Operationalizing the IAP Accountability Framework

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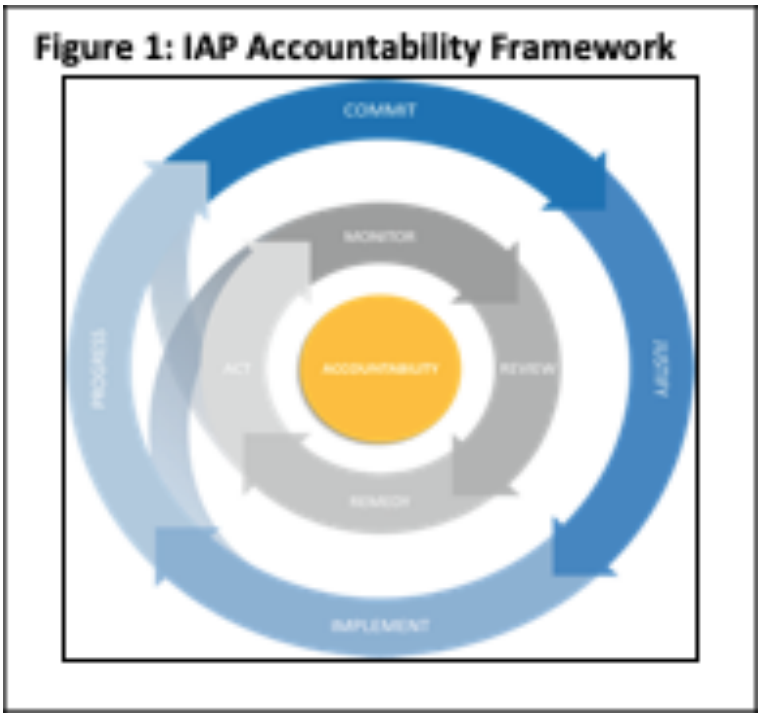
Introduction

In its 2020 report *Caught in the COVID-19 storm: women's, children's and adolescents' health in the context of UHC and the SDGs*, the UN Secretary-General's Every Woman Every Child (EWEC) Independent Accountability Panel (IAP) sets out an accountability framework that can be used by governmental and non-governmental actors to track duty bearers' obligations and rights holders' claims pertaining to health and health-related goals and rights (see Figure 1) [1].



The IAP Accountability Framework is founded on a human rights approach to health, and evolved from previous EWEC Global Strategy initiatives [2]. It is based on an integrated, whole of government, whole of society approach in which accountability connects commitment to progress in a justifiable and constructive way. The framework includes four essential functions—*monitor*, *review*, *remedy*, and *act*. These are combined with four pillars of effective accountability—*commit*, *justify*, *implement*, and *progress*. All four pillars must be present for accountability; if one is missing, the entire accountability structure will fail. Accountability processes are implemented in unique contexts and involve a diverse set of stakeholders including governments and non-state actors, individuals and institutions.

The concept of *constructive accountability* is central to the framework, in which accountability is not about blame and punishment but rather a process for identifying what works (so it can be repeated) and what does not (so it can be revised) in order to increase efficiency, effectiveness, and equity, and to realize rights [2-4]. An integral part of the process is that accountability must be *institutionalized*, so that leaders and governments justify and carry out their commitments and progressively realize goals and rights. Additionally, *democratization* is at the heart of the accountability process, meaning that all people can participate fully, voice their experiences, and claim their rights. The accountability process is also fostered

by an *enabling environment* and is strongly influenced by the political, economic, legal, and socio-cultural context in which citizens and states interact [5].

This report operationalizes the IAP Accountability Framework. It is based on an evidence synthesis on benchmarks, indicators, and information sources relevant to accountability generally and each component of the framework specifically. In the sections that follow, each of the four pillars of the framework are presented along with definitions, operational characteristics, case examples of accountability in action, and examples of indicators and their sources. These are also summarized in Appendix 1. Appendix 2 summarizes criteria for selecting indicators of the extent to which accountability is present, and Appendix 3 provides details on examples of indicators for accountability in health.

Pillar 1: Commit

The "Commit" pillar refers to commitment to achieving health and health-related goals and rights, with defined responsibilities and required resources throughout the accountability cycle. Commitment—whether political, strategic, executive, policy, or programmatic—is the willingness and intent of leaders to act and keep on acting to achieve a set of objectives [6, 7]. While all stakeholders have a role to play, governments have specific obligations as duty bearers and have an overarching stewardship role.

Commitments involve statements made by leaders that a health or health-related issue is a problem, and that determined action is required and forthcoming [7, 8]. These statements might be made by government officials (such as heads of state, members of parliament, and senior bureaucrats) or influential non-governmental actors (from civil society, business and philanthropic sectors, and international organizations), or by key actors from community organizations, social movements, or service providers. Statements might be verbal or written, and expressed in a variety of different fora, for example in national political manifestos, voluntary national reviews, international political declarations and resolutions, and/or multi-stakeholder commitments on health or health-related sustainable development goals (SDGs) and rights.

Strong commitments have the following characteristics:

- ❑ SMART (specific, measurable, achievable, relevant, and time-bound)
- ❑ Voluntary and public
- ❑ Supported by a wide range of actors, including those who are most affected by the health or health-related issue
- ❑ Institutionalized (leadership, resources, and roles)

Research shows that strong, genuine commitments (more than merely "symbolic" or "lip-service") are explicit and set clear and attainable goals [8, 9]. In other words, they are SMART—specific, measurable, achievable, relevant, and time-bound. SMART commitments provide more focus and clarity for action and enhance accountability (see Box 1). Commitments are also strong when they are voluntary (as opposed to commitments that might be "coerced," for example by donors) and public (in terms of leaders publicly stating their support and citizens being able to access and track public policies) [8, 9]. Strong commitments also involve the active mobilization of support by a wide range of actors, including those who are most affected by the health or health-related issue, to build consensus [9]. Building support involves multiple activities including: framing the issue and raising awareness about the definition of, causes of, and solutions to the problem; advocacy activities to mobilize leaders and groups to take action; strategic planning activities; network- and coalition-building activities to create supportive linkages; capacity-building interventions; and building in significant time to build trust, promote dialogue, allow representation of divergent issues, and create constructive relationships [9-11].

Commitments are strong when they are institutionalized. This is indicated by the conversion of expressed commitments into institutional and operational commitments which take commitments forward—these come about through political processes, including negotiations and agreements, and are thus hard to undo once established, making later policy reversals more difficult and less likely [12]. Institutional commitments might involve the establishment or strengthening of agencies for coordinating actions. They might also include the adoption of legislation, policies, plans, and interventions needed for the response, such as implementation plans and arrangements for ensuring accountability. Mechanisms also might need to be put in place for creating linkages across government, civil society, and businesses for multisectoral, multi-stakeholder action. Operational commitments are tangible commitments to on-the-ground actions such as the mobilization and disbursement of human, technical, and financial resources by governments and donors [7]. Adequate budgets for achieving policy goals indicates strong commitment (for example, budget allocations are equal to budgets requested and actual spending is equal to the amount allocated) [13]. Operational commitments might also involve the effective coordination of actors at national and subnational levels, as well as the monitoring and enforcement of laws and regulations.

Box 1: Making SMART Commitments in Nutrition

The UN General Assembly in April 2016 proclaimed 2016-2026 as the Decade of Action on Nutrition ("Nutrition Decade"). Integral to the Nutrition Decade are country commitments for action with countries encouraged to set SMART (specific, measurable, achievable, relevant, and time-bound) commitments to help bring clarity to all stakeholders on what action is needed and to allow better tracking. The Scaling Up Nutrition (SUN) Movement works with countries to establish SMART commitments; these are then tracked regularly by countries in self-assessment processes. The process of formulating SMART commitments includes: bringing stakeholders together; analyzing barriers; balancing national and sector priorities; linking to global initiatives; aligning with regional processes; and formulating commitment take-aways, making sure commitments are monitored in a credible way but not too complicated at the start [14].

