Evaluation Report

Evaluation of the United Nations Secretary-General's

Independent Accountability Panel (IAP) for Every Women, Every Child, Every Adolescent

UNFPA Evaluation Office
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Evaluation of the *United Nations Secretary-General's* Independent Accountability Panel (IAP) for Every Woman, Every Child, Every Adolescent

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ABBREVIATIONS AND ACRONYMS

CSO	Civil Society Organization
CoIA	The Commission on Information and Accountability
DFID	Department for International Development (United Kingdom)
EOSG	Executive office of the Secretary-General
EWEC	Every Woman, Every Child, Every Adolescent
GAP	Global Action Plan
GFF	Global Financing Facility
GPMB	Global Preparedness Monitoring Board
Global Strategy	Global Strategy for Women's Children's and Adolescents' Health (2015-2030)
IAP	United Nations Secretary-General's Independent Accountability Panel for Every Woman, Every Child, Every Adolescent
iERG	Independent expert review group
INGO	International non-governmental organization
IPU	International Parliamentary Union
MAR	Multilateral Aid Review
MDGs	Millennium Development Goals
MOPAN	Multilateral Organisation Performance Assessment Network
NCDs	Non-communicable diseases
OECD	Organization for Economic Cooperation and Development
OIG	Office of the Inspector General – Global Fund
PHC	Primary health care
PMNCH	The Partnership for Maternal, Newborn and Child Health
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SDG	Sustainable Development Goals
SG	Secretary-General
The Global Fund	Global Fund for Aids, Tuberculosis and Malaria
ToR	Terms of reference
UAF	Unified Accountability Framework
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
UNGA	United Nations General Assembly
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USD	United States dollar
WEF	World Economic Forum
WHA	World Health Assembly
WHO	World Health Organisation

EXECUTIVE SUMMARY

Scope, objectives and methods

This evaluation of the United Nations Secretary-General's Independent Accountability Panel (IAP) for Every Woman, Every Child, Every Adolescent aims to assess its performance in relation to its mandate and terms of reference within the context in which it is working, including with and through key partners. The objectives are to evaluate the extent to which the IAP has met its objectives, its significance in the global health architecture, and the nature and breadth of support it received from Every Woman, Every Child, Every Adolescent (EWEC) partners. In order to structure the data collection and analysis process, the evaluation was presented along (a) three dimensions, namely: the IAP organisation and management, processes and delivery, as well as products and their dissemination, and against (b) three criteria: progress, effectiveness and influence.

This is a formative evaluation designed to support decision-making on the evolution of the IAP as we prepare to enter the last decade of Agenda 2030. A simple evaluation matrix was developed and revealed that a number of data collection methods were required and would provide an opportunity for triangulation by source of evidence/data collection methods: (a) document review, (b) interviews with key informants, (c) stakeholders survey. A reference group consisting of technical experts supported the evaluation at critical milestones by providing substantive inputs, facilitating access to documents and informants, and ensuring the high technical accuracy of the findings. This participatory approach maintained throughout the evaluation process was instrumental in ensuring that the results of the evaluation will have a meaningful and practical impact on the operation of the IAP moving forward.

Context

The IAP operates in a complex environment. It was created as part of the Unified Accountability Framework (UAF) designed to support accountability for progress on the implementation of the Global Strategy for Women's, Children's and Adolescents' Health (2015-2030) (the Global Strategy). When launched in 2015, the Global Strategy reflected a refreshed and rejuvenated approach to well-articulated achievable targets for health outcomes developed through a comprehensive consultative process and primed to enable the so-called EWEC eco-system to shift gears as the switchover took place from MDGs to SDGs.

The IAP has operated in a global architecture in support of women's, children's and adolescents' health that is constantly evolving and adapting to shifting conditions. These have included the emergence of universal health coverage (UHC), the revitalisation of primary health care (PHC), the strengthening focus and work of the Global Financing Facility (GFF) and accompanying shifts to domestic resource mobilisation, and the Global Action Plan (GAP) as a country-focused initiative, all of which suggests that countries (individually) should be the primary unit of engagement. In this context, the IAP has faced critical challenges such as: ensuring that its structure and approach to accountability are fit for purpose, attracting appropriate and sustained support from EWEC partners and successfully engaging in a multisectoral, multi-stakeholder accountability process that promotes strong country leadership and commitment to health.

Findings

IAP organisation and management

The mandate for the IAP emanates from the office of the Secretary-General (SG). The terms of reference for the panel, its secretariat and its host (the PMNCH) lack detail and are vague on mutual obligations and critical IAP operational matters. Under the new SG, competing international priorities have drawn attention away from health and the oversight role of the SG-appointed EWEC High-Level Steering Group is ineffective with regard to accountability. Drawn from multiple sectors (health, human rights, gender), the IAP panel members are selected for their recognized technical expertise.

However, their terms of reference and those of the IAP Co-Chairs lack specificity while the process of making appointments to the panel and the responsibility of the Executive Office of the Secretary-General are opaque.

Appointed on WHO terms and conditions, and despite long staffing gaps, the IAP Secretariat has been hard-working and productive. However, in practice, the IAP budget has been largely consumed by salaries (IAP panel members offer their services *pro bono*) with limited resources to support the work of the panel such as research, dissemination of findings and on-going advocacy for accountability. As for relationship between the IAP and PMNCH, it has not been fully productive. It has been affected by confusion about roles and responsibilities, competition for resources, and an insistence by the IAP to maintain a certain level of institutional independence as a means to protecting its own voice. While PMNCH has been ambivalent about promoting or championing the IAP as the principal accountability mechanism and global platform for EWEC accountability, the Panel attracted limited support from EWEC partners.

IAP processes and delivery

The IAP produced an annual report for three consecutive years to 2018, foregoing 2019 (in favour of a larger, more expansive report in upcoming 2020). An annual report has been the main vehicle through which the IAP has exercised its accountability function, supplemented with shorter, more opportunistic outputs related to topical issues (on shortage of HPV vaccine, for example). IAP reports do not review the 16 EWEC key indicators but, rather, focus on a single specific theme. Reviewing progress against a set of indicators would have afforded the IAP a clearer opportunity to assume a more direct accountability function and role and compiling its review in the form of league tables or score cards would have further enhanced its ability to draw attention to performance and progress (or gaps and stagnation). As it was, the process of theme selection was not well understood by partners and the choice to focus on a theme meant the IAP report strayed into advocacy. Although reports were high quality and hard-hitting compilations of important issues affecting women's, children's and adolescents' health they did not, in themselves, create a pathway to accountability. Reports did not enable the IAP to call out specific partners and countries lagging behind or encourage remedial action. To this day, the Panel has not assumed the authority that would allow it to "rock the boat" or make others uncomfortable by drawing attention to insufficient progress. The decision to focus on a theme was motivated partly by a concern not to duplicate what others were doing, itself indicative of confusion among EWEC partners, particularly PMNCH, about roles and responsibilities.

IAP products and their dissemination

IAP report dissemination has been largely limited to global health leaders and other partners, through manual distribution (with accompanying letters from the co-chairs) or at relatively small events such as during the United Nations General Assembly (UNGA). Report recommendations tend to be high level, lacking in specificity, difficult to act upon or not amenable to progress monitoring during implementation. Crucially, reports were not shepherded through any kind of visible process that led to EWEC partners accepting responsibility for responding to specific recommendations and for being held accountable for that response. IAP reports thus created the *possibility* of accountability (to the extent that their recommendations could be implemented) but the absence of an accompanying process meant that the essential follow-up and remedy component was lacking. Since neither the PMNCH, as IAP host, nor any other EWEC partner convened stakeholders to review, respond to and take forward the recommendations, IAP reports did not lead to significant impact on the implementation of the Global Strategy. In a United Accountability Framework where the role and responsibilities of EWEC partners in participating in and being held accountable is only vaguely described and entirely voluntary, the setup of the IAP has effectively limited its ability to compel global health partners (let alone countries, where the Panel has almost no visibility) to materially modify or alter their programme or policy approach as a result of its reports' recommendations.

Conclusions

Progress

The IAP has faced a range of organisational, institutional, budgetary and operational challenges that have affected the extent to which it has been able to firmly establish its position and role as a leading voice on accountability in a crowded global health space.

Effectiveness

The effectiveness of the IAP has been limited by the weak recommendations of its reports, their consequent lack of institutional response by key stakeholders, and the absence of methodical follow-up to their implementation. Confusion about how independence should be nurtured and preserved has further inhibited the ability of the IAP to develop a clearly defined and singular role in the EWEC eco-system that adds value and does not duplicate the work of other partners. These failings belong, in different ways, to all EWEC partners, not the IAP alone.

Influence

In the context of its limited progress and uneven effectiveness, the IAP influence has not yet been strong enough to break through in a crowded global health arena. The need remains acute for accountability and the IAP is needed as much as ever. Yet its voice is not sufficiently heard in ways that will guide EWEC stakeholders towards making faster progress on the Global Strategy priorities.

Recommendations

As political support has shifted away from EWEC to other areas, notably universal health coverage, the IAP has the potential to be an important voice in a complex setting. It is particularly needed when the health outcomes for women, children and adolescents are at risk of stalling.

Recommendation 1: Evolve the remit of the IAP to include accountability for "who is being left behind, where and why" across health and well-being in the SDGs.

The IAP should become the independent accountability panel for health and well-being in the SDGs in the context of the commitments made in the 2019 High Level Meeting on universal health coverage. In this role, its main focus should be to identify who is left behind and why in ways that support defined and concrete actions, which motivate stakeholders to effect change.

Recommendation 2: Invigorate political commitment and institutional support for the IAP shifting it to a more visible place in the global health architecture

Ensure that the mandate of the IAP continues to come from the SG and is renewed in support of the Panel's redefined remit [recommendation 1]. Include the IAP report as one input into the SG's planned progress reports to member states on implementation of the 2019 UHC High Level Meeting (HLM) Political Declaration and at the High-Level Political Forum (HLPF) for tracking SDGs progress. Consider options to strengthen IAP hosting, oversight, reporting, resourcing and management to enable the IAP to deliver its accountability function fully. Finally, clarify roles and responsibilities of all partners linked to the accountability process.

Recommendation 3: Increase the influence of the IAP

Include a broader range of political and other voices in the IAP whilst still protecting its technical quality and independence. The panel should be adjusted to include high profile individuals to help the IAP attract and maintain commitment to accountability for leaving no one behind. All appointments should be made on the basis of a transparent process for a pre-determined period of service and with clear terms and conditions.

Recommendation 4: Develop a biennial progress review that is submitted to the SG

This review should include: (i) An assessment of progress against a set of core indicators drawing on available analysis provided by relevant partners, particularly identifying gaps and challenges to progress for women, children and adolescents and incorporating score cards or league tables; (ii) A human rights analysis including an equality focus, calling attention to those left behind, where, and why. The review should also: (iii) Integrate the voices and experience of people; (iv) Identify risks to results and progress including humanitarian, peace and security risks; and (v) Issue a limited set of actionable recommendations that can be monitored and followed-up.

Recommendation 5: Define the full accountability cycle more clearly including undertakings in response to IAP recommendations

The IAP and its partners should elaborate and agree on the accountability cycle and its relevant stages identifying key roles and responsibilities across the whole Monitor-Review-Act/Remedy cycle to ensure that the IAP is able to follow-up and report on progress with implementation of recommendations. The IAP should elaborate a strategy and accompanying workplan and budget for each biennial cycle. Once agreed, resources should be mobilised to enable the IAP to work at an efficient level to deliver its plan.

Recommendation 6: Develop an expanded and more comprehensive IAP communications strategy

The strategy should include outreach with a more accessible, navigable website able to project a public face for the IAP.

1 OBJECTIVES AND SCOPE

This report presents the findings and conclusions of an evaluation of the work of the United Nations Secretary-General's Independent Accountability Panel (IAP) for Every Woman, Every Child, Every Adolescent. The report also formulates a set of recommendations for the way forward. The evaluation was carried from September to December 2019 by an external consultant under the management of the independent Evaluation Office at UNFPA.

Purpose and objectives

This evaluation aims to assess the progress, effectiveness and influence of the IAP in relation to its mandate and terms of reference (ToR) and in the context in which it is working, including with and through key partners. The evaluation takes as its starting point the main objectives and functions of the IAP based on its terms of reference.[1] These include:

- Identify progress towards the delivery of the Global Strategy for Women's, Children's and Adolescents' Health[2] (the Global Strategy) and the factors that support and challenge this progress in ways that focus global attention on specific problems to be overcome, including the identification of who is being left behind, gaps and challenges in implementing the Global Strategy, and purposeful steps to be taken to redress these;
- Periodically issue recommendations and reports ("expected to garner global attention"[3]) with a view to providing constructive, solution-oriented directions based on the best available evidence and analysis in order to contribute to strengthened accountabilities for accelerated achievement of the Global Strategy and the SDGs.
- Be guided by principles and values of human rights, equity, gender equality, inclusiveness and transparency, also "in line with core principles of accountability as per its mandate."[4]
- Make the best use of available, credible data and draw on stakeholder consultations and views, including civil society;
- Ensure wide dissemination to relevant bodies with a timeliness that enables IAP findings to influence decision-making.

The **objectives** of this evaluation are to:

- Identify whether and how the IAP has met its objectives, especially in relation to its role as a meaningful accountability mechanism (taking into account the changing global context and its effect on the IAP)
- Assess whether and how the IAP has been able to influence and shape the wider community in which it operates, specifically in relation to resource allocations for women's children's and adolescents' health, and towards addressing accountability bottlenecks
- Assess Every Woman Every Child (EWEC) partners' coordination with and support for the IAP and in particular, identify key actions for Global Strategy partners including EWEC, the High-Level Steering Group (HLSG), the H6 and the Partnership for Maternal, Newborn and Child Health (PMNCH) as both a partner and as the host of the IAP Secretariat
- Support the alignment and coordination with other related accountability mechanisms and assess the role of the IAP in harmonising accountability

[1] IAP terms of reference: https://iapewec.org/wp-content/uploads/2018/12/IAP-TORs_updated_Sept2018-2.pdf
[2] The Global Strategy for Women's, Children's and Adolescents' Health (here) is a roadmap to achieve the highest attainable standard of health for all women, children and adolescents –to transform the future and ensure every newborn, mother and child not only survives, but thrives. The Global Strategy was updated through collaborative process led by WHO and explicitly builds on the 2010 Strategy and accompanying Every Woman Every Child movement that aimed to accelerate the health-related Millennium Development Goals. PMNCH led a global consultative process to collect and analyse the views of stakeholders on the drafts of the strategy as it was produced. The Global Strategy aims to put women, children and adolescents at the heart of the new UN Sustainable Development Goals incorporating a multi sectoral approach to health.
[3] IAP ToR, p.1.
[4] IAP ToR, p.1.

- Formulate conclusions and recommendations for the way forward.

Scope of the evaluation

The evaluation considers all aspects of the IAP from the point of its foundation in 2015 to its current and on-going work. Although the evaluation focuses principally on the IAP itself, the scope of the evaluation also takes into account the context in which the IAP works and the broader global health architecture especially – albeit not exclusively – in its focus on the Global Strategy. In this regard, the evaluation considers all meetings, activities and products of the Panel and its interactions with other entities. It does not focus on the overall effectiveness of any other stakeholders other than in their relations to, or connection with the IAP.

The evaluation was carried out in three phases. The inception phase (August - September 2019) was used to document the nature and work of the IAP, draft the ToR and develop the evaluation methods and tools, including a simplified evaluation matrix. The inception phase was also used to further specify the evaluation questions (initially proposed in the ToR) with the evaluation reference group, hence delineating the thematic scope of the evaluation.[5] The data-collection phase (October), which consisted of an in-depth document review of over a hundred documents (Annex 1), interviews with 48 key informants (Annexes 2 and 3) and a stakeholder survey (Annex 4), was followed by the analysis and reporting phase (November).

Table 1: Evaluation questions

Evaluation questions addressed three dimensions of the IAP:

The organisation and management of the IAP (was it set up to deliver?): This dimension considered questions about the way the IAP was structured, its operational arrangements, independence, how it was managed, financed, and positioned in the EWEC eco-system and other related matters.

Process and delivery of outputs and results (did it work in ways that were conducive to delivering its mandate?): This dimension considered questions related to the IAPs processes such as how it chose topics to focus on, what its priorities were, how it worked, made decisions, identified opportunities, and was integrated into the EWEC eco-system and beyond.

The production and dissemination of IAP findings (were IAP products and activities the right ones coming at the right time?): This dimension grouped together questions related to the "so what?" aspects of the IAP: what it produced (including speeches, briefs, formal and informal reports) and what was done with its products, how products were disseminated and what influence they had.

The evaluation considered these dimensions in relation to three criteria:

Progress: What progress the IAP made in advancing its role, establishing itself at the heart of the Global Strategy accountability framework and delivering on its mandate?

Effectiveness: How and to what extent did the IAP work effectively, asking the right questions, developing sound analyses, making recommendations that resonate and making use of opportunities and context?

Influence: Whether and to what extent the IAP had discernible influence on actions at global or country level including commitments, decision-making, implementation of programmes and processes to support the implementation of the Global Strategy.

Concurrently with this evaluation the Partnership for Maternal, Newborn and Child Health was undergoing an evaluation as well although with a longer timeframe. The two evaluations were undertaken with as much coherence and joint-working as was practicable and the findings of this IAP evaluation will feed into the PMNCH evaluation.

[5] The evaluation methodology is described in section 3 below and, in more detail, in the inception report available at: https://www.unfpa.org/admin-resource/mid-term-evaluation-unfpa-supplies-programme-2013-2020. Data collection instruments are presented in Volume Two: Annex 3.

2 THE EWEC UNIFIED ACCOUNTABILITY FRAMEWORK

Context

The IAP operates in a complex environment. The global architecture in support of women's, children's and adolescents' health is constantly evolving and adapting to shifting conditions. Progress was made towards saving lives and improving life opportunities under the rubric of the Millennium Development Goals (MDGs) which largely focused on women's and children's health, education, poverty reduction and nutrition. The Sustainable Development Goals (SDGs) have expanded the global approach with a qualitatively different strategy, integrating outcomes for women, children and adolescents across seventeen diverse areas of action.[6]

The global EWEC movement started in 2010, under the leadership of the United Nations Secretary-General with the aim to address the major health challenges facing women and children[7]. Accountability in the EWEC space has evolved over the last decade building on the Commission for Information and Accountability[8] and learning lessons from the experience of the independent Expert Review Group (iERG), an independent accountability group that published a frank review of progress and challenges every year between 2012 to 2014.[9] It is worth remembering that the accountability framework now at the heart of the current Global Strategy has its roots in a human rights-based approach. In its recommendations to the Commission on Information and Accountability (CoIA), the Working Group on Accountability for Results said, "the accountability framework we are recommending to the Commission is based on a fundamental human right - namely, the right of every woman and child to the highest attainable standard of health. We see this right to health for women and children as a foundation for the Commission's work. Implementation of the Global Strategy must be consistent with the standards and obligations of human rights law."[10]

Text Box 1: The Commission on Information and Accountability (CoIA)

The origins of the CoIA:

- In September 2010, in an effort to accelerate progress on Millennium Development Goals 4 and 5 – to improve maternal health and reduce child mortality -- the United Nations Secretary-General, Ban Ki-moon launched the Global Strategy for Women's and Children's Health.
- The Secretary-General asked the Director-General of the World Health Organization to coordinate a process to determine the most effective international institutional arrangements for global reporting, **oversight and accountability on women's and children's health**.
- In response, the Commission on Information and Accountability for Women's and Children's Health (Accountability Commission) was created.
- The Commission was co-chaired by President Jakaya Mrisho Kikwete of Tanzania and Prime Minister Stephen Harper of Canada, with WHO (Dr Margaret Chan) and ITU (Hamadoun Touré) as vice-chairs.

The CoIA made ten recommendations to strengthen tracking, oversight and accountability for commitments to and results for the health of women and children. The accountability framework had three

[6] Areas of action: end poverty; end hunger; ensure healthy lives; ensure quality education; achieve gender equality; clean water and sanitation, clean energy, promote economic growth; reduce inequality; make cities safe and resilient; responsible production and consumption, climate action, promote peaceful and inclusive societies; strengthen means of implementation. https://sustainabledevelopment.un.org/post2015/transformingourworld

[7] http://www.everywomaneverychild.org/about/#sect1

[8] https://www.who.int/woman_child_accountability/about/coia/en/

[9] The website for the iERG is here: https://www.who.int/woman_child_accountability/ierg/en/

[10] The Commission on Information and Accountability, Working Group on Accountability for Results, Draft Final Paper, May 2011.https://www.who.int/topics/millennium_development_goals/accountability_commission/Working_Group_on_Results_Final_Paper.pdf?ua=1

interconnected processes – monitor, review and act – which were aimed at learning and continuous improvement. The framework linked accountability for resources to the results, outcomes and impacts they produced.[11]

One of the Commission's ten recommendations was the creation of an **independent Expert Review Group (iERG)** to report regularly to the UN Secretary-General on the results and resources related to the Global Strategy, and on progress in implementing the Commission's recommendations.

The iERG was established in September 2011 and produced an annual report with an analysis on progress, results and resources related to the UN Global Strategy and on progress related to implementing the first nine recommendations of the Accountability Commission. The iERG is discussed further in section 4.3 and Text Box 4.

The iERG, a group that aimed to strengthen accountability for the Global Strategy for Women's and Children's Health (2010-2015) is a direct antecedent to the IAP, created to strengthen accountability around the Global Strategy for Women's Children's and Adolescents' Health (2015-2030).

Source: https://www.who.int/life-course/about/coia/coia-and-ierg/en/

In 2014, as the MDG era was ending and in preparation for the transition, the Executive Office of the Secretary-General (EOSG) commissioned a review of accountability in the EWEC system. The review[12] made recommendations to support: strengthened data collection and use; improved accountability especially at country level; more focus on open source accounting to strengthen the EWEC governance structure; the management of challenges related to multisectoralism, communication and sustaining commitment (to accountability).

