

# WEB ANNEXES. IAP 2020 Report: Caught in the COVID-19 storm: women's, children's and adolescents' health in the context of UHC and the SDGs

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## Overview of methods to develop the IAP 2020 report and recommendations

A range of methods informed the development of the IAP 2020 report, building on a decade of experience with the evolution of the EWEC accountability framework (Annex 1).

Targeted literature reviews and narrative syntheses of the evidence considered the impacts of implementing accountability in countries, and then the implications of COVID-19 for women's, children's and adolescents' health and rights (Annex 2).

Statistical analysis of countries' progress toward EWEC and SDG targets (Annex 3) first considered the latest published global estimates and the expected or projected rates of progress to achieve 2030 targets. A review of published scenarios of the impact of the COVID-19 crisis indicate that progress could be further set back (Annex 3.2).

Country scorecards were developed to present the latest available global estimates on key EWEC indicators aligned with the SDGs. Countries were grouped by income category so that they may be compared with their peers. Countries were marked as having surpassed/achieved global targets, or as advanced, intermediate or catching up to the targets (Annex 3.3). Factors for success were identified based on IAP expert assessments of requirements for country progress. Differences in the factors for success indicators between countries that performed better vs. countries that performed worse on key EWEC survive indicators were then analyzed statistically (Annex 3.4).

Methods to develop five country case studies in the IAP 2020 report included document reviews, field visits, key informants' interviews, focus groups and multistakeholder dialogues (Annex 3). Summary highlights of these case studies are presented in the IAP Report. The full country case study reports are available on the IAP website.<sup>a</sup>

The following annexes include more methodological details.

The approach to developing recommendations was based on qualitative analysis of the themes and topics emerging from the literature reviews and front chapters of the report, including the statistical analyses and country case studies. Recommendations also drew on the IAP external evaluation of 2019 and a review of the evolution of the EWEC accountability framework. This process led to the development of an accountability framework with essential accountability functions and features to be integrated and institutionalized at all levels. The framework was cross-checked with all IAP members and validated through iterative review and refinement with respect to the findings in the literature and the IAP 2020 report.

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<sup>a</sup> Available from (forthcoming): <https://iapewec.org/reports/annual-reports/iap-2020-report/>

## Annex 1. Evolution of the EWEC accountability framework

### Human rights foundations

- The Universal Declaration of Human Rights (1948) positions effective remedy as a fundamental right.<sup>1</sup> The International Covenant of Economic, Social and Cultural Rights (1966) requests states to report on what they have done to uphold the right to health and other rights.<sup>2</sup> In 2000, the UN Committee on Economic, Social and Cultural Rights confirmed that the right to health includes underlying determinants of health, freedom from discrimination, participation and accountability.<sup>3</sup>
- Paul Hunt, the first UN Special Rapporteur on the right to the highest attainable standard of health (2003–2008),<sup>4</sup> noted that “like any other human right, the right to health is almost meaningless if unaccompanied by mechanisms of accountability”.<sup>5</sup> A human rights approach emphasizes obligations and requires all duty-holders to account for their conduct.<sup>6</sup> This should not be misunderstood as “naming and shaming”, or blame and punishment. Hunt employed the concept of *constructive accountability*, as defined by Lynn Freedman.<sup>7</sup> This is a process of identifying “what works, so it can be repeated, and what does not, so it can be revised”.<sup>8</sup> Hunt set out the *monitor, review, remedial action* framework<sup>9</sup> and the importance of transparency and independent review.<sup>10</sup>
- Hunt emphasizes the opportunity and need for an independent review body for the EWEC Global Strategy. This would build on the experience of human rights treaty body mechanisms and add technical expertise to enhance the specificity and actionability of review recommendations. With respect to how members would be selected and appointed, he cites, “numerous precedents within the UN and beyond for the appointment of independent experts who have the confidence of governments and other stakeholders.”<sup>9</sup>
- The linkages between the MDGs and human rights, and shared commitments for women’s, children’s and adolescents’ health and rights, were explained in a publication by a working group on the MDGs and Human Rights for the UN Secretary-General’s Global Strategy for Women’s and Children’s Health.<sup>11</sup>
- Mappings of global and national accountability mechanisms and lessons<sup>12,13</sup> inform EWEC partners in setting up the Commission on Information and Accountability (CoIA) that underpinned the first EWEC Global Strategy.

### EWEC Global Strategy (2010–2015): CoIA and iERG

- The CoIA working group on accountability for results recommended the creation of National Health Commissions.<sup>14</sup> With government backing, these would coordinate national accountability systems and integration of CoIA recommendations in national planning, budgets and timelines.

- CoIA recommended that a global independent Expert Review Group (iERG)<sup>15</sup> should synthesize all available information and evidence, address discrepancies and make its own analysis and recommendations in an annual report to the UNSG. It also concluded that further thought needs to be given on how better to harmonize accountability efforts.<sup>16</sup>
- Both CoIA and the iERG were hosted at WHO. CoIA 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 Toure) as vice-chairs. The iERG was chaired by Professor Richard Horton Editor of The Lancet and Joy Phumaphi Executive Secretary of the African Leaders Malaria Alliance.
- The final CoIA report highlighted the importance of learning and continuous improvement, and simplified the accountability framework to a monitor, review and act cycle. It states that monitoring is just the first step towards accountability and that review is needed to evaluate “whether pledges, promises and commitments have been kept”.<sup>17</sup> The framework links accountability for resources to results, i.e. the outputs, outcomes and impacts they produce.<sup>18</sup>
- The iERG adopted the CoIA framework of monitor, review and act.<sup>19</sup> In its final report, iERG asserts the importance of independent accountability and calls for much stronger links between monitor, review and act for results and resources. However, the EWEC accountability framework has not been implemented through, or integrated in, a system, with clear partner roles and institutional mechanisms linking these functions.

#### Updated EWEC Global Strategy (2016–2030): UAF and IAP

- Accountability for the updated EWEC Global Strategy was updated by the development of a multistakeholder unified accountability framework (UAF) to help countries drive results, resources and rights.<sup>20</sup> Its functions included: facilitating tracking of resources, results and rights; promoting alignment of national, regional and global investments and initiatives to support the Global Strategy; and contributing to national and SDGs monitoring through the Global Strategy indicator and monitoring framework.<sup>21</sup> The UAF identified harmonized roles in Global Strategy accountability for partners, for example, for PMNCH<sup>22</sup> as host of the IAP secretariat and for Countdown to 2030 as a key partner in monitoring coverage and equity of health services for women, children and adolescents.<sup>23</sup> WHO and H6 partners developed a data portal for Global Strategy monitoring on the Global health observatory.<sup>24,25</sup> For Review, the IAP took over from the iERG as the global independent review group for the updated EWEC Global Strategy. The IAP has been co-chaired by Sania Nishtar, Kul Gautam, Carmen Barroso and at the time of the IAP 2020 report, by Joy Phumaphi and Elizabeth Mason.
- In its first report, the IAP built on the CoIA and iERG framework, and amended the accountability cycle to monitor, review, *remedy* and act.<sup>20,26</sup> This recognizes remedy as a formal enforceable change, including through existing judicial accountability mechanisms at national level. This is at the core of effective remedy for rights and is set out in instruments accepted by states through intergovernmental processes. This also aligned the accountability framework with the 2030

Agenda for Sustainable Development, which notably sets out the importance of rule of law, access to justice, independent review and effective, accountable and inclusive institutions.

- Subsequent IAP reports applied the updated framework to accountability for adolescents' health (2017)<sup>27</sup> and the private sector (2018).<sup>28</sup> However, despite these contributions and a decade of EWEC accountability, the need for a better shared understanding of accountability persists.
- The 2019 external evaluation of the IAP highlights strategic and operational challenges related to the EWEC accountability system overall, and specifically in relation to the IAP. The evaluation highlights examples of other independent accountability mechanisms as context for recommendations on the IAP.<sup>29</sup>
- IAP's 2020 report sets out an accountability framework to bring together essential functions (monitor, review, remedy and act) and features (commit, explain, implement and progress) of effective accountability contributing to universal goals and implemented in unique contexts.<sup>30</sup> The updated framework gives due prominence to the importance of institutionalizing accountability functions and features in a 'whole of government and whole of society' approach, and the intrinsic value of a culture of accountability as a driver for learning and progress towards realizing goals and rights.

