ACCOUNTABILITY FOR WOMEN'S AND CHILDREN'S HEALTH

Implementing the Commission on Information
and Accountability Recommendations

TRANSLATING THE RECOMMENDATIONS INTO ACTION

Phase II Work Plan and Budget

2014 – 2015 Work Plan

Introduction

The creation of the Commission on Information and Accountability for Women's and Children's Health (CoIA) in 2011 was an unprecedented step towards strengthening global reporting, oversight and accountability for women's and children's health. The Commission, convened by President Jakaya Mishro Kikwete of the United Republic of Tanzania and Prime Minister Stephen Harper of Canada, put forth ten recommendations to strengthen this accountability (see box). These recommendations concern improvements in information, in tracking of resources, and in oversight of both results and resources

The Commission's 10 recommendations

Better information for better results

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

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

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

Better tracking of resources

4. **Resource tracking**: By 2015, all 75 countries where 98% of maternal and child deaths take place are tracking and reporting, at a minimum, two aggregate resource indicators: 1) total health expenditure by financing source, per capita; and 2) total reproductive, maternal, newborn and child health expenditure by financing source, per capita.

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

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

Better oversight of results and resources: nationally and globally

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

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

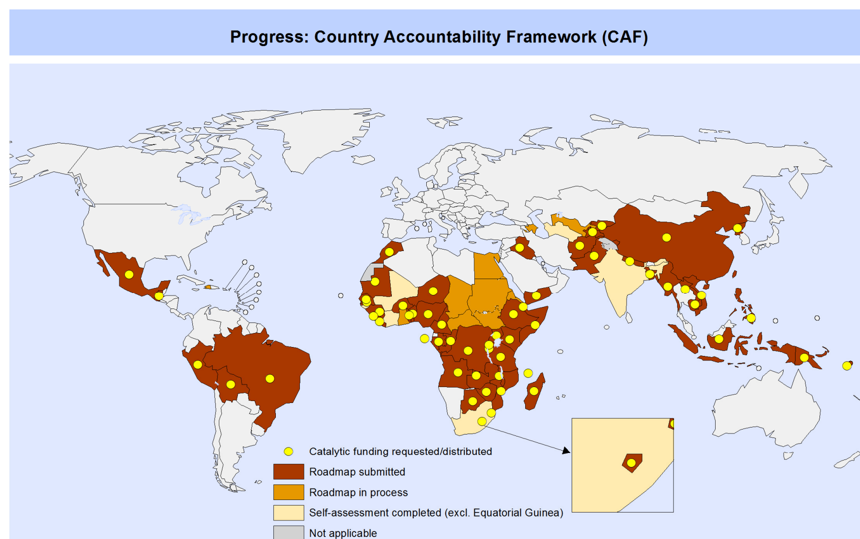
9. **Reporting aid for women's and children's health**: By 2012, development partners request the OECD-DAC to agree on how to improve the Creditor Reporting System so that it can capture, in a timely manner, all reproductive, maternal, newborn and child health spending by development partners. In the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

10. **Global oversight**: Starting in 2012 and ending in 2015, an independent "Expert Review Group" is reporting regularly to the United Nations Secretary-General on the results and resources related to the Global Strategy and on progress in implementing this Commission's recommendations.

Country accountability frameworks are developed to translate these recommendations into practical steps. These frameworks aim to strengthen monitoring, review and remedial action for the provision of high-quality health services, with special attention to interventions for women and children. They are designed to bring together all the elements of monitoring and review of the implementation of a national health strategy and related national disease plans, and to improve effective measurement of health sector performance and use of data to inform action. The platform is the basis for both national and global reporting and should lead to a reduction in duplication and transaction costs and an improvement in accountability.

The process of developing these frameworks has proved to be an innovative approach to strengthening accountability and transparency, and improving data quality. It has also provided an excellent platform for bringing together donors and country stakeholders. The accountability framework builds on the International Health Partnership (IHP+) common framework and platform for monitoring, evaluation and review of national health strategies. It places accountability soundly at the country level, with active engagement of national governments, parliaments, communities and civil society. Key principles include focusing on national leadership and ownership of results; strengthening country capacity for monitoring and evaluation; and reducing the burden of reporting by aligning efforts with the national monitoring and evaluation platform.

The concepts of accountability and transparency are recognized by countries and donors alike as critical elements for reaching MDGs 4 and 5. The framework has gained significant traction in countries; at the time of this writing, 70 countries have completed, or are very close to completing, country accountability frameworks. The favourable and higher-than-expected response from countries has elevated the importance and visibility on accountability and has created an immediate need for financial investment in countries. This marks the end of the first phase of implementation, where all 75 priority countries with the highest burden for maternal and child deaths had the opportunity to develop a Country Accountability Framework and 58 countries received catalytic funds for its implementation. Phase I of the work of the Commission will be completed by June 2014; key achievements are presented in the box below.



The boundaries and names 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.

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Phase I : Key achievements to end 2013[1]

- ✓ **70 *countries have completed (or are very close to completing) Country Accountability Frameworks*.** As part of this process, countries assess progress under specified work streams, and prioritize action areas based on identified gaps.

- ✓ More than 30 countries have assessed their **Civil Registration and Vital Statistics** (CRVS) systems in order to develop national plans of action; and at least half of these countries are showing commitment and progress in strengthening their systems.

  Malawi *conducted its CRVS assessment and developed its National Registration Bureau Strategic Plan (2013-2018). Birth registrations in hospitals started in 2012 and scaled up to 41 health centres in Lilongwe district; close to 880 health personnel have been oriented and are implementing birth registration in maternity wards.*

- ✓ **Maternal death review and response** (MDSR) is being implemented in 50 countries.

  Cambodia *has begun implementing the MDSR approach, where all maternal deaths and causes of deaths are to be reviewed. Cambodia has developed protocols and training materials and has established national and provincial maternal death audit committees. The provincial committee reviews causes of maternal deaths, makes recommendations, and provides feedback to the community, to health facilities and to the national maternal death audit committee. Annual meetings are held to monitor progress towards recommendations.*

- ✓ Routine **monitoring of core indicators** has improved through the use of web-based reporting in over 30 countries, demonstrating that countries are taking concrete actions to strengthen their **health information systems**. Global partners such as the Global Fund, GAVI, PEPFAR and the European Union are increasing investment in building national capacity for health information systems, data quality and analytic capacity.

