2020 REPORT

CAUGHT IN THE COVID-19 STORM:

women's, children's, and adolescents' health in the context of UHC and the SDGs

INDEPENDENT ACCOUNTABILITY PANEL
EVERY WOMAN, EVERY CHILD, EVERY ADOLESCENT.

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FOREWORD

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ABBREVIATIONS

ADHD	attention deficit hyperactivity disorder
CoIA	Commission on Information and Accountability
COVID-19	coronavirus disease 2019
CSOs	civil society organizations
CRVS	civil registration and vital statistics
ECHD	early childhood health and development
EOSG	Executive Office of the Secretary-General, United Nations
EWEC	Every Woman, Every Child global movement
FCS	fragile and conflict-affected situations
FGD	focus group discussion
FGM	female genital mutilation
GDP	gross domestic product
Global Strategy	Global Strategy for Women's, Children's and Adolescents' Health 2016-2030
HDI	Human Development Index
HIS	health information systems
HPV	human papillomavirus
IAP	Independent Accountability Panel for Every Woman, Every Child, Every Adolescent
iERG	independent Expert Review Group
IHR	International Health Regulations
KII	key informant interviews
LMICs	low- and middle-income countries
MDGs	Millennium Development Goals
M&E	monitoring and evaluation
MSD	multistakeholder dialogue
NCDs	non-communicable diseases
NGOs	non-governmental organizations
OOP	out-of-pocket
PHC	Primary Health Care
PMNCH	Partnership for Maternal, Newborn & Child Health
PPE	personal protective equipment
QA/QI	quality assurance/quality improvement
RMNCH	reproductive, maternal, newborn and child health
SDGs	Sustainable Development Goals
TEAM	Together Everyone Achieve More
UAF	Unified Accountability Framework
UHC	universal health coverage
UHC2030	International Health Partnership for UHC 2030
UK	United Kingdom
UN	United Nations
UN H6	United Nations H6 Partnership (comprising the WHO, UNAIDS, UNFPA, UNICEF, UN Women and the World Bank)
UNICEF	United Nations Children's Fund
UNSG	United Nations Secretary-General
US	United States
WASH	water, sanitation and hygiene
WCAH	women's, children's and adolescents' health
WHO	World Health Organization

EXECUTIVE SUMMARY

STATUS OF WOMEN'S, CHILDREN'S AND ADOLESCENTS' HEALTH AND RIGHTS IN THE CONTEXT OF UHC AND SDGs

In 2016, the United Nations Secretary-General mandated the Independent Accountability Panel for Every Woman Every Child (IAP) to review accountability and progress in women's, children's and adolescents' health towards the 2030 Sustainable Development Goals (SDGs).[1,1a] Work for this report began before COVID-19, however, impacts of the pandemic (in both real time and in the projected implications) have been considered throughout this report. In this report, the IAP highlights what is working and what is not. It recommends how countries, development partners and stakeholders can strengthen accountability to accelerate progress.

COVID-19 is making a bad situation worse

Even before COVID-19, global progress towards 2030 targets to save the lives of women and children was already lagging by around 20% (see Annex). On universal health coverage (UHC), only between one-third and one-half of the world's population were covered by the essential health services they needed, including interventions for women, children and adolescents, and over 900 million people experienced catastrophic health expenditure.[2] Mistrust (in governments, private sector, media and non-governmental organizations) was rising globally, driven by the "growing sense of inequity and unfairness".[3]

Now, the global pandemic is making a bad situation even worse, as countries that were unprepared try to cope by diverting resources away from essential services or by pushing through retrogressive legislation.

Many countries did not have the required International Health Regulations (IHR)[4] core capacities or health service coverage to respond fully to COVID-19.[5] Others are pushing through retrogressive backdoor legislation. This includes pulling back on abortion laws,[6] restricting sexual and reproductive health and rights education,[7] using border closings and lockdowns to allow legally dubious, hardline migration policies[8] and legislation to censor the media and public protests.[9,10]

While older people are most likely to be directly affected by COVID-19, the indirect effects on pregnant women, newborns, young children and adolescents are huge. Health services and social and financial support for them are simply crumbling, including as a result of closures and constraints. Reports from reproductive health stakeholders, including IPPF, indicate there have been mass, worldwide closures of both static and mobile reproductive health clinics, scale-down of sexual and reproductive health services (including HIV testing and post-abortion care) and widespread reproductive supply shortfalls as factories reduced capacity, ports closed and transport networks were shut.[11,12] A survey of 30 countries found that 73% of health workers cited shortages of sanitary products,[13] while another 58% cited price hikes, and 50% reported reduced access to clean water to help manage menstrual hygiene.[14] Lockdowns and movement restrictions, and health workers being diverted from maternity to COVID-19 units, limits availability of life-saving services for pregnant women and newborns, as occurred in previous pandemics and outbreaks too.[15,16] Immunization campaigns were halted, leaving at least 13.5 million children unprotected against life-threatening diseases.[17] The closure of schools meant 370 million children missed out on meals,[18] and adolescents suffered from greater physical threats, isolation and mental health issues.[19] With more children and adolescents relying on technology for learning and social interaction, there is an increased risk of online abuse and exploitation.[20] And domestic violence increased – in Argentina, emergency calls increased by 25%; and calls to helplines in Singapore, France and Cyprus rose by more than 30%.[21,22]

Since complete and validated data for 2020 are not yet available, several studies are using a variety of assumptions, scenarios and study designs to estimate the effects of COVID-19 on the health of women and children. Tragically, the predicted scenarios paint an even grimmer future for women, newborns, young children and adolescents. We could see a big rise in deaths among pregnant women and young children (8% to 45% higher than would have occurred in the absence of the pandemic).[23] Disruption to contraceptive supplies could lead to 15 million more unintended pregnancies in low- and middle-income countries (LMICs).[24] Even a 10% shift in abortions from safe to unsafe in a 12 month period in LMICs could lead to 3.3 million additional unsafe abortions.[24] For every 3 months of lockdown, 15 million more cases of gender-based violence are anticipated.[25,26] 2 million additional cases of female genital mutilation (FGM) could take place over the next decade due to delays in the implementation of programmes to end these harmful practices.[26] As a result of wide-reaching economic impacts and disrupted programmes, 13 million more child marriages are estimated over the coming 10 years.[26] Prevalence of wasting due to malnutrition in children could increase by 10–50%, in hypothetical scenarios used to model COVID-19 impacts.[23] And an estimated 40–60 million people could be pushed into extreme poverty,[27] with women and children disproportionately affected, particularly in accessing financial and social support.[28,29]

COUNTRY SCORECARDS: SOME COUNTRIES SPEND THE SAME ON HEALTH BUT GET BETTER RESULTS THAN OTHERS

The IAP developed and analysed country 'scorecards', by income category[30] and key indicators for EWEC[31] and related SDGs, which show that all countries can achieve big improvements by using their resources more effectively. Pre-COVID-19, some countries in the same income category were performing better than others on women's, children's and adolescents' health and rights and ensuring universal health coverage (UHC). For example, the United States (US) spends more than twice as much on health than either Japan or France,[32] yet children in the US are more likely to die before their fifth birthday[33] and women are more than twice as likely to die in childbirth.[34] Nigeria spends around double per capita on health than Tanzania and has similar service coverage (around 40 on the UHC service coverage index).[2,32] But Nigeria has over double the under-five mortality rate as Tanzania (120 and 53 deaths per 1000 live births respectively)[33] due in part to sub-national inequalities, and critical gaps in health and multisectoral service delivery and financial protection.

CRITICAL CHALLENGES

Fragility and conflict situations

Women, children and adolescents are far more likely to die in countries affected by fragility and conflict situations (FCS)[35] than in other countries. For example, the median under-five mortality rate is 58 per 1000 live births in FCS countries versus 14 per 1000 in other countries. However, mortality rates in some FCS may be underestimated, as reliable data are not available for recent years particularly during crises.[33]

Data gaps are a national and global security risk

The health of women, children and adolescents is put at risk when countries have limited capacity to gather and analyse health and population data,[36] such as for births and deaths. The births of one in four children under age of 5 are not registered;[37] 93 of 193 countries are currently able to register more than 80% of adult deaths.[38] Lack of disaggregated data and over reliance on global estimates and modelling limit the ability to identify who is in greatest need.[39,40] Emerging COVID-19 data have also generally been incomplete, unreliable and is rarely gender- and age-disaggregated.[41] Political leadership, multisectoral investments and a whole-of-government, whole-of-society approach is needed to fill country data gaps and ensure data are used strategically to improve health and rights.

Gaping inequities are commonplace

Women, children and adolescents are disproportionately affected by gaping inequities between and within countries, such as low coverage of essential health services, catastrophic health

expenditures and a projected shortfall of 18 million health workers worldwide.[42] Women are up to 500 times more likely to die as a result of pregnancy and child birth complications in some countries than in others.[34] There are significant equity gaps within countries too, for example, in some countries there is around a 50-percentage point difference between the richest and poorest in service coverage for women, children and adolescents.[43] Black and other racial and ethnic groups in North America and Europe have experienced disproportionately high rates of morbidity and mortality from COVID-19.[44,45] The protests in the US and other countries against racial injustice in response to the death of George Floyd in Minneapolis on 25 May 2020 by the police, highlights the need to address the root causes for such inequalities and injustice at all levels.

Inefficiencies and corruption divert scarce resources

An estimated 20–40% of health expenditure is wasted globally due to inefficiencies and corruption; this has been a repeated finding over the past 10 years,[46-48] and amounts to around 2 trillion USD a year currently. During the pandemic, this has been seen in procurement of personal protective equipment (PPE) that is not fit for purpose and COVID-19 test kits that are substandard. Development assistance for women's, children's and adolescents' health is not necessarily invested in areas of greatest need. Wasted health expenditure severely constrains the resources available for women's, children's and adolescents' health, and undermines trust globally.[3] It highlights the need for accountability to ensure budget transparency across the work of government, development partners, the private sector, media and civil society.

FACTORS FOR SUCCESS

Countries that perform better on reducing maternal and child mortality are also performing better on a range of evidence-based factors for success, such as data and information, and laws and policies. They invest in a justifiable way, based on evidence, rights and rule of law, and use innovation to catalyze progress. This suggests that how health spending is used is as important as how much is spent.

UHC and PHC – pre-pandemic priorities are more valid than ever

Improvements in UHC and primary health care (PHC) were already a priority pre-COVID-19.[2] They are strongly linked to improvements in women's, children's and adolescents' health – particularly when targeting known issues such as quality of care, financial protection for individuals, families and communities, protection of health workers, multisectoral action and public engagement. All countries need to take care that when planning to increase service coverage, financial protection measures are in place, too. Otherwise efforts to increase service coverage will exacerbate catastrophic expenditure, which will be counterproductive for health and SDG outcomes. An especially important consideration for women, children and adolescents (WCA) as they lack the financial resources and decision-making power to mitigate the risks.

Use domestic expenditure to invest in UHC and multisector factors

Most countries, except low-income and those in FCS, should be able to use their domestic resources to fund required investments in UHC and PHC.[2] Critical investment should include essential interventions for women's, children's and adolescents' health, financial protection provisions, and strategic investments across multisectoral areas such as education, water, sanitation and hygiene, and clean energy. Evidence from the Millennium Development Goals (MDGs) shows that health and multisectoral factors contribute about 50:50 to improving the health of women, children, and adolescents, and SDG analyses highlight emerging evidence from countries on what works in multisectoral collaboration.[49,50]

Use progressive realization to advance health and rights

Progressive realization is a fundamental principle of human rights and an essential feature of accountability.[51,52] Governments should apply it alongside good governance and accountability to ensure proper administration and targeting of investments. Accountability is not a one-time action. Once elected, governments need continually to demonstrate accountability for their actions, and citizens should be able to participate and voice their concerns.

Chronic challenges persist because weak accountability arrangements leave critical aspects of service delivery and decision-making unchallenged and unremedied.

COUNTRY CASE STUDIES: UNIQUE CONTEXTS AND ACCOUNTABILITY EXPERIENCES

The IAP commissioned case studies to examine health and accountability experiences for women, children and adolescents in five countries (Ethiopia, Georgia, Guatemala, Kenya, Papua New Guinea) and to inform its 2020 report and recommendations. The use of direct quotes in the case studies places the voices of women, children and adolescents and key stakeholders where they belong – at the centre of the accountability process. Some participants directly challenge the effectiveness of government:

> *"We tend to re-engineer policies instead of implementing the ones we already have."*
> **Kenya**

Others call for more meaningful and respectful dialogues on health, and more publicity for health and rights:

> *"It is very important to have spaces for dialogue to help review the health system in a cultural context. It must also focus on rights, respect, and collaboration."*
> **Guatemala**

> *"[Expand] partnerships with the media to ensure more regular coverage of UHC topics and to raise awareness about the health and rights of women, children and adolescents."*
> **Georgia**

An overarching conclusion is that:

> *"Voice does not equate to accountability if there is no one to listen, act and respond."*[53]

ACCOUNTABILITY FRAMEWORK AND RECOMMENDATIONS

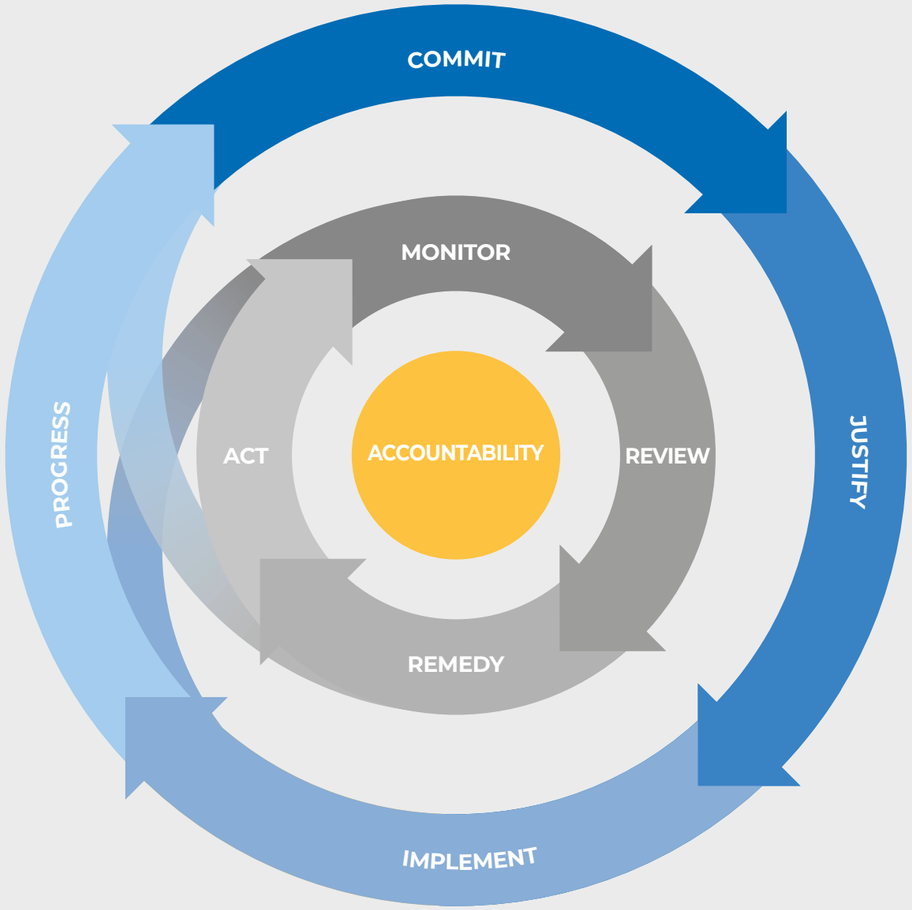
In order to reverse the downward turn and accelerate progress towards the 2030 targets, the IAP sets out an accountability framework (based on the evolution of the EWEC accountability framework, see Annex) and three overarching recommendations.

Accountability is connecting commitments to progress in a justifiable and constructive way. It has four pillars – Commit, Justify, Implement and Progress. Every single one of these pillars must be present – if just one of them is missing, the whole structure falls.

- **Commit:**
  all those who have commitments and a responsibility to act should be clear on their roles and obligations towards achieving agreed goals and realizing rights.
- **Justify:**
  decisions and actions related to commitments must be supported and explained on the basis of evidence, rights and the rule of law.
- **Implement:**
  core accountability functions of Monitor-Review-Remedy-Act[54] should be institutionalized and implemented in a constructive way to facilitate learning and progress.
- **Progress:**
  continuous progress towards agreed goals and rights should be ensured, justifying any reversals – this is the human rights principle of 'progressive realization'.[51,52]

The figure below shows the accountability framework.

Figure. Accountability: connecting commitments to progress in a justifiable and constructive way



Accountability in a socio-political context, applies to governments and non-state actors, to individuals and institutions, and can be used to track duty bearers' obligations and rights holders' claims.

The following recommendations indicate how countries and other stakeholders should seek to use the IAP framework to revitalize accountability and achieve targets.

RECOMMENDATION 1

Invest in country data systems for national and global security

The COVID-19 pandemic has again highlighted the importance of basing critical decisions and investments for women's, children's and adolescents' health and rights on reliable and complete data. As an urgent priority, countries should invest in data systems, such as birth and death registration, ensuring every woman, child and adolescent counts and is counted.

Countries, political leaders, governments and development partners should ensure the highest level of political commitment and sufficient investment to develop harmonized data systems. They should steadily improve data quality and communication to enable decision-making. Private sector and civil society organizations (CSOs) should drive innovation and create demand for information and evidence that reflects lived experiences.[55] Media and public-interest organizations should support data collection and evidence-gathering, translate it into information that is easily understood and encourage public debate based on the findings.

RECOMMENDATION 2

Institutionalize accountability functions and features — voluntary arrangements are insufficient

For the accountability cycle to work, an acknowledged, formal relationship is needed between the monitoring, review and recommendations, and the remedy and action that follow. All functions and features must be fully present and operational, and should be embedded in all relevant political, administrative, operational, and oversight institutions.

By investing to institutionalize accountability processes, countries can increase their capacity to apply lessons rapidly and effectively during and after events such as the COVID-19 pandemic, and to rectify and remedy violations. They should establish clear roles and responsibilities and agree timings for implementing accountability functions. All institutions, policies, programmes and processes related to women's, children's and adolescents' health should have explicit accountability arrangements in place that incorporate institutionalized monitoring and review, and lead to remedy and action based on concrete recommendations. Actions taken should be verified and processes themselves should be regularly audited. Investments in accountability can have high returns on investment by driving more effective, efficient and equitable governance, systems and services towards realizing health, SDGs and rights.

RECOMMENDATION 3

Democratize accountability to include the voices of people and communities

The direct voices of people are crucial to effective accountability. It is essential that all levels of political leadership, governments and other stakeholders listen to, and act upon, the expressed needs and priorities of people. For example, sustained criticism during the COVID-19 pandemic over the lack of PPE or testing services has compelled decision-makers to take action. A global debate on racism was initiated by protests over the brutal killing by the police of George Floyd in Minneapolis on 25 May 2020. Experiences such as these should be embodied and amplified in future accountability arrangements for communities, including for women's, children's and adolescents' health. Key institutions and sectors should take the lead. Parliaments should hold governments to account for enabling voice and participation in accountability, and equally, the governments' responsiveness to it. The media and CSOs and social networks should convey the range of people's lived experiences in their work, creating meaningful spaces for the articulation of community, regional and national voices.