The Government of Brazil already had a solid existing foundation of political, policy, and financial commitments to reduce malnutrition. For example, the country had in place a school food procurement law limiting the amount of processed foods procured by schools to 30 percent and had committed over US $600 million to the purchase of healthy foods for schools and other public institutions [15]. In spite of this progress, Brazil recognized at the beginning of the Nutrition Decade that 70 percent of all premature deaths remained due to non-communicable diseases (NCDs), many of which had a foundation in overnutrition and that—while children had been a sustained focus of nutrition commitments—there remained a gap with respect to action on adult malnutrition. With these issues in mind, in 2017, Brazil became the first country to make SMART commitments.

Brazil's three SMART commitments, announced by the Minister of Health at a ceremony in Geneva, were to be achieved over the course of two years: 1) to stop the growth in the adult obesity rate (which at the time stood at 20.8 percent); 2) to reduce by at least 30 percent the consumption of sugar-sweetened

beverages among adults; 3) to increase by at least 17.8 percent the proportion of adults who regularly eat fruit and vegetables [16]. To achieve these commitments, a further 38 sub-commitments were created, under six action areas aligned to commitments spelled out in Brazil's 2nd National Food and Nutrition Security Plan, which runs concurrently from 2016-2019. These actions areas are [17, 18]:

- Sustainable, resilient food systems for healthy diets
- Aligned health systems providing universal coverage of essential nutrition actions
- Social protection and nutrition education
- Trade and investment for improved nutrition
- Safe and supportive environments for nutrition at all ages
- Review, strengthen and promote nutrition governance and accountability

Each of these action areas is tied to financial and other resources, along with multi-sectoral targets, indicators, and guidelines for implementation [19, 20]. To achieve commitments, Brazil further committed to a number of specific policy measures to leverage, strengthen, and build upon progress. These included additional fiscal measures (e.g. tax reductions and subsidies) to reduce the price of fresh foods, microcredit loans to small farmers, and cash transfers to poor families to purchase fresh fruits and vegetables [16]. For example, states and municipalities were already required to buy a percentage of produce from smaller farmers as part of the National Food Acquisition Programme. SMART commitments provided a policy basis for strengthening farmers' ability to participate in such programs [20]. The Ministry of Health has further committed to objectives set forth by both SMART and the National Food and Nutrition Security Plan by increasing the budget for nutrition activities by 40 percent since 2015 and strengthening regulation to respond to obesity [19].

Measuring Commitment

National governments that have a strong *commitment* to achieving health and health-related goals and rights will make commitments at political fora. An indicator of commitment would be whether SMART commitments were made at selected meetings, such as the annual World Health Assembly or at ad-hoc high-level meetings convened by the United Nations General Assembly. These commitments may be extracted and evaluated through a desk review of relevant meetings. For example, UHC2030 has extracted and compiled forward-looking and actionable verbal commitments to universal health coverage (UHC) made at the 71st World Health Assembly and the September 2019 United Nations High-Level meeting on Universal Health Coverage [21]. It is recommended to further evaluate whether commitments are SMART through a numeric scoring: commitments that are not SMART do not imply specific actions which will be taken and may be nothing more than symbolic statements. UHC commitments scored according to SMART criteria may be used for a wide range of health and health-related SDGs given that UHC encompasses many health services, from health promotion to prevention, treatment, rehabilitation, and palliative care. Investment in UHC is the process by which most health- and health-related SDGs will be achieved. Further, the database of commitments prepared by UHC2030 enables rapid extraction, uptake, and use of this indicator. UHC2030 has also searched for measurable national targets, which could be considered in

conjunction with the verbal commitments at the two high-level meetings. It would also be possible to adapt this indicator to specific programmatic areas through a desk review of statements made at relevant high-level political fora.

Indicators like expressed UHC commitment that track statements do not measure whether these commitments are institutionalized. Indicators of whether governments institutionalize commitments, such as institutional structures or budgetary commitments, are discussed within the Implement pillar.

Pillar 2: Justify

In the "Justify" pillar, decisions and actions to strengthen the achievement of health and health-related goals and rights are justified by (and rooted in) evidence, rights, and the rule of law.

Stakeholder commitments, and the decisions and actions that stem from these commitments, are more likely to lead to better outcomes when informed and justified by evidence [22, 23]. For example, a government's decisions and actions related to its maternal and child health commitments might be grounded in evidence-based global strategies, such as the EWEC Global Strategy and the Immunization Agenda 2030. Justifications informed by evidence involve decision-makers asking critical questions about the research evidence available and demonstrating that they are using good information on which to base their decisions, including the perceptions of people affected by the health or health-related issue [24].

The "justify" pillar also emphasizes the importance of rights and the rule of law. Stakeholder commitments, and related decisions and actions, should be justified and grounded in internationally recognized human rights standards and principles. Additionally, they should be aligned with a country's laws that are publicly disseminated, equally enforced, and independently judged, and which harmonize with international human rights norms and standards [25].

Strong justifications have the following characteristics:

- ❑ Informed by the "best available" evidence, which has been identified and appraised systematically and transparently
- ❑ Informed by the views and experiences of people who are most affected by the health or health-related issue
- ❑ Aligned with international human rights standards and principles
- ❑ Aligned with a country's laws that are publicly disseminated, equally enforced, and independently judged
- ❑ Made available and accessible to citizens

Strong justifications are those informed by high-quality evidence, defined as the "best available" evidence that is appropriate for the problem [23]. Evidence includes both "global evidence" (the best evidence available around the world, important for assessing impacts of policies and programs) and "local evidence" (evidence from the specific setting, important for assessing problems, options for addressing problems, and implementation strategies) [24]. Evidence-informed justifications allow for the possibility that there may be new, better ways of addressing health and health-related issues that do not yet have a large, published literature on effectiveness. Strong justifications are underpinned by systematic processes that have been used to identify and appraise evidence and that are transparent so that others can assess what evidence has been used and what tradeoffs have been made in decision-making [24]. This requires that decision-makers have sufficient expertise to understand or use high-quality evidence (see Box 2) [23,

26]. The identification and appraisal of evidence should be complemented by the views and experiences of the people most affected by the health or health-related issue.[1]

Justifications should also be rooted in international human rights standards and principles and the rule of law. Strong justifications based on a rights approach involve paying attention to: 1) the legal and policy context within which a response to a health or health-related issue occur; 2) the participation of affected groups in decisions and actions that relate to them; 3) non-discrimination, ensuring the absence of discrimination in service delivery and outcomes among different population groups; 4) human rights standards in service delivery to ensure availability, accessibility, acceptability, and quality; and 5) transparency and accountability in decision-making and its impact [27, 28]. The rights-based approach places focus on relationships of power and how issues affect different population groups and what can be done to address disproportionate effects (see Box 3). Additionally, strong justifications are in accordance with a country's legal framework in which laws are disclosed publicly, applied evenly, judged independently, and which protects fundamental rights.[2]

Strong justifications are made available and accessible to citizens so that there is transparency as to how and why decisions are made and actions taken, and what are the trade-offs involved therein.

Box 2: Using evidence to make new vaccine policy decisions

When new vaccines become available, governments are confronted with hard decisions about whether to introduce the new vaccine into national immunization programs. New vaccines are more expensive than traditional vaccines and some have target populations other than young children, a population for which there tends to be more guidelines and tools available for new vaccine introduction. Expertise and skills in "decision science"—a set of tools and methodologies used to inform decision-making (e.g. cost-benefit and cost-effectiveness analysis, behavioral decision theory, risk analysis, and operational research) [29]—is needed to ensure that decisions about new vaccine introduction are based on the best available evidence about technical, operational, and societal factors.

