at the genocide that overtook Rwanda in 1994. "We believed in the promise of our future", she said. The maternal health community, a vital part of the movement for women's and children's health embodied in the UN Secretary-General's *Every Woman, Every Child* initiative, also believes in the promise of a future for women and mothers. This manifesto is one small contribution towards that future.

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AL and GC cochaired the Global Maternal Health Conference 2013, which was convened by the Maternal Health Task Force, the flagship project of the Women and Health Initiative at the Harvard School of Public Health and Management and Development for Health, a Tanzanian non-profit organisation.

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Independent global accountability for NCDs

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Promises are easy to make, but harder to deliver and even more difficult to monitor. In the political declaration from the UN high-level meeting on non-communicable diseases in September, 2011, heads of state made many welcome promises.[1] But how should the global community ensure that these commitments are adhered to? How can all partners who support the political declaration be mobilised to ensure that tangible progress is being made on the commitments? In one word, the answer lies in accountability. Only by establishing a rigorous, independent accountability mechanism will we be certain that the goal of a 25% global reduction in mortality from non-communicable diseases (NCDs) by 2025 (the 25 by 25 goal) is on track to be met.[2] But what does the idea of independent accountability mean?

In this Comment, we propose an NCD accountability mechanism based on recent global experience, including: the Millennium Development Goals;[3] Every Woman, Every Child;[4] and the reporting framework developed for the 2001 Declaration of Commitment on HIV/AIDS.[5] Our proposal goes further than the WHO Global Monitoring Framework, which covers only voluntary global targets and indicators.[6] However, progress is also dependent on a robust global NCD architecture to mobilise all partners to ensure that they are accountable.

There are three essential principles to consider when devising an effective system of independent accountability. First, there must be a shift from the concept of mutual accountability to one of independent accountability. Mutual accountability seems an attractive idea—each of us holding the other accountable for what we say and do. But, too often, mutual accountability translates into mutual appreciation, since each party has an incentive to do what it can to alleviate pressure on itself by being less rigorous in its evaluation of others. This tendency reduces the force of accountability. One solution is independent accountability—ie, the creation of a mechanism whereby an independent group is mandated and authorised to gather and analyse data to assess progress on commitments, and then to submit its report and recommendations to the highest possible multilateral authority.

The second principle concerns the accountability framework. Commonly, accountability is equated with so-called M and E—ie, monitoring and evaluation. While both of these processes are important, they do not constitute an effective, independent accountability framework, since they leave out crucial aspects of what accountability should mean. A better model has emerged from the human rights community and is based on three activities: monitoring, review, and remedy. Monitoring means careful tracking of progress based on a predefined set of targets and indicators. Review means a participatory and democratic process whereby all parties can review the information derived from monitoring. (By participatory, we mean inclusive of civil society, academia, and the private sector—appropriately regulated and with a firewall to separate the private sector from policy and strategy development[7]—in addition to politicians and policy makers.) Remedy means taking action on the findings that emerge from the monitoring and review processes and accelerating progress.

The third principle concerns the targets and indicators to underpin an accountability framework. Indicators need to be measurable and sensitive to changes in policy and practice. The experience from the women's and children's health community is that a small group of indicators is more helpful than a long and inclusive list (the independent Expert Review Group on Information and Accountability for Women's and Children's Health uses 11 indicators[8]). We have proposed a small subset—one goal and five targets—of the WHO voluntary targets and indicators as priorities for monitoring.[9,10]

Within countries, accountability begins with the responsibility of governments to provide leadership to promote the health of its people on the basis of sound health information—notably, data about results and resources. Three aspects of national leadership require ongoing monitoring: explicit support by heads of state and government for NCD prevention and management, measured by the establishment and implementation of nationally agreed plans, goals, and targets; formation of an adequately staffed and funded NCD unit within each ministry of health to implement the national NCD response; and creation of a national multisectoral group beginning with a few key sectors to stimulate and coordinate action and reporting. The HIV/AIDS response is now based on the so-called three ones—one national plan, one coordinating body, and one monitoring system—which provides an excellent model for NCDs.

A key step is the creation of national NCD commissions (or the equivalent) to monitor, review, and remedy areas that need increased attention. The commissions could be modelled on national HIV/AIDS commissions, which have successfully led coordinated multisectoral responses and are usually situated in the office of the head of government. National NCD commissions will need an independent chair and should include several NCD experts to represent the interests of NCD partners. Appropriate protection from vested interests is essential. The monitoring and review processes of the commission must be transparent and independent of government agencies, reporting regularly to the national parliament. Where national health commissions already exist—eg, for HIV/AIDS, and women's and children's health—their mandates could be expanded to cover NCDs.

