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GUIDELINES FOR PARLIAMENTARY STANDING COMMITTEES ON OVERSIGHT OF PROGRAMMING TO REDUCE CHILD AND MATERNAL MORTALITY

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The Health Finance and Governance Project

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GUIDELINES FOR PARLIAMENTARY STANDING COMMITTEES ON OVERSIGHT OF PROGRAMMING TO REDUCE CHILD AND MATERNAL MORTALITY

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This publication was produced for review by the United States Agency for International Development. It was prepared by Jeremy Kanthor for the Health Finance and Governance Project.

Contents

Acronyms

CHWS	Counseling Health and Wellness Services
CPD	Cephalopelvic Disproportion
CSBA	Community Skilled Birth Attendants
CSO	Civil Society Organization
DfID	Department for International Development
EmOC	Emergency Obstetric Care
EPCMD	Ending Preventable Child and Maternal Deaths
EPHS	Essential Package of Health Services
FCHV	Female Community Health Volunteers
HBP	Health Benefit Plans
HEP	Health Extension Program
ITN	Insecticide-treated Bednets
MDG	Millennium Development Goal
MHCH	Maternal Health and Child Health
MP	Member of Parliament
NGO	Non-governmental Organization
ORS	Oral Rehydration Salts
PMNCH	Partnership for Maternal, Newborn and Child Health
UNICEF	United Nations Children's Fund
UNPFA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Introduction

Public health responses to priority health challenges are complex, technical, and involve numerous institutions, funding sources, and commitments to international strategies. Efforts to end preventable child and maternal deaths, for example, may include initiatives targeting both child and maternal health, malaria, immunizations and nutrition, among others. This guide will use maternal health and child health as themes to illustrate the challenges that face MPs and parliamentary committees while addressing these complex issues, however the approaches described here can be employed in a variety of contexts within the health field as well as other public policy areas. In addition, for the purposes of this guide, it is important to note how efforts to reduce child and maternal mortality differ and converge with the broader effort to improve maternal and child health. While these two are closely related, they are not identical. Improving child and maternal health is an umbrella term that addresses a full range of efforts to help pregnant women and children thrive. Programming to reduce child and maternal mortality seeks to target the key causes of preventable deaths of pregnant women and children under 5 years of age. The approaches and techniques discussed here can apply to variety of situations facing standing health committees as they seek to develop their objectives and action plans.

There have been several efforts to engage Parliaments in issues of maternal and child health, including the Asian Forum of Parliamentarians on Population and Development's "Maternal Health: An Advocacy Guide for Parliamentarians"[1] and the Inter-Parliamentary Union's "Sustaining Parliamentary Action to Improve Maternal, Newborn and Child Health."[2] These guides focus on the role of individual Members of Parliament (MPs) and what they can do to address issues of maternal and child survival. These guides also emphasize increasing MPs' understanding of maternal and child health issues over the specific parliamentary mechanisms for increasing oversight and monitoring government performance.

At an individual level, MPs have limited authority and mechanisms to conduct oversight over government performance or review budgets. In this light, empowering committees, rather than individual members, can provide a more effective method for promoting external oversight over government efforts to improve maternal and child survival. The vast majority of Parliaments today employ a system of both standing and ad hoc committees, Standing Committees have the responsibility for monitoring government performance and conducting oversight on how public resources are allocated and spent, often with a sector specific portfolio, while ad hoc committees are struck to address a specific, and often urgent, issue and have a limited lifespan. It is not unusual for Parliaments to group sectors together under one committee, as one finds in Afghanistan

[1] Chatterjee, Subeditor. Maternal Health: An Advocacy Guide for Parliamentarians. Asian Forum of Parliamentarians on Population and Development (AFPPD). 2010. Web [http://www.commonhealth.in/pdf/47.pdf]

[2] Long, Sian, et. al. Sustaining Parliamentary Action to Improve Maternal, Newborn and Child Health. Inter-Parliamentary Union. Handbook for Parliamentarians No.21. 2013. Web [http://www.ipu.org/PDF/publications/mnch-e.pdf]

(Commission on Health, Sports, Labor, and Workers), Senegal (Committee on Health, Population, Social Affairs and National Solidarity) and Zambia (Health, Community Development and Social Services). Other countries may have standing committees with sole responsibility for health (such as in Ghana and Kenya). Standing committees will have defined roles and authorities, including reviewing the sector budget, holding hearings, and calling witnesses, Committees also typically have staff support to provide research and analytical services.

The rate of child and maternal mortality is affected by a myriad of factors, including access to clean water, nutrition, and community infrastructure. Because of the complexity of a government's response to child and maternal mortality, Standing Committees for Health can find it difficult to assess whether priorities are being achieved, international commitments are being met and adequate funds are being allocated. Committee members and their staff support may not be familiar with Health Ministry priorities or methods for assessing performance. The Ministry may not articulate clear standards on which to measure performance. In addition, while committees can serve as advocates for increasing allocations to underfunded health priorities, the lack of oversight over child and maternal mortality diminishes the Parliament's ability to assess whether sufficient funds are being allocated to health and how those funds are being spent.

What are the objectives for these guidelines?

This guide has three key objectives:

- Position efforts to reduce child and maternal morality within the portfolio of a standing committee of health. Because the challenge of reducing child and maternal mortality is an issue that cuts across numerous health programs and social sectors, it is important to position the goal of ending preventable deaths within the broader mandate of a standing committee of health. There is rarely a dedicated child and maternal health budget to scrutinize, nor specific staff to question, let alone stand alone programming to reduce maternal and child mortality. This guide will build the awareness for Members and staff of standing committees on the principle causes for maternal and child deaths and how this relates to their broader health sector oversight.
- Review possible standing committee oversight tools relevant for the oversight of health programming. Committees have a varying degree of tools at their disposal to conduct oversight over budgets and policies. This guide will review these possible tools through the lens of efforts to reduce child and maternal mortality.
- Provide practical approaches for how standing committees can implement plans. This guide offers practical guidance for how Committee chairs, MPs, and committee staff can conduct robust and regular oversight over progress towards reducing child and maternal mortality in their countries.

Who is the target audience for these guidelines?

Although these guidelines and the approaches described within can be applied to any targeted health issue, they are focused on child and maternal death due to the scale of the problem in the 25 priority countries listed above, and its preventable nature. As such, these guidelines are intended for two key audiences. The primary audience is the Health committees in 25 Priority countries. For most countries, these guidelines are applicable to the national parliament; for those countries (Nigeria, Ethiopia) with regional or state legislatures, these guidelines may also be applicable. The target audience is inclusive of the Committee chairs, MPs sitting on the committee, and the staff assigned to support the committee. The guidelines provide information and strategies for asking the right questions, requesting the right information and taking a leading role in building public awareness around the goal of ending preventable child and maternal deaths. The second audience is donors and organizations that support Parliaments in countries where maternal and child deaths remain a significant issue. Lastly the guidelines may be useful for civil society groups to understand the potential role of standing committees on health, and how they may most effectively interact with these important actors.

USAID's EPCMD Priority Countries

As part of its approach to this issue, USAID has designated 25 priority countries; together these 25 countries account for 70% of preventable child and maternal deaths, and are therefore critical to achieving advances in this area.

How are these guidelines organized? What do these guidelines not cover?

In **Section 2**, we position child and maternal mortality into the broader mandate of a Standing Committee on Health by present an overview of the key causes of preventable deaths and country experience in achieving success. In **Sections 3 and 4,** we present several committee oversight tools and describe how they can be applied to health oversight. In **Section 5**, we provide strategies for using oversight tools to monitor the performance of child and maternal mortality initiatives and effectiveness of funding spent in this area. In **Section 6**, we present examples of how selected countries (to be more specific, USAID's 'EPCMD priority countries') have achieved success in reduction maternal and child mortality rates.

These guidelines are not a reference on ending preventable maternal and child deaths. While they provide some summary information in Section 2 on the primary causes for preventable deaths, those seeking more detailed materials can reference the following:

- Acting on the Call: Ending Preventable Child and Maternal Deaths: A Focus on Equity USAID, 2016: https://issuu.com/usaid/docs/usaid_2016_mcs_aotc_brochure_v15_si/1?e=4465259/36650940
- Trends in Maternal Mortality 1990 – 2015, WHO, 2015: http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf?ua=1

SECTIONS

Section 1: The Scale and Complexity of the Problem

UNICEF estimates that in 2015, nearly 6 million children under the age of 5 years died of preventable causes, 75% of whom were less than a year old. The World Health Organization estimates that in 2013, 289,000 women died while pregnant or shortly after terminating their pregnancy. While both infant mortality and maternal mortality rates have declined significantly over the last 20 years, these recent figures are a stark reminder of the hazards faced by mothers and children.

To ground this guidebook in the realities of child and maternal deaths, Table 1 presents the data on the child and maternal deaths globally and for each of the 25 USAID priority countries.

The effort to address child and maternal deaths is very complex; while globally the major causes are known, each country has its own profile with different factors, both direct and indirect, and country specific - with some causes being more significant than others depending on the country. This means there is no standard approach that can be replicated across countries; what is needed in South Sudan is very different from what is needed Pakistan.