When launched in 2015, the Global Strategy reflected a refreshed and rejuvenated approach to driving outcomes focused on well-articulated achievable targets developed through a comprehensive consultative process. The so-called eco-system surrounding women's, children's and adolescents' health was ready to shift gears as the switchover took place from MDGs to SDGs at least in relation to strategy, priorities and targets.

The Unified Accountability Framework (UAF) was formulated to support accountability for progress on the Global Strategy and was founded on the recommendations made by the iERG, itself a creation of the CoIA set up to support focus and action on the delivery of the MDGs. The UAF was designed by broad consensus among global and country stakeholders drawing on experience with previous accountability processes. It is a complex set of arrangements and the IAP is only one element of it (albeit a very important element). According to its terms of reference, the UAF should, "Support the critical independent review function through the Independent Accountability Panel (IAP). The IAP will produce an annual 'State of the World's Women's, Children's and Adolescents' Health' report and in so doing identify areas to increase progress and accelerate action".[13] Other partners had other responsibilities in relation to accountability. For example, the PMNCH was given responsibility for coordinating accountability efforts. The three over-arching objectives of the framework are shown in Table 2.

[11] The final report of the CoIA is here: https://www.who.int/topics/millennium_development_goals/accountability_commission/Working_Group_on_Results_Final_Paper.pdf?ua=1

[12] Peter Godwin and Sujaya Misra, Report of the External Review of the Accountability Work for Women's and Children's Health, Consultant Report, 15 October 2014

[13] http://www.everywomaneverychild.org/wp-content/uploads/2016/12/UAF-2-pager.pdf pg. 3.

Table 2: The Unified Accountability Framework focus on results, resources and rights

1. Support for country-lead plans and investments	2. Improve multi-stakeholder engagement and harmonization	3. Strengthening accountability at all levels
• Scaling up activities to a national level is a long- term process: In looking beyond 2015, the UAF is a key vehicle to sustain the momentum and investments towards achievements already made	• Strengthen both the alignment of reporting with the SDGs, and intersectoral-accountability to promote full implementation and harmonization for the Global Strategy • The UAF calls for citizens' hearings for the free, active and meaningful participation of citizens at all stages	• Improve linkages between SDG monitoring mechanisms, UN agencies, and other established global monitoring processes such as the IAP, and in health and other sectors • Provide technical support, such as for Countdown 2030, to inform the review and updating process

Source: EWEC, The Unified Accountability Framework: Supporting country-led efforts with the Global Strategy for Women's Children's and Adolescents' Health, 2015, World Health Organization, Geneva

The UAF included a three-point approach to Global Strategy accountability (monitor, review and act) which, together, were intended to engage a wide range of stakeholders empowering them to hold each other to account for delivery. In addition to the IAP, other accountability mechanisms were anticipated to include sub-sector specific reviews, country led reviews (for example, by parliamentary groups) and so on. The UAF as an approach to accountability, together with the anticipated roles and responsibilities of different partners in the UAF is elaborated in the Global Strategy and accompanying documents.[14] The framework for the approach to accountability (Figure 1) shows the complementary roles of monitor, review, act and, added subsequently, a specific reference to "remedy".

Within this intricate accountability framework, the IAP is one of several arrangements to "review" progress against the Global Strategy.The role of the IAP is to review progress (using evidence and analysis undertaken by others in the broader EWEC eco-system), identify gaps and challenges and highlight where progress has been insufficient "with a view to providing constructive, solution-oriented directions based on the best available evidence and analysis, with the aim of contributing to strengthened accountabilities for accelerated achievement of the Global Strategy and the Sustainable Development Goals".[15] Following its publication in 2015, the framework evolved in numerous ways. Firstly, the "Act" function (which follows the review of progress) was modified to include "Act and Remedy" creating the critical component of improvement, redress and follow-up. The process of reviewing action taken and remedies implemented as a result of "review" creates an important component of the accountability process. Although roles and responsibilities are loosely assigned in the framework, the detail is missing (and has never been completely fleshed out or agreed). The IAP has a ToR (discussed in findings) but no ToRs for other actors was found.

[14] The three-step accountability framework is based on one developed to support the CoIA, and draws on the work of Paul Hunt, the United Nations Special Rapporteur on the right to the highest attainable standard of health (2002-2008) notably: Paul Hunt: A Three-Step Accountability Process for the UN Secretary-General's Global Strategy for Women's and Children's Health. Paper presented at "From Pledges to Action", a Partners' Forum on Women's and Children's Health, Organised by Ministry of Health and Family Welfare, Government of India and the Partnership for Maternal, Newborn and Child Health (PMNCH), New Delhi, India. 12-14th November 2010.

The framework was evolved and refined by a broad group of technical and other stakeholders, including Paul Hunt, working under the auspices of the PMNCH in 2011. A review of global accountability mechanisms for women's and children's health. PMNCH: Geneva, Switzerland.
http://www.who.int/pmnch/topics/part_publications/accountability-mechanisms/en/index.html

[15] EWEC, The Unified Accountability Framework: Supporting country-led efforts with the Global Strategy for Women's Children's and Adolescents' Health, 2015, World Health Organization, Geneva.

Figure 1: The Unified Accountability Framework and the Global Strategy

Accountability in the SDGs

All SDG 3 and 5 targets[16] are closely relevant to women's, children's and adolescents' health. However, the emphasis in the global community around SDG 3.8 on achieving universal health coverage (UHC) to ensure access to quality health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all has taken prime position given its perceived underlying importance to the achievement of other SDG 3 targets. The High-Level Meeting at the United Nations General Assembly (UNGA) in September 2019 sets out commitments to advancing UHC in ways that could transform health for women, children and adolescents.[17]

While all the nine targets under SDG 3[18] pertain to the health of women and children, targets under SDG 5 (gender equality) SDG 1 (poverty), SDG 2 (Nutrition) and others also contribute, sometimes significantly. The health of women, children and adolescents has thus expanded into a huge agenda that stretches across this substantially enlarged global development agenda, taking into its ambit not just the nine targets associated with SDG 3 but a number of targets across many (most) of the other SDGs and an underlying recognition of the inter-relatedness of peace, prosperity, people, the planet, and partnerships.

Linking closely to the UHC agenda, the newly developing SDG 3 Global Action Plan for Healthy Lives and Well-Being[19] (the GAP), the thrust of the Global Strategy, Family Planning 2020[20] and other specific

[16] Goal 3 targets (health) are here: https://www.un.org/sustainabledevelopment/health/ and Goal 5 targets (gender equality and empowerment of women and girls) are here: https://www.un.org/sustainabledevelopment/gender-equality/
[17] https://www.un.org/pga/73/event/universal-health-coverage/
[18] Health targets cover a broad range beyond maternal and child health including communicable and non-communicable diseases, exposure to risk factors, UHC and environmental health among others.
[19] https://www.who.int/sdg/global-action-plan
[20] https://www.familyplanning2020.org

initiatives, the Global Financing Facility (GFF)[21] aims to advance Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) priorities. GFF aims to do this by supporting countries to raise more money for health (domestic resource mobilisation) and to deliver more health for the money (for example, through efficiency gains and improved budget management) among other things. The majority of financing for health already comes from domestic resources and given the economic development outlook, this is almost certain to continue. As a result, countries should be supported to (i) mobilise sustainable resources for health, (ii) pool these resources in ways that enable them to reach marginalised and underserved populations, and (iii) prioritise health actions that deliver best value for money especially for women's, adolescents' and children's health.

The recent commitments made in Astana, which updated the Alma Ata Declaration, bring Primary Health Care (PHC) back into the centre of country health reforms as a platform on which to deliver a wide range of health priorities in the context of UHC. Investing in PHC to drive UHC represents a shift to horizontal systems and potentially a step-change away from vertical action. Given the wide ambit of women's, children's and adolescents' health sketched out above, this shift possibly represents an important opportunity for the Global Strategy to accelerate its efforts.

A recent global health development, the GAP is a joint commitment of twelve global health partners to work more collaboratively and in a more streamlined and efficient way that aims to put the country at the centre of their collective efforts using a framework of "align, accelerate and account". There are some signs that this approach could shift focus to country-led processes and bespoke responses based on gaps and challenges identified in individual countries. However, it is early days and at the time of this evaluation, GAP partners were structuring (globally) around seven accelerators[22] while somewhat disparagingly, the accountability component was reportedly being focused on monitoring the achievement of SDG outcomes in countries rather than on the behaviours and performance of the twelve global health partners, an equally important aspect of the GAP.

All of these developments – the growing focus on UHC, the revitalisation of PHC, the strengthening work of the GFF and accompanying shifts to domestic resource mobilisation, and the GAP as a country-focused initiative – suggest that countries should be an important unit of engagement.

In light of this complex environment, the IAP faces a number of challenges to deliver its mandate. Among the most critical of these will be ensuring its structure and approach to accountability is the right one, attracting appropriate and sustained support from EWEC partners and successfully engaging in a multisectoral, multi-stakeholder accountability process that promotes strong country leadership and commitment to health.

3 EVALUATION APPROACH AND METHODOLOGY

This section summarises the evaluation approach and the methodology used by the evaluation.

Evaluation approach

The four phases of the evaluation are elaborated in Figure 2 below. They are the inception phase, the data collection and analysis phase, the development of findings and conclusions and the formulation of recommendations.

[21] https://www.globalfinancingfacility.org

[22] The seven accelerators were: 1) Primary health care 2) Sustainable financing for health 3) Community and civil society engagement 4) Determinants of health 5) Innovative programming in fragile and vulnerable settings and for disease outbreak responses 6) Research and development, innovation and access, and 7) Data and digital health.

Figure 2: Four phases of the IAP evaluation

Evaluation matrix

The process of developing the evaluation matrix is described in the inception report.[23] The matrix reflects three dimensions of the IAP:

- The organisation and management of the IAP
- The processes used by the IAP to plan and deliver its work
- The products or outputs of the IAP and the dissemination of IAP recommendations.

Each of these dimensions is evaluated against three criteria: progress, effectiveness and influence. The resulting evaluation matrix (Table 3) expands on and arranges the evaluation questions against these dimensions and criteria. The evaluation findings are not presented in a way that mirrors the evaluation matrix as this approach would have resulted in duplication or a false division in the presentation of key issues. The findings are presented by evaluation dimension and the conclusions are structured around the evaluation criteria. However, it is important to note that all the evaluation questions have in fact been addressed in the findings.

Table 3: The IAP Evaluation Matrix

	Progress	Effectiveness	Influence
Organisation and management	How is the IAP organised and managed? Are these arrangements functioning well?	To what extent does this organisation and management approach facilitate or hinder the effectiveness of the IAP and its ability to achieve its mandate? To what extent does the organisation and management approach facilitate or hinder links to the wider Women's Children's and Adolescents' health community and range of EWEC partners/ stakeholders?	How does the organisation of the IAP drive or hinder its influence? Is the IAP optimally positioned, managed and structured to maximise its influence?
Process and delivery	To what extent is the IAP delivering on its objectives? If not, why not? To what extent have EWEC partners provided support for IAP to deliver on its objectives?	How effective is the IAP in delivering its mandate and objectives and where and why is it more or less effective? What challenges does it face in operational terms?	As an organisation in the global health architecture, how and to what extent has the IAP been influential? What are the key drivers enabling or hindering influence? What role have EWEC partners played?
Products and dissemination	What are the products of the IAP? Are products (including speeches, briefs and reports) produced on time, with the right frequency and to a high-quality standard? Are reports disseminated appropriately?	Is IAP report content perceived as appropriate, effective, and valued by partners and stakeholders? To what extent are IAP's products discussed, used or integrated into policy processes, relevant guidance notes and high-level decision-making? If not, why not?	To what extent do IAP reports have influence on global health processes related to women's children's and adolescents' health? How tangible is this influence? What are the drivers or conditions under which influence is achieved?

[23] To obtain a copy of the inception report, please send a request to charpentier@unfpa.org

Data collection

3.1.1 Data-collection methods

The evaluation is largely based on qualitative methods for data collection and analysis, including a comprehensive review of documents (Annex 1), key informant interviews (see Annex 2 and Annex 3), an online survey of key informants from across the EWEC eco-system (Annex 4), and a review of other accountability mechanisms as an aid to benchmarking IAP performance. Quantitative methods included, in particular, profiles of financial data, and some analysis of product outcomes including social media analysis.

Most key informants were identified across a wide range of constituencies including the IAP itself (past and present), the PMNCH as host, national health authorities, bilateral and multilateral donors, H6 partners, academics and professionals, the private sector, civil society and others. In total, 48 key informant interviews were conducted. The online survey of key informants was open for two weeks and comprised 18 questions. The link to the survey was circulated to the mailing list of the IAP Secretariat, the PMNCH and the EWEC Secretariat and 74 respondents completed the survey. Across both groups, therefore, a total of 122 key informants and respondents contributed their views to the evaluation.

To support the analysis of the IAP, a brief review of other accountability instruments was undertaken (Annex 5) and the results were used to benchmark performance and behaviours identified in the IAP. This review was by no means exhaustive. A short analysis of the approach adopted by the Commission on Human Rights towards holding countries accountable was also undertaken.

3.1.2 Data analysis and triangulation

Data collected were analysed using rigorous qualitative data analysis techniques. Evidence was consolidated, triangulated and analysed according to thematic areas using a tabular approach. Themes were refined and combined and mapped against the evaluation framework to ensure all questions were addressed. It is worth remarking that the evidence emerging from this review reached thematic saturation in relation to all its main findings. Findings were thus remarkably coherent and aligned. On the rare occasions where divergent views or evidence was found (and this was only on marginal issues), this has been noted in the findings. On the whole, the findings of this review were supported by a cohesive and solid body of evidence.

Limitations and evaluation response

The evaluation relied on triangulation - drawing on and comparing evaluation evidence gathered from different sources using different data-collection methods to address each evaluation question or sub-question. However, it must be noted that some key informants were unavailable for interview or declined to participate. In this case, where possible, interviews were conducted with nominated alternates. The overall timeframe for the evaluation was limited which affected the extent to which consultations could be conducted across a wide range of countries or regional settings. Also, the time available did not allow for an in-depth social media analysis or an economic evaluation of the IAP. The evaluation did not extend to some relevant corollary issues including the evaluation of data collection, analysis and use in country and global health systems for SDG monitoring. None of these limitations are considered to have unduly affected the overall validity of evaluation findings and conclusions.

4 EVALUATION FINDINGS

The organisation and management of the IAP

Summary

The mandate for the IAP emanates from the office of the Secretary-General (SG). Terms of reference for the panel, its secretariat and its host, the PMNCH, lack detail and are vague on mutual obligations and critical IAP operational matters. Under the new SG, competing international priorities has drawn attention away from health. The oversight role of the SG-appointed EWEC High-Level Steering Group is ineffective with regard to accountability.

Drawn from multiple sectors (health, human rights, gender), IAP panel members are selected for their recognized technical expertise. However, their terms of reference and those of the IAP Co-Chairs lack specificity while the process of making appointments to the panel and the responsibility of the Executive Office of the Secretary-General are opaque. Appointed on WHO terms and conditions, and despite long staffing gaps, the IAP Secretariat has been hard-working and productive. However, in practice, the IAP budget has been largely consumed by salaries (IAP panel members offer their services *pro bono*) with limited resources to support the work of the panel such as research, dissemination of findings and on-going advocacy for accountability.

Despite some successful collaboration, the relationship between the IAP and PMNCH has not been fully productive and has been affected by confusion about roles and responsibilities, competition for use of resources, and an insistence by the IAP to maintain a certain level of institutional independence as a means to protecting its independent voice. PMNCH appears to have been ambivalent about promoting or championing the IAP as the principal accountability mechanism and global platform for EWEC accountability. The IAP has had limited support from EWEC partners.

Findings presented in this section relate to the following evaluation questions	
Organisation and management of the IAP	• How is the IAP organised and managed? Is it working? • To what extent does this organisation and management approach facilitate or hinder the effectiveness of the IAP and its ability to achieve its mandate? • To what extent does the organisation and management approach facilitate or hinder links to the wider Women's Children's and Adolescents' health community and range of EWEC partners/ stakeholders? • How does the organisation of the IAP drive or hinder its influence? Is the IAP optimally positioned, managed and structured to maximise its influence?

All quotations, where not referenced, are taken from comments of key informants and survey respondents collected specifically for this evaluation. All other quotations, including from documents or other material are referenced.

The IAP mandate and its terms of reference

The mandate for the IAP was conferred by the Secretary-General (SG) and emanates from the arrangements agreed around the Unified Accountability Framework (UAF) of the Global Strategy (see Figure 1). This mandate is expressed through the specific assignment to the IAP of the lead role in compiling an annual report on progress towards the implementation of the Global Strategy using data analysed and made available by EWEC stakeholders and partners, including H6 partners, Countdown to 2030, and others. In the revised IAP ToR, its mandate is "centred on assessing the state of the world's accountability for delivery of the Global Strategy's vision and commitments to the health and well-being of women, children and adolescents, taking a gender equality and human rights-based approach"[24].

[24] IAP ToR, Revised (2018), pg. 1. Updated by the Executive Office of the Secretary General based on operational considerations.

In practice, although most key informants and survey respondents were aware of the IAP mandate in general terms, many were unable to identify critical elements of the mandate – in particular: to whom was the IAP accountable, for what is it accountable and how is this accountability mediated. In addition, for several key informants, the mandate was not framed in terms that were strong enough to allow the IAP to demand action from stakeholders and partners or to call out countries. As one key informant said, the IAP "*is hobbled through its design and has no mandate or authority to take its own report and submit it to heads of state. All it can do is speak and hope someone listens*". Another commented that this has led to a limited ability to speak beyond EWEC: "They are looking at each other and talking to the same circle". The range of views about the extent to which the IAP has delivered on its mandate is discussed in section 4.3.

The IAP ToR was first sketched out in the Global Strategy itself. The first standalone ToR is dated 12 November 2015 and focused on the IAP products (its report) and its composition and necessary skills. A revised ToR (2018) was more explicit about the mandate and composition including some reference to the role of the IAP Secretariat and the host agency (PMNCH) but dropped the comprehensive description of the report content required from the IAP. Across both these ToRs there is a lack of detail relating to the relationship between the IAP and (a) its host PMNCH and (b) the broader EWEC partners. The roles and responsibilities of the host are sketched out in simple terms but the mutual obligations or expectations of each entity in relation to the other is absent in this ToR or in any kind of operationalisation document.

Role of the Secretary-General

The IAP is rooted in the Office of the Secretary-General and the SG is responsible for appointing IAP members and co-chairs (discussed further under *Selection of IAP members*). While in practice, the current SG is not – according to all respondents who had a view of this – personally engaged in the IAP or even the broader EWEC process, a large majority of key informants and survey respondents agreed that IAP authority, to the extent it did exist, rested on its link to the SG. "IAP can only be at its best if given the chance to communicate through the Executive Office." The importance of SG backing and sponsorship was widely felt among survey respondents, the majority of whom thought the IAP should be accountable to the SG. This was partly because without this backing, the IAP had significantly less authority to work across sectors and agencies in what is a very multisectoral agenda. It is also due to the nature of the work – holding stakeholders to account – which was seen as a role of the SG and thus one that could be delegated to the IAP by the office of the SG. Many key informants commented on the impact of the changeover in SG which took place on 1 January 2017 pointing out that EWEC had been a creation of the previous SG and the new SG had new priorities (peace and security foremost amongst these).

IAP oversight

The oversight arrangements for the IAP have thus shifted several times and for reasons that are not always clear. In the text of the Global Strategy, it was anticipated that the IAP would submit its reports directly to the Executive Office of the SG (EOSG) and this was confirmed in the IAP original (2015) ToR. The idea was that the reports could then be discussed at the High-Level Political Forum (HLPF),[25] the body mandated in 2012 to act as the main United Nations platform on sustainable development. Its

[25] The HLPF is the main United Nations platform on sustainable development and it has a central role in the follow-up and review of the 2030 Agenda for Sustainable Development the Sustainable Development Goals (SDGs) at the global level. The establishment of the United Nations High-level Political Forum on Sustainable Development (HLPF) was mandated in 2012 by the outcome document of the United Nations Conference on Sustainable Development (Rio+20), "The Future We Want". The format and organizational aspects of the Forum are outlined in General Assembly resolution 67/290. The Forum meets annually under the auspices of the Economic and Social Council for eight days, including a three-day ministerial segment and every four years at the level of Heads of State and Government under the auspices of the General Assembly for two days.

central role is to follow and review progress towards the 2030 Agenda for Sustainable Development and the Sustainable Development Goals (SDGs) at the global level. This forum creates a direct link with countries and is the main forum through which countries report on and discuss their progress towards SDG achievements. In a paper presented at the 69th World Health Assembly (WHA) to support the operationalisation of the Global Strategy, it was anticipated that the IAP annual "review of progress" would be "submitted to the Secretary-General in time for deliberations by the High-level Political Forum on Sustainable Development"[26]. There was apparently (according to one key informant and unconfirmed) a last-minute alteration to the text of the associated resolution to remove a proposal that the IAP would report to the WHA as well. Whatever the case, the proposed formalised system set out in the resolution did not materialise in practice and the IAP was not given a formal reporting line to the WHA. It was however, given a formal reporting option in the margins of the HLPF.

In the same WHO paper associated with resolution 69.2 in 2016, PMNCH was identified as the body that would coordinate the Global Strategy implementation monitoring report and for overall management of the UAF. The WHO, on behalf of H6 partners and the PMNCH, submitted Global Strategy implementation/ monitoring progress reports to the WHA in 2017, 2018, and 2019[27]. These were largely silent about the IAP and its work, mentioning the IAP 2017 report on adolescents in passing and dwelling with more attention on its own update on the Global Strategy 16 key indicators and the newly launched online portal at the Global Health Observatory to collect and track the 60 EWEC indicators[28]. The annual reports commented on health-related human rights issues and pointed out where insufficient progress on relevant areas had not been made.