  The ***Democratic Republic of the Congo*** *has adopted a new Health Information System framework, where various partners, including the Global Fund are investing in a common monitoring and evaluation platform. A Service Availability and Readiness Assessment (SARA) survey conducted in last quarter of 2013, co-financed by the Global Fund, will also be used to provide information for the UN Commission on Life Saving Commodities recommendations.*

- ✓ 65 countries have completed eHealth profiles, which provide a base-line for monitoring the uptake of **information and communication technologies (ICT);** 27 of these countries have eHealth strategies**.**

[1] The annual report on progress in implementing the CoIA recommendations will be available in June 2014 and will provide a comprehensive picture of progress up until April 2014.

***Pakistan** completed its eHealth profile and is finalizing its national eHealth strategic plan. The federal and provincial health departments, selected NGOs and private hospitals have established a number of isolated initiatives for use of ICT for Health, which include telemedicine, telehealth, call centres, surveillance, electronic patient records, surveys, and eLearning in health.*

- ✓ The revised **System of Health Accounts 2011 (SHA 2011**) has been endorsed by numerous partners including the Global Fund, the Bill and Melinda Gates Foundation and GAVI. This standard platform for tracking flows of health expenditure increases cost-effectiveness and data quality, and allows for tracking expenditure over time. 18 countries are implementing SHA 2011 with results available from eight of these.

***The United Republic of Tanzania** has institutionalized the revised SHA 2011 methodology, integrating different data collection processes including National AIDS Spending Assessment and PEPFA). This is among the first countries to have data available on spending for reproductive, maternal, newborn and child health (RMNCH). Preliminary results indicate important findings on total and per capita expenditure and financing sources for health and for RMNCH. For example, financing sources for reproductive health are 6% public, 60% private and 32% external. Financing sources for child health are 35% public; 35% private and 27% external.*

- ✓ Joint country reviews of national health plans are key to strengthening harmonization. 53 countries indicate having conducted an **annual health sector reviews** in 2013. Broader participation of stakeholders in critical to increasing transparency and accountability.

***Nepal** has a joint financing arrangement signed by GAVI, USAID, World Bank, AusAID, DFID, German government, UNICEF WHO and UNFPA. Nepal conducts joint annual health reviews with broad participation of partners, who critically review areas where progress is lagging and identify action to improve performance. The Aide Memoire produced for the review is a public document.*

- ✓ PMNCH, WHO, Save the Children, the Inter-Parliamentary Union (IPU), UNICEF, Evidence for Action, the East African Community Open Health Initiative, Family Care International, White Ribbon Alliance, Countdown to 2015, and World Vision International are supporting **capacity building of parliamentarians, civil society and the media** to understand national budgets and undertake budget advocacy for improved women's and children's health.

*Participants from **Kenya, Liberia, Sierra Leone, Uganda, and the United Republic of Tanzania** took part in a workshop on budget advocacy for improved women's and children's health. Following the workshop, civil society coalitions from the five countries are developing proposals for catalytic funds to apply the new skills to national budget advocacy plans.*

- ✓ The Organisation for Economic Co-operation and Development - Development Assistance Committee (OECD – DAC) Working Party on Development Finance Statistics completed the reporting guidance for the newly approved RMNCH scoring system/marker.

Phase II Plan of work: Strengthening a common country-led platform for results and accountability

The proposed approach and plan of work for 2014-15 have been adapted from the original 2011 budget in order to integrate lessons learned and build on successes from Phase I. Many countries, as well as development partners, are paying more attention to setting targets for core indicators, monitoring resources and results on a regular basis to inform regular reviews and corrective action. A recent assessment conducted at the request of Global Health Agency Leaders showed that there is ample room for reducing the number of indicators and reporting requirements for global initiatives. The assessment also showed that there are opportunities to enhance the efficiency of current investments in support of a single country-led platform for results and accountability and for greater alignment and investment globally.

Phase II aims to further enhance the implementation of the accountability frameworks, as recommended by the Commission. It is organized around three key components: strengthening measurement and tracking, strengthening analysis and review, and dissemination, advocacy, and transparency. Phase II will also review the lessons learned from Phase I, focus on a sub-group of countries, and assist countries in identifying a short list of priority content areas. (see box) A key element of the Phase 2 approach will be to actively maximise opportunities to leverage the modest available funding to attract additional investments and partners to expand the capacity to support countries. This includes domestic government investment, as well as engaging with funders at a regional or country level to extend the work and its impact.

Phase II Approach

Review the lessons learned from Phase I implementation : Mid-term reviews will be conducted in up to eight countries to identify successes and lessons learned and to explore which areas of work should be prioritized in Phase II. The reviews will also identify models of national accountability that can be expanded to other countries and other sectors. The reviews will clearly enunciate practical and specific recommendations and time frames for their execution. The reviews will be completed by June 2014.

The Every Woman Every Child advocacy movement, led by the United Nations Secretary-General, will focus on global and country level accountability. The results from the implementation of the Accountability framework workplan will be one of the components. Together with other assessments (including one done by the iERG) the country reviews will contribute to the Secretary-General's assessment of Accountability for Women's and Children's Health in the context of the global strategy, as a potential model for the post-2015 agenda.

Country Focus: The CoIA supports the implementation of a common Country Accountability Framework and platform that underpin the accountability efforts of all health initiatives. Phase II will focus on up to 40 countries that have demonstrated results, that wish to continue the work on their accountability framework and that have expressed strong commitment to furthering its implementation. The selection of countries will be based on the Phase I review as well as country applications reviewed by a multi-stakeholder group; at least one large country with a high MNCH burden will be included. In addition to supporting countries that have made significant progress, special attention will be paid to supporting a small group of fragile states or countries with weak health infrastructures, which have expressed a strong interest in accountability but have not been able to implement to scale due to lack of stability and weak health systems. Opportunities to support these countries, including through Partner organisations will be explored in Phase II.

Identification of priority content areas: In Phase I, countries completed a self-assessment and set priorities among the different possible areas of the multi-stakeholder workplan. Base on this experience, a limited number of priority areas can be identified. These will be adjusted based on reviews to be carried out in the second quarter of 2014.

The three key components of Phase II, and the proposed actions for each are described in the following section. Actions, deliverables and principal partners are summarized in Annex 3, Workplan matrix 2014-2015.

Component 1. Strengthening monitoring results and tracking resources

Each country accountability framework includes an analysis of existing health information systems and a roadmap that outlines how the gaps and priorities will be addressed and implemented. Country level and global partners such as The Global Fund, GAVI, PEPFAR and the European Union are increasingly investing in improving strategic areas of country accountability, including birth and death registration, resource tracking, routine health facility data, facility surveys of service readiness, data quality, household surveys and disease surveillance, and analytical reviews of progress and performance. The role of innovative approaches, in

particular the use of recent information and communication technologies, is growing in its importance in generating and sharing data and information.