In addition, in any one country there is rarely a single initiative or dedicated funding source for this type of health programming. Rather, efforts to promote maternal and child health are supported through numerous health programs, by multiple donors and potentially across numerous social sectors. This has significant implications to the oversight of country efforts to reduce preventable deaths - it can be difficult to discern an overall strategy, who is in charge for executing that strategy, and how funds are being spent to achieve the strategy. As these guidelines will discuss later, it is imperative that the standing committees on Health undertake an effort to identify and map the various actors and organizations involved in child and maternal health, at the national, sub-national and municipal levels.

Table 1: Child and Maternal Death Data

Country	1990 Maternal Deaths[3]	2015 Maternal Deaths	1990 Maternal mortality ratio (per 100 000 live births)	2015 Maternal mortality ratio (per 100 000 live births)	1990 Child Deaths[4]	2015 Child Deaths	1990 Child Death Rate (per 1000 live births)[5]	2015 Child Death Rate (per 1000 live births)
Global								
Afghanistan	8 400	4 300	1 340	396	100437	94261	181	91
Bangladesh	21 000	5 500	569	176	527587	119326	144	38
Myanmar (Burma)	5100	1700	453	178	120691	46284	110	50
DRC	15 000	22 000	879	693	294179	304558	187	98
Ethiopia	29 000	11 000	1 250	353	446103	184186	205	59
Ghana	3 600	2 800	634	319	69971	54061	127	62
Haiti	1 700	950	625	359	36833	17841	146	69
India	152 000	45 000	556	174	3357317	1200998	126	48
Indonesia	21 000	6 400	446	126	395094	147162	85	27
Kenya	6 800	8 000	687	510	99742	74429	102	49
Liberia	1 400	1 100	1 500	725	23307	10509	255	70
Madagascar	4 100	2 900	778	353	81636	40075	161	50
Malawi	4300	4200	957	634	105576	40048	242	64
Mali	4200	4400	1010	587	98211	82710	254	115
Mozambique	8700	5300	1390	489	140492	82387	240	79
Nepal	6600	1500	901	258	97907	19900	141	36
Nigeria	57000	58000	1350	814	848601	750111	213	109
Pakistan	19000	9700	431	178	592722	431568	139	81
Rwanda	4200	1100	1300	290	50493	14207	152	42
Senegal	1800	1800	540	315	43760	27059	140	47
South Sudan	6300	4100	744	311	66316	39487	253	93
Tanzania	11000	8200	997	398	177635	98180	165	49
Uganda	5900	5700	687	343	151343	85291	187	55
Yemen	3500	3300	547	385	74895	34351	126	42
Zambia	2200	1400	577	224	69664	38990	191	64

[3]World Health Organization (WHO). Global Health Observatory Data Repository. Maternal Mortality: Data by Country. 2015. Web [http://apps.who.int/gho/data/node.main.15]

[4]The United Nations Children's Fund (UNICEF). Child Survival: Under-five Mortality. June 2016. Web. [http://data.unicef.org/child-mortality/under-five.html]

[5]The World Bank. 2.21 World Development Indicators: Mortality. 2014. Web. [http://wdi.worldbank.org/table/2.21]

Key causes of preventable child death

Over the past 25 years, the number of children who die of preventable causes before reaching their fifth birthday has fallen by more than half. While concerted global efforts have led to dramatic reductions in under-five mortality, progress has not been enough to achieve the Sustainable Development Goal (SDG) 3.2's target of ending preventable deaths of newborns and children under five years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births by 2030. Most under-five deaths are still caused by diseases that are readily preventable or treatable with proven, cost-effective interventions. Pneumonia, diarrhea, and malaria are main killers of children under age 5; preterm birth and intrapartum-related complications are responsible for the majority of neonatal deaths.[6]

- **Pneumonia.** When children become ill and show signs of pneumonia, they need to receive a prompt diagnosis and treatment from a facility-based health provider or a qualified community health worker. Progress in reducing pneumonia-related deaths requires quickly seeking care from a health care provider once children develop symptoms of pneumonia, followed by appropriate treatment with antibiotics for bacterial pneumonia.
- **Diarrhea.** As with pneumonia, decreasing deaths in children from diarrhea requires both prevention and appropriate treatment. Improvements in drinking water, sanitation and hygiene are essential for preventing diarrheal infections and other diseases. When children do become ill with diarrhea, one of the most effective treatments is both inexpensive and easy to administer—oral rehydration salts (ORS). Today, just two in five children who become ill with diarrhea receive ORS.
- **Malaria.** In malaria endemic regions, vector control is one of the most effective interventions for prevention. Malaria prevention efforts have focused heavily on increasing the use of insecticide-treated bednets (ITNs) to prevent transmission. When children do show signs of malaria, appropriate and rapid diagnosis is necessary before administering treatment. The WHO updated its treatment recommendations in 2010 to recommend a confirmatory diagnostic test for young children with fevers in malaria-endemic areas. This is to counter the systematic treatment of children who showed signs of fever with an antimalarial, which could cause the development of parasite resistance.
- **Preterm birth.** Prematurity is the leading cause of newborn deaths. In low-income settings, half of the babies born at 32 weeks (two months early) continue to die due to a lack of feasible, cost-effective care, such as warmth, breastfeeding support, and basic care for infections and breathing difficulties. Family planning, and increased empowerment of women, especially adolescents, plus improved quality of care before, between and during pregnancy can help to reduce preterm birth rates.
- **Intrapartum-related complications.** A major cause of intrapartum or early very neonatal death is asphyxia, which can result from poorly managed obstetric complications and from the absence of neonatal resuscitation. Good quality intrapartum care is crucial for both mothers and their infants, and where appropriate and timely care is provided, most maternal and neonatal deaths can be prevented.

[6] "Other" post-neonatal period deaths account for the biggest number of under-five deaths. Because this is a catchall category, it is excluded in our detailed summary.

Key causes of preventable maternal death

Every day, approximately 830 women die from causes related to pregnancy and childbirth: most of these deaths could have been prevented. While efforts have been made to achieve SDG 3.1 - reducing the global maternal mortality ratio to less than 70 per 100,000 live births by 2030- the lifetime risk of death due to pregnancy and childbirth is still high for women living in developing countries where 99% of all maternal deaths occur. The high number of maternal deaths in some areas of the world reflects inequities in access to health services, as well as weak health systems that result in poor health outcomes. High maternal mortality rates however, are not due exclusively to factors related to economic or human resources limitations rather the death of a women during childbirth is the product of numerous elements often all related to a delay in care. The WHO defines such delays in a model titled "the three-delay model" which designates the delays most likely to adversely affect the ability of women to seek or reach care. The delays identified in the model include: 1) delay in the decision to access care 2) delay in transportation to a medical facility 3) delay in the receipt of adequate and appropriate treatment.

Delays in care often result in maternal mortality, but the actual complications that women die of during and following pregnancy and childbirth are usually preventable or treatable. The leading causes of maternal deaths include:

- **Hemorrhaging.** After giving birth a woman is most at risk for hemorrhaging - if left unattended severe bleeding can kill a woman within hours. Postpartum hemorrhage (PPH) is responsible for approximately 27 percent of maternal mortality worldwide. To help offset the risk of a hemorrhage all births need to be attended by skilled health professionals with care and support during and after childbirth. Given immediately post-birth uterotonics can decrease blood loss and help prevent 50 percent to 60 percent of PPH.
- **Sepsis.** After childbirth, the chance for sepsis is very high due to the stress that birthing places on a woman's body. To prevent and manage the risk of infections, birthing sites need to practice good hygiene with high standards for infection control. Clean delivery kits and health education can help reduce infection rates, but many of the crucial factors that give rise to unclean delivery are usually related to poverty and lack of facilities. To help offset the chance of infection, early detection needs to occur with appropriate prenatal testing and treatment of maternal infection and appropriate use of intravenous or intramuscular antibiotics during the labor and post-partum periods.
- **Hypertension (pre-eclampsia and eclampsia).** Hypertensive disorders are the second highest direct obstetric cause of maternal death and account for 14 percent of maternal deaths. Pre-eclampsia can be identified in the prenatal stage by monitoring blood pressure, screening urine for protein, and through physical assessment. If pre-eclampsia is left untreated it can lead to exclampsia, which is characterized by kidney failure, seizures, and coma during pregnancy or post-partum. To prevent pre-eclampsia/eclampsia, low-dose aspirin and calcium supplements should be given as deterrents before birth.
- **Complications from delivery/direct causes.** Many women can experience a prolonged or obstructed labor with an increased incidence among women with poor nutritional status. Women can also experience cephalopelvic disproportion (CPD) - a disproportion between the size of the fetal head and the maternal pelvis or by the position of the fetus at the time of delivery – the leading cause of obstetrical fistulas. To help deter complications the use of assisted vaginal delivery methods such as forceps, vacuum extractor, or performing a Caesarean can prevent adverse outcomes.

- **Unsafe abortions.** Approximately 67,000 cases of abortion related deaths occur each year. Unsafe abortion accounts for approximately 8 percent of global maternal deaths. Unsafe abortions can cause severe infections, as well as bleeding from the procedure or organ damage all of which risk the life of a woman. The prevention of unsafe abortions and subsequent maternal deaths can be avoided with the provision of safe abortions, quality family planning services, and competent post-abortion care.
- **Indirect causes.** Pre-existing medical conditions such as anemia, malaria, hepatitis, heart disease, and HIV/AIDS can increase the risk of maternal death. To reduce the risk of disease complicating pregnancy and childbirth prenatal identification and treatment, as well as the availability of appropriate basic emergency obstetric care (EmOC) are necessary at the time of delivery.