In its revised (2018) ToR, and reflecting what happens in practice, the IAP presents its findings to the EWEC High-Level Steering Group (HLSG) co-chaired by the SG.[29] This is an advisory group convened in 2015 by the SG to "provide leadership and […] encourage collaboration" in support of the Global Strategy. The terms of reference for this group, its mode of working, frequency of meeting, minutes of meetings, decisions and actions are undocumented on its webpage.

Key informants and respondents reported that, in practice, the SG does not personally chair the meeting that occurs during the September UNGA, which is furthermore often rushed and in the margins of a very busy UNGA week. In this meeting, the IAP presentation is reported to be a matter of formal information rather than discussion, decision-making and action. As an agenda item, it is completed in a few minutes. No action points, follow-up or next steps were identified by informants who attended these meetings in the past. Among key informants, there was a general sense that the HLSG was an ineffective group and that its interest in and ability to champion accountability specifically was limited. This has resulted, *de facto*, in leaving the IAP without a global sponsor to champion its work.

Beyond the HLSG, and in its ToR, the IAP is encouraged to engage other high-level groups such as the HLPF[30] and the Human Rights Council. However, it is left to do this on its own rather than being supported and "accompanied" by other high-level stakeholders. In effect, this results in a situation where the IAP may not reach the most strategic fora where its findings and recommendations could be amplified to relevant stakeholders.

[26] WHA Resolution 69.2: WHA69.2 Committing to implementation of the Global Strategy for Women's, Children's and Adolescents' Health, Geneva, 2016.
[27] These reports are here:2017: https://apps.who.int/iris/bitstream/handle/10665/274949/A70_37-en.pdf?sequence=1&isAllowed=y 2018: https://apps.who.int/gb/ebwha/pdf_files/WHA72/A72_30-en.pdf and 2019: https://apps.who.int/gb/ebwha/pdf_files/WHA72/A72_30-en.pdf
[28] Global Health Observatory Data Portal for the Global Strategy for Women's Children's and Adolescents' Health: https://www.who.int/gho/publications/gswcah_portal/en/
[29] Membership of the HLSG is here: https://www.everywomaneverychild.org/about/ewec-ecosystem/
[30] Despite the Resolution 69.2 of the 2016 WHA identifying the HLPF as the forum for the IAP report to be presented, the TOR of the IAP merely "encouraged" the presentation of the report to the HLFP.

Panel member selection

The IAP is comprised of ten technical experts who are 'leaders in their field'. Panel members come from different countries and cover a wide range of expertise from law to public health, quality assurance to human rights.

Panel members were initially appointed by the EOSG from a pool of candidates. This pool was created in 2015 under the leadership of PMNCH following a well-publicised call for nominations. From time to time, as vacancies in the Panel appear, PMNCH identifies candidates, the EOSG selects from these and the SG makes the appointments. The selection of candidates from the candidates nominated by PMNCH is done by the EOSG with a view to maintaining a balanced composition in the panel across geographic regions and disciplines. Appointments are made for two to three years, renewable once. Members thus serve for a minimum of two and a maximum of six years.

The EOSG role in appointing panel members appears to be well understood, yet the way it has been handled is less clear. Among key informants and survey respondents, the process of identifying and selecting candidates to the IAP, including criteria and timing, was not considered to be fully transparent and most were either unable to say how IAP members were appointed or did not know the process. For example, of survey respondents, 40% did not know while 37% said they thought there was limited or insufficient transparency in the process. The criteria for selection onto the IAP are not posted on any known webpage linked to any of the relevant actors including the EOSG, PMNCH (which has the responsibility to advertise for and collate the pool of candidates), or the IAP itself. Given that these are technical expert posts with limited terms of office, the process was not considered to require the opacity it currently has. In a letter to the SG dated 18 December 2018[31], IAP members themselves requested more transparency in the appointment process, articulating a, "need for a more transparent and consultative process of nomination and vetting for new members whenever there is a major rotation exercise".

Regarding the composition of the panel, two main views emerged. First, the value of having technically competent experts ("leaders in their field") on the panel, particularly given the nature of the work, the limited resources, and the expectation that the panel will do much of its own writing. The other observation – not contradictory –was that the panel should also be populated in a way that allows the IAP to strengthen its reach and influence. As one respondent said, what is needed are, "panel members who are politically astute and can open doors, command action, galvanise people like young people and pharma and countries." In a review of other accountability mechanisms (section 4.3 and Annex 5), it is evident that most panels or boards that govern, lead or front accountability instruments have a mix of individuals including high-profile political figures, technical experts, heads of agencies or industry and others.

Panel members' terms and conditions

Panel members serve in their personal capacity and are expected to dedicate 20 to 30 days to the IAP each year. They do not receive an honorarium. Their travel arrangements for IAP working meetings are handled by the IAP Secretariat while additional travel for events and public engagements may also be covered (discussed below).

Most panel members are either retired or have institutional backing that allows them to volunteer their time to the panel. However, their commitment delivering IAP objectives is inevitably highly variable depending on their other obligations, and opportunities to add IAP meetings or speaking engagements to their schedule. There was evidence that some panel members were able to draw on resources available to them through their other professional lives (research assistance, administrative

[31] Letter addressed to the EOSG from the Co-Chairs (18 December 2018) covering a range of matters including the decision to forego a report in 2019, a request for clarity about rotation times, more clarity about the process of appointing panel members, an observation that the budget requested had not been granted and information about intended actions to support communications in 2019.

support). Engagements were often undertaken for the IAP whilst panel members were attending events with other professional 'hats' on.

While it was clear why panel members were not paid an honorarium, there were pros and cons to this policy identified by key informants and respondents. Chief among the concerns were the cost given the limited budget of the IAP and the risk to independence somehow if panel members were to be paid anything. Somehow working *pro bono* was considered a hallmark of independence. However, those who saw the benefit of honorariums pointed out that a broader range of applicants could be attracted to the IAP. Honorariums in this case could promote independence since applicants would not need sponsorship from their own institutions and could afford to put the time into supporting the IAP genuinely as independent voices.

Chair selection

There are no written procedures outlining the process of appointing co-chairs of the IAP and limited guidance around their terms of office. Following the almost immediate departure of the first chair appointed in 2016, the IAP nominated a replacement from among their own group. They also requested the appointment of a co-chair who was subsequently identified from the pool of candidates. One co-chair retired at the end of 2018 after just over two years and was replaced by an appointment by the SG at the same time that four new members were appointed. Chairs are expected to serve a term of three years according to the ToR while new member appointments should be staggered to maintain institutional memory.

The IAP Secretariat

The IAP is supported by a small secretariat hosted by the PMNCH. PMNCH is itself hosted by the WHO and subject to its administrative, legal and HR procedures, including a 13% levy by WHO on all funds raised by PMNCH. The Secretariat is comprised of three roles: a director, a project manager and a project officer. The Secretariat facilitates "the effective functioning of the IAP and its activities"[32] including the submission of the budget to the PMNCH and the management of IAP funds. The Secretariat does not have a separate or more detailed ToR and its responsibilities in relation to IAP panel members (individually and to the IAP as an entity) is not fully elaborated. PMNCH is responsible for the appointment of the Secretariat Director with guidance from the Co-Chairs while the IAP Director appoints other Secretariat staff with administrative support from PMNCH as host and in consultation with the Co-Chairs.

Recruitment and staffing follow WHO human resources policies and procedures. There have been at least two protracted periods of understaffing at the Secretariat (six months or more without a director in 2019 and during part of 2016). The Secretariat is currently staffed with two full time project staff, one recently appointed, and a part-time director on loan from another WHO department to fill the gap during a lengthy recruitment process. The Secretariat handles all the planning, administrative, management, financing and logistical support for the IAP. It also contributes substantial research and report drafting capacity to the IAP as well as communications and outreach support.

The IAP Secretariat was considered by respondents and key informants to be very capable and hard-working (too hard-working possibly in that they were obliged to work long hours especially at certain times of the year to manage the wide range of IAP functions and activities). Yet, the staffing gaps were frequently raised as an obstacle to the effective working of the IAP. Several informants thought that the Secretariat needed to expand to include a more dynamic communications strategy with accompanying skills to deliver it.

The IAP hosting arrangements

In the Global Strategy, the PMNCH was assigned the role of aligning global stakeholders and accountability in the EWEC architecture. In its 2016-2020 Strategic Plan, the PMNCH identifies 'Accountability' as one of its four strategic objectives (accountability is SO2 and there is a "SO2

[32] IAP revised ToR, pg. 4.

Working Group" in PMNCH). Within the accountability objective, it highlights two major elements to its ambition on driving accountability one of which is: "Coordinate the Global Accountability Framework, support the Independent Accountability Panel and put into action recommendations from its annual report on the "State of Women's, Children's and Adolescents' Health"[33]. However, in its updated Business Plan (2018-2020), the accountability commitment has been reframed to "Ensure effective tracking of the Global Strategy's goals and of national commitments to WCAH, including through supporting partner engagement and accountability at the national level and through hosting the Independent Accountability Panel".[34] The PMNCH was assigned the role of hosting the IAP and to "*play a coordination role in the global Accountability Framework to ensure all stakeholders can act on recommendations*"[35]. The ToR for the IAP is, as mentioned, cursory and the PMNCH role as the host is referenced in very limited terms. In the current IAP ToR, the PMNCH role is defined as providing fiduciary, legal and administrative support to the IAP to preserve "*its perceived integrity as an independent body*". PMNCH requires WHO to support it in this role as it (PMNCH) is a partnership hosted by WHO. The PMNCH is responsible for allocating resources to the IAP based on its proposed budget and depending on its own resources. According to its webpage, the IAP is thus administratively and legally a project within the Partnership, which is itself administratively and legally hosted by WHO.

The PMNCH has provided some platform for the IAP, for example through co-hosting the Accountability Breakfast at UNGA. Although this was the forum for the launch of the 2016 IAP report, other reports and most other activities and engagements are organised by the IAP Secretariat and by IAP members[36]. As one key informant said, "Complementarity between IAP and PMNCH needs to be enhanced".

This seems to be confirmed by the PMNCH website where the IAP presence is marginal and referenced as a hosted secretariat only, rather than the leading mechanism for accountability in the EWEC eco-system. Indeed, PMNCH continues to use its resources to expand its own accountability projects and role while – according to some – leaving IAP somewhat isolated. There is evidence of duplication and overlap between the two entities especially in relation to reporting and advocacy functions. In 2017, for example, it was the PMNCH that published a progress report compiled by EWEC core partners including the H6, PMNCH itself and the Global Financing Facility. The report covered key indicators and progress on commitments and accountability.[37] Furthermore, in a report to the EOSG about its end of 2018 work, the Co-Chairs report that they had been invited to attend the PMNCH Board meeting "as observers and were given a brief opportunity to intervene on IAP's work and importance of accountability for EWEC".[38]

In fact, key informants and survey respondents suggested this duplication strayed into competition. A wide range of informants from different stakeholder groups suggested that the PMNCH had characterised the IAP as a project within its programme rather than thinking about it strategically as "a major, global resource" with an expanded remit encompassing all EWEC stakeholders for which the "PMNCH was a custodian and should be a champion". There is a strand of thinking that emerges from the evidence (interviews, documents, and the survey) to suggest that IAP is seen by some as a cost centre or a project, and one that does not carry its weight, for example, as suggested by comments such as "The IAP is expensive and only delivers one report which costs one million dollars".

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[33] PMNCH, Strategic Plan 2016-2020, Geneva, 2016. Pg. 18. https://www.who.int/pmnch/knowledge/publications/pmnch_strategic_plan_2016_2020.pdf?ua=1

[34] PMNCH Business Plan 2018-2020, Geneva, 2018. P.8. https://www.who.int/pmnch/PMNCH_Business_Plan_2018-2020.pdf

[35] Global Strategy, pg. 71.

[36] For example, other kinds of events organised by the IAP Secretariat include the SDG Media Zone interview led by Noma Bolani with one of the IAP co-chairs and the Minister of Health of South Africa discussing accountability for UHC https://iapewec.org/news/accountability_uhc-2/

[37] Every Woman Every Child and Partnership for Maternal, Newborn & Child Health. Progress in Partnership: 2017 Progress Report on the Every Woman Every Child Global Strategy for Women's, Children's and Adolescents' Health. Geneva: World Health Organization; 2017. https://iapewec.org/resources/gspr2017/

[38] Letter addressed to the EOSG from the Co-Chairs (18 December 2018).

There are a number of reasons why the complementarity or collaboration between the IAP and PMNCH may have gone a little off-track. It has already been mentioned that the ToR setting out the PMNCH role was not clear or very detailed while its delivery of this role was not monitored or reviewed, at least recently. There are other factors to be considered. For example, the IAP start-up was hampered by a complete rotation of its founding champions[39]. The thinking around the IAP when it was first mooted and then established was, to some extent, lost as these multiple – and protracted – changeovers occurred. The PMNCH itself was undergoing a number of changes in direction and staffing during the first year of the IAP's work. An evaluation[40] of the PMNCH may be a good opportunity to identify the effects of this period on the PMNCH relationship to and promotion of the IAP. The effects of this period on the institutional development of the IAP and its choices about how it would work is discussed further in section 4.2 below.

A second factor that is likely to have affected the relationship between the PMNCH and the IAP is to some extent a consequence of the first. There was, according to a large number of key informants, a concern with the independence of the IAP both in general terms and specifically in relation to the PMNCH. Reportedly, there was quite a lot of discussion about creating a "firewall" ensuring a division at an institutional level and protecting the IAP to enable its voice to be autonomous. This raises a crucial question about what independence means in the context of accountability (section 4.3) but it is likely that this concern with independence early on led to the establishment of an operational and coordination barrier between the two organisations that prevented the development of mutually supportive working arrangements and common goals. The IAP became a cost centre to the PMNCH – a project it was obliged to host and prioritise funding for, but which it was not monitored or reviewed for – rather than being adopted and nurtured as a strategic global programme that PMNCH would use its own platform to boost and promote.

The consequences of this have been significant for both the IAP – inasmuch as it has limited its influence and reach (section 4.3) – and for the PMNCH (including the PMNCH Board), which did not in practice, appear to see its role as that of championing IAP recommendations too much beyond the UNGA accountability breakfast event, and ensuring that these recommendations were taken forward and implemented by relevant stakeholders despite the commitment in its strategic plan.

Resources and budget

Resources for the IAP are allocated from the PMNCH budget and a basic amount has been protected for the IAP each year. The IAP budget has, in practice, been roughly USD1 million each year. This represented 25 per cent of the PMNCH funds raised in 2017 while in 2019, it was closer to ten per cent of its funds. The PMNCH reported that it took a decision after 2017 to allocate ten per cent of its budget to the IAP whatever that was (in 2018 it was USD 1 million). The budget covers the cost of the three Secretariat staff and the costs associated with researching reports, convening the IAP working meetings and selected external engagements. In 2019, the IAP has proposed a slightly higher biennial budget linked to a more clearly articulated workplan that includes more country focused work (discussed further in section 4.2).

PMNCH identified accountability as one of its four strategic pillars in relation to its own current strategy reflecting its role in tracking commitments and supporting increased accountability monitoring among stakeholders, including civil society. Yet, in relation to the IAP its approach has been somewhat confusing. The basic costs of the IAP have been protected by PMNCH to some extent regardless of its own income. However, the IAP budget has never been much more than a minimum sufficient to enable it to fund the Secretariat and the IAP working meetings and report delivery. It has not had the resources to develop and expand its reach (assuming it had the ambition, skills and other resources needed to do that). Being an entity hosted by PMNCH, itself hosted by WHO, the IAP

[39] For example, the IAP leadership changed, the IAP Secretariat director post was vacated early on and remained vacant for some months. Meanwhile, at PMNCH, the leadership changed and the director post was vacant for some months, and the broader WHO leadership changed as well.

[40] The PMNCH evaluation was underway while the IAP evaluation was conducted. The PMNCH evaluation will report in January 2020.

secretariat is obliged to appoint staff on WHO terms and conditions. In 2014 and 2015, when the UAF was in negotiation, the PMNCH advocated strongly to host the IAP secretariat as part of its broader remit to coordinate accountability within the UAF for the implementation of the Global Strategy.

The IAP ToR suggests that it could raise additional funds, noting that the PMNCH "*need not be the exclusive source*" of its resources although, in practice, there is no clarity regarding scope to conduct additional fund raising. The IAP has not conducted independent fundraising but IAP members reported confusion over whether they were actually allowed to fundraise independently of the PMNCH. Some key informants believed that donors considered the IAP to be expensive or informants said that they themselves believed that the IAP Secretariat was expensive although there is a minimum cost to maintaining a Secretariat. As the budget became more limited over the first years of its lifespan (as a result of PMNCH budget limitations), the scope for the IAP to do more was also limited creating a potentially downward spiral. However, from the activity reports maintained by the Secretariat, it is evident that almost 50 outreach activities have been undertaken in 2019 alone with events organised at the September UNGA to interact with a range of stakeholders including the World Economic Forum (WEF), the Scaling Up Nutrition Movement, the Organisation for Economic Co-operation and Development, and others. Activities varied of course between short speeches and more prolonged engagements and this evaluation has not been able to undertake a methodical value for money review of the IAP. It has been difficult also to locate the costs of other accountability mechanisms (for example, those referenced in Text Box 3 and Annex 5) although the Global Preparedness Monitoring Board Secretariat, also based in WHO, has a two-year budget of about USD4 million.

IAP processes and delivery

Summary

The IAP produced an annual report for three consecutive years to 2018, foregoing 2019 (in favour of a larger, more expansive report in upcoming 2020). The annual report was the main vehicle through which the IAP exercised its accountability function supplemented with shorter, more opportunistic outputs related to topical issues (a shortage of HPV vaccine for example). IAP reports did not review the same 16 EWEC key indicators but rather focused on a single specific theme. Reviewing progress against a set of indicators would have afforded the IAP a clearer opportunity to assume a more direct accountability function and role and compiling its review in the form of league tables or score cards would have further enhanced its ability to draw attention to performance and progress (or gaps and stagnation). As it was, the process of theme selection was not well understood by partners while the choice to focus on a theme meant the IAP report strayed into advocacy. Although reports were high quality and hard-hitting compilations of important issues affecting women's, children's and adolescents' health they did not, in themselves, create a pathway to accountability. Reports did not enable the IAP to call out specific partners and countries lagging behind or encourage remedial action. To this day, the Panel has not assumed the authority that would allow it to "rock the boat" or make others uncomfortable by drawing attention to insufficient progress. The decision to focus on a theme was motivated partly by a concern not to duplicate what others were doing, itself indicative of confusion among EWEC partners, particularly PMNCH, about roles and responsibilities.

Findings presented in this section relate to the following evaluation questions	
Process of work and the delivery of results	• To what extent is the IAP delivering on its objectives? If not, why not? To what extent have EWEC partners provided support for IAP to deliver on its objectives? • How effective is the IAP in delivering its mandate and objectives and where and why is it more or less effective? What challenges does it face in operational terms? As an organisation in the global health architecture, how and to what extent has the IAP been influential? • What are the key drivers enabling or hindering influence? What role have EWEC partners played?

All quotations, where not referenced, are taken from comments of key informants and survey respondents collected specifically for this evaluation. All other quotations, including from documents or other material is referenced.

IAP ways of working

The IAP has adopted a more or less similar approach to its work pattern over its first three years of existence. Each year, the Panel produced a report with recommendations that it launched at a high-level event held in the United Nations headquarters during UNGA, co-hosted by governments and then submitted to the HLSG. Then, taking opportunities where they arose, members of the Panel talked about and promoted the findings and recommendations of the annual report to as wide a range of stakeholders as possible. For example, IAP members participated in the well-established Accountability Breakfast event held during UNGA in a neighbouring hotel and at another event held during the World Health Assembly.

IAP members, as professionals in their own right, used their speaking engagements to promote the IAP reports when possible. Some of these engagements were mentioned or posted on the IAP website and IAP resources supported some of these engagements although it has not been possible to summarise them nor to fully assess their value for IAP results. According to panel members and Secretariat staff, travel outside of IAP working meetings and agreed priority events or meetings has (until very recently) been decided in an *ad hoc* fashion based on opportunities as they arose, individual IAP member inclinations, and budget availability.

So far in 2019, the Secretariat has arranged a wide range of events and advocacy engagements, including participation in seven events at UNGA in September organised by the IAP Secretariat at a distance. In 2019, the majority of IAP activities have been undertaken mainly by the co-chairs and three or four IAP members but all or most members have been active in helping promote IAP messages.

In relation to its workplan, this year has seen a step-change from previous years. With new leadership and support, the IAP made a decision to avoid producing a report this year, focusing instead on building momentum towards a 2020 report (section 4.2).[41] This decision is in line with comments received that the annual reporting pattern was "too onerous" and led to insufficient time expended on addressing the findings and implementing the recommendations of one report before the next was issued. The workplan for the IAP has become more strategic. It covers 2019 and 2020 encompassing the report writing process and related outreach work. The workplan sets out the key events or processes where the IAP will invest time and resources. Travel by IAP members has been planned more methodically and limited to these specific events. The IAP expects that this shift will increase the likelihood of linking the use of IAP resources to outcomes and influence and will eventually have a positive effect on lifting its voice in the global health system.

Thematic reports vs progress monitoring

Between 2016 and 2018, the IAP produced three annual reports. In 2017 and 2018 the report was focused on a specific theme: adolescents and youth, and the private sector in health, respectively.

[41] The decision to forego a report in 2019 was also a recommendation from an external consultation: Ann Starrs, Final analysis of Global Strategy Reporting on Progress and Accountability, 1 July 2019, Commissioned by the PMNCH.

Reports were developed using a similar approach: the IAP called for submissions, conducted research, wrote and published the report, presented it to the UN Steering Group and then, as mentioned above, at a number of events where IAP members promoted the findings and recommendations.

Although one key informant thought that the selection of the theme was the result of "extensive consultation", there were concerns and questions expressed among most informants regarding the decision to select a theme and the process used to identify specific themes for IAP reports; informants were unclear as to why particular themes were selected. One for example asked, "Were they difficult or controversial issues? The IAP ToR suggests that themes should be rooted in the previous year's report results". There was a lack of understanding about when and how a theme was selected, or why a particular theme was identified. Some suggested the theme should be rooted in gaps identified by the report of the previous year while others thought it should be more forward looking and consider a major topic emerging at UNGA or the World Health Assembly. For example, one key informant pointed out that, "Panel topics seem piecemeal or *ad hoc*, rather than a progressive view across issues adding up to a strategic whole".

