

The Health of Women, Children
and Adolescents is at the Heart of
Transforming our World:

Empowering Accountability



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IAP 2021 Report

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Executive summary

Lessons from five years of the IAP and a decade of EWEC accountability

By far the most important lesson we take from five years of our work as the UN Secretary-General's Independent Accountability Panel (IAP) and across a decade of Every Woman Every Child (EWEC) accountability is that **accountability is about people**. Not merely as the 'end receivers', but as the first consideration and as essential contributors and partners. Our most lasting achievement will probably be our **accountability framework** (Section 1) that we evolved by continually gathering and evaluating evidence, and by stress testing ideas and assumptions about the best way to do accountability. Our framework now stands as a coherent, evidence-based tool that any country or organization can use to inform its accountability practice. Section 2 of our report highlights how countries have instituted and implemented accountability in a people-centred way have accelerated progress and effectively achieved goals.

COVID-19 has been the greatest stress test. The pandemic provides incontrovertible evidence for the importance of accountability – and particularly of independent review – in achieving health and development goals. The history of the pandemic to date has been littered with a lack of preparedness and poor decision-making which could have been largely avoided through more genuine accountability. Further, COVID-19 has reversed many of the gains achieved in women's, children's and adolescents' health. As we attempt to emerge stronger from the pandemic, **we need accountability more than ever** to get back on track and achieve the Sustainable Development Goals (SDGs). But this cannot be merely a top-down exercise. Independent review and full and inclusive **participation**, particularly by those left furthest behind, is essential to give accountability legitimacy, momentum and impact.

IAP recommendation

Based on our experience, the lessons we have learned and the findings of the 2019 external IAP evaluation, we make one overarching recommendation for health and SDG accountability: **Institutionalize an Independent Review Mechanism (IRM) for health across the SDGs as a major input to the High-level Political Forum on Sustainable Development (HLPF) and the United Nations Economic and Social Council (ECOSOC)**.

The IRM will develop a standardized process to independently review progress on health across the SDGs. It would build on existing Member State HLPF

mechanisms: Country Voluntary National Reviews (VNR), Regional Sustainable Development Fora (RSDF), and Global HLPF and ECOSOC reviews. **At the global level the IRM would be the IAP successor.** The IRM would add value with independent review, inclusive participation and forward-looking guidance based on lessons learned, best practices, recommended remedies, strategic priorities, and results of multisectoral action. It will require strengthening and institutionalizing independent review at all levels with the participation of existing HLPF Major Groups and Other Stakeholders (MGOS) and review stakeholders. These groups include women, children and youth, civil society, academia, parliamentarians, special rapporteurs, media and others. It would be implemented with the support of key partners, including UN Country Teams, the Global Action Plan for Healthy Lives and Well-being for All (SDG 3 GAP), PMNCH (on women's, children's and adolescents' health), UHC2030 (on Universal Health Coverage and Primary Health Care), multisectoral partnerships and existing country support mechanisms to follow-up on the implementation of recommended remedies and actions to achieve the SDGs.

What the IRM would do

- **Action 1.** Inform ECOSOC annual reporting themes and follow-up on countries' implementation of the HLPF ministerial declarations.
- **Action 2.** Develop strategic guidance to support country Voluntary National Reviews to the HLPF.
- **Action 3.** Promote country-level independent review as the heartbeat of all IRM action, engaging Major Groups and other Stakeholders (MGOS) and review stakeholders, and flowing into HLPF regional fora and global reporting.
- **Action 4.** Synthesize regional patterns, best practices and priority issues with independent review reports forming a major section of HLPF Regional Sustainable Development Fora.
- **Action 5.** Submit a global IRM report as a primary focus of the ECOSOC Coordination Segment and HLPF thematic reviews with an overview of country, regional and global inputs.
- **Action 6.** Follow country implementation and impact with support from UN Country Teams and partners.

Given what is at stake, and now even more so in light of COVID-19, we cannot afford to shirk this responsibility. We must objectively and uncompromisingly maintain an accountability spotlight on our collective progress and the road ahead, ensuring that no woman, child or adolescent is left behind.



**NIÑAS
NO
MADRES**

HOY NO ESTÁN
TODAS
NUESTRAS VOCES
JUNTAS
PORQUE DESDE LA
TOMBA NO SE PUEDE
GRITAR

RESPECTA MI
EXISTENCIA
O ESPERA MI
RESISTENCIA

¡VIVA
APRIL!

NO
SOLAS
SINO
JUNTAS

BOL

WU

Section 1

Lessons on accountability for health and SDGs

Establishing the right foundation for accountability

People at the centre

By far the most important lesson we take from five years of our work as the IAP¹ and across a decade of EWEC² accountability is that **accountability is about people**. Not merely as the 'end receivers', when all the systems and activity of accountability have been taken care of, but as the first consideration in every case and as essential contributors and partners. The international community has committed to leaving no one behind in the health-related SDGs.³ Accountability has to begin by asking "how can women, children and adolescents, and *all* who are left behind, become partners in its process"?

People can have a genuine voice through accountability when they are supported by institutional and legal frameworks (see Democratization). And accountability is a tool for putting the voices and concerns of people at the centre. But we know these things are not happening in many parts of the world. All too often, policy and programme decisions are made without people's voices and concerns being central to shaping them. In particular, we consider that women, children and adolescents lie at the heart of social well-being – a barometer of commitment to the vulnerable and excluded. As we move collectively towards universal health coverage (UHC), it is therefore vital to keep focused on people, and especially women, adolescents and children, to ensure that every step forward increases their voice, their participation and their influence.

Political responsibility, multisectoral action and independent review

Political leaders and governments **are in the hot seat** when it comes to being responsive to people's needs. This is a critical part of the social contract, and accountability processes should remind governments (and people) of this continually. Governments are responsible for improving people's health and rights and ensuring sustainable development. But a vital lesson is that **accountability for health is better framed as a shared responsibility across all parts of society and government**. The evidence shows that

social determinants, such as poverty, education, nutrition and environmental health – and inequities across all these areas – have a significant impact on people's health and wellbeing.⁴ **Multisectoral factors** such as these contribute to around 50% of reduction in maternal and child mortality.⁵⁻⁷ Multisectorality is integrated in the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030)⁸ (EWEC Global Strategy) and defines the SDGs⁹ overall. **Engagement** from a wide range of partners is also critical – across public and private sectors, and civil society.