National NCD surveillance systems are key to the monitoring framework; mortality data from civil registration systems or verbal autopsy programmes are central to monitoring progress towards the overall NCD mortality reduction goal. Population surveys, preferably nationally representative with adequate sample sizes for detecting important age, sex-specific, and socioeconomic trends in risk factors, are required at regular intervals and at least every 5 years. The WHO STEPwise approach to chronic disease risk factor surveillance is ideal for risk factor surveillance.[11] Surveillance systems for NCDs will be more sustainable if they are incorporated into strengthened national health information systems.

A challenge for countries is to align health spending with the scale of the NCD challenge. The most sustainable method for raising additional revenue for NCD prevention and management is to develop a health promotion fund (or the equivalent) by substantially and regularly increasing the price of tobacco, alcohol, and unhealthy food products through large and phased increases in taxes. Countries dependent on aid assistance to progress the NCD agenda need to ensure that NCDs are on their priority list of requests for assistance, part of their national health and development plans, and incorporated into their UN Development Assistance Frameworks.

Accountability at the global level is equally vital. The figure shows the relationship between national and global accountability mechanisms. Two key aspects of global accountability are reporting of national progress and assessment of the performance of international stakeholders. International cooperation for NCDs requires independent monitoring, including: the level of priority and funding given to NCDs by WHO and key development agencies, foundations, and

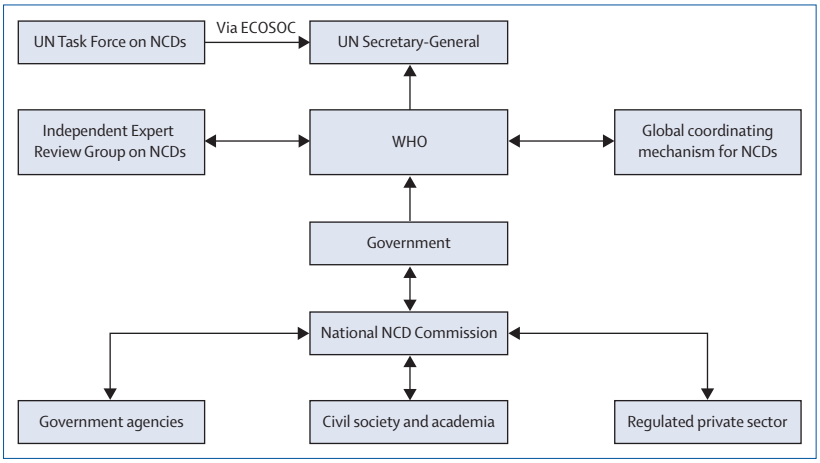

Figure: **Global and national independent accountability pathways**
NCD=non-communicable disease. ECOSOC=UN Economic and Social Council

donor countries; the way in which donors fulfil their commitments to aid effectiveness and track official development assistance for NCDs; and how donor governments address the determinants of poverty and poor health that are their responsibility.

A prerequisite for independent global accountability is the strengthening of global NCD governance. Political leadership on NCDs has increased since the UN high-level meeting. However, it has not been accompanied by the global coordinated approach necessary for the unique scale, complexity, and urgency of the NCD epidemic. By contrast, innovation and shifts in global governance have been made over the past decade to great effect in the global responses to HIV/AIDS and women's and children's health.

At the UN level, the role and leadership of WHO—as the leading technical agency for health—remains paramount. However, because of the multisectoral nature of NCDs, the expertise and knowledge of the whole UN system must be harnessed. Substantial progress has been made in this regard, with NCD focal points of UN agencies meeting on a regular basis since the UN high-level meeting. In December, 2012, the ad-hoc UN agency meeting reached consensus on the need to formalise this group into a UN Task Force on NCDs that will report to the UN Economic and Social Council.