Stronger partner collaboration and harmonization, with a focus on aligning activities and investments, will be required to accelerate progress. Building upon the IHP+ approach, WHO will intensify its work with partners to strengthen and scale up support for a common country-led platform for information and accountability. It is intended that this platform become the basis for national and global reporting, with reliable, up-to-date, high quality data for the core indicators for women and children's health, and for the health sector more broadly.

1.1 Strengthening registration of births, deaths and cause of death

Strengthening systems for civil registration and vital statistics (CRVS) is essential for numerous reasons. For the health sector it provides critical information on mortality by age, sex and cause, as well as birth and population data. For individuals, CRVS provides a basis for social protection. A well-functioning system is also essential for improving the quality of health services. Yet, birth and death registration, with a reliable conclusion of cause of death, are often the weakest elements of national data collection systems. This fact notwithstanding, a majority of countries have prioritised CRVS strengthening in their accountability roadmaps for funding. There is no doubt that the accountability framework has accelerated country interest in strengthening CRVS. More than 30 countries have completed CRVS assessments and now need to develop plans to strengthen CRVS, and an investment case to support those plans.

Making the required improvements to CRVS (whether registration, cause of death statistics, or compilation of vital statistics) will require guidance to donors and countries alike on where to focus, and on the scale of investment needed. Experience shows that countries may not be in a full position to understand how best to make the investment case, and at the same time the lack of costed investment cases makes it difficult for governments and donors to make informed investment decisions.

In 2012 and 2013, more than 30 country assessments were carried out, and number of relevant global and regional political declarations were made. Building on this progress, Phase II will provide support to the development of national multi-sector strategic and investment plans. The main deliverables for each country will be: a completed CRVS assessment, a national strategic plan and investment plan, and a functioning coordinating committee. In addition, a number of countries are expected to make significant progress in generating information on cause of death. Country work will be supported by a global and regional interagency group.

Principal actions:

- Support strengthening of CRVS systems through **assessment and national planning**: the assessments provide the technical basis for the political mobilization process and for the development of comprehensive national strategic plans and coordinating mechanisms;
- Facilitate the development of **national investment plans** that can be used to secure domestic government investment, apply for World Bank IDA grants or a to a global investment fund for CRVS strengthening;

- Ensure **effective collaboration** between global and regional partners including support for the newly established Interagency group on CRVS, led by the UN Statistical Division;
- Support **innovative community-based approaches** in countries for the registration of births, deaths and causes of death;
- Support the improved use of **the International Classification of Disease** in health facility settings to improve monitoring of results with reliable information on cause of death;
- Strengthen tracking of pregnant women through innovative approaches that ensure linkages with community and facility reporting systems and allow **measurement and monitoring of equity and coverage of essential RMNCH interventions**.

1.2 Monitoring results

The core health indicators are intended as tracers of progress in improving women's and children's health. These indicators are derived from a combination of administrative, survey and health facility data sources that need to be tracked and analysed in a regular and transparent manner with data quality issues systematically addressed. Efforts to improve the availability, quality and reporting on core indicators, particularly using annual subnational data, are under way in many countries. These efforts include the initiation of web-based facility reporting and systematic data quality monitoring mechanisms, and the strengthening of analytical capacity including equity analyses. Countries are also making progress in monitoring the scale-up of interventions, services and the availability of the 13 essential life-saving commodities for women and children through regular and comprehensive facility assessments.

However, the approach needs broader partner support, in particular to scale up and align investments, to ensure better measurement of results and to improve the linkages between results and decision-making. In addition, there is a continuing need to ensure that global initiatives on reproductive, maternal, newborn, child health are aligned with the common country platform for information and accountability.

Principal actions:

- Strengthen national **monitoring and evaluation plans**, ensuring better alignment between the reproductive, maternal, newborn and child health plans and indicators and the national health sector plan. This implies agreement on harmonized indicators across the various plans, and streamlined reporting requirements to donors and partners.
- Scale up innovative approaches for collecting health facility information to ensure routine **real-time data** for decision-making. This includes integrating harmonized core indicator sets into national facility reporting systems, training on standards for reporting such as ICD, building analytical capacity.
- Institutionalize regular and transparent **data quality controls** as well as assessments of service readiness, supply chains for commodities, workforce availability, quality of care and patient satisfaction.
- Support regular and harmonized population-based **surveys**, through the development of a comprehensive set of survey modules, in collaboration with global partners and led by the International Household Survey Network and WHO.

- Promote joint partner investments in country data systems and better **alignment and harmonization** of global reporting requirements.

1.3 Scaling up maternal death surveillance and response and quality of care

Over the last two years, all 75 countries have been oriented on the Maternal Death Surveillance and Response (MDSR) approach. Every maternal death should be notified and counted, ideally within 24 hours. This should be followed by the response: a review of causes and circumstances leading to death, the identification of correctable or avoidable factors and the implementation of actions to prevent similar deaths in future. Notification of deaths contributes to improved civil registration and maternal mortality measurements. Maternal death reviews assess the quality of care; responding to findings contributes to improvements in this quality.

Most countries have included MDSR as a priority activity and have national policies requiring notification of all maternal deaths. In Phase II, while continuing support for MDSR implementation, it will be important to study how this implementation is done, to monitor results, and to focus on improving quality of care. Lessons learned from successful and less successful experiences will be documented and shared widely.

Principal actions:

- **Document country experiences** in implementing MDSR, focusing on success, scaling up and lessons learned.
- **Update, test and incorporate MNCH quality of care modules** in facility assessment tools and indicators.
- **Assess and monitor quality of care** through facility surveys including through near-miss reviews, and dashboards and in quality improvement activities in facilities.

1.4 Innovation and eHealth

WHO and the International Telecommunication Union are supporting countries to integrate information and communication technologies (ICT) into their health systems and services for women and children. 65 countries have completed eHealth profiles that provide a baseline for measuring the uptake of ICT for women's and children's health. 27 countries have eHealth strategies, developed through a stakeholder process that reflects national priorities and builds the foundations for systematic, coordinated use of ICT in health services and systems.

Information and communication technologies are instrumental in improving the performance of health systems and services, including for example, surveillance of maternal and child deaths, facility reporting, data administration and sharing, and civil registration and vital statistics. To ensure that such services can be developed and integrated, an enabling environment for eHealth at the national level is required.. This environment is also crucial to allow eHealth innovations to go beyond the testing phase and be deployed at scale, and to allow the impact on women's and children's health to be evaluated over time. The focus is on building the foundations for the systematic and strategic adoption of eHealth to support health priorities.