Independent review complements political oversight and social commitment by providing a continual, objective assessment and overview of **progress towards defined goals**. When independent reviewers find something off-track, they should doggedly call for remedy and corrective action – as in the case of polio eradication in Nigeria summarized in Section 2.¹⁰ To be most effective, independent review processes need actively to incorporate the participation of a wide range of stakeholders from across society especially those most often left behind. Box 1 lists the groups and stakeholders in the categories discussed above (major groups and other stakeholders – MGOS).¹¹

Box 1. Major groups, other stakeholders and review stakeholders

Major groups

Women, children and youth; indigenous people; non-governmental organizations; local authorities; workers and trade unions; business and industry; scientific and technological community; farmers.

Other stakeholders

Local communities and volunteer groups; migrants and families; older persons; persons with disabilities; private philanthropic organizations and foundations; educational and academic groups; other stakeholders active in areas related to sustainable development.

Review stakeholders – IAP addition

Parliaments; civil society organizations; special rapporteurs or independent commissioners; media; leading academic experts; auditors; legal tribunals or fora; representatives for the interests of newborns; other stakeholders with a sociopolitical review function, independent from those directly responsible for oversight, implementation, or advocacy of the policies and programmes reviewed.

A strong framework supports accountability

We have learned over 10 years of experience that **accountability is connecting commitment to progress in a justifiable and constructive way**.¹² Reflecting on this learning, we have developed a holistic accountability framework which includes four pillars (Commit, Justify, Implement, Progress) where *Implement* incorporates the accountability cycle (Monitor, Review, Remedy, Act). When fully in place, this cycle works in a coherent way to strengthen accountability.

Commit: Transparent commitments enable accountability to be focused on concrete results

Having made commitments to the SDGs, political leaders and governments need to make strong, clear commitments to achieving progress on health-related SDGs, rights and accountability – and they need to mean it. **Commitments should be made publicly** to gain a clear mandate for accountability. High-performing governments confirm these commitments regularly and communicate them to people. Their pledges to achieve goals lead to concrete policies, plans and strategies and are underwritten by the required budgets, resources and roles to prompt action. They also track existing country commitments to the SDGs, health and human rights. It is important to **maintain continuity of commitment**. Governments change, which often makes it difficult to sustain long-term progress. This is where global leadership from a movement such as EWEC² has been invaluable as a rallying point for continued government commitments to the EWEC Global Strategy⁸ by a range of stakeholders. EWEC mobilized 776 commitments from state and non-state actors, including financial commitments worth a cumulative total of nearly US\$ 186 billion.¹³

Justify: The basis for policy commitments, strategies for action and planned implementation are evidence, rights and laws

We learned that it is critical to ensure that policies, plans, strategies and actions are fully justified by **evidence, rights and rule of law**. In this way they are much more likely to achieve sustainable progress, backed by strong explanations on which accountability processes can be based. Countries draw evidence from sources such as monitoring data (see below), the results of independent review, case law and other reliable sources, such as the EWEC Global Strategy.⁸

Global and regional bodies and countries have used the latter to justify policy and legislation on women's, children's and adolescents' health. For example, the Inter-Parliamentary Union (IPU) adopted a resolution on achieving women's, children's and adolescents' health^{14,15} based on the EWEC Global Strategy objectives and aims to hold governments to account for achieving them. The ultimate justification should be to people, and women, children and adolescents themselves.

Implement: Enabling a virtuous cycle of improvement through constant assessment and adjustment

Accountability has to be an *active* process to be effective. Our accountability cycle – monitor, review, remedy, and act – will lock governments, development partners and all stakeholders into an active and self-sustaining implementation process with people at the centre and the voices of those most affected constantly heard.

- **Monitor** – the government in each country and all other stakeholders design and agree on the indicator and monitoring framework for health across the SDGs, e.g. as agreed in the World Health Organization's (WHO) General Programme of Work (GPW 13) results framework¹⁶ and for the EWEC Global Strategy indicator and monitoring framework.¹⁷ Regular monitoring collects *quality* data and evidence needed to track progress (see Data for Decisions below).
- **Review** – the government and accountability institutions set up a clear schedule of review. They scrutinize all relevant data and evidence, including people's experiences, to assess progress towards goals and to ensure accountability is working. Independent review serves as a checkpoint in review processes to course correct as needed.
- **Remedy** – for accountability to have 'teeth', commitments have to be subject to regulation and enforcement. Voluntary codes of conduct and unenforceable political promises are not always adequate for meaningful accountability.¹⁸ Legal regulation and enforceability require fit-for-purpose, adequately resourced institutions, including parliaments, courts and administrative agencies. Under international law, countries also assume some obligations for transboundary impacts of their own actions and those of transnational corporations over which they have effective control, including, for example, pharmaceutical companies.¹⁸
- **Act** – governments and other stakeholders take action to ensure review recommendations are acted upon and remedies are enforced in an effective, efficient and equitable manner to move forward.



Progress: Clear and comprehensive visibility around progress towards results and impact

Accountability is meaningless unless it leads to sustained progress on agreed goals and rights. This means leaving no one behind in the health-related SDGs. The role of accountability processes is to shout loudly and demand remedy and action when progress stalls or goes into reverse. In our 2020 report, we raised the alarm that progress on 2030 goals for women's, children's and adolescents' health was lagging by 20% even before the pandemic, and COVID-19 was making the situation worse.¹² Effective accountability helps countries achieve progressive realization of their goals, celebrate success, and promote best practice.^{19,20} This is illustrated by a 2018 study of routine childhood vaccination coverage in India. Although coverage was increasing, family health surveys and expert analysis showed that progress was too slow and uneven.²¹⁻²³ India's Ministry of Health and Family Welfare launched Mission Indradhanush in 2014, and the subsequently Intensified Mission Indradhanush (IMI) in October 2017 working across sectors to reach the most underserved, vulnerable, resistant and inaccessible populations. As a result of these cross-sectoral initiatives, the proportion of children with full immunization coverage in IMI districts increased from an estimated 50.5% to 69%.²⁴

Although our accountability cycle does not spell it out explicitly, there is a further implied step and that is **continual adaptation, renewal and evolution** as the cycle moves forward. Based on progress, commitments need to be renewed, adjusted or adapted and the cycle begins again.