As the COVID-19 response progresses – and countries assess the impact and implications for women's, children's and adolescents' health – the IAP's recommendations and its model of independent review offer a template for accountability across health and the SDGs. Building a strong culture of accountability will give all countries a real chance to get through COVID-19, achieve the SDGs, and realize the rights of every woman, child and adolescent.

Chapter 1

Status of women's, children's and adolescents' health in the context of UHC and SDGs, and implications of COVID-19

Caught in the COVID-19 storm: women's, children's, and adolescents' health in the context of UHC and the SDGs

INTRODUCTION: WHAT COVID-19 TELLS US ABOUT ACCOUNTABILITY FOR THE HEALTH OF WOMEN, CHILDREN AND ADOLESCENTS

Effective global accountability for women's, children's and adolescents' health and UHC is needed through the COVID-19 pandemic and beyond. This report of the United Nations Secretary-General's Independent Accountability Panel for EWEC (IAP) is written at a landmark moment: 2020 marks 10 years of the Every Woman Every Child (EWEC) movement, and accountability framework (see Annex),[56] five years since the adoption of the 2030 Sustainable Development Goals (SDGs),[29] the year following the political declaration of the United Nations high-level meeting on UHC,[57] and the start of the COVID-19 pandemic.[58] While the report is concerned with much more than one seismic event, the pandemic casts a long shadow over the findings and recommendations of this document.

What role should accountability play in learning lessons from COVID-19, and how do these relate to lessons across accountability for women's, children's and adolescents' health? What do they tell us about the need for a reinforced and coherent global approach to accountability? At time of writing, it is too late to prevent the pandemic and too early to draw comprehensive conclusions on COVID-19 impact. However, certain findings are already self-evident.

UHC AND PHC: PRE-PANDEMIC PRIORITIES ARE MORE VALID THAN EVER

In September 2019, the IAP welcomed the United Nations High-level Meeting Declaration on UHC.[57] In order to grasp the opportunity presented by high-level political commitment to UHC and PHC, and the huge potential benefits for women, children and adolescents, the IAP recommended an integrated approach to accountability towards realizing health and rights. The IAP's statement re-emphasized the importance of "accountable and transparent institutions to ensure social justice, rule of law, good governance and ending corruption".[59] Reinforcing this message, UHC2030 called for political leadership including and beyond health as a social contract to ensure healthy lives and well-being for all at all stages.[60]

In an editorial in the WHO Bulletin, the IAP elaborated accountability requirements within UHC to ensure women's, children's and adolescents' health and rights, including provisioning of essential services, enabling legal and policy frameworks, effective transnational and private sector regulation, support for those in fragile settings, and strengthened country data to identify inequities and rights violations to effect remedy and action.[61]

These political commitments and accountability requirements are even more important during the COVID-19 pandemic and beyond.

PROGRESS WAS LAGGING EVEN BEFORE COVID-19 STRUCK

Pre-COVID-19, there was already around a 20% progress lag to achieve the 2030 targets to reduce preventable mortality among women, children and adolescents (see Annex). In the MDGs era, countries made significant progress in improving health. For example, globally, maternal and child mortality almost halved,[62,63] and even countries in the lowest income categories made significant advances (see Annex), but now progress is slowing.

The latest statistics available at the beginning of 2020 indicate that less than half the world's population had full coverage of essential health services, including those for women, children and adolescents; coverage needed to double to meet the SDG targets for UHC.[2] Over 900 million people experienced catastrophic health expenditures[2] and there was a projected shortfall of 18 million health workers worldwide.[42]

For decades, countries have under-invested in common, or public, goods for health.[64,65] For instance, through the International Health Regulations (IHR),[4] countries committed to building their capacities to detect, assess and report public health events and outbreaks. However, when assessed for IHR capacity during the COVID-19 pandemic, approximately one-third of all countries scored below 50%[5]. This undermines global security, both health and socioeconomic.[5]

Transnational cooperation and regulation are often needed to create common goods for health, as seen in the global research collaboration to develop a COVID-19 vaccine. Another example is the need for increased global production of human papillomavirus (HPV) vaccine based on the creation of new facilities in countries where unmet demand is highest. An IAP paper on the subject also calls for comprehensive guidelines for all at risk from HPV and all who could benefit from the vaccine.[66] Other transnational accountability issues include constraints around programming priorities, fiscal space and financing, pricing and production of products, inequitable access to global public health goods, unlawful use of private data, and insufficient support for fragile states and for protecting migrants' health.[61,67]

In the IAP's view, investing in health systems foundations and transnational cooperation for public health goods is a continued matter of urgency. This needs strong leadership from governments, the WHO, and other agencies working on health. It cannot be left to the market economy to deliver UHC or to tackle threats such as COVID-19, failures of which continue to be documented throughout the pandemic.

Ensuring the efficiency, effectiveness, and equity of investments is also critical. Pre-COVID-19 estimates by a range of international and non-governmental organizations suggest that 20–40% of health expenditure across all countries globally is wasted due to inefficiencies; this has been a repeated finding over the past 10 years.[46,47] They result from systemic issues such as under-investment in evidence-based approaches, and from corruption, waste, substandard aid, and failing to reach those in greatest need.[47,48,68,69] Global health expenditure was 7.8 trillion USD in 2017, or 10% of global GDP, so between 1.56 trillion USD and 3.12 trillion USD (approximately 2 trillion USD) a year may be wasted due to inefficiencies.[70] This could pay for UHC globally,[2] and is more than total global military expenditure.[71] More accountable health systems management is another critical area for remedy and reform.

There are vast inequities in women's, children's and adolescents' service coverage and health outcomes between and within countries, based on wealth, sex, ethnicity, education, urban or rural settings and other stratifiers.[2,72] Inequities are also seen in relation to ethnic disparities in COVID-19 survival. For example, in the UK,[44] an array of factors was found to contribute to this disparity, including occupation, living conditions and country of birth.

The United Nations Secretary-General (UNSG) highlighted global mistrust as one of the greatest threats facing the international community at the start of 2020.[73] Even before COVID-19, inequities were eroding public trust and security nationally and globally. Globally, mistrust was pervasive, driven by a "growing sense of inequity and unfairness".[3] People distrusted governments, private sector, media and non-governmental organizations to varying degrees based on ethics and competence. There was a sense that the globalized economy was geared to making profits for the few at the expense of the many.[3] In many countries this mistrust has been exacerbated during the pandemic.

Progress also lags on a number of multisectoral factors (see Box 1 and Chapter 2), for example on country data systems, education, climate change and the elimination of violence against women.[74]

The lives of women, children and adolescents matter … we must all be accountable and take action to improve their health and safeguard our national and global future.

Carol Kidu, IAP member

COVID-19 IS MAKING A BAD SITUATION WORSE

While older people are most likely to be directly affected by COVID-19, the indirect effects on pregnant women, newborns, young children and adolescents are huge.[75] The impact of the pandemic has strongly reinforced the urgency of ensuring UHC and PHC in all countries and the need for stronger accountability for people's health and rights. It has also illustrated how government action, or lack of it, has a direct effect on levels of mortality and morbidity. Existing challenges are, and will continue to be, exacerbated by COVID-19. Most countries – high- and low-income alike – were unprepared for COVID-19. The inefficiencies and inequities are now being compounded with resources being diverted from essential health and multisectoral services to the pandemic response, and retrogressive legislation being pushed through. Together with imposed 'lockdowns', this severely restricts women's, children's and adolescents' access to essential health and multisectoral services.

With progress towards the EWEC 'survive' targets already lagging by 20% (see Annex), the pandemic could have devastating impacts on women's, children's and adolescents' health and rights. Since complete and validated data for 2020 are not yet available, several studies are using a variety of assumptions, scenarios and study designs to estimate the effects of COVID-19 on women and children. For example, scenario-based projections in selected LMICs of disruptions of health systems and decreased access to food, indicate that potentially 12 200 to 56 700 additional maternal deaths could occur in six months with increases of 8.3 to 38.6% in maternal deaths per month. These projections also show a potential 253 500 to 1,157 million additional child deaths in six months, with an increase of 9·8–44·7% in under-5 child deaths per month.[23] Box 1 summarizes the pre-pandemic status on the 16 EWEC key indicators, and emerging evidence and projections on the impact of COVID-19.

BOX 1

EWEC 16 KEY INDICATORS OF WOMEN'S, CHILDREN'S AND ADOLESCENTS' HEALTH, AND COVID-19 IMPLICATIONS

16 key EWEC indicators, latest published global estimates at the time of writing

COVID-19 implications, emerging evidence and potential projected impacts at the time of writing[75]

Survive

REDUCING PREVENTABLE MORTALITY

1. Maternal mortality ratio (SDG 3.1.1)

295 000 women died of causes related to pregnancy and childbirth in 2017.[34] Globally, the leading causes of maternal deaths are haemorrhage, hypertensive disorders and sepsis.[76]

2. Under five mortality rate (SDG 3.2.1)

5.3 million children (90% UI 5.1, 5.7) under 5 years died in 2018. Worldwide, the leading causes of death among children 1–59 months are pneumonia, diarrhoea and injuries.[33]

3. Neonatal mortality rate (SDG 3.2.2)

An estimated 2.5 million neonates died (90% UI 2.4–2.7 million) in 2018. The leading causes of death among newborns are preterm birth complications and intrapartum- (during childbirth) related complications, and sepsis.[33]

4. Stillbirth rate

There were 2.6 million stillbirths (95% UI 2.4–3.0 million) in 2015, more than 7 000 a day.[77,78] Nearly all stillbirths occurred in low- and middle-income countries. Half of stillbirths happen during childbirth, reinforcing the importance of skilled attendance at birth.[78]

5. Adolescent mortality rate

1.1 million adolescents aged 10-19 years died in 2016, a decline from 1.4 million in 2000. Nearly half of male deaths and 29% of female deaths were caused by injuries, predominantly road traffic injuries. Among adolescent girls aged 15–19 years, pregnancy related complications and suicide were the leading causes of death.[79]

COVID-19 IMPLICATIONS

Emerging evidence

- Reported declines in access to, and attendance of, antenatal and postnatal maternal health services due to closures and movement restrictions. Health workers are being diverted from maternity to COVID-19 units, with maternity units converted into COVID-19 centres, limiting availability of services, as also occurred in previous pandemics and outbreaks.[15,16]
- Ethics, rights and health concerns on measures taken to address service limitations and transmission of COVID-19, e.g. women being required to give birth without family or other birth helpers, and a denial of autonomy in decision making;[80] medical interventions – C-sections, induced births – without evidence-based indication; separating mothers and newborns, preventing breastfeeding.[81]
- As of late April, 13.5 million children missed out on vaccinations for polio, measles, HPV, yellow fever, cholera and meningitis, while 21 countries reported vaccine shortages due to supply chain bottlenecks emerging from COVID-19.[17,82] Polio vaccination campaigns were paused and 23 countries suspended measles immunization campaigns.[20]

Projected potential impacts

- 12 200 to 56 700 additional maternal deaths in 6 months, in plausible scenarios in selected LMICs of disruptions of health systems and decreased access to food, with increases of 8.3–38.6% in maternal deaths per month.[23]
- 10% decline in service coverage of essential pregnancy-related and newborn care could result annually in 2,591,000 additional newborns experiencing major complications without care and potential 168,000 additional newborn deaths.[24]
- 1.745 million additional women could experience major obstetric complications without care.[24]
- Past epidemics suggest the potential impacts of COVID-19: e.g. during the West African Ebola outbreak, maternal mortality increased by 75% during the epidemic, and the number of women giving birth in hospitals and health clinics dropped by 30%.[83,84]
- 80 million children under the age of one year could be potentially affected by suspension of routine vaccination services in at least 68 countries.[85] Increased likelihood of outbreaks of vaccine-preventable diseases,[20] leading to increased child mortality.

Thrive

HEALTH NEEDS, INCLUDING UHC AND HEALTH SERVICES

6. Prevalence of stunting among children under 5 years (SDG 2.2.1)

144 million (21.3%) children under 5 years were stunted in 2019, a decrease from 164 million (24.8%) in 2012.[86]

7. Adolescent birth rate (10–14, 15–19) (SDG 3.7.2)

Adolescent birth rate globally was 44 births per 1 000 girls aged 15–19 years in 2018; in West and Central Africa, this figure stood at 115 births per 1 000 girls aged 15–19 years, the highest regional rate in the world.[87]

8. UHC: Service Coverage Index (SDG 3.8.1)

The UHC service coverage index increased to 66 (out of 100) in 2017, from a global average of 45 in 2000. Between one-third and one-half of the world's population were covered by the essential health services they needed in 2017, including services for women, children and adolescents.[2]

9. UHC: Catastrophic health expenditure (SDG 3.8.2)*

An estimated 930 million people spent more than 10% of their household income on health care in 2015. Of those, an estimated 210 million people spent more than 25% of their household income.[2]

** Current SDG indicator updated from the initial EWEC indicator framework.*

10. Current country health expenditure per capita (including specifically on reproductive, maternal, newborn, child and adolescent health) financed from domestic sources

The average national percentage of total government expenditure devoted to health increased slightly to 10.6% in 2016, from around 9% in 2000.[38] Currently, data in the Global Health Expenditure database on domestic investments in RMNCAH are limited, with data on domestic government expenditures on reproductive health, immunizations and children under the age of 5 available for 45, 50 and 21 mainly low- and middle-income countries, respectively.[32]

11. Number of countries with laws and regulations that guarantee women aged 15–49 years access to sexual and reproductive health care, information and education (SDG 5.6.2)

67% of countries (99/148) self-reported having a national policy/law on sexual health information and services in the WHO 2018–2019 policy survey on sexual, reproductive, maternal, newborn, child and adolescent health. Close to 90% of countries (131/146) self-reported having a national policy/guideline on reproductive health care that promotes universal access to care.[88]

COVID-19 IMPLICATIONS

Emerging evidence

- *Nutrition.* With school closures, around 370 million children are missing out on school meals,[18] and another 9 million at-risk children no longer benefiting from WFP-sponsored school feeding initiatives.[89] Major disruptions to food supply chains in numerous countries around the world.[90] Studies in Italy, the US and China have shown major disruptions to childhood obesity programmes as children are forced indoors by lockdown policies.[91-93]
- *Sexual and reproductive health commodities and services.* Reports from reproductive health stakeholders, including IPPF, indicate that there have been mass, worldwide closures of both static and mobile reproductive health clinics, scale-down of sexual and reproductive health services (including HIV testing and post-abortion care) and widespread reproductive commodity and supply shortfalls and supply chain constraints as factories reduce capacity, ports close and transport networks shut.[11,12] A survey of 30 countries found that 73% of health workers responding cited shortages of sanitary products,[13] while another 58% cited price hikes, and 50% reported reduced access to clean water to help manage menstrual hygiene.[14]
- *Mental health.* Studies from across low-, middle-, and high-income countries have shown that women under COVID-19 lockdown conditions are more likely than men to exhibit post-traumatic stress disorder, alterations in cognition or mood, and higher levels of fear, anxiety and depression.[29,94-96] Children's mental health is being impacted with reports of increased depression, stress, anxiety and uncertainty, loss of sleep, increased screen time, and a decline in activity levels, alongside an increase in drivers of eating disorders, ADHD and other mental health issues.[97-99] Adolescents and students who are not in school or college may face greater exposure to physical threats, while social isolation due to the virus may exacerbate mental health issues.[19,97]
- *Non-communicable diseases (NCDs).* People living with NCDs who become infected with COVID-19 can experience greater severity of disease as well as poorer outcomes.[100] There is limited information on the effect of COVID-19 on women, children and adolescents with NCDs and more studies are needed, along with gender- and age-disaggregated data on NCDs.

Projected potential impacts

- Prevalence of wasting due to malnutrition in children could increase by 10–50%, based on plausible hypothetical scenarios used to model COVID-19 impacts, based on emerging reports of the supply-side and demand-side effects of the pandemic.[23]
- Coverage of essential maternal and child health interventions could reduce by around 9·8–51·9%, based on different scenarios used to model COVID-19 impacts.[23]
- For every 3 months of lockdown, 13 million women might not be able to access modern contraceptives and there could be an estimated 325 000 unintended pregnancies.[26]
- A 10% decline in use of short- and long-acting reversible contraceptives over a 12-month period in LMICs will lead to around 15 million additional unintended pregnancies.[24]
- Even a 10% shift in abortions from safe to unsafe in a 12 month period in LMICs might lead to 3.3 million additional unsafe abortions and 1 000 additional maternal deaths.[24]

Transform

MULTISECTORAL ACTION AND ENABLING ENVIRONMENTS

12. Proportion of children under 5 years whose births have been registered with a civil authority (SDG 16.9.1)

One in four children under the age of 5 (166 million) were not registered with a civil authority in 2018.[37,101]

13. Proportion of children and young people in schools with proficiency in reading and mathematics (SDG 4.1.1)

An estimated 617 million children and adolescents of primary and lower secondary school age lacked minimum proficiency in reading and mathematics in 2015. This represents more than half of children and adolescents of primary and lower secondary school age.[74]

14. Proportion of women, children and adolescents subjected to violence (SDG 5.2.1, 16.2.3)

Latest available data from 106 countries show that 18% of ever-partnered women and girls aged 15-49 years experienced physical and/or sexual partner violence in the last 12 months during 2005–2017. The prevalence is highest in least developed countries, at 24%.[74]

15. Proportion of population with primary reliance on clean fuels and technology (SDG 7.1.2)**

61% of the global population had access to clean and safe cooking fuels and technologies in 2017. Close to 3 billion people are still dependent on inefficient and highly polluting cooking systems, resulting in nearly 4 million premature deaths each year.[74]

*** Shifted this indicator to the multisectoral section from the initial EWEC framework.*

COVID-19 IMPLICATIONS

Emerging evidence

- *Education.* 90% of the world's school and university population was out of school in April 2020.[103] 90% of high-income countries are using distance learning strategies to continue education, but only 25% of low-income countries are doing so (mainly through television and radio); these differences are increasing inequities both within and between countries.[104]
- *Violence against women and girls.* Around the world, increasing rates of domestic violence and emergency calls to services have been reported, including among displaced populations.[21,22] In Argentina, emergency calls related to domestic violence increased by 25%; there are increases in calls to helplines in Singapore, France and Cyprus by more than 30%.[21,22]
- *Environment and health.* Over 90% of COVID-19 cases have been in urban spaces where population density, crowded public transport and other aspects of built environments (ventilation, air flow, shared spaces, number of contact surfaces, etc.) increase opportunities for infection and often coexist with greater air pollution.[105-109] Specifically in relation to built and natural environments and COVID-19, the implications of gender, age and equity need to be better understood.

Projected potential impacts

- Girls might be less likely to return to school after the lockdown; e.g. as seen in many countries after the 2014 West Africa Ebola outbreak.[110] School closures can also contribute to a sharp rise in adolescent pregnancies; e.g. in some parts of Sierra Leone after the Ebola outbreak, there was a 65% increase.[110]
- An additional 15 million cases of gender-based violence could potentially be expected, for every 3 months the lockdown continues.[25] Other forms of violence against women and girls could also occur, including against female healthcare workers, migrant or domestic workers, xenophobia-related violence, harassment, and violence in public spaces and online.[22] More children are relying on technology for learning and social interaction, and there is an increased risk of online abuse and exploitation.[20]
- 2 million additional cases of female genital mutilation (FGM) could take place over the next decade due to delays in the implementation

16. Percentage of population using safely managed sanitation services, including a hand-washing facility with soap and water (SDG 6.2.1)

45% of the global population was using safely managed sanitation services in 2017, an increase from 28% in 2000.[102]

of programmes to end these harmful practices.[26] Millions more child marriages are estimated over the coming 10 years due to programmatic and socioeconomic disruptions.[26]

- There is a risk of disruption to WASH services from lockdown measures.[28] In addition to having critical implications for COVID-19 control, there are additional risks of increased water-borne diseases.