The ProVac Initiative was established by PAHO in 2004, with catalytic funding by the Bill & Melinda Gates Foundation provided in 2009. Initially, ProVac was focused on strengthening national capacity in the Americas in decision science in order to make informed, evidence-based decisions on new vaccine introduction [30]. This included building capacity for economic analyses related to introducing new vaccines, optimizing national immunization program performance, carrying out post-introduction impact evaluations, and supporting regional and national vaccine advisory bodies [31]. Key activities have

[1] See, for example, how citizens' perceptions complement the findings of the Ibrahim Index of African Governance. 2020 Ibrahim Index of African Governance: Index Report. Available from: https://mo.ibrahim.foundation/sites/default/files/2020-11/2020-index-report.pdf

[2] The World Justice Project defines rule of law in terms of four universal principles: accountability, just laws, open government, and accessible justice. For more information, see: https://worldjusticeproject.org.

included training workshops for country teams to familiarize themselves with both economic evaluation and ProVac decision-making tools, as well as direct technical support to help countries carry out cost-effectiveness analyses and costing studies for new vaccine introductions [30, 32]. The two primary tools ProVac uses are UNIVAC and COSTVAC. UNIVAC is a vaccine impact and cost-effectiveness Excel-based tool involving estimates of age-specific disease burden, age/dose specific vaccine coverage, and effectiveness to establish the impact of vaccine introduction and coverage on a country's health outcomes [33]. COSTVAC, meanwhile, is an Excel-based tool helping countries estimate the cost of routine immunization from a sample of health facilities and administrative levels of the health system [33].

In 2011, PAHO began partnering with WHO Regional Offices and agencies to establish a ProVac International Working Group to transfer the ProVac framework for new vaccine decision support and other tools and training to other regions of the world and, in 2015, scaled up its work to countries outside the Americas [34]. Since then, the ProVac Initiative has trained technical staff from ministries of health and provided direct technical assistance to over 30 countries in the Americas, Europe, Asia, and Africa, training more than 25 countries on vaccine economic evaluations, carrying out more than 40 country-level vaccine cost-effectiveness analyses, and strengthening more than 20 National Immunization Technical Advisory Groups through direct support [31].

In 2015, for example, ProVac supported cost-effectiveness studies to support decision-making around the introduction of the pneumococcal conjugate vaccine in Azerbaijan, Croatia, and Georgia and for the rotavirus vaccine in Albania, with the objective to help these countries estimate the extent to which the new vaccines would affect the burden of disease. Albania and Croatia used evidence generated by ProVac technical support to ultimately make the decision to introduce the new vaccines and negotiate appropriate prices, while Azerbaijan and Georgia used the evidence to ensure existing decisions received appropriate financial commitments [35].

Box 3: Human rights and COVID-19

First reported in December 2019, the COVID-19 pandemic has led to 57.7 million cases and 1.3 million deaths globally (as of November 21, 2020). The pandemic has required an unprecedented response and has highlighted the fact that some population groups (including older populations, people with chronic conditions, minority ethnic populations, and frontline workers both inside and outside of the health sector) are at heightened risk of infection and death, while others (such as those doing manual work, children kept home from school, and women experiencing abuse) are disproportionately affected by COVID-19 stay-at-home measures.

In many countries, governments failed in their early COVID-19 decision-making to make adequate provisions for disproportionately affected population groups despite early analyses pointing to the likely economic and social impact of COVID-19 on at-risk groups [36]. Decision-makers in some settings, however, used a human rights lens to put a focus on how the pandemic is affecting people, particularly

the most vulnerable, and what can be done immediately and in the longer term to address their needs. Specifically, they have used a rights-based approach to justify fiscal, financial, and economic measures to address the negative impact of COVID-19 such as provision of emergency water supplies to slum areas; suspension of housing evictions for unpaid rent; preserving jobs and wages through targeted economic measures; providing or extending paid sick leave to workers or unemployment benefits; securing emergency shelter for the homeless; expanding domestic violence responses; and providing child care for essential workers [37].

For example, early COVID-19 outbreaks at slaughterhouses and meat-processing plants in Germany served to highlight long-standing poor conditions in the country's meat industry and the disproportionate effect that human rights abuses in the sector have on foreign migrant workers. Following a May 2020 outbreak in North Rhine-Westphalia in which 150 out of 200 predominantly Romanian and Bulgarian employees tested positive for COVID-19 and 13 were hospitalized, the German Cabinet utilized a human rights framework to justify urgent action on regulating the practice of subcontracting in the meatpacking industry and securing workers' rights. On July 29, 2020, a draft law was passed banning temporary worker subcontracting, introducing new standards for employee housing, and improving labor protection checks, in effect as of January 2021 [38, 39].

Measuring Justify

The *justify* pillar of accountability refers to whether expressed commitments materialize in decisions and actions (including the adoption of laws and policies) that are grounded in evidence and uphold international human rights principles and rule of law. For instance, there are well documented, cost-effective tobacco control and cessation interventions [40]. WHO tracks the level of implementation of six such interventions that are included in the MPOWER measures [41]. Advances in these measures illustrate that countries are fulfilling commitments by enacting evidence-based laws and implementing evidence-based policies and regulations.

As with the MPOWER measures, the adoption of evidence-based laws and policies for other programmatic areas may be monitored using key-informant interviews, *e.g.,* surveys to government functionaries. It is important to note that key-informant interviews may introduce social desirability bias—that is when an informant may misreport in an effort to provide answers that they perceive are acceptable or normative. As a result, key-informant interviews should always be supplemented with a legal document review.

Another indicator which would measure multiple aspects of *justify* in action would be to measure the extent to which countries have laws and regulations that guarantee full and equal access to sexual and reproductive health care—including abortion rights (SDG indicator 5.6.2 [component 3]; assessed by legal review in a larger number of countries by the Center for Reproductive Rights) [42]. Protection of abortion rights tracks adherence to evidence-based interventions, alignment with international human rights standards, and whether the rights of those most affected by policies and laws are prioritized.

Pillar 3: Implement

Progress is charted by monitoring and reviewing data (including through independent review), enacting remedies, taking necessary action and – critically – being seen to be taking action.

The implement pillar has four components. First is *monitoring*, or the collection of data and information to assess whether progress is being made. The monitoring component is focused on collecting select data in a timely way in order to allow decision-making and seeks to avoid creating parallel systems. Monitoring might occur, for example, through national and UN health and SDG monitoring; human rights treaty monitoring bodies; joint monitoring programs such as the WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation, and Hygiene; or through collection, analysis, and dissemination of surveillance data (such as for tobacco).

The second component of the Implement pillar is *review*—this is a formal process for reviewing the monitoring data. An important part of the review process is independent review. This helps to better identify laws, policies, and programs that are functioning well (so they can be strengthened) and areas for improvement and increased attention (so they can be addressed) [43]. Examples of review mechanisms in the Implement pillar are citizens' hearings (in which government and community members gather to discuss concerns and jointly develop solutions and plans for action) and national health assemblies (see Box 4), the High-Level Political Forum on Sustainable Development (state-led, voluntary reviews involving multiple stakeholders and focused on the 2030 Agenda), and Universal Periodic Review (a state-driven process, under the auspices of the Human Rights Council, reviewing human rights). National institutions such as courts, parliaments, and other institutions also have an important role to play in review and oversight including of executive branch policies and plans, and budget allocations [43].