Women around the globe still do not receive the maternal health care and family planning services they need to survive pregnancy and thrive. To help end preventable maternal deaths all women, including adolescents, need access to well-equipped health facilities with trained staff, contraception, and if allowed by the country safe abortion services, and quality post-abortion care. It is also vital to prevent unwanted and too-early pregnancies. Understanding the causes of maternal death and their subsequent life-saving interventions is key to saving women from a preventable death.


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Section 2: How Standing Committees Contribute to Oversight of Programming to Reduce Child and Maternal Mortality

Parliamentary Standing Committees typically have three major functions:

- **Review and deliberate on policy development** - Standing committees usually are responsible for deliberating and commenting on draft laws that address the health sector, including those that define the health services available to women and children.
- **Monitoring policy implementation** – Once policies are passed, and implementing regulations are in place, Standing committees typically serve a role of monitoring the performance of government programs, including those addressing preventable child and maternal deaths.
- **Approve budgets and/or monitor budget execution** – Many, but not all, standing committees are charged with reviewing and commenting on the annual health budget. Once the budget is passed, standing committees monitor how funds are spent.

The following section outlines how standing committees can apply these functions to the effort to end preventable child and maternal deaths.

Reviewing health policies

There are several national level policies that are relevant to efforts to reduce preventable child and maternal deaths. Below, some key policies are described along with how Standing Committees might contribute to their review.

- **Essential Package of Health Services (EPHS):** An EPHS is a policy statement that outlines the package of health services that the government provides or aspires to provide to its citizens in an equitable manner. EPHS' often include a list of priority reproductive, maternal, newborn, and child health (RMNCH) interventions that encompass child and maternal health interventions as well as a larger set of interventions for high priority groups. The EPHS serves as a policy statement of what health services should be available to all citizens. The Standing Committee can review the EPHS and advocate that future revisions:

  a. Include, with specificity and not simply with general references, the maternal and child health interventions that are key to reducing child and maternal mortality;

  b. Reflect the issues of equity – that women and children with less access to quality health care (whether due to geographic location, income level, or other socio-economic reasons that make them vulnerable) are more susceptible to maternal or child morbidity and mortality.

c. Outline clearly how the policy objectives in the EPHS will be achieved.

- **Health Benefit Plans (HBP):** A HBP is a list of guaranteed health services, accessed at approved health care providers by specified populations, with pre-established levels of financial support for beneficiaries. In contrast to an EPHS, which is a statement of policy, a HBP requires specific and clear funding mechanisms, including social insurance schemes. The definition of a HBP requires decisions about what segments of the population are entitled to different services. This rationing of priority services may be explicit – specifically including or excluding by policy certain population groups from services. The rationing may also be implicit – limiting services to the public due to their limited availability.

  The HBP serves as a key policy mechanism for a country to determine what services will be available to citizens and the funding required to delivery it. The Standing Committee can review the HBP and advocate that future revisions:

  a. Include, with specificity, priority maternal and child health interventions that are key to reducing mortality rates;

  b. Become more equitable – ensuring that those women and children who are most vulnerable to preventable deaths are covered by the HBP and that services included in the HBP are actually available; and

  c. Enhance sustainability – scrutinizing the HBP to ensure funding is sufficient to delivery priority services aimed at reducing child and maternal mortality.

- **National Commitments**: Countries regularly make commitments to achieve levels of health performance or targets for access, availability and coverage in line with the SDG's – which is a positive, enabling factor because it demonstrates that countries are committed to achieving the goal of reducing child and maternal death. For example, all of the 24 EPCMD priority countries have made commitments on improving achievements in family planning, and many have made commitments specifically relating to child and maternal mortality.

These commitments are typically not approved by parliament, nor have the power of law. Nonetheless, a standing committee can review their country's national commitments and advocate for their achievement by:

a. Ensuring these commitments are reflected in policy and budgets. Standing committees can monitor and inquire how subsequent health policies and decisions on funding levels are consistent with these international commitments.

b. Increasing public awareness of these commitments. Often governments make these commitments with little publicity. Standing committees can use the media coverage of their work to raise public awareness of these commitments.

Monitoring policy implementation

Once policies are in place, a standing committee can play a role in monitoring how they are put into practice. Sections 3 and 4 outline different tools at a Committee's disposal to do this type of monitoring. The following section details aspects of health policy implementation that are particularly relevant to child and maternal mortality.

- **Data Availability:** A national effort to end preventable maternal and child deaths requires strong surveillance and the collection and analysis of high quality data on health system performance and coverage. Health policy makers need to know whether priority interventions are being put into practice and where and why preventable deaths are happening. This information must be documented at the point of service delivery and aggregated up to provide a national picture of both how effectively services are being delivered and where there are problems. It is also necessary to document behaviors and the use of interventions to help guide community health measures and identify the gaps in care. Reliable, high quality and timely data necessary for a strong response, however, is not always available. A study of maternal and newborn health information collected in 13 countries[7] (Bangladesh, Ethiopia, India, Kenya, Malawi, Mali, Mozambique, Nepal, Nigeria, Rwanda, Tanzania, Uganda, and Zimbabwe) documented the inconsistent collection of data on 17 key intervention during pregnancy, birth, and postpartum periods.

  Likewise, while documentation of maternal and newborn complications is high – 11 of the 13 countries document complications; how these complications are managed and treated is weak and inconsistent. To end preventable deaths, health policy makers need to understand what treatments are being offered, what is effective, and what is ineffective.

[7] Divehi, Vikas. et. al. The Maternal and Child Health Integrated Program (MCHIP). November 2014. A Review of the Maternal and Newborn Health Content of National Health Management Information Systems in 13 Countries in Sub-Saharan Africa and South Asia. Washington, DC. Maternal and Child Survival Program (MCSP).

In this light, the standing committee can be an important advocate for the public health sector to improve data collection. Ending preventable deaths requires a firm understanding of where and why those preventable deaths are happening, what segments of the population are most affected, and whether proven interventions are being targeted to at-risk populations. The standing committee can advocate for improved data collection by:

a. Promoting data and evidence driven policy decisions. The committee should ask for the data used by policy makers when making decisions and what data is collected as policies and programs are being implemented.

b. Filling data gaps. When public health officials report that they don't have data on a particular issue, the committee should continue to follow up to advocate that the data be collected.

c. Strengthening data collection systems and sources. The committee can seek to increase investments in the health information systems ministries use to collect and analyze data. The committee can seek funding for household data collection through demographic and health surveys which can strengthen understanding on health behavior and use of interventions such as bednets.

Equity of child and maternal health efforts: Promoting equity, particularly in health care for mothers and children, means that all citizens have access to quality health services, regardless of their socio-economic position. There are several factors that can make women and children more vulnerable to preventable deaths than others. For example a study on data from Ghana, Kenya and Ethiopia on four indicators relevant to child and maternal mortality: use of a skilled birth attendant during delivery, contraceptive prevalence rate, AIDS knowledge and access to a health facility, looked at several dimensions of vulnerability: poverty status, education, region, ethnicity and the more traditional wealth quintile.[8] The study found that all the dimensions of vulnerability had an impact on access to health services. Importantly, the study found that each country had a unique inequity profile. For example, for some countries urban populations were less served, while in others rural populations had less access to services. Likewise, a study of maternal and child health care coverage in 28 states in India found that across all states, those in the wealthiest fifth of the population had more access to health care than those in poorer quintiles. In some states, the wealthy had two times the access to maternal and child care.[9]

The standing committee can work to ensure that health programming focused on reducing child and maternal mortality is equitable by insisting that health programs are specifically designed to address women and children most vulnerable to preventable deaths. The following factors should be considered:

- Has the program or policy been designed to promote equity? Does it include a commitment to Universal Healthcare (UHC) and/or strategies or policies supporting UHC which address equity?
- Poverty – will the health policy or program specifically target poor women and children to ensure they are covered by priority health services and efforts? Will the program or policy focus specifically on reducing the out of pocket expenditures (which serves as an obstacle for services) of the poor for maternal and child health services?
- Marginalized populations – will the public health initiative focus on those segments of the population most marginalized – including ethnic and religious minorities, the less educated, etc.?

[8] Wirth, Meg. et. al. "Delivering" on the MDGS?: Equity and Maternal Health in Ghana Ethiopia and Kenya. East Afr J Public Health. 2008 Dec; 5(3): 133-141. Web. [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4414036/]

[9] Singh, Prashant K. et. al. Equity in Maternal, Newborn, and Child Health Care Coverage in India. International Institute for Population Sciences. 10 September 2013. Global Health Action. Web. [http://www.globalhealthaction.net/index.php/gha/article/view/22217]

- Rural and/or urban populations – will the program or policy promote the location and distribution of public health resources (including infrastructure and public health professionals) to enhance access to underserved populations?

The questions above serve to also highlight the challenge of standing health committees to understand the linkages between other government and donor efforts to address the broader issue of equity, and assess the impacts of other programs in the areas of infrastructure, poverty reduction, job creation, community engagement and others. This may entail coordinating actions with other standing committees, as well as other Ministries.

Performance of Program or Policy Implementation: Once policies or programs to focus on child and maternal mortality are being implemented, the standing committee has a role in monitoring performance to achieve the intended results. The performance of policy and programs could include the following elements:

- Clearly stated performance measures. From the onset, programs and policies should have clearly stated performance measures that articulate what will be achieve over a set time period. It should be clear to the standing committee what the performance measures are.
- Frequent and effective monitoring. As programs are implemented, they should have a clear explanation of how they will be monitored. There are a range of methods for monitoring that can range from routine supervisory visits to impact evaluation studies. The standing committee should know how the program is being monitored.