ADDITIONAL CRITICAL CONSIDERATIONS

Inequities

There are vast inequities between and within countries. For example, due to vastly different resource and development contexts, and global health expenditures, the maternal mortality ratio is 500 times more in the highest-burden countries than in the lowest-burden countries.[34] There are significant equity gaps within countries too, for example, in some countries there is around a 50-percentage point difference between the richest and poorest in service coverage for women, children and adolescents.[43] Inequities are also seen in relation to COVID-19 survival; for example, in the UK, people of Chinese, Indian, Pakistani, other Asian, Caribbean and other Black ethnicity were found to have a 10–50% higher risk of death.[44] An array of factors contribute to these disparities, including occupation, living conditions and country of birth.[44]

Protection of women health workers

The health of women health workers has to be safeguarded, as the COVID-19 crisis showed. Frontline workers consist of a diverse group of industries, many of which are mostly made up of women.[111] Evidence is emerging that female health care workers are more likely to be infected by COVID-19 compared to male, and more likely to experience psychological distress and stress than male colleagues. They are also more likely to be disadvantaged when it comes to access to workplace safety, as PPE is not proportioned to women's bodies, and workplace guidelines for issues such as pregnancy and interaction with families have not yet kept up with evolving evidence. A glaring gap exists too with respect to information on outcomes on the long-term care facility workforce, where a distressing proportion of cases and deaths have been logged among patients.[112]

Poverty and livelihoods

A UN Women study in the Asia Pacific region indicates that significantly more women are reporting a decrease in formal employment than men due to COVID-19 mitigation policies, definitions of essential workers, workforce demographics, nature of work with social distancing, etc. (unlike former economic crises that affected men more).[29] Women are also disproportionately reporting loss of support from governments, charity, agriculture, savings, and support from family and friends.[29]

COVID-19 is likely to cause the first increase in global poverty since 1998 (Asian Financial Crisis).[27] Though Sub-Saharan Africa so far has been hit relatively less by the virus from a health perspective, it could be hit hardest in terms of increased extreme poverty. The three countries with the largest change in the number of poor are estimated to be India (12 million), Nigeria (5 million) and the Democratic Republic of Congo (2 million).[27]

42–66 million children could fall into extreme poverty due to the socioeconomic impacts of the pandemic, adding to the estimated 386 million children already in extreme poverty.[28]

Retrogression with 'backdoor' legislation

Human rights are coming under attack during the COVID-19 pandemic. In addition to violations of the International Health Regulations by a number of countries,[113] some are pushing through retrogressive backdoor legislation. For example, some countries are pulling back on abortion laws,[6] restricting sexual and reproductive health and rights education,[7] using border closings and lockdowns to push through legally dubious, hard-line migration policies,[8] and legislation to censor the media and public protests by limiting freedom of expression, political demonstrations and independent media.[9,10]

Without a concerted global effort to ensure essential health services, sustainable development and human rights throughout the COVID-19 pandemic and beyond, decades of progress on women's, children's and adolescents' health and rights may be reversed, with significant risks to global and national security and sustainable development, and millions of lives lost or adversely affected.

THE IMPORTANCE OF LEADERSHIP AND PEOPLE'S VOICE FOR ACCOUNTABILITY

The COVID-19 pandemic and our collective response to it has provided a compacted illustration of accountability in action. For example, it raises questions about: data, including how they are generated, validated and shared, what they mean and who decides; fair and equitable access to quality services; whether political leaders are guided by science and evidence; how to manage the economic and social impact of the health response; the inevitable recriminations and debate about health systems preparedness; and the voluntary (or involuntary) forfeit of individual freedoms and liberty in lockdown.

The course of the pandemic has vividly illustrated the role of accountability and the multifaceted way in which governments, decision-makers and health providers can be held to account. Accountability is difficult to embed into the socio-political culture of health and development in a structured way; from the COVID-19 experience, we see that gains made are fragile and can erode quickly. Accountability relies on public support and engagement, which in turn relies on open and transparent information and sound institutions. To enable accountability, political leadership needs to be clear but open to criticism. Decisive political leadership and strong public engagement can be the difference between an optimal response and a suboptimal one.

Women political leaders attracted praise during the COVID-19 pandemic for the effectiveness of their countries' responses[114] and for taking into account the experiences and needs of women, children and adolescents. This was highlighted at the EWEC women leaders round table in May 2020.[115] It raises the issue of whether a more informed response (i.e. one with gender-disaggregated data, and planning for and addressing potential impacts of COVID-19 on women, children and adolescents) is made when women have leadership roles and equal decision-making power in governments. Denmark, Finland, Germany, Iceland, New Zealand and Taiwan all have female leaders, and were among countries with the lowest COVID-19 death rates (mid-May 2020).[114] Decisive action was a feature of female leaders' responses. For example, German Chancellor Angela Merkel alerted her country early to the possibility that the virus would infect up to 70% of the population. Germany's policy of rigorous and widespread testing from an early date was credited with keeping the number of deaths from COVID-19 much lower than in neighboring countries.[114] These women leaders also championed innovation and the use of technology and social media to engage the public, including children and adolescents. Sanna Marin, prime minister of Finland and the world's youngest head of state, championed the use of social media influencers to spread information about the pandemic. Women leaders also specifically engaged with children, for example organizing press conferences to hear from them and respond to their questions.[116-118]

To engage the public – and to make accountability for women's, children's and adolescents' health more valid and valuable – people's voice, their lived

Mass protests clamoring for racial justice in both health and policing in the United States (and around the globe) have laid bare how central accountability is to achieving the SDGs and a fairer world.

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experiences, needs and priorities need to be included at every opportunity. However, *voice* does not equate to *accountability* if there is no one to listen, act and respond.[53] Some states and global actors are putting in place measures to do this and use people's input to effect remedies and catalyze positive transformation.[53]

At time of writing, people around the world are making their voices heard – on the streets and on social media – demanding transformative change and accountability in the response to the death of George Floyd in Minneapolis on 25 May 2020 while in police custody. The protests in the US and other countries against racial injustice are a powerful example of how public opinion, freely expressed, aims to hold governments and institutions to account. Protests alone are insufficient for effective accountability. This requires effective democratic process, including in elections, and whole of government, whole of society remedies and actions to ensure that the required structural and systems changes are being made for genuine, meaningful progress.

Attention to people's lived experiences and voice is essential for good governance and accountability, but is often lacking in political leadership. In the UHC declaration and the World Health Assembly resolution on COVID-19, member states made commitments that: "people's engagement, particularly of women and girls, families and communities, and the inclusion of all relevant stakeholders is one of the core components of health system governance"[119] and "to strengthen actions that involve women's participation in all stages of decision-making processes, and mainstream a gender perspective in the COVID-19 response and recovery".[119]

In the human rights framework, governments have a legal obligation to ensure all individuals and communities have the knowledge, means and a range of opportunities to participate in decision-making related to their health and rights.[120] Custodians of accountability – such as parliamentarians, civil society organizations (CSOs) and media – should all be able to participate effectively, reflect citizens' lived experience and needs, and amplify their voices. For example, in 2019 the Community of Practitioners on Accountability and Social Action in Health (COPASAH)[121] adopted a Charter and Call to Action for Social Accountability for Health[122] (see Box 2). Among other actions, constituencies are called on to engage communities in health governance and promote gender and social equity in social accountability processes and mechanisms.

BOX 2

SOCIAL ACCOUNTABILITY IN ACTION: THE COMMUNITY OF PRACTITIONERS ON ACCOUNTABILITY AND SOCIAL ACTION IN HEALTH (COPASAH)

COPASAH is a global network of community practitioners. It has worked on accountability and social action in health since 2011 and is an example of how effective social accountability can complement and reinforce top-down monitoring approaches. The network strengthens accountability links between communities and health systems in order to improve the quality of health care, primarily in Africa, Asia and Latin America. It builds the knowledge, skills and capacity of community-oriented organizations and health activists.

In October 2019, COPASAH adopted a Charter and Call to Action for Social Accountability for Health at the Global Symposium on Citizenship, Governance and Accountability in Health. This was a response to growing levels of inequality and inequity in healthcare. A particular focus was sexual and reproductive health and rights. Other issues of concern were poor transparency in programmes, governments and the private sector, and the lack of active engagement of citizens in health. Going forward, COPASAH will lobby for socially responsive regulation, patients' rights and legal entitlements, and equitable social accountability processes and mechanisms.

DEVELOPING THE IAP REPORT AND RECOMMENDATIONS TO REVITALIZE ACCOUNTABILITY

The IAP is mandated to review independently if governments, development partners and all key stakeholders are meeting their commitments to identify good practices so they can be replicated, and to highlight gaps and challenges requiring urgent remedy and action.[1a,123,124] This year, the IAP considers emerging evidence of the impact of the COVID-19 pandemic on the health and rights of women, children and adolescents, including their access to UHC and multisectoral services, which are summarized by the Survive, Thrive, Transform indicators of the EWEC Global Strategy in Box 1. Work for this report began before COVID-19, however, impacts of the pandemic (in both real time and in the projected implications) have been considered throughout this report, and reflected particularly in the first and final chapters.

Development of the IAP 2020 report was informed by a range of sources and methods (see Annex). To start, a review and narrative synthesis of the literature focused on the impact of accountability platforms, mechanisms, actions, or activities in countries.[53] Chapter 2 includes statistical review and analysis of the latest available global estimates for the 16 key indicators of the EWEC Global Strategy and key governance, accountability and data indicators. Using scorecards, countries are categorized by income categories, distinguishing between those that have surpassed global targets and those catching up. Factors for success that differentiate better performing countries are also analyzed. Five country case studies (chapter 3) were developed using data and document reviews, key informant interviews, focus groups and multistakeholder dialogues. The IAP's accountability framework and recommendations (chapter 4) were informed by the findings of these methods and developed to strengthen accountability in the context of UHC and the SDGs, to mitigate the impacts of COVID-19 and accelerate progress towards realizing women's, children's and adolescents' health and rights.

Chapter

2

INTRODUCTION

Fast lane, slow lane – countries with similar resources achieve different results

Caught in the COVID-19 storm: women's, children's, and adolescents' health in the context of UHC and the SDGs

RESULTS DEPEND ON MORE THAN COUNTRY RESOURCES

This chapter examines whether all countries are ensuring progressive realization of women's, children's and adolescents' health, related SDGs[1] and rights. Progressive realization means governments should continually make progress on health and related rights, and need to justify any reversal of spending or gains.[51,52] For their part, private sector, donors and development partners should (1) 'do no harm' (they should not create obstacles for states); and (2) provide assistance and technical cooperation to help countries make progress on health targets.

With this objective, the chapter queries whether in order to achieve EWEC targets, countries have the required data capacities, enact evidence-based policies and legislation, make the right investments in UHC, ensure multisectoral progress, use innovation and technology, and show leadership to achieve the required results. Although most of the data presented in this chapter are pre-COVID-19, reference is made to the implications of the current pandemic.

All governments are obligated to take steps, individually and through international co-operation, to the maximum of available resources progressively to achieve the right to health for all.[125] This is the human rights principle of progressive realization.[51,52] Not all countries have the same available resources. For example, whilst health spending per person was the highest in the US and Switzerland, USD 10,246 and USD 8,217 respectively in 2017, adjusted for purchasing power parity it was the lowest in Democratic Republic of Congo (DRC) with USD 37 and in Central African Republic at USD 42 in the same year.[32] Therefore, to track progress and assess accountabilities for women's, children's and adolescents' health and rights, the IAP assessed countries within the same income category (Table 1).[30] This approach ensures greater comparability across countries and reflects an understanding that resource constraints – financial, health workforce and others – in turn constrain the realization of people's right to health. For the scorecards (Table 1) countries were grouped by World Bank income-group categories, as a proxy for resources more broadly.

Table 1. Country scorecards, by income category, on women's, children's and adolescents' health in the context of UHC and the SDGs

Rank within income category based on under-five mortality rate	UNITED NATIONS MEMBER STATE	DEATHS DURING PREGNANCY AND CHILDBIRTH, CHILDHOOD AND ADOLESCENCE (global estimates)					CIVIL REGISTRATION AND VITAL STATISTICS (CRVS)	
		Maternal mortality ratio (per 100 000 live births), 2017[34]	Stillbirth rate (per 1000 total births), 2015[77]	Neonatal mortality rate (per 1000 live births), 2018[33]	Under-five mortality rate (per 1000 live births), 2018[33]	Adolescent mortality rate age 10-19 years (per 100 000 population), 2016[79]	Birth registration (proportion of children under 5 years with civil authority registered births), 2010-2019[101]	Death registration (completeness of cause-of-death data), 2010-2017[38]
HIGH INCOME COUNTRIES								
1	Finland	3	1,8	1,0	1,7	19	100	100
2	San Marino	..	2,5	0,9	2,0	..	100	100
3	Iceland	4	1,3	1,0	2,0	26	100	100
4	Slovenia	7	2,9	1,2	2,1	19	100	100
5	Cyprus	6	3,6	1,4	2,4	15	100	68
6	Luxembourg	5	2,8	1,4	2,4	13	100	100
7	Japan	5	2,1	0,9	2,5	14	100	100
8	Norway	2	2,2	1,5	2,5	15	100	100
9	Estonia	9	2,7	1,2	2,6	30	100	100
10	Sweden	4	2,8	1,5	2,7	15	100	100
11	Singapore	8	2,6	1,1	2,8	15	100	66
12	Andorra	..	1,6	1,4	2,9	..	100	100
13	Italy	2	3,3	2,0	3,0	16	100	100
14	Spain	4	2,9	1,7	3,0	13	100	100
15	Republic of Korea	11	2,1	1,5	3,2	17	..	100
16	Monaco	..	5,7	1,7	3,2	..	100	100
17	Czechia	3	2,5	1,8	3,4	19	100	100
18	Austria	5	3,6	2,1	3,5	20	100	100
19	Belgium	5	3,0	2,0	3,7	18	100	100
20	Ireland	5	2,7	2,3	3,7	17	100	100
21	Germany	7	2,4	2,2	3,7	16	100	100
22	Australia	6	2,7	2,3	3,7	20	100	100
23	Israel	3	4,2	1,9	3,7	18	100	100
24	Portugal	8	2,2	2,1	3,7	17	100	100
25	Latvia	19	3,6	2,0	3,9	32	100	100
26	Netherlands	5	1,8	2,1	3,9	13	100	100
27	Lithuania	8	3,2	2,1	4,0	39	100	99
28	France	8	4,7	2,5	4,0	15	100	100
29	Switzerland	5	2,8	2,9	4,1	16	100	100
30	Denmark	4	1,7	3,1	4,2	12	100	100
31	United Kingdom	7	2,9	2,6	4,3	17	100	100
32	Hungary	12	3,7	2,3	4,3	22	100	100
33	Poland	2	2,3	2,7	4,4	27	100	100
34	Greece	3	3,6	2,6	4,5	19	100	100
35	Croatia	8	2,0	2,6	4,7	21	100	100
36	Canada	10	3,1	3,4	5,0	22	100	100
37	Slovakia	5	2,9	2,8	5,6	26	100	100
38	New Zealand	9	2,3	3,5	5,7	34	100	100
39	Antigua and Barbuda	42	6,4	3,4	6,4	53	..	83
40	United States of America	19	3,0	3,5	6,5	34	100	100
41	Qatar	9	5,8	3,5	6,8	38	100	50
42	Malta	6	3,5	4,7	7,0	18	100	100
43	Saudi Arabia	17	13,9	3,7	7,1	52	..	42
44	Bahrain	14	5,5	3,0	7,1	30	100	96
45	Chile	13	3,1	4,9	7,2	31	99	95
46	Uruguay	17	6,6	4,5	7,6	50	100	100
47	United Arab Emirates	3	7,4	4,0	7,6	38	100	59
48	Kuwait	12	5,1	4,5	7,9	36	..	59
49	Bahamas	70	10,3	5,4	10,2	45	..	89
50	Oman	19	8,5	5,1	11,4	37	100	74
51	Brunei Darussalam	31	6,5	5,5	11,6	24	..	100
52	Saint Kitts and Nevis	..	7,5	7,9	12,0	..	..	88
53	Barbados	27	8,5	7,9	12,2	36	99	79
54	Seychelles	53	9,5	8,8	14,5	36	..	91
55	Panama	52	6,1	8,5	15,3	77	96	92
56	Palau	..	8,4	9,4	17,9	..	..	95
57	Trinidad and Tobago	67	11,1	11,7	18,3	93	97	83
	Liechtenstein	..	..	..	..	..	100	..
UPPER MIDDLE INCOME COUNTRIES								
1	Montenegro	6	3,9	1,7	2,5	22	99	..
2	Belarus	2	3,0	1,3	3,4	27	100	100
3	Cuba	36	6,2	2,1	5,0	29	100	100
4	Serbia	12	6,0	3,4	5,5	15	99	94
5	Bosnia and Herzegovina	10	5,4	4,1	5,8	18	..	95
6	Bulgaria	10	5,7	3,6	7,1	34	100	100
7	Russian Federation	17	4,5	3,2	7,2	44	100	100
8	Romania	19	4,1	3,4	7,3	32	100	100
9	Lebanon^	29	9,9	4,3	7,4	26	..	..
10	Sri Lanka	36	4,9	4,5	7,4	53	..	..
11	Malaysia	29	5,8	4,3	7,8	50	..	52
12	China	29	7,2	4,3	8,6	29	..	62
13	Maldives	53	7,7	4,8	8,6	39	99	91
14	Costa Rica	27	6,0	5,9	8,8	44	100	87
15	Albania	15	4,0	6,5	8,8	48	98	53
16	Thailand	37	5,0	5,0	9,1	73	100	87
17	Georgia	25	11,2	5,9	9,8	45	100	90
18	Republic of North Macedonia	7	7,7	7,4	9,9	23	100	100
19	Kazakhstan	10	6,5	5,6	9,9	51	100	87
20	Argentina	39	4,6	6,4	9,9	55	100	100
21	Turkey	17	7,0	5,5	10,6	52	98	92
22	Libya^	72	8,8	6,4	12,0	100	..	..
23	Armenia	26	13,8	6,5	12,4	32	99	100
24	Mexico	33	5,5	7,5	12,7	47	95	100
25	Belize	36	9,8	8,6	13,0	71	96	89
26	Colombia	83	8,1	7,8	14,2	107	97	80
27	Ecuador	59	7,7	7,2	14,2	75	82	82
28	Peru	88	9,0	7,3	14,3	50	98	57
29	Brazil	60	8,6	8,1	14,4	87	96	99
30	Iran (Islamic Republic of)	16	6,4	8,9	14,4	37	99	90
31	Jamaica	80	18,8	10,2	14,4	57	98	94
32	Grenada	25	8,0	9,9	15,2	37	..	100
33	Mauritius	61	9,5	9,2	15,5	42	..	100
34	Tonga	52	8,6	6,5	15,6	34	93	..
35	Samoa	43	11,1	8,3	15,8	28	59	..
36	Jordan	46	10,5	9,5	16,2	48	98	56
37	Saint Vincent and the Grenadines	68	10,7	9,7	16,4	79	..	100
38	Saint Lucia	117	12,1	12,4	16,6	62	92	97
39	Suriname	120	19,3	10,0	18,9	63	98	80
40	Paraguay	84	13,4	10,7	20,2	76	69	88
41	Azerbaijan	26	16,5	11,2	21,5	39	..	..
42	Algeria	112	19,3	14,6	23,5	48	100	..
43	Tuvalu^	..	13,8	15,7	24,4	..	..	..
44	Venezuela (Bolivarian Republic of)^	125	7,1	15,1	24,5	125	81	89