The review process leads to a set of actions to be implemented. The *remedy* component of the Implementation pillar refers to those actions that involve structural, legal, and policy changes that are enforceable, including legal remedies for rights violations, and that create the conditions for transformative change. This includes regulation of all entities that have an impact on people's health, including the private sector (for example, regulating the marketing of unhealthy foods) [43, 44]. It also includes legal actions that ensure citizen participation in policy formulation and accountability processes (see Box 4). The remedy component emphasizes the role of national and international law in making progress toward health and health-related goals and rights [43]. At the national level, remedies could include national health laws and UHC service and financial protection programs. Global-level mechanisms include international human rights law, conventions such as the framework convention on tobacco control, global agreements such as the Paris Agreement on Climate Change, and international standards such as the WHO International Code of Marketing of Breastmilk Substitutes.

The final component in the Implement pillar is *act*, and this refers to all actions identified in the review stage (often written into an action plan) that need to be put in place. Actions include remedies (mentioned above) as well as other actions that emerge from the review process—for example, national budget allocations. Action plans can be implemented through relevant national-level platforms such as the UHC

Partnership's Joint Working Team (for UHC action plans), Global Fund Country Coordinating Mechanisms (for AIDS, TB, and malaria), or the SDG3 Global Action Plan PHC Accelerator (for primary health care).

Strong implementation has the following characteristics:

Overall process

- ❑ There is a clear link between monitor, review, remedy and act, with each component feeding into the next
- ❑ The implementation process is formal (not voluntary), with clear roles, responsibilities, timelines, and institutional arrangements

Monitor

- ❑ High-quality data and information are collected through a monitoring mechanism
- ❑ Indicators to monitor progress are relatively few in number and strategically selected, with local stakeholders involved in the selection process
- ❑ Data and information are both qualitative and quantitative
- ❑ Data and information are disaggregated to detect disparities
- ❑ Data and information that are collected are presented in a way that is understood by all stakeholders and actionable

Review

- ❑ A formal process exists for reviewing the monitoring data
- ❑ This process includes an independent review mechanism
- ❑ The review process involves all relevant stakeholder groups and is equitable
- ❑ The review process makes space for stakeholders to bring additional information about an issue and propose solutions, rather than just talking about the issue
- ❑ The review process leads to documented and clearly communicated decisions and recommendations

Remedy and Act

- ❑ An action plan is determined, with clear roles and responsibilities
- ❑ Implementation of the action plan is put in motion including structural, legal, and policy changes (remedies)
- ❑ There are consequences for duty bearers who do not implement the actions for which they are responsible
- ❑ Actions implemented are clearly communicated to all stakeholders, completing the feedback loop

Strong implementation requires the collection of high-quality data and information that are accurate, complete, reliable, relevant, and timely. Indicators to monitor progress should be relatively few in number and strategically selected, with local stakeholders involved in the selection process [45]. Data and information should be both quantitative and qualitative to ensure a complete understanding of people's experiences and be disaggregated to highlight disparities [43, 46]. Additionally, data and information that are collected should be presented in a way that is understood by all stakeholders and is actionable [43, 47]. Achieving these characteristics of strong monitoring may require strengthening capacity in national

statistical institutions and civil society to collect and analyze data and build political independence (see Box 5) [43, 47].

Strong implementation necessitates a formal process for reviewing monitoring data. Multi-stakeholder review mechanisms, the executive and legislative arms of the government, and the legal system should complement and support each other, rather than duplicate efforts [46]. The review process should include independent review mechanisms which are an essential means for feedback, particularly when they are collaborative and constructive rather than oppositional, and are an important checkpoint in the accountability process [45]. Moreover, the process should include all stakeholder groups and be equitable in that attention is given equally to all affected groups [47]. Strong review processes involve making space for stakeholders to bring additional information about an issue and propose solutions, rather than just discussing the issue [47]. The review process should lead to documented decisions and recommendations, clearly communicated to all internal and external stakeholders, ensuring the feedback loop [47].

Following monitoring and review is the determination of an action plan which emerges from the review stage, including the structural, legal, and policy changes that enable transformation (remedy). Strong implementation involves not only that these structural and legislative changes are instituted, but also that they are enforced. Implementation of action plans is not a one-off event but a process of carefully planned steps that build upon each other [48]. This process of implementing actions is likely to be stronger when stakeholders are motivated to carry out the actions for which they are responsible [47, 49]; roles and responsibilities should be clear, with adequate capabilities, resources, and authority. Implementation may also need to include consequences for duty bearers who do not implement the actions for which they are responsible (for example, disciplinary procedures or litigation), and the effective use of a recourse mechanism [47]. Full and transparent implementation of the action plan is needed, with activities clearly communicated to all stakeholders [47]. Completing the feedback loop is important, in which information is shared with and received by stakeholders through multiple channels [45]. Once actions, including remedies, are implemented, the *monitor* and *review* components of this pillar should be repeated to examine whether problems have been fully addressed [47].

Box 4: Implementing public accountability structures through Thailand's Universal Health Coverage Scheme

In 2002, Thailand implemented a universal health coverage (UHC) scheme entitling the country's population to a comprehensive package of essential health services through one of three national health insurance schemes. While private sector employees and civil servants are covered through social health insurance and a public sector employee benefit scheme respectively, the rest of the population is covered through the National Health Security Office which was established through the National Health Security Act of 2002 [50]. UHC in Thailand, however, is interpreted more broadly than just as a mechanism for health insurance coverage. Rather, UHC also involves a broad platform of citizen-driven accountability structures enabling citizens to claim their health-related services and rights [51].

For example, the National Health Security Act also established the National Health Security Board, the purpose of which is to convene annual public hearings at regional and national levels to ensure key UHC stakeholders—including patients—have a voice in how UHC is implemented so quality and other concerns can be addressed [51]. Meanwhile, the National Health Security Office also implements a publicly accessible beneficiary registration system to enable UHC recipients to be tracked within the system and access health services no matter where in the country they might move; a 24/7 telephone helpline linked to health security service centers (with additional structures run by civil society organizations) to enable UHC recipients to access benefits and report complaints; and a no-fault adverse event system to enable recipients to receive financial support promptly in the event of an adverse event [51, 52]. In 2018 alone, the helpline fielded over 900,000 calls, the majority of which were concerned with how to access benefits and services, while the no fault adverse event system—which earmarks an annual per capita amount from the fiscal budget towards financial assistance for adverse events— awarded 755 patients compensation of roughly US$ 5.30 million [51].

In 2007, the National Health Act further expanded UHC's role as a mechanism for voice and accountability by the establishment of the National Health Commission Office with the mandate to hold yearly National Health Assemblies (NHA), bringing together three key constituencies: 1) government; 2) health professionals and technical experts; and 3) civil society, media, and private sector organizations. All three constituencies have equal rights under the NHA and resolutions can only be passed with consensus (i.e., no two constituencies can outvote the third). In the absence of consensus, an ad-hoc drafting group is established to continue discussions and seek modifications and compromise on resolutions. The Assembly itself, moreover, consists of not only the annual event, but a months-long process of information sharing, dialogue, and consensus building leading up to the event [52].

While stakeholders acknowledge that the process can still be refined to improve representation of and within constituencies, build constituents' capacity to participate, better link resolutions to policies and practices, create stronger ties between national and provincial assemblies to ensure provincial issues are more strongly elevated, and raise awareness of the assembly process to expand public awareness, the NHA nevertheless plays a key role in monitoring, reviewing, and remedying citizens' and other stakeholders' concerns about how UHC is performing [51, 52].

Box 5: Capacity-building in Indonesia's mortality statistics program

In order for countries to be accountable to their national and global commitments, they require data [53]. A number of SDGs, for example, require accurate data on mortality which, in turn, requires countries to have a civil registration and vital statistics system able to capture numbers and causes of deaths in the population, disaggregated by age and sex [54].