Approving and monitoring budgets

One of the key responsibilities of a standing committee is their role in approving and monitoring budgets. The Parliamentary Rules of Procedures define the specifics this role and there are significant differences among the 25 priority countries regarding how committees may participate in the budget process. For example, in Afghanistan, once the Government submits the annual budget, the budget for the health sector is sent to the Standing Committee on Health of the lower house (Wolesi Jirga) for the committee's review and comment. The committee's comments are aggregated into the Parliament's consolidated response to the Government. By contrast, in Bangladesh, when the Government submits its budget to Parliament, committees do not review the budgets for the sectors within their portfolio. Members of Parliament may provide their individual feedback.

The ability for standing committees to monitor budgets associated with child and maternal health is complex. As Section 2 illustrated, there are multiple causes of preventable deaths for both mothers and children. For children, only malaria may have stand-alone programs with dedicated budget lines that makes budget monitoring relatively straightforward. Budget allocations for other key causes of child preventable deaths, such as diarrhea or pneumonia, however, will be not have stand-alone budgets and will be incorporated into general public health budgets. The same is true for efforts to prevent maternal deaths – there may be no dedicated budget lines to monitor.

Recognizing that there are differences between the powers of standing committees and the key causes of preventable deaths in the 25 EPCMD countries, the following section details how the standing committee's engagement in different stages of budget formulation and execution are relevant to EPCMD.

- **Setting budget priorities:** The earlier the Standing Committee engages with the Ministry of Health in the setting of budget priorities for child and maternal health, the better. It is often observed that, by the time the budget is presented by the government to Parliament, it is too late to influence government priorities.

  A mid-term budget review can be an effective way for the Committee to initiate discussion with the Ministry on budget priorities. A mid-term budget review entails the Standing Committee to hold a hearing with the Ministry of Health to discuss the progress in implementing the current year budget and articulate the Committee's priorities for future year budgets. Such a review would allow the Committee to ask questions of the Ministry such as:

  - How are child and maternal health investments reflected in the current year budget? Are there specific programs, with budgetary line items?
  - How effective has the Ministry been in reducing preventable deaths? Has the Ministry increased access or availability to care by expanding key program coverage? Have necessary health services seen an increase in use?
  - How is the Ministry addressing each of the multiple causes for maternal and child deaths?
  - What could the Ministry be doing differently to be more effective in preventing maternal and child deaths?
  - How will the Ministry prioritize child and maternal health in next year's budget?

  The mid-term budget review is the opportunity for the Committee to clearly articulate its interest in child and maternal health and expectations for an increase in priority for the coming year budget. The presentation of specific rather than general expectations is more effective. Specific expectations might include:

  - Scale up of community health worker programs to increase children's access to life saving treatment of pneumonia, diarrhea and malaria.
  - Investment in ambulance services to transport women to public health facilities.
  - Expansion of geographic coverage for bed net distribution programs.
  - Investment in data collection and analysis for targeting public health resources to the most vulnerable.

  When the budget is presented, the Committee can assess whether this priority is reflected in the budget for public health resources.

  Where a mid-term review with the Ministry is not possible, Standing Committees may also submit documentation to the Ministry on its priorities for the upcoming budget. The committee may also hold a public hearing to present priorities to the media, maternal and child health oriented-NGOs, and advocacy groups.

- **Reviewing budgets:** Once the budget is presented to Parliament, it is important for the Committee to assess the funding for resources critical for child and maternal health. Where there are programs with dedicated budget lines (i.e. malaria or HIV/AIDS) this entails the Committee assessing:

  - Has funding risen, fallen or stayed the same? A basic level of assessment is whether or not funding is increasing. Understanding historical trends is important for the Committee to assess whether the budget reflects its priorities.
  - How is the program funded relative to other health priorities? While allocations may increase, it is important for the Committee to assess these program funding levels relative to other health programming.

- What are the assumptions on which the budget allocations were made? Assumptions for health funding levels may include issues such as:
  - Coverage: programs may not cover the entire country or population, but may target specific areas or segments of the population. The committee should know these assumptions.
  - Donor investments: Donor funding for priority health services may or may not be reflected in the budget. It is important for the committee to understand what investments are being made domestically and what is being funded by donors. If there is low domestic investment in priority programs, what are the assumptions of donor support?

The challenge of monitoring budgets for child and maternal health is that many of the public health interventions to reduce preventable deaths are not reflected in specific line items. This requires that the Standing Committee review the entire health budget through the lens of this issue. The Committee should pay particular attention to:

- Community Health Workers: Community health worker programs have contributed to the reduction in preventable deaths in several countries. The committee can review the budget to make sure that such programs are expanded.
- Primary health care: The ready access to primary health care facilities is important for reducing preventable deaths. The committee should review the budget to assess primary health care resources and availability relative to more sophisticated health care. Urban rural disparities in resource allocation (both human and financial) also prevent equitable access.
- Ambulance services: Services that enable women to get to medical facilities to deliver their babies has proven to reduce preventable maternal and newborn deaths.
- Family planning programs: Investments in family planning can contribute to reducing both maternal and child deaths.

Where Standing committees have the powers to review budgets, this analysis can be provided by committee staff, parliamentary budget offices or by partnering with maternal and child health oriented NGOs or think tanks. The results of this analysis can inform the committee's response to the Government's budget proposal. In countries where standing committees do not have the formal powers to review budgets, it may be still possible to conduct the analysis and partner with NGOs to highlight the needs for child and maternal health funding priorities.

Monitoring budget implementation: Once the budget is approved by Parliament, the Standing Committee plays an important role in monitoring how funds are being spent. In some countries, the Ministry of Finance puts out regular reports on budget execution, while in other countries it may be necessary to request budget updates from the Ministry of Health. Factors that the Committee should consider in monitoring budget execution include:

- Efficiency. Monitoring budget performance includes an assessment of how the level of performance relates to the amount of funding required. A large investment for low return does not represent an efficient use of resources. The standing committee should inquire about the efficiency of program implementation.
- Timely execution. The committee should monitor how evenly funds are being spent. It is often the case that spending levels are low in the beginning of the year and then accelerate in the latter half of the year. While this likely relates to the entire public health sector, it will necessarily impact health funding. The committee can be asking why spending is slow and where necessary, support the Ministry to advocate with other government institutions (Ministry of Finance, Treasury, Procurement

bodies) for more even spending. The mid-term budget review discussed above is another method for engaging in dialogue with the Ministry on budget execution.

- Internal controls. The committee can monitor the effectiveness of spending by promoting strong internal controls within the public health sector. The leakage of funds – whether through mismanagement, inefficiencies or corruption – reduce the resources available for child and maternal health. To promote internal controls, the committee can:
  - Inquire about Ministry systems and structures to promote accountability. The committee can ask: does the Ministry have an internal audit function? Is it sufficiently funded? What are the weaknesses the Ministry is seeking to address?
  - Monitor government audits of the health sector. The committee can ask: how is the Ministry seeking to address audit findings? How do the audit findings impact priority services?
- Total expenditures. The annual budget allocation to health is often not fully expended. Lower than expected budget execution rates can result from several factors that the Standing Committee can monitor. These include:
  - Weak management and budget control. Low expenditures can result from weak management and oversight. The ability to accurately estimate required funding levels and implement health programs requires capacities at the national, subnational and facility level.
  - Funding delays. Delays in the transfer of funds to the health sector – from the Ministry of Finance or Treasury – can affect spending levels. If funding is delayed, it can be difficult to fully expend resources over a shorter period of time.
  - Procurement delays. In some countries, institutions outside the health sector manage major procurements, for equipment or pharmaceuticals. Delays in procurements can affect the ability to spend funds. The committee can inquire about the causes of these delays and help the Ministry to advocate for timely procurements.

It is also important to monitor budget execution within the budget lines. Are there areas where expenditures exceeded budgets? Are there areas where budgets exceeded expenditures? The committee should ask the Ministry to explain these discrepancies.

Section 3: Tools for Parliamentary Committee Oversigh

Oversight is a critical function of an effective Parliament, and to be successful must be deliberate, planned and well-executed. As with many areas, the plenary is often too cumbersome for undertaking the detailed plans and activities involved in effective oversight, and so the main actor in the oversight process is the committee.

Cross-cutting nature of health programming oversight. However, it is important to realize that the committee and its members are not alone, and these are numerous groups inside and outside of Parliament that have resources and expertise that can be accessed by the committee. Parliamentary budget offices and research departments often contain experts that can be seconded to the committee for a period, especially if committee support staff are not subject matter experts in areas such as health policy and finance. Due to the interlinked nature of child and maternal health responses, other standing committees are a potential resource to be consulted. Outside of Parliament, civil society groups and community groups are a valuable source of information and expertise and in most cases, are eager to interact with Parliamentary committees and its members.

Authority to conduct oversight

The authority to conduct oversight by parliament is usually established at two levels: the Constitution will speak to the ability of the Parliament as a whole to oversee the plans and programs of the Executive, while such documents as the Rules of Procedures will dictate exactly how that oversight can take place. Together these documents address such questions as:

- Are Ministers and other senior members of the Executive ratified by Parliament?
- Can Parliament compel testimony from Ministers and Ministerial officials?
- Does the national budget need approval from Parliament?
- Does the Parliament have access to credible information relating to government activities and performance (departmental performance reports, public accounts, etc.)?
- To what extent can Parliament make changes to key legislation, including the budget?