In addition to collaboration and coherence across the UN system, institutional arrangements are required to convene and mobilise all relevant sectors in the global NCD response. The UN political declaration recognised that the burden of NCDs is too great for one sector to solve alone, and called for multisectoral action and a whole-of-society approach. A formal mechanism is required to bring together all relevant sectors—including multilateral and bilateral agencies, governments, NGOs, academia, and the regulated private sector—to catalyse collective and coordinated global action. Options for such an arrangement are now emerging following a WHO consultation that led to a UN Secretary-General's Report.[12] The NCD Alliance has proposed a light-touch Global Coordinating Mechanism for NCDs, similar to the Partnership for Maternal and Newborn Child Health,[13] housed within WHO. The Global Coordinating Mechanism would mobilise a range of sectors and coordinate action to support progress towards the global NCD targets and the Global NCD Action Plan 2013–2020 that is currently under development.[14]

Global NCD governance also requires an independent Expert Review Group for NCDs that is modelled on the group established by the Commission on Information and Accountability for Women's and Children's Health.[8] This independent Expert Review Group would be responsible for providing an independent assessment of all stakeholder progress against the Global NCD Action Plan 2013–2020 and the UN political declaration, and would make recommendations to improve accountability. It would be appointed by the UN Secretary-General and comprise up to ten members, with at least half from low-income and middle-income countries. It would be housed and supported by a small and adequately resourced secretariat within WHO, which could ensure the availability of all data required by the group to exercise its functions and assist with the preparation of regular reports through the Director-General of WHO to the UN Secretary-General. The independent Expert Review Group should work closely with the Global Coordinating Mechanism for NCDs.

If the proposed accountability mechanism is to work, several issues require immediate attention. First, independent global and national accountability mechanisms must be established with urgency and be fully supported. Second, capacity for all aspects of NCD prevention and management needs to be strengthened, especially for multisectoral action. Third, implementation research will be needed to support the interventions for the priority targets. Fourth, the equity impact of the interventions will require close monitoring, since equity must be a central goal of any response to the epidemic of NCDs.[15] Finally, the NCD mortality reduction goal (the 25 by 25 goal) should be included as part of the post-2015 development agenda, and NCDs should be integrated throughout all dimensions of this agenda.[16]

The 2014 progress review meeting at the UN General Assembly mandated in the political declaration of the UN high-level meeting on NCDs provides the timeframe within which important progress must be made and reported. If the proposed accountability and coordinating mechanisms are set in place quickly, progress in NCD prevention and management will meet the expectations raised by the high-level meeting.

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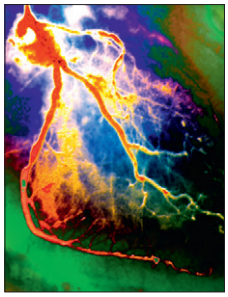
CABG or stents in coronary artery disease: end of the debate?

The relative merits of coronary artery bypass graft (CABG) surgery and percutaneous coronary intervention (PCI) in patients who merit revascularisation for stable coronary artery disease have been strongly debated during the past two decades, based on more than 20 randomised clinical trials. The general conclusion, that CABG reduces the need for repeat intervention, but has no survival benefit compared with PCI, has been disputed because the trials only enrolled very highly selected populations largely unrepresentative of routine clinical practice.[1] Two important studies that might help finally resolve this issue are reported in *The Lancet*.[2,3]

Friedrich Mohr and colleagues[2] report the final 5-year follow up of the SYNTAX trial. SYNTAX is arguably the most important trial of CABG and PCI ever undertaken and is unique for several reasons. First, and by contrast with all previous such trials, SYNTAX randomised 1800 patients with severe coronary artery disease, including multivessel and left main disease. Even so a further 1275 patients (around 40% of the total) were deemed ineligible for randomisation because their coronary artery disease was either thought to be too complex for PCI (1077 who underwent CABG) or too high risk for CABG (198 who underwent PCI); these patients were followed up in a nested parallel registry. A second unique feature of the trial was the introduction of the SYNTAX score, categorising the anatomical severity of coronary artery disease as low (<23), intermediate (23–32), or severe (>32). Because of the ability of this scoring system to predict clinical outcomes in PCI it has already been adopted into both European[4] and US[5] guidelines on revascularisation for coronary artery disease. Finally, SYNTAX emphasises the importance of the heart team—consisting of a core minimum of an interventional cardiologist and cardiac surgeon, and recruiting additional expertise as necessary—in making recommendations about revascularisation.

The results of SYNTAX are clear. Overall, at 5 years CABG significantly reduced major adverse cardiac and cerebrovascular events (MACCE) at 26·9% in the CABG group versus 37·3% in the PCI group (p<0·0001), including cardiac death (5·3% *vs* 9·0%; p=0·003), myocardial infarction (3·8% *vs* 9·7%; p<0·0001), and repeat revascularisation (13·7% *vs* 25·9%; p<0·0001). The investigators



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