After decades of collecting civil registration data through a patchwork of regionalized, non-standardized special surveys, the Government of Indonesia passed Law No. 23 in 2006 stating that vital statistics should

be provided through civil registration across all levels, conducted from village level up to provincial level and national level [55]. At the time, the registration of deaths in the country was estimated at less than 25 percent and captured mainly in big cities and in hospitals, and it was noted that capacity to carry out systematic vital registration data was quite low in much of the country [55].

The Indonesian Mortality Registration Strengthening Project (IMRSSP) was launched as a pilot which then scaled to 158 urban wards (kelurahan) and 638 rural villages (desa) in 2007, serving as a sentinel mortality surveillance initiative until 2011, then scaled again to reach national coverage with support from the Global Fund [56]. The Government of Indonesia then launched a national Sample Registration System (SRS) in 2014, covering a population of 9 million across 128 sub-districts and involving multiple institutions and personnel at national and subnational levels [57]. Recognizing the importance of civil registration and vital statistics, the government committed to funding the SRS with domestic financing through the Indonesian National Development Planning Agency in 2016 [56].

The SRS serves to capture reported births and deaths at health facilities around the country, with causes of death assessed by verbal autopsy [57]. Following the establishment of the SRS, mortality registration has been much improved; however, as of 2017, data completeness remained 55-72 percent [58]. An evaluation of the SRS, moreover, found that—besides problems with completeness—there were additional problems with accuracy, leading to the implementation of a capacity-building initiative involving Indonesian and Australian academic and government institutions [56].

The capacity building initiative identified problems with lack of capacity at point of data capture, inefficient centralized data management, and lack of sufficient skills in data quality evaluation and analysis. It noted two key challenges: 1) a widely dispersed workforce that covers large populations, with capacity-building requiring a range of skills development activities, considerable funding, and trained personnel; 2) the majority of personnel involved in SRS activities are government employees and thus in-service training may require managing change in existing work environments [57].

In partnership with the Government of Indonesia, the initiative then developed a comprehensive system strengthening strategy, implemented in 2018, to support the decentralization of data management and improve performance at the site level, as well as a data entry tool to improve data capture at community and district levels and to feed into data quality assurance processes [56, 57]. In parallel, the Government of Indonesia committed to scaling and speeding up civil registration, formulating a ‘Presidential Decree on National Strategy of Civil Registration and Vital Statistics (CRVS) 2017–2024 and increasing the local budget for SRS field operations [58].

Measuring Implement

Monitor

The basis of strong *monitoring* of health and its determinants is the existence of quality health information systems, comprising regular censuses, household surveys (with health modules), registration of births and deaths (including information on cause of death), health facility information systems, and specialized data and information collection systems [59]. The data and information collected by these systems are used to compute international, national, and local indicators, and underpin effective and accurate communication about health and its determinants in a country. In the field of global health, statistical models are often used to estimate indicator values for all countries and years in a defined period. These model-based estimates may give a false impression of ample data for monitoring, but these estimates are only as good as the underlying primary data upon which they are based. Therefore, the ideal indicator for evaluating a monitoring system is the availability of up-to-date primary data from which key program-specific indicators are computed. An example of this that reflects the range of data sources required to monitor health and health-related indicators, is the average availability of recent primary data on the health-related SDG indicators [59]. This indicator is computed as the percentage of health and health-related SDG indicators for which underlying primary data were available for the 4-5 years preceding the last data compilation date (*i.e.*, availability of model-based estimates were not sufficient). The selected indicator could be adapted to a specific programmatic area to focus on data availability for monitoring key program-specific indicators, if desired. For most health program areas, such as SRMNCAH or NCDs, the average data availability across all health and health-related SDGs is already available and would best reflect the variety of data sources used for monitoring health and its determinants. The availability of data for monitoring allows for clear, accurate communication about health goals and targets, including sharing of information in ways that are responsive to locally determined priorities.

It would also be possible to consider indicators of specific aspects of health monitoring in place of this indicator, such as the percentage of births registered (SDG indicator 16.19.1) and coverage of death registration (part of SDG indicator 17.19.2). However, a narrower indicator would not reflect the breadth of data collection required for monitoring progress toward health and health-related goals. Finally, availability of disaggregated data is a particular focus of the SDG Agenda.[3] At this point in time, disaggregated data is systematically extracted and compiled at the global level for only a subset of health and health-related SDG indicators, even when disaggregated data are available at the national level. Therefore, a global indicator focusing on disaggregated data is not currently feasible. If high-quality data systems for monitoring are available—as would be measured by the percentage of health and health-related SDG indicators with recent primary data available—it is generally possible to compute some key disaggregated statistics.

[3] SDG indicator 17.18.1 aimed to monitor countries' ability to produce disaggregated data, but the indicator is currently being revised.

Review

An indicator for *review* should assess whether a formal review process is in place, one which entails an independent mechanism and is inclusive of all relevant stakeholders. Such an indicator can be constructed by assessing whether national governments have included the program area of interest in a voluntary national review (VNR). As part of the follow-up and review mechanism of the 2030 Agenda, member states are encouraged to conduct regular and inclusive reviews of progress at the national and sub-national levels, which are country-led and country-driven. Since 2016, national governments have had the opportunity to prepare a VNR report and present it to the high-level political forum on sustainable development, under the auspices of the UN Economic and Social Council, for review. The United Nations Department of Economic and Social Affairs (UN DESA) maintains an online database of the reports that provide the basis of the voluntary national reviews (VNRs).[4] Since VNRs are presented to the high-level political forum, an independent international body, these may be considered an independent review process. This indicator has been operationalized by UHC2030 for the area of universal health coverage. UHC2030 have reviewed all VNRs to determine whether universal health coverage was included in the VNR [21]. As discussed above, UHC is the vehicle by which health and many health-related SDGs will be achieved, and its inclusion in the VNR process is therefore relevant to all programmatic areas concerned with health. It would be possible to modify this indicator to focus on specific programmatic areas with the support of a desk review.

The proposed indicator does not reflect whether stakeholder feedback was sought and taken into account. Further, national governments may have their own independent review processes. Ideally these would be taken into account, following a careful external assessment to determine whether they are independent and inclusive.

Remedy

Remedies and *actions* taken should be a result of the *monitor* and *review* steps of the cycle. Indicators to measure *remedies* will ascertain whether duty bearers are held accountable for the actions for which they are responsible through mechanisms such as fora for complaints/grievances. The acceptance of 9 individual complaints procedures [60]—an indicator captured by the United Nations Human Rights Office of the High Commission (OHCHR)—evaluates a state's commitment to ensuring individuals are provided the option to complain at international committees (known as treaty bodies) about potential human rights violations. Acceptance of these procedures illustrates the state's commitment to the protection of human rights, including health-related human rights, by providing individuals with recourse in the case that those rights are violated. Indicators captured in the 2018-2019 Sexual, Reproductive, Maternal, Newborn, and Adolescent Health policy survey [61]—the implementation of maternal/neonatal/stillbirth death reviews—are also demonstrative of grievance platforms that, when implemented effectively, may result in systems level improvements to the quality of service delivery (*e.g*. training of health workforce). Legal

[4] Available at: https://sustainabledevelopment.un.org/vnrs/

and policy reform *remedies* executed at a state or national level might also be captured through periodic legal document reviews.