## Annex 2. Literature reviews

2.1 Literature review on how accountability platforms, mechanisms, actions or activities carried out by stakeholders (public, private or partners) impact systems performance, health outcomes and/or health relevant SDG outcomes in countries<sup>31</sup>

*January 15, 2020*

The literature review was commissioned to analyse whether accountability factors (e.g. civil registration and vital statistics (CRVS), corruption, transparency, human rights complaints procedures and mechanisms etc.) could be associated with progress in systems performance and health/SDGs outcomes in countries.

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### Methods

This review focused on where and how *measurable* health or health-related outcomes were achieved by accountability mechanisms implemented at national and subnational levels. Alternately, if outcomes were not achieved, the review was tasked with analyzing why. Specifically, the literature review was asked to examine ‘the campfire – what do accountability mechanisms look like on the ground? How do they work? Indeed, do they work, and, if so, in what contexts? The scope, then, focuses on the downstream level and on citizens themselves and their relationship to the state rather than higher-level, global mechanisms for accountability. The review also focuses primarily on health, development, and governance fields as these are disproportionately represented in the literature with respect to richly described downstream examples tied to outcomes. Other fields – for example, law and human rights – also have a vital interest in, particular perspective of, and vast literature on accountability; however, the bulk of the literature from these fields did not meet the inclusion criteria for the study.

This literature review is a narrative review and *not* a systematic meta-review in which examples of accountability mechanisms are identified in the literature, selected for evidence of demonstrated outcomes and measured with respect to demonstrated significance both in relation to other like and not-like mechanisms. A meta-review such as this would be a difficult exercise as even mechanisms like scorecards or maternal death audits are implemented in vastly different contexts for different purposes through different entry points and, therefore, the outcomes are non-comparable.

Thus, the intent of this literature review was not to weigh in on which mechanisms ‘work better’ than others, or which are more effective at creating change. In fact, as the review makes clear, no single mechanism is in itself catalytic in creating change in the absence of an overarching edifice of accountability made up of multiple frameworks, structures, processes, inputs and citizens’ pathways.

This narrative literature review drew from English language articles, reports and other literature published between January 2000 and September 2019 – a time frame selected to span the adoption of the MDGs through the SDGs. Publicly available databases were searched, including PubMed, Transparency International, Corruption Watch, ODI, World Bank, Aspen Institute, Harvard Business Case

Studies, Stanford Social Innovation Review and other relevant sources. These databases were searched purposively for articles that specifically focused on accountability mechanisms' linkage to health systems performance, health outcomes and/or health-relevant SDG outcomes, with an emphasis on *how* these worked.

The full methodology of the literature review is available in the report. [Read and download full report](#)

## 2.2 COVID-19 and the Status of Women's, Children's, and Adolescents' Health and Rights: a targeted literature review of current evidence for action on Universal Health Care (UHC) and accountability<sup>32</sup> *May 19, 2020*

This targeted, rapid review sought to quickly assess the state of knowledge with respect to evidence of outcomes in areas of relevance to women's, children's and adolescents' health and rights in the context of COVID-19. The review sought data on areas of interest to the IAP – including UHC – and to those working on the Global Strategy, and attempts to identify: 1) what information on outcomes relevant to accountability exists and 2) where there are gaps in data. The paper prioritized areas where EWEC and accountability intersects: 1) the economic and social burden of COVID-19 containment and mitigation measures; 2) maternal, child and adolescent health and rights issues, including sexual and reproductive health and rights; and 3) data systems. At the same time, the paper recognized that (at the early stage in the pandemic at which it was written) it is likely that documentation on accountability is extremely scarce and, thus, it may not be possible to, for example, map findings clearly utilizing IAP terminology.

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### Methods

This rapid narrative review was conducted over a two-week period in May 2020. It looked at literature published between 1 January 2020 and 7 May 2020, and utilized the following initial search string in PubMed and Google Scholar:

```
((("covid") OR ("coronavirus")) AND (("gender") OR ("sex") OR ("women") OR ("children") OR ("adolescent")))
```

Adding (“accountability”) to the search string produced no significant papers. Hence, the individual papers had to be skimmed for issues specific to women's, children's, and adolescents' health or rights. The review then searched purposively for topics that came up in the literature in order to fill gaps. Thus, the search string was utilized with additional subjects added to it (e.g. AND “domestic violence” or AND “nutrition”).

Because the COVID-19 pandemic was being experienced in real time while the review was being conducted, the number of articles produced by this search string increased exponentially each day. Many articles had not yet been properly abstracted or attached to key words clearly. The search strategy pursued eventually became one of ‘combing the literature’ relevant to the particular topic being explored, following potential leads and allowing oneself to engage evidence that perhaps had not yet been broadly explored but does, in fact, have interesting data potentially salient to issues of accountability.

Because this review looked only at evidence of impact on areas relevant to women's, children's and adolescents' health and rights in the context of the first four months since the beginning of the COVID-19 pandemic, the exclusion criteria for literature discussed within is as follows:

1. Literature that discusses concerns about the impact of COVID-19 on women's, children's, and adolescents' health and rights not tied to either qualitative or quantitative measurement of outcomes. Thus: literature must discuss some sort of research tied to some sort of outcome.
2. Literature that projects or models potential outcomes on women's, children's, and adolescents' health and rights based on evidence from past crises (e.g. the 2008 financial crisis, the H1N1 pandemic, the Ebola epidemic, etc.). Thus: literature must discuss evidence collected since the start of the COVID-19 pandemic.
3. Literature that advocates for interventions/investments in various areas of relevance for women's, children's, and adolescents' health and rights in the absence of real-time data on the relationship between these investments and real-time outcomes. Thus: literature must tie advocacy to documentation of COVID-19 impact on women's, children's, and adolescents' health and rights.

In short, the papers we included had to have evidence on women's, children's, and adolescents' health and rights as they have been impacted over the first four months of the COVID-19 pandemic.

This means that many very good papers either imploring urgent action on behalf of subjects relevant to both EWEC and the IAP, or mapping out potential areas of concern, interest or investment, have necessarily been excluded, as have newspaper articles and blog posts in the absence of robust sources for the information within. Unfortunately, in the COVID-19 publication glut, what this review found is that many of these articles about what "may" or "could" or "should" happen have already been cited in other articles – often multiple times – as representing evidence of outcomes having already come to pass. While there is much that the global community needs to do both to secure women's, children's, and adolescents' health and rights in the context of COVID-19, and ensure global and national accountability to the Global Strategy in spite of the ongoing pandemic, this review emphasizes that there is still very much we do not know.

Note: Since 1 January 2020, there have been thousands of articles published, many of which are currently pre-peer-reviewed preprints made available through open-source information sharing platforms given the rapid evolving nature of the pandemic. Therefore, the publication status of some of the articles discussed in the review will change over the weeks and months following publication of this report. Any utilization of examples from this paper will need to be checked against citations going forward in case the publication status of the article has changed, and in case data within these articles undergoes rethinking/reanalyzing as the article moves through peer review.

The full methodology of the literature review is available in the report.

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## Annex 3. Statistical analyses