An enabling environment is needed for effective accountability

Democratization

Accountability is about people – this is crucial to its foundation as we have seen – so it has to ensure that *all* people can have a meaningful say and the opportunity to influence decisions that affect their health and well-being.²⁵ We call this the *democratization* of accountability. It is a crucial factor in converting passive beneficiaries of health services into powerful agents who demand and drive change. It can also be a powerful source of innovation – as in the case of two brothers in Ghana who created a solar-powered basin to encourage regular hand washing.²⁶ However, on the whole, we have often been struck by the lack of input from 'ordinary' citizens and note that women, young people and children tend to have less access to institutionalized spaces, even though these are so critical to their lives and health. Why would this be? Who knows better what works, or how, where and when services meet people's needs? Everyone has a role to play, particularly those whose voices are rarely heard, such as children and adolescents. Governments can foster greater participation through national and international legal and institutional frameworks. From evidence and experience, we have learned that **"voice does not equate to accountability if there is no one to listen, act, and respond"**.^{27,28}

Institutionalization

Democratization of accountability is most effective when institutionalized in planning, implementation and review, including through public hearings and other fora. In this sense, it matters a great deal who ‘owns’ accountability. People and organizations are much more likely to ‘drop the ball’ or to quietly forget their obligations when roles and responsibilities are loosely defined. To counter this tendency, governments and other stakeholders should institutionalize accountability by formally **embedding it in all aspects of their work**. Accountability mechanisms need to be fit for purpose, while linking coherently to each other and pulling in the same direction. In this way, they commit not only to carry out their specific obligations to the best of their abilities (e.g. monitoring or review) but also to cooperate fully to ensure accountability recommendations are implemented and remedies enforced. The government of Bangladesh achieved this when it rolled out a national maternal and perinatal death review system in 2016, with the institutionalized support of development partners, professional associations and NGOs. Health managers took remedial action to implement strategies based on real-time data from the health information management system. A study found that this institutionalized approach has been critical to successfully reducing maternal and newborn deaths.²⁹ Institutionalization enables commitments to be budgeted, planned for and managed. People can form expectations and shape demands of institutions and office holders within institutions with expectations that these will be fulfilled.

Data for decisions

High-quality data are the life blood of accountability and of decision-making. They bring the decision-making process to life by showing countries how things stand and where they need to invest. They strengthen equity by shining a light on those left furthest behind and give governments strong evidence with which to justify policies, plans and actions to help them. Data that recognize different groups (for example through disaggregation) are a critical first step to addressing exclusion. However, many countries have weak data systems – even in basic areas such as birth registration – and lack capacity to disaggregate data against important criteria such as sex, income and ethnicity to identify who is being left behind. Estimates and models are no substitute for high-quality data. Where they *are* used, they should be transparent, with open access, so all can interrogate, understand and act on the information in a justifiable and constructive way. But, currently, the births of 1 in 4 children worldwide are not registered, neither are 4 of 10 deaths, and data are insufficiently disaggregated across the SDGs to identify who is left behind and why.^{30,31} The scope of monitoring ought to be widened considerably to capture data about previously neglected groups such as children and adolescents with disabilities or migrants.

We made **strengthening country data systems** a core recommendation of our 2020 report,¹² and it features strongly in preceding EWEC accountability reports.² Investment in strong country civil registration and vital statistics (CRVS) and health information systems is crucial. It is also a matter of global and national security as COVID-19 has demonstrated. Governments and development partners must cooperate better to develop robust, harmonized country data systems. Private sector and civil society organizations drive innovation and create demand for information and evidence that reflects people’s lived experience and needs. Media and public-interest organizations augment routine data collection and encourage public debate based on the findings. Investments are also needed to make data accessible and understandable to all people, so they have information to participate meaningfully in decision making and accountability for health and sustainable development.

Blueprint for the accountability nutcracker: a checklist of best practice

Accountability can help countries crack some pretty tough nuts if it is based on the accountability framework and applied using the lessons we outline above. Case studies from Thailand³² and Nigeria¹⁰ demonstrate the effectiveness of accountability in practice (Section 2).

COVID-19 is one of the toughest nuts to date. However, we believe countries can use our accountability framework to build more resilient systems in the COVID-19 recovery period. Our blueprint for high-performing accountability includes nine ‘checklist’ elements, based on the three lessons we have set out above on the foundation of accountability, the application of the accountability framework, and its enabling environment (Table 1 below, and web annex 6).³³ Together, this checklist creates a useful tool to support the design, implementation and assessment of accountability processes.

The accountability blueprint can also help fireproof the EWEC² and IAP¹ transition arrangements. For example, in the first decade of EWEC, the accountability enabling environment suffered from being largely voluntary and lacking institutional arrangements. This meant that monitoring reports and review recommendations had limited systematic follow through with country remedy, action and impact. Future arrangements should seek, therefore, to ensure continuity and coordination throughout the accountability cycle and to ensure the right enabling environment – given that the primary objective of the EWEC transition is better to support country implementation and accountability efforts towards the achievement of the SDGs.⁹

The blueprint can also be applied to the COVAX initiative,³⁴ which will only achieve its ambitious goals if it is supported by comprehensive, serious and sustained accountability processes. Global partners launched COVAX exceptionally quickly, and the overall response to COVID-19 has illustrated extraordinary global cooperation. However, the uneven rollout of vaccines *so far* (recognizing it is early days) highlights how equity in programme delivery cannot be guaranteed in the absence of effective accountability.³⁵ In this situation, independent review especially can help guide, advise and support the achievement of COVAX goals in a number of ways.