Key: Surpassed; Advanced; Intermediate; Catching up; No data available

Rank within income category based on under-five mortality rate	UNITED NATIONS MEMBER STATE	DEATHS DURING PREGNANCY AND CHILDBIRTH, CHILDHOOD AND ADOLESCENCE (global estimates)					CIVIL REGISTRATION AND VITAL STATISTICS (CRVS)	
		Maternal mortality ratio (per 100 000 live births), 2017[34]	Stillbirth rate (per 1000 total births), 2015[77]	Neonatal mortality rate (per 1000 live births), 2018[33]	Under-five mortality rate (per 1000 live births), 2018[33]	Adolescent mortality rate age 10-19 years (per 100 000 population), 2016[79]	Birth registration (proportion of children under 5 years with civil authority registered births), 2010-2019[101]	Death registration (completeness of cause-of-death data), 2010-2017[38]
45	Fiji	34	11,9	10,9	25,6	63	..	100
46	Guatemala	95	11,9	12,3	26,2	79	96	100
47	Iraq^	79	15,5	15,3	26,7	143	99	65
48	Dominican Republic	95	11,1	19,4	28,8	63	88	58
49	Guyana	169	17,2	18,2	30,1	99	89	90
50	Nauru	..	15,5	19,9	31,8	..	96	..
51	Marshall Islands^	..	15,6	15,5	33,1	..	84	..
52	South Africa	119	17,4	10,7	33,8	134	89	92
53	Dominica	..	11,6	28,3	35,7	..	..	100
54	Botswana	144	15,2	24,5	36,5	138	88	..
55	Namibia	195	11,3	15,6	39,6	147	78	..
56	Gabon	252	14,0	21,0	44,8	217	90	..
57	Turkmenistan	7	17,0	21,0	45,8	64	100	85
58	Equatorial Guinea	301	16,2	29,9	85,3	203	54	..
LOWER MIDDLE INCOME COUNTRIES								
1	Ukraine	19	8,8	5,2	8,7	37	100	92
2	El Salvador	46	12,2	6,7	13,7	105	99	93
3	Republic of Moldova	19	7,9	11,9	15,8	36	100	80
4	Mongolia	45	7,3	8,7	16,3	39	100	84
5	Tunisia	43	9,2	11,5	17,0	32	100	29
6	Honduras	65	12,6	9,6	17,6	75	94	14
7	Nicaragua	98	7,4	9,4	18,3	78	85	79
8	Kyrgyzstan	60	10,2	13,2	18,9	45	99	91
9	Cabo Verde	58	14,3	11,6	19,5	46	91	93
10	Solomon Islands^	104	17,6	8,2	20,0	52	88	..
11	Viet Nam	43	10,1	10,6	20,7	50	96	..
12	Egypt	37	12,2	11,2	21,2	68	99	94
13	Uzbekistan	29	12,0	11,6	21,4	51	..	93
14	Morocco	70	24,5	13,8	22,4	34	96	29
15	Indonesia	177	13,2	12,7	25,0	74	72	..
16	Vanuatu	72	13,9	11,5	26,4	49	43	..
17	Bolivia (Plurinational State of)	155	12,9	14,3	26,8	111	92	..
18	Cambodia	160	11,9	14,4	28,0	75	73	..
19	Philippines	121	10,9	13,5	28,4	84	92	89
20	Bhutan	183	16,0	16,4	29,7	105	100	..
21	Bangladesh	173	25,4	17,1	30,2	63	56	..
22	Micronesia (Federated States of)^	88	17,8	16,0	30,8	67	..	..
23	Sao Tome and Principe	130	16,3	14,0	31,2	103	95	..
24	India	145	23,0	22,7	36,6	84	80	10
25	Kenya	342	22,5	19,6	41,1	148	67	..
26	Senegal	315	24,5	20,6	43,6	143	77	..
27	Timor-Leste^	142	17,8	20,4	45,8	73	60	..
28	Myanmar^	250	20,0	23,1	46,2	87	81	..
29	Zimbabwe^	458	20,6	20,9	46,2	196	49	..
30	Lao People's Democratic Republic	185	23,7	22,7	47,3	85	73	..
31	Papua New Guinea^	145	15,9	22,1	47,8	76	13	..
32	Ghana	308	22,7	23,9	47,9	157	71	..
33	Congo^	378	15,1	20,3	50,1	160	96	..
34	Kiribati^	92	16,3	22,8	52,5	89	..	..
35	Eswatini	437	12,3	17,2	54,4	227	54	..
36	Zambia	213	20,9	23,5	57,8	199	14	..
37	Djibouti	248	34,6	31,7	59,3	193	..	..
38	Sudan^	295	24,4	28,6	60,5	127	67	..
39	Comoros^	273	30,5	31,6	67,5	114	87	..
40	Pakistan	140	43,1	42,0	69,3	102	42	..
41	Mauritania	766	27,1	33,5	75,7	106	66	..
42	Cameroon^	529	19,6	26,6	76,1	266	66	..
43	Angola	241	27,3	28,5	77,2	163	25	..
44	Côte d'Ivoire	617	26,7	33,5	80,9	337	72	..
45	Lesotho	544	19,5	34,9	81,1	242	45	..
46	Nigeria^	917	42,9	36,0	119,9	254	43	..
LOW INCOME COUNTRIES								
1	Syrian Arab Republic^	31	11,1	8,8	16,7	345	..	83
2	Democratic People's Republic of Korea	89	13,5	9,7	18,2	59	..	..
3	Nepal	186	18,4	19,9	32,2	56	56	..
4	Tajikistan	17	14,0	15,0	34,8	26	96	87
5	Rwanda	248	17,3	15,9	35,3	146	56	..
6	Eritrea^	480	22,5	18,4	41,9	100	..	..
7	Uganda	375	21,0	19,9	46,4	222	32	..
8	Malawi	349	21,8	22,4	49,7	161	6	..
9	United Republic of Tanzania	524	22,4	21,3	53,0	164	26	..
10	Madagascar	335	18,2	20,6	53,6	142	78	..
11	Yemen^	164	29,0	27,0	55,0	113	31	..
12	Ethiopia	401	29,7	28,1	55,2	162	3	..
13	Gambia^	597	23,9	26,3	58,4	172	58	..
14	Burundi^	548	26,6	21,7	58,5	282	84	..
15	Afghanistan^	638	26,7	37,1	62,3	191	42	..
16	Haiti^	480	24,9	26,0	64,8	195	85	..
17	Togo	396	34,2	24,9	69,8	223	83	..
18	Liberia^	661	21,4	24,5	70,9	179	25	..
19	Mozambique	289	19,1	27,8	73,2	224	55	..
20	Burkina Faso^	320	21,2	24,7	76,4	221	77	..
21	Guinea-Bissau^	667	36,7	36,6	81,5	162	24	..
22	Niger^	509	36,7	25,2	83,7	304	64	..
23	Democratic Republic of the Congo^	473	27,3	28,3	88,1	243	25	..
24	Benin	397	30,3	31,3	93,0	207	86	..
25	Mali^	562	32,5	32,7	97,8	232	87	..
26	South Sudan^	1150	30,1	40,0	98,6	203	35	..
27	Guinea	576	21,1	31,1	100,8	217	62	..
28	Sierra Leone	1120	24,4	32,8	105,1	279	81	..
29	Central African Republic^	829	34,4	41,2	116,5	280	61	..
30	Chad^	1140	39,9	34,2	119,0	322	12	..
31	Somalia^	829	35,5	37,5	121,5	239	..	..

Key Surpassed · Advanced · Intermediate · Catching up · No data available

United Nations member states are shown. Member states are listed in rank-order based on under-five mortality rate -the mortality indicator with the most underlying primary country data available for monitoring.

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

Targets used to determine progress are based on SDG/ENAP global and country targets for the year 2030. 'Surpassed' countries have achieved or surpassed the SDG/ENAP global or country target. Per indicator, countries (with available data) that fell short of the target were split into the following tertiles: 'advanced' countries (top 1/3); 'intermediate' countries (middle 1/3); 'catching up' countries (bottom 1/3). Adolescent mortality has no global/country target and color coding refers to quartiles.

^ Denotes fragile & conflict-affected situations. In countries experiencing high-intensity conflicts, including the Syrian Arab Republic and Yemen, statistics may reflect the pre-conflict situation.

For technical notes please refer to Annex 3.3.

Table 1 indicates that women and children in countries with access to similar economic resources can experience different health outcomes. For example, the US spends more than twice as much on health than either Japan or France,[32] yet children in the US are more likely to die before their fifth birthday[33] and women are more than twice as likely to die in childbirth.[34] Nigeria spends around twice per capita on health than Tanzania (2017 current health expenditure per capita of 74 USD and 34 USD respectively)[32] and service coverage is around the same (around 40 on the UHC service coverage index). But Nigeria has over double the child mortality rate as Tanzania (120 and 53 deaths per 1 000 live births respectively).[33] This reflects significant underlying sub-national inequalities, critical gaps in health and multisectoral service delivery and financial protection, governance and other factors, as further analyzed in following sections, that require urgent remedy and action.

CRITICAL CHALLENGES

COUNTRIES IN FRAGILE AND CONFLICT-AFFECTED SITUATIONS (FCS)

FCS countries[35] make significantly less progress (see Table 1) and usually have significantly less available resources and ability to invest. Maternal, child and adolescent mortality is estimated to be particularly high in these contexts (Table 1). The median child mortality in FCS is 58 per 1 000 live births, versus 14 per 1 000 in other countries. Further, 7 of the 10 countries with the highest estimated child mortality globally are FCS. The mortality rates in these countries may be underestimated due to gaps in monitoring and breakdown in data collection systems: the latest reliable data on the under-five mortality rate in the Syrian Arab Republic are from a survey conducted in 2007–2008, prior to the start of the war, though the reclassification of its income status is from 2020 – hence an apparent discrepancy with it appearing at the top of the low-income country category. Although child mortality estimates in Table 1 include an estimate of direct crisis deaths, they do not reflect the breakdown in health systems caused by the conflict.[33] Similarly, the latest reliable data for Yemen pertain to 2011, and for Somalia, the country furthest behind in Table 1, the latest data were collected in 2006 and pertain to 2003.[33]

A CONTINUING CRISIS OF DATA

Data emerging from countries on COVID-19 have generally been incomplete, with unprecedented all-cause death rates (in countries with high-quality death registration systems) revealing substantial undercounts. They are rarely gender- and age-disaggregated.[41] This patchy reporting of COVID-19 cases and deaths sheds light on the long-standing challenges of poor-quality data systems. Nine years after the Commission on Information and Accountability recommended that all countries take significant steps to establish systems for registration of births, deaths and causes of death,[126] unacceptable gaps remain in civil registration and vital statistics (CRVS) and health information systems (HIS). Investment in timely and accurate CRVS is critical to the Monitor, Review, Remedy, Act cycle of accountability.[40] Indeed, quality of country death registration is associated with health outcomes, independent of country wealth, health system access and development status.[36] Only 93 of 193 countries are currently able to register more than 80% of adult deaths (Table 1), and less than one-third of countries have high-quality cause-of-death data.[38]

As a result, countries must monitor maternal and child mortality using other sources, such as household survey data. Survey data are less timely, less accurate than complete death registration, and conceal actionable public health information such as detail on causes of death. Global actors develop estimates that are invaluable to compare and interpret country progress, but their quality is only as good as the monitoring data upon which they are based.[39,40] There continues to be an over-reliance on global estimates and modelling to assess country risks and progress, which is not helpful, and can be confusing, for context-specific investment, implementation, and reviews of progress.

Progress on birth registration will need to be accelerated to meet the target of universal birth registration: today 1 in 4 children under age 5 are not registered (166 million), in violation of their human rights.[37] There is also a paucity of disaggregated data as envisaged in SDG 17.18.1 (by age, sex, socioeconomic status, ethnicity, urban rural differences and other considerations) to identify who is being left behind and in greatest need. For example, sex disaggregation is currently available for less than half (11/28) of relevant SDG indicators at global level, where it would be relevant.[38] The IAP wanted to analyse country data using a life course approach to health, including considerations of people's health, well-being and enabling environments – at and across all life phases (e.g. early risk exposures and later health impacts).[127] Currently, country data and global estimates are not considered in this way. This reduces countries' ability to target investments towards those with the greatest health risks and needs, and to assess if investments are having the desired impact towards the realization of people's health and rights at all ages.

Data gaps have been a serious security risk during the COVID-19 pandemic – within and across countries. The lack of relevant data constrains governments' abilities to make informed decisions to ensure people's health and well-being at all ages (SDG 3)[1] and secure livelihoods, through the COVID-19 pandemic and beyond.

There is a need for more research and better understanding of risks and case definitions on COVID-19 specific to women's, children's and adolescents' health.[75] On one hand, there are indications of minimal risk for uncomplicated pregnancies, but on the other, serious concerns for pregnancies with existing complications and for pregnant women with COVID-19. Questions remain on the effect of COVID-19 in early pregnancy and on fetal development. Pregnant women are not yet included in clinical trials, and there is a lack of research protocols for pregnant COVID-19 patients.[75,128]

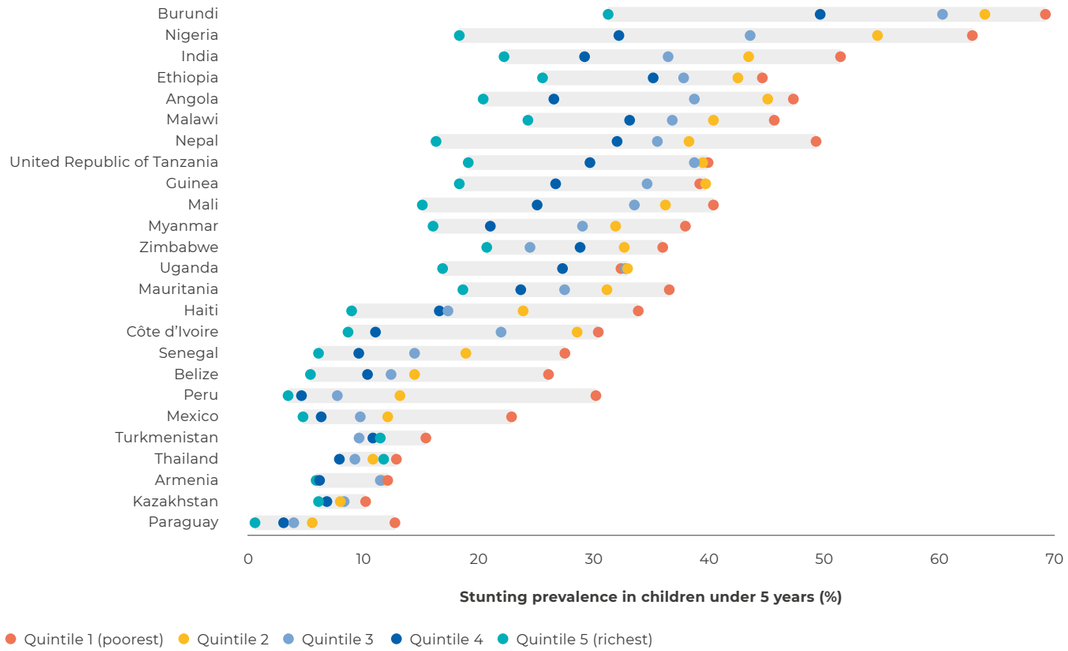
INEQUITIES BETWEEN AND WITHIN COUNTRIES

There are vast inequities in health service coverage and health outcomes for women's, children's and adolescents' health as highlighted in Chapter 1 and Box 1. Inequities are apparent in multisectoral outcomes too; for example in Burundi, children under 5 years in the poorest wealth quintile have more than twice the prevalence of stunting than those in the richest quintile (Figure 1).[129]

Every woman, child and adolescent counts and has the right to be counted. Making them ALL count is fundamental to accountability.

Elizabeth Mason, IAP Member

Figure 1. Stunting prevalence in children under 5 years in low- and middle-income countries, by wealth quintile



Source: Health Equity Monitor. Most recent data from 2015-2017 from re-analysis of Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) and Reproductive Health Surveys (RHS) micro-data are shown. The analysis was done by the WHO Collaborating Center for Health Equity Monitoring (International Center for Equity in Health, Federal University of Pelotas, Brazil).

The pandemic has exacerbated existing health inequities and highlighted new or emerging ones. For example, women migrant workers have long been known to face many health risks while enjoying few health protections.[130] Lockdowns resulting from COVID-19 have severely disrupted their employment and access to health care. COVID-19 is taking an alarming toll on black and other racial and ethnic groups in North America and Europe, resulting in disparity of both morbidity and mortality.[44,45] A number of factors feed into this disparity, including both heightened vulnerability and greater exposure to the socioeconomic and environmental risks that exacerbate poor health, lack of access to health, water and sanitation services, and a greater likelihood of working in unsafe or insecure employment.[131,132]

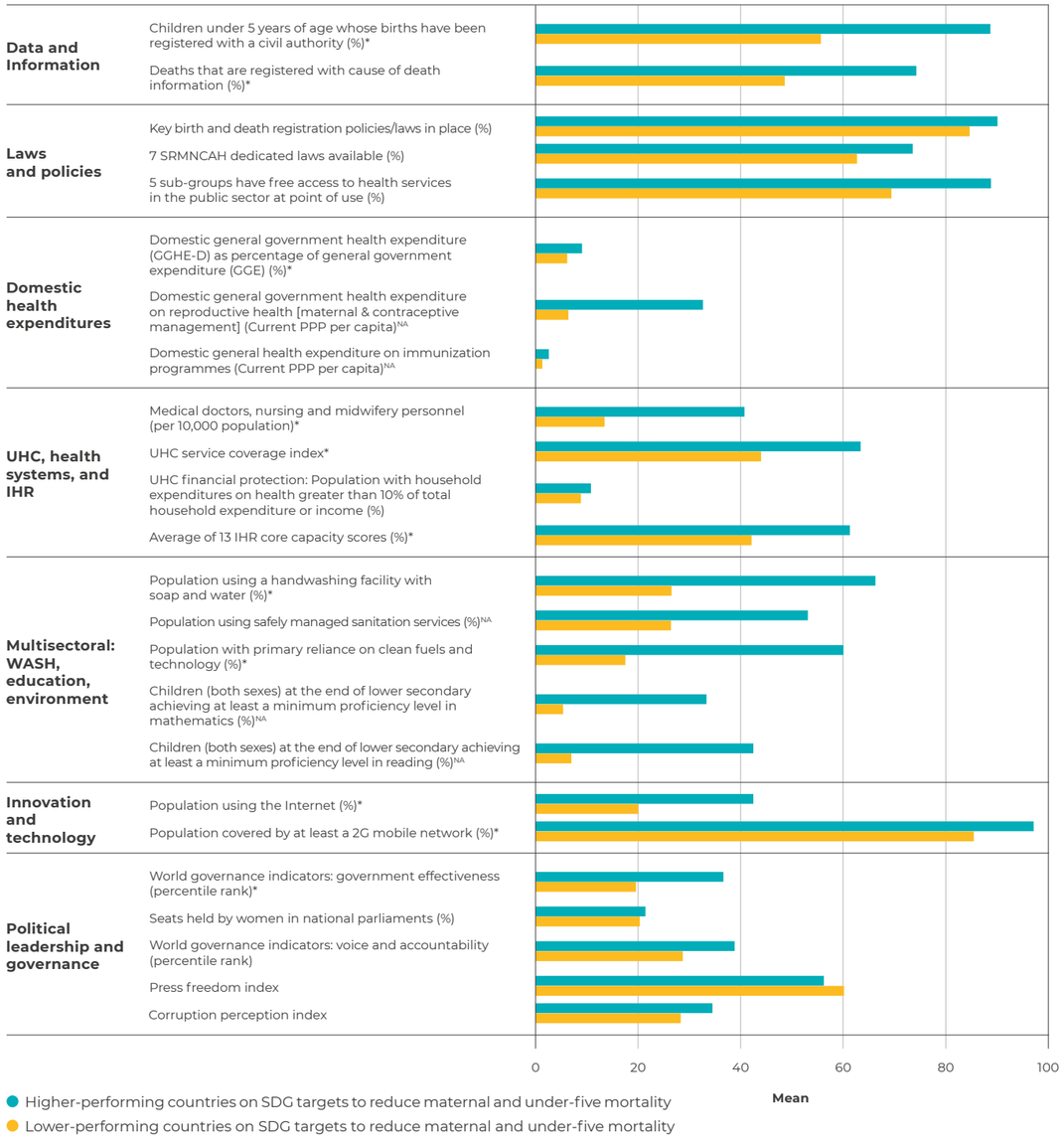
In country after country, the struggles of informal and migrant workers, women and girls prominent among them, to survive through the COVID-19 pandemic show how fragile existing accountability mechanisms are in shielding those most at risk and most vulnerable.