In many developing and post-conflict countries the lack of clarity in Parliament's authority, as well as an incomplete understanding of these authorities by various actors can lead to conflicts, with the Executive claiming Parliament is exceeding its powers, and Parliament feeling too constrained in their ability to properly undertake its responsibilities. In this way, oversight can be a defining issue in the balance of power in the Executive-Legislative relationship.

Tools for oversight by committees

In most cases, oversight on a certain issue will be the focus of a sectoral committee – such as health, or natural resources – and budget committees. Oversight on child and maternal health programs presents a special challenge, as the Health Committee may be best situated to lead the effort, but reducing child and maternal mortality also encompasses investments in infrastructure, sanitation, and other important areas, and therefore other committees, dealing with rural and urban development, for example, need also to be involved.

Regardless of which committee is leading the effort in child and maternal health oversight, there are various tools of oversight including ministerial briefing sessions, ministry budget analyses considering strategic plans and annual reports, and public hearings. Common tools for oversight at the Committee level include:

- Ministerial Performance Reports
- National Budget
- Public Accounts
- Committee Hearings
- Public Hearings
- Field / Site Visits

Ministerial Performance Reports. These reports are prepared by Executive agencies on an annual or semi-annual basis. These reports should include annual progress of their sector or ministry strategy, and implementation of laws and agreements that were enacted or agreed upon. Given that committees also engage in deliberation of bills, it is important to plan and set aside sufficient time for oversight activities to include detailed discussion of annual reports. As these are usually required by Parliament, they are tabled in plenary sessions and can be the basis for questioning of Ministers and debate in the plenary, during Question Period, and within the committee's regular agenda.

National Budgets: Budgetary oversight is one of the core functions of the sectoral committees. The budget law, authorized by Parliament, details how much is allocated to each ministry and explains the policy objectives that are to be achieved by concerned ministries. Budget oversight is therefore the key tool with which sectoral committees assess government programs. For many committees and individual members the challenge is to be able to analyze and identify the specific commitments within the budget document that relate to child and maternal health. With any one issue this can be difficult; often spending and investments are presented in such a manner that sectoral and geographic distribution of funding is almost impossible to discern. With the multitude of issues falling within the EPCMD framework, this becomes even more troublesome.

As mentioned above, national budgets are usually subjected to a simple up/down vote, and therefore there is little possibility of fine-tuning the document once it reaches committee stage. Similarly, the window of time to study the budget document is limited; should the committee have multiple mandates (such as Health and Education) the leadership will have to limit its scrutiny to several specific sectors. To address both issues, the committee should integrate its work into the overall budget cycle and plan its interventions at key points, such as the initial formulation of Ministerial inputs into the budget or during the pre-budget consultation process, should one exist. In this manner the mid-year budget review also becomes a valuable tool with which to oversee the government's commitments to child and maternal health efforts.

The health sector employs several tools that tracing funds throughout the health system to determine where the funds originate and how funds are linked to their intended outcomes. These resource tracking tools – that are led by the government, often with donor support – can provide the Standing Committee with important information and data to inform their oversight.

Table 2 below describes three of the major resource tracking approaches and how they might be used by the Standing Committee.

Table 2: Major Resource Tracking Approaches

Methodology	Key Features	Questions Methodology Helps Answer	How Standing Committees Can Use for Health Oversight
National/ System of Health Accounts (N/ SHA)	• Used to determine a nation's health expenditure patterns • Describes the magnitude and flow of funds through a health system; uses expenditure as a basis • Looks at overall health expenditures, including public, private, and donor contributions • Provides standard set of tables that organizes information in an easy-to-understand manner	• Who finances health care? • How much do they spend? • Where do their health funds go? • How are the resources pooled and managed? • Who benefits from this health expenditure pattern?	• Differentiates between country and donor investments in health programming, including changing trends – key to determining country priorities • Details out-of-pocket expenses that can be a major obstacle for maternal and child health care
Public Expenditure Review	• Analyzes public sector spending against policy, efficiency, effectiveness, equity, and sustainability parameters • Focused on spending in social sectors; not limited to health • Provides policy and finance management information	• How are budgetary allocations and public expenditures, as well as services, distributed among the population? • How efficient/effective is the use of public spending to achieve the desired health outcomes?	• Cross sectoral focus aligns with the nature of effective EPCMD responses. • Highlights issues of efficiency and effectiveness that are key to oversight. • Describes service coverage
Public Expenditure Tracking Survey	• Tracks the flow of resources through the various layers of government bureaucracy • Has diagnostic purpose – to identify bottlenecks and leakages	• Where are the key impediments of public resource flows to the service providers? • What is the magnitude of these impediments?	• Highlights inefficiencies and obstacles to funding key services. • Details leakage and potential corruption

Public Accounts. The budget and related documents are important expressions of the Executive's intentions and policies; however it can be argued that the Public Accounts – usually defined in most jurisdictions as the consolidated statement of actual expenditures during the most recently fiscal year – are a much more valuable tool for oversight. The Public Accounts can be a powerful reflection of the ability of Ministries to carry out programs in a cost-effective (and programmatically-effective) manner. In many jurisdictions, the Public Accounts have been used as a way of identifying delays in project implementation, and cost overruns. The Public Accounts can also show the geographic distribution of health project funds, providing the committee the ability to verify that regional needs and priorities are matched with actual government investments.

- **Reports of the Supreme Audit Authority.** In most countries, a supreme audit authority exists, independent from the government, and often with a reporting mandate directly to Parliament. These institutions will produce audits on major government programs and expenditures, either on a pre-determined, rolling basis or in response to an expressed need or contingency. Standing committees on health often use these reports as the basis for further investigation and oversight of a health issue, and often follow-up on recommendations and findings to ensure compliance and implementation.
- **Committee Hearings.** In addition to written reports by ministries, committees may ask ministers and other government officials to explain the reports and answer questions by members of the committees. By obtaining clarifications from government officials, committees are better equipped to assess these activities. Oral exchanges in committee rooms, which are broadcast by television, enable members of Parliament to hold government officials to account for their actions. For these to be effective and credible, research and preparation are needed; relevant data should be gathered prior to calling ministry witnesses. Almost equally important is the manner in which these are conducted; committee hearings can set the tone of the legislative-executive relationship, and either build trust amongst the two branches of government or diminish it.
- **Public Hearings.** Members can supplement information received from government officials or reports with information from other sources. Most parliaments invite experts from outside government to provide knowledge and analysis. They may also want to hear the opinion of those citizens or citizens' groups who are either positively or negatively affected by a program. Parliamentary Committees conduct hearings with public officials, experts, interested parties, and the general public. Committees conduct these hearings as a form of consultation or a means of obtaining evidence.
- **Field/Site Visits.** Committees or a group of members from a committee can visit government agencies and other sites to examine details of specific administrative programs and their implementation. Site visits should include physical inspections, conversing with local citizens, and assessing the impact of service delivery. Reports should be developed for adoption by the whole committee, which contains recommendations for plenary meetings to consider. Field visits can be an important symbol of the Parliament's interest in a certain issue but also in the case of efforts to reduce child and maternal mortality, they can be a powerful tool with which the Parliament connects with stakeholders such as women in impoverished areas, who would normally not have the means and the voice to connect with lawmakers. These visits can also serve to build the network of civil society partners in the regions.


Talk Family Planning
wit ya partner
Waka go do
Family Planning

Section 4: Applying Oversight Tools to Child and Maternal Health

The following offers options to Standing Committees on how they might conduct oversight over health efforts.

Step 1: Determine how the government is addressing child and maternal health

A first step in conducting oversight is to establish how the government strategy for ending preventable child and maternal deaths is articulated. To do so, the following questions should be answered:

- **What is the scope of the problem?** Figures X and Y provide a high level assessment of the primary causes of preventable child and maternal deaths across the 25 priority countries. Additional documentation[10] is available to provide country level detail. Asking the Ministry of Health to articulate the problem, however, can be useful for the Committee to check the degree to which public health officials are collecting and analyzing timely data on preventable deaths. Can they provide updated information on vaccination coverage rates, the number of assisted deliveries, the number who sought care for fever within 24 hours of the onset of fever, and other indicators. It can also be helpful to ask the ministry where child and maternal deaths are happening; the causes of those deaths; and what segments of the population are most affected.
- **What is the strategy?** EPCMD countries are working with donor organizations to develop strategies[11] to address preventable deaths. Each donor may frame their strategy differently – it is important that these donor strategies fit within a national strategy. If there is no stand-alone strategy, the committee can ask for an articulation of the Ministry's strategy for ending preventable child and maternal deaths. Within this strategy it is important for the committee to understand the specific goals and targets of the strategy and the metrics for measuring its performance. It is also important for the committee to get the advice of technical experts in order to understand the more complex approaches to child and maternal health such as emergency obstetric care, vaccinations, and prevention of post-partum hemorrhaging etc.
- **What are the initiatives to reduce preventable deaths?** The committee should understand the specific public health initiatives designed to address preventable deaths. Some may fall under distinct vertical programming (such as malaria and HIV/AIDS), while others may be included in broader public health efforts such as expanding access to family planning or community health worker programs.