Key informants also questioned the choice by the IAP to focus on a single theme rather than to track a set of core indicators year on year that would enable it to identify gaps and assess progress[42]. For a majority, the IAP should be the body that assesses and comments on progress, identifies gaps, pointing to best practice, and directing stakeholders to address challenges through a series of recommendations that clearly identify roles and responsibilities. It could only fulfil this role, according to respondents and key informants, if it is tracking progress over time and identifying what is not working and where. As one survey respondent noted, "We are ten years from goal. Are we on track or not?" Another informant connected with the IAP said the decision to focus on a theme rather than key indicators was taken because of a belief that to review the progress and gaps related to the 16 EWEC key indicators "would duplicate what others were doing".

Text Box 2: The sixteen EWEC indicators

The EWEC Core Indicators are a subset of the 60 Global Strategy indicators. The sixteen in this subset are shown in the table below. They cover all aspects of the Global Strategy and were elaborated and agreed through a consensus – driven process in 2015 and 2016 by a wide group of EWEC stakeholders. Indicators 8 and 9 were updated by the World Bank and WHO to reflect the two agreed tracking indicators for UHC (the composite coverage index and the indicator to track catastrophic payments).

[42] This was possibly one of the most common and far reaching issues to emerge from the data and close to 100 per cent of respondents raised this issue or one very similar to it (other comments included the difficulty identifying progress, where partners were on track, where gaps and challenges were, who was making gains and why). The core indicators are here: http://apps.who.int/gho/data/node.gswcah

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

***Source**: Every Woman, Every Child, "Country data, universal accountability: monitoring priorities for the Global Strategy for Women's, Children's and Adolescents' health (2016-2030)", Geneva, 2016.*

The role of the IAP in relation to monitoring progress around the Global Strategy implementation was elaborated in the Strategy itself (p.73) and in the first (2015) ToR. Although somewhat weakened in the 2018 revision:

> *In the fulfilment of its mandate and functions, the IAP periodically issues recommendations and reports with a view to providing constructive, solution-oriented directions based on the best available evidence and analysis, with the aim of contributing to strengthened accountabilities for accelerated achievement of the Global Strategy and the Sustainable Development Goals. (p. 1)*

Nonetheless, there remains a reference to a report, "The IAP produces reports on the State of the World's Accountability to the Health and Human Rights of Women, Children and Adolescents, the main platform through which it issues its assessments and recommendations to the international community".[43] According to this expression of its mandate and role, the IAP no longer had a clearly defined or explicit responsibility to deliver a report that included specific monitoring points such as a defined set of indicators, a human rights assessment, or progress addressing the determinants of health and others.[44]

Data

The IAP has used its resources to research its thematic reports, gathering evidence and taking oral and written submissions from stakeholders and developing reports from these and its independent

[43] IAP ToR, paragraph 4

[44] According to some, PMNCH should have coordinated this aspect but other EWEC partners including Countdown 2030 and the H6 had roles to play as well. Although this evaluation did not assess the roles and performance of other EWEC partners, it seems to be the case that there was a lack of clarity about roles and responsibilities across the eco-system.

research. It was anticipated in the Global Strategy that the IAP would rely on information "routinely provided from UN agencies and independent monitoring […] and should not require additional data".[45] The consultations undertaken for the IAP reports suggest that a wider range of data were sought and this was almost certainly because the IAP reports were focused on under-researched thematic issues rather than analysis produced by H6 partners. Because the IAP does not, in fact, annually review the established 16 EWEC key indicators (Text Box 2) to track progress, its reports have not been able to establish a pattern among EWEC stakeholders that reinforces different roles and responsibilities within the EWEC eco-system related to the analysis of data by some agencies or partners to support the critical IAP function of conducting a review of progress, with recommendations to address gaps and challenges.

According to key informants, there is a range of data available through the Interagency Working Groups (for example on child mortality, maternal mortality and others) as well as data already analysed by Countdown to 2030. Each H6 agency, partner countries, and others in the global health system including Gavi, the Global Fund for Aids, Tuberculosis and Malaria (the Global Fund), and the GFF regularly publish results and data as well. The sixteen indicators have not therefore been assessed as a group in the first few years since 2015 (although they have been tracked by WHO). Although the role of the IAP was originally linked quite clearly to review functions that would have more clearly facilitated accountability for overall EWEC progress, the revised ToRs removed these details. In any event, the IAP has not undertaken a regular and systematic review of progress and gaps expressed through the regular analysis of the 16 EWEC key indicators by H6 agencies as anticipated in the Global Strategy.

The use of score cards or league tables was raised a number of times across the interviews and surveys. Indeed, it was raised in the PMNCH commissioned review of Global Strategy Reporting.[46] Many felt that the idea of a league table or score card would engender action from countries or from global stakeholders. Others pointed out that a United Nations agency or organisation could not undertake such a task but the IAP, being independent, had the opportunity and the position to enable it to develop such an accountability instrument. Score cards or league tables are not always successful, but they do help to identify where countries or partners stand in relation to agreed goals. The short review of other accountability instruments undertaken to add context to this evaluation (Annex 5) includes instruments that have successfully used score cards and leagues tables. The IAP informed this evaluation that it planned to inaugurate a league table approach in its 2020 report (see below, the 2020 IAP report and development process).

Accountability vs advocacy

One of the consequences of the approach adopted early on by the IAP – dropping the progress report of the sixteen key indicators to focus exclusively on a single theme – was that the reports were less easily styled as accountability reports. In fact, although they were considered by many – a majority even – to be excellent reports, they were characterised as advocacy rather than accountability. A majority of key informants raised this as a serious challenge to the IAP's ability to deliver on its mandate. For example, one survey respondent said, "The functions of IAP to do more calling out of areas with no or little progress is important, instead of duplicating monitoring which others are already doing" while another said, "I find them to be more akin to global advocacy for neglected areas of public health than clear accountability analyses. Accountability should consider what stakeholders are doing, where progress is being made, and more systematically, versus just these major gap analyses and recommendations."

Furthermore, in developing technical reports with recommendations on thematic areas, the IAP was thought to be straying towards a duplication of mandate. Other stakeholders in the EWEC eco-system had a responsibility to undertake technical analysis, they said, and IAP should not try to duplicate but rather to be "something unique, different from everything else". To some, this issue related to the

[45] Global Strategy, pg. 73.
[46] Starrs, 2019, pg 7.

position the IAP holds in the EWEC architecture (hosted by a partnership that is itself hosted by one of the EWEC partners) leading one key informant to the conclusion that, "When you push the IAP down the system [to be a project in a partnership in a technical agency], it risks becoming duplicative of the monitoring functions of individual agency evaluation offices". For most informants, however, the approach adopted by the IAP to deliver only thematically based reports every year without also monitoring progress against a set of key indicators, was a choice it made on its own.

The accountability role

There is a broader question, then, about what accountability is in the context of EWEC and the interpretation of accountability by the IAP in delivering its mandate and work. For most key informants and survey respondents, although the reports were engaging, high quality and motivating, they did not lay the groundwork for an accountability process as such.

What distinguishes accountability from monitoring and advocacy? To some extent, the realisation of *accountability* relies on what happens *after* the report is published and this angle is discussed in section 4.3. However, when asked what accountability meant in terms of the IAP, informants identified a wide range of actions and behaviours they consider appropriate or desirable (Table 4). Some informants explicitly linked the accountability role of the IAP to its origins in human rights-based thinking as referenced in section 2 above. Almost everyone had an idea of what accountability looked like in practice and for most it meant being able and willing to speak clearly, frankly and openly about progress, gaps and challenges in ways that assigned responsibility to specific partners or stakeholders and which led to more commitment to address problems and keep moving forward. For most informants and survey respondents, the IAP was not able to take on this role in a systematic way. A comment published in the Lancet just after the launch of the 2018 report concluded, "The IAP report would have been stronger if it had evaluated and judged specific private sector promises and commitments. This lack of scrutiny feels like a self-imposed and unnecessary restraint. Independent accountability sometimes means delivering unpalatable and undiplomatic truths. The future health of women and children depends on such unvarnished honesty."[47]

Table 4: Views about the essence of accountability in the context of the IAP

Views expressed by key informants and by survey respondents about the extent to which the IAP has fulfilled its mandate were consistently focused on the importance of being prepared to speak out:

"The IAP should have been the **reality check**"

"… need to **be prepared to rock the boat**…"

"…**making people uncomfortable** is part of the role…"

"Call out the laggards and **point out the gaps**"

"Not clear whether even in EWEC it **engenders a flicker**…"

"Accountability is a **watchdog**"

"Hear the **voices of women**…"

"Identify where civil society is **not given space**"

"If the accountability mechanism is serious and meaningful, you have to be serious. Rocking the boat is part of accountability. It's not about transparency, it's about **effecting change**, strengthening commitment, increasing efforts and persevering towards difficult but worthwhile outcomes.

"Needs to ensure it is decision-makers whose **feet are held to the fire** not the managers. Enforceable and changes the way people behave."

"Need to be fearless, **disruptive in the right way**."

[47] Richard Horton, Offline: It's time to hold the private sector accountable, The Lancet, Vol 392, September 29 2018. Pg. 1100.

"**Accountability is hard**; there are issues of mandate and authority, rigour, accepted data sources…"

"Duty bearers have an **obligation to rights holders**"

"The **country is the unit of engagement** yet where is the mandate?"

"**Confront the backlash on women's issues**, women's health and rights"

"No one is saying 'I thought you were going to do x or y' and then no one is saying '**why didn't you do it**?'"

"Too many reports; not enough **reckoning**"

"When countries feel like their information has to be reported, they take it more seriously. If IAP reporting was **linked to countries on-off track for indicators** they would take it more seriously"

"**No word for accountability in some languages** so it takes time to explain it"

"A mechanism that **challenges whether partners are doing the right thing**"

"**League tables, score cards**, progress reporting…"

"**Parliament and the courts are at the centre of accountability**."

"Need to **be the bad guy, to raise red flags**. Must be willing to say 'this is not going well'"

The 2020 IAP report and development process

It is worth noting that the plan for the 2020 IAP report is already in development and based on the draft table of contents, it already addresses some of the gaps identified in this evaluation related to engaging countries, assessing progress against the EWEC key indicators, using a league table and preparing to engage in a more explicit level of accountability. According to the chapter outline available[48], the 2020 report will focus on a wider vision to include: a review of progress made towards implementing the Global Strategy linking women's, adolescents' and children's health to the broader UHC goals; reflect country experience and the voices of women and others from countries; produce the first league tables or score cards; and lessons learned. The report aims to integrate several country case studies and to identify ways to embed accountability into country systems, both important, reflecting to the call for broader voices and more country engagement (section 4.3).

IAP products and dissemination

Summary

IAP report dissemination has been largely limited to global health leaders and other partners, through manual distribution (with accompanying letters from the co-chairs) or at relatively small events such as during UNGA. Report recommendations tended to be high level, lacking in specificity, difficult to act upon or not amenable to progress monitoring during implementation. Crucially, reports were not shepherded through any kind of visible process that led to EWEC partners accepting responsibility for responding to specific recommendations and for being held accountable for that response. IAP reports thus created the *possibility* of accountability (to the extent that their recommendations could be implemented) but the absence of an accompanying process meant that the essential follow-up and remedy component was lacking. Since neither the PMNCH, as IAP host, nor any other EWEC partner convened stakeholders to review, respond to and take forward the recommendations, IAP reports did not lead to any significant impact on the

[48] The 2020 IAP report chapter outline is here: https://iapewec.org/wp-content/uploads/2019/11/IAP-2020_-Report_Concept-note_20-11-19_web.pdf

implementation of the Global Strategy. In a United Accountability Framework where the role and responsibilities of EWEC partners in participating in and being held accountable is only vaguely described and entirely voluntary, the setup of the IAP has effectively limited its ability to compel global health partners (let alone countries, where the Panel has almost no visibility) to materially modify or alter their programme or policy approach as a result of its reports' recommendations.

Findings presented in this section relate to the following evaluation questions	
IAP products and their dissemination and reach	• What are the products of the IAP? Are products (including speeches, briefs and reports) produced on time, with the right frequency and to a high-quality standard? Are reports disseminated appropriately? • Is IAP report content perceived as appropriate, effective, and valued by partners and stakeholders? To what extent are IAP's products discussed, used or integrated into policy processes, relevant guidance notes and high-level decision-making? If not, why not? • To what extent do IAP reports have influence on global health processes related to women's children's and adolescents' health? How tangible is this influence? What are the drivers or conditions under which influence is achieved?

All quotations, where not referenced, are taken from comments of key informants and survey respondents collected specifically for this evaluation. All other quotations, including from documents or other material is referenced.

IAP products and outputs

While the main deliverable of the IAP as anticipated in its ToR, is an annual report, the Panel delivers a wider range of products. In addition to three annual reports, the IAP has published commentaries on a range of topics (women, children and adolescents' health in the context of UHC, for example, and a forthcoming statement on the limited availability of the HPV vaccine) in 2019. IAP members also speak at a range of events both about the IAP report and more broadly about accountability and the importance of maintaining focus on the health of women, children and adolescents.

Some of these products are on the IAP webpage. The webpage contains useful material that can help newcomers understand the IAP but much of this is buried. For example, the appointment of five new members, including the co-chair is announced at the end of a piece in the "News" section about IAP participation in the 2018 Partners' Forum in India.[49] The "About Us" section of the website includes highlights from 2017 but no other year and it is not clear why only one year would be included. Having reviewed the activities undertaken by the IAP during 2019 as an example, or the submissions process for the research in preparation for the 2018 report, it is evident that the majority of activity, processes and workflow undertaken by the IAP is not reflected nor captured on the website. The call for submissions for the aborted 2019 report is still posted. Thus, there are a number of ways in which the website currently supports, but also limits the public communication about the IAP and its work and the presentation of its own role and contribution.

Among key informants, several pointed out that when the IAP was established it was seen as something "very new and innovative". Informants had the impression that accountability was now "more commonly spoken about" and that was partly because the IAP efforts have expanded understanding and helped to enhance the value of accountability to the broader EWEC community.

It has not been possible in this evaluation to assess the extent to which this is the case. In fact, the IAP communications strategy was difficult to identify although it engaged in communications activities and aimed to do more in 2019 especially to deliver its messages and recommendations to a wider

[49] https://iapewec.org/news/accountability_uhc-2/

audience.[50] As noted in section 4.2, IAP members engage in a range of speaking functions, some planned and some opportunistic, related to events that individuals are already attending. The IAP has a Wikipedia page[51] and a social media presence and uses *#AccountabilityMatters* among other hashtags; its twitter handle has just under 500 followers suggesting that social media is not a significant mode of communication for the IAP. As noted in the limitations of this evaluation, however, a full social media analysis has not been possible.

Report content

Across all aspects of this review, the content of the IAP reports received the most consistently positive feedback. Reports were considered to be "insightful", "hard-hitting", "well-written", "absorbing" and "useful summaries of challenging topics". In fact, 74% of survey respondents said they thought the reports were of a high or very high standard and, in relation to the topics covered, were a contribution to the dialogue. The private sector report in particular was judged to be a useful presentation of a complex area and the calling out of the negative or harmful effects of the private sector on the health of women, children and adolescents was particularly noted.

Many informants identified the topics of the reports as "interesting" and "useful" and the IAP was commended widely for its work on the private sector and confronting the commercial aspects of private sector links to health. As indicated, a large proportion of informants posed questions about topics selection (section 4.2) and critically, what would happen as a result of the report publication. Only a third of respondents believed that IAP reports were valued by the right stakeholders or were treating the most relevant topics.

In his analysis of the 2018 report, Richard Horton suggested that the IAP should be bolder and more direct in their language commenting, "the lack of attention given by the IAP to government failures feels like punches being pulled. The IAP should not be afraid to name and criticise governments (and political leaders) whose decisions have failed to accelerate progress towards better health".[52]

Dissemination of the reports

IAP reports are published on the IAP website, through social media channels and in hard copy. They were disseminated to a range EWEC and other stakeholders. The IAP co-chairs sent letters to global health agency leaders accompanying reports, requesting assistance with dissemination of the report and its recommendations to country and regional offices as well as, through country offices, to parliaments and ministries of health.

Reports were targeted for dissemination to relevant sub-sector leaders as well. For example, the 2018 private sector report was distributed to global health experts specialising in private sector engagement. Sometimes there were specific requests in the accompanying cover letters such as the request to establish a working group and suggestions regarding upcoming opportunities for more dialogue on the contents of the report and the challenges it raised (such as at UNGA or the World Health Assembly).

Among key informants and survey respondents, the dissemination strategy of the IAP was not always clear. One respondent said, "The IAP seems to only disseminate its findings to leaders in global health" while another pointed out that, "The IAP reports do not reach the stakeholders who I work the most with - the human rights community. More needs to be done to extend the reach".

[50] For example, in late 2018, the IAP laid out four priorities for 2019 Communication strategy: The production of videos targeting specific audiences; Developing a community engagement strategy to organize consultations with communities; Policy briefs to provide further guidance on implementing IAP recommendations to specific stakeholders, such as Governments/ministers, NGOs, parliamentarians, donors, private sector etc; A structured outreach strategy aimed at key stakeholders to become champions for IAP recommendations, including members of the EWEC HLSG. (Extract from a letter to the EOSG signed by the IAP Co-Chairs 18 December 2018).

[51] https://en.wikipedia.org/wiki/Independent_Accountability_Panel

[52] Richard Horton, Offline: It's time to hold the private sector accountable, The Lancet, Vol 392, September 29 2018. Pg. 1100.

A review of engagements following the 2018 report publication shows that IAP members engaged with the World Economic Forum (WEF) as the newly established private sector constituency of UHC 2030, the Organization for Economic Cooperation and Development (OECD) during the WHA, and WHO in relation to the newly established Advisory Group on Private Sector Governance for UHC.

IAP outreach efforts included to parliaments mainly through the International Parliamentary Union (facilitated by PMNCH). Parliaments are a critical body entrusted to hold governments to account for commitments made to populations or citizens and the International Parliamentary Union (with 179 member-parliaments from across the world) has been cultivated as a partner by the IAP. It has been interested in maternal and child health issues as a matter of government accountability since 2008. Parliaments hold governments accountable and, as key informants pointed out, the IAP has not been able to systematically engage directly with country governments. Recently, 1800 parliamentarians passed a resolution calling on all parliaments to take whatever policy and legal steps are necessary to achieve UHC by 2030.[53] This kind of resolution, passed by parliaments directly, creates a pathway for accountability monitoring.

Reflecting on the limited engagement of the IAP with countries themselves, with women and adolescents, with decision-makers 'on the frontline', a wide range of informants spoke about this as a persistent limitation of the IAP approach in relation to its ability to speak about progress and gaps in different country settings[54]. Several key informants linked the limited dissemination, especially regarding country engagement, to either a limited budget (the IAP does not have the resources to actively engage countries) or a limited mandate (the IAP does not have the mandate to engage countries) or both.

IAP recommendations

The IAP website states that report recommendations "are included on ways to help fast-track action to achieve the Global Strategy for Women's, Children's and Adolescents' Health 2016–2030 and the Sustainable Development Goals – from the specific lens of accountability and of who is responsible for delivering on promises, to whom, and how"[55]. General best practice suggests that recommendations need to consider operational implications, be fully actionable, technically sound, time-bound and also identify who should take action.

Attitudes to the IAP recommendations varied significantly. Some considered them to be helpful and useful while others saw them as "too high level", not in accessible language, or did not serve to, "Help countries figure out where they have to take action". For many key informants, the use of score cards or league tables (as discussed in section 4.2) would highlight the gaps or challenges, making them more evident and rendering the actions to be undertaken more obvious.

Few institutional or management responses to the recommendations made in IAP reports were identified. Only one example of institutional commitment was found (from Gavi, stating how it would take forward the recommendations of the 2017 report on adolescents and young people). However, institutional commitments to act on recommendations were not common.

For some respondents, the global or high level of the reports made them difficult to translate to countries or to their own environments. One said, "To be clear, I am well familiar with the IAP annual reports. I have not seen any intermediary actions."

[53] International Parliamentary Union, Press Release "#IPU141 Assembly adopts first parliamentary resolution to achieve health coverage for all by 2030", IPU website, 17 October 2019. https://www.ipu.org/news/press-releases/2019-10/ipu141-assembly-adopts-first-parliamentary-resolution-achieve-health-coverage-all-2030

[54] The IAP spoke in country contexts quite often. For example in Jordan: Jordan https://iapewec.org/news/jordan-iap-2017-report-2/ and in Georgia https://iapewec.org/news/iap-at-parliament-of-georgia-urges-action-for-adolescents/

[55] IAP Website About Us page: https://iapewec.org/about/

Taking recommendations forward: a critical step in accountability

As well as being actionable and clear, recommendations should be met by a commitment to ensure they are followed up. As one IAP member stated recently, "Commitments are only as valuable as the follow-up".[56] This aspect of the approach adopted by the IAP is perhaps the most crucial to actually achieving accountability. In this step of the accountability process, those targeted by recommendations (assuming they are actionable and clearly targeted) should explicitly take ownership of the recommendations and identify what they will do, by when in order to be seen to be responding. This stage in the accountability process links "review" with "act" in the accountability framework (Figure 1). One respondent summarised it by saying, "It isn't so much the report or the products as the follow up which is worth considering. How many of the measures or recommendations are taken up and by whom? Has this made a difference to the issue?"

The question about follow-up and action as a result of recommendations was raised by almost all key informants and a large proportion of survey respondents making it a critical area of concern. For most, the publication of reports should have triggered the start of a process of outreach, communication and coordinated action that would bring major global health leaders to take ownership and identify their commitments in response to the recommendations. These commitments could then be tracked and monitored with a follow-up report on progress at a specified time in the future. This kind of process is about advancing the institutionalisation of accountability, creating a feedback process in the system to anticipate and engage in course correction. It creates pressure on stakeholders to pay attention, to respond and to act, creating visibility around those actions. It is almost entirely absent in the wake of the IAP report publication.