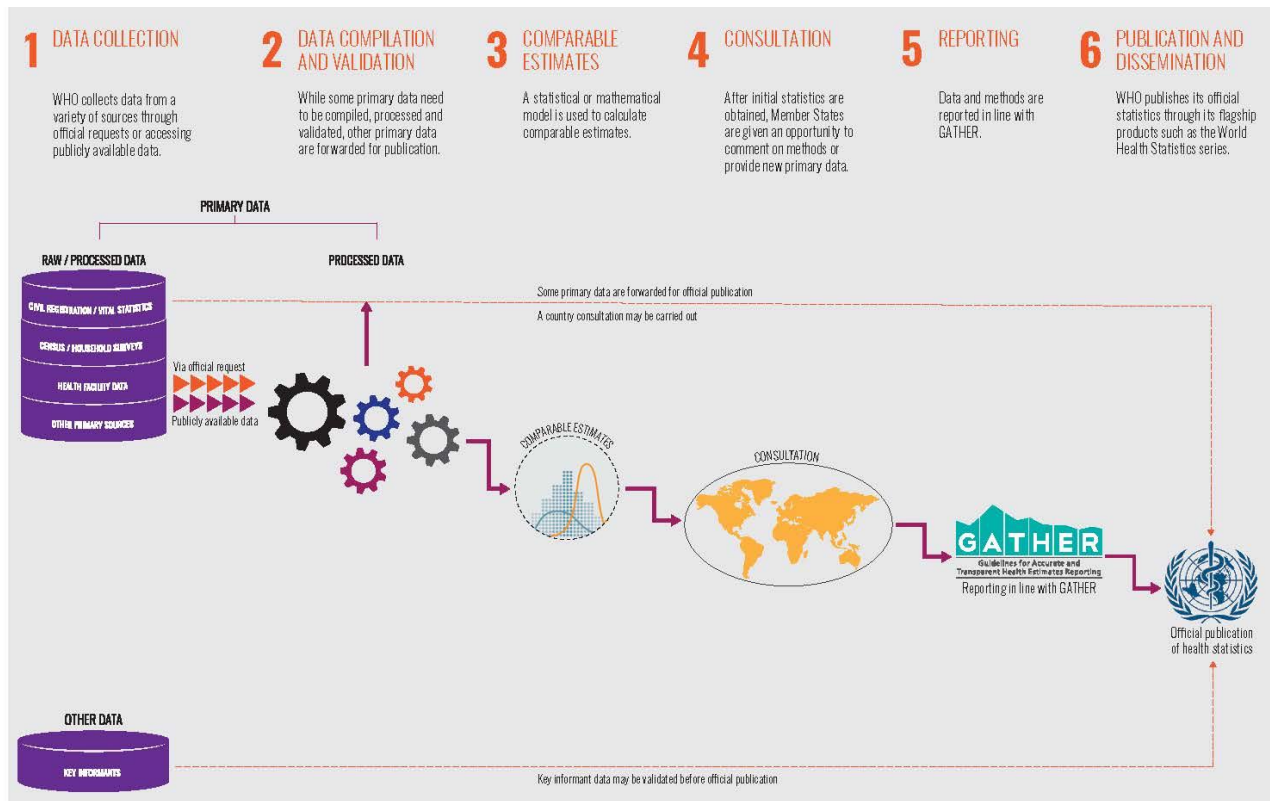
### 3.1 Context of country data and global estimates

With respect to its mandate, the Independent Accountability Panel's role is not to collect country data nor to develop global estimates. The IAP reviews the latest available data and estimates published by the UN agencies and inter-agency groups as these are in line with Member State agreed processes, and link to Member State goals and commitments against which progress and accountability can be assessed.

There are currently gaps in the completeness, and inconsistent quality, of primary country data on health indicators. Further, there are delays between collection of country data and their availability for use at the global level. To address these gaps, UN agencies and other global actors develop estimates, generally for all Member States and for a common, recent year. These estimates are invaluable to compare and interpret country data, but their quality is only as good as the monitoring data upon which they are based.<sup>33,34</sup> In some cases, there is an over-reliance on global estimates and modelling to assess country risks and progress. The distinction between measured health data from countries and global estimates, which may be made for countries with little or no recent data, can be confusing for users.

As an example, Annex figure 1 depicts the WHO process for compiling country data and computing official global estimates. As seen in this figure, there are many steps between country data collection in health facilities or the field and publication of official WHO estimates. At a given point in time, newly published UN databases and estimates may be based on data collected three to five years earlier. Further, while some databases and estimates are updated annually, others are updated less frequently. Thus, the IAP may appear to be using older data when, in fact, it is using the latest published UN data. The latest UN data do not yet reflect the effects of COVID-19, and therefore the IAP has surveyed the literature to assess the likely effect of COVID-19 on key health indicators.

**Annex Figure 1. Schematic overview of country data, global estimates and reporting processes**



Source: World health statistics 2018: monitoring health for the SDGs, sustainable development goals. Geneva: World Health Organization; 2018. Licence: CC BY-NC-SA 3.0 IGO. p, 2. Print.

Note: Data on emergencies does not pass through the country consultation and reporting process in most cases

### 3.2 Progress lag analysis towards 2030 EWEC and SDG ‘Survive’ targets

#### Methods for computing the lag in progress toward the 2030 SDG targets for maternal and child mortality – pre COVID-19

To assess progress toward the global maternal mortality, neonatal mortality and under-five mortality Sustainable Development Goals (SDG) targets, an average progress lag was computed. These three Survive indicators were selected because SDG/EWEC targets and UN estimates covering the SDG era are available. The latest UN interagency estimates for these indicators were published prior to the COVID-19 pandemic, and the progress lag computation assumes that prior rates of improvement continued in 2020. Although an EWEC target is available for stillbirth, the latest estimates available at the time of writing the IAP report are for the period 2000-2015 – prior to the SDG era. For adolescent mortality, there is currently no globally agreed target against which progress can be measured.

The progress lag was computed for each target as the required percentage of total global progress toward the 2030 SDG target achieved by 2020, less the expected percentage of total global progress toward the 2030 SDG target achieved by 2020, computed assuming that the past rates of improvement continue (a pre-COVID-19 assumption). The formula used for each of the three indicators was (equation 1):

$$\frac{R_{2015} - R_{2020}^r}{R_{2015} - R_{2030}^r} - \frac{R_{2015} - R_{2020}^p}{R_{2015} - R_{2030}^r}$$

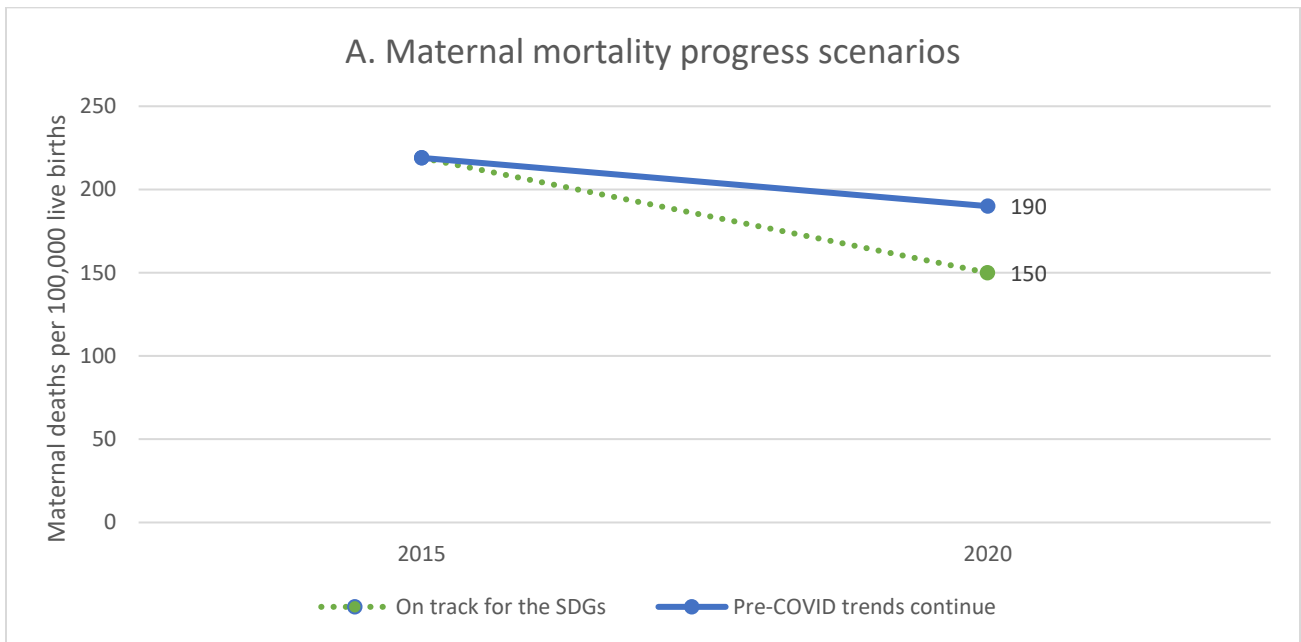
Where, for each indicator,  $R_{2015}$  is the estimated global mortality rate in 2015,  $R_y^r$  is the global mortality rate required to meet the SDG target in year  $y$ , and  $R_y^p$  is the projected global mortality rate in year  $y$  assuming that past trends continue to 2020. Further details on input values for equation 1 are given below for each indicator, and estimated/projected values during 2015-2020 are depicted in Annex Figure 2. Annex Table 1 shows the input data used for the calculation and the results by indicator. The mean progress lag across the three indicators was 17%.