Act

Remedies, such as law/policy reform, should be followed by country *action* to achieve health and health-related goals, including providing sufficient health systems funding and resources to improve the coverage, quality, and equity of services provided. An indicator of the act function is a measure of whether the means to achieve key goals have been implemented. For example, health goals must be achieved by strengthening health systems. This can be monitored by the indicators for SDG 3.8., achieve universal health coverage. The universal health service coverage index (SDG 3.8.1) [62], is a readily available indicator that provides a composite index score of 14 essential health service indicators that countries at all levels of development should provide. Expansion of service coverage should always be accompanied by financial protection, which can be monitored by the incidence of catastrophic expenditures on health (SDG 3.8.2) [63]. Unlike most other health financing indicators, incidence of catastrophic expenditures has a clear optimum: no financial hardship as a result of accessing health services. Evidence of actions resulting in improved service coverage—without financial harm—lends credibility to a country's ability to *act* on commitments to health.

Other health systems strengthening indicators may also illustrate country *action,* be it changes in government spending on health as a percent of GDP [64], total health expenditure [65], or improvements to health worker density [66, 67]. However, these indicators are challenging to operationalize because they have no clear optimum.

Pillar 4: Progress

Continuously making effective, efficient and equitable progress toward agreed rights and goals, with all available resources—this is the human rights principle of progressive realization.

The concept of progressive realization comes from the International Covenant on Economic, Social and Cultural Rights [68] and emphasizes governments' obligations to take appropriate measures towards the full realization of economic, social, and cultural rights—these include the right to health, the right to education, and the right to water, among others. The principle recognizes that realization of rights may be constrained by a lack of resources, but governments do have an immediate obligation to take appropriate steps. While states have specific obligations as duty bearers, the principle of progressive realization is also applicable to efforts to hold other stakeholders accountable, such as donors [28].

Progress on health and health-related goals and rights might be assessed through national audits and progress assessments, WHO General Programme of Work delivery stock takes, progress reports (such as Global Strategy Progress Reports), and through the lived experience of people on improved health and rights.

Strong progress has the following characteristics:

- ❑ The maximum of available resources is being expended
- ❑ Expenditures are efficient, effective, and equitable
- ❑ There are positive, equitable, continuous rates of change toward the health or health-related goals and/or rights
- ❑ All stakeholders, including those who are most affected by the health or health-related issue, are engaged in making progress

It is rarely possible to fully achieve health and health-related goals and rights immediately. However, governments can demonstrate strong progress by showing that sufficient effort is being expended to the maximum of available resources. Such a demonstration requires that the government and partners mobilize as many resources as possible (both domestic and external resources) to realize goals and rights, and they must prioritize allocations and expenditures, including with input from civil society and the public (see Box 6) [69]. Additionally, governments should not divert resources that are essential to the realization of rights and goals in other areas [69]. Expenditures must be efficient, effective, and equitable, and innovative efforts should be made in order to accelerate progress. Moreover, funds allocated must be fully spent. Progress is then demonstrated when there are positive, continual rates of change (rather than merely levels of attainment) compared to benchmarked rates [70]. This progress should be equitable in that service provision and/or outcomes are similar in all groups, including disadvantaged populations (this is referred to as substantive equality in human rights treaties) [70]. All stakeholders—those who affect and are affected by the health or health-related issue—should be jointly engaged in the process of advancing progress and ensuring accountability.

Box 6: Treatment Action Campaign and PMTCT in South Africa

The Treatment Action Campaign (TAC)—a civil society organization—was founded in South Africa in 1998 in order to campaign on behalf of better service delivery and increased access to effective, safe, and affordable medicines for people living with HIV [71]. One of TAC's first advocacy initiatives was on behalf of the provision of medicines for the prevention of mother to child transmission of HIV (PMTCT).

By 1998, millions of adults and children in South Africa were living with HIV/AIDS and antenatal prevalence was estimated at 22 percent, with 1500 people newly infected with HIV every day [71]. TAC began a campaign to insist that the government introduce a PMTCT program based on the only antiretroviral medicine available at the time, AZT. The South African government, however, argued that not only did they believe AZT to be toxic, but also that there were insufficient government resources to fund a PMTCT program [72, 73]. In March 1999, the health minister at the time stated that the R500 (US$67) required to treat one pregnant woman with AZT was too costly and would strain the limited budget [74]. TAC threatened legal action since extensive evidence had already been presented that AZT was safe to use within a PMTCT program and would be cost effective due to infections averted [74].

In early 2000, TAC's efforts received an additional boost when Nevirapine was found to be as effective as AZT, could be administered in a single dose, and was more affordable. Within a year, the Medicines Control Council of South Africa approved Nevirapine for use in the country [72, 73]. However, the government still refused to roll out a comprehensive PMTCT program citing cost and lack of capacity in the public sector health services; antenatal prevalence rose to 26.5 percent [71]. Meanwhile, three separate provinces—Western Cape, KwaZulu Natal, and Gauteng—frustrated with government inaction, moved forward with their own PMTCT programs [71].

In August 2001, TAC filed papers with the High Court requesting that the government be ordered to make Nevirapine available to pregnant women with HIV who give birth in the public health sector and to their newborns. Citing Section 27 of the South African Constitution, TAC argued that the South African government was legally required to " take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights" [75]. In their filing, TAC also included cost projections from a health economist that showed how public funds spent on a PMTCT program would save money over the long term by decreasing costs associated with HIV/AIDS cases in the future, including $45,000 every six months by using Nevirapine [72, 76]. Although the government argued that the amount of resources needed to roll out PMTCT—an estimated US$33 million for a full provincial rollout—was not available, TAC pointed to the 2001 Intergovernmental Fiscal Review showing that the government in 2000 systematically underspent a vital portion of its health budget by an estimated US$ 63 million [72, 73].

The High Court in December 2001 ruled in favor of TAC, stating that resources were clearly available and must be used to safeguard the right to life and the right to health of children to be born to HIV positive

mothers [74]. The government, according to the judge, had violated Section 27 of the Constitution by not taking reasonable steps within available resources to achieve progressive realization of the rights of people living with HIV. While it would be a number of years of political bottlenecks before PMTCT was subsequently rolled out across all provinces in South Africa, by 2013, PMTCT was reaching close to 100 percent of women in the public sector, thus culminating in the progressive realization of rights of pregnant women living with HIV and their children [74].

Measuring Progress

An indicator of improvement in a key outcome in a disadvantaged population demonstrates that a country is making *progress* toward programmatic goals and targets. In the area of health, under-five mortality is the SDG indicator with the strongest data for monitoring. Regular data collection takes place in countries across the development spectrum [77]. Reducing under-five mortality is possible for countries at all levels of health status, from high mortality countries, where young children are dying from preventable infections, to countries that have already achieved SDG target 3.2 on child mortality, yet still experience disparities in neonatal and child mortality.[5] Because the focus of the progress pillar is on continuous improvements, the average annual rate of reduction in under-five mortality in the previous 10 years would be a relevant, valid, feasible, and harmonized indicator of progress in health. This indicator may be computed from the estimates of under-five mortality published by the United Nations Inter-agency Group for Child Mortality Estimation (UN IGME) [77]. It is aligned with the human rights principle of progressive realization, without additional complex benchmarking: in low mortality countries, higher monetary investment is needed to further reduce mortality. Thus, countries with more available resources will need to invest more to achieve a given rate of reduction. Finally, it is possible to incorporate equity into this indicator, by assessing only rates of reduction in rural populations (the disadvantaged population with the most comprehensive data availability). UN IGME is currently refining methods for estimates by place of residence and anticipates releasing these in September 2021.