The question, then, is who is responsible for making this stage of the process happen? In the past, during the Commission on Information and Accountability (CoIA), high-level follow up on implementation of recommendations was actively promoted among all partners engaged in the work of the Commission. The WHO-based Secretariat, co-chaired with the International Telecommunication Union (ITU), worked with UNICEF and other partners to develop and deliver concrete investments in country information systems in accordance with Commission recommendations (and to report on progress). Major donors were engaged directly in CoIA and it was a much higher-level political process than either the iERG (created on the recommendation of the CoIA) or the IAP (created on the recommendation of the iERG). During the period when the iERG published its annual accountability report, WHO undertook a process of convening all major institutions to assess recommendations made and to identify what could be taken forward and how. Participants at these workshops were reportedly encouraged to make explicit commitments and report on progress in due course[57]. This process was referenced by a significant group of key informants who remembered it and pointed out that it no longer takes place. One informant suggested this may be because the IAP is hosted by a convening partner rather than an institutional or implementing partner ("an institutional hub is needed, not a convening hub"). Another pointed out that "IAP is not given a platform to ensure the recommendations are institutionalised and stakeholders express commitments".

One key informant pointed out that the Accountability Steering Group in PMNCH led a process to "review and recommend what PMNCH and its partners" might take forward from the IAP report presented and approved by the Executive Committee. In 2017, this included internal circulation of the report to PMNCH constituencies with a request for comments and the formation of a group of PMNCH Board members (Norad, UNICEF, WHO and the World Bank) who developed a response to the 2016 IAP report on behalf of PMNCH[58]. However, this response identified how PMNCH aligned itself with the IAP report and did not, in itself, contain specific commitments by either the PMNCH or any H6

[56] https://twitter.com/AE_Yamin/status/1194318921140191232

[57] One of these meetings, significantly amplified beyond the H6 because of a broader agenda focused on taking forward the development of the Global Strategy and associated accountability arrangements is reported here: https://www.who.int/maternal_child_adolescent/news_events/news/2014/MCA_post2015_meeting_agenda.pdf?ua=1

[58] This process was described in Item 5 of the PMNCH Executive Committee teleconference on 2 February 2017.

agency. Nor was the process at all methodical in relation to convening EWEC stakeholders more broadly to identify commitments related to IAP report recommendations. It is important to note that when asked, PMNCH indicated that it was already considering adopting a more proactive approach in the future, convening more EWEC stakeholders to review IAP recommendations and formulate commitments to take specific recommendations forward.

Text Box 3: How do other accountability instruments create traction and drive action?

A brief analysis of accountability instruments elsewhere in the global health and development system (Annex 5) identifies this element as a crucial step in many – although not all – examples identified. Among the accountability instruments modelled, there were three main approaches to follow up action or redress. These were:

1. The targeted institution was required (compelled) to make a management response to the recommendations and to identify what action it would take and by when. The accountability process included a review at a set point in the future to verify results. Examples of this were more common where there was a harmonised system under one authority, fully acknowledged as an authority by all partners, such as the UK parliament or the Global Fund Board, or potentially under the United Nations Secretary-General.

2. Accountability was based on a published league table or score card only and did not always require a response from targeted bodies (usually governments but also multilateral institutions). However, the instrument creates peer pressure and highlights where progress has and has not been made. Examples include the Mo Ibrahim Foundation Governance Index. Other similar processes were undertaken less frequently but had implications for funding decisions such as the Multilateral Aid Review (MAR) by the UK government and the Multilateral Organisation Performance Assessment Network (MOPAN) process.

3. A third approach was to adopt a clear framework for monitoring progress, document challenges, harmonise analysis among stakeholders, and make targeted, actionable recommendations which are followed up through advocacy and a proactive communications strategy engaging political leaders and other decision-makers. The mandate and provenance of board members facilitates this process. The Global Preparedness Monitoring Board (GMDP) is an example although a recently formed one. Another excellent example is the Commission on Information and Accountability which functioned in much the same way.

The IAP Secretariat recently undertook its own analysis identifying different accountability instruments at country, regional and global level, using a framework based on monitor-review-act. Lessons and best practice identified included: the importance of institutionalising accountability mechanisms; the role of meaningful community engagement, parliamentary oversight and an open media as the custodians of effective accountability; critical conditions for success include hosting, clear mandate, autonomy, and public awareness and understanding; integrated global and regional review mechanisms should be linked to national processes; and there is a compelling need to ensure accountability links across a spectrum of health and broader development issues/ priorities.*

**Summarised from: IAP Secretariat, Types of Accountability Mechanisms, 2019.*

There may also be a relationship between the role of the body to whom the IAP is accountable and the explicit commitment to follow-up. In the case of the iERG, the report was submitted first to the WHO Director General as the lead institution for the work of the iERG. Although also submitted to the EOSG, WHO took responsibility to follow up recommendations using its convening power and implementation role.

Howsoever it is taken forward, the process of engaging stakeholders (duty bearers) to analyse and respond to recommendations requires institutional lead with resources and capacity. In the most explicit examples of accountability processes, the targeted stakeholder is compelled to respond to the recommendations. A common theme emerging from the data collected for this evaluation strongly

indicates that the "recommendations, relevant as they may have been, were not followed up with diligence, nor were they monitored or tracked".

Reflecting on how this happened, several factors seem to be at play. One key informant suggested that "the system around [the IAP] has not effectively interacted with it" reflecting on the role of the broader EWEC eco-system and in particular the role of the H6 in making accountability a central component of common efforts. Another factor not yet explored is the role and concept of *independence* in the context of the IAP. These factors are considered in turn.

Text Box 4: Lessons from the iERG experience 2012-2015

When established, the independent Expert Review Group was the first of its kind – genuinely independent and mandated to review and speak openly about progress made towards achieving MDGs 4 and 5. Key features of the iERG:

- Experts served in their own capacity
- Remit to monitor all aspects of the health of women and children
- Funded by donors and supported at an institutional level in WHO
- Limited term of office
- Independent in relation to their freedom to speak but institutionally embedded in WHO

The iERG reports influenced the global maternal and child health agenda to at least some extent (for example, through focusing on adolescent health). Its ability to engage with and influence countries directly was limited by its mandate, time and resources available, institutional support and focus.
iERG reports were widely read and an institution-led process aimed to strengthen uptake of recommendations. The group reported during UNGA although off-site rather than directly to countries.

The role of the H6 and EWEC stakeholders

Key informants articulated a challenge related to the relationship between IAP and other partners in the EWEC architecture as well as a lack of support specifically from H6 agencies. One pointed out that, "Each H6 is focused on their own thing" developing in-house evaluations, monitoring reports and a series of internal processes linked to accountability within their own systems and to their own donors and country partners. In this context, they said, what is the role of the IAP and how should agencies engage with it?

Others identified that the roles and responsibilities of H6 agencies in the context of the whole UAF generally and the IAP in particular were (and still are) insufficiently defined or agreed upon. Much of the UAF relied on volunteerism (mutual accountability and voluntary engagement with accountability processes). To some extent, the IAP itself contributed to this perceived duplication by focusing its efforts on reports that are perceived as largely advocacy in nature. And, in a year during which a range of EWEC partners published similar types of reports that monitored, called for action, and made recommendations, this perception is well-founded; *"*Too much duplication of effort with what results?"[59]

[59] For example, in 2018, Global Strategy monitoring reports were published by various H6 partners as identified in Starrs (2019), pg 9:
Survive, Thrive, Transform: Global Strategy 2018 Monitoring Report- current status and strategic priorities (branded EWEC and H6 partners; released at World Health Assembly, Geneva, May); Report by the Director General on the Global Strategy for World Health Assembly (Geneva, May); thematic focus on early childhood development (documentation for WHA); *IAP Annual Report: Private Sector: Who is Accountable?* (released at UNGA, New York, September); Reports on EWEC commitments (all covering the period September 2015 to December 2017; branded PMNCH/FP2020 in support of EWEC; launched at Accountability Breakfast, UNGA, September); PMNCH Report: Commitments to the EWEC Global Strategy; Commitments in Support of Humanitarian and Fragile Settings; Commitments in Support of Adolescent and Young Adult Health and Well-Being; 2017 Progress Narratives for Commitments Made in Support of EWEC; *Global Strategy Data Portal*,

But, the IAP is not solely responsible; one key informant summed up a view expressed by many saying, "What is common is that there is a lack of consensus around what accountability is and what framework will work in global health to deliver accountability."

There was a clear sense that the IAP should not duplicate H6 or others but rather identify critical gaps. The IAP "should not, itself, be in the business of finding or generating data but should rather be focused on making a judgement about what available data means". However, the "independent voice is at risk … and there is a risk even now of the IAP being marginalised." The IAP was an idea which "everyone said was a good idea but for which there is limited buy-in at the moment."

Perhaps in response to the evident critique about duplication, the H6, Countdown 2030, PMNCH and the IAP, working together, are reportedly producing a series of progress reports to be published by the British Medical Journal in a January 2020 supplement called "Leaving no one Behind".

Independence

The concept of being independent has been at the centre of the IAP's role and work since its inception. In its "About Us" page, the IAP refers to its independence thus:

"…the IAP needs to have a real and perceived independence from current institutional structures, while at the same time avoiding the creation of new and burdensome administrative structures."

When asked, survey respondents and key informants were clear that independence was a critical element of the IAP role and was possibly its principal distinguishing feature or value added. Independence, they said, "denotes that it does not belong to EWEC", and, "in a corporate sense, is something not owned or funded by the corporate". In effect, independence creates a "firewall between the IAP and everyone else".

A common feature of accountability instruments working elsewhere (Annex 5) was that in many of them (not all) was their "tethering" to specific institutions either directly or indirectly. Sometimes this was obvious (the UK Parliament reviewed UK aid). Others were indirect. For example, there are Boards with heads of H6 agencies, leaders of stakeholder institutions (such as the Wellcome Trust) and government ministers, which aimed to oversee accountability across a disparate system involving multiple stakeholders (for example, the Global Preparedness Monitoring Board (GPMB)).[60] The more tethered an accountability process was, the more likely it was to compel a response to and action on its recommendations. Yet these processes were still characterised as "independent" because the body undertaking the review was deemed to be so through a variety of mechanisms related to how it was appointed, how it was funded or managed and to whom it was itself accountable.

However, other key informants were more focused in their assessment of independence saying that it is linked to "talking truth to power" and being able to say whatever they want or to develop recommendations that cover any angle of the field they are working in without hindrance or

Lesson from the CoIA process:

Given the multiple CoIA recommendations, inevitably some were more highly prioritized than others, by both implementing countries and donors. Those workstreams with outputs that were less defined, less immediately translatable into actions for improving maternal and child health, or politically sensitive, tended to receive less focus from countries and donors.

Source: Every Woman, Every Child, "Country data, universal accountability: monitoring priorities for the Global Strategy for Women's, Children's and Adolescents' health (2016-2030)", Geneva, 2016. Pg. 52.

which allows downloading of data on key indicators globally, by country and by region; it is currently being redesigned, for launch later in 2019; part of the Global Health Observatory; H6: Range of collaborative and individual agency reports related to WCAH; see http://www.everywomaneverychild.org/publications/ for selected products
Countdown to 2030: Range of scientific articles, including country case studies and thematic papers, as well as country profiles (see http://countdown2030.org/reports-and-publications/publications)

[60] For example, there are heads of H6 agencies, leaders of stakeholder institutions (such as the Wellcome Trust) and government ministers participating in the GPMB. https://apps.who.int/gpmb/board.html

censorship. What is crucial, they said, is the freedom to speak out. The institutional relationships may help or hinder this (protect independent speech or limit it) but are not in and of themselves crucial to having an independent voice. This is certainly borne out by the experience of other accountability mechanisms. The independent voice is most important to accountability not the institutional relationships although inevitably these two are linked to some extent.

Engaging country stakeholders

IAP activity and engagement, like the iERG before it, has been primarily focused on the global health system rather than countries. This was related to two factors primarily: the resources available to reach out to countries in a systematic way did not allow for extensive country engagement, while some key informants were not sure whether the mandate of the IAP was clear about whether it could engage directly with countries

In a shift from previous years, in 2019 the IAP developed plans (budget pending) to engage a series of countries in reflecting on what accountability means to different stakeholders and how it could be enhanced in their contexts. This is already part of the 2020 report plan (assuming funds are available). The absence of country engagement at a systematic level up to now has led to what some stakeholders consider the "creation of an echo chamber" and a situation where the IAP speaks out primarily to other global health partners engaged in women's children's and adolescents' health. The "voice of women" was considered to be missing from accountability and many survey respondents and key informants commented on their sense of the limited country voice in the work of the IAP. In addition, there was a sense that the recommendations were geared more towards global level agencies. Although one key informant pointed out that it was, "Difficult to hold countries to account", it is desirable to build a stronger link to the women and children, "to hear the voices of people who are living and experiencing the issues we are talking about… younger, older and more dynamic voices should be heard" suggesting that reports should be inclusive and participatory.

One way that the IAP reaches countries indirectly is through the International Parliamentary Union (IPU). In this approach, the IAP recognised "the fact that change must be led at the national political level", although more direct links to parliamentary bodies could increase effectiveness and reach. As mentioned, the proposed 2020 report will concentrate more systematically on countries including engaging with different stakeholder groups. This would be a step change for the IAP and one that, based on the evidence gathered here, would mark an important shift in the direction of course correction.

5 CONCLUSIONS

The IAP is an important and unique resource in the global health system. Its influence has been affected by the factors that have limited its progress and effectiveness: its own approach to its mandate, a lack of budget and other resources, confusion about the meaning of independence, limited support from its host and from across the H6 and broader EWEC eco-system, and the absence (for a range of reasons) of an appropriate, capacitated institution to which it could anchor or tether itself for the purposes of driving commitments in response to its recommendations. These conclusions, emanating from the findings laid out above, are discussed in relation to the three dimensions of the evaluation framework: progress, effectiveness and influence.

Progress

The IAP has faced a range of organisational, institutional, budgetary and operational challenges that have affected the extent to which it has been able to firmly establish its position and role as a leading voice on accountability in a crowded global health space.

It is important to acknowledge that the IAP has had to work and operate in an environment that has not always been supportive. It has struggled to secure and maintain a fully functioning secretariat, a budget that enables it to take action beyond a minimal workplan, with uneven institutional support from a host institution that appears itself to be struggling in some respects, finding its way with a weak ToR that has fluctuated on some of the most important aspects of its role.

It should also be acknowledged that if there had been a stronger institutional backing for the IAP at the start, the panel may have been reminded of broader expectations about their role and set on a different course, for example in relation to the selection of a thematic approach rather than a more objective EWEC progress review. This decision and the subsequent theme-based reports focusing on topics selected by the Panel without much justification (despite the importance of the topics themselves) has almost certainly inhibited the establishment of the IAP as a unique entity delivering a function no other entity can. The sixteen Global Strategy key EWEC indicators would have been an ideal framework for the IAP to build its role and position in the EWEC eco-system as there was no other entity explicitly tasked to undertake this kind of periodic review although the PMNCH did one in 2017. Moreover, this would not have precluded the identification of a theme as well. Instead, it would have acted to establish the IAP firmly in a defined space with a clear purpose that in addition, would have been largely country facing. To a certain extent, this has squandered an opportunity to raise its independent voice in a crowded global health arena.

Although it got off to a bumpy start, the IAP has, nonetheless, carved out a niche for itself, albeit a fragile one. Its panel members are – on the whole – hard working and many clearly commit well beyond their expected level of effort to ensure that work is advanced at a high standard. Panel members have been vocal about the importance of accountability and there is a sense that this voice has grown over time becoming clearer and stronger and more assured. There are important stakeholders that have partnered with the IAP including parliaments, some governments, and global leaders. Less clear is the extent to which it has been able to systematically engage country stakeholders including, crucially, women and adolescents themselves. In the context of UHC and especially the welcome focus on revitalising investment into primary health care, the voice of women, adolescents and communities is more important than ever.

However, the position of the IAP as a project positioned within a partnership that has a broad convening function but not an implementing role may not have served the IAP well given that the recommendations required H6 agencies (and others) to make concrete changes to their approach and delivery. The PMNCH commitment to accountability in its 2016-2020 strategy laid out a strong argument for the IAP to be rooted within it and subsequently, the 2018-2020 Business Plan[61] described how PMNCH would advance accountability with EWEC including commitment tracking. Yet, for a variety of reasons, the two entities have not, apparently, been able to cooperate on building a coordinated approach to accountability that enables each to flourish in distinct but complementary ways. This has probably also limited the progress that the IAP might otherwise have made.

Regarding the IAP budget and available resources, it seems clear that because of the decision to locate the IAP within PMNCH and to give the responsibility of funding the IAP entirely to PMNCH as its host, the budget of the IAP (and thus to some extent, its scope to operate) has always been determined by the PMNCH. However, if the IAP is valued as an independent entity serving the broader EWEC eco-system, its budget really ought to be determined (and funded) by the community it serves rather than a single organisation within that community.

The shift in 2019 and 2020 towards the development of an IAP report based on assessing progress across the range of Global Strategy indicators is a positive development. Critically, the plan to reach out to countries and to reflect the voices of people living and experiencing health challenges could help to strengthen the credibility and relevance of the report. The plan to develop a scorecard or league table as one of a number of accountability tools, is also welcome. In addition, the proposal to position the report firmly in a larger SDG 3 context, particularly related to UHC and primary health

[61] https://www.who.int/pmnch/PMNCH_Business_Plan_2018-2020.pdf

care, is strategic and again, aims to make it more relevant to a wider audience which is crucial to ensuring the needs of women, children and adolescents are understood and prioritised.

Effectiveness

The effectiveness of the IAP has been limited by the weak recommendations issued in its reports, the consequent lack of institutional response by key stakeholders to recommendations, and the absence of methodical follow-up to their implementation. Confusion about how independence should be preserved has further inhibited the ability of the IAP to develop a clearly defined and singular role in the EWEC eco-system, one that adds value and does not duplicate the work of other partners. These failings belong in different ways to all EWEC partners, not the IAP alone.

The IAP has demonstrated some verifiable elements of effectiveness. Its reports were considered by almost all to be of high quality and sound content, valued by many stakeholders as useful summaries of complex topics and, at the time of publication, responsive to an apparent gap. IAP members have undertaken a wide range of engagements and speaking roles to promote accountability generally and their report recommendations in particular, deepening partnerships with a range of stakeholders. These have been crucial and have enabled ideas the IAP has developed most – about the health risks posed by commercial interests, the neglect of adolescent health needs, human rights unfulfilled and others – to be discussed with a wider audience, adding much needed credibility to its work and profile.

Critically though, reports were in balance closer to advocacy pieces than a means to drive accountability. Three inter-related factors concerning the recommendations lead to this judgement: First, and already referenced, is that by focusing on recommendations related to a thematic area rather than reviewing the EWEC core indicators, the main opportunity of the IAP to offer a unique voice and fulfil its objectives was lost.

Secondly, the use of recommendations thus becoming the main accountability tool available to the IAP, placed particular pressure on them to meet certain criteria: they needed to be implementable, clear about who should take responsibility, the action required or the outcome anticipated, with timing identified as well as how the result could be tracked or verified. However, many IAP recommendations did not meet these criteria, being instead too high level, lacking in detail or too difficult to track, making them in one way or another, unsuitable to be used to drive accountability.

The third, and most crucial, factor related to a lack of institutionalisation of recommendations - akin to a process where relevant stakeholders accept responsibility for taking forward specific recommendations and being held accountable for those actions. This is the critical step in creating the possibility of follow-up and redress (and actually the full accountability process) which was not visible in relation to IAP recommendations.

In other words, in focusing on recommendations as its core offer, the IAP *created the potential* for accountability but it required other actors to ensure that accountability was fully realised through the critical follow-up process. This process did not happen. Neither the PMNCH as the IAP host, nor any H6 agency, nor the HLSG, nor the EOSG nor any other EWEC partner, played the critical role of convening (or causing to be convened) EWEC stakeholders to develop a response to recommendations, elicit commitments and follow-up. Because this process did not occur (because it was not required by the ToR, demanded by the EOSG or EWEC partners, championed by PMNCH as IAP host, or effectively advocated for by the IAP itself) the effectiveness of the IAP and its main instrument – its reports - was diminished.

Another critical issue relates to the historical (if not current) confusion about *independence* and what this means in practice. There are different types of independence including institutional, functional and others. What is vital among these is to have freedom of voice, freedom to speak and to use that voice to 'talk truth to power'. That freedom of voice does not require institutional freedom. In fact, when considering other accountability processes, the most effective in terms of eliciting a response and effecting real change, were those embedded in institutions.

What is unique about the IAP is this freedom of voice which no other entity in the EWEC eco-system has to the same extent. The misinterpretation of how to protect the independent voice of the IAP while ensuring it could be an effective accountability body has led to unnecessary self-isolation (the so-called firewall) from its closest partners (PMNCH and WHO). Building a complementary understanding about accountability roles and responsibilities with PMNCH as a host would not necessarily conflict with maintaining an independent voice. It is in fact possible to be hosted by an institution and also be institutionally or operationally independent from it. It is also not desirable if the effect of demanding that institutional independence results in the host institution (in this case the PMNCH and, more broadly, WHO) feel relieved of the responsibility to support the IAP in meaningful ways that enable effective EWEC accountability. By trying to be untethered to any institution, the IAP interpreted its freedom of speech in a way that weakened its effectiveness.

So it is, again, a range of factors that are at play in making the judgement that the IAP has not been as effective as it could have been. These include the strategic, tactical and operational choices made by the IAP at different points in its evolution. The IAP can only be as effective as the system in which it operates, and crucially, there are a range of stakeholders and partners that are implicated in this and not the IAP alone.

Influence

In the context of its limited progress and uneven effectiveness, IAP influence has not yet been strong enough to break through in a crowded global health arena. The need remains acute and the IAP is needed as much as ever. Yet its voice is not sufficiently heard in ways that will guide EWEC stakeholders towards making faster progress on the Global Strategy priorities.