Principal actions:

- Conduct three multi-country workshops on **eHealth strategy development** to reach those countries requesting support.
- Provide **technical support to countries for eHealth strategies**, with priority given to those countries having eHealth in their roadmap.
- **Build technical capacity,** and develop guidance and tools on eHealth components:. governance, policies, standards, workforce.
- **Monitor, evaluate** and report on eHealth adoption, trends, resources and best practices.

1.5 Tracking resources

The health accounts methodology has been the international reference for tracking expenditures on health for over a decade. The revised version, **System of Health Accounts 2011 (SHA 2011)**, offers an approach that better supports country policy development and monitoring. Its strong advantage, compared to the earlier methodology, is that it standardizes the measurement of expenditure by beneficiaries, including expenditure by disease/condition and by age. Countries are now able to produce more rigorous statistics on expenditure on reproductive and child health thanks to this new approach.

WHO also built upon a USAID-funded health accounts production tool to develop a combined set of two tools that facilitates both the production of data and the analysis of results. Because the production tool reduces the cost and time-line for generating data, countries are now able to track expenditure on a yearly basis. The previously limited RMNCH data can now be enriched with regular reporting of the two indicators recommended by the Commission.

The WHO health accounts platform has received support and buy-in from various partners including The Global Fund, the Bill & Melinda Gates Foundation, and GAVI. This standard platform for tracking health expenditure flows increases cost-effectiveness and data quality and allows for tracking expenditures over time.

In February 2014, WHO hosted a meeting of specialists in resource tracking for specific diseases and partners. The meeting aimed at harmonizing resource-tracking initiatives at country level, to address issues of inconsistent data generated by individualized disease-specific resource tracking exercises. The conclusions exceeded expectations, with all participants agreeing to use a common set of resource tracking methodologies, tools, and production of data.

WHO provided health accounts technical assistance to 18 countries in 2013, and is due to support another 16 countries in 2014. This technical assistance is organized over two years. During the first year, WHO builds country teams' capacity in SHA 2011 and the production tool; the second year, it supports country teams in institutionalizing the production of health accounts. Prior to providing technical assistance, WHO reviews countries' resource tracking workplans to ensure that they include the participation of the health accounts focal point at the annual health sector strategic review. This ensures that the resource tracking results, including those for RNMCH, can be used directly for policy purposes during the review.

Because of the very large number of requests for technical assistance, WHO is training consultants and experienced country health account team leaders to use the WHO technical assistance approach, with clear terms of reference and deliverables. This has proven to be of great help to ensure that SHA 2011, and the tracking of expenditure by disease/condition and age, are used by countries starting a new expenditures tracking exercise.

Principal actions :

- Support up to 34 countries to **deliver timely and annual data** on two indicators: 1) total health expenditure by financing source, per capita; and 2) total reproductive, maternal, newborn and child health expenditure by financing source, per capita.
- Build national capacity in **use of the SHA 2011 methodology** and production tool.
- Support the **production of a first set of SHA 2011 data**, using the production tool, in up to 26 countries, and support the **institutionalization process of data collection** and data use in another eight.
- Facilitate **country dissemination and use of results**: presenting results in a digested and meaningful way to policy makers and other stakeholders, and working with the ministry of health to post the results online in the form of a database, including saved reports.
- Increase the pool of **trained francophone experts** to provide technical assistance when needed.
- Build the capacity of **parliamentarians, civil society organizations, and media** on budget analysis for greater transparency and stronger advocacy.

Component 2. Strengthening analysis and country review mechanisms

The Commission urged the establishment or scale-up of national-level accountability mechanisms that are transparent and that involve all relevant stakeholders, including the engagement of parliamentarians for national level review and action on women's and children's health. The primary aim is to strengthen existing country review and planning processes, such as national health sector reviews, and to strengthen linkages between health sector reviews, disease and programme-specific reviews and global reporting.

2.1 Strengthening of health sector reviews

Health sector reviews are long-established traditions in many countries. These are generally designed to review the implementation of national health sector plans or to assess performance, and to agree on corrective measures. RMNCH forms a critical component of such reviews. Well-prepared and organized reviews provide multiple benefits to the country including to: improve policy dialogue; increase accountability for results; increase mutual accountability; complete the cycle of data collection, analysis, and policy formulation; have a comprehensive rather than partial review of progress, and avoid setting up

parallel processes. They also help foster agreement on the way forward; set future benchmarks and targets; and define priorities for further information collection and analysis.

Currently, over 50 countries indicate conducting regular reviews, but the quality of such assessments varies, and the quality of analytical reports that inform the reviews is often weak. While recent efforts have attempted to capture countries' experiences of reviews, comprehensive, practical guidance on how to conduct reviews is lacking. WHO has been working with national and regional institutes and global partners such as the Global Fund to guide and improve the quality of analysis of results and to better link the results to decision making and remedial action, including resource allocation and financial disbursement.

In response to this lack, WHO has been providing technical support to countries to strengthen their review mechanisms. The major focus during Phase II will be to strengthen and scale up national capacity for programme and health sector analytical reviews. As part of this work, WHO will develop a guidance document for strengthening health sector reviews and policy dialogue processes.

Principal actions:

- Develop a **guidance document** for countries that outlines key elements of preparing and conducting health sector reviews including participatory processes, links to other components of the health planning cycle and strengthening RMNCH programmes in health.
- Promote greater transparency including greater **engagement of relevant health programmes, civil society, media and parliamentarians**.
- Support **greater transparency of the process of decision-making** through publication and web sharing of key documents, including health sector review reports.
- Strengthen **analytical reviews of health sector progress and performance**, including a strong focus on RMNCH acceleration plans.
- Strengthen and **scale up institutional capacity** within countries to conduct stronger analytical progress and performance assessments that inform annual health sector reviews.

2.2 Global Analytical reports: best practice, guidance, scorecards

Although most of the work on accountability supports the implementation of the Commission's recommendations in countries, several of these recommendations relate to improvements in global-level practices and mechanisms. This includes the harmonization of reporting requirements around core indicators, improving reporting on expenditures, and regular reporting on overall progress.

Phase II will focus on analysis and communication of results and lessons learned. Such analyses will aim to improve methodologies in the global synthesis of results, for example strengthening methodologies and reporting for maternal mortality estimates. and to enhance the interpretation of results, for example equity analyses for various population characteristics. The development of an accessible platform for an open

reporting system, which allows transparent reporting of commitments and progress, in conjunction with UNSG and PMNCH is in the planning stages and will be implemented in Phase 2.

Principal actions:

- Work to develop and refine **reporting instructions and guidance for the new RMNCH scoring system/marker** has been completed and sent to members of the OECD-DAC Working Party on Development Finance Statistics for approval under the OECD's written procedure. These will be formally incorporated into the directives for entities reporting to the DAC statistical system.