For low- and middle-income countries, progress on stunting would be an alternative indicator to under-five mortality. Stunting prevalence reflects the total environment that young children are experiencing, from maternal health prior to conception, quality nutrition and health care during pregnancy and the first five years of life, to the presence of safe water and sanitation. Further, stunting has negative implications for life-long well-being that go beyond survival. Data for monitoring are ample and are regularly compiled by UN agencies. Further, data by area of residence (urban/rural) are compiled by the Joint Child Malnutrition Estimates group, meaning that this indicator can already be adapted to assess whether progress is equitable [78]. However, in high-income countries, stunting is not a public health concern and data are not regularly collected or compiled. One possibility would be to introduce an indicator that would depend on the countries' level of development, i.e., stunting for countries where it remains a public health concern, and another indicator such as NCD mortality (SDG 3.4.1) for the remaining countries, which is a public health concern and for which ample high-quality data exist in the high-income countries.

[5] Analysis of recent reductions in under-five mortality rates presented in: UN IGME, 2020.

Health-adjusted life expectancy is a comprehensive indicator of non-fatal and fatal health status, and is a conceptually ideal indicator over overall health [79]. However, data on non-fatal health outcomes are sparse and unreliable, as are data on older-age mortality in most low- and middle income countries. These data are not adequate for monitoring progress [79]. Under-five mortality, stunting in countries where it is a public health concern, or NCD mortality in countries with high-quality death registration systems are preferred over health-adjusted life expectancy because these data are of sufficient quality to detect recent progress. Further, it is straightforward to incorporate equity into a single indicator by monitoring these indicators in disadvantaged groups.

Conclusion

The IAP Accountability Framework can be used by governments and non-governmental actors to track duty bearers' obligations and rights holders' claims pertaining to health and health-related goals and rights. This report has presented this framework and its four pillars of Commit, Justify, Implement, and Progress. It has provided definitions, operational characteristics, case examples of accountability in action, and examples of indicators and their sources (see Appendix 1 for a summary). The accountability checklist in Box 7, developed from the information in this report, includes eight questions that can be asked by individuals and groups as they conduct accountability processes.

Box 7: Accountability checklist

- ✓ Is there a public commitment to the specific goal?
- ✓ What is the strength of the commitment?
    - Is it SMART?
    - Is there stakeholder support and participation?
    - Is the commitment institutionalized (in terms of leadership, resources, and roles)?

- ✓ Are there strategies, laws and policies, or plans to operationalize the commitment?
- ✓ Are these strategies, laws and policies, or plans explained and justified based on:
    - Best available evidence?
    - Human rights?
    - Rule of law?

- ✓ Are there high-quality data and information for monitoring, specifically including:
    - The selection of a parsimonious set of key indicators?
    - Quality data and monitoring mechanisms for these indicators?
- ✓ Is there required and regular review of progress and accountabilities? Is this review:
    - Institutionalized?
    - Does it include independent review?
- ✓ Are enforceable, timely remedies enacted and actions taken based on review recommendations? Do these include:
    - New or adapted strategies, laws and policies, plans, and budgets; recovery/restitutions?
    - Improved, scaled-up implementation and ways of working?

- ✓ Is there evidence of sustained progress towards the goal, and justification for exceptional reversals?

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Appendix 1. Operationalizing the IAP Accountability Framework – A Summary

Pillar	Definition	Accountability Checklist	Operational Characteristics	Indicators
COMMIT	Commitment to achieving health and health-related goals and rights, with defined responsibilities and required resources throughout the accountability cycle.	✓ Is there a public commitment to the specific goal? ✓ What is the strength of the commitment? • Is it SMART? • Is there stakeholder support and participation? • Is the commitment institutionalized (in terms of leadership, resources, and roles)?	*Strong commitments are:* ❑ SMART (specific, measurable, achievable, relevant, and time-bound) ❑ Voluntary and public ❑ Supported by a wide range of actors, including those who are most affected by the health or health-related issue ❑ Institutionalized (in terms of leadership, resources, and roles)	1. Expressed commitment, scored according to SMART criteria
JUSTIFY	Decisions and actions to strengthen the achievement of health and health-related goals and rights are justified by (and rooted in) evidence, rights, and the rule of law.	✓ Are there strategies, laws and policies, or plans to operationalize the commitment? ✓ Are these strategies, laws and policies, or plans explained and justified based on: • Best available evidence? • Human rights? • Rule of law?	*Strong justifications are:* ❑ Informed by the "best available" evidence, which has been identified and appraised systematically and transparently ❑ Informed by the views and experiences of people who are most affected by the health or health-related issue ❑ Aligned with international human rights standards and principles ❑ Aligned with a country's laws that are publicly disseminated, equally enforced, and independently judged ❑ Made available and accessible to citizens	2. Enactment of evidence-based laws (percentage of a small set of laws), as determined by a legal review

IMPLEMENT	Progress is charted by monitoring and reviewing data (including through independent review), enacting remedies, taking necessary action and – critically – being seen to be taking action.	✓ Are there high-quality data and information for monitoring, specifically including: • The selection of a parsimonious set of key indicators? • Quality data and monitoring mechanisms for these indicators? ✓ Is there required and regular review of progress and accountabilities? Is this review: • Institutionalized? • Does it include independent review? ✓ Are enforceable, timely remedies enacted and actions taken based on review recommendation? Do these include: • New or adapted strategies, laws and policies, plans, and budgets; recovery/restitutions? • Improved and/or scaled-up implementation and ways of working?	*Strong implementation involves:* <u>Overall process:</u> ❑ A clear link between monitor, review, remedy, and act, with each component feeding into the next ❑ A process that is formal (not voluntary) with clear roles, responsibilities, timelines, and institutional arrangements <u>Monitor</u> ❑ High-quality data and information that are collected through a monitoring mechanism ❑ Indicators to monitor progress that are relatively few in number and strategically selected, with local stakeholders involved in the selection process ❑ Data and information that are both qualitative and quantitative ❑ Data and information that are disaggregated to detect disparities ❑ Data and information that are presented in a way that is understood by all stakeholders and actionable <u>Review</u> ❑ A formal process for reviewing the monitoring data ❑ A process that includes an independent review mechanism	4. Percentage of key indicators with recent primary/underlying data available (monitor) 5. Inclusion of key indicators in the voluntary national review process (review) 6. A formal complaints procedure with a mechanism for reform (remedy) 7. Means to achieve goals have been implemented (act)

			❑ A review process that includes all relevant stakeholder groups and is equitable ❑ A review process that makes space for stakeholders to bring additional information about an issue and propose solutions for the issue, rather than just talking about the issue ❑ A review process that leads to documented and clearly communicated decisions and recommendations <u>Remedy and Act</u> ❑ An action plan, with clear roles and responsibilities ❑ An action plan that has been put in motion including structural, legal, and policy changes (remedies) that are instituted and enforced ❑ Consequences for duty bearers who do not implement the actions for which they are responsible ❑ Clear communication of actions to all stakeholders, completing the feedback loop	

PROGRESS	Continuously making effective, efficient and equitable progress toward agreed rights and goals, with all available resources—this is the human rights principle of progressive realization.	✓ Is there evidence of sustained progress towards the goal, and justification for exceptional reversals?	*Strong progress involves:* ❑ The maximum of available resources being expended ❑ Expenditures that are efficient, effective, and equitable ❑ Positive, equitable, continuous rates of change toward the health or health-related goals and/or rights ❑ All stakeholders, including those who are most affected by the health or health-related issue, are engaged in making progress	8. Improvement in a key outcome indicator (for which data are of sufficient quality to detect trends), preferably in a disadvantaged population

Appendix 2. Criteria for indicator selection

A parsimonious set of indicators may be useful for monitoring whether an effective accountability structure for a specific programmatic area is in place. Previously adopted indicator selection frameworks, such as the EWEC Indicator Monitoring Framework [80], and the framework underpinning the Universal Health Coverage index (SDG 3.8.1) [81], have laid out criteria for indicator selection. Further, the IAP undertook a consultation on stakeholder experiences, needs and perspectives to improve accountability for health-related goals, including a focus on data needs for accountability [45]. Drawing on this prior work, the following criteria are proposed to guide indicator selection:

1. Relevant – reflects the accountability pillar, as defined in this report.
2. Valid/conceptually sound – the indicator measures what it is supposed to measure, and the optimal level is clear.
3. Feasible – data are available for monitoring. Specifically,
    a. The indicator is monitored at the country level,
    b. A monitoring database is currently being maintained (data compilation is not within the IAP's remit),
    c. Recent (since 2010) primary data (vs. estimates) are available for at least 50 countries (out of 193 UN member states), with preference for indicators with better data availability,
    d. Preference for objective measures such as high-quality primary data collection or independent evaluations (vs. key informant reports).
4. Harmonization – indicators that have been endorsed by countries are preferred, e.g., are included in the EWEC Indicator Monitoring Framework or the SDGs or have otherwise been endorsed by UN governing bodies.
5. Parsimony – the total number of indicators should be minimized, and specifically limited to ten or fewer indicators. Limiting the number of indicators facilitates communication of the index, compilation of the data, and reduces the need for imputations when calculating country values.