Firstly, independent review could help the global community develop and implement a credible vaccine distribution plan. This would balance competing factors such as managing the impact of COVID-19 variants and targeting supplies to where they will benefit those most affected. Secondly, independent review could be an objective broker helping to resolve problems and challenges. The clearest example, at this stage of COVAX rollout, is the pressing need to scale up vaccine production, build more country capacity and negotiate intellectual property considerations.

Section 1 conclusion

Holistic accountability is based on nine essential elements and lessons learned. They can be grouped as foundational elements, the accountability framework itself, and the enabling environment that allows accountability to fulfill its potential role. As in a natural ecosystem, all the elements are interlinked and hold each other in balance when they are fully implemented and working together. People lie at the heart of accountability and the voices and participation of women, children and adolescents is vital. Everyone survives, thrives and transforms beneficially when this is the case. In Section 3 of this report, the accountability checklist (the blueprint) will be used to appraise options to transition the IAP to a stronger overall accountability mechanism for health in the SDGs. First though, in Section 2, we illustrate where and how accountability has contributed to concrete successes in a number of different countries in order to show the way that end-to-end accountability systems drive progress.

Table 1. Accountability blueprint: a checklist of best practice

The Foundation of Accountability

1. People-centred	All people have access to opportunities and services for their health and well-being and get redress when things go wrong. Women, children and adolescents are NOT left behind.
2. Oversight	Political responsibility for progress and shared accountabilities is supported by independent review.

The Accountability Framework

3. Commit	Highest level political commitment and engagement; pledges to achieve goals are made publicly and backed by budgeted resources and designated roles.
4. Justify	Plans and strategies to achieve goals are justified on the basis of evidence, rights and rule of law.
5. Implement	A continual and complete cycle of monitor, review, remedy and act drives course correction and progress, renewal and adjustment.
6. Progress	Improvements are sustained towards realizing goals and rights and exceptional reversals are justified, including renewal of commitments in a continuing cycle and evolution that is fit for purpose.

The Enabling Environment

7. Institutionalization	Fit-for-purpose mechanisms are established with interlinkages across the accountability system.
8. Democratization	Inclusive participation exerts influence through institutional and legal frameworks.
9. Data for decisions	High-quality data are understandable, accessible and actionable to inform decisions at all levels.



Section 2

Cracking the nut: where and how accountability has had impact in countries

Accountability improves country implementation and impact

The lessons that underpin accountability (laid out in Section 1) led us to reflect on the missing links between our proposed universal framework, the commitments that countries make, and individual and community impact. In particular, we explored how the IAP framework could help deliver fuller, more rigorous accountability for people and communities. When all these accountability elements are present and operational, they help countries engage fully in accountability in ways that can drive progress for women, children and adolescents, and reinforce an upward cycle of accountability strengthening. When they are absent or failing, they become inhibiting factors and their absence stifles accountability and holds back progress on health, in particular for those most in need.

Our 2020 report highlights a fundamental point about impact.¹² Countries that achieve the best results for women's, children's and adolescents' health and rights are not necessarily those that spend the most money (relative to other countries in the same income bracket). We found that better performing countries are often those that **make the most accountable use of their resources**. They also tend to be well on the way to delivering UHC and have a strong grip on multisectoral issues that directly support health – such as voice and participation, education, clean water and adequate sanitation.¹²

There is a clear link between these factors for success¹² and our accountability framework. For example: political leadership and governance (Commit); laws and policies based on evidence, rights and rule of law (Justify); health expenditure, UHC and innovation monitored and put in practice (Implement); and measurable results that are transparently reported (Progress).

Country examples of accountability in action

So, what does the accountability framework actually look like in practice and what impact does it have when the framework is in place and operating as it should, built on a sound foundation and positioned with the right enabling environment at country (and global) level? We selected two country case studies to illustrate accountability in action (they are summarized here with the full case studies in annexes (2 and 3)).^{10,32} These country case studies illustrate the positive impact accountability can have when it is people-centered, led by strong political commitment and implemented with institutionalized mechanisms.

The first focuses on people-centred approaches for UHC in Thailand demonstrating the impact of in-country accountability.³² The second is a case study on polio eradication in Nigeria demonstrating the effectiveness of an enabling environment with both national and international accountability.¹⁰

The selection of these case studies does not imply IAP¹ endorsement of the overall sociopolitical contexts in which they are situated. Rather, we selected them because of specific programmatic results and accountability for women, children and adolescents and communities, even in challenging contexts. They were also among the few examples that had supporting evidence and documentation of end-to-end accountability processes. We encourage more analyses using an accountability lens to determine whether, and how, political commitments are connected in justifiable and constructive ways to progress on health-related SDGs⁹ and rights.

People-centred foundations: Universal health coverage in Thailand³²

UHC has been implemented in Thailand since 2002 and involves a system in which the population is covered under one of three public health insurance schemes: a tax-funded Civil Servant Medical Benefits Scheme (CSMBS) which covers government employees, pensioners, and dependents; a social health insurance scheme for private sector employees, funded by contributions from employers, employees, and the government; and the tax-funded Universal Coverage Scheme (UCS) for the remainder of the population. For the non-Thai population, a voluntary migrant health insurance scheme is available, and in 2010 a new temporary scheme was introduced for stateless people which consists of a comprehensive benefit package similar to the UCS. Although there are certainly a number of broader sociopolitical issues related to the Thai experience of expanding access to basic services, Thailand's progress with introducing and scaling up UHC demonstrates how critical features of accountability can help countries drive progress for all people, leaving no one behind.