- **Scorecards and dashboards** used to better communicate evidence to decision makers on equitable coverage of priority services for RMNCH.

- **Regular progress reports produced,** including:

    - **WHO annual report** on progress towards implementing the recommendations of the Commission;

    - **PMNCH Accountability Report**, a web-based report on commitments to the Global Strategy;

    - **iERG report** to the Secretary-General on implementation of the Global Strategy and CoIA recommendations;

    - **Global maternal mortality progress report** including progress in improving routine measurement using recommended methods.

Component 3. Action: advocacy, transparency and enhancing accountability

3.1 Using evidence to influence policy

Policies are essential for an enabling environment for women's and children's health. WHO recently developed a "RMNCH Policy Compendium[2]" which presents key health systems-related policies that support the delivery of proven interventions (see Annex 4). The compendium is a dynamic document, regularly updated to reflect new evidence on effective interventions and delivery channels. It includes health sector policies directly related to RMNCH, as well as multi-sectoral policies that influence RMNCH, including financing, social and community development and human rights. The compendium can serve as a tool or checklist for countries to analyze which policies are in place and identify gaps to be addressed. Once policy gaps are identified, it can also provide the technical basis for advocacy messages. Informed stakeholders can then build consensus on the approaches required to develop and adopt needed policies.

[2] A Policy Guide for Implementing Essential Interventions for Reproductive, Maternal, Newborn and Child Health. RMNCH Policy Compendium. World Health Organization, Partnership for Maternal, Newborn, and Child Health. (include link)

Principal actions:

- Countries identify which policies for improving women's and children's health are in place, and which new policies might be needed, using the compendium as a guide.

- Ensure that RMNCH policies are incorporated into national health strategies and plans.

3.2 Advocacy, transparency and enhancing accountability

Advocacy is a powerful means of influencing policy for women's and children's health and stimulating the implementation of the Commission's recommendations. Phase II work will support countries to translate policy into action through enhanced advocacy.

This work will also support a strategic advocacy and communication campaign on accountability, coordinated by the Every Woman Every Child movement and running from August 2014 to September 2015. The campaign will share the results of a high-level review, commissioned by UN Secretary-General, of the Global Strategy accountability effort. The purpose of the campaign is to showcase results, highlight gaps, promote accountability and push for the Every Woman Every Child commitments to be delivered. The campaign supports the implementation of the CoIA recommendations and promotes the findings of the iERG.

Principal actions:

- **Sensitize national advocacy groups** on global action plans and policies for coordinated advocacy efforts to promote and operationalize policies**.** This includes supporting countries to identify policy gaps and use advocacy to develop policy.

- **Increase media reporting on women's and children's health.** Develop and distribute media facing **scorecards** that present in a visual manner, progress on five indicators (proposed list: contraceptive prevalence rate, maternal mortality, newborn mortality, under-five mortality and government health expenditure), with regional comparisons. Partners will secure upfront placement deals with media organizations to ensure widespread distribution.

- **Engage civil society in budget tracking:** PMNCH will build on the existing budget tracking advocacy work, piloted in 2011 by Save the Children and the Budget Advocacy Network. Thanks to its success, membership of the coalition was expanded in 2012 to include four additional organizations: Evidence for Action, World Vision, Freetown WASH Consortium and Health Alert. The scope of the tracking was also expanded to include the involvement of key stakeholders in the ministries of health, sanitation and finance. In 2014, activities will include tracking the flow of resources allocated within the health sector to inform and support advocacy and popular mobilization events.

- PMNCH, Countdown to 2015, A Promise Renewed, and the independent Expert Review Group will be hosting the **PMNCH Partners' Forum.** Approximately 800 participants from a wide range of countries will come together to take stock of lessons learned from MDG achievements to date that can inform and guide future investment and action.

3.2 Engagement with parliamentarians

There are increasing examples of how advocacy has had a positive influence on the political environment for RMNCH; some of these include actions by parliaments and civil society, leading to increased budget allocations and legislation for women's and children's health. For example, advocacy work in Cameroun and Malawi led to an increased ministry of health budget for contraceptives. Phase II will leverage and build on such examples. National level advocacy can ensure that the policy guidance developed for various work streams (MDSR, CRVS, eHealth, SHA2011, and others) is understood and promoted by civil society groups, media and parliamentarians.

The Commission urged the establishment or scale-up of national level accountability mechanisms that are transparent and inclusive of all relevant stakeholders for national level review and action. The engagement of parliamentarians is key to these efforts and the Inter-Parliamentary Union (IPU) is a key partner that can influence the role of parliaments, and can build capacity for promoting investments in RMNCH and providing oversight. The IPU promotes greater international involvement of parliaments. It develops a parliamentary dimension to international cooperation, enhances transparency and accountability of global processes and mobilizes parliamentary action on major global challenges. At its 126th Assembly in 2012, the Inter-Parliamentary Union adopted a resolution on the role of parliaments in achieving maternal, newborn and child health as a basic right. The IPU supports the resolution through the development of tools that parliamentarians will be able to use in their efforts to promote accountability for better results.

Principal actions:

- **Sensitize parliamentarians** on the implementation of the IPU resolution and the Millennium Development Goals and post-2015 development agenda.
- Support the **implementation of the IPU resolution** in countries, drawing from the prioritized activities included in the country accountability frameworks and roadmaps.
- Facilitate **legislative reform** to improve the access of women and children to more effective health services.
- Conduct surveys to review **parliamentary activity on RMNCH in key areas** such as political will, awareness, representation/advocacy, oversight, legislation and budget.

Budget and Financial Situation

The original budget developed in 2011 amounted to US$ 88 million for the period 2012 – 2015. This was revised in 2013 to US$ 96 million to accommodate additional demand from countries and to implement selected iERG recommendations identified during the 2012 Stakeholder meeting.

WHO has received US$ 34.6 million (net of programme support costs) thanks to the generous contributions of the governments of Canada, Germany, Norway, and the United Kingdom (Table 1) Of this, US$ 30.5 million has been distributed to countries, partners and to WHO[3]. There is an additional pledge of US$ 6.7 million for Phase II from Norway.