Gita Sen, IAP Member

FACTORS FOR SUCCESS

Sufficient spending on health is associated with better outcomes, but countries' progress also depends on factors beyond financial resources. Higher-performing countries are those making the best, evidence-based use of their resources. Figure 2 illustrates that countries performing better on meeting SDG targets to reduce maternal and child mortality, are also performing better on a range of evidence-based factors for success across the following categories: data and information; laws and policies; domestic health expenditures; UHC, health systems and IHR core capacities; multisectoral factors with water, sanitation and hygiene (WASH), education and environment; innovation and technology; and governance and accountability. These findings reinforce those from MDG studies that both health and multisectoral factors contribute around 50-50 to improving the health of women, children, and adolescents, and emerging evidence from countries in the SDG era highlights what works in multisectoral collaboration, including leadership.[49,50]

Figure 2. Factors for success correlated with higher- and lower-performing countries in reducing maternal and under-five mortality (lower-middle and low income countries)



In this figure, low and lower-middle income countries were assessed to see whether they met SDG targets for both under-five mortality (country target: 25 per 1,000 live births) and maternal mortality (global target: 70 per 100,000 live births). Those countries that met or surpassed the global targets were noted. Those countries that fell short of the target were then split into tertiles based on the sum of maternal and under-five deaths per 1,000 live births.

Countries, for which data were available, were then grouped as follows: (1) 'Higher-performing countries' have met, surpassed, or are in the highest tertile of remaining countries advancing towards meeting both the child and maternal mortality SDG targets; and (2) 'Lower-performing countries' are those in the bottom two tertiles of countries that have not yet met both under-five and maternal mortality SDG targets.

For each factor for success indicator, the bars show unweighted means of latest indicator values (2000-2019) for countries in each group. P-values were estimated using Wilcoxon rank-sum tests of the hypothesis that the indicator distribution of 'higher-performing countries' is the same as that of 'lower-performing countries' (* Bonferroni adjusted p-value <0.0025; NA= Not applicable; analysis not conducted for indicators with <50 observations total or <5 observations in each group).

Statistical tests were also performed for high income and upper-middle income countries with similar results.

For methodological details, including data sources, please refer to Annex 3.4.

Some key factors notably differentiate higher- and lower-performing countries, including sufficient financing, UHC and multisectoral factors. Governments and partners need to scale up what works and address the critical, often chronic, challenges highlighted in the previous section in order to ensure progress and mitigate the adverse effects of COVID-19. Without urgent investment and action, decades of gains in women's, children's and adolescents' health and rights, and on UHC, could be lost.

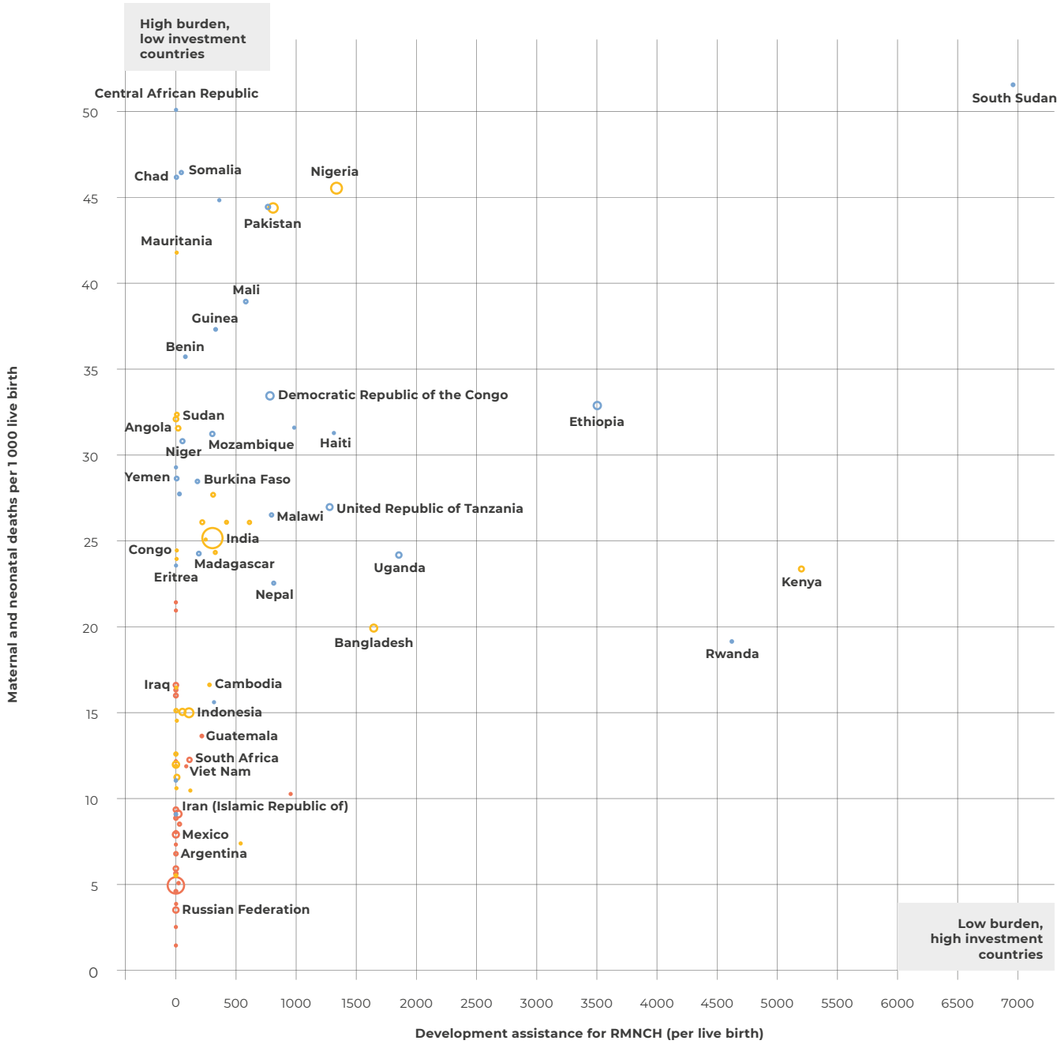
SUFFICIENT AND SMART FINANCING – DOMESTIC EXPENDITURE AND DEVELOPMENT ASSISTANCE

Country investment in UHC, with a focus on PHC, could see major improvements in women's, children's and adolescents' health. Most countries, except low-income and those in FCS, should be able to fund appropriate investments in UHC and PHC using their domestic resources; following the principle of progressive realization, they will need to increase or reallocate their investments to do so.[2] Some low-income countries, especially those affected by FCS, will continue to rely on development assistance for health, meaning that development partners must commit to directing resources to those states with the highest need.

Countries that spend the most will not necessarily achieve better results, unless they invest strategically and in an evidence-based way (for example in the indicative factors for success shown in Figure 2). As noted in chapter 1, an estimated 20–40% of health expenditure globally is wasted due to inefficiencies and corruption.[46-48] Currently this amounts to around 2 trillion USD a year.

For example, around 45% of development assistance is substandard, by one estimate.[68] This results from aid going to unwanted, overpriced and poor-quality technical assistance, failing to support country leadership and plans, not being directed to the poorest, double counting aid as debt relief, spending on students from donor countries, and tied aid.[68,69] Development assistance is also not necessarily invested in countries of greatest need (see Figure 3).

Figure 3. Development assistance for reproductive, maternal, newborn and child health (RMNCH) is not always targeted to countries with the greatest burden



Live births per year

- 112,244
- 5,000,000
- 10,000,000
- 15,000,000
- 20,000,000
- 25,169,393

World Bank Income Group

- Low income
- Lower middle income
- Upper middle income

Notes: All data are for the year 2017.

Sources: This illustrative figure includes estimates from different sources on development assistance for health,[133] neonatal mortality,[33] maternal mortality[34] and annual live births.[134]

Siloed approaches to health financing decrease health systems efficiency and responsiveness. Approaches to health financing that bring additional resources, but further fragment systems, may become obstacles to UHC and the EWEC Global Strategy, rather than enablers.[2] Relative expenditure on a specific disease should depend on the country's age and disease profile. Currently, data in the WHO's Global Health Expenditure database[32] on domestic investments in RMNCAH are limited, with data on domestic government expenditures on reproductive health and immunizations available for 45 and 50 mainly low- and middle-income countries, respectively. Data on health expenditures on children under 5 years are even more limited: data are only available for 21 countries.

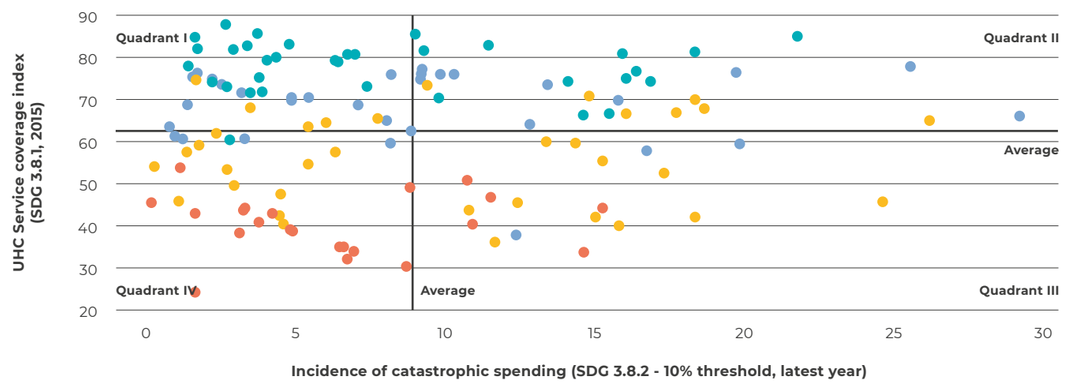
One of the smartest investments that countries can make is in PHC. Governments need to increase investments in PHC by an additional 1% of their gross domestic product (GDP).[2] Heads of health and financing agencies advise that this "can be achieved through additional investments or through efficiency and equity gains. Resources for health should be pooled, prepaid and managed efficiently. That is the surest way to move us closer to a world where everyone benefits from the human right to health."[2] Investing an additional 200 billion USD a year on scaling up PHC across low- and middle-income countries could save 60 million lives, increase average life expectancy by 3.7 years by 2030 and contribute significantly to socioeconomic development.[2]

As noted in chapter 1, there has been vast underinvestment in common goods for health over decades. These form the foundation for strong health systems that are resilient and responsive, not only to continuing population health needs, but also to emergencies.[64] The lack of these critical investments in public goods for health – both national and international – has shown up in the fault lines of the COVID-19 response, with millions of people's lives, and livelihoods, put at risk.

UHC FOR HEALTH AND FINANCIAL PROTECTION, AND THE NEED TO PROTECT HEALTH WORKERS

UHC comprises both health service coverage and financial protection. There is a risk that country efforts to increase service coverage might exacerbate catastrophic expenditure and out-of-pocket expenses for people, which does not achieve the goal of UHC. A growing number of people, and share of the population, incurred catastrophic health spending during 2000–2015.[2] Figure 4 indicates how the risk may rise as countries increase service coverage if they do not also increase financial protection.

Figure 4. Countries are at difference stages of service coverage and financial protection



Countries by World Bank income group

- Low
- Lower middle
- Upper middle
- High

Note: SDG 3.8.1 values and income group classification for 2015. SDG 3.8.2 estimates for the most recent year available.

Source: World Health Organization. Primary Health Care on the Road to Universal Health Coverage. 2019 Global Monitoring Report. Geneva: World Health Organization, 2019.

In Figure 4, countries in quadrant IV ideally should try to improve service coverage, while ensuring financial protection, to progress towards quadrant I. Taking a path through quadrants III and II would mean that improvements in service coverage are accompanied by financial hardship. Women, children and adolescents – and others who lack financial means to mitigate these risks – will be most adversely affected as a result.

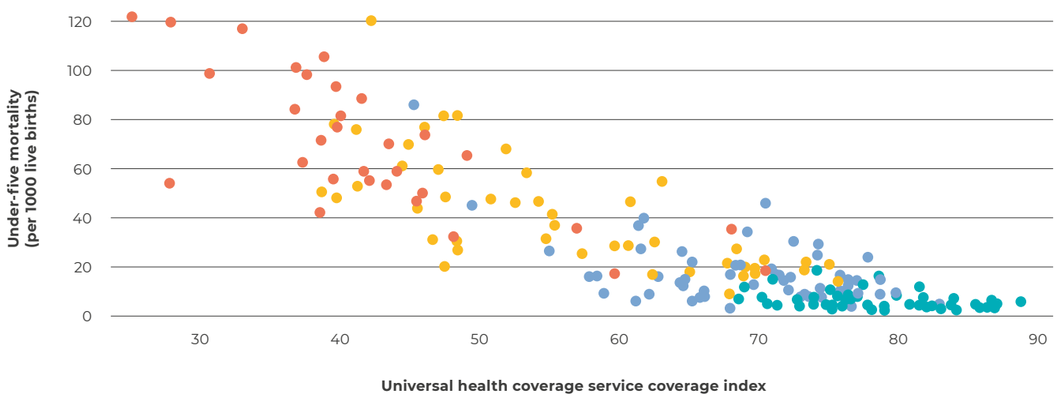
Some health financing mechanisms, such as higher reliance on out-of-pocket payments, are more likely to result in families experiencing financial hardship after accessing health services. For example, in the WHO European region, countries that rely on percentage co-payments for medications, without protection mechanisms, have higher incidence of catastrophic expenditures on health.[2]

Improving service coverage is essential to improving health. Figure 5 shows the correlation between lower child mortality and higher UHC service coverage index values, with some low-income countries achieving better outcomes than others as a result. Quality of care is also a critical consideration to ensure that services are provided in a way that responds to the needs of women, children and adolescents, and respects their rights.[61]

However, millions of children and adolescents are not reached with life-saving interventions. For example, in 2018, around 19 million infants worldwide did not get routine immunization services. Around 60% of these children live in 10 countries: Angola, Brazil, the Democratic Republic of the Congo, Ethiopia, India, Indonesia, Nigeria, Pakistan, the Philippines and Viet Nam.[135] The COVID-19 pandemic had exacerbated the situation for several million children, who are missing access to life-saving vaccines.[136] Box 3 highlights the importance of adolescents being able to access sexual and reproductive health information and services.

As the COVID-19 crisis has shown, the health of health workers also has to be safeguarded. Compelling evidence is rapidly accumulating on the toll taken by COVID-19 on health workers in both the formal and informal sectors, and the fact that frontline workers operate in a diverse group of industries, many of which mostly employ women.[111] Evidence is emerging that female health workers are more likely than their males colleagues to be infected by COVID-19, and more likely than them to experience psychological distress and stress.[137-139] They are also more likely to be disadvantaged when it comes to access to workplace safety, as PPE is rarely proportioned to women's bodies.[112] Workplace guidelines for issues such as pregnancy and interaction with families has yet to catch up with evolving evidence. There is also a conspicuous gap in evidence on outcomes among the workforce in facilities that provide long-term care. In these settings, health workers face greater exposure due to the high proportion of infections and deaths among patients.[140]

Figure 5. Lower under-five mortality is correlated with higher UHC service coverage index values even for countries within the same income category



Countries by World Bank income group ● Low income ● Lower middle income ● Upper middle income ● High income

Sources: This figure displays estimates of under-five mortality in 2018[33] and universal health coverage service coverage index in 2017.[2]

BOX 3

ADOLESCENTS REQUIRE UNRESTRICTED AND STIGMA-FREE ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES UNDER UHC – LAURA'S STORY

Laura, 14, lives in Caracas, next door to her boyfriend, 15. Her positive experience of accessing SRH services highlights the benefits for adolescents – and the risks when services are not included in UHC packages or are withdrawn due to COVID-19.

"My mother is open with me about sex. She tells me that protecting myself is important because there were no options except to have a baby if you got pregnant. There were a lot of girls who I knew from school who had. A friend of mine from school told me about an organization called PLAFAM. She said I should go there since I'm sexually active. There, she said, I can get all kinds of information about sex and things like condoms and implants. I asked my mom to take me. She had me when she was a teenager, so she understood. My mom told me that they would insert something in my arm to make sure I didn't get pregnant, which sounded painful – but it was like a little pinch! The doctor was nice. She explained everything that was happening while she was doing it and my mother held my hand. It was all much easier than I thought. Right now, I'm not having sex because of COVID-19, but I know that when I do, I will be protected. I made the right decision for me."

The IAP asked if Laura and her boyfriend had the HPV vaccine to protect them from HPV infection and related cancers. Unfortunately, the vaccine is unavailable in Venezuela.

Governments and health providers must be accountable to ensuring that girls like Laura get the care they need and deserve to survive, thrive and transform during the COVID-19 pandemic and beyond.

Jovana Rios Cisnero, IAP Member

MULTISECTOR FACTORS AND ENABLING ENVIRONMENTS ARE KEY TO SUCCESS

Multisectoral factors such as WASH, education and clean energy play a significant role in accelerating progress toward health targets for women, children and adolescents. Access to improved sanitation has been associated with lower incidence of diarrhoea, stunting and child mortality.[141,142] From 2000 to 2017, the population using safely managed sanitation services increased from 28% to 45%. Though 60% of the global population had basic hand-washing facilities with soap and water available at home, 3 billion people still lacked such facilities and 1.4 billion had no facilities at all.[102] Here too, inequities are a critical concern. Capital regions often have higher coverage of basic sanitation services than other sub-regions (e.g. Colombia or Central African Region) demonstrating sub-national inequalities. Some countries fare better on equity, with similar

sanitation service coverage enjoyed between sub-regions and the capital region – regardless of whether coverage is high (e.g. Serbia) or low (e.g. Madagascar) (Figure 6).