From the beginning of the development of the UCS scheme, citizens actively participated in policy formulation by on the basis of a constitutional right in which citizens can propose legislation. Implementation of the UCS is overseen by a diverse board, with five members of the 30-member board selected from civil society constituencies, and through annual public hearings. *Data* have been central to decision-making throughout the development of UHC in Thailand, building on a strong, existing infrastructure and information system (including the CRVS system that was established in 1956) and adopting the health technology assessment approach that has become *institutionalized and integrated* into the policy-making process for the UCS benefit package.

After years of planning, implementation, and adaptations, UHC in Thailand is leading to measurable, positive outcomes for the population. Household out-of-pocket payments decreased from 34% to 11% of total health expenditure between 2000 and 2018. Access to health services for the country's population has increased, and there are low levels of unmet needs for both outpatients and inpatients. Annual check-ups have increased, in particular among women, and better access to health services has reduced gaps in infant mortality between provinces (see web annex 2 for the full Thailand case study). Overall, Thailand's experience demonstrates the power of participation by a broad range of stakeholders in building an efficient, responsive, evidence-based scheme that people can trust, use, and have ownership over and that leaves no one behind in pathways to UHC.

The enabling environment: Institutionalizing accountability to drive polio eradication in Nigeria as part of a global effort¹⁰

In 2020, WHO awarded 'polio-free' certification to Nigeria. While many partners played a role in the successful elimination of polio, key aspects of the partnership formed in 2010 between the government of Nigeria, the Global Polio Eradication Initiative (GPEI) – a partnership between national governments, WHO, Rotary International, the United States CDC, and UNICEF, and later joined by the Bill & Melinda Gates Foundation (BMGF) and Gavi, the Vaccine Alliance – and the GPEI's Independent Monitoring Board (IMB). These elements map directly to the IAP's accountability framework and pillars and demonstrate the value of institutionalized accountability linking global to national and subnational efforts. The GPEI was founded in 1988 following a resolution at the 41st World Health Assembly by all 125 WHO member states to commit to the permanent worldwide eradication of endemic poliomyelitis. With support from long-term partnerships, the GPEI enabled countries to reduce global polio cases by 99% from over 350,000 to about 1000 in 1999. After 2006, Nigeria was the only country in Africa with endemic polio. It took years for sufficient internal commitment to be mobilized to address the challenges seriously. When it finally did, however, progress rapidly accelerated. This experience illustrates very well the importance and influence of political commitment that then translates into institutionalized accountability at all levels.

First, the government formally *committed* to eliminating polio and established a Presidential Task Force. It *institutionalized* its response through the establishment of a central polio Emergency Operations Centre, which was eventually replicated at state level. It *justified* its approach with data that showed both the seriousness of the problem, particularly in northern states, and serious gaps in immunization coverage. It proposed evidence-based strategies to address these gaps and strengthened its *monitoring* programme, in response to the findings of *independent review* by the IMB, which demonstrated the urgent need for more data.

The IMB played a critical role in *remedy*. It continually urged and supported the government to maintain its focus on the eradication programme in the face of multiple distractions and difficulties, such as the 2014 Ebola outbreak. A joint review by the IMB and the programme highlighted resistance by civil society, poor community linkages and an over-reliance on the military as barriers to progress. The government responded by *democratizing* the programme, setting up social accountability mechanisms to increase citizens' voice and participation. It also addressed *equity* issues centred on underdevelopment and poor health outcomes in key states.

What lessons can the Nigeria polio example teach us about accountability? First, achieving progress on polio eradication was an iterative process requiring trust, collaboration and confidence on all sides. GPEI funded the IMB to carry out quarterly visits and the Government of Nigeria cooperated in these. This ensured the IMB continually increased its knowledge of conditions on the ground as it revisited the key issues and stakeholders repeatedly. Second, by tracking progress in real time, the government and the IMB were able to course correct rapidly and flexibly, and innovate to address programme bottlenecks and accountability issues, as these evolved over time or as new challenges arose. Third, IMB review missions encouraged an inclusive approach, widening the contribution and participation of all relevant stakeholder groups – from the President and National Assembly to local government officials and citizens on the ground in the affected states. Fourth, GPEI and its partners ensured that both the IMB and subsequent work on coordination, alignment and oversight with the Government of Nigeria was sufficiently resourced. Finally, the IMB insisted on full transparency and openness. Together, the Government of Nigeria, IMB, and GPEI created the space for frank, open, and substantive discussions, including at the global level, by instituting ‘Chatham House rules’ (i.e. what is said in this room, stays in this room). It used hard-hitting, sometimes harsh, language in its quarterly reports, while never deviating from its commitment to support the country to succeed in its objective.



Section 2 conclusion

This section has drawn on two examples to explore the accountability blueprint in action across different countries. The next section will build on this evidence to explore ideal arrangements for accountability and how independent review, a critical part of that wider system, can help take global and country health efforts forward to achieve the SDGs, while always ensuring that women, children and adolescents remain firmly at the centre of all efforts.



Section 3

Independent review adds rigour to the accountability system

IAP recommendation

The IAP¹ considers that the absence of independent review in any future accountability system will be a clear and potentially damaging gap in our collective efforts to accelerate progress for women, children and adolescents and others left behind. Independent review has a critical role to play in a robust accountability system. Given what is at stake, and now even more so in light of COVID-19, we cannot afford to shirk this responsibility. In preparing this report, the IAP assessed a range of options for the future development of accountability generally, and independent review in particular. We took into account the recommendations of the 2019 external IAP evaluation,³⁶ the IAP's own broad consultations,³⁷ and lessons learned (summarized in Section 1).

The panel makes one overarching recommendation:

Institutionalize an Independent Review Mechanism (IRM) for health across the SDGs as a major input to the HLPF³⁸ and ECOSOC.³⁹

The IRM would enhance and reinforce existing country, regional, and global HLPF processes and inputs on health-related SDGs. It would institutionalize the systematic, active participation of HLPF Major Groups and Other Stakeholders (MGOS),¹¹ including women, children and youth and civil society, with contributions from review stakeholders, e.g. parliamentarians, special rapporteurs, academia, media and others. At the global level, independent review would be through the successor to the IAP.

