the 2015 Report. Geneva, Switzerland: World Health Organization; 2015.
15. Institute for Health Metrics and Evaluation (IHME). Seattle, USA. 2016. <http://www.healthdata.org>
16. Every Woman Every Child. Independent Accountability Panel. <http://www.everywomaneverychild.org/news-events/news/1298-announcement-of-every-woman-every-child-s-independent-accountability-panel>
17. Independent Expert Review Group (iERG). iERG final report: 2015 and beyond. Geneva, Switzerland: World Health Organization; 2015.
18. United Nations. High-Level Political Forum on Sustainable Development. 2016. <https://sustainabledevelopment.un.org/hlpf>
19. Every Woman Every Child. Global Strategy Indicator and Monitoring Framework. Geneva, Switzerland: World Health Organization; 2016.
20. African Union. African Peer Review Mechanism: Africa's self-assessment for good governance. 2016. <http://aprm-au.org/>
21. Office of the United Nations High Commissioner for Human Rights (OHCHR). Universal Periodic Review. 2016. <http://www.ohchr.org/EN/HRBodies/UPR/Pages/UPRMain.aspx>
22. Office of the United Nations High Commissioner for Human Rights (OHCHR). Treaty Body Database. 2015. http://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/Treaty.aspx
23. African Leaders Malaria Alliance (ALMA). Developing a country RMNCH scorecard: facilitator's guide. 2014. http://alma2030.org/sites/default/files/initiatives/rmnch_workshop_english_facilitator_guide_april_2014.pdf
24. Every Woman Every Child. UN Secretary-General announces members of the High-Level Advisory Group for Every Woman Every Child. <http://www.everywomaneverychild.org/news-events/news/1291-un-secretary-general-announces-members-of-the-high-level-advisory-group-for-every-woman-every-child>
25. World Bank Group. Global Financing Facility in support of Every Woman Every Child (GFF). Washington DC, USA: World Bank Group; 2014.
26. The Global Fund. The Global Fund to Fight AIDS, Tuberculosis and Malaria. <http://www.theglobalfund.org/en/>
27. Gavi. Gavi, the Vaccine Alliance. 2016. <http://www.gavi.org/>
28. World Health Organization, Office of the United Nations High Commissioner for Human Rights (OHCHR). WHO and OHCHR launch landmark working group on health and human rights of women, children and adolescents. 2016. <http://www.who.int/reproductivehealth/news/human-rights-women-children-adolescents/en/>

LIST OF ABBREVIATIONS

ALMA	African Leaders Malaria Alliance
ANC	Antenatal care
APR	A Promise Renewed
ART	Antiretroviral therapy for HIV
CAF	Country accountability framework
CARMMA	Campaign on Accelerated Reduction of Maternal, newborn and child Mortality in Africa
CCI	Composite coverage index
CoIA	Commission on Information and Accountability
CRVS	Civil registration and vital statistics
CSO	Civil society organization
DESA	Department of Economic and Social Affairs
DHIS	District Health Information System
DHS	Demographic and health survey
EOSG	Executive Office of the Secretary-General (United Nations)
EWEC	Every Woman Every Child
FGM/C	Female genital mutilation/cutting
FP	Family planning
FP2020	Family Planning 2020
GATHER	Guidelines for Accurate and Transparent Health Estimates Reporting
Gavi	Gavi, the Vaccine Alliance
GBD	Global burden of disease
GFF	Global Financing Facility in support of Every Woman Every Child
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHF	Geneva Health Forum
GDP	Gross domestic product
H6	H6 Global Health Partnership: UNAIDS, UNFPA, UNICEF, UN Women, WHO and the World Bank Group
HBSC	Health Behaviour in School-Aged Children
HDC	Health Data Collaborative
HIS	Health information system
HIV	Human immunodeficiency virus
HLAG	High-level Advisory Group
HLPF	High-Level Political Forum on sustainable development
ICT	Information and communication technology
IAP	Independent Accountability Panel
iERG	independent Expert Review Group

IGME	Inter-agency Group for Child Mortality Estimation
IHME	Institute for Health Metrics and Evaluation
IHP+	International Health Partnership+
IHSN	International Household Survey Network
IRS	Indoor residual spray
ITN	Insecticide-treated net
LMICs	Low- and middle-Income countries
MDSR	Maternal death surveillance and response
MMEIG	Maternal Mortality Estimation Inter-agency Group
MDGs	Millennium Development Goals
MICS	Multiple indicator cluster survey
M&E	Monitoring and evaluation
NCD	Noncommunicable disease
OECD	Organisation for Economic Co-operation and Development
OECD-DAC CRS	Organisation for Economic Co-operation and Development-Development Assistance Committee (Common Reporting Standard)
OHCHR	Office of the High Commissioner for Human Rights
ORS	Oral rehydration solution
PEP	Post-exposure prophylaxis
PISA	Programme for International Student Assessment
PMNCH	Partnership for Maternal, Newborn & Child Health
RMNCAH	Reproductive, maternal, newborn, child and adolescent health
SBA	Skilled birth attendant
SDGs	Sustainable Development Goals
TIMSS	Trends in International Mathematics and Science Study
UAF	Unified Accountability Framework
UHC	Universal health coverage
UHC 2030	Universal Health Coverage 2030 Alliance
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGA	United Nations General Assembly
UNICEF	United Nations International Children's Emergency Fund
UNFPA	United Nations Population Fund
UNPD	United Nations Procurement Division
USAID	United States Agency for International Development
WASH	Water, sanitation and hygiene
WHO GHED	World Health Organization Global Health Expenditure Database
WHO	World Health Organization

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