Example indicators for accountability in health were selected following the criteria listed above and are listed in Appendix 3. For each accountability pillar, candidate indicators were identified from prior IAP work, which includes a review of the SDGs and the EWEC Indicator Monitoring Framework, from the qualitative literature review above, and from published accountability scorecards. Since feasibility is a key criterion for indicator selection, indicators were reviewed together with their data sources. Data produced by the UN system, such as those for SDG monitoring, were prioritized over data and estimates produced by non-governmental organizations and academia. However, if the UN system does not produce indicators fulfilling the above criteria then other data sources were sought, prioritizing trusted international actors.

A particular focus was parsimony, the importance of which was highlighted in the IAP stakeholder consultation [45]. In most settings and program areas, a parsimonious set of indicators that are valid, feasible, and fully reflect all aspects of the IAP accountability framework will not exist. Therefore, it may be necessary to select indicators that are tracers of the extent to which each accountability pillar is present in countries. Selection of tracer indicators that are valid and feasible is preferred over selecting indicators that are conceptually superior, but unmeasurable. Thus, selected indicators may not provide a comprehensive measure of all relevant aspects of accountability.

Appendix 3. Examples of indicators of accountability for health, and their characteristics

Indicator name	Source / data compiler	Latest year available	Countries with data 2010-latest year	International endorsement	Data type	Rationale/interpretation
Commit						
Expressed UHC commitment, scored according to the SMART criteria	UHC2030	2018-2020	193 (since absence of a commitment is meaningful too; the dataset contains commitments from 141 countries)	Commitments were obtained from statements at UN meetings	primary data	Universal health coverage, with an emphasis on primary health care, is the vehicle by which most health and health-related goals will be achieved. In this dataset, forward-looking and actionable verbal commitments made at the 71st World Health Assembly and the September 2019 United Nations High-Level meeting on Universal Health Coverage were compiled. Presence/absence of a commitment could be used as the indicator, or, with a small amount of additional analyst work, these could be scored according to the SMART criteria.
Justify						
Percentage of evidence-based measures to control tobacco consumption that have been implemented	World Health Organization	2018	195	Data are compiled by WHO	primary data	WHO compiles data on the implementation of six evidence-based and cost-effective tobacco control policies: increase in taxes and prices, implement plain packaging or graphic warnings; ban tobacco advertising, promotion, and sponsorship; eliminate second-hand exposure; implement antitobacco mass media campaigns; and provide tobacco cessation support. These may be scored by level of implementation to derive an overall implementation average. Advances in these measures illustrate that countries have enacted evidence-based laws and implemented evidence-based policies.

Implement						
Monitor						
Percentage of health-related SDG indicators with recent primary/underlying data available	World Health Organization	2020	194	Prepared by the WHO on the basis of data for health and health-related SDGs	primary data	This indicator is defined as the percentage of indicators for which underlying primary data were available for the 5 years preceding the last data compilation date was computed (i.e., availability of model-based estimates was not sufficient). This indicator reflects the breadth of health information sources used to monitor health and its determinants, including death registration data, household survey and census data, including physical measurements, health facility data including reporting of notifiable diseases, qualitative evaluation of laws and regulations, and specialized data collection systems, such as air quality monitoring networks.
Review						
Inclusion of UHC in the voluntary national review (VNR) process (yes/no)	UNDESA, UHC2030	2016-2020	162 (remaining countries did not participate in any VNR)	VNR reports are reviewed at the high-level political forum on sustainable development	primary data	As part of the follow-up and review mechanism of the 2030 Agenda, member states are encouraged to conduct regular and inclusive reviews of progress at the national and sub-national levels, which are country-led and country-driven. The United Nations Department of Economic and Social Affairs maintains an online database of reports prepared by countries participating in voluntary national reviews (VNRs). These reports are the basis of independent review by the high-level political forum on sustainable development. The VNR reports have been reviewed to determine whether universal health coverage was included in the VNR.
Remedy						
Acceptance of 9 individual complaints procedures	United Nations Office of the High Commissioner for Human Rights	2020	197	Included in the UN OHCHR's indicator framework	primary data	This indicator is a count of the number of human rights treaties for which the State accepts that treaty bodies may receive complaints from individuals, out of the 9 core international human rights treaties. It captures the State's commitment to the protection of human rights, including health-related human rights by providing individuals recourse in the case that those rights are violated.

Availability of national policy/ guideline/law on notification and review of maternal, stillbirth and neonatal deaths	World Health Organization	2019	150	Data are compiled by the WHO	key informant data	This indicator describes the availability of a national policy/ guideline/law on notification and review of maternal, stillbirth and neonatal deaths. This indicator was captured in the 2018-2019 comprehensive policy survey on sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH), conducted to assess the adoption of WHO recommendations in national health policies and guidelines. Availability of such policies/laws to review and process grievances, when implemented effectively, can result in systems level remedies to the quality of service delivery.
Act						
Universal health coverage index - service coverage	World Health Organization	2017	183	SDG 3.8.1, EWEC key indicator	composite model-based estimate	Specific priorities and actions taken should be a result of the monitor and review steps of the cycle. However, at a minimum, actions would include ensuring coverage of essential health interventions. SDG 3.8.1, an index of health service coverage, is a composite index of 14 indicators of essential health services that should be available in every country, regardless of economic status.
Universal health coverage index - financial protection	World Health Organization/ The World Bank	2010-2018	110	SDG 3.8.2, EWEC key indicator	primary data	Increasing coverage of health services sometimes also brings increasing financial hardship due to health expenditures. For this reason, service coverage should be considered in conjunction with financial protection. Unlike most other health financing indicators, SDG 3.8.2 has a clear optimum -- no financial hardship as a result of accessing health services.

Progress						
Improvement in under-five mortality (computed as the average annual rate of reduction 2010-2019)	United Nations Inter-agency Group for Child Mortality Estimation	2019	195	SDG 3.2.1, key EWEC indicator	estimate derived from a model	Reducing under-five mortality is possible for countries at all levels of health status, from high mortality countries, where young children are dying from preventable infections, to countries that have already met SDG target 3.2, yet still experience disparities in neonatal and child mortality. Unlike other health status indicators such as health-adjusted life expectancy or maternal mortality, high-quality data, including reliable time trend data, are available for countries across the development spectrum. This indicator is aligned with the human rights principle of progressive realization, without additional complex benchmarking: at lower mortality levels, higher investment is needed to further reduce mortality. This implies that countries with more available resources will need to invest more to achieve a given rate of reduction. Finally, pending data availability, it is possible to incorporate equity into this indicator, by assessing only rates of reduction in rural populations (disadvantaged populations).