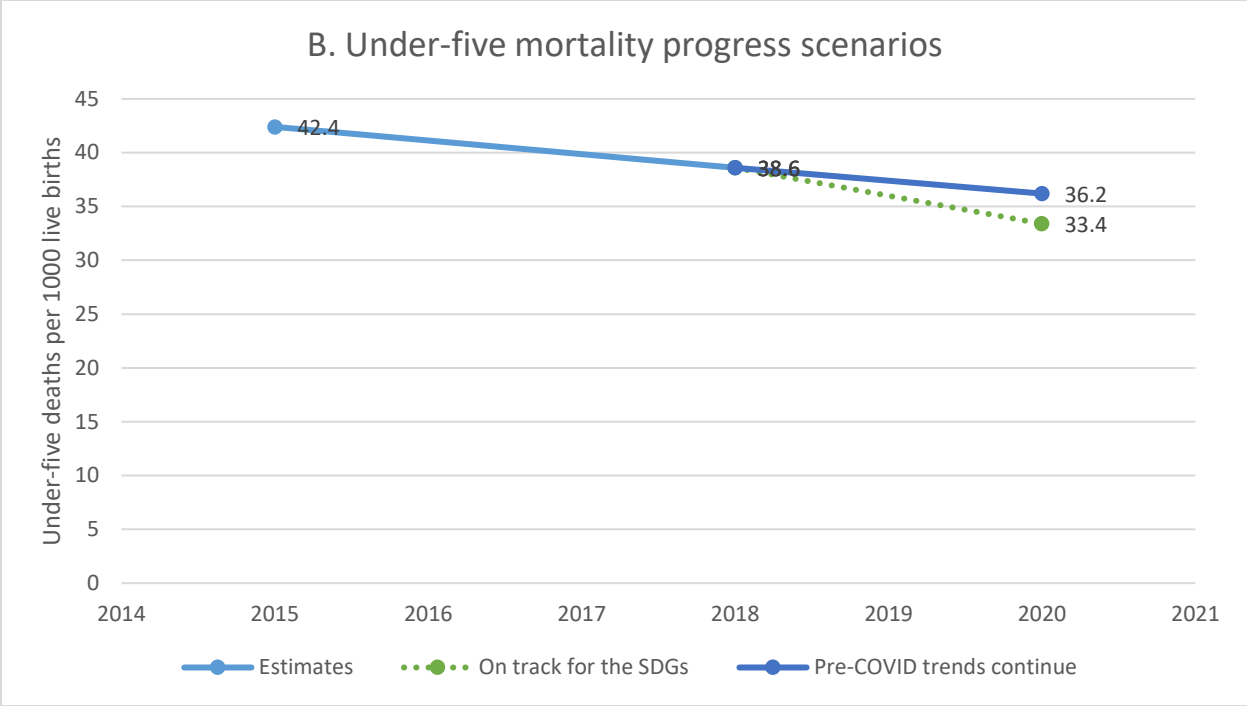
**Annex Table 1. Input and intermediate values used to compute progress lag for each indicator. Values shaded in blue were extracted from global reports.**<sup>35,36</sup>

	Maternal mortality ratio (per 100 000 live births)	Neonatal mortality rate (per 1000 live births)	Under-five mortality rate (per 1000 live births)
Global estimate in 2015 ( $R_{2015}$ )	219	19.1	42.4
2030 global target ( $R_{2030}^r$ )	70	8.8	16.6
ARR for 2015-2030 required to meet target (maternal mortality column)	-8%	country computations done by UN IGME	

Estimated ARR 2000-2017 (maternal mortality column)	-3%		
Global projection for 2020 ( $R_{2020}^p$ )	190	16.9	36.2
Required global mortality rate in 2020 to meet target ( $R_{2020}^r$ )	150	15.7	33.4
Progress lag	27%	12%	11%

**Annex Figure 2. Maternal (A) and Under-five (B) mortality progress scenarios**





**Maternal mortality**

The global maternal mortality ratio for the years 2000, 2015 and 2017 were extracted from UN estimates of maternal mortality.<sup>35</sup> The global average annual rate of reduction (ARR) during 2000-2017 was computed, and was applied to the 2017 estimates to project the maternal mortality ratio to 2020, assuming past rates of reduction continue. The average annual rate of reduction from 2015 to 2030 needed to meet the global target of 70 deaths per 100 000 live births was also computed, and was applied to the estimated mortality ratio in 2015 to compute the required global maternal mortality ratio to meet the target in 2020.

**Child mortality**

SDG targets for child mortality are country targets, not global targets. Therefore, any assessment of whether progress is sufficient to meet the targets must be made country-by-country. The UN Interagency Group for Child Mortality Estimation (UN IGME) has projected country and global neonatal and under-five mortality rates under two scenarios:<sup>36</sup>

1. Continue current trend: each country’s estimated ARR for the period 2000-2018 was applied to its 2018 value (with some limits for internal consistency of estimates)
2. Achieve SDG by 2030: in countries that are not projected to meet the country target under scenario 1, progress starting in 2019 is accelerated to meet the country target. In all other countries, estimates are identical to scenario 1. In addition, all country estimates for 2015-2018 are identical in scenarios 1 and 2.

Projections of global neonatal and under-five mortality for 2020 and 2030 were extracted from the UN IGME scenario-based projections,<sup>37</sup> with  $R_y^r$  corresponding to the ‘achieve SDG by 2030’ scenario and  $R_y^p$  corresponding to the ‘continue current trend’ scenario.

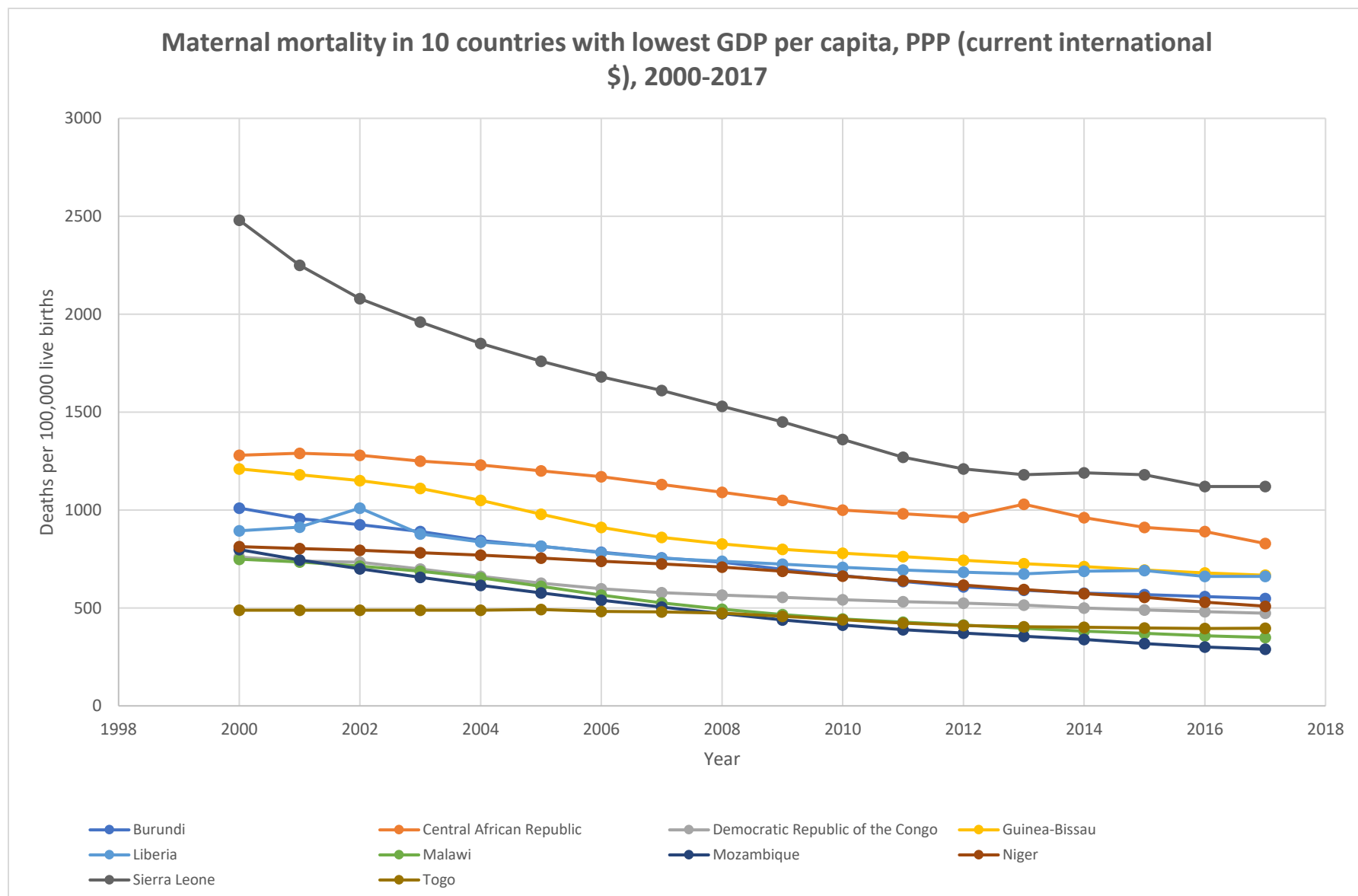
### *Limitations*

Simplifications were made to compute a global progress lag for maternal and child mortality, given that child mortality goals are country-level. Supplemental country targets for maternal mortality were not taken into account.<sup>38</sup> Further, the progress lags computed for maternal and child mortality are not fully comparable. Specifically for child mortality, the progress lag is computed assuming that all countries are on track for the SDGs starting in 2019, while the progress lag for maternal mortality is computed assuming that the globe was on track for the SDGs starting in 2016.