The IRM would follow-up on country implementation with the support of UN Country Teams, SDG 3 GAP⁴⁰ and key partners.

As an institutionalized part of the HLPF,³⁸ the IRM would add value with independent review, inclusive participation and forward-looking guidance based on lessons learned, best practices, recommended remedies, strategic priorities and results of multisectoral action. Through support to social accountability the IRM would encourage people to carve out the power or space to influence decision-making, and ensure their interests are well represented in all related decisions. The IRM would explore a range of options for stimulating participation and accountability especially among young people (for example, through social media, innovative participation mechanisms and other methods⁴¹).

Such an interface would be a win-win. With COVID-19 a priority across the SDGs in building back better, health agencies (WHO/H6⁴²) would assume a leadership role in providing this HLPF thematic review across the SDGs⁹ to accelerate progress and benefit those left behind. Importantly, it would shine a light on how investments across the SDGs in women's, children's and adolescents' health are central to achieving a transformed world, and ultimately how this requires being accountable to them and all those left behind.

The IRM would be co-hosted by WHO/H6⁴² and convened by ECOSOC³⁹ with secretariat support from UN DESA.⁴³ This interface would help position health systematically across the SDGs (health in all policies) at the highest political level and across sectors. It would also focus on the specific SDGs,³ themes and countries that are selected for annual review. For MGOS¹¹ and review stakeholders, the IRM would provide a systematic, institutional framework for their active participation to review progress, influence decisions and catalyse change towards achieving a transformed world in 2030.

What will the IRM do?

The IRM will develop a standardized process to review progress on health across the SDGs. Independent review process would start in February in the year preceding the HLPF³⁸ reporting under consideration. This is when the ECOSOC³⁹ agrees the reporting themes and countries for the following year's HLPF. The IRM would consider inputs throughout the HLPF cycle, including a representative sample of country Voluntary National Reviews (VNRs)⁴⁴ submitted between May and June. The IRM would compile a comparative analysis across countries using existing accountability frameworks to document successful strategies, assess progress and identify gaps for action.

This process will require the support of the UN Resident Coordinator system⁴⁵ (including EVEC Focal Point in the UN Development Coordination Office) working with relevant government counterparts at country level to organize country-led reviews and follow-up on implementation and progress of the SDGs.

The lead institutions and partners for this activity in support of the IRM would be UNDESA⁴³ (as secretariat to HLPF and ECOSOC) with support from WHO/H6⁴² and all UN agencies, Major Groups and Other Stakeholders (MGOS).¹¹ This process would also be supported by PMNCH⁴⁶ partners in country (on women's, children's and adolescents' health) and UHC2030⁴⁷ partners in country (on health overall), as well as key multisectoral partnerships and existing country support mechanisms, such as the SDG 3 GAP,⁴⁰ to follow-up on the implementation of recommended remedies and actions to achieve the Goals.

The basis of action for the IRM in support of the HLPF is to capture and disseminate lessons and trends through the ECOSOC coordination segment and HLPF thematic reviews based on VNRs presented by countries, inputs from global and regional levels, and additional independent analyses as required on SDG implementation and progress. This reporting will include relevant thematic overviews in addition to lessons from the reviews of specific SDGs decided by ECOSOC for each year. Additionally, through this process, the IRM will provide strategic input to the report of the President of ECOSOC who prepares a summary of the discussions which also informs an inter-governmentally negotiated political declaration at the end of the meeting.

The IAP recommends six main actions for the IRM on health across the SDGs.

- **Action 1.** Inform ECOSOC³⁹ annual reporting themes and follow-up on countries' implementation of the HLPF ministerial declarations.
- **Action 2.** Develop strategic guidance to support country VNRs⁴⁴ to the HLPF.³⁸
- **Action 3.** Promote country-level independent review as the heartbeat of all IRM action, systematically engaging MGOS¹¹ and review stakeholders, and flowing into HLPF regional fora and global reporting.
- **Action 4.** Synthesize regional patterns, best practices and priority issues with regional independent review reports forming a major section of HLPF Regional Sustainable Development Fora (RSDF).⁴⁸
- **Action 5.** Submit a global IRM report as a primary focus of the ECOSOC Coordination Segment and HLPF thematic reviews with an overview of existing country, regional and global inputs and independent reviews at all levels.
- **Action 6.** Follow country implementation and impact with support from UN Country Teams and partners.

The IRM would follow the annual HLPF³⁸ cycle, primarily reporting to/through the ECOSOC Coordination Segment and HLPF thematic reviews. While we have laid out the broad direction, we recognize that there is an ongoing review of ECOSOC and HLPF processes.⁴⁹

To take forward the recommendations, these bodies and the supporting UN agencies would need to figure out the logistics and detailed arrangements. Each of the six recommended actions is detailed below.

Guidance to support country reporting and implementation

Action 1. Inform ECOSOC³⁹ annual reporting themes and follow-up of the HLPF³⁸ ministerial declarations. The lead institutions/partners for this process will be ECOSOC/UNDESA⁴³ (as support secretariat) with inputs from all partners. Timeline: February annually.

Action 2. Develop strategic guidance to support country VNRs⁴⁴ to the HLPF. The IRM will provide an input to the UN Secretary-General's guidelines for preparing VNRs⁵⁰ that is updated every year. It will produce a series of action-training toolkit modules on independent review for counterparts and organize/facilitate virtual sessions and webinars in support of country VNR preparation. The lead institutions and partners for this action will be the UN Resident Coordinator System, UNDESA with inputs from UN agencies (WHO, H6⁴² and others), academia, MGOS¹¹ etc. Timeline: October/ November (Prep. I) and March (Prep. II).