These services are under threat from the COVID-19 pandemic. The United Nations has warned of the risk of disruption to WASH services from lockdown measures, and the danger of increased threat to health from waterborne diseases.[28]

Figure 6. Proportion of population with basic sanitation services, by sub-national region, 2017 (%)

Source: Progress on household drinking water, sanitation and hygiene 2000-2017. Special focus on inequalities. New York: United Nations Children's Fund (UNICEF) and World Health Organization (WHO), 2019.

HUMAN RIGHTS AND ACCOUNTABILITY MATTER

Progressive realization, as described earlier, is a fundamental principle of human rights and a core feature of accountability. It is also a powerful engine for achieving 2030 targets for health and sustainable development. As a logical implication of the requirement to invest to the maximum of available resources, the IAP concludes that states should invest in ways justified by evidence of what works – including evidenced-based investments across multiple sectors – to achieve progressive realization and maximize positive impact.

A further implication is that states, governments and political leaders should apply principles of good governance and accountability to ensure the proper administration and targeting of investments. Citizens should be able to hold them fully to account through the ballot box and other democratic means, including having their voices heard through formal and informal participation in accountability. Attention to people's lived experiences and voice is essential for good governance and accountability, but is often lacking in political leadership (chapter 3 and chapter 4, recommendations). As noted in chapter 1, mistrust in government and other public institutions erodes quickly in these circumstances.[73] Engaging the public meaningfully and inclusively is not only a matter of rights, but also of effective sociopolitical action, including in response to the COVID-19 pandemic or protests against racial injustice. The same holds true for multilateral decision-making. These measures engender trust within and between countries, without which national and global security are at stake (Box 4).

BOX 4

THE IMPORTANCE OF HUMAN RIGHTS AND ACCOUNTABILITY

It is not enough for a government to assert that they are doing what is necessary or effective. The foundation of human rights – and democracy – is that the authority of government resides in the people.[143] Governments must be able to provide people with adequate and transparent justification for the measures being taken (and those not taken) on the basis of evidence, rights, and rule of law. Through the COVID-19 pandemic, the extent to which leaders are meeting this requirement is highly variable. And contrary to views that people's active participation would slow down command-and-control decisions regarding the virus, every experience with past outbreaks everywhere in the world demonstrates that the agency and meaningful (not tokenistic) engagement of individuals and communities is essential for effectively managing the spread of disease. The public are not all the same; gender, race, caste, class, disability, ethnicity and other axes of identity[144] determine inclusion within society[145] and, by extension, vulnerability to epidemics.

Taking these rights seriously underscores the need for accountability. Without transparent and evidence-based information (as well as justification for policy and programmatic actions, budgets and outcomes), disease outbreaks both reflect and exacerbate lack of trust in democratic and multilateral institutions. Communities need to trust the information and policy and budgetary responses from their national governments. And national governments need to trust the coordinating role of the WHO and defer to its navigation of the outbreak. Accountability and transparency also must apply to the private sector, from providers to industry, which is rapidly developing therapeutics and vaccines. For example, there should be no price gauging on essential food or medical supplies and, at a minimum, a very high burden of justification to obtain exclusive licensing of any potential new therapy during a pandemic.[146]

We should have learned by now that human rights protections cannot be an afterthought, including in dealing with a pandemic. This crisis may provide an opportunity to see the value of truth, and trust in democratic processes and multilateralism, and the dystopian realities we face without them.

From Yamin AE, Habibi R. Human Rights and Coronavirus: What's at Stake for Truth, Trust, and Democracy?[147]

Chapter 3

Unique contexts, global challenges – accountability to accelerate country progress

Caught in the COVID-19 storm: women's, children's, and adolescents' health in the context of UHC and the SDGs

COUNTRY CASE STUDIES: INTRODUCTION

Five country case studies were commissioned to inform the development of the 2020 IAP report. The case studies used an accountability lens to examine challenges for women's, children's and adolescents' health and UHC. They aimed to amplify the voices of women, children, adolescents and key stakeholders, and to learn from their lived experiences. Case studies were undertaken in:

ETHIOPIA
on community scorecards to strengthen quality of care[148]

GEORGIA
on public-private partnerships for UHC

GUATEMALA
on barriers to accessible, affordable and culturally acceptable care[149]

KENYA
on medical detentions

PAPUA NEW GUINEA
on complex challenges and women's children's and adolescents' health and rights

We advocate an approach to sustainable development that is driven by good leadership, community participation and strong citizens' voices for full accountability, because development outcomes are always much better when civil society participates and is more engaged in implementing development policy.

People need to drive planning, monitoring and remedial action for positive health outcomes.

Nicholas Kojo Alipui, IAP Member

An IAP focal point was established for each country case study, who then worked closely with a national institution to lead the case study development. The IAP secretariat supported the overall coordination of the case studies and provided additional administrative, technical and writing support to country teams as required. Guidance on methods for developing the case studies was designed to be adaptable to specific country contexts.

Case studies were developed through targeted literature reviews and direct stakeholder inputs through key informant interviews (KII), focus group discussions (FGD) and multistakeholder dialogue (MSD) meetings.

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

Most of the case study work was carried out during the early months of the COVID-19 pandemic, so adaptations to the methods were necessary. For example, virtual interviews and MSDs were used in place of face-to-face meetings.

Case study teams documented the accountability context: what accountability means for different stakeholders, the factors that supported and enabled accountability, and the barriers to progress. The case studies were conducted in countries with local stakeholders, which created a sense of ownership for the discussions and the ways in which complex challenges can be jointly worked on across the cycle of accountability with engaged political leadership. For example, the Georgia case study outlines both the challenges and opportunities of a health sector where over 85% of health care providers are operated by the private sector, and the implications for accountability and stewardship. The Kenya case study highlights medical detentions – a practice declared illegal but which persists in some of the country's hospitals due to the interplay of complex social, legal and economic factors. The case studies present three to five emerging actions for strengthening accountability for women's, children's and adolescents' health in their country context.

The case studies reveal a range of stakeholders' experiences and perspectives of both successes and challenges to accountability within their own country contexts. However, several common themes emerged:

- Accountability may not have a specific word in local languages, or people may define it differently, but everyone can say whether they feel it is there or not, and if it is working and applied effectively at all levels.

- Accountability can be a powerful tool to ensure and advance progress for women's, children's and adolescents' health if all elements of the accountability cycle – Monitor, Review, Remedy, Act – are institutionalised and applied effectively.

- Robust country data is fundamental, and sufficient capacity and resources are needed to translate data into information for decision-making and action.

- The needs and priorities of women, children and adolescents must be explicitly and genuinely considered in policies and programmes to understand the root causes and challenges women, children and adolescents face.

- People want access to information, to be listened to by decision-makers and be part of the solution. It is central to accountability for relevant, responsive remedies and progress, as well as credibility and trust. As noted in a UNICEF-commissioned report on the Ethiopia community score card initiative featured in this chapter: "True engagement … followed by tangible changes that reflect the responses of the citizens … [is needed to] build the trust of citizens over time."[150]

This report presents highlights of the case studies and reflects on some of the experiences and emerging innovative and practical actions. Importantly, the case studies evoked interest among stakeholders to continue discussions for in-country follow-up, including to communicate the findings further and to take forward the emerging actions.

Plans for follow-up at the country level include profiling the case study findings in each country and engagement with government ministers, taskforces and other key stakeholders on actionable next steps. The full case study reports are available on the IAP website at: www.iapewec.org/reports/annual-reports/iap-2020-report/casestudies.

CASE STUDY

ETHIOPIA

Community Score Card to strengthen quality of care

CONTEXT

Ethiopia is a lower- middle-income country with a population of close to 110 million. Although access to health care and use of services have significantly improved, there is still a significant burden of disease and low levels of skilled birth attendance and post-natal care. Equity of access and quality of care are ongoing concerns. In 2017, the Federal Ministry of Health (FMoH) introduced a Community Score Card (CSC) for Woreda (district) health offices, PHC facilities and the community to monitor service quality, and respond to community needs. As of June 2019, the CSC had been rolled out in four agrarian regions: Tigray, Amhara, Oromia and the Southern Nations, Nationalities, and Peoples' Region. This case study draws on the findings of three case studies commissioned by the FMoH,[151] a 2019 UNICEF-led report to support the Health Social Accountability Technical Working Group 2019[152] and a FMoH and ALMA Best Practices and Lessons Learned review.[153]

Experiences

- **"The CSC makes the community feel as the owner of the health centres and health services … Social accountability will come. Government responsiveness is different when the community regularly and measurably is engaged."** *(Health worker).* CSC is an institutionalised tool that is expected to be implemented by all primary level health facilities and health centres. Although initiated by the health authorities, the process is led by community elected client councils, made up of diverse individuals, including women's and youth groups, and other constituencies. Service users score services at formally convened sessions with government representatives and health providers. The aim is to develop a joint action plan with attention paid to areas that received low scores. The expectation is that because health workers are formally engaged in the process, there is a much higher likelihood that citizens' feedback will be acted on by health facilities.

- **"The health centre staff used to say, 'It [the facility] is not yet open. Wait for the opening time.' So, we would have to wait for long periods of time despite a lot of work awaiting us at home …"** *(Community member).* If implementation is supported and implemented well, the CSC can become a powerful tool to improve health service delivery. It can also create greater trust in the health service and stimulate demand for timely and routine preventative and curative care.

- **"When I read out the indicators and I told them to score, some women were fearful, they did not want to score. When I asked the women to raise their hand for a 3 or a 4, some never raised their hands at all."** *(Health worker)* Power imbalances between community members, the client council and health workers could adversely affect the equity and efficacy of the CSC. These may centre on attitudes (e.g. prejudice against adult females with low literacy) or real power (e.g. where individuals or groups misuse power to provide or withhold health services). Irrespective of whether this power is exercised improperly, the perception that it is could impede the effectiveness of CSC.

RECOMMENDED ACTIONS

Based on the documents reviewed,[151-153] further actions were identified for strengthening the roll-out of the CSC:

1. **"Patients are benefiting from improvements made due to community feedback, especially women and children under five years. The health centre staff are also benefiting because we better know our strengths and weaknesses. This motivates us in our work."** *(Health worker)* CSC is a useful tool for addressing health inequities and can lead to significant improvements in timely quality of care and health service delivery. Further steps should be taken to ensure coordinated and regular direct feedback from service users is used to improve health care in communities and contribute to people's realization of their rights and entitlements. It complements 'long route' accountability, which – though essential – takes more time as it involves institutional review and other means.

2. **"Good leadership, strong training, regular community feedback meetings and supportive supervision to health centres are all important for success."** *(Health worker).* It is critical to cement political will and leadership for institutionalization and full scale-up, and to ensure accountability mechanisms mandated by government provide the opportunity for a responsive 'ear' to people's 'voice'. It is also important to recognize and address health worker anxiety about citizen feedback processes. High level commitment to social accountability should also provide an enabling environment for multiple accountability mechanisms to build on and reinforce each other. For example, the CSC cooperates closely with the Ethiopia Social Accountability Program, which is one of three tools created by the government to increase accountability in basic public service delivery. The others are the Grievance Redress Mechanism and Financial Transparency and Accountability.

3. **"Communities are very eager and engaged. If the quarterly feedback meetings are delayed, the community demands the meetings be held."** *(Health worker)* Building trust in the system is critical. There is a need to create a balance between government ownership/political support for social accountability mechanisms and the meaningful participation of individuals and communities and other stakeholders. Only good facilitation and the true engagement of citizens during the interface meeting, followed by tangible changes that reflect the responses of the citizens, can build the trust of citizens over time. This is why supporting the scale-up and ministry level monitoring and evaluation (M&E) of the CSC to ensure the tool is properly executed is so important.

4. **"The community discussion is the most important part of the process and requires good management and leadership by the client councils."** *(Health worker).* To help address power imbalances, client councils should contain a balance of men and women. Support and investment are needed to counter power imbalances by ensuring that vulnerable people – those with disabilities and chronic illnesses, pastoralist communities and refugees – are included in CSC. Client council guidance should be appropriate to all contexts, ensuring that power imbalance between citizens and health service providers does not affect CSC scoring.

5. **"We intend to learn and adapt as we move forward with CSC implementation."** *(FMoH)* M&E is needed to strengthen the scale-up of the CSC. An M&E tool, based primarily on data that already gets collected by health facilities, will allow the FMoH to check on progress regularly and correct the course as needed. The resulting data will also be used for planning and budgeting.

Follow-up with the Minister of Health and the government is already planned to consider these recommendations in the roll out of the CSC.

CASE STUDY

GEORGIA

Public-private partnerships for UHC

CONTEXT

Georgia, a country in Eastern Europe, has a population of 3.7 million. Despite substantial economic growth, over 420 000 citizens live in socially vulnerable households[154] and 6.8% of children live in extreme poverty.[155] The government launched its flagship UHC programme in 2013.[156] This showed that countries with limited resources can significantly improve access to health services for their citizens, including for women, children and adolescents. The success is particularly interesting in a context where over 85% of health care providers are owned and operated by the private sector. Currently over 90% of the population has access to a basic package of primary, emergency and in-patient services, complemented by 23 disease-specific programmes funded or co-funded by government. Progress has been made against maternal and child health indicators, though Georgia still lags behind the European average. Out-of-pocket (OOP) expenditures for health are high. However, they were substantially reduced from 73.4% in 2012 to 54.7% in 2017.[157]

Experiences

- Participants emphasized that despite successes of the national health system, health governance could be more open, as a critical element of accountability. For example, respondents noted public reporting of health system data and analysis could be improved: **"Reports, particularly those which concern children's, women's and [older people's] health must be more available to public."** *(KII, Health worker).* Participants also stressed the need to establish an independent advisory body to critically assess or advise on health sector performance. Such mechanisms would also help to address the perceived lack of mutual accountability: **"The topic of accountability is extremely important…but everyone avoids it. People must be involved in health-related planning processes."***(MSD, CSO)*

- **Accountability is based on partnerships…but we don't have this accountability. Sometimes state and healthcare institutions communicate and cooperate, but the process is not transparent."** *(KII, CSO).* The private sector is an important partner in UHC implementation, but improvements could be made to ensure systematic engagement in dialogue or decision-making that directly affects its workforce and services. The participation of professional associations and patient groups in decision-making could also be strengthened.

- Georgia has universal, common reporting tools for health statistics and financial reporting for public and private providers. However, monitoring and reporting mechanisms could be expanded beyond mainly quantitative and financial measures to incorporate feedback mechanisms on performance. Participants also suggested public reports should present a balanced, critical assessment of the overall performance of UHC or the health sector in general, to address the concern that: **"They talk about small achievements, while totally ignoring great problems and weaknesses."** *(KII, CSO)*

- Patients and UHC stakeholders can claim their rights through the professional council (within the health ministry), courts or the office of the ombudsman. However, **"Many people have the wrong insight on health. We need more activities to raise awareness. Universities should support such activities… this would also contribute to establishing an accountability culture."** *(KII, medical student)*

RECOMMENDED ACTIONS

The case study identified emerging actions for consideration at the country level to address the accountability challenges related to private-public partnerships in Georgia.

1. **"The same businesses which own hospitals also own insurance companies and pharmaceutical companies. The UHC programme allowed big businesses [to] grow even further. Businesses must be effectively regulated by the state…"** *(KII, academia).* Participants emphasized the need to strengthen the stewardship capacity of the national health authority. Although private health services are regulated, improved monitoring, reporting and responding to health sector challenges is critical in a business-dominated health sector. This environment should also assure adequate quality of services and the financing of common goods for health.

2. **"[Stakeholder] involvement is very insignificant. Relationships need to expand and get stronger."** *(KII, health professional association).* It is critical to improve dialogue, partnerships and mutual accountability among all stakeholders. The government should establish mechanisms for systematic engagement of professional associations, private sector, civil society, health service users and international development partners in dialogue about how to strengthen UHC, specifically for women, children and adolescents. The engagement should include policy advice on standard-setting, continuous medical education and protection and promotion of health-related rights of patients and health workers. Partnerships with the media should also be expanded to ensure more regular coverage of UHC topics and raise awareness about the health and rights of women, children and adolescents.

3. **"I think we have enough resources; good management would give much better outcomes even today."** *(KII, health worker).* Participants recommended that opportunities for diversification of UHC financing sources should be further scrutinized, including from the private sector, to ensure **"more effective use of available scarce public resources"** *and to* enhance private-public partnerships in the sector.[158-162] Case study participants suggested further exploring the potential of innovative local and international PPPs to address gaps in reproductive health commodities for women, children and adolescents, and other limitations of UHC to provide universal access to high-cost diagnostics, treatment of rare diseases, oncology or rehabilitation services.

4. Focus on quality assurance/quality improvement (QA/QI) of UHC to address the issue that **"the Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs Of Georgia neither demands external accreditation [of healthcare facilities], nor has its own standards."** *(KII, health worker).* Building on the successful reform of the QA/QI system in perinatal care for maternal and newborn health, partnerships should be established with national and international stakeholders to develop and support an effective independent QA/QI and accreditation system in health. While Georgia demonstrated sound public health and multi-sectoral emergency response during the pandemic, study participants noted some concerns with the crisis management, such as patients being turned away from hospitals of their choice for diagnostics and/or treatment. Overall, COVID-19 was also seen as an opportunity for strengthening collaboration within health and across sectors, including with the media and the public.

5. **"Primary health care is the level which must fill gaps in people's health education. Not only family physicians, but also nurses, need to be prepared to educate people."** *(KII, patient representative).* It is critical to provide relevant health education and information as part of UHC to promote the health and rights of women, children and adolescents. This includes building the health literacy capacity of health workers, working closely across government, academia, civil society, patient groups, the media and youth-led organizations, among others.

Stakeholder commitment is critical for next steps and a clear plan of action, including who will do what, by when and how progress will be monitored, reviewed and acted on. The first in-country follow-up already planned includes discussion with an expanded group of stakeholders, followed by the division of labour on advocacy, capacity building and technical support for implementation of specific recommendations.

The full country case study is available at: www.iapewec.org/reports/annual-reports/iap-2020-report/casestudies.

CASE STUDY

GUATEMALA

Barriers to accessible, affordable and culturally acceptable care

CONTEXT

Guatemala is an upper-middle-income country[163] with a population of 16.3 million.[164] Over half of the population is indigenous – mainly Mayan groups. Guatemala has the largest economy in Central America, but it is one of the countries with the lowest Human Development Index (HDI) and the highest inequality in the region.[165] Close to 60% of the population lives below the poverty line and 23.4% below the extreme poverty line.[166] Children and adolescents in the country suffer a series of violations of their health rights, presenting several of the worst indicators in the region in terms of malnutrition, poverty, access to housing, education, water and sanitation.[167] When the data is disaggregated, the indigenous population and people living in rural areas are the worst affected.[166,168] The case study is informed by a review of barriers and bottlenecks to early childhood health and development (ECHD),[169] and complemented by interviews and a multi-stakeholder dialogue, mainly with civil society representatives. This case study highlighted several barriers that apply more broadly to the health of women, children and adolescents that must be addressed in order to implement ECHD mechanisms, structures and policies more specifically.

Experiences

- Stakeholders recognised that Guatemala has a robust legal system related to accountability processes and the protection of women, children and adolescents. However, policies and legislation were not enforced. **"Both CSOs and health workers need to understand the legal framework to implement it and make demands. There is a lot of ignorance and lack of knowledge of the current and complete legal framework."** *(CSO)*

- **"When the Development Law Council was created 10 years ago, there was a space for open dialogue with the community … however, since then, its mission – to offer to the health beneficiaries a platform [on which] to speak – has disintegrated. This space has now become a political power manipulation tool."** *(CSO)* Participants recognised the need to promote, maintain and strengthen spaces for genuine public dialogue and feedback. But it was important to ensure the space was not used for political purposes or co-opted by special interest groups.