### *Progress trends in 10 lowest income countries*

As background for the progress lag analysis and the country scorecards, estimated trends in reductions of maternal and child mortality during the Millennium Development Goals were reviewed, including in the 10 lowest income countries. In all 10 countries, maternal and child mortality is estimated to have declined. The declines in maternal mortality vary from a 63.8% decline in Mozambique to a 19.0% decline in Togo (Annex Figure 3 and Annex Table 2). For under-five mortality, the declines ranged from 71.3% in Malawi to 32.2% in the Central African Republic (Annex Figure 4 and Annex Table 3). These estimates indicate that even countries with extremely limited financial resources can implement policies that safeguard the lives of mothers and children.

Annexe Figure 3. Maternal mortality in 10 countries with lowest GDP per capita, PPP (current international \$), 2000-2017

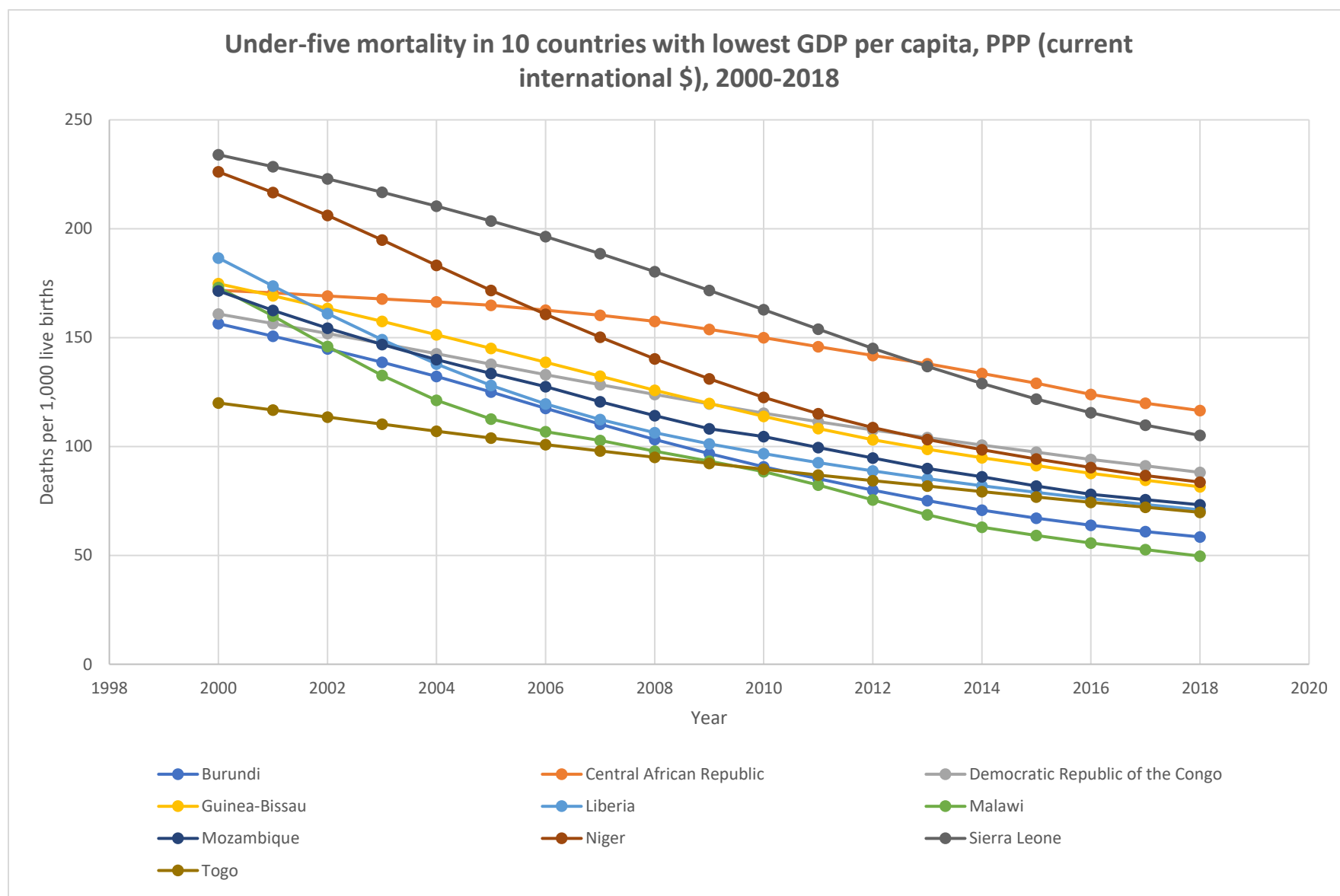


**Annex Table 2. Maternal mortality (per 100 000 live births) in 10 countries with lowest GDP per capita, PPP (current international \$), 2000-2017<sup>35</sup>**

year	Burundi	Central African Republic	Democratic Republic of the Congo	Guinea-Bissau	Liberia	Malawi	Mozambique	Niger	Sierra Leone	Togo
2000	1010	1280	760	1210	894	749	798	813	2480	489
2001	956	1290	740	1180	913	735	745	803	2250	489
2002	925	1280	734	1150	1010	714	700	795	2080	489
2003	890	1250	699	1110	878	687	657	782	1960	489
2004	844	1230	661	1050	837	654	615	770	1850	488
2005	814	1200	627	979	816	610	577	755	1760	492
2006	785	1170	598	912	782	566	539	739	1680	482
2007	756	1130	578	860	754	526	505	725	1610	480
2008	733	1090	565	827	738	493	471	709	1530	473
2009	698	1050	555	800	724	466	439	688	1450	458
2010	665	1000	542	779	708	444	412	663	1360	440
2011	635	981	532	762	694	428	389	639	1270	422
2012	608	963	524	744	683	413	371	616	1210	410
2013	591	1030	514	726	674	396	356	594	1180	404
2014	576	961	500	711	688	381	339	573	1190	401
2015	568	912	490	694	691	370	318	555	1180	398
2016	558	890	481	679	661	358	301	530	1120	395
2017	548	829	473	667	661	349	289	509	1120	396
<b>Percent decline 2000-2017</b>	46	35	38	45	26	53	64	37	55	19



Annex Figure 4. Under-five mortality in 10 countries with lowest GDP per capita, PPP (current international \$), 2000-2018



**Annex Table 3. Under-five mortality (per 1000 live births) in 10 countries with lowest GDP per capita, PPP (current international \$), 2000-2018<sup>36</sup>**

year	Burundi	Central African Republic	Democratic Republic of the Congo	Guinea-Bissau	Liberia	Malawi	Mozambique	Niger	Sierra Leone	Togo
2000	156	172	161	175	187	173	171	226	234	120
2001	151	171	156	169	174	160	163	217	229	117
2002	145	169	152	163	161	146	154	206	223	113
2003	139	168	147	157	149	133	147	195	217	110
2004	132	166	143	151	138	121	140	183	210	107
2005	125	165	138	145	128	113	134	172	204	104
2006	118	163	133	139	120	107	128	161	196	101
2007	110	160	128	132	112	103	121	150	189	98
2008	103	157	124	126	106	98	114	140	180	95
2009	97	154	120	120	101	93	108	131	172	92
2010	91	150	115	114	97	88	105	123	163	90
2011	85	146	111	108	93	82	100	115	154	87
2012	80	142	108	103	89	75	95	109	145	84
2013	75	138	104	99	85	69	90	103	137	82
2014	71	134	101	95	82	63	86	98	129	79
2015	67	129	97	91	79	59	82	94	122	77
2016	64	124	94	88	76	56	78	90	115	74
2017	61	120	91	85	73	53	76	87	110	72
2018	58	116	88	81	71	50	73	84	105	70
<b>Percent decline 2000-2018</b>	63	32	45	53	62	71	57	63	55	42

#### Effect of COVID-19 progress toward goals

Although COVID-19 is expected to affect progress toward global maternal, neonatal and child mortality goals, primary data on the effects are currently limited. Studies have been published that estimate potential ranges of effects, based on plausible scenarios of health service disruption.<sup>39,40</sup> These studies indicate that maternal and child mortality is expected to be higher than projected, based on pre-COVID-19 trends, and, further, may deteriorate relative to estimated 2015 mortality levels.<sup>39</sup> Thus, the progress lag estimated above is expected to be underestimated.