[10] USAID. Acting on the Call: Ending Preventable Child and Maternal Deaths. June 2016

[11] Ibid

More specifically, it is important for the Committee to know the details on these initiatives:

a. Geographic/demographic focus: What are the geographic or demographic targets of these initiatives? How does the target relate to the scope of the problem?

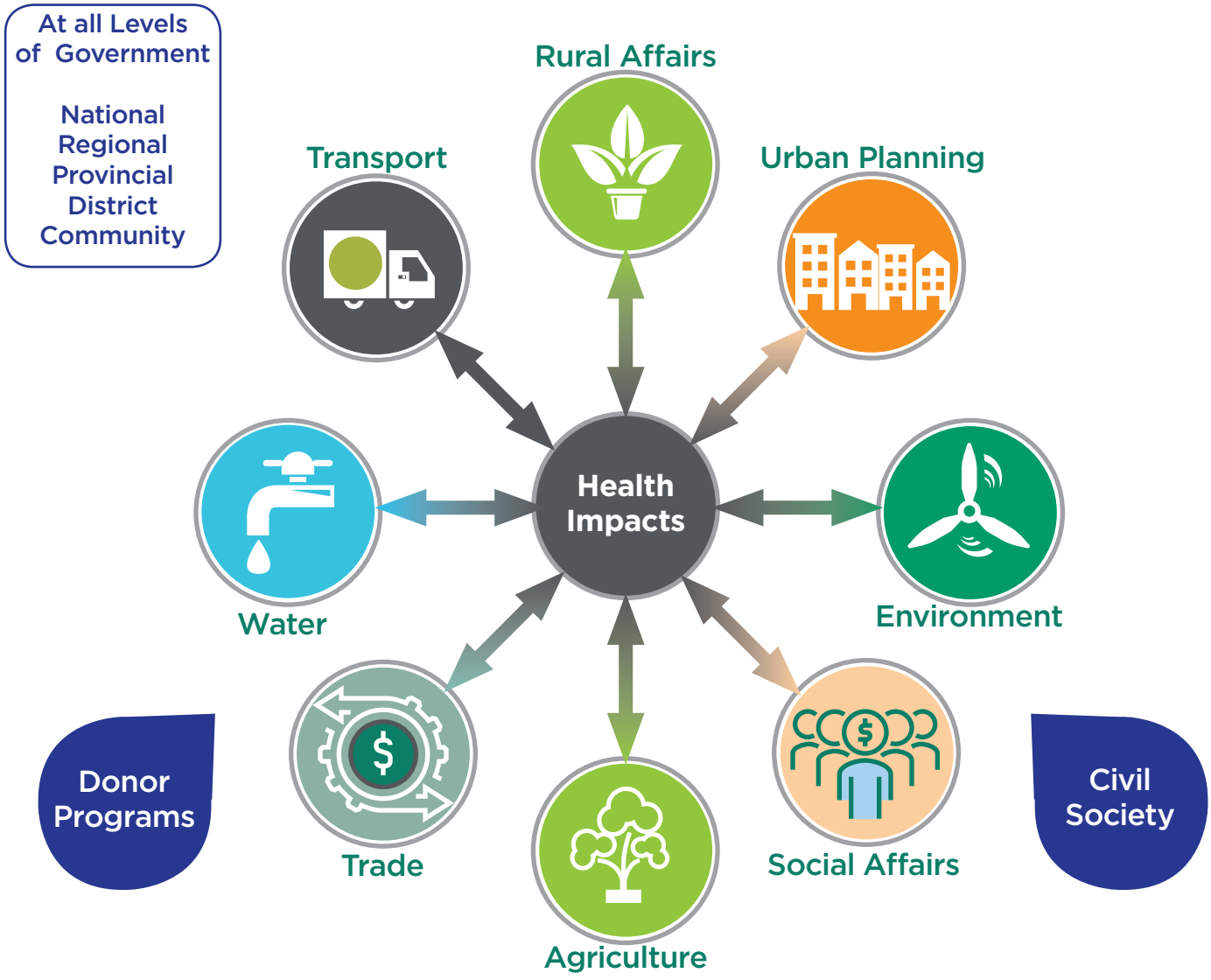
b. Performance targets: What does the Ministry expect to achieve through these initiatives?

c. Cost: What levels of resources are being directed towards child and maternal health?

Addressing the cross-cutting nature of child and maternal health impacts

As has been mentioned, there are many potential factors that reduce child and maternal mortality rates. Improvements in local roads and transportation facilities will enable families to access better healthcare; trade and agriculture policy will impact food security and quality; environmental investments could increase the quality and quantity of potable water, etc.

Mapping Potential Government Investments
that Impact Child and Maternal Health



The task for the Standing Committee on Health is to be able to measure these efforts, and that requires a concerted efforts to understand government efforts in a wide variety of areas, and at all levels of government – national, regional and local:

Committee leadership can establish several mechanisms to ensure that the cross-cutting nature of child and maternal health is recognized and measured. These include:

- **Establishment of liaison staff with other standing committees.** Health committee leadership can assign support staff to act as permanent or temporary liaison to sectoral committees to ensure that there is an awareness of current and planned investments that may affect health outcomes.
- **Inclusion of sectoral committee observers in Health committee sessions.** Similar to the establishment of liaison staff, the Chair can ensure that members and staff of relevant committees are present when the Health committee holds hearings dealing with cross-cutting issues.
- **Calling Ministers and Ministry Officials to the Health Committee.** In most Parliament there are no restrictions regarding the ability of a committee to call government ministers and officials to testify; for example, the Health committee has the same power to call the Minister of Transport to testify as the Transport committee does. To adequate assess the government total investment in child and maternal health, the committee may feel it important to call on officials from all of the ministries shown above – water, environment, social affairs, etc. In these cases, it is important to liaise with the other relevant committees, both as a courtesy and as matter of practical coordination of effort.

Step 2: Oversight planning

For committees to be effective in improving child and maternal health outcomes it is imperative that committee leadership create long-term oversight plans that focus on one or more objectives that can be measured and accomplished. Systematic planning of oversight activities allows members and staff to be well prepared and effective, to avoid planning on an ad hoc basis, and most importantly, to allow for inclusion of other stakeholders in the process, such as government agencies, audit institutions, and independent experts such as civil society organizations, university professors, researchers, and technical/medical experts.

- **Drafting health oversight activities:** A committee oversight action plan of the working group may include the following elements:
  - Designation of Responsibilities: The plan might focus on oversight activities of the committee as a whole, or establish a sub-committee specifically focused on child and maternal health. In order to manage its workload more efficiently, committees usually establish sub-committees or working groups to handle certain issues. Working groups and or sub-committees may be established to review a draft law or oversee implementation of laws or a government policy. Often committees conduct more than one oversight activity, therefore members are split in working groups. The working group should be comprised of diverse members, with the composition of the working group/sub-committee is based largely on the issue that is being overseen and the background and interest of members.
  - Selection of Oversight Focus: Sections 2 presents three dimensions of oversight where committees can engage: 1) oversight of policy formulations; 2) policy implementation; and 3) budgets. The oversight plan should break out committee actions over these three dimensions.

- Selection of Oversight Tools: Section 3 presents numerous oversight tools at a committee's disposal. As described, some of these can include: 1) field visits to closely observe the implementation of a law or policy, or the functioning of an institution; 2) inviting government officials or heads of independent institutions to report to the committee or the working group; and, 3) conducting oversight hearings.

Given Parliament's responsibility in the areas of lawmaking, oversight, and representation, the Chamber and the Committee need to strategically plan their work for the year. This needs to happen at the beginning of each year. Systematic planning of oversight activities allows members and staff to be well prepared and effective, to avoid planning on an ad hoc basis, and most importantly, to allow for inclusion of other stakeholders in the process, such as government agencies, audit institutions, and independent experts of civil society organizations.

The period of the oversight plan should be tied to the overall parliament calendar, which typically has four distinct phases:

October – December: Fall Budget Session

January – March: Winter Recess

April – June: Spring Legislative Session

July – September: Summer Recess

Although there are many variations on this schedule, this is the most common pace of parliamentary activity. Overlaid on this calendar are the typical components of oversight plans:

- Initial planning and prioritization
- Budgetary oversight activities
- Legislative oversight activities
- Assessment of oversight plan and preparation for upcoming year

The following section outlines an illustrative workplan for how a Standing Committee might develop an annual oversight plan focused on government efforts to reduce child and maternal mortality. The Annex provides a template for documenting the plan details and monitoring implementation of the plan.

Activity 1: Planning and Prioritization

Task 1.1: Initial Planning

Upon the return of the Parliament in Fall session, the committee chair initiates the process of drafting oversight plans by convening its members and beginning the process of prioritizing the areas within child and maternal health in which they are to focus their efforts:

- Is current data available relating to child and maternal health?
- What is the coverage area for access to care? Are there significant gaps or areas where the health system is not performing? ?
- Within each, do the indicators show certain key causes are dominant?
- Has the government expressed its commitments and priorities with respect to child and maternal health?
- Are there civil society groups active in areas relevant to this issue? Is there a database of active civil society stakeholders?
- Who are the relevant Ministries that are dealing with this issue?

Asking these questions will determine the priority areas for the committee.

Task 1.2: Establishment of Sub-committees (optional)

It is often efficient to establish sub-committees to focus on various aspects of oversight; usually oversight committees establish sub-committees to examine issues from a *budgetary* perspective as well as from a *legislative/regulatory* perspective.