- **"We need to have a dialogue exchange with community leaders and traditional birth attendants, not only train them in health systems but also learn from them about how they help the community to improve its health. We must have staff who speak the [community's] local language and know and respect their culture."** *(Ministry of Health).* Stakeholders highlighted indigenous peoples' experiences of racist, discriminatory and culturally insensitive health care, and many women, children and adolescents have limited access to relevant health education and information in their own language. A culture of 'machismo' was also noted as limiting women's voice and participation in health.

- In addition, working more effectively across health and other sectors was highlighted. **"Another issue linked to structure, that is not discussed much, is that a lot of policies have come out, but none have been done in a coordinated manner; each focused on their own sectors (i.e. each separate for early childhood, adolescents, youth, children, etc) working in silos".** *(CSO).* As a result, accountability processes are addressed in a fragmented way. Civil society participants felt that their work was a **"process to recover the trust and credibility of the community, [and] can help to ensure that we are seen as allies and not as enemies."**

RECOMMENDED ACTIONS

Participants identified emerging actions for consideration at the country level to address the bottlenecks and barriers to women's, children's and adolescents'.

1. **"It is very important to have spaces for dialogue to help review the health system in a cultural context. It must also focus on rights, respect and collaboration, including families (both men and women)."** *(CSO)* Participants recommended promoting and maintaining spaces for dialogue and participation between the provider institutions, the community and the organizations that carry out or support accountability, taking care they do not become spaces for political manipulation unrelated to the right to health.

2. **"A good strategy is to create a national meeting (dialogue) to identify institutions, actors, experiences and lessons learned on the issue of accountability, and also to have the opportunity to create strategic alliances to help raise the issue on the national public health agenda."** *(Academia)* Inter-institutional alliances and cooperation are essential to this process. This includes building citizen awareness – especially of women, children and adolescents – of their rights and entitlements to health and well-being.

3. **"Accountability gives a clear idea of the challenges, opportunities and actions to assist these families (women, children and adolescents) that we want to assist and support."** *(CSO)* Strengthening comprehensive accountability for resources, service delivery and institutions is critical. This could include investing in the full cycle of accountability – monitor, review, remedy, act – to ensure the transparent use of resources (material, financial and human) and that the identified challenges to women's, children's and adolescents' health are acted upon; increasing accountability for service delivery to women, children and adolescents, particularly for indigenous populations.

4. **"It is important to create a space for dialogue and respect."** *(CSO)* **"We need to create a circle of trust. Listen to the complaints from the community leaders and their communities so that we can analyse well their requests and give them the appropriate answers."** *(CSO)* There is a critical need to promote responsive, humane and culturally sensitive health services for women (including migrant women), children and adolescents in support of effective implementation of existing legal frameworks – including dignified care that takes full account of cultural differences and traditions.

Stakeholder commitment is critical for next steps and a clear plan of action, including who will do what, by when, and how progress will be monitored, reviewed and acted on. Follow-up at the country level already planned includes to continue reinforcing spaces for dialogue with the main stakeholders to help strengthen existing accountability mechanisms, and to propose concrete action plans to solve existing problems and guarantee everyone's right to health.

The full country case study is available at: www. www.iapewec.org/reports/annual-reports/iap-2020-report/casestudies.

CASE STUDY

KENYA

Medical detentions

CONTEXT

Kenya is a lower-middle-income country with the ninth largest economy in Africa. Just over 36% of the country's 45.4 million population live in poverty.[170] Post-2013, Kenya adopted a devolved form of government with two levels – national and county – and a constitutional commitment to delivering UHC.[171,172] One of four goals in President Uhuru Kenyatta's Big 4 Agenda is to provide affordable health care for all.[173] The 2017 Health Act protects individual rights and commits to supporting emergencies as well as ensuring progressive overall financial access to UHC. The National Health Insurance Fund (NHIF) is a critical vehicle used by Government to achieve this. Although coverage of essential health services has improved, gaps persist for WCA, including access to family planning, antenatal care and vaccinations. It is estimated that OOP health care expenses make up close to 25% of the country's total health expenditure, disproportionately affecting the poorest.[174,175] The government set up the Linda Mama program to address this population group. However, due to inability to pay medical bills, women who have given birth, their children and other vulnerable people are sometimes detained, – despite laws and high court ruling that medical detention is illegal.[176,177] Such medical detentions are a denial of people's rights and dignity and can push people into poverty. In 2019, the government ordered a probe into facilities engaged in this practice.

Experiences

- **"In Kenya, we tend to re-engineer policies instead of implementing the ones we already have. The government is not enforcing the law and that is why we have people acting with impunity. The waiver policy is not activated until the media is involved."** *(KII, CSO)* The right to health is explicit in the Kenyan constitution and supported by key policies and regulations.[178]

- **"We know the price of a tomato is this much and the price of electricity is this much … but not health care."** *(CSO, MSD).* **"Even if they keep me here for a year, I will not be able to pay the money. I cannot afford it. All I am requesting is that they release my child so that I take care of him at home. If I get money, I will always send it to the hospital."[177]** Several social protection measures exist for Kenya's poorest citizens: 2004 user fee policy, including fee waivers, 2014 Health Insurance Subsidy, and free maternity services since 2013 in all public health institutions. Overall access could be improved by public and facility education. However, participants highlighted that people tend to be admitted to hospitals for emergency treatment, such as caesarean operations, which are subject to high out-of-pocket costs they did not expect.

- **"It takes long to get a waiver within the public health facility … But most of the time even that waiver system doesn't work, so someone will come back and say, 'I have not collected enough information' after you have been detained."** *(KII, CSO).* For most people who cannot afford to pay hospital bills, the process for getting a waiver is reported to be complicated, long-winded and overly bureaucratic.

- **"The quality of service within the different departments in the health facilities needs to improve so that we can reduce preventable mortalities. This means a focus on the care and not just coverage, as is the case currently."** *(KII, CSO).* Many health facilities lack essential infrastructure, equipment and supplies, compounded by an insufficient and poorly distributed workforce. [179] This contributes to people seeking care in tertiary and/or private institutions and being charged fees beyond their ability to pay.

- **"Many of the private facilities are struggling with outstanding bills from NHIF and insurance companies."** *(Participant, MSD).* This in turn hinders the provision of quality services by facilities and may lead to illegal debt recovery through medical detentions.

RECOMMENDED ACTIONS

The case study identified emerging local recommended actions for consideration at the country level to enhance and complement government efforts to protect people against medical detentions in the context of UHC, acknowledging the complexity of the issue; and to avoid unintended consequences. **"I'd like to ask us to be very careful in the way we handle this issue. We may force people to release patients, but we will end up making facilities to have a very strict screening process of offering services to patients. We need to be objective in finding a sustainable solution and not militant…"** (Private hospital, MSD).

1. **There needs to be valid ways of recovering debts. And that is the message health care providers need to take … so that we approach the access to health care really as an essential service and it's not just a commodity where we say, 'if you cannot pay, we block you in to get the money'."** *(CSO, MSD).* Steps to achieve this include: working with private health care providers to develop flexible, affordable patient payment plans and alternative debt-collection processes that do not entail medical detention; establishing systems for monitoring, reporting and resolving breaches of people's rights; use of innovation and technology to fast-track patient applications for financial support; prompt identification of an alternative debt collection process; and importantly, an effective mechanism to enforce regulations. **"In the absence of direct legislation for individuals to rely on with regard to medical detention, the courts have been forced to be imaginative and to rely on the development of common law to enforce accountability in cases such as patient detention and medical negligence."** *(KII, Judiciary)*

2. **"A medical fund is very important. The running costs of a hospital are not small. We might want to put this legislation but as long as the running costs are not met, we are not going to achieve anything. NHIF must pay in a timely manner. More people need to have access to NHIF accredited facilities. Also, those that cannot pay for NHIF premiums need to be supported by the fund."** *(Private hospital, MSD).* Broadening the income base for health insurance, timely payments to hospitals by government, insurance houses and the fund.

3. **"Let us sort first the cost of health care. Can health care costs be brought down so that detentions can also reduce? When you consider health-seeking behaviour, patients need to be informed of what they can afford."** *(Participant, MSD)* Actions to achieve this include: having a discussion (that respects the rights of people as well as the needs of health service providers) with all stakeholders on the costs of health care and how to reduce and manage them; using evidence-based approaches to ensure access to a maternal health care benefits package for pregnant women and childbirth; as well as the planned cover for unexpected complications and emergencies; and working closely with health care institutions to clarify the NHIF access, Linda Mama access and emergency care, and at public and private hospitals.

4. **"We have a Mum's Club, where we have sessions to inform and advise both members and non-members on what they are to expect."** *(KII, Private sector).* Building on such examples, participants suggested developing a strategy to communicate health care costs and payment mechanisms, as well as the waiver scheme to citizens, health workers and other relevant stakeholders; and working together with civil society, the media, government and others to raise awareness about right to health and health literacy. **"So, robust citizen awareness is required … to understand what exactly NHIF is. What do you gain by having this in place?"** *(Participant, MSD).*

Stakeholder commitment and a clear plan of action is critical for next steps under the President's UHC agenda. This includes, using the results of the 2019 probe to inform government deterrent action going forward; the establishment of an emergency medical treatment fund to address unexpected emergency treatment currently leading to out-of-pocket costs and establishment of training programs for facilities to effectively use the waiver system among other efforts. More details of the Governments response are captured in the case study documentation.

The full country case study is available at: www. www.iapewec.org/reports/annual-reports/iap-2020-report/casestudies.

CASE STUDY

PAPUA NEW GUINEA

Complex challenges and women's, children's and adolescents' health

CONTEXT

Papua New Guinea (PNG) is the most populous country in the Pacific region. The nation of 9 million people is diverse, with over 800 tribal groups. About 80% of the population lives in rural areas with poor or no roads, making access to health care challenging. Women's, children's and adolescents' health (WCAH) is compromised by multiple, negative, socioeconomic factors. For example, a recent analysis indicates that PNG only has 24% of the health workforce required for current needs.[180] Other factors include the lower status and restricted autonomy of women in PNG, high rates of early marriage, gender-based violence, poverty and the illegality of abortion. Violence and abuse towards women and children, and lack of state and judicial action to protect them, are of particular concern. The case study highlighted the positive work on WCAH, notably that of the Ministerial Taskforce on Maternal Health and its upcoming inaugural report. However, complex challenges continue to impact the provision of services and the health of women, children and adolescents.

Experiences

- **"No one takes responsibility for our health needs."** *(Adolescent, FGD)* It was commonly voiced that different agencies 'should be', 'must be' accountable for service delivery, but there was uncertainty among key populations as to where accountability lies. This was due to the decentralized nature of governance and the devolved responsibility for service delivery between government and non-government agencies. This perceived disjuncture in responsibilities also impacted on service provision, such as the lack of youth friendly services[181] and poor quality of care. **"Staff scream and swear at labouring mothers and say unwelcoming comments to teenagers who are pregnant; and therefore many mothers are still delivering at home."** *(Female, FGD)*

- **"In the past, there was proper monitoring and evaluation (M&E), whereas today there is only one staff, the health manager, to do M&E, supervisory visits and compile reports. It is a big challenge."** *(KII)* At the provincial level many WCAH services are not being systematically monitored, which makes any nationwide assessment challenging. Systemic and infrastructural problems, such as lack of technology and overstretched workforce, were identified as barriers to effective monitoring and assessment. Participants also expressed concern that many services were neither monitored nor being held accountable, with little or no feedback to the communities.

- **"There is a dearth of fully qualified and proactive epidemiologists able to put all the data together and turn the data into information, and give feedback, and look at the gaps, and know what gaps there are and try and fill them."** *(Health worker, MSD)* Participants identified there was limited workforce capacity and professional development to use data effectively for decision-making. There is hope that the Electronic Health Information System (E-HIS) will provide a strong basis for data collection and greater accountability once it is rolled out beyond five pilot provinces.

- **"Health awareness and information sharing is not available to us from growing up, to pregnancy, to childbirth, and how to take care of us and our babies."** *(Female adolescent, FGD)* A lack of WCAH education and information impedes women's and adolescents' ability to make informed decisions about their health. Participants also identified the importance of health information for combating long-standing social and cultural norms: **"Death and illness are too often accepted fatalistically, and sorcery or ancestor anger will often be used to explain death or chronic illness. Failures in the system are acknowledged, but people often feel powerless to change these things."** *(Participant, MSD)* Also, the media rarely pursues WCAH-related stories.

RECOMMENDED ACTIONS

The case study identified emerging actions for consideration to strengthen accountability for WCAH.

1. **"We need to focus the people at the decision-making level on the needs of people – particularly women – at the community level."** *(Participant, MSD)* Participants stressed the need to raise the profile of WCAH. This could be done in a range of ways, including: supporting and encouraging the heightened profile of the Ministerial Taskforce and its current initiatives; encouraging leadership and championing of WCAH at all levels of political leadership; encouraging forums, such as the Business for Health (B4H), of the private sector to add WCAH to its portfolio; advocating for a Parliamentary Forum on WCAH; identifying and supporting prominent champions and relevant bodies/agencies to raise the profile of WCAH; and addressing significant barriers to success, notably corruption and resource allocation that disadvantages those in greatest need in remote and rural areas. Another idea based on previous work[182] was to draw attention to WCAH priorities and challenges in "an annual accountability letter to Members of Parliament".

2. **"The media can play a far more prominent role in reaching people."** *(KII)* Participants recommended proactively engaging with a wide range of media outlets (social and traditional media) to promote WCAH and to explain rights and accountability concepts. Utilizing PNG's expanding mobile network and potential for e-learning would be key. Other suggestions included using short video clips of successes to inspire communities.

3. **"Communities could be organized from the bottom up so that the community voice becomes much more powerful."** *(Health worker, MSD)* Participants stressed the need to enhance user engagement in WCAH, which in turn relied on the sharing of open and transparent information. **"When the hospital has meetings, health board members should return to communities and share information with them."** *(Female, FGD)* Digital technology (such as closed user groups) can be expanded to disseminate WCAH education and information, and obtain community feedback, as well as provide support to the health workforce. It is also critical to encourage greater engagement of adolescents in communities around WCAH using a variety of mechanisms, such as the Integrated Community Development and Together Everyone Achieves More (TEAM) approach.

4. **"Information doesn't get back to the health workers. So, they don't know if they're doing a good or bad job and nobody ever tells them."** *(Civil society, MSD)* Participants recommended improving health worker skills for WCAH, including using and interpreting data for decision-making. This included initiating a proactive programme of upskilling to address staff shortages and poor performance for WCAH, including access to digital support and training; and adopting a mechanism to collect and analyse data and feed the results to the service level, which would engage health workers and involve them in making improvements.

5. **"Institutionalization is a mandatory component, but perhaps if there are ways to strengthen community voices or 'volume', things might be more sustainable.** *(Health worker, MSD).* It is critical to support and institutionalize a robust accountability cycle for WCAH services. This could include reinforcing the responsibilities of existing structures to support the accountability cycle; developing routine, robust data collection and analysis for WCAH, building on the E-HIS; ensuring that data are made available at all levels in appropriate formats and forums to inform decision-making; upskilling at all service levels, ranging from expertise in epidemiology at NDOH to basic data collection at the clinic level; and providing broader training on data and accountability as part of all health worker professional development.

Stakeholder commitment is critical for next steps and a clear plan of action, including who will do what, by when, and how progress will be monitored, reviewed and acted on. Follow-up in country already planned includes sharing and discussing the findings of the case study with the Minister of Health and identifying and working with champions, including the media, on WCAH.

The full country case study is available at: www. www.iapewec.org/reports/annual-reports/iap-2020-report/casestudies.

Chapter

4

Revitalizing accountability – a framework and recommendations to accelerate progress

Caught in the COVID-19 storm: women's, children's, and adolescents' health in the context of UHC and the SDGs

Accountability is about delivering prompt effective quality results for the well-being of people; every woman, child and adolescent, without exception. COVID-19 has demonstrated the centrality of health to this social political and economic imperative.

Joy Phumaphi, IAP Co-chair

The global response to the COVID-19 pandemic and our collective reaction to it has provided a compacted illustration of accountability in action, or the lack thereof. For example, it raises questions about: data, including how they are generated, validated and shared, what they mean and who decides how data are interpreted; whether and how political leaders are guided by science and evidence; whether and how people gain fair and equitable access to quality services and whether their voices and concerns are heard; how the economic, social and environmental impact of the health response is managed; the inevitable recriminations and debate about health systems preparedness, early warning and swift action; and the voluntary (or sometimes, involuntary) forfeit of individual freedoms and liberty in lockdown. The course of the pandemic has vividly illustrated the role of accountability and the multifaceted ways in which governments, decision-makers and health providers can be held accountable. It has also highlighted its complexities and the challenges associated with clearly identifying who knew what, when and whether the right action was taken at the right time by the right people.

Recognising the direct link between health in countries and global health resilience is more pertinent than ever. The critical contributing conditions for the successful achievement of EWEC targets and goals – from the quality of individual health systems to effective investment in global public goods such as vaccines and tackling antimicrobial resistance – are leading socioeconomic indicators and should be treated as such. In 2016, the UK's Independent Review of antimicrobial resistance identified it as a threat to health across the world.[183] The Chair of the 2016 review, Jim O'Neill, stressed since then that the International Monetary Fund should assess the strength and readiness of national public health systems in its annual Article IV reviews of member states as part of a more comprehensive approach to risk management. Given the sweeping, multi-layered impact of COVID-19 on health and economies across the world, this recommendation seems particularly astute for health and global security overall.[184] Recently, Jim O'Neill argued, *"As the COVID-19 crisis makes abundantly clear, there is no useful distinction to be made between health and finance. The two policy domains are deeply interconnected, and should be treated as such."* [185]

The recommendations of this report are based on the findings in preceding chapters with the literature reviews, statistical analyses and case studies. The recommendations build on the experience of CoIA,[186] the subsequent work of the independent expert review group (iERG).[187] They also draw on lessons learned from a decade of EWEC accountability framework (see Annex), four years of IAP independent reporting[1a] and its external evaluation.[188]

From this evidence and experience, there are key lessons about how accountability could be a powerful driver of change, and some barriers that prevent it from doing so. The first is that accountability is difficult to embed into the socio-political culture of health and development in a structured way; from the COVID-19 experience, we see that gains made are fragile and can erode quickly. In addition, present necessity moves people on, and addressing gaps or failures can easily become yesterday's challenge rather than today's priority. The case studies in chapter 3 of this report reveal the extent to which accountability relies on public support and engagement, which in turn rely on open and transparent information, sound institutions and leadership that is strong enough and wise enough to embrace criticism rather than shun it.

ACCOUNTABILITY FRAMEWORK

In order to reverse the downward turn towards the 2030 targets, and to protect health and rights through the COVID-19 pandemic and beyond, the IAP sets out an accountability framework (based on the evolution of EWEC accountability framework, see Annex), and three overarching recommendations.

Accountability is connecting commitments to progress in a justifiable and constructive way. It has four pillars – Commit, Justify, Implement and Progress. All four of these pillars must be present to constitute accountability. Where one is missing, the result cannot be considered accountability.

- **Commit:** all those who have commitments and a responsibility to act should be clear on their roles and obligations towards achieving agreed goals and rights.

- **Justify:** decisions and actions related to commitments must be supported and explained on the basis of evidence, rights and the rule of law.