Country-level Processes

Action 3. Promote country-level independent review as the heartbeat of all IRM action, systematically engaging MGOS¹¹ and review stakeholders, and flowing into HLPF regional fora⁴⁸ and global reporting. IRM action at the country-level consists of organizing country independent reviews and reporting as a major section of country VNRs⁴⁴ comprising progress across all 17 SDGs⁹ and annual ECOSOC themes.³⁹

These country-level independent review reports will include input from MGOS, and 'review' stakeholders such as parliamentarians, media, national human rights institutions, independent commissions, legal tribunals etc. The lead institutions and partners for this priority are the UNCTs (including the EWEC Focal Point in DCO⁵¹), UNDESA⁴³ and WHO/H6⁴² as co-conveners. Additional support for the VNR process and MGOS' participation would be through the SDG 3 GAP,⁴⁰ PMNCH⁴⁶ partners in country (focusing on women's, children's and adolescents' health) and UHC2030⁴⁷ partners in country (on health overall) and key multisectoral partnerships. Timeline: May and June. Main messages in May, and final reports and presentation materials in June annually.

Regional Links of IRM

Action 4. Synthesize regional patterns, best practices and priority issues with regional independent review reports forming a major section of HLPF Regional Sustainable Development Fora (RSDF).⁴⁸ The basis for IRM action at the regional level will be to provide regional independent review reports to the RFSD leading to the preparation of independent regional reviews and recommendations highlighting best practices, barriers, regional issues, etc. Lead institutions/partners for this priority will be all five UN/ECOSOC³⁹ regional Commissions supporting the process, with inputs from WHO/ H6⁴² regional bodies, and independent review from regional MGOS,¹¹ review stakeholders and others. Timeline: March/April annually.

Global IRM reporting

Action 5. Submit a global IRM report as a primary focus of the ECOSOC³⁹ Coordination Segment and HLPF³⁸ thematic reviews with an overview of existing country, regional and global inputs and independent reviews at all levels. It will examine and develop recommendations on key policy issues, lessons learned and best practices emanating from HLPF processes and outcomes including interlinkages among the SDGs⁹ to guide the integrated implementation of the 2030 Agenda and other major UN conferences and summits.

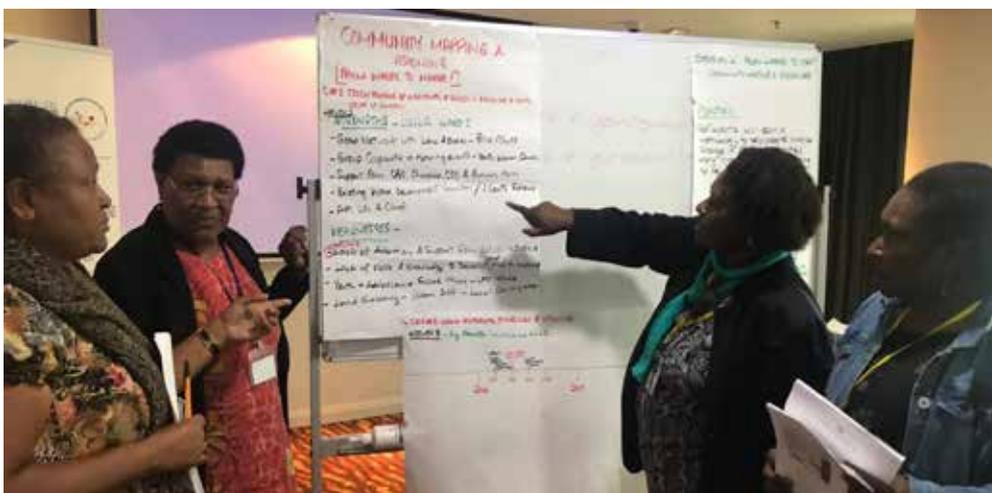
A global independent review commentary with action-oriented recommendations will be produced with detailed guidance, to support country-level implementation and reporting for the following year's HLPF. The lead institutions/partners for this priority will be ECOSOC supported by UNDESA⁴³ (as support secretariat to ECOSOC), with inputs from specialized agencies e.g. WHO and H6⁴² for health, and other agencies for multisectoral issues and MGOS.¹¹ This could follow the model of the UN Interagency Task Force (UNIATF) on the Prevention and Control of NCDs, also supported by the NCD Alliance.³⁹

Key inputs to the IRM review would include: on the SDGs overall, the UN SDG progress reports with country data and multisectoral analyses from UN agencies and all MGOS. On health-related SDGs and building back better after COVID-19, the IRM would consult the WHO GPW¹⁶ stocktakes, UHPR reports, and UHC 2030⁴⁷ commitments tracking. For women's, children's and adolescents' health, building on the WHA progress report on the EWEC Global Strategy,⁸ a key global input would be the annual report of the UN SG's Special Advocate for EWEC, supported by the H6⁴² on technical monitoring data, PMNCH⁴⁶ on diversity in participation for women's, children's and adolescents' health, and key multisectoral partnerships. On the realization of rights related to health and SDGs, the Universal Periodic Review⁵² and shadow reports from civil society, as well as Treaty Monitoring Body⁵³ reports would be important sources for the IRM's review.

Timeline: Throughout the HLPF³⁸ cycle, from February the preceding year when the ECOSOC³⁹ agrees the HLPF themes and countries for the follow year's reporting to global preparatory support for VNRs⁴⁴ in October/November, regional fora in March, and submission of VNR main messages in May, presentation to HLPF in July).

Country implementation

Action 6. Independent follow-up on country implementation of review recommendations with support from UN and development partners. The IRM will coordinate technical guidance and tools, broad participation in dialogues, webinars, and follow-up on discussion on previous HLPF³⁸ and independent review recommendations. Lead institutions/partners for this priority are UNCTs (including the EWEC Focal Point in UN DCO⁵¹), WHO/H6,⁴² SDG 3 GAP,⁴⁰ PMNCH⁴⁶ partners in country (focusing on women's, children's and adolescents' health), UHC2030⁴⁷ partners in country (on health overall), key multisectoral partnerships and others. Timeline: on-going.



IRM Operational Considerations

The operational considerations for the IRM are based on the findings and recommendations of the 2019 external evaluation of the IAP,³⁶ the IAP stakeholder consultation in 2020,³⁷ and a WHO consultation on accountability and independent review.⁵⁴ These considerations are also based on the evidence and our reflections in the preceding sections of this report.