### 3.3 Country scorecards (Table 1 in the report)

Governments should continually make progress on health and related rights, individually and through international cooperation, and need to justify any reversal of spending or gains.<sup>3,41</sup> This is the human rights principle of progressive realization.<sup>3,41</sup> Not all countries have the same available resources nor spend the same amount on health. To track progress and accountabilities for women's, children's and adolescents' health and rights, the IAP assessed the performance of countries within the same income categories. This approach ensures greater comparability across different sets of countries based on an understanding of resource constraints – financial, health workforce and others – that in turn constrain the realization of people's right to health. Countries were grouped by World Bank income group categories<sup>42</sup> in the scorecards, as a proxy for resources more broadly.

#### Annex Table 4. Notes and legend

All United Nations Member States were included. Within each income category, Member States are listed in rank-order based on under-five mortality rate – the mortality indicator with the most underlying primary country data available for monitoring.

Completeness of cause-of-death data is not estimated for countries that do not submit data to the WHO mortality database (due to low completeness) or are not WHO Member States (Liechtenstein).

Within income categories, countries were marked as having surpassed or achieved global targets or as advancing, intermediate or catching up to the targets. Targets used to determine progress are based on SDG/ENAP global and country 'Survive' targets for the year 2030.<sup>20</sup> 'Surpassed' countries were those that achieved or surpassed the SDG/ENAP global or country target. Per indicator, countries (with available data) that fell short of the target were split into the following tertiles: 'advanced' countries (top third); 'intermediate' countries (middle third); 'catching up' countries (bottom third). Adolescent mortality has no global/country target and colour coding refers to quartiles.

#### Key:

	Surpassed country		Intermediate country		No data available
	Advanced country		Catching up country		

^ was used to denote fragile and conflict-affected situations. In countries experiencing high-intensity conflicts, including the Syrian Arab Republic and Yemen, statistics may be based on data collected prior to the conflict, with adjustment for direct conflict deaths.

**Annex Table 5. Indicators' sources in the country scorecards**

<b>Indicator</b>	<b>Source</b>
Maternal mortality	WHO, UNICEF, UNFPA WBG and the UNPD. Trends in Maternal Mortality: 2000 To 2017. WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. 2019.
Stillbirths	World Health Organization. Global Health Observatory data repository. Stillbirth rate. (accessed 25 February 2020)
Neonatal mortality	United Nations Inter-Agency Group for Child Mortality Estimation (UNIGME). Levels & Trends in Child Mortality: Report 2019, Estimates developed by the United Nations Inter-Agency Group for Child Mortality Estimation. United Nations Children's Fund, New York, 2019.
Under-five mortality	
Adolescent mortality	Global health estimates 2016: Deaths by cause, age, sex, by country and by region, 2000-2016. Geneva: World Health Organization, 2018.
Birth registration	United Nations Global SDG Indicators Database (downloaded 11 April 2020). United Nations Statistics Division, New York, 2020.
Completeness of cause-of-death data	World Health Statistics 2019: monitoring health for the SDGs. World Health Organization, Geneva, 2019.

### 3.4 Factors for success analysis (Figure 2 in the report)

The aim is to assess whether country situation relative to mortality targets corresponds to a number of factors for success that are evidence-based and based on the IAP’s expert assessment.

The IAP identified the following categories of factors for success for countries’ progress: data and information; laws and policies; domestic health expenditures; UHC, health systems and IHR core capacities; multisectoral factors; innovation and technology; and political leadership and governance. Indicators for these categories were selected prioritizing SDG indicators and indicators agreed by EWEC partners. Data were collated using the latest published global data, and differences in data year reflect the constraints outlined earlier in relation to the collation of country data and publication of global estimates. Statistical analyses, detailed below, were performed for all countries – whereas the figure presented in the report is limited to low-income and lower-middle income countries (Figure 2 in the IAP report).

**Annex Table 6. Indicators of factors for success for reducing maternal and child mortality**

Indicator type	Indicator	Year (1)	SDG Indicator Number	Data Source
Data and information	<b>Children under 5 years of age whose births have been registered with a civil authority (%)</b>	2010-2019	16.9.1; 17.19.2.1	United Nations Global SDG Database <sup>43</sup>
	<b>Deaths that are registered with cause of death information (%)</b>	2010-2017	17.19.2	World Health Organization. World Health Statistics 2019: monitoring health for the SDGs <sup>44</sup>
Laws and policies	<b>Key birth and death registration policies/laws in place (%) (2)</b>	2019		World Health Organization. Global Reproductive, maternal, newborn, child and adolescent health policy Survey. 2018-2019 (unpublished) <sup>45</sup>
	<b>Seven SRMNCAH dedicated laws available (%) (3)</b>	2019		World Health Organization. Global Reproductive, maternal, newborn, child and adolescent health policy Survey. 2018-2019 (unpublished) <sup>45</sup>
	<b>Five sub-groups have free access to health services in the public sector at point of use (%) (4)</b>	2019		World Health Organization. Global Reproductive, maternal, newborn, child and adolescent health policy Survey. 2018-2019 (unpublished) <sup>45</sup>
Domestic health expenditures	<b>Domestic general government health expenditure (GGHE-D) as percentage of general government expenditure (GGE) (%)</b>	2011-2017	1.A.2	World Health Organization. Global Health Observatory. <sup>46</sup>

	<b>Domestic general government health expenditure on reproductive health [maternal and contraceptive management] (Current PPP per capita)</b>	2016-2017		World Health Organization. Global Health Expenditure Database. <sup>47</sup>
	<b>Domestic general health expenditure on immunization programmes (Current PPP per capita)</b>	2016-2017		World Health Organization. Global Health Expenditure Database. <sup>47</sup>
UHC, Health Systems, and IHR	<b>Medical doctors, nursing and midwifery personnel (per 10 000 population)</b>	2010-2018	3.C.1	World Health Organization. Global Health Observatory. <sup>48,48a</sup>
	<b>UHC service coverage index (5)</b>	2017	3.8.1	World Health Organization. . Global Health Observatory. <sup>49</sup>
	<b>UHC financial protection: population with household expenditures on health greater than 10% of total household expenditure or income (%)</b>	2010-2018	3.8.2	World Health Organization. Global Health Observatory. <sup>50</sup>
	<b>Average of 13 IHR core capacity scores (%)</b>	2010-2018	3.D	World Health Organization. Global Health Observatory. <sup>51</sup>
Multisectoral : WASH, education, environment	<b>Population using a handwashing facility with soap and water (%)</b>	2010-2017	6.2.1	World Health Organization. Global Health Observatory. <sup>52</sup>
	<b>Population using safely managed sanitation services (%)</b>	2017	6.2.1	World Health Organization. Global Health Observatory. <sup>53</sup>
	<b>Population with primary reliance on clean fuels and technology (%)</b>	2017	7.1.2	World Health Organization. Global Health Observatory. <sup>54</sup>
	<b>Children (both sexes) at the end of lower secondary achieving at least a minimum proficiency level in mathematics (%)</b>	2011-2018	4.1.1	United Nations Global SDG Database <sup>43</sup>
	<b>Children (both sexes) at the end of lower secondary achieving at least a minimum proficiency level in reading (%)</b>	2015-2018	4.1.1	United Nations Global SDG Database <sup>43</sup>
Innovation and technology	<b>Population using the internet (%)</b>	2011-2018	17.8.1	International Telecommunication Union (ITU). Statistics. <sup>55</sup>
	<b>Population covered by at least a 2G mobile network (%)</b>	2015-2018	9.C.1	United Nations Global SDG Database <sup>43</sup>