Table 1 : Funding and Pledges as of March 2014

	Phase I			Phase II		
Donors	**2011**	**2012**	**2013**	**2014**	**2015**	**Totals**
CIDA	**155,300**	**19,822,162**	**-**	**-**		**19,977,462**
DFID	**-**	**796,133**	**1,592,267**	**2,388,420**		**3,980,687**
NORAD	**155,045**	**11,553,752**	**2,995,572**	**3,900,000***	**3,900,000***	**22,504,369**
NORAD/iERG	**-**	**-**	**300,000**	**-**		**300,000**
GIZ	**-**	**-**	**844,297**	**-**		**884,297**
SWEDEN				**TBC**	**TBC**	
Totals:	**310,345**	**31,375,914**	**5,372,136**	**6,288,420**	**3,900,000**	**47,606,815**
Running Totals		**31,686,259**	**37,418,395**	**43,706,815**	**47,606,815**	
Net Programme Support Costs 13%	**270,000**	**27,279,045**	**4,986,958**	**2,077,925**	**3,393,000**	
Funds Received						**34,632,000**
Funds received and pledged						**41,418,000**

- Donor pledges

Phase I: 58 countries received catalytic funding of US$ 250,000 to support the implementation of the country accountability frameworks. The remaining funds in Phase I are being used to support countries in the process of finalizing their accountability frameworks, and to conduct selected priority activities. (see Annex 4 for financial status of countries with accountability frameworks).

Phase II: We propose a budget of US$ 30 million for Phase II. A subset of countries will receive a second tranche of funding on the basis of performance in Phase I, evidence of country commitment and receipt of a country application that will be reviewed by a small multi-stakeholder group. The amount of funding for each country will depend on the overall resources available, but we proposed that it should US$ 300,000 per country.

[3] This includes costs for project management and iERG costs that have been distributed until the end of the project.

An expanded set of partners will be sought to support countries and to build capacity within the various work streams. 25% of funds will be committed to this expanded set of partners, with a focus on regional institutions that can provide direct support to countries.

WHO will continue to coordinate the implementation of the work plan and be responsible for global and country reporting on behalf of partners implementing the work plan. WHO and partners will focus on providing technical assistance to countries, ensuring coordination, harmonizing and aligning initiatives, and developing tools and methods where needed.

Budget 2014 - 2015 [4]

Activity areas	2014	2015	Total	Implementer
Country accountability frameworks and roadmaps				
Phase II: Additional support to select Country Accountability Frameworks and roadmaps (300k for 40 countries)	6,500,000	5,500,000	12,000,000	Countries
Support to fragile states or countries with weak health systems	600,000	400,000	1,000,000	Countries
Regional Partners - technical support to countries	3,000,000	2,000,000	5,000,000	Partners
Regional Office support to countries	500,000	500,000	1,000,000	WHO Regions
Component 1: Strengthening measurement and tracking: common monitoring and evaluation platform				
1.1 Strengthening civil registration vital statistics (CRVS)	500,000	450,000	950,000	WHO/HQ
1.2 MDSR and Quality of Care	500,000	450,000	950,000	WHO/HQ
1.1 Monitoring results	500,000	450,000	950,000	WHO/HQ
1.4 Innovation eHealth	400,000	350,000	750,000	WHO/HQ
1.5 Resource tracking	400,000	350,000	750,000	WHO/HQ
Component 2: Strengthening analysis and review				
2.1 Health sector reviews	250,000	200,000	400,000	WHO/HQ
2.2 Best Practices, analytical reports and scorecards	500,000	500,000	1,000,000	WHO/ Partners
Component 3: Dissemination, advocacy, transparency and enhancing accountability				
3.1 Strengthening policy environment	100,000	100,000	200,000	WHO/ Partners
3.2 Advocacy, transparency (media, civil society budget tracking, media training)	400,000	400,000	800,000	Partners
3.2 Engaging Parliamentarians	200,000	200,000	400,000	Partners
Programme Support Costs (13%)	2,223,000	1,677,000	3,900,000	WHO/HQ
Grand total	**16,273,000**	**12,827,000**	**30,100,000**	

[4] It is expected that Phase II will start in June 2014.

Distribution of Funds

Distribution	2014/15	%
Countries	13,000,000	50%
HQ/RO	6,950,000	26%
Partners	6,200,000	24%
Total (net psc)	**26,150,000**	100%

Annex 1: Countries with faster implementation [5]

Afghanistan, Bangladesh, Benin, Burkina Faso, Cambodia, Cameroun, Comoros, Democratic Republic of Congo, Guinea, Kenya, DRP Korea, Kyrgyzstan, Lao PDR, Lesotho, Malawi, Mauritania, Myanmar, Nepal, Nigeria, Pakistan, Papua New Guinea, Philippines, Senegal, Sierra Leone, Solomon Islands, Somalia, Tajikistan, Tanzania, Togo, Uganda, Viet Nam, Zambia, Zimbabwe.

Annex 2: Fragile states and countries with weak health systems

There are several countries which have expressed interest in the accountability processes but due to either their political situation or weak health infrastructure have not been able to complete their Country Accountability Frameworks. Phase 2 would include a revised approach on how to work with such countries, including strengthened regional approaches from either WHO regional offices or other regional organizations or Partners to support those countries.

These countries include: Central African Republic, Chad, Côte d'Ivoire, Egypt, Eritrea, Guinea-Bissau, Haiti, Mali, Sudan, South Sudan.

[5] The table includes the Countries that have a higher level of implementation based of the country accountability framework, based on the progress reports submitted by countries.

Annex 3: Work plan matrix 2014-15

Action item	2014-15 Expected Results/Products	Partner
Country Accountability Frameworks and roadmap activities		
Country Accountability Frameworks and roadmaps	• Mid-term assessment of Country Accountability Frameworks implementation in 5-10 countries to identify models of accountability • Phase II: 30 countries supported receiving additional funds to continue work on accountability – based on performance • Support to fragile states or countries with weak health systems	TA from UN, bilaterals, academic institutions Partnerships, CSOs
Component 1: Strengthening monitoring results and tracking resources		
1.1 Strengthening registration of births, deaths and cause of deaths	**Deliverables:** • Countries with completed CRVS assessment and national plan • International Classification of Death (ICD) regional strengthening and country technical support for countries • Integrated routine information systems including client-level service delivery tested. **Activities:** • Support strengthening of CRVS systems through assessment and national planning • Facilitate development of national investment plans • Support to innovative community based approaches • Support to the improved use of the International Classification of Disease (ICD) in health facility settings • Deployment and testing of routine information systems that integrate monitoring of client-level service RMNCH delivery	UNECA, UNESCAP, EURO, EMR UNECA / South Africa FIC / Stats Canada
1.2 Scaling up maternal death surveillance and response and quality of care	**Deliverables**: • Countries implementing Maternal Death Surveillance and Response approach • Improved quality of care of RMNCAH services in facilities **Activities:** • Documentation of country experiences in implementing MDSR (6 countries) • 5 multi-country meetings (2 AFRO, 1 SEARO, EMRO, WPRO) to review results of country experiences, focusing on success, scaling up and lessons learned (based on country review of experiences) • RMNCH quality of care modules in facility assessment tools and indicators updated, tested and applied in countries • Guidance for conducting stillbirth and newborn death reviews developed • Evidence, gaps and best practices in improving and	WHO, UNFPA, UNICEF, CDC Foundation, FIGO, Norway Institute of Public Health, West African Health Organization, South African Network of Obstetricians and Gynecologists