Building on the limited progress and effectiveness of the IAP, there has also been a broader challenge related to the shifting global agenda and the priorities of the United Nations Secretary-General which have evolved over time. Multisectoral working and horizontal health systems reforms (UHC, primary health care) combined with rapidly emerging global challenges like the climate crisis and antimicrobial resistance have shifted to the centre of attention for policy makers and global leaders. In this "multipolar" health environment, an important question, then, concerns who the IAP should be influencing? Almost its entire governance system is internal to EWEC (it reports to the EWEC Steering Group, communicates to EWEC stakeholders, and is situated in/ hosted by an EWEC partner). How does it raise its voice beyond the EWEC eco-system or influence the way new priorities are addressed?

In the context of the operational, institutional and other factors set out above, getting beyond the EWEC eco-system relies on the IAP Co-Chairs themselves being able to carve out a session at the High-Level Political Forum, the United Nations General Assembly, the World Economic Forum, parliamentary fora and elsewhere. Naturally, the IAP should expect to advocate for itself of course. However, it is also handy to have champions. To their credit, panel members, supported by a tenacious Secretariat, have been able to organise and hold a range of meetings and events to broaden the audience and call out partners and stakeholders around different aspects of accountability, raising the concept and importance of accountability in different fora. The private sector report was launched in the United Nations rather than a neighbouring hotel, and government co-sponsors helped increase the gravitas and reach of the Panel on that occasion.

However, beyond this, the evidence points to a range of failures across all EWEC partners associated with or in some way responsible for the IAP. While some of these may be challenging to resolve in the short term (such as political will), most are not (budgets, institutional arrangements and support, work-planning) although clearly there is a relationship between the two.

As pointed out by many during the course of this evaluation, accountability is hard. It is hard to be responsible for delivering accountability but to be on the receiving end of an accountability process is hard too, and sometimes uncomfortable. Done properly, it takes resources, organisation, and political commitment and in the absence of any of these contributing ingredients, the quality of accountability

processes will be diminished. The Global Strategy UAF was ambitious and potentially far-reaching, distinguishing among critical elements (Monitor – Review – Act) and loosely assigning or envisioning roles and implied responsibilities to different partners. To a great extent these roles were voluntary as they had been previously. There was an anticipation that the political commitment to the health of women, children and adolescents that had been such a hallmark of the MDGs would continue into the SDG era and with that commitment, the voluntary participation of EWEC stakeholders in an accountability process – even when uncomfortable - would also continue.

To a large extent, this has not happened. The political backing from donors, governments, heads of agencies, the Secretary-General and others behind the sustained MDG 4 and 5-linked focus on maternal and child health has shifted to a new and broader set of priorities more consistent with the ethos of the SDGs. In tandem with that shift, voluntary participation in accountability for women's and children's health has somewhat weakened. Some of this is a natural (inevitable) result of rationing: time and resources are limited; what is measured is done; political commitment drives participation and presence. The IAP was established by the maternal and child health champions of the MDG era and, in a number of ways, it may not be the right format or structure that is most suited to meet the demands of the SDG era.

This is not to say that either the IAP or the accountability it seeks to deliver are any less important or less relevant. In many ways, as the global health agenda shifts to large, conceptually opaque, horizontal health goals like UHC, accountability for the health outcomes of women and children is more relevant than ever. It is also not to say that there is less concern for the health of women, children and adolescents as such, although there is certainly no doubt that aspects of women's health are under serious threat.

The conclusions of this evaluation point to a range of ways in which the IAP has so far failed to deliver on its potential. Nonetheless, it should be protected, enhanced, and supported. There are important elements of the IAP that should be safe-guarded even if they have not yet reached their potential: its independent voice; its reliance on experts from a wide range of fields and specialisms; its expectation to comment on neglected aspects of health outcomes for those most in need. The IAP offers the *possibility* of a critical voice in a crowded arena.

The question is how the IAP and its partners can maintain and grow a concern for the health of women, adolescents and children in the SDG era that meaningfully brings those concerns under the umbrella of current political commitment. It is the overarching conclusion of this evaluation that it remains worthwhile trying to find the right way forward and to nurture and promote the prize of independent critique. The recommendations that follow are proposed with this in mind.

6 RECOMMENDATIONS

Introduction to the recommendations

The findings and conclusions of this evaluation lead to the question: "where to next" for the IAP? Approaching the first five-year mark in the SDGs, it is germane at this juncture to reflect on whether a continued focus on one segment of health – albeit a big one – is actually reflective of the new global agenda or indeed, actually in the best interests of women, adolescents and children. The integrative, multisectoral approach encompassed by Agenda 2030 as well as the accompanying need to shift towards a life-course approach requires a broader way of thinking and working. Countries are both the lead and the focus, which should mean global partners gathering around individual countries to support bespoke plans, challenges and gaps. This is not to say that global health partners should not be held to account as well. If it is really the case that the GAP approach to accountability will primarily focus on country progress towards SDG 3, the opportunity to hold the twelve major global partners accountable for their work (individually and collectively) may be weakened. WHO has the lead in convening partners for the delivery of the GAP and, jointly with the World Bank, to support and track progress towards UHC.

During the course of this evaluation, many informants argued that the best way to promote the health of women, children and adolescents would be for the IAP to shift its focus to UHC. There is a strong argument in this: UHC implies universal coverage and it cannot be achieved without covering everybody including women, children and adolescents. There is a high level of political commitment around UHC that creates an important opportunity for increasing attention to and investments into the needs of women, children and adolescents. But there are risks as well. UHC is a concept and although there are agreed monitoring indicators, there is limited definitional clarity. In practice, UHC is advancing in countries with highly diversified interpretations, pathways and presentations; to some extent, 'you know it when you see it'.

At the same time, there is evidence that improved health outcomes for women and children are stalling: vaccine hesitancy limits immunisation coverage; there is a global roll-back on SRHR; and maternal deaths have not declined significantly in the last few years. The risk is that by shifting to UHC, the needs of marginalised groups will be further displaced by a focus on systems that become an end in themselves and are not linked directly to the experience and lives of people – the human impact. The solution perhaps lies in taking the opportunity presented by the significant political support for UHC across the world to shape the IAP around a broader health agenda centred on "Leave no on Behind".

There are multiple challenges facing the achievement of better health including vertical inequalities and inequities, broad global-scale crises such as climate change, and persistent humanitarian emergencies that create structural setbacks for large numbers of people. Seen across the life-course, the health needs of populations, especially women, children and young people, continue to grow.

The recommendations made in this report reflect the evaluator's expert judgment based on the evaluation findings and conclusions, supported by key stakeholders' feedback and the assessment of the evolving global health context. The recommendations are rooted in the expectation that the IAP will be protected although its shape and structure should evolve to better meet the challenges of the next decade in the SDGs era. It is also important to acknowledge that this evaluation concludes at a point in time when many of the main stakeholders involved in the IAP are in the midst of their own reflections on the future (for example, the EOSG and PMNCH are undertaking internal review processes that will conclude in 2020).

Recommendation 1: Evolve the remit of the IAP to include accountability for "*who is being left behind, where and why*" across health and well-being in the SDGs.

The IAP should become the independent accountability panel for health and well-being in the SDGs in the context of the commitments made in the 2019 High Level Meeting on universal health coverage. In this role, its main focus should be to identify who is left behind and why in ways that support defined and concrete actions that motivate stakeholders to effect change. Its mandate should require and support it to:

- **a)** Identify gaps in and challenges to progress from the perspective of the EWEC key indicators with respect to who is left behind focusing particularly on equity;
- **b)** By calling attention to coverage, quality and equity gaps, ensure UHC delivers for those left furthest behind, prioritizing women, children and adolescents;
- **c)** Call attention to global health issues of a trans-national nature;
- **d)** Hold global health partners accountable for their commitments to supporting 'leave no one behind'.

Priority: Very high
Directed to: United Nations Secretary-General and the Executive Office of the Secretary-General

Rationale:
In the SDGs era, it is difficult (and contrary even to the explicit approach of the SDGs) to isolate vertical programmes or demographic groups from the context of horizontal systems reforms. The broad political will behind the EWEC movement has shifted. A remit based on health across the SDGs would require a continued focus on women, children and adolescents, concurrently with the

current political commitments linked to UHC, PHC, disease control, and environmental health. Focusing on "who is left behind" would empower the IAP to consider all aspects of women's, children's and adolescents' health in a context that will attract/ maintain political will and commitment and to which all partners, governments and civil society actors can associate themselves.

Operational actions required:

- The Secretary-General to reframe or reshape the mandate of the IAP within the evolving global health context.
- A process required that would collaboratively oversee the development of a more detailed ToR for an integrated accountability system that covers the IAP and the processes and roles of key partners including a detailed operational ToR for the IAP itself.

Recommendation 2: Invigorate political commitment and institutional support for the IAP shifting it to a more visible place in the global health architecture

To do this:

a) Ensure that the mandate of the IAP continues to come from the SG and is renewed in support of the Panel's redefined remit [see recommendation 1]
b) Include the IAP's report as one input into the SG's planned progress reports to member states on implementation of the 2019 UHC HLM Political Declaration and at the High-Level Political Forum (HLPF) for tracking SDG progress.
c) Consider options to strengthen IAP hosting, oversight, reporting, resourcing and management to enable the IAP to fully deliver its accountability function.
d) Once identified, ensure that the roles and responsibilities of all partners linked to the accountability process, including the IAP, are fully elaborated in a comprehensive ToR.

Priority: High
Directed to: United Nations Secretary-General and the Executive Office of the Secretary-General, WHO, PMNCH, IAP, H6 partners

Rationale:

Accountability requires political will and active engagement across the health and development system. To this end, the IAP should be mandated by the SG and be situated where is can work across many organisations in a context that is clearly linked to action and implementation. It requires an institutional home that can enable and support it to convene a wide range of disparate partners (including global health partners, countries and civil society) to consider, adopt and take forward its recommendations and support countries to do so as well.

WHO is a clear option but there may be others and these should be considered in light of on-going internal reviews and taking into account current commitments, the leadership of WHO for health in the SDGs, the role of the WHA in monitoring UHC and the Global Strategy and other relevant factors. Options for hosting the Secretariat should also include an academic institution in partnership with a UN agency (probably WHO).

Operational actions required:

- The SG/ EOSG should mandate the IAP with a redefined scope (see recommendation 1)
- The SG/ EOSG should consider (with IAP partners) options and models for IAP hosting, resourcing, management and reporting
- The IAP should time its reports to ensure they contribute meaningfully to the SG's progress report to member states in relation to the UHC political declaration and HLPF meetings.

- **Arrangements** should build on existing commitments and comparative advantage in order to ensure harmonious links/ integration with on-going processes, notably in relation to the WHO in its role as GAP convenor and lead agency for UHC.
- A comprehensive ToR should be developed and agreed among all parties clarifying roles, responsibilities, obligations, timing and procedures.

Recommendation 3: Increase the influence of the IAP

Include a broader range of political and other voices in the IAP whilst still protecting its technical high-level quality and independence. The panel should be adjusted to include high profile individuals to help the IAP attract and maintain commitment to accountability for leaving no one behind. Individuals could be political (ex-heads of state or government), global development leaders (economists, policy leaders), heads of corporations, or leading activists and voices for specific groups (civil society, adolescents and young people for example). All appointments should be made on the basis of a transparent process for a pre-determined period of service and with clear terms and conditions.

Priority: High/ Medium
Directed to: United Nations Secretary-General and the Executive Office of the Secretary-General, IAP and partners

Rationale:
The IAP is currently comprised of primarily technical experts who are leaders in their field and this adds considerable credibility to its work. However, the balance between the technical substance and the ability to "open doors" and draw attention to the work of the IAP is an important finding from the evaluation as well as a notable feature observed in the review of other accountability mechanisms (for example, the GPMB and the Independent Monitoring Board for GPEI). Achieving a better balance between technical expertise and political leverage could help the IAP extend its reach in ways that would enhance its purpose and influence.

Operational actions required:

- In consultation with stakeholders and depending on budget availability the SG to consider expanding the panel or altering the balance in the membership.
- The IAP ToR should reflect a more transparent appointment process for the Panel, as well as terms and conditions including length of appointment, and expected level of effort.
- This (together with the other recommendations) implies a better resourced secretariat to include a communications specialist as well as additional research capacity and writing skills.

Recommendation 4: Develop a biennial review that is submitted to the SG

Once submitted to the SG, the biennial review should be distributed widely through a range of mediums including social media, public presentations, and online. This review should include:

- An assessment of progress against a set of core indicators drawing on available analysis provided by relevant partners (including the UHC monitoring reports and others),particularly identifying gaps and challenges to progress with focus on women, children and adolescents. Consideration should be given to the use of scorecards or league tables building on its experience once the 2020 report is published.
- A human rights analysis including an equality focus, calling attention to who is left behind, where, and why. This analysis could focus on a specific theme, population group or health dimension selected in a systematic or transparent way.
- Integrate and reflect the voices of people and their experience. To do this, the IAP should engage relevant partners (such as H6 regional offices) to capture country experience and

reflect the voices of those most left behind, putting people (and countries) closer to the centre of accountability.

- Identify risks to results and progress including humanitarian, peace and security risks
- Issue a limited set of specific, actionable, results-focused, and time-bound recommendations that can be monitored and followed-up.

Priority: Very high
Directed to: IAP, the Executive Office of the Secretary-General, broader partners and stakeholders

Rationale:
The conclusions of the evaluation point clearly to the need for:

- An accountability process that incorporates a more systematic review of progress
- Using methods that make it easier to identify where progress has (and has not) been made and why;
- Reports with more actionable recommendations;
- Including the voices of people more clearly and systematically;
- Engaging countries and putting countries closer to the centre of accountability;
- While also maintaining accountability of global health partners;
- A shift from annual to biennial reporting to reduce the pressure on the IAP, enable it to strengthen its findings and achieve longevity from each report.

Operational actions required:

- The IAP budget to support: (a) more efforts to incorporate country experience (probably through the regional offices) and to gather inputs for the review along with (b) outreach to a range of stakeholders including countries in support of disseminating findings and building commitment to recommendations;
- Adapt the IAP ToR to reflect this review structure and approach and its accompanying process as a core requirement of the IAP in order to ensure that resources, calendarization and work delivery arrangements are aligned;
- Develop, agree, and incorporate into the ToR a clearly laid out process to engage partners in implementing recommendations, including roles and responsibilities.

Recommendation 5: Define the full accountability cycle more clearly including undertakings in response to IAP recommendations

The IAP and its partners should elaborate and agree on an accountability cycle and its relevant stages clearly articulating key roles and responsibilities across the whole Monitor-Review-Act/Remedy cycle.

(a) The accountability cycle should lay out the responsibilities of the IAP to deliver its review accompanied by a clear undertaking by other relevant partners (such as regional offices) to engage with and respond to the recommendations, ensuring that the IAP is able to follow-up on these responses and report on progress with recommendation implementation.

(b) The IAP should elaborate a strategy and accompanying workplan and budget for each two-year (biennial) cycle. Once agreed, resources should be mobilised to enable the IAP to work at an efficient level to deliver its plan. Resources should primarily support: (a) an expanded panel and secretariat; (b) the collection of analytical material as inputs to the biennial review; (c) outreach and dissemination of findings; (d) additional activities foreseen in the workplan including engagement in key global health and other fora; and (e) better communication.

Priority: Medium
Directed to: The IAP, Its host and the EOSG

Rationale:
The IAP has been funded at a minimal level to support a Secretariat and travel costs associated with essential working meetings. In some years, there have been resources available for additional research. However, the IAP budget has been limited to such an extent that the overall value for money of the IAP's work has probably been less than it could have been. In other words, a little more funding would probably have delivered disproportionately more impact since it would have enabled fuller use of the expertise offered by the panel and the Secretariat. Additional funds could also significantly increase the influence of the IAP through better outreach, engagement with countries, and other stakeholders (also see Recommendation 6). Finally, there has been confusion about the extent to which the IAP can itself mobilise funds and this should be clarified.

Operational actions required:

- The IAP to elaborate a work plan and budget that reflects the implementation of the recommendations agreed from this evaluation, including: more outreach; the development of tools that could support countries to strengthen their own accountability processes; strengthened communications; expanded research support (especially for the league table/ score card and the human rights analysis); and the inclusion of country case studies where possible.
- The new host agency working with the IAP and its partners (depending on where it is positioned) would step up resource mobilisation efforts assuming IAP had the go-ahead or leeway to conduct its own fund-raising.

Recommendation 6: Develop an expanded and more comprehensive IAP communications strategy

Develop a more comprehensive and expanded communications strategy including outreach with a more accessible, navigable website to project a public face for the IAP.

Priority: High
Directed to: IAP

Rationale:
The findings of the evaluation suggest that the IAP is doing more than it presents itself as doing especially in relation to engaging stakeholders across the EWEC system and in countries. It is difficult to see the extent of IAP activities and publications when looking at the website or to locate key documents or information including about its role, mandate, meetings, processes, workplan and budget. IAP communications are an important part of its role and should be strengthened. The website is a critical portal for individuals, partners and countries to understand and engage with the IAP and it should be redesigned to be more intuitive, comprehensive, logical and open.

Operational actions required:

- Strengthen IAP communication strategy and approach
- Professionally redesign the IAP website (and keep it updated) such that it enables information and materials to be easy to find, especially those concerning IAP history, mandate, terms of reference, strategy, workplans, budget, past activities, future plans and engagements, options for those who want to get in touch or submit findings.

7 ANNEXES

Annex 1: Documents consulted

IAP key documents

IAP website: www.iapewec.com
IAP Member bios: https://iapewec.org/about/members-2
IAP Terms of Reference 2018
https://iapewec.org/wp-content/uploads/2018/12/IAP-TORs_updated_Sept2018-2.pdf
IAP Terms of Reference dated 12 November 2015
IAP Twitter: https://twitter.com/iapewec
IAP Wikipedia entry: https://en.wikipedia.org/wiki/Independent_Accountability_Panel

IAP strategies and results

IAP Results Framework (Draft)
IAP Statement at the United Nations High-level Meeting on UHC and key messages
IAP 2020-2021 Results Framework (Draft) (12 Sept 2019)

IAP reports

2016 **Inaugural report**: Old Challenges New Hopes
Full report and Executive summary: https://iapewec.org/reports/2016report/ and dedicated website: http://iapreport.org/2016/

2017 **Transformative Accountability for Adolescents**
Full report and Summary recommendations in 5 languages, and related links, e.g., Lancet comment, editorials etc. https://iapewec.org/reports/2017report/ ; Dedicated website, including multi-stakeholder submissions: http://iapreport.org/2017/ Press release: https://iapewec.org/news/2017report-pressrelease/

2018 **Private Sector – Who is Accountable?**
Full report and Summary recommendations in 5 languages, and related links, e.g., Lancet comment, editorials etc. https://iapewec.org/reports/2018report/ Dedicated website, including multi-stakeholder submissions: http://iapreport.org/ Press release: https://iapewec.org/news/2018-report-launch/

Additional IAP publications

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2018: Data monitoring, without independent accountability will not deliver for women and girls, (Women Deliver blog) here

2018: Newsletter with highlights of IAP activities and events in 2017 here

IAP, with H6, Countdown and PMNCH, Stronger accountability is needed to deliver UHC and improve women's children's and adolescents' health: Lessons from a decade of EWEC accountability, British Medical Journal, January 2020 (forthcoming).

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IAP, UN Secretary-General's Independent Accountability Panel for Every Woman, Every Child, Every Adolescent: Highlights From 2017, Locking in Accountability to Adolescents under the SDGs. Geneva, March 2018. https://iapewec.org/wp-content/uploads/2018/05/IAP2017Highlightsreport.pdf

IAP, 2017: Transformative Accountability for Adolescents. Accountability for the Health and Human Rights of Women, Children and Adolescents in the 2030 Agenda. Independent Accountability Panel, 2017.

News stories about IAP activities from the website. For example, Jordan https://iapewec.org/news/jordan-iap-2017-report-2/ ; Georgia https://iapewec.org/news/iap-at-parliament-of-georgia-urges-action-for-adolescents/

Internal IAP documents:

Information and documentation for IAP evaluation. Internal Note, October 8, 2019.

2019: IAP Activities and Products list of outreach, advocacy, governance and publications for 2019 (to date).

Letters and correspondence related to appointments, report distribution, planning and follow-up for events, progress reporting to EOSG. For example, a letter addressed to the EOSG from the Co-Chairs (18 December 2018); a letter from the Co-Chairs to the Minister of Health, South Africa thanking him for his role in the IAP events at UNGA 2019; a letter from the SG appointing a new Co-Chair in 2018; a letter to the DG WHO enclosing the 2018 Accountability Report.

Extract from accountability records showing the commitments made by Gavi to take forward the 2017 IAP Report recommendations.

IAP budgets and workplans 2017, 2018, 2019 and prioritised workplan and budget for 2020-2021.

List of consultations and targeted requests for evidence, July 2018

Lessons about types of Accountability mechanisms: IAP internal analysis, 2019.

Working draft outline (21 October 2019) and draft chapter outline, 2020 Annual Report: "Universal health coverage for all people: accountability for every woman, child, adolescent and those left furthest behind"

EWEC documents and webpages

Commission on Information and Accountability (CoIA) and the independent Expert Review Group

Every Woman Every Child, Delivering together for Every Woman Every Child: Aligning Action for Better Results. Undated.

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Every Woman Every Child and Partnership for Maternal, Newborn & Child Health. Progress in Partnership: 2017 Progress Report on the Every Woman Every Child Global Strategy for Women's, Children's and Adolescents' Health. Geneva: World Health Organization; 2017. https://iapewec.org/resources/gspr2017/

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PMNCH, 2017 Progress Report on the Every Woman Every Child Global Strategy for Women’s, Children’s and Adolescents’ Health Executive Summary, WHO, 2017

PMNCH, Strategic Plan 2016-2020, Geneva, 2016 https://www.who.int/pmnch/knowledge/publications/pmnch_strategic_plan_2016_2020.pdf?ua=1

PMNCH, Business Plan 2018-2020, Geneva, 2018. https://www.who.int/pmnch/PMNCH_Business_Plan_2018-2020.pdf

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Starrs, Ann, Final analysis of Global Strategy Reporting on Progress and Accountability, 1 July 2019, Commissioned by the PMNCH.