This may be appropriate in those parliaments where there is a practice of working in sub-committees. It is also possible to create and implement an oversight plan as a whole committee.

Task 1.3: Coordination with Committees and Parliamentary Leadership

Once completed, the draft plan should be circulated to the leadership of the Chamber, Secretariat and other Committees. The plan needs to be discussed and finalized by the Administration Board and Chairs of the Committee. This is critical as inevitably the task of overseeing programming to reduce child and maternal mortality will involve more than just the Health Committee, and will require the coordination of several other committees. Likewise the oversight plan will require resources from within the Secretariat – such as the Parliamentary Budget Office, and Office of legislative Research – and therefore integrating them into the plan will be critical. Lastly, keeping the Speaker and his staff informed will ensure that permission to travel for field visits, and time in the plenary to present and discuss findings will be provided.

Activity 2: Budgetary Oversight

Task 2.1: Scrutiny of the National Budget

2.1.1. Research and data collection/analysis. Determine the existing available data on the priority issue – i.e., can we determine past and current investments in malaria eradication? Is there recent resource tracking data available? If so, do we have staff or access to outside experts who can analyze the incoming budget to determine planned government expenditures in malaria eradication?

2.2.1. Civil society interactions. Engage civil society groups active in maternal and child health policy development and health policy advocacy. Do they have access to other data? Were they consulted by the government during the process of budget formulation at the ministry level?

It is important to recognize that grassroots organizations outside the capital may have greater access to data and a nuanced understanding of health service provision.

2.2.2. MoH/MoF testimony. Supplemented with data and outside advice, the committee can effectively engage officials of relevant Ministries on the budget as it relates to investments in EPCMD. It is important to recognize that senior officials may have greater insight into budget development and priorities, while those at the subnational level (region, district) may have greater understanding of how funds are actually spent.

2.2.3. Report on the National Budget. The output of this activity will be a report, submitted to the plenary, on their assessment of the national budget as it pertains to, in this case, the eradication of malaria. Included in this report would be the following:

Level of investment: does the proposed budget represent an increase or a decrease in investment in the eradication of malaria and other drivers of preventable child and maternal death? What are the long-term trends in this area?

Areas of focus: are the focal points of the investments appropriate with respect to the key drivers of preventable child and maternal death? Is the geographical distribution of investment as portrayed in the budget appropriate? Does the budget represent accurately the government's previous and current national health commitments?

Task 2.2: Scrutiny of Public Accounts

2.2.1. Scrutiny of Public Accounts. As the Public Accounts are released – usually at the end of the government fiscal year – the committee will assign staff and members to examine the spending on issues related to child and maternal health. This may include a review of findings from a malaria control program or the purchase and distribution of medical equipment for safe deliveries.

2.2.2. Report on the Public Accounts. The committee will develop a report on the government's investment in child and maternal health for the previous year. These reports should highlight the percentage of expenditures as compared to the government stated commitment. Usually the Public Accounts can highlight the completion rates of major projects, which will lead to the identification of existing and potential problem areas. Development projects which are behind schedule or experiencing cost over runs can then be designated as the focus of greater scrutiny in the form of additional hearings and field visits. The committee, in coordination with the leadership of Parliament, will release the report to both internal stakeholders as well as civil society and the wider public.

Task 2.3: Scrutiny of Budget Implementation and Government Performance

2.3.1. Examination and Hearings on Ministerial Performance Reports. As the Ministerial Performance Reports are tabled, the committee will review them and call Ministry officials to explain the progress of various government programs related to child and maternal health. The testimony will feed into the planning of field visits and other activities at the local level. The Committee can request that Ministerial Performance Reports use of clear and consistent metrics (see Step 4 below) for different key issues to allow for more effective monitoring of program performance.

2.3.2. Field Visits to Clinics and Health Center in Districts. A delegation from the committee will execute a series of field visits to the districts, attempting to observe first-hand the progress – or lack thereof – of government efforts as articulated in the budget and ministerial performance reports. Committee staff will liaise with both MoH and district government officials prior to the visits, giving them notice of the purpose and focus of the visits and to assist in making the appropriate arrangements, including security if required.

2.3.3. Town Hall Meetings in Communities with High Maternal and Child Morbidity. As part of the field visit, it will be important to hold town hall meetings in relevant communities; not only will this provide powerful and compelling testimony from affected groups, it will send a strong signal that the center is aware of, and responding to, the needs of the local community and the quality of care being offered.

2.3.4. Report on Government Efforts. As with each component of this plan, it is critical that a report is developed that highlights the committee's efforts at scrutinizing the government's efforts at implementing its response to child and maternal health issues. In accordance with the practices of many legislatures, the committee chair will liaise first with the Speaker's office and the Secretariat to coordinate the release of the report publicly.

Activity 3: Legislative Oversight

Efforts to undertake budgetary oversight on a specific issue are dictated by several events throughout the year, such as the tabling of the national budget and the release of various performance reports. Legislative oversight can be undertaken throughout the year, and is not just contained within the Spring sessions, even though these sessions are often referred to as the legislative session.

Task 3.1: Assessment of Pending Legislation

3.1.1. Meetings with Speaker's Office/Secretariat. The committee chair will meet with the Speaker's office and the Secretariat to determine the status of any pending legislation that may affect the effort to improve child and maternal health outcomes. This could involve legislation that enables spending and investment or changes in government processes and practice.

3.1.2. Meetings with MoH Officials. Following the meetings with the Parliamentary leadership, the committee will meet with MoH officials to confirm the government's legislative agenda as it relates to child and maternal health, and recommend approaches which will assist in the passage of required legislation in this area.

3.1.3. Recommendations for Pending Legislation. The committee will draft a short report for the attention of the leadership of Parliament with recommendations related to the passage of pending legislation related to the eradication of malaria.

Task 3.2: Assessment of Implementation of Legislation

3.2.1. Examination and Hearings on Ministerial Performance Reports. As with the budgetary oversight, the committee will examine the relevant ministerial performance reports and hold hearings to collect testimony on the issues within the report – primarily dealing with the implementation of legislation that has an impact on priority health issues.

3.2.2. Field Visits to Selected Sites. Field visits will be conducted that support the initial findings of the scrutiny of ministerial performance reports as they relate to the implementation of legislation.

Activity 4: Annual Oversight Report

Task 4.1: Development of Annual Report.

At the end of the Spring session, the committee will consolidate the year's work and produce an annual oversight report, highlighting the performance of the government in committing to, and realizing progress in, the fight to end preventable child and maternal deaths.

Task 4.2: Presentation to Plenary.

The committee will table the annual report in the plenary, which can then be the subject of debate, and the focus of questioning Ministers and officials, and during regular Question Period sessions. To promote a spirit of collegiality, the report should be provided to MoH prior to its public release to ensure that senior officials have the ability to prepare appropriate responses to the issues raised in the report. The report will be reviewed by public health experts who have been assisting the committee with complex technical and medical oversight.

Task 4.3: Media Release and Distribution to Stakeholders and Public.

The release of the annual report should be coordinated with the leadership of Parliament to ensure maximum public impact. Committee staff will work with the Public Relations office of the Secretariat and office of the Speaker to produce media releases, press conferences and other media products for distribution. Members of the committee should be made available for media appearances and be provided with speaking points and summary of the report to ensure common messaging throughout.

Parliamentary oversight activities are a good opportunity to inform the public about the work of the Parliament and the work of institutions in general. Therefore, the Committee should respect the principle of transparency and ensure openness towards the media and the public. While citizens should be able to see their Members voting and approving legislation, the Parliament should also make sure the public is informed about activities of Members ensuring proper implementation of laws.

Step 3: Engaging partners

Engaging civil society organizations and independent experts: Apart from an invitation to participate in a public hearing, CSOs and independent public health experts can be engaged in all stages of oversight, and this is certainly applicable to this issue area. In most jurisdictions there are CSOs, both domestic and international, actively engaged in the issues surrounding child and maternal health, and therefore the working group, assisted by the support staff, should as a priority 'map out' these CSOs and outside experts at the early stages of the work-plan. Inclusion of independent experts and civil society organizations increases the credibility of findings and recommendations revealed by the committee. Also, civil society organizations work on the grass root level and can better verify the status of laws or implementation of health-related projects.

Step 4: Applying metrics for child and maternal health oversight

Ministries of Health, the World Health Organization, USAID and USAID-implemented projects use metrics designed to measure both maternal mortality and child morbidity, access to services, coverage and quality of care to measure EPCefforts to reduce child and maternal portality. These metrics can be used throughout the design and implementation of the Committee's oversight plan to:

- Craft questions for MOH officials and civil society during meetings and hearings;
- Request data from MOH officials and CSOs;
- Identify areas for possible investigation and review of public accounts; and
- Create routine reporting with MOH to monitor progress of child and maternal health programming.

As described in Section 2, data collection systems are often weak resulting in limited information on the causes of maternal and child health. The following are examples of indicators Committees can use to monitor the performance of government programming. It is important to note that this information may not be available because data is not being collected. Also, many of these metrics derive from the WHO or household surveys that are not updated regularly. For example, the Demographic and Health Surveys (DHS) is taken every five years. Whether or not the information is available, as a part of the its oversight mandate, the Committee can request it. It is important for the Committee to know what information, or lack of information, the Ministry is using to make policy decisions.