	monitoring intra-partum care shared	
1.3 One monitoring and evaluation (M&E) platform	**Deliverables:** • Common framework and platform for monitoring and evaluation in countries strengthened. • Harmonized partner investments in results monitoring, with streamlined reporting to global partners, based on global core indicators **Activities**: • Real-time monitoring (based on DHIS platform), RMNCH service delivery including health service readiness assessments, supply chains for commodities and workforce availability, quality of care and patient satisfaction. • Countries implementing data quality controls and transparency • Standard core indicators and guidance on analytical review of progress and performance for women and children's health, including UHC monitoring • National institutional capacity building with enhanced capacity to conduct analytical performance assessments and reports to inform national reviews • Innovative systems for monitoring universal coverage of essential interventions	Health and statistical sectors IHP+ partners, African Population Health Research Council, Statistics Norway, University of Oslo (HISP), Norway Institute of Public London School of Hygiene and Tropical Medicine Health/(NIPH), Global Fund, GAVI,USAID, UNICEF, UNFPA, WHO
1.4 Innovation and eHealth	**Deliverables:** • Countries with national eHealth strategies, including women's and children's health as a priority area • Countries with integrated use of ICT in their national health information systems and health infrastructure **Activities:** • Multi-country workshops on eHealth strategy development, reaching all COIA countries requesting support • Technical support to countries for eHealth development, (priority on countries with eHealth in their roadmap) • Monitoring, evaluation and reporting on eHealth adoption, trends, resources and best practice • Capacity-building (technical training), guidance and tools on eHealth components: e.g. governance, policies, standards, workforce.	WHO, ITU
1.5 Resource tracking	**Deliverables:** • 40 countries have to date and accurate data on the two indicators: 1) total health expenditure by financing source, per capita; and 2) total reproductive, maternal, newborn and child health expenditure by financing source, per capita.	WHO, World Bank, USAID Global Fund, FP2020, Decade of Vaccines, PMNCH

<table>
<tr><td></td><td>Activities:
• Technical support for countries to start data collection process
• Technical support to civil society workshops on budget transparency (see below on advocacy)</td><td></td></tr>
<tr><td colspan="3">Component 2: Strengthening analysis and reviews</td></tr>
<tr><td>2.1 Analytical reports : best practice, guidance, scorecards</td><td>Deliverables
• PMNCH Accountability Report: Update on commitments to the Global Strategy – web-based report
• iERG country case studies (3 countries)
• OECD reporting on 2013 commitments
• WHO report on progress towards the Commission on Information and Accountability recommendations
• Global progress report on maternal mortality including progress in improving measurement based on causes of maternal deaths information
• Universal health coverage and equity analyses : Scorecards/dashboards on equitable coverage of priority services for primary care across MDG and UHC priorities</td><td>PMNCH, OECD, iERG, WHO</td></tr>
<tr><td>2.2 Health Sector Reviews</td><td>Deliverables:
• National health strategy review processes strengthened through technical support, based on guidance developed on “best practice” and based on analytic data available for reviews.

Activities:
• Develop “best practice” guidance that establishes criteria for reviews, including broad stakeholder participation in health sector annual reviews.
• RMNCAH short programme review updated in line with global action plans to end preventable maternal, newborn and child deaths</td><td>IHP+ and its partners, including countries, WHO, World bank
CSOs</td></tr>
<tr><td colspan="3">Component 3: Dissemination, advocacy, transparency and enhancing accountability</td></tr>
<tr><td>3.1 Policy environment</td><td>• Based on policy compendium, countries to identify which policies are important for improving women’s and children’s health, using the compendium as a guide.
• Through health sector reviews (see Health reviews section) identify policy gaps.
• Ensure that RMNCH policies are incorporated into national health strategies and plans.</td><td>WHO, countries, PMNCH</td></tr>
<tr><td>3.2 Advocacy and action</td><td>• EWEC strategic advocacy and communication campaign on accountability: Coordinated by Every Woman Every Child campaign will showcase results, highlight gaps,</td><td>PMNCH
CSOs
Africa Public Health</td></tr>
</table>

	strengthen the push for EWEC commitments and promote accountability. • **Sensitize national advocacy groups** on global action plans and policies for coordinated advocacy efforts to promote and operationalize policies. • **Media engaged and disseminating scorecards** related to accountability for women's and children's health • **Civil society engaged on budget tracking:** development of regional workshops and tools (West Africa, SEARO) PMNCH Partner Forum: Accountability as central theme in PMNCH Partners Forum with examples of lessons/success factors.	Alliance Office of the UN Secretary-General Associations of journalists H4+
3.3 Engagement with Parliamentarians	• Sensitize Parliamentarians on implementing the IPU resolution on accountability for women's and children's health • Support implementation of IPU resolution in countries that have prioritized advocacy work in the country accountability frameworks. • Facilitate legislative reform to improve access of women and children to more effective health services • Conduct surveys to review parliamentary activity on MNCH in key areas.	Inter Parliamentary Union, WHO, PMNCH