Political leadership and governance	<b>World governance indicators: government effectiveness (percentile rank) (5)</b>	2013-2018		The World Bank. Worldwide Governance Indicators (WGI). <sup>56</sup>
	<b>Seats held by women in national parliaments (%)</b>	2019-2020	5.5.1	United Nations Global SDG Database <sup>43</sup>
	<b>World governance indicators: voice and accountability (percentile rank) (5)</b>	2013-2018		The World Bank. Worldwide Governance Indicators (WGI). <sup>56</sup>
	<b>Press freedom index (6)</b>	2019		Reporters Without Borders. 2020 World Press Freedom Index. <sup>57</sup>
	<b>Corruption perception index (5)</b>	2019		Transparency International. Corruption Perceptions Index. <sup>58</sup>

#### Notes:

1. If a range is shown, data refer to the latest available year for each country (limited to 2010-2019).
2. Composite score of the availability of the following national policies/laws: (a) requiring birth registration (b) requiring death registration (c) requiring routine audit and/or review of death certification for maternal, perinatal, neonatal and/or child deaths. Rescaled out of 100.
3. Percentage of countries responding yes to having the following seven SRMNCAH dedicated laws: sexual health, reproductive health, reproductive rights, maternal health, newborn health, child health and adolescent health. Indicator only presented for countries that responded to at least four of seven sub-questions. Rescaled out of 100.
4. Percentage of the following key sub-groups covered by national policy/legislation on free access to health services in the public sector at point of use: newborns (0-4), children under the age of 5 years, children 5-9 years, adolescents (10-19 years) and pregnant women. Indicator only presented for countries that responded to at least three of five sub-questions. Rescaled out of 100.
5. A higher value corresponds to a better outcome (e.g. higher service coverage, lower perceived corruption).
6. Reverse scaled so that a higher value corresponds to a free press.

#### **Country grouping**

Countries were assessed to see whether they met SDG targets for both under-five mortality (country target: 25 per 1000 live births) and maternal mortality (global target: 70 per 100 000 live births). Those countries that fell short of the target were then split into tertiles based on the sum of maternal and under-five deaths per 1000 live births. Countries, for which data were available, were then grouped as follows:

- (1) **Higher performing countries on SDG targets to reduce maternal and under-five mortality:** have met, surpassed or are in the highest tertile of remaining countries that are advancing towards meeting both the under-five and maternal mortality targets

- (2) **Lower performing countries on SDG targets to reduce maternal and under-five mortality:** are in the bottom two tertiles of those countries that have not yet met both under-five and maternal mortality targets.

### Statistical analyses

Assumptions of normality and equal variance were assessed for all success factor indicators, listed in Annex Table 7. As most outcomes were non-normal and many did not also meet expectations of equal variance, a non-parametric test was selected. A Wilcoxon rank-sum test, a non-parametric alternative to the two-sample t-test, was performed to test the hypothesis that the success factor indicator distribution for *'higher performing countries'* was the same as that of *'lower performing countries'*. For indicators where the difference was significant, values were checked to determine whether success factor indicator was better in *'higher performing countries'* than *'lower performing countries'*, as expected. The direction of all significant differences was consistent with prior expectations. Though Figure 2 only depicts lower-middle and low income countries, statistical tests were also performed for high income and upper-middle income countries – with similar results (see Annex table 7).

When conducting multiple independent tests, there is an increased likelihood of observing a significant finding due to chance alone (known as a type I error – rejecting the null hypothesis when we should not). To account for approximately 20 independent tests conducted within each income group, a Bonferroni adjusted *p*-value cutoff was used (equation 2):

$$\frac{\alpha - \text{value}}{\text{number of comparisons}} = \frac{0.05}{20} = 0.0025$$

Tests of association between population-level statistics such as the one performed here indicate that two variables are associated, but causality may not be inferred. The analysis is illustrative of factors that differentiate higher and lower-performance in countries within the same income categories.



**Annex Table 7. Performance on success factors between ‘higher performing countries’ compared to ‘lower performing countries’, within two income groupings ([a] lower-middle and low income countries [b] high income and upper-middle income countries)**

	Outcome variable	Lower-middle income and low income countries			High income and upper-middle income countries		
		Higher performing countries	Lower performing countries	P-value	Higher performing countries	Lower performing countries	p-value
		Mean	Mean		Mean	Mean	
1	Corruption perception index	34.63	28.61	0.0316	52.89	37.17	0.0747
2	Press freedom index	56.52	60.33	0.403	69.24	59.06	0.468
3	Voice and accountability (world governance indicators) (percentile rank)	39.01	28.67	0.0486	59.49	36.95	0.796
4	Seats held by women in national parliaments (%)	21.43	20.43	0.5642	25.06	26.77	0.8162
5	World governance indicators: government effectiveness (percentile rank)	36.65	19.65	<0.001*	65.43	38.46	0.0253
6	Population covered by at least a 2G mobile network (%)	97.39	85.84	<0.001*	98.22	93.62	0.1995
7	Population using the internet (%)	42.41	20.01	<0.001*	74.19	43.94	<0.001*
8	Children (both sexes) at the end of lower secondary achieving at least a minimum proficiency level in reading (%)	42.64	6.85	NA	64.72		NA
9	Children (both sexes) at the end of lower secondary achieving at least a minimum proficiency level in mathematics (%)	33.52	4.95	NA	58.28		NA
10	Population with primary reliance on clean fuels and technology (%)	59.98	17.27	<0.001*	90.3	65.25	0.0015*
11	Population using safely managed sanitation services (%)	53.44	26.21	NA	73.43		NA

12	Population using a handwashing facility with soap and water (%)	66.58	26.47	<0.001*	84.3	53.31	NA
13	Average of 13 IHR core capacity scores (%)	61.61	42.12	<0.001*	73.75	44.87	0.0020*
14	UHC: population with household expenditures on health greater than 10% of total household expenditure or income (%)	10.63	8.54	0.3095	8.42	1.41	NA
15	UHC service coverage index	63.63	44.05	<0.001*	74.78	59.52	<0.001*
16	Medical doctors, nursing and midwifery personnel (per 10 000 population)	40.36	13.34	<0.001*	91.13	34.02	0.0043
17	Domestic general health expenditure on immunization programmes (current PPP per capita)	2.27	1.14	NA	5.3	15.64	NA
18	Domestic general government health expenditure on reproductive health [maternal and contraceptive management] (current PPP per capita)	32.58	6.3	NA	54.25	74.75	NA
19	Domestic general government health expenditure (GGHE-D) as percentage of general government expenditure (GGE) (%)	9	5.95	<0.001*	12.72	9.95	0.2192
20	Individual human rights communications procedures accepted (%)	2.28	1.6	0.3835	3.47	2.67	0.4989
21	Five sub-groups have free access to health services in the public sector at point of use (%)	89	69.57	0.0097	88.7	73.33	0.0163
22	Seven SRMNCALH dedicated laws available (%)	73.56	62.86	0.3974	63.68	69.05	0.9242
23	Key birth and death registration policies/laws in place (%)	90.48	85.11	0.2281	91.79	77.78	0.493
24	Deaths that are registered with cause of death information (%)	41.67	1.87	<0.001*	83.3	29.6	0.0021*

25	Children under 5 years of age whose births have been registered with a civil authority, by age (%)	89.01	55.72	<0.001*	97.61	82.82	<0.001*
<p>Notes:</p> <p>* Bonferroni adjusted p-value &lt;0.0025</p> <p>NA= Not applicable; analysis not conducted for indicators with &lt;50 observations total or &lt;5 observations in each group.</p>							

## Annex 4. Country case studies

### 4.1 Methods guide for country case study development

Customized and adapted to the context and topic of each country case study.

#### Background

To inform the IAP's 2020 report, five country accountability case studies were commissioned as a way of amplifying country experiences and the voices of women, children and adolescents. This document provides guidance on the methods for developing these case studies, with slight adaptations for specific case studies.

#### Objectives of the country case studies

The country case studies used an accountability lens to:

1. Examine challenges for women's, children's and adolescents' health in the context of UHC and SDGs
2. Amplify the voices of women, children and adolescents, and key stakeholders in countries, and to learn from their lived experiences
3. Identify three to five actions that could be undertaken to drive the change that is needed

#### Considerations for selecting IAP case study countries

Case study countries were selected based on the following considerations:

- Purposive selection of countries based on IAP members' in-depth experience in countries, and their being able to mobilize a multistakeholder dialogue with the required institutional linkages to enable follow up of recommendations
- Country stakeholders having identified an ongoing challenge and started a change process, with a whole of government, whole of society approach, where an accountability perspective could add value
- Variation of selected country case studies across geographical regions
- Potential to link to national health and SDG reviews, e.g. voluntary national reporting in 2020

#### List of countries, IAP focal points and lead national institutions

- Ethiopia on community scorecards to strengthen quality of care. Joy Phumaphi as IAP focal point, and based on existing evaluations/case studies by UNICEF, Federal Ministry of Health of Ethiopia and ALMA <sup>59-61</sup>
- Papua New Guinea on complex challenges and women's children's and adolescents' health and rights. Dame Carol Kidu as IAP focal point, with Burnet Institute in Australia and PNG.
- Kenya on medical detention. Joy Phumaphi as IAP focal point, with FIDA KENYA.
- Georgia on public-private partnerships for UHC. Professor Giorgi Pkhakadze as IAP focal point, with David Tvildiani Medical University.