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Wider context

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World Bank Group, High-Performance Health Financing For Universal Health Coverage: Driving Sustainable Inclusive Growth in the 21st Century, Washington D.C., The World Bank, 2019.

Websites from related partners

https://www.familyplanning2020.org

https://www.globalfinancingfacility.org

https://www.who.int/sdg/global-action-plan

Global Strategy Data Portal

http://countdown2030.org/reports-and-publications/publications

https://www.un.org/sustainabledevelopment/health/

Annex 2: List of key informants

Name	Last Name	Position	Organisation
Nicholas	Alipui	Member	IAP
Anshu	Banerjee	Director, Maternal Newborn Child and Adolescent Health and Ageing	WHO
Carmen	Barroso	Former co-chair	IAP
Aleksandra	Blagojevic	Programme Manager for International Development	Inter-Parliamentary Union
Flavia	Bustreo	Board Member	Botnar Foundation
Jovana Magdalein Rios	Cisnero	Member	IAP
Peter	Colenso	Consultant	PMNCH consultant
Maria Jose Alcala	Donegani	Formerly: Director	IAP Secretariat
Fiona	Duby	Consultant	CEPA consultant
Leslie	Elder	Nutrition and IAP Focal Point	Global Financing Facility
Helga	Fogstad	Executive Director	PMNCH
Meena	Gandhi	Team Leader, SRHR Team (acting)	DFID - UK
Kul	Gautam	Co-chair	IAP
Kate	Gilmore	Deputy High Commissioner for Human Rights	Office of the High Commissioner for Human Rights
Githinji	Gitahi	Co-Chair and Global CEO	Amref Health Africa
Richard	Horton	Editor	The Lancet
Mariam	Jashi	MP and Chair of the Education, Science and Culture Committee	Parliament of Georgia
Ilze	Kalnina	Project Manager	IAP Secretariat
Carol	Kidu	Member	IAP
Anneka	Knutsson	Chief, Reproductive and Sexual Health Branch	UNFPA
Taona (Nana)	Kuo	Senior Health Adviser	EOSG
Shyama	Kuruvilla	Secretariat Director a.i. Senior Strategic Adviser	IAP Secretariat WHO
Anne-laure	Lameyre	Programme Officer	WHO
Alice	Levisay	Consultant	Health Systems Specialist
Thiago	Luchesi	Senior Manager, Public Policy Engagement	Gavi
Elizabeth	Mason	Member	IAP
Lori	McDougall	Coordinator	PMNCH
Mawad	Narissia	Programme officer	IAP Secretariat
Marjolaine	Nicod	Coordinator	Secretariat, UHC2030, WHO
Anders	Nordstrom	Ambassador for Global Health	Ministry for Foreign Affairs, Sweden
Nosa	Orobaton	Deputy Director, MNCH	Bill and Melinda Gates Foundation
Stefan Swartling	Peterson	Chief of Health	UNICEF
Gogontlejang	Phaladi	Founder and Executive Director	Pillar of Hope Organization (GPPHO)

Joy	Phumaphi	Co-Chair	IAP
Giorgi	Pkhakadze	Member	IAP
Alex	Ross	Director	Secretariat, Global Preparedness Monitoring Board (GPMB) WHO and WB
Miriam	Sabin	Accountability leader	PMNCH
Peter	Salama	Executive Director, UHC and Life course	WHO
Julien	Schweitzer	Consultant	PMNCH consultant
Gita	Sen	Member	IAP
Dorothy	Shaw	Professor Emerita, University of British Columbia	University of British Columbia and PMNCH Evaluation Review Group
Princess Nothemba (Nono)	Simelela	Assistant Director General (ADG) Special Programs and Focal Point for the Global Strategy	WHO
Kate	Somers	Senior Programme Officer, MNCH Team	Bill and Melinda Gates Foundation
Marcus	Stahlhofer	Lawyer	WHO
Ann	Starrs	Director, Family Planning	Bill and Melinda Gates Foundation
Marijke	Wijnroks	Chief of Staff	Global Fund
Alicia Ely	Yamin	Member	IAP
Robert	Yates	Head, Centre on Global Health Security	Chatham House

Survey responses by type of organization

Respondent's organization	Number of responses	Percent
Academic or policy research centre	3	3%
Bilateral development partner or Foundation	3	3%
H6, United Nations or and Financing Facilities	15	20%
Health care provider or professional association	2	3%
IAP panel members or former members	2	3%
International Non-Governmental Organisation (NGO)	19	27%
National civil society organisation (CSO)	8	11%
National health authority/ government	9	13%
Other (e.g. Consultant)	1	1%
Private sector, business or industry	10	14%
Secretariat to the IAP, UN EOSG, EWEC, PMNCH	2	3%
Totals	74	100%*

* Not 100% due to rounding

Annex 3: Key informants interview guide

Interview guide for key informant interviews: Questions were adjusted depending on the key informant.

Organisation and management

How is the IAP organised and managed? [*criteria:* Progress]
(Probe on the positioning and effectiveness of the IAP within the Universal Accountability Framework, size, terms of office, optimal location)

Are these arrangements functioning well? [Progress]
(Probe on scope, level of activity, the right level of budget, approaches to balancing funds without compromising integrity?)

To what extent does this organisational approach facilitate its functionality including its links to the wider Women's Children's and Adolescents' health community and range of EWEC partners/ stakeholders? [Effectiveness]
(Probe: Does the composition of the IAP conduce to its purpose?)

How does the organisation of the IAP drive its influence? [Influence]
(Probe: Composition, position within EWEC, PMNCH, structure based on level of activity)

Is the IAP optimally positioned and structured to maximise its influence? [Influence]

Process and delivery

To what extent is the IAP delivering its objectives? [*criteria:* Progress]
(Probe: what are the factors that enable or inhibit the IAP to deliver)

How effective is the IAP in delivering its mandate and objectives? Where and why is it most effective? [Effectiveness]
(Probe: Processes of the IAP during the development of messages and products, discussions, focus, identification of what it will focus on, research assistance, preparation of analysis)

What challenges does it face in operational terms? [Effectiveness]
(Probe: How is the evidence collected and analyzed; Are the best sources tapped, and is the information accurately interpreted?)

As an organisation in the global health architecture, how and to what extent has the IAP been influential? [Influence]

What have been the drivers of this? [Influence]

Products and dissemination

What are the most important products of the IAP? [*criteria:* Progress]
(Probe: Why were these products useful?)

Are products produced on time, with the right frequency and to a high standard? Are reports disseminated appropriately? [Progress]

(Probe: Are IAP products practical and appropriate? Are they targeting the right stakeholders?)

Is IAP report content valued by partners and stakeholders? [Effectiveness]
(Probe: The nature and quality of the IAP products. Do they address the right questions? How can EWEC partners support better implementation of recommendations?

How is it discussed, used or integrated into policy processes, relevant guidance notes and high-level decision-making? [Influence]
(Probe: If IAP recommendations are implemented, what is the influence? Are they having the desired influence through implementation?)

Do IAP reports have discernible influence on global health processes related to women's children's and adolescents' health? [Influence]
(Probe: The relevance and appropriateness of the Recommendations; do they address the gaps in accountability for implementation? Are the Recommendations being implemented at global, regional and country level? If not, why not?)

How and to what extent is this influence felt and what are the drivers or conditions under which influence is achieved? How visible is this influence? [Influence]
(Probe: The dissemination and implementation strategy -is it working? What are the roles of the HLSG, H6 at country-level and other partners in the dissemination and implementation of recommendations? Is everyone playing their role?)

Lessons and thoughts on benchmarking for independent accountability panels as mechanisms to support and deliver accountability
(Probe: How might lessons from the EWEC IAP experience be relevant to positioning independent accountability mechanisms for SDG3, NCDs or UHC?)

Annex 4: Survey

Welcome to the Independent Accountability Panel (IAP) evaluation survey. Thank you for taking the time to share your views. The IAP works to support the Every Woman Every Child (EWEC) movement. It was first convened in 2016 with a mandate to provide an independent and transparent review of progress on the 2015-2030 Global Strategy for Women's, Children's and Adolescents' Health (the Global Strategy) and to identify and promote the necessary actions to ensure achievement of the Strategy's goals using an accountability lens. It forms a part of the Global Strategy's Unified Accountability Framework. The Terms of Reference for the IAP are here. This survey is part of a structured evaluation of the IAP which is being conducted under the auspices of UNFPA. Survey responses are fully confidential. Questions may be skipped if you are not sure or have no comments.

Q1: Please select your affiliation:

Academic/ policy think tank
Bilateral donor
Funds, foundations or financing facilities
Government/ national health authority
H6, UN or other international agency
Health care provider/ professional association
IAP member or past member
IAP Secretariat/ UN EOSG/ EWEC Secretariat/ PMNCH
International NGO
National civil society organization
Private sector, business and industry
Other: _____

Section 1: The management and role of the IAP

Q2: In your view, on a scale of 1 to 5 to what extent do you agree with the following statements

Scale 1-5 with 1 as Do not Agree and 5 as Strongly Agree

- I have a full understanding of the IAP's role and purpose in supporting accountability
- The IAP's role and purpose is widely understood by those I work with
- It is most effective for the IAP to be comprised of a panel of experts serving in their own capacity
- The selection of panel members is transparent
- Please add your comments [open text]:

Q3. How well has the IAP performed its role (as defined in its Terms of Reference)?

Scale 1-5 with 1 as Not Well and 5 as Very Well.

3a: The IAP fulfils its mandate:

- By providing rigorous, independent and transparent assessment of progress on implementing the Global Strategy
- Identifying and monitoring commitments to the health and well- being of women, children and adolescents, taking a gender equality and human rights-based approach.
- Periodically issuing reports with constructive, solution-based recommendations based on the best available evidence;

- Contributing to strengthening accountability for the achievement of the Global Strategy objectives and SDGs.

3b: The IAP meets its obligation to be guided by principles and values of human rights, equity, gender equality, inclusiveness and transparency.

Q4. The IAP comprises an independent group of 10 internationally recognized experts appointed by the United Nations Secretary-General. To what extent do you agree with the following statements:

Scale 1-5 with 1 as fully disagree and 5 as fully agree.

- The selection and nomination of the IAP members is fully transparent
- The individual panel members are fully independent
- The Panel has the right number of members to do its work with credibility
- The collective expertise gathered in the IAP fits its role and mandate
- Members of the IAP should receive an honorarium
- Members of the IAP should be sponsored by their organisations
- Members of the IAP should have international standing but not necessarily as technical experts in women's, children's and adolescents' health

Please add detail about your answers

Q5. Please indicate whether and to what extent PMNCH (the current host) is able to meet the hosting and secretariat needs of the IAP.

Scale 1-5 with 1 as Not Well and 5 Very Well

- The role and responsibility of the IAP Secretariat is clearly detailed in the IAP TOR
- Adequate resources for effective IAP functioning are mobilised and managed
- The IAP is supported through active promotion and positioning by the host to enable the IAP to perform effectively in the EWEC ecosystem and beyond
- The IAP host actively disseminates the IAP's reports, recommendations and other products to stakeholders at national, regional and global levels
- The IAP host actively promotes IAP recommendations as a critical check point for all Global Strategy stakeholders
- The IAP host actively aligns stakeholders around the IAP recommendations and follows up on implementation with mutual accountability
- Supports the management and administrative functions of the IAP

Please add detail about your answers

Q6: In your view, to what extent does the organisation of the IAP, its Terms of Reference, hosting and management arrangements make it effective?

Scale 1-5
Please explain

Q7: How might the IAP be better positioned and supported to maximise its influence?
Please explain

Q8: Independent review is one of five components of the Every Woman Every Child accountability framework: Monitor, Review, including Independent Review, Remedy and Act. In general, how important do you think the following functions are for an independent review mechanism?

Scale 1-5 with 1 as Not Important and 5 as Very Important.

- Independent review of progress and accountabilities towards the EWEC Global Strategy objectives, including health and multisectoral SDG targets
- Highlighting gaps and calling out failures of accountability
- Making targeted, actionable recommendations to different actors
- Disseminating independent review findings and recommendations
- Promoting accountability principles and advocating for remedy and action
- Effective and accountable governance and management of the independent review mechanism
- Other, please specify

Section 2: Process and delivery

Q9: To what extent do you agree that the IAP follows processes that

- Utilize reliable and credible information provided by a range of sources, including the United Nations System agencies, academia, civil society, and independent monitoring groups and bodies, such as national human rights institutions.
- Disseminate its recommendations and reports widely to Member States and other stakeholders, including from civil society, academia, donors, the private sector, and the Every Woman Every Child global partners and architecture.
- Issues relevant and timely policy briefs, statements and recommendations, including for specific audiences, constituencies and meetings.

Q10. What are, in your view, the main five factors (listed in the order of importance) that enable the IAP to deliver?

Q11. What are, in your view, the 5 main factors (listed in the order of importance) that inhibit IAP delivery?

Q12: To whom should the IAP be accountable?

Q13: Can you provide examples of where the IAP has been most effective or where it could be more effective? (for example, the development of messages and products, depth of discussions, relevance of technical focus, quality of analysis)

Q14: To what extent has the IAP been influential in shaping the focus and actions of the EWEC ecosystem?

Scale 1-5 with 1 as Not Influential to 5 as Very Influential
Please explain your answer and provide example(s) if possible

Section 3. Products and dissemination

Q15: What have been the most important products or outputs of the IAP? And Why?
Please explain

Q16: In your view, on a scale of 1 to 5 to what extent do you agree that:

Scale 1-5

- Products are produced on time,
- With the right frequency
- To a high standard (in terms of research, analysis, recommendations)
- Reports are disseminated widely
- Reports target the right stakeholders
- Report content is valued by partners and stakeholders
- Other, please specify

Please explain your answer

Q17: To what extent are the IAP report recommendations relevant and influential for global and regional and country health processes related to women's children's and adolescents' health?

Scale of 1-5 with 1 as Do not Agree and 5 as Strongly Agree

- Recommendations are relevant, appropriate and actionable for different stakeholders
- Recommendations address the critical gaps in accountability for implementation
- Recommendations are disseminated to/ reach the key stakeholders to which they are directed including in countries
- Recommendations made by the IAP will be actioned by the right stakeholder at global, regional or country level.
- Recommendations are implemented at the right level (global, regional and country level).
- The IAP follows up on its recommendations to assess what has been taken forward
- Other, please specify

Please expand on your answers

Q18: Please indicate the extent to which you think the IAP gets the right kind of support from each of the following organisations:

Scale of 1-5 with 1 as Do not Agree and 5 as Strongly Agree

- EWEC
- PMNCH
- H6
- GFF
- Other key stakeholders

Please expand on your answers

Q19: What are the three most important lessons for other independent accountability panels would you identify from the IAP experience in the last three years?

Q20: Please make any further comments you may have about the IAP, its management, contribution and influence.

Thank you for your participation!

Annex 5: Examples of other independent accountability mechanisms

	ICAI (Independent commission for Aid Impact)	Mo Ibrahim Governance Index	GPMB (Global Preparedness Monitoring Board)	Office of the Inspector General (OIG) of the Global Fund
Mission or purpose	Provide independent evaluation and scrutiny of the impact and value for money of all UK Government ODA	A quantifiable tool to measure and monitor governance performance in African countries, to assess their progress over time and to support the development of effective and responsive policy solutions.	An independent monitoring and accountability body to ensure preparedness for global health crises. - To highlight critical gaps in preparedness - Identify potential mechanisms for addressing gaps - Mobilize its influence with leaders and policy makers to increase preparedness activities and ownership at global, national and community levels	Reports on all activities of the Global Fund in "the interests of transparency and accountability".
Mandate	All UK aid/ ODA	Governance index – all African countries	Ensuring system wide accountability for preparedness efforts across the world	All Global Fund activities
Governance	Operates independently to government; reports to Parliament through the House of Commons' International Development Committee to which they are accountable.	The Index is overseen by the Board chaired by founder Mo Ibrahim	Co-convened by the WHO and the World Bank Group. Governed by a Board appointed on a five-year term.	Independent from the Secretariat of the Global Fund; reports directly to the Global Fund Board.
Structure	Three commissioners supported by a secretariat. Evaluations contracted out to a service provider; commissioners issue reports.	Supported by an Advisory Council.	15-member Board made up of political leaders, heads of agencies and experts. The Board is supported by a Secretariat with outsourced research processes.	Inspector-led department with in-house audit and evaluation capacity.

Products	RAG rated evaluations of projects, programmes, or thematic areas.	Index measuring performance published regularly.	Annual report identifying progress, challenges and actions required to address key risks. Required actions are tailored to specific actors/ stakeholders	Audit and accountability reports using five colour coded ratings scaled from 'unacceptable' to 'exceeding expectations'
Frequency of reporting	Several reports on different subject areas each year	Annual index that shows trends and previous scores	Annual report (only one report so far)	Various reports each year on countries and programme/ thematic elements.
Institutional tethering	The International Development Committee, Parliament	Independent Foundation that sponsors the Governance Index	Builds on the Secretary General's Global Health Crises Task Force and Panel; based in WHO.	Global Fund for AIDS, TB and Malaria – the OIG is the independent audit office of the Global Fund.
Response expected (consequences)	Management response from DFID or other UK government department. Response indicates whether the finding and recommendations are accepted and what action will be taken, by when in response.	No response required; peer pressure effects.	Monitoring framework to track progress. Use of advocacy from high level Board.	Management response from relevant Secretariat department identifying actions to be taken by when. Follow up by the OIG.
Website	https://icai.independent.gov.uk	http://mo.ibrahim.foundation/iiag	https://apps.who.int/gpmb/about.html	https://www.theglobalfund.org/en/oig/
Other similar or related accountability instruments	The Multilateral Aid Review (MAR) assessed the performance and value for money of development partners including the global health agencies against a range of criteria. No longer undertaken but still available on the DFID website: https://www.gov.uk/government/collections/multilateral-aid-review.	The Ibrahim Prize for Achievement in African Leadership (http://mo.ibrahim.foundation/prize) rewards leadership and performance although it has not been awarded recently.	Other review processes (not related to GMDP) include the Multilateral Organisation Performance Assessment Network (http://www.mopanonline.org) which assessed and published the work of multilateral agencies.	The TERG (Technical Evaluation Review Group) of the Global Fund is a group of independent experts who commission evaluations of the Global Fund which require a management response and the identification of explicit action to be taken. https://www.theglobalfund.org/en/technical-evaluation-reference-group/

Annex 6: Terms of reference

TERMS OF REFERENCE

FOR THE EVALUATION OF THE WORK OF THE INDEPENDENT ACCOUNTABILITY PANEL

1. Introduction

The UN Secretary-General (UNSG) appointed the Independent Accountability Panel for Every Woman, Every Child, Every Adolescent (IAP) in 2016 to provide an independent and transparent review of progress and challenges on the implementation of the 2016-30 Every Woman Every Child Global Strategy for Women's, Children's and Adolescent's Health (Global Strategy) to strengthen the response from the international health community and member states.

1.1 A Brief History

The IAP was appointed in early 2016. Since its appointment, better clarity has been achieved by global stakeholders in determining how the SDGs and in particular SDG 3 will be achieved. The Universal Health Coverage agenda has been clarified in the context of Primary Health Care and the prioritization of communities, putting people at the centre of UHC. There is a better clarity as to roles and responsibilities of stakeholders, and a stronger emphasis on integration at country level, and between stakeholders' groups; including the need for data sharing and common monitoring and reporting, to ensure the implementation of a single unified country led strategy.

The IAP is an independent panel of experts, whose secretariat is hosted by the PMNCH, which in turn is hosted by WHO. The budget for the work of the IAP as well as the staff complement of the IAP secretariat are set by the board of the PMNCH partnership, and funds are allocated by the PMNCH secretariat. The IAP is a key part of the Global Strategy's Unified Accountability Framework (UAF), which aims to minimize the reporting burden on countries and facilitate effective follow up action under the auspices of the Global Strategy and *Every Woman Every Child* movement.

The IAP is responsible for developing its own program, within the budgetary and personnel limits set by the PMNCH, in line with its mandate. In line with the IAP Terms of Reference (TOR), the IAP reports to the HLSG, chaired by the UN Secretary General[62]. The IAP is supported by a small IAP Secretariat

[62] The HLSG comprises:

1. The UNSG as the Senior Chair
2. Sitting and former Heads of State and Government as Co-chair and Alternate Co-Chairs
3. Ministers of various national portfolios
4. Representative Principals of EWEC partners (H6, PMNCH, GFF)
5. Representatives of key diverse stakeholder groups and influencers

Each HLSG member represents a critical stakeholder group with which they are expected to coordinate to meet the mandate of the HLSG given their individual expertise:

1. To provide recommendations on financing the EWEC Global strategy, including the accountability function and the IAP;
2. To enhance accountability, including by implementing the recommendations of the IAP;
3. To strengthen cross sectoral action to implement the Global Strategy and other SDGs, including implementation of IAP recommendations in the Adolescent and Private sector IAP reports.
4. To advocate for country level implementation, including supporting countries to implement the IAP recommendations.

Initially the IAP formally submitted their reports to the UNSG. As of 2018, in line with the revised IAP ToR, the IAP reports are formally submitted to the HLSG. IAP ToR available at: https://iapewec.org/wp-content/uploads/2018/12/IAP-TORs_updated_Sept2018-2.pdf

that is hosted by the Partnership for Maternal, Newborn & Child Health (PMNCH) which fulfils the role of fiduciary, legal and administrative agent of the IAP, and which preserves its perceived integrity as an independent body. PMNCH is hosted by the World Health Organization (WHO). PMNCH is also mandated by the Global Strategy to play a coordinating role to ensure all stakeholders can act on recommendations.