Political mandate: The IRM's mandate should be from the UNSG and Member States, drawing on existing provisions in UNGA,⁵⁵ ECOSOC/HLPF,^{38,39} WHA⁵⁶ and HRC⁵⁷ resolutions (web annex 5). The mandate should include institutionalized links with HLPF global, regional and country reviews and presentation to the ECOSOC Coordination Segment and HLPF Thematic Reviews.

Composition and nomination: The IRM would have around 15 to 20 members. They should include HLPF Major Groups and Other Stakeholders as well as representatives of associations that have a sociopolitical review function e.g. parliaments, special rapporteurs, civil society, media, auditors and others. High-level experts and sociopolitical influencers could also play an important role. The process by which members are nominated should be inclusive, consultative, and transparent, and could be coordinated by broad partnerships comprised of diverse stakeholders e.g. PMNCH⁴⁶ and UHC2030⁴⁷ for health, and relevant multisectoral partnerships.

Hosting and co-convening arrangements: We recommend the IRM be hosted by WHO on behalf of the H6⁴² for health leadership. It should be co-convened with UN DESA⁴³ (as secretariat to HLPF and ECOSOC) for links to HLPF³⁸ reporting and follow-up on country implementation with UN country teams and partners.

Secretariat: A small secretariat in WHO as host agency, on behalf of H6,⁴² benchmarked with other well-functioning independent panels. Through the host agency it needs strong institutional links across the HLPF³⁸ cycle and for follow through to country implementation and impact.

Technical Support: Scope to commission independent technical inputs from academia and partners across regions to supplement more established inputs on the health-related SDGs⁹ and HLPF³⁸ reports.

Cost, benefit and risk analysis

- **Costs and funding.** We estimated the indicative costs of such an independent review mechanism based on the resources needed to carry out the functions (above) effectively and efficiently. Costs were also benchmarked to other independent mechanisms and panels, e.g. the GPMB for emergencies,⁵⁸ IMB for polio eradication,⁵⁹ and SAGE for immunization.⁶⁰ Potentially, WHO with other H6 agencies⁴² and partners could jointly mobilize resources and fund such an independent review mechanism as it serves a critical function for health and SDG accountability.

Resources for country follow-up on recommendations and remedies should be considered separately, through governments and with support provided as needed through existing country support mechanisms e.g. UN Country Teams, SDG3 GAP⁴⁰ and other development partners.

- **Benefits.** Accelerated progress with stronger accountability and independent review contributing to efficiency, effectiveness, equity and trustworthiness of decisions and progress on health-related SDGs. Sociopolitical, and multisectoral engagement. Adopting independent review as a time-tested principle of good governance, science, and human rights.
- **Risks.** Potential duplication if roles and mandates with the accountability system are not expressly clarified from the outset or there is insufficient institutional support for effective functioning. There could be pushback on the IRM composition, and resistance to its 'speaking truth to power' function.
- **Institutional support** for the IRM should be designed to maximize benefits and mitigate risks.

Conclusion: The IAP's view of the road ahead

In this reflections report, we identified a number of tough nuts to crack in global health and sustainable development in order to build back better through COVID-19 and achieve the SDGs. The urgency has never been greater and one of the effects of the pandemic is that women, adolescents and children are falling behind and losing out.

Accountability will get us to the goals much faster and more efficiently than without it. We identified the nutcracker – our framework for accountability – based on evidence, country examples and experience. We provided a blueprint for best practice (the nine features that need to be present for accountability arrangements to flourish). We have shown countries can use accountability to benefit their populations.

We must objectively and uncompromisingly maintain a spotlight on our collective progress and the road ahead, ensuring that no women, child or adolescent is left behind.



Web annexes

These annexes are each hyperlinked to the relevant online documents.

1. [Evolution of the EWEC accountability framework with independent review](#), including a 2-minute video on accountability
2. [Nigeria GPEI accountability case study](#)
3. [Thailand UHC accountability case study](#)
4. [WHO consultation on accountability and independent review](#), December 2020
5. [IAP analysis of institutional hosting arrangements for an independent review mechanism](#).
6. [Evidence summary: Operationalizing the IAP Accountability Checklist](#). GLOHI, 2020.
7. [IAP Stakeholder Consultation on Accountability and Independent Review](#), 2020.



About this report

With our mandate from the United Nations Secretary-General, we came together as a group of experts to form the Independent Accountability Panel¹ in 2016. Our brief was to act as the independent accountability arm of the Every Woman Every Child (EWEC) global movement.²

A lot has changed since 2016. At the time of writing, the world is still in the middle of the COVID-19 pandemic and there is a global crisis of accountability on many fronts.²⁸ Accountability is critical at this time; it can make all the difference between success and failure. Although there has been progress on achieving results for women, children and adolescents, improvements have been uneven and inequitable. The COVID-19 pandemic has disrupted positive trends and threatens to stall or even reverse progress while the indirect effects of the crisis are threatening the health, lives and livelihoods of the most vulnerable women, children and adolescents.

Against this background, the UN Deputy Secretary-General asked us to reflect on a decade of EWEC accountability⁶¹. These reflections would inform a transition to stronger arrangements that support country implementation through a Decade of Action to achieve the Sustainable Development Goals (SDGs).⁶²

The result is this report. We hope it will prove valuable and help governments, UN agencies and partners put in place effective arrangements for accountability to build back better through COVID-19 and ensure no one is left behind in the SDGs.

Since 2016, the IAP has evolved the EWEC accountability framework,⁶³ building on the pioneering work of the Commission on Information and Accountability⁶⁴ (CoIA, 2011) and the Independent Expert Review Group⁶⁵ (IERG, 2011-2015).⁶⁶ Across four major reports, journal articles and commentaries, we defined accountability and identified the lessons learned and elements needed to make it work for women's, children's and adolescents' health and rights.^{12,25,67,68} In the process, we consulted widely and gathered and evaluated evidence. Above all, we listened to people's experiences of accountability for their health and rights.

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