Key metrics include both the causes of deaths as well as the coverage of programs to improve maternal and child health.

A. Maternal Mortality Indicators

General Indicators:

- Maternal mortality ratio
- Maternal mortality rate
- Proportion of maternal deaths among all deaths of females of reproductive age

Hemorrhaging:

- Percent of live births attended by skilled health personnel
- Population coverage of community health worker programs
- Percent of community health workers or staff trained in the use of uterotonics
- Blood storage availability

Sepsis:

- Percent of live births attended by skilled health personnel
- Availability of screening tools for sepsis detection
- Access to sanitation and clean delivery sites
- Postnatal care for mothers and babies within two days of birth

Hypertension:

- Percent of live births attended by skilled health personnel
- Availability of magnesium sulfate
- Percent women aged 15-49 years attended by a skilled health provider during pregnancy

B. Child Death Indicators

General Indicators:

- Under-five child mortality, with the proportion of newborn deaths
- Stillbirth rate
- Neonatal mortality rate per 1000 live births / Infant Mortality Rate

Pneumonia:

- Percent of children <5 with symptoms of pneumonia taken to appropriate health provider
- Percentage of babies exclusively breastfed at 1 month and 6 months of age

Diarrhea:

- Percent of children <5 with diarrhea treated with oral rehydration salts
- Percentage of households with hand-washing materials in dwelling/yard/plot

Malaria:

- Coverage of bednet/indoor residual spraying program
- Percentage of households with at least one mosquito net
- Percent children < 5 years sleeping under insecticide-treated bed nets

Preterm Birth:

- Number of newborns weighing less than 2,500 grams at birth
- Percent of infants <6 months exclusively breastfed


Manage or refer for further evaluation if any complication is detected
Register the mother on ANC registry
World Health Organization
2013

Section 5: Country-level Efforts to Reduce Child and Maternal Mortality

The following presents examples of how EPCMD countries have been able to achieve success in ending preventable child and maternal deaths.

Bangladesh

The Government of Bangladesh has pledged to end preventable child deaths by scaling up interventions proven to address preventable causes of child mortality, with a special emphasis on newborn survival. The health, nutrition, and population sector program of Bangladesh has adopted a national strategy for maternal health focusing on Emergency Obstetric Care (EmOC) for reducing maternal mortality, early detection and appropriate referral of complications, and improvement of quality of care. Since 2001, the government has embarked on program to retrain existing government community health care workers as Community Skilled Birth Attendants (CSBA) as the primary operational strategy for achieving the 2015 target of 50% skilled attendance at births. Bangladesh achieved a 5% annual rate of reduction in maternal mortality since 1990 despite poverty and other challenges. Economic growth, decreased fertility, increased use of facilities, improved roads, and more focus on girls' education has all contributed to Bangladesh's progress in decreasing maternal mortality.

Ethiopia

Due to the government's Health Extension Program (HEP) modern method contraceptive use increased in Ethiopia from 15% to 40% in the last 10 years, and the total fertility rate declined from 6.4% to 4.8%. The HEP is a network of 38,000 frontline health workers stationed at 15,000 health posts throughout the country, and 3 million volunteers (the Health Development Army) who bring health information to households. A recent survey found overall satisfaction with HEP services to be over 60%, with family planning services rated the highest.

Kenya

The Government of Kenya has committed to providing free maternity services throughout the country, and in 2014 Kenya's First Lady launched the "Beyond Zero" campaign to mobilize additional resources towards ending preventable child and maternal deaths. Subsequently, mortality rates for children under age five have dropped by 30% from 72 to 54 per 1,000 live births since 2009. Through the Ministry of Health's technical working groups and various inter-agency meetings, key development partners align their investments to reduce duplication of efforts and increase efficient use of resources. Those partners include: the UK Department for International Development (DfID), the United Nations Population Fund (UNFPA), and the United Nations Children's Fund (UNICEF). In addition, Kenya has invested in high-impact, life-saving interventions, such as use of insecticide-treated nets (ITN) to protect children from malaria.

Malawi

Nearly a third of Malawi's population lives in severe poverty, but Malawi met its MDG 4 target as early as 2013 despite having the world's highest recorded rate of babies born prematurely. Malawi's achievement of MDG 4 was driven by its early adoption and effective implementation of key evidence-based policies and programs to address the major causes of child deaths. Sharp increases in national coverage for treatment and prevention of childhood pneumonia, diarrhea, and malaria, and effective implementation of programs to reduce child malnutrition, were key contributors to the country's success. Malawi prevented an estimated 280,000 child deaths between 2000 and 2013 through scale-up of these and other high-impact child health interventions.

Nepal

Nepal's 50,000 Female Community Health Volunteers (FCHVs) have played an integral role in improving RMNCH and nutrition intervention coverage. FCHVs deliver services, engage communities with the formal health system, and promote healthy behaviors and practices in households and communities. These strategies have helped reduce the deaths of children under age five by more than 50% in the last 15 years. For example, to prevent deaths from umbilical cord infection, one of the major causes of neonatal deaths in Nepal, FCHVs contribute to increased application of chlorhexidine to the cord during home visits immediately after birth. This life-saving intervention has been scaled up to 49 of the 75 planned districts, reaching approximately 45 to 50% of newborns.

Rwanda

Rwanda implemented a very effective public education campaign on the importance of family planning, antenatal care, and health center deliveries which have been supported by a system of fines imposed on women who fail to attend antenatal care and deliver in health care centers. To combat the practice of traditional birth attendants Rwanda integrated them into village community health systems that have allowed their practices to be replaced by skilled, trained professionals. Rwanda also instituted a community health insurance scheme that covers 90% of the cost of ambulance transfers and has issued CHWs with specially programmed mobile phones so they can contact health facilities for referral. To make accidental home births less likely Rwanda increased availability of 'waiting wards' for expectant mothers at rural Rwandan health centers thereby enabling the swift diagnosis of complicated deliveries. As a result of these initiatives, Rwanda has achieved MDG 5 due in part to a national health insurance that makes maternity care affordable.

Annex: Sample EPCMD Oversight Plan

Activities and Tasks	Quarter 1 Month			Quarter 2 Month			Quarter 3 Month			Quarter 4 Month			Output	Annual Key Performance Target(s)
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug		
Activity 1: Planning and Prioritization														
Task 1.1: Initial Planning													Committee Oversight Plan with defined EPCMD focus	% tasks completed
Task 1.2: Establishment of Sub-committees (optional)													Subcommittee leadership and TOR	# subcommittee meetings
Task 1.3: Coordination with Committees and Parliamentary Leadership													Regular meeting agenda	# meetings between committee and leadership completed
Activity 2: Budgetary Oversight														
Task 2.1: Scrutiny of the National Budget														
2.1.1. Research and data collection/analysis													Research reports completed	# MPs using research reports
2.1.2. Civil society interactions													Meetings with CSOs	# of CSO committee meets
2.1.3. MoH/MoF/Other Ministry testimony													Meetings with MOF	# of meetings with MOF
2.1.4. Report on the National Budget													Committee report	# of recommendations on budget
Task 2.2: Scrutiny of Public Accounts														
2.2.1. Scrutiny of Public Accounts													Meetings on audit reports	# of meetings on audit reports
2.2.2. Report on the Public Accounts													Committee report	# of recommendations on audit
Task 2.3: Scrutiny of Budget Implementation and EPCMD Program Performance														
2.3.1. Examination and Hearings on Ministerial Performance Reports													Meetings on EPCMD performance	# meetings on EPCMD performance
2.3.2. Field Visits to Clinics and Health Centers in Districts													Field visit	# of field visits
2.3.3. Town Hall Meetings at Community level													Town hall meeting	# of local organizations attending town hall meeting
2.3.4. Report on Government Program Efforts													Committee Report	# of recommendations
Activity 3: Legislative Oversight														
Task 3.1: Assessment of Pending Legislation														
3.1.1. Meetings with Speaker's Office / Secretariat													Meetings with Speaker/Secretariat	# meetings
3.1.2. Meetings with MoH Officials													Annual Legislative oversight plan	# of EPCMD policies reviewed
3.1.3. Recommendations for Pending Legislation													Committee report	# of recommendation on EPCMD policies
Task 3.2: Assessment of Implementation of Legislation														
3.2.1. Examination and Hearings on Ministerial Performance Reports													Hearing on proposed legislation	# of meetings
3.2.1. Field Visits to Selected Sites													Field visits	# of local organizations attending field visit meetings
Activity 4: Annual Oversight Report														
Task 4.1: Development of Annual Report													Committee Report	% of oversight tasks completed
Task 4.2: Presentation to Plenary													Committee Report	# MPs present
Task 4.3: Media Release and Distribution to Stakeholders and Public													Press Release/Conference	# of media reports on committee report

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About HFG

A flagship project of USAID's Office of Health Systems, the Health Finance and Governance (HFG) Project supports its partners in low- and middle-income countries to strengthen the health finance and governance functions of their health systems, expanding access to life-saving health services. The HFG project is a six-year (2012-2018), $209 million global health project. The project builds on the achievements of the Health Systems 20/20 project. To learn more, please visit www.hfgproject.org.

The HFG project is led by Abt Associates in collaboration with Avenir Health, Broad Branch Associates, Development Alternatives Inc., Johns Hopkins Bloomberg School of Public Health, Results for Development Institute, RTI International, and Training Resources Group, Inc.

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