1.2 Objective of IAP

The objective of the IAP is to provide an independent and transparent review of progress on the implementation of the Global Strategy and to identify and promote the necessary actions to ensure achievement of the Strategy's goals using an accountability lens.[63] IAP members engage in advocacy for WCAH through high level engagements at country, regional and intergovernmental levels and collaborate with OECD, Countdown 2020, PMNCH and other bodies as well as engaging and advocating virtually. An independent evaluation of the IAP is especially relevant today as the EWEC IAP is the first and so far, the only "independent" accountability mechanism for implementation of the SDGs. There are calls to establish similar independent accountability mechanisms for UHC, NCDs, other areas of global health, and even to monitor achievements toward other SDGs. The EWEC IAP independent evaluation will consider lessons that may be relevant to establishing similar independent accountability mechanisms for UHC, NCDs or SDG-3.

1.3 IAP reports

In line with the mandate from the UN Secretary-General, the IAP periodically issues reports that provide an independent snapshot of progress on delivering results to the world's women, children and adolescents for their health and well-being with a view to providing constructive, solution-oriented directions based on the best available evidence and analysis, with the aim of contributing to strengthened accountabilities for accelerated achievement of the Global Strategy and the Sustainable Development Goals[64].

1.4 Dissemination and Use of IAP Reports

The IAP strives to get its messages out to the widest possible audience for review and action of diverse stakeholders. Member States and other stakeholders are encouraged to discuss the reports at global and regional fora such as the High-Level Political Forum on Sustainable Development, the World Health Assembly, annual meetings of the international financial institutions, human rights treaty bodies, the Inter-Parliamentary Union, and other high-level political assemblies and events, and to take appropriate actions.

1.5 IAP Products and Actions to Date

- In 2016 the IAP produced its first report "Old challenges new hopes"[65]. The report called for urgent action in three key areas: leadership, resources, and institutional capacity building.
- In 2017 the IAP report "Transformative Accountability for Adolescents"[66] focused on adolescents and called for "Making Universal Health Coverage work for adolescents". The report sought to make adolescents visible by measuring what matters; providing a package of

[63] The IAP espouses the full cycle of accountability: monitor, review, act and remedy.
1. "Monitor" refers to better data and disaggregation to help reveal inequities and inefficiencies.
2. Under "Review", the IAP stresses importance of independent oversight institutions.
3. Under "Action" and "Remedy" the IAP focuses on the policies and investments for transforming the underlying conditions that prevent women, children and adolescents from thriving.

[64] In line with the terms of Reference of the IAP, available at: https://iapewec.org/wp-content/uploads/2018/12/IAP-TORs_updated_Sept2018-2.pdf

[65] Available at: https://iapewec.org/reports/2016report/

[66] Available at: https://iapewec.org/reports/2017report/

essential goods and services for adolescents, and includes mental health and the prevention of non-communicable diseases.

- In 2018 IAP focused on the private sector "Private Sector: Who is accountable?"[67] In looking at how the private sector could be held accountable for protecting women's, children's and adolescents' health, the report addresses the question of who is responsible for holding them to account, and the mechanisms for doing so in the areas of:
  1. Health service delivery;
  2. The pharmaceutical industry and access to medicines; and
  3. The food industry and its significant influence on health and nutrition, with a focus on NCDs and rising obesity.

The dissemination of the IAP reports has followed a standard process of:

1. Launch of the report at the UNGA; the 2017 and 2018 reports were launched at high-level events co-hosted by governments with a submission to Every Woman Every Child High-Level Steering Group (HLSG), chaired by the UNSG.
2. Dissemination during the WHA, and WHO regional meetings, as well as at major global health events.
3. Dissemination to governments via UN missions in Geneva and New York and EWEC global stakeholders.
4. Dissemination to partners and publication of a comment in Lancet.

2. Rationale for the Evaluation

The IAP has been in existence for three years, during which time it has delivered and disseminated three annual reports, the goal of which was to make recommendations to potentially shape dramatic stakeholder action to implement the Global Strategy for Women's, Children's and Adolescents' health. The goal of this evaluation is to assess the extent to which the IAP engagement, advocacy, reports and recommendations have impacted stakeholders' actions and lead to better results for women, children and adolescents to achieve the goals set forth in the Global Strategy and broader 2030 Agenda. The independent evaluation of the IAP will take place in tandem with an independent evaluation of PMNCH. The two evaluations will be designed to "speak to each other," based on separate analyses of the management and execution of IAP/PMNCH functions. In making this assessment, the evaluation will consider the IAP's role within the Universal Accountability framework and overall delivery on the SDGs. The findings will help shape the future strategic priorities of the IAP. In addition, the evaluator may consider how lessons learned through the EWEC IAP evaluation could be relevant to positioning independent accountability mechanisms for SDG3, NCDs or UHC.

3. Users of the Evaluation

The Evaluation will position the IAP appropriately within the Unified Accountability Framework to ensure that the IAP fulfills its primary mandate whilst at the same time:

- Adding value to IAP reporting
- Facilitating effective follow up action at country level and among the HLSG, H6 UN agencies and PMNCH.
- Ensuring alignment and co-ordination with other related accountability mechanisms (this should be made explicit in the evaluator's proposal).

4. Evaluation Objectives and Scope

4.1 Specific Objectives

The Evaluation will examine:

[67] Available at: https://iapewec.org/reports/2018report/

1. Whether the IAP is functioning as a meaningful accountability mechanism, engaging all relevant stakeholders, including the H6 agencies at country-level, for the implementation of the Global Strategy and ensuring that:
   • It is known who is being left behind, why and by whom?
   • It is known what the critical accountability gaps that need to be redressed are, and where intensified policy attention and investments are required.
   • It is known what course can be taken to improve institutional and collective accountabilities.
2. Based on the evidence gathered and to the extent possible given the short life of the IAP to-date, does the evidence show how IAP advocacy efforts and reports are contributing to a shared understanding of meaningful accountability, shaping leadership agendas, influencing resource allocations for every woman, every child, every adolescent, and how institutional priorities are being affected? What has been the IAP's role in addressing key accountability bottlenecks, including better tracking of resources, ensuring social accountability and the engagement of communities and civil society stakeholders?
3. Is the current arrangement with PMNCH the most advantageous to effectively deliver on the IAP's independent accountability mandate?
4. How effective has been the IAP's internal process for the theme selection?
5. What has been the effectiveness of the IAP in harmonizing monitoring and reporting within the multi-stakeholder EWEC architecture?

4.2 Scope of the Evaluation

The Evaluation shall limit itself to the role of the IAP within the EWEC framework and the supporting functions of other stakeholders within the framework.

- The focus of the evaluation shall be (1) the IAP's products, their relevance, dissemination, adoption, impact on implementation and stakeholders, and (2) the IAP's advocacy and high-level engagement in national and international fora.
- The Evaluation shall assess EWEC partners' coordination with and support for the IAP, including support for implementation of IAP recommendations at national and international levels.
- The Evaluation shall not focus on the overall effectiveness of any other stakeholder, save where it affects the fulfillment of the IAP objectives.

5. Evaluation Questions

In making these assessments, the evaluation will look into:

- The positioning and effectiveness of the IAP within the Universal Accountability Framework.
- The structure of the IAP: what should be the composition of the IAP? How big should it be? How long should the terms of office be? Where should it be housed? What should its budget be? How should the funding be mobilized, without compromising integrity?
- The nature and quality of the IAP products (reports): Do they address the right questions? How is the evidence collected and analyzed; Are the best sources tapped, and is the information accurately interpreted?
- The relevance and appropriateness of the Recommendations; do they address the gaps in accountability for implementation? Are they practical? Are they targeting the right stakeholders? Are they having the desired impact through implementation?
- The dissemination and implementation strategy: Is it working? What are the roles of the HLSG, H6 at country-level and other partners in the dissemination and implementation of recommendations? Is everyone playing their role?
- Are the Recommendations being implemented at global, regional and country level? If not, why not? How can EWEC partners support better implementation of recommendations? If IAP recommendations are implemented, what is the impact?

- How might lessons from the EWEC IAP experience be relevant to positioning independent accountability mechanisms for SDG3, NCDs or UHC?

  Note: The evaluation questions will be further refined during the inception phase of the evaluation

6. Evaluation Methodology and Approach

The evaluation will be managed by the EWEC Secretariat, hosted by UNFPA, according to that agency's policies and procedures for external evaluations. The Evaluation shall be conducted over a period of 4 months.

Proposals should specify the overall approach of the evaluation with a detailed description of methodology in line with the UN Evaluation Group's guidelines. Key elements highlighted must include:

1. The overarching methodological framework
2. Expected data collection techniques, and analysis methods, with descriptions of any instruments used to collect needed information
3. Outcome and output indicators that are being proposed or have been used to measure performance, along with associated baseline and target data
4. The process for verifying findings/triangulating findings with key stakeholders
5. Meetings or consultations or other interactions expected with particular stakeholder groups
6. Which stakeholders in the evaluation are likely to be involved (for example, EO of the UNSG, HLSG, Member States, PMNCH Board, etc.) and the criteria for selection

6.1 Evaluation Process and deliverables

Evaluation Phases	Methodological Stages	Deliverables
1. Preparatory	➢ Drafting of terms of reference ➢ Setting-up of reference group ➢ Assessment of proposals	➢ Final terms of reference (EWEC Secretariat/UNFPA Evaluation Office) ➢ Selection of evaluation consultant and communication to the Evaluation Reference Group (ERG)
2. Inception	➢ Structuring of the evaluation ➢ Desk Review of documents	➢ *Kick-off workshop with ERG and other stakeholders (NYC or Geneva) to present Methodology of the Evaluation (presented in a PowerPoint)*
3. Data collection	➢ Data collection, structured interviews	➢ *Stakeholder Workshop: Presentation of the results of data collection, draft report and recommendations to the ERG (PowerPoint)*
4. Reporting	➢ Analysis ➢ Judgments on findings (conclusions) ➢ Recommendations	➢ *Draft final report and PowerPoint virtual presentation for ERG (back to back with Stakeholder Workshop)* ➢ *Recommendations Worksheet* ➢ *Final report*
5. Management response	➢ Response to recommendations	➢ Management response (EWEC Secretariat on behalf of EWEC partners)

6. Dissemination	➢ Dissemination electronically on PMNCH and EWEC websites	➢ *Report* ➢ *Executive Summary* ➢ *PowerPoint presentation of the evaluation results and recommendations*

6.2 Preparatory phase

The evaluation manager (EWEC Secretariat) leads the preparatory work. This phase includes:

- The constitution of an evaluation reference group.
- The drafting of the ToR
- Selection of a consultant to carry out the evaluation

6.3 Inception phase

The evaluator will conduct the design of the evaluation in consultation with the evaluation manager. This phase includes:

- Identification, compilation and review of relevant documents
- Development of the list of evaluation questions, as well as the respective indicators, sources of information and methods and tools for the data collection
- The development of a data collection and analysis strategy as well as a detailed work plan for the reviewing, interviewing and reporting phases
- The evaluator will produce an inception note in PPT format to present evaluation approach and methodology to the evaluation manager and reference group. The evaluation approach and methodology will be subject to the approval by the evaluation manager and the representative of the UNFPA Evaluation Office.

6.4 Data collection phase

6.4.1 Desk study-document review

The desk study will analyze all existing and available documentation, data and information that have been compiled during the inception phase of the evaluation. The evaluator will identify informants and solicit information, documentation and data relevant to the study. To the extent possible, the desk study should produce information on all evaluation questions and associated indicators identified during the inception phase.

6.4.2 Interviews

Interviews (in-person or virtual) will be conducted with relevant international experts, stakeholders and partners of the EWEC IAP, including the H6 Technical Working Group, the GFF, EWEC Secretariat, the Executive Office of the Secretary General, PMNCH staff and board members, selected EWEC High Level Steering Group Members, researchers and INGO partners. The interview protocol will be guided by the interview questions outlined in the TOR.

6.5 Reporting Phase

The reporting phase will open with a half-day analysis workshop bringing together the evaluator, evaluation manager and stakeholders to discuss the results of the document review and interview phases, presenting preliminary findings and recommendations in PPT format. The objective is to ask the various stakeholders to deepen their analysis of the findings, after which the evaluator will proceed to finalize the report.

This final report will be submitted to the evaluation manager for comments. Prior to submission, the evaluator will ensure that it was internally quality controlled against the evaluation quality assessment requirements of UNFPA (to be provided to evaluator). The evaluation manager will assess the quality of the submitted draft report. If the quality of the draft report is satisfactory (form and substance),

the report will be circulated to the ERG. In the event that the quality is unsatisfactory, the evaluator will be required to produce a new version of the draft report.

On the basis of the comments expressed (if any) by the ERG, the evaluator should make appropriate amendments and submit the final report. For all comments, the evaluator will indicate in a detailed manner and in writing how s/he has responded. This will constitute a specific document ("Trail of comments") for the review of the evaluation manager and which will be circulated to the evaluation reference group together with the final evaluation report. The final report should clearly account for the strength of the evidence on which findings are made so as to support the reliability and validity of the evaluation. The report should reflect a rigorous, methodical and thoughtful approach. Conclusions and recommendations need to be built upon the findings of the evaluation. Conclusions need to clearly reference the specific evaluation questions they have been derived from; recommendations need to reference the conclusions they are responding to.

The report is considered final once it is formally approved by the Evaluation Manager. The evaluation products delivered must abide by the UN editorial guidelines, including the supplementary editing guidelines to be provided by UNFPA Evaluation Office. Deliverables that do not meet these standards will be rejected by the evaluation manager.

6.6 Recommendations

The evaluator is charged with carrying out the evaluation and has responsibility for its overall quality and content. Working under the direction of the evaluation manager, the evaluator will ensure that:

- All evaluation **findings** presented in the draft report **must be based on and linked to evaluation evidence** as presented in the report and its annexes
- The **evaluation conclusions** must, in turn, be **grounded in the evaluation findings** presented in the evaluation report
- *Suggested* evaluation **recommendations** put forward by the evaluator must **arise from and be logically linked to the conclusions** presented in the evaluation report

In keeping with its responsibility to carry out the evaluation from an external, independent and unbiased perspective, the evaluator is most directly responsible for ensuring that the first two of these conditions (grounding findings in evidence and ensuring that conclusions are based on findings) are met. It is also responsible for developing *suggested* recommendations that are directly linked to the evaluation conclusions.

The evaluator is, however, less well equipped to ensure that the final recommendations arising from the evaluation consider operational implications and are fully actionable, technically sound and consistent with ongoing and planned activities of the IAP. In fact, the Evaluation Reference Group has a direct role to play in the development and refinement of evaluation recommendations.

In order to facilitate dialogue with, and the strongest possible input from the Evaluation Reference Group, the Evaluation Manager will (a) circulate the suggested recommendations to its members for preliminary comments/inputs; (b) host a half-day workshop on the evaluation recommendations for the detailed presentation by the team leader and discussion with the members of the Evaluation Reference Group of the draft evaluation recommendations.

After discussion and endorsement of the recommendations by the Evaluation Reference Group, the final set of recommendations will be included in the final evaluation report. The evaluator and the evaluation manager will ensure that all final recommendations stem logically from the conclusions of the report.

6.7 Management response

During this phase, the Evaluation Manager will coordinate the preparation of the management response to the evaluation report. The management response will be prepared following the template and process established in accordance with UNFPA Evaluation Policy. The Management Response must be completed following the release of the final report and will be published on the EWEC and PMNCH websites.

7. Dissemination

The evaluation report will be published on the PMNCH and EWEC websites. The evaluator will prepare a detailed power point presentation on the process and results of the evaluation. Further, the evaluator will prepare a short power point presentation, which conveys the evaluation results in a user-friendly way. The evaluator may be asked to assist the evaluation manager during the dissemination phase. The results, the conclusions and recommendations of the evaluation may be presented in a number of fora which will be decided at a later stage.

8. Management and Governance

The EWEC Secretariat will lead the management of the evaluation. Its main responsibilities are to support and oversee the evaluation processes and ensure the quality and independence of the evaluation (in line with UNEG Norms and Standards and Ethical Guidelines). The main responsibilities of the **evaluation manager** are:

- draft the terms of reference
- lead the hiring of the team of external evaluator, reviewing proposals and approving the selection of the evaluator
- chair the reference group and convene review meetings with the evaluator
- guide the evaluator all through the evaluation process
- review, provide substantive comments and approve the inception PPT (including the work plan, analytical framework and methodology)
- review and provide substantive feedback on draft and final evaluation reports, for quality assurance purposes
- approve the final evaluation report in coordination with the reference group
- disseminate the evaluation results and contribute to learning and knowledge sharing among EWEC partners

The progress of the evaluation will also be followed closely by the **evaluation reference group** as well as other key stakeholders who are directly interested in the results of this evaluation. The reference group will support the evaluation at key moments of the evaluation process. They will provide substantive technical inputs, will facilitate access to documents and informants, and will ensure the high technical quality of the evaluation products.

The main responsibilities of the reference group are to:

- contribute to the methodology of the evaluation during the inception workshop
- act as a source of knowledge for the evaluation and facilitate access to information and documentation
- assist in identifying external stakeholders to be consulted during the evaluation process;
- participate in review meetings with the evaluator as required
- provide comments and substantive feedback to ensure the quality – from a technical point of view - of the draft and final evaluation reports
- play a central role in assessing and refining the recommendations suggested by the evaluator
- contribute to learning, knowledge sharing, the dissemination of the evaluation findings and follow-up on the management response

Membership of the ERG will include:

1. Executive Office of the Secretary General
2. EWEC Secretariat (Chair of ERG)
3. External experts
4. H6 representative
5. IAP Co-chair (declined to participate)
6. PMNCH nominee
7. GFF representative
8. UNFPA Independent Evaluation Office

9. The evaluator

The Evaluator will have the following mix of knowledge, skills, and experience:

1. Master's degree and relevant expertise in women's, children's and adolescents' health
2. At least ten years' experience at international senior management or policy level in a relevant area, or
3. At least ten years' experience in Evaluation, with experience in organizational analyses, change management, risk assessment, or related fields.

Desirable:

Senior level experience in global health or public health, specialized in one of the SRMNCAH fields.

10. Schedule and deliverables:

Evaluation Phases	Outputs or Deliverables	Dates	Meetings
INCEPTION PHASE			
Inception report setting out research design, methodological approach, data collection strategy, analytical framework and timeframe.	Inception Report	To be submitted 19 September	N/A
	ERG Inception meeting by teleconference to present evaluation methodology (inception report)	End of September (25 or 26 or 27)	Evaluation manager, Evaluator and **ERG members** (*Video conference)*
RESEARCH PHASE			
Desk review and key informant Interviews	Documentary review and stakeholder **interviews with EWEC ecosystem and partners**	20 September to 31 October 2019	Evaluator
SYNTHESIS AND DRAFTING STAGE			
Data analysis and report drafting with conclusions and preliminary recommendations	Draft final report and recommendations worksheet	1-12 November 2019	Evaluator ; Evaluation manager
	ERG Workshop: (i) presentation of draft final report ; (ii) Finalisation of recommendations with ERG	Mid November 2019	Evaluation manager; Evaluator; **ERG members** *(meeting in NYC or in Geneva tbc)*

	Completion of Final Report, and Trail of comments compiled by Evaluation Manager	19 November 2019	Evaluator ; Evaluation manager
REPORTING PHASE			
Presenting Final Evaluation	Final Report (a Word document) with Executive Summary PowerPoint Presentation of the evaluation main results	29 November 2019	(a) presentation by Evaluation manager and evaluator to **ERG members** *(video conference)* (b) presentation by Evaluation manager and evaluator to EOSG *(video conference)*

As outlined in the above table, the sequencing of deliverables will be as follows:

a. 10 days Desk Review
b. 1-day Inception workshop to Present PPT Methodology of Evaluation to ERG
c. 13 days Interviews
d. 10 days Writing of Report, recommendations worksheet and PPT
e. 2 days Prepare for and conduct Stakeholder Workshop on Recommendations

11. Budget and payment schedule

The budget maximum ceiling for the proposal is USD 29,000. The costs to the consultant will include:

- Services (36 days)
- Travel and DSA for two trips (6 days total) to Geneva and New York (Travel related costs for participation in the two meetings with the reference group, interviews of key informants)
- Incidentals

Applicants are reminded that their financial proposals are evaluated for competitiveness even if they are within budget.

The payment schedule will be as follows:

I. 30% on acceptance of the PPT at inception phase
II. 20% on acceptance of Draft Final Report
III. 50 % on presentation of the Draft final report (PowerPoint) and Stakeholder Workshop and on acceptance of the Final Report and Final PPT

Note: No payment will be processed until the corresponding deliverables are formally approved by the Evaluation Manager. Travel Related and 'Other' Out-of-Pocket expenses will be paid in a total of instalments to be decided with the Evaluation manager and to be agreed upon contract signature.

12. Bidding instructions

1. The Technical Bid should be concisely presented and structured in the following order to include, but not necessarily be limited to, the following information:

a. Understanding of the Terms of Reference and requirements for services (1 page). This section should include any assumptions as well as comments on the scope of services as indicated in the TOR or as you may otherwise believe to be necessary.

b. Proposed Approach and Methodology of the evaluation, including a description of the manner in which you would respond to the ToR (1 page). This section should address:

   i. An understanding of the objective and scope of the evaluation

   ii. A discussion on which methodologies will be applied

   iii. Comments on any challenges or difficulties, which might arise in structuring and conducting the evaluation, suggesting solutions when applicable

c. CV of evaluator

2. The technical bid is evaluated on the basis of its responsiveness to the Terms of Reference by reviewing the technical proposals submitted by the bidders against the evaluation criteria published below. (Maximum score allocated is 100 total points, after calculations based on weighting of each of the evaluation criteria.)

Criteria	**[A] Maximum Points**	**[B] Points attained by the bidder**	**[C] Weighting %**	**[B] x [C] = [D] Total Points**
a) Understanding of the terms of reference	100		20%	
b) Methodology and approach in responding to the ToR	100		30%	
c) Expertise (CV)	100		50%	
GRAND TOTAL ALL CRITERIA	400		100%	

Ensuring rights and choices for all

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