- Guatemala on barriers to accessible, affordable and culturally acceptable care, as a follow up to a previous study to be published on early childhood health and development. Observatory in Sexual and Reproductive Health, Guatemala with PAHO.

## Methods and timeline

The steps for developing the case study are based on methods used to develop the previous country case study series on women’s, children’s and adolescents’ health in the context of the MDGs and SDGs.<sup>62-65</sup> The IAP focal point worked closely with a national institution to lead the case study development. The IAP Secretariat supported the overall coordination of the case studies and provided additional administrative, technical and writing support to country teams as required.

**Annex Table 8. IAP accountability country case study steps**

Steps to develop the country case study	Lead institution, IAP focal point, consultants and partners	Estimated timeframe, for a draft case study by 30 May 2020*
<b>Country case study coordination and communication</b> IAP focal point: Lead academic institution:		15 days
<b>Step 1. Introduction, socialization and buy-in by the government and other stakeholders as appropriate</b> Ensure the government (e.g Ministry of Health) and key stakeholders are aware of the case study and explore how it can add value to strengthening accountability by linking it to country review process, e.g. for national or global reviews (e.g. VNR at HLPF) etc.	Lead academic institution, in coordination with IAP focal point and IAP Secretariat	5 days
<b>Step 2. Data collection, evidence gathering and document review and key stakeholder interviews</b> Review of background documents, videos and context, including field visits as required to understand the accountability context and identify key stakeholders. Identify key videos and background materials that amplify the voices of women, children and adolescents, and others left furthest behind, ‘the human face’ of why accountability matters.  Based on the review of the background documents and context, use purposive sampling to identify key stakeholders and undertake interviews and/or focus group discussions. The aim is to garner different perspectives and experiences from a range of stakeholders and to address any information gaps.	Lead academic institution, supported by consultant(s) as needed and coordinating with IAP focal point  Note: the approach at this step is to identify and review existing materials, including videos.  Key partners and stakeholders across sectors and levels, including women and adolescents, government, civil society, patient groups, private sector, health workers, etc. (TBC)  Note: The case study questions to guide Step 2 are presented separately to this table (see below).	30 days

Steps to develop the country case study	Lead institution, IAP focal point, consultants and partners	Estimated timeframe, for a draft case study by 30 May 2020*
<b>Step 3. Development of the working draft for the multistakeholder dialogue meeting</b> Based on Step 2	Lead national institution, supported by consultant(s) as needed and coordinating with IAP focal point	5 days
<b>Step 4. Multistakeholder dialogue meeting</b> Plan and conduct a small multistakeholder dialogue to gain different perspectives on the findings of Step 1 and 2, and build shared understanding of the accountability issues and agreement on the case study findings	Lead academic institution, supported by consultant(s) as needed and coordinating with IAP focal point Around 10 to 15 key stakeholders for country accountability: civil society, parliamentarians, media, policy-makers, service providers, private sector and academia, to participate in the dialogue (TBC)	10 days
<b>Step 5. Case study write up of around five pages (2000 words), plus references, videos and annexes for more information if needed</b>	Lead academic institution, supported by consultant(s) as needed and coordinating with IAP focal point	15 to 20 days

\* Time may vary depending on existing capacities to undertake the development of the case studies, available information on the accountability questions, and the level of effort/logistics to organize the key stakeholder interviews and multistakeholder dialogue.

More than 200 people participated across the country case studies, and a wide range of stakeholders shared their experiences and perspectives; these included community members (importantly, women and adolescents), health professionals, civil society, government representatives, patient groups, researchers and academics, the private sector, UN representatives and the media.

The COVID-19 pandemic occurred as the case studies were getting underway, so adaptations to the methods were necessary. For example, some virtual interviews and MSDs were used in place of previously planned face-to-face meetings.

#### 4.2 Case study semi-structured questions

The questions to inform data collection, evidence gathering and key stakeholder interviews (Step 2 above) were based on EWEC accountability framework and literature reviews. These were semi-structured questions that were adapted to context-specific needs.

**Country context:** Describe the geographical, political, economic, sociocultural, environmental, epidemiological and demographic context

#### Institutions:

1. What institutions and infrastructure are in place to support accountability for women's, children's and adolescents' health (e.g. political and legislative' governance and systems' security and protection' information and media)? How are these foundations applied (or not) to ensure people's participation and mechanisms (for monitor, review and act) are both mandated and legally actionable?

2. Is there a perceived culture of accountability for women's, children's and adolescents' health (transparency, answerability, controllability, decisions based on evidence, rights and rule of law, with universality, equity, equality and commitment to shared goals)?

**Participation:**

3. Among different country stakeholders, what is the understanding of what accountability is and why it matters?
4. To what extent are there provisions for people to:
  - a. have access to relevant information and resources for their health and rights
  - b. have their voices heard to inform priorities and decision-making for their health and development
5. What are the barriers to people knowing and claiming their rights and holding duty bearers accountable, e.g. lack of awareness of rights, health information, etc; power differentials such as between clients and health providers, etc?

**Mechanisms and processes:**

**Monitor (related to resources, results and rights)**

6. What mechanisms are used to monitor progress on universal health coverage, women's, children's and adolescents' health, human rights and sustainable development?
7. What are the strengths and weaknesses of these monitoring mechanisms?
8. What do the data show as areas where there is progress or lack/reversal of progress in accountability along the continuum of care and service delivery and along the life course, who is left behind, where and why?

**Review (related to resources, results and rights)**

9. What mechanisms exist to review monitoring data and people's lived experiences, and is there independent review?
10. What are the strengths and weaknesses of these different review mechanisms?
11. What recommendations did the review processes generate?

**Remedy/Reform and Act (related to resources, results and rights)**

12. Are there provisions to link the review recommendations to required remedies and actions to address the gaps and reach those left behind?
13. Are there examples where remedies and actions effectively addressed the problems identified?
14. Considering examples of positive accountability impact, what were key contributing factors?

## Annex Table 9. Overview of research quality criteria

Criteria for ensuring rigor in quantitative and qualitative research<sup>66</sup>

Quality criteria	Quantitative	Qualitative
Generalizability	<ul style="list-style-type: none"> <li>- Statistical generalizability</li> </ul>	<ul style="list-style-type: none"> <li>- Analytical/ theoretical generalizability; transferability within and across contexts</li> </ul>
Validity	<ul style="list-style-type: none"> <li>- Accuracy of measurement</li> <li>- Validity: face, construct, criterion</li> </ul>	<ul style="list-style-type: none"> <li>- Appropriateness of methods and expertise and experience of researchers</li> <li>- Validity: democratic (all perspectives accurately represented); dialogic (review and deliberation of findings); process (cogent and dependable); outcome (resolution of research question)</li> </ul>
Reliability	<ul style="list-style-type: none"> <li>- Precision</li> <li>- Replicability: inter-observer, test-retest, triangulation</li> </ul>	<ul style="list-style-type: none"> <li>- Auditability and transparent documentation of methods</li> <li>- Consistency in applying methods</li> <li>- Achieving theoretical saturation</li> </ul>
Credibility	<ul style="list-style-type: none"> <li>- Triangulation of data sources</li> <li>- Counterfactual analysis and causal inference</li> </ul>	<ul style="list-style-type: none"> <li>- Triangulation of data sources</li> <li>- Expertise and experience of researchers</li> <li>- Diverse perspectives to test and refine the findings, including consideration of alternative interpretations</li> </ul>
Context for application of quality criteria	<ul style="list-style-type: none"> <li>- Embedded in a broader understanding of and expertise in quantitative research design, data analysis, application, and limitations</li> </ul>	<ul style="list-style-type: none"> <li>- Embedded in a broader understanding of and expertise in qualitative research design, data analysis, application, and limitations</li> <li>- In-depth understanding of context of analysis from different stakeholder perspectives and 'thick description'</li> </ul>



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