Annex 4: [6] **Financial status of all country accountability frameworks**

Region	Countries	National Amount transferred ($)	Breakdown of catalytic funding request by priority area (000 $) CRVS	Monitoring Results	MDSR	E-health Innovation	Resource tracking	Reviews	Advocacy	Catalytic funding Award Distribution date	Total amount distributed (000 $)	Budet Expenditures as at 9 January 2014	Budet Expenditures % as at 9 January 2014
AFRO	Central African Republic	12,280									0	22,871	0%
AFRO	Chad	15,580									0	-	0%
AFRO	Congo	15,000									0	-	0%
AFRO	Côte d'Ivoire										0	13,737	0%
AFRO	Eritrea	12,600									0	-	0%
AFRO	Gabon	7,500									0	-	0%
AFRO	Gambia	4,721									0	-	0%
AFRO	Ghana	9,960									0	-	0%
AFRO	Guinea-Bissau										0	-	0%
AFRO	Mali										0	-	0%
AFRO	Mozambique	12,098	25	36	80	20	50	15	24		0	-	0%
AFRO	Sao Tome and Principe	11,151	33	53	50	12	74.5	16.5	11		0	-	0%
AFRO	South Africa										0	-	0%
AFRO	Swaziland	15,000	35	85	55	9.5	50	12.5	3		0	-	0%
AMRO	Haiti	15,000									0	-	0%
AMRO	Mexico	15,000									0	-	0%
EMRO	Djibouti	–	11	33	67	32	41	36	30		0	-	0%
EMRO	Egypt	10,000									0	-	0%
EMRO	Sudan	9,680									0	-	0%
EMRO	South Sudan	26,430									0	-	0%
EURO	Azerbaijan	15,000									0	-	0%
EURO	Uzbekistan	14,895									0	-	0%
EURO	Turkmenistan										0	-	0%
SEARO	India										0	-	0%
AFRO	Benin	15,000	18.5	39.5	131	–	10	30	21	02-Jul-12	250	274,345	110%
AFRO	Tanzania-Mainland/Zanzibar	21,555	102.5	45	60	45	42.5	20	35	04-Jul-12	350	110,922	32%
WPRO	Lao PDR	–	50	90	70	–	10	30	–	11-Jul-12	250	159,647	64%
WPRO	Solomon Islands	–	55	90	105	–	–	–	–	13-Jul-12	250	70,764	28%
AFRO	Malawi	9,000	42	30	30	22	60	26	40	21-Aug-12	250	244,360	98%
AFRO	Senegal	13,719	35	30	50	27	70.075	10	28	21-Aug-12	125	78,498	63%
AFRO	Sierra Leone		–	235.5	–	–	–	14.5	–	20-Sep-12	250	222,940	89%
AFRO	Togo	10,600	69	129	–	–	30	22	–	21-Sep-12	250	241,884	97%
AFRO	Uganda	10,551	–	30	130	10	30	10	40	25-Sep-12	250	137,189	55%
AFRO	Zimbabwe	15,000	75	120	–	–	40	–	15	20-Sep-12	250	102,058	41%
WPRO	Philippines	–	95	40	70	20	25	–	–	10-Oct-12	250	157,514	63%
AFRO	Ethiopia	–	125	–	–	–	50	–	75	16-Nov-12	250	194,880	80%
AFRO	Madagascar	–	115	22	54.5	15	4	18.5	21	16-Nov-12	250	72,339	29%
WPRO	Viet Nam	13,271	58	117	40	10	–	–	25	16-Nov-12	250	147,155	59%
AFRO	Cameroon	13,300	60	110	54	10	16	–	–	14-Dec-12	250	293,001	117%
AFRO	Mauritania	14,548	40	65	55	10	10	42	28	26-Nov-12	250	141,924	57%
WPRO	Papua New Guinea	15,128	75	40	25	–	80	–	30	26-Nov-12	250	157,828	63%
SEARO	Dem. People's Rep. of Korea	10,000	50	90	15	70	10	5	10	30-Jan-13	250	139,427	57%
SEARO	Nepal	14,613	49	83	40	38	12.5	18.5	9	30-Jan-13	250	173,469	69%
WPRO	Cambodia	8,614	113.5	54	–	–	82.5	–	–	7-Feb-13	250	130,964	52%
AFRO	Zambia	14,639	60	65	45		50		30	5-Mar-13	250	285,462	114%
AFRO	Liberia	–	45	17.5	118	17.5	10.5	13.5	28	18-Mar-13	250	247,147	99%
AFRO	Lesotho	–	74.5	23.2	84	30.5	14.4	11.2	12.2	26-Mar-13	250	167,433	70%
AMRO	Bolivia	15,000	62.5	50	50	17.5	25	20	25	27-Mar-13	250	177,000	71%
AMRO	Guatemala	14,000	83	25	50	10	32	30	20	27-Mar-13	250	178,000	71%
AFRO	DRC	25,000	40	125	5	–	40	–	40	11-Apr-13	250	71,345	28%
EMRO	Yemen	10,967	35	30	122	–	63	0	0	11-Apr-13	250	25,208	10%
EURO	Tajikistan	15,000	35	15	105	23	35	10	27	11-Apr-13	250	249,799	100%
EMRO	Afghanistan	9,850	26.5	29.9	46	33	15.5	60	39	17-Apr-13	250	134,490	54%
AFRO	Kenya	16,000	40	30	40	20	40	20	50	23-Apr-13	250	241,710	97%
EMRO	Pakistan	17,681	13	84	47	39	26.5	16.5	24	20-May-13	250	215,215	86%
SEARO	Myanmar	14,984	46	61	50	51	20	10	12	20-May-13	250	234,013	94%
EMRO	Iraq	11,802	40	70	60	10	10	20	40	31-May-13	250	128,035	51%
AFRO	Burkina Faso	14,530	28	57	27	34	47	22	35	17-Jun-13	125	178,331	143%
AFRO	Comoros	–	24.628	14.238	100	7.535	49.822	4.135	50	17-Jun-13	125	137,150	110%
AFRO	Guinea	–	85	39	33	36	12	40	5	17-Jun-13	125	130,038	104%
AFRO	Nigeria	21,493	64	66	60	0	60	0	0	17-Jun-13	125	107,185	86%
AMRO	Brazil	15,000	0	20	170	0	60	0	0	17-Jun-13	125	177,000	141%
AMRO	Peru	15,000	20	9.3	140.7	0	80	0	0	17-Jun-13	125	-	0%
EURO	Kyrgyzstan (catalytic 2nd tranche=GIZ funds)	8,470	39	18	103	50	19	7	14	17-Jun-13	250	124,959	50%
WPRO	China	–	40	80	30	–	30	–	70	3-Jul-13	125	-	0%
AFRO	Rwanda	15,500	6	86.75	75.25	–	45	17	20	15-Aug-13	125	79,504	66%
SEARO	Indonesia	15,000	84.5	50	500	40	–	25	50	19-Aug-13	125	14,995	110%
SEARO	Bangladesh (catalytic 2nd tranche=GIZ funds)	15,000	18.5	167	28	14.5	6	1	15	20-Aug-13	250	124,595	50%
EMRO	Somalia	31,650	65	40	76	–	–	10	59	22-Aug-13	125	102,888	82%
AFRO	Angola	22,620	20	19	47	4	41	27	92	18-Nov-13	130	27,108	21%
AFRO	Burundi (catalytic=GIZ funds)	–	79	38.7	41.531	3	18.662	25.588	43.558	29-Nov-13	250	24,444	10%
AFRO	Niger (catalytic=GIZ funds)	7,741	0	78.5	95.68	0	75.76	0	0	29-Nov-13	250	1,146	4%
		753,721	2,303	2,733	3,094	711	1,373	584	1,042		10605	6,871,914	

* Countries showing more than 100% implementation received a portion of the HQ funding for COIA activities outside of their road maps.

[6] Updated expense figures will be provided in the annual report which will be available in June 2014.