- **Implement:** core accountability functions of Monitor-Review-Remedy-Act[54] should be institutionalized and implemented in a constructive way to facilitate learning and progress.

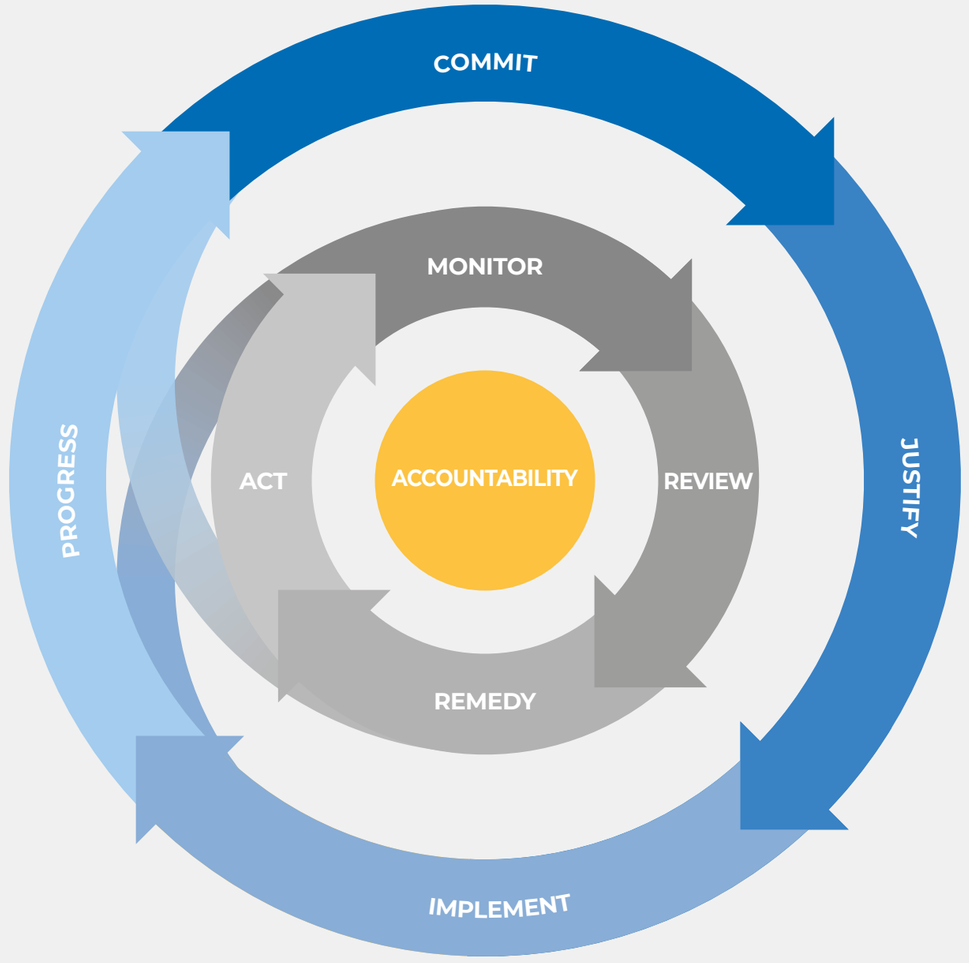
- **Progress:** continuous progress towards agreed goals and rights should be ensured, with governments and all other actors justifying any reversals or harmful impacts – this is the human rights principle of 'progressive realization'.[51,52]

The accountability framework is shown in Figure 7. It depicts an integrated, whole of government, whole of society approach to accountability.

Accountability in a socio-political context, applies to governments and non-state actors, to individuals and institutions, and can be used to track duty bearers' obligations and rights holders' claims. It is clear that while accountability needs to be considered in the context of achieving universal rights and goals, it needs to be adapted and operationalized in unique and changing contexts – as the country case studies demonstrate.

With this analysis in mind, the IAP gives three overarching recommendations.

Figure 7. Accountability: connecting commitments to progress in a justifiable and constructive way



RECOMMENDATION 1

Invest in country data systems for national and global security

Data and evidence are the bedrock of accountability. Although not sufficient in and of itself, a sound evidence base is the necessity without which the functions and features of accountability cannot be realized.

The COVID 19 pandemic highlighted the direct link between country data, or lack thereof, and national and global health and financial security. Critical decisions and investments – on international health regulations and health systems capacities, PPE for health workers, conditions for social distancing, research on new tests and vaccines, and enabling factors for people's health, financial and social protection, and livelihoods – all depend on good data as illustrated in chapters 1 and 2 of this report. However, while some countries are capable of providing good, disaggregated data, many others do not have data systems set up to collect the necessary gender- and age-disaggregated data. Despite the overwhelming number of articles, online traffic, television debates and social media noise, the evidence and real data on COVID-19 emerging from countries and making it into the public domain have generally been incomplete and of variable quality.[44] This fits a long-term pattern of data for women's, children's and adolescents' health, where even births and deaths are still not fully reported or recorded in many countries, and information about health systems performance is patchy. Legal, logistical and political barriers to birth registration must be tackled as a matter of urgent priority in order that every birth is counted.

Data need to be collected considering a life course approach to health and sustainable development – taking into account people's needs, opportunities, risks and enabling environments related to their health and well-being at and across all life phases.[127] This should be achieved by collecting disaggregated data by sex, socio-economic status, ethnicity, urban/rural differences and other considerations, as envisaged by SDG 17.18.7.[1] Data on people's lived experience, their expectations and voice are also critical, and underpin accountability functions and features.

Data gaps result in crucial rights being unfulfilled for millions of individuals and weak accountability to drive progress towards the attainment of priority outcomes for women, children and adolescents, including those contained in the SDGs. Even this report demonstrates that when data are more fully available and analysed, they offer important insights to guide decision-makers as in Figure 2 (chapter 2), for example, identifying the relevance of political leadership and multisectoral investments for women's, children's and adolescents' health. This requires a whole of government, whole of society approach.

It is in everyone's interests to build strong accountability systems: to reach every women, child and adolescent with the services they demand; to learn from our mistakes and build on our successes; and to strengthen our collective resilience to crises like COVID-19.

Brenda Killen, IAP Member

Data are an essential ingredient to identifying, measuring and rectifying inefficiencies, mismanagement and corrupt practices, and to support the delivery of social justice, including the realization of rights and correction of inequities. Chapter 2 of this report considers factors for success that differentiate higher and lower performing countries, while noting the data limitations. Without these data, it is not possible to pursue transparent monitoring of accountability processes themselves, the pursuance of evidence- and rights-based remedy according to the rule of law, and action by leaders and decision-makers following commitments made.

Progress remains inexcusably slow. Data gaps can only be addressed when countries build unified, holistic national data collection processes and systems, and create reliable data banks that are (1) used by the government, service providers and all partners, (2) quality assured, (3) complete and disaggregated to move away from modelling, and inform 'real world' investment and implementation, and (4) communicated in open and transparent ways to people and communities. Leading global health agencies have committed themselves to working more cooperatively to support countries in these efforts, and they must do more.[189]

To accelerate progress, global health and development partners must cooperate with each other and with countries to develop harmonized data systems, enable users and decision-makers to access and understand data, and steadily improve data quality. CSOs can help by driving innovation and creating demand for information and evidence that reflects lived experiences. A positive example of this comes from Mexico's extension programme for social inclusion (PROSPERA), where CSOs aided development of relevant indicators and disaggregated data.[55] Media and public interest organizations also play a critical role in creating and promoting accuracy and transparency, supporting data and evidence-gathering in the public interest and encouraging debate.

RECOMMENDATION 2

Institutionalize accountability functions and features – voluntary arrangements are insufficient

Accountability works most effectively when it is not voluntary, is tethered to institutional processes and can be fully verified at each stage of the accountability functions. Not only does accountability need to be embedded into institutions and processes, it needs to be seen.

Institutionalizing and embedding accountability functions and features is a difficult but necessary path to challenging chronic failures underpinned by corruption, violations of human rights and rule of law, and inequities and inefficiencies resulting from actions and investments that are not evidence-based. Many accountability recommendations – including those made in the High-level Political Forum for the SDGs[190] – are, at best, never fully implemented or, at worst, ignored entirely because implementation is seen as voluntary rather than mandatory. A lack of sustained political will and commitment enables actors at all levels to avoid being held to account. While scapegoating is unhelpful, identifying responsibility

and – crucially – implementing remedy are essential for action and, ultimately, change.

EWEC commitments are not currently subject to the full Monitor, Review, Remedy, Act cycle. Governments and development partners – including UN agencies, donors, private sector and NGOs – focus mainly on monitoring, rarely considering independent review as a formal 'check point'. There is a tendency to stop short of effective remedies and action most of the time. These lessons could usefully inform reviews of the high-level political commitments made in the UHC political declaration and the WHO-coordinated international health response to COVID-19.[57,119]

For the accountability cycle to work, decision-makers must be obliged to respond appropriately and fully to recommendations. It is evident from the IAP's experience, for example, that voluntary accountability (the approach adopted in the Global Strategy to drive the improvement of women's, children's and adolescents' health) has largely failed to spark consistent, institution-led, proactive monitoring, remedy and action. Accountability requires an acknowledged, formal relationship (between the development of recommendations and remedy and action) rooted soundly in its core features (commit, justify, implement and progress), such as when a government implements the recommendations of a commission it has itself convened. This 'tethering' of recommendations to institutions can help ensure that the accountability cycle is meaningful, and that recommendations are taken seriously, in theory, resulting in concrete reforms or policy change.

Having an accountability process is necessary, but not sufficient; implementing that process consistently is necessary to the realization of an accountability outcome. Examples include scrutiny of national health review processes by parliamentarians or, at subnational level, the maternal and perinatal death surveillance and response process.[191] In each case, processes should formally influence policy, investment decisions and programmes.

However, such processes require clear procedures, good leadership and recognized guidelines or they can easily become unproductively mired in politics or scapegoating. At the health facility level, when done properly and with integrity, the maternal and perinatal death surveillance and response process shines a light on an individual maternal death, identifying contributing factors and feeding data to the regional and national levels, enabling, in principle, the rapid implementation of evidence-based recommendations across the health and social care system.[191] In practice, without political commitment, leadership and adherence to guidance or best practice, maternal death reviews can easily be foreshortened into a superficial effort to blame individual people or to identify hazy systemic flaws. In blaming either a single individual as a scapegoat or, conversely, alluding to broad, sweeping, yet vague and non-specific policies or conditions, the opportunity is lost to build depth of understanding and then to constructively remedy contributing factors underlying a maternal death; crystallizing accountability around that death is also lost. Scapegoating and blame games have been a prominent feature of COVID-19 responses across the world.

All institutions, policies, programmes and processes related to women's, children's and adolescents' health thus should have explicit accountability arrangements in place that incorporate institutionalized monitoring and review, and lead to remedy and action based on concrete recommendations. Action taken should be verified and processes themselves should be regularly audited. Investments in accountability save resources in the longer term through better quality services, averting preventable deaths and boosting health systems and governance effectiveness.

Investments in institutionalizing accountability processes can improve the use of resources and the realization of results and rights. Progress is not wholly dependent on the scale of investment. Indeed, the evidence in chapters 2 and 3 shows clearly how data *availability* is only part of the story. How decision-makers choose to act on data and evidence is just as crucial, as well as how these actions are justified and communicated to people – as was highlighted in the country case studies. While acknowledging the data limitations, Table 1 and Figure 2 indicate that how countries invest and the choices they make (for example, on evidence- and rights-based laws and policies, investments, and implementation) is at least as important as how much they spend. Enforcing action, ensuring that existing policies and laws are implemented, is also part of the full accountability process as highlighted in both the Kenya and the Guatemala case studies. Accountability processes can also help to ensure funds are invested where they will make the greatest impact on the health of women, children and adolescents – especially those in fragile situations and hard-to-reach areas – strengthening visibility of that process and reinforcing the dynamic link between investments, scrutiny (including remedy and action) and outcomes.

Every women, child and adolescent is entitled to quality healthcare. Independent accreditation of health facilities is not a luxury, but a vital tool to help them make the right decisions.

Giorgi Pkhakadze, IAP Member

RECOMMENDATION 3

Democratize accountability to include the voices of people and communities

Ensure that all people have the opportunity to voice their experience and to be heard. Create accountability processes that enable all people's experience to be considered valuable and valued in the context of delivering credible accountability processes.

The direct voices of people are crucial to effective accountability. For example, during the COVID-19 pandemic, sustained criticism over the lack of PPE or testing services have compelled decision-makers to take action and to demonstrate the action taken. However, formal mechanisms to record the lived experience of people as a driver of accountability for women's, children's and adolescents' health are relatively rare. Where they do exist, although they often fail to capture views articulated by the most vulnerable and marginalized, the voices of people's experience can be a powerful influence on public views and thus on political action.[192] During the COVID-19 pandemic, people's participation in data collection – for example, through mobile apps – has had a real impact on improving the definition of clinical symptoms. In some countries, daily obituaries intended to honour and remember some of those who have died, help raise compelling questions about equity, access to services, vulnerability and fairness. Through the participation, voice and experience of those most affected, the accountability of governments for their actions to combat COVID-19 has been at the forefront of public discussion and has formed a critical contribution to the response.

As reinforced in the high-level commitments to UHC and the COVID-19 response,[57,119] all partners should work to create a culture of inclusivity and participation, actively including women, children and adolescents; this is fundamental to the credibility of accountability processes. By opening up space for women, children and adolescents, and allowing time and opportunity for their participation, accountability processes aimed at addressing their health needs will be more effective, more relevant and more likely to lead to meaningful results. In the context of the COVID-19 pandemic, voices of frontline workers – health workers and others – and those in difficult situations, are indispensable if we truly want and are committed to learn and do better.

Parliaments have a duty to hold governments to account for their commitments to women, children and adolescents, and to build a culture of more consistent and active accountability between governments and people. The International Parliamentary Union, for example, passed a resolution in 2019 that called for all its members to monitor and track progress towards UHC in their countries with specific emphasis on women's, children's and adolescents' health needs addressed through a primary health care approach at its core.[193] The media and civil society networks, such as COPASAH,[121] can convey the range of people's lived experience and genuinely create space for local and community voices, even while reflecting the articulation of a more distilled regional and national voice.

As a multi-stakeholder, multi-country effort, UHC 2030 will develop a 'State of UHC Commitment' report. The aim is provide country stakeholders with the information needed for inclusive and participatory reviews of UHC commitments and progress,[60] leading up to the comprehensive SDG progress reviews in 2023 and 2030.

WHERE NEXT FOR INDEPENDENT ACCOUNTABILITY?

As health security increasingly takes centre stage, independent accountability is needed more than ever to protect gains, secure rights to health and realize health for all.

The EWEC accountability framework, and the independent review function of the IAP, is a microcosm of accountability across the SDGs, and its experience can offer lessons for the future. Governments and development partners, including UN agencies, donors and NGOs, often do not meaningfully make or implement commitments, nor do they adequately act on accountability recommendations. We have evidence of incomplete and poor quality country data, slowing or reversal of progress, widespread inequities, around a 2-trillion dollar inefficiency and corruption gap in health expenditures, and other areas of critical importance to progress. But we have insufficient remedy and action and therefore lack the necessary commitment and change to make concrete gains.

Drawing on lessons from EWEC accountability, Paul Hunt, the first UN Special Rapporteur on the Right to Health, emphasized the importance of independent review in the SDG era, and the opportunity for health to lead the way.[194,195]

BOX 5

THE IMPORTANCE OF INDEPENDENT ACCOUNTABILITY

The question - did they deliver? - has to be asked of governments, development partners and all key stakeholders, an explanation provided, and an independent assessment made. Did they deliver? If they did, what good practices can be learned? If they didn't deliver, why not? There may be legitimate reasons beyond their control.

Of course, thoughtful self-accountability is welcome and important – but history tells us that it is not enough. Independence is critically important for the objectivity, legitimacy and credibility of the process. Independence is a vital feature of accountability.

It is also difficult for states at the national level to hold accountable stakeholders, including other states and non-state actors, for their transnational commitments to development, such as SDG17. This is also a role for independent review.

An independent review provides expert evaluation about progress, promises and commitments, while political bodies make decisions about what to say or do as a result.

With "the commitment to an ongoing public, transparent process of assessment, change and reassessment", the political body's view has greater credibility, authority and legitimacy if it benefits from an evaluation prepared by way of independent review.

From Hunt. P. A Three-Step Accountability Process for the UN Secretary-General's Global Strategy for Women's and Children's Health, and SDG series: SDGs and the importance of formal independent review: an opportunity for health to lead the way [194,195]

Independent review is not a finger-wagging exercise. Rather, it is a constructive, learning process that involves recognizing success and drawing attention to good practice, identifying shortcomings and, as required, recommending remedy and action.[196] Independent review provides expert evaluation about progress, promises and commitments, while political bodies makes decisions about what to say or do as a result – in a synergistic interaction that confers transparency and credibility.[194,195]

In May 2020, member states at the World Health Assembly, adopted the principles of independent review and constructive accountability around the COVID-19 response when they called for "impartial, independent and comprehensive evaluation, including using existing mechanisms, as appropriate, to review experience gained and lessons learned from the WHO-coordinated international health response to COVID-19".[119] A critical aspect of this must be to account for the impact of the COVID-19 response on women's, children's and adolescents' health, including preventable maternal deaths, increased gender-based violence, unwanted pregnancy, missed child vaccinations, foreshortened adolescent education, mental health and other impacts.

As the COVID-19 response progresses, the lessons from the IAP can be used to chart the way forward – focus on robust data and evidence, making it available and accessible, and build independent accountability into systems and processes to ensure constant, rigorous learning, tethered through the core accountability features of commit, justify, implement and progress to the institutions that govern our decision-makers.

These processes centre on putting resources to work for people, and making room for the voices of people themselves – all people – to ensure that those resources are used in ways that make material improvements to the lives of those most often left behind. The right to health for all is attainable and valuable. Accountability has a vital role to help achieve it.

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ANNEXES

The IAP 2020 Report was developed using a range of methods, building on a decade of experience with the evolution of the EWEC accountability framework. A review of the literature and narrative synthesis of the evidence informed the analysis. Country scorecards were based on a statistical analysis of the latest global estimates on key indicators of the Every Woman Every Child Global Strategy, SDGs and accountability. Factors for success differentiating higher and lower performing countries were hypothesized based on the evidence and IAP expert assessments of requirements for country progress, and differences between countries' performance on were analyzed statistically. Country case studies were developed through document reviews, field visits, key informant interviews and multistakeholder dialogues. The IAP report recommendations were based on qualitative analysis of the themes and topics emerging from the literature reviews and front chapters of the report including the statistical analyses and country case studies. Further details are available in a series of web annexes for the IAP 2020 report.

LIST OF WEB ANNEXES

Overview of methods to develop the IAP 2020 report and recommendations

Annex 1. Evolution of the EWEC accountability framework

Annex 2. Literature reviews

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

2.2 COVID-19 and the status of women's, children's, and adolescents' health and rights: A targeted literature review of current evidence for action on Universal Health Care (UHC) and accountability

Annex 3. Statistical analysis

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3.2 Progress lag analysis towards 2030 EWEC and SDG 'Survive' Targets

3.3 Country scorecards (Table 1 in the report)

3.4 Factors for Success analysis (Figure 2 in the report)

Annex 4. Country case studies

4.1 Methods guide for country case study development

4.2 Case study semi-structured questions

4.3 Full country case study reports (available on the IAP website)

All Annexes are available from the IAP website:
https://iapewec.org/reports/annual-reports/iap-2020-report/annexes