

2016: OLD CHALLENGES, NEW HOPES

Accountability for the Global
Strategy for Women's, Children's
and Adolescents' Health



INDEPENDENT
ACCOUNTABILITY
PANEL

EVERY WOMAN, EVERY CHILD, EVERY ADOLESCENT.

2016: OLD CHALLENGES, NEW HOPES

TABLE OF CONTENTS

Executive Summary	2
1. A World of Change, a World of Opportunity	5
2. Conceptual Framework	8
3. Monitor: Solid Data for Effective Decision-making	13
4. Review: A World of Inequalities	17
4.1 Women: Progress Slower than Expected	22
4.2 Adolescents: Do We Have a Future?	26
4.3 Children: Positive Trends, but Not Fast Enough	31
5. Remedies and Action for the World We Want	37
5.1 Humanitarian Settings	44
5.2 Adolescents: The Future Begins Now	48
5.3 Human Resources for Health	51
6. Resources: The Key to Results and Accountability	54
7. Conclusion: A Time for Action	60

EXECUTIVE SUMMARY

Undoubtedly, 2015 was a watershed year for the international community. The Sustainable Development Goals were adopted, with a new sense of ownership by Member States, along with an updated, more robust Global Strategy for Women's, Children's and Adolescents' Health 2016–2030 and its associated unified accountability framework.

The Global Strategy has already galvanized enthusiasm worldwide to achieve better health outcomes for all, attracting 177 commitments, from governments, donors, civil society and the private sector, including financial commitments totalling US\$ 25.5 billion as of June 2016. But while the IAP welcomes these developments and the general clamour to put women, children and adolescents at the heart of the way we tackle public health, the overriding theme of this report is that much more can be done – must be done – and quickly.

The IAP has a mandate from the UN Secretary-General through the Global Strategy to report annually on progress and to use our expertise to ensure the strategies are being implemented effectively. We do not have a direct monitoring function: our role is to review and comment on the results of monitoring by others. The objective, therefore, is not to report all the latest data, but to provide a snapshot of progress in the Global Strategy and help harmonize reporting.

The international community must tackle deficiencies in public health with a heightened sense of urgency. Efforts under the previous Global Strategy, for example, helped reduce maternal mortality from 385 deaths per 100 000 live births in 1990 to 216 in 2015. But gross inequalities between countries and within countries remain, and to reach the global goal of no more than 70 deaths per 100 000 live births, the rate of progress will need to be three times faster than that achieved during the 1990–2015 period.

In this, our inaugural report, the IAP presents its **conceptual framework** (chapter 2), inspired by human rights principles and extending the aspects of monitoring and review, with a particular emphasis on actions and remedies in their various forms – administrative, political, legal and social – which are not merely remedial actions that re-establish the state of affairs prior to an alleged violation, but must be the key instruments in transforming the underlying situation and dismantling entrenched resistance to change.

In chapter 3 on **monitoring**, we describe the welcome progress in data collection and analysis but note that a dramatic improvement is still required in national statistical offices and administrative data collection agencies. The availability of solid, effective data is crucial to progress on the Global Strategy and the Sustainable Development Goals but we are some way from having the disaggregated data needed for a more accurate picture of the realities on the ground. It is imperative that monitoring exercises are coordinated in ways that promote transparency and accountability of all stakeholders, rather than leading to fragmentation or duplication of efforts, and unnecessary burdens on national governments.

Similarly, **in a world of inequality** there is an urgent need to accelerate progress in **women's, adolescents' and children's** health, as described in chapter 4. The IAP has made inequality the centrepiece of its review of results. The focus is on economic, gender and age



inequalities where appropriate, and where disaggregated data is available. We note that while there has been some progress in closing gaps between the richest and the poorest groups within countries – especially in neonatal and under 5 mortality – such progress is slow in stunted growth among children and in the demand for family planning satisfied, and in other areas the gaps are increasing, such as in the adolescent birth rates which have decreased among the wealthiest groups but not among the poorest.

In this part of the report, we also highlight the unique opportunity to engage the largest generation of **adolescents** in history to be both the primary beneficiaries of the new international development agenda and a force driving it. The opportunity must be grasped. Using the resourcefulness and determination of young people will bring tremendous social, political and economic benefits for whole societies, a prospect fully appreciated by outgoing UN Secretary-General Ban Ki-moon, who said adolescents can be a key driving force in building a future of dignity for all.

For each of the three age groups of women, adolescents and children, we review the results of indicators in the four dimensions of survive, thrive, transform and legal rights.

In chapter 5 we describe the **actions and remedies required to achieve the world we want**, one where women, children and adolescents have the capacity

to lead healthy and rewarding lives. The chapter presents the challenges of accountability specific to **humanitarian settings** and how these impact women, young people and children, who are particularly vulnerable in such environments.

Resources, both human and financial, are the key to achieving results and accountability. In chapter 5 we describe the gap in human resources and the need to fully implement the Global Strategy on Human Resources for Health: Workforce 2030, the monitoring of which we plan to include in future reports. In chapter 6, we turn to financial resources, including the commitments to the Global Strategy for Women's, Children's and Adolescents' Health. We recommend that donors earmark resources for civil society and national accountability mechanisms.

New, inclusive and participatory national mechanisms are essential, but they must complement existing ones – parliaments, branches of government, the judiciary and human rights institutions – to provide remedies for the inequalities and inequities that prevent disadvantaged groups from enjoying the health benefits that are their right.

We conclude with a call for **action** in three key areas. For women, children and adolescents to survive and thrive, and for the environments that produce poor health outcomes to be transformed, such action is required on three fronts: leadership, resources and institutional capacity-building.

1. LEADERSHIP – A transformational agenda such as the Sustainable Development Goals requires strong institutional leadership. The IAP applauds the key role the UN Secretary-General has played in positioning the health of women, children and adolescents at the forefront of global efforts towards better health and well-being for all the world's population.

The IAP urges the UN Security Council and General Assembly to choose, as the next Secretary-General, a candidate who has a clear commitment to vigorously promoting and implementing the Global Strategy; to making sure mechanisms at the global, regional and national level are in place to make accountability much more than rhetoric; and to powerfully support the achievement of the Sustainable Development Goals and the centrality of the health of women, children and adolescents to the 2030 agenda. Similarly, we urge the World Health Assembly to elect a candidate with a strong commitment to the Global Strategy, to advancing meaningful accountability and to robust collaboration across sectors.

2. RESOURCES – To ensure that women, children and adolescents survive and thrive will require more resources than are currently available. But more than that, an investment framework, with more precise estimates of the costs and potential benefits of various investments, is needed, along with a clear plan from world leaders and UN agencies to tap additional resources. Both domestic resources and greater international aid are necessary, but a clearly defined roadmap is crucial. All governments must work together to set new expectations for policies on tax collection and use, and to combat tax evasion, within and between countries. Donors, meanwhile, must reassess their aid eligibility criteria, which excludes two

thirds of the world's poor who live in middle-income countries. It is crucial for governments to have sufficient fiscal space to pursue the goals of the Global Strategy, such as reducing disparities across populations in access to reproductive, maternal, newborn, child and adolescent health care.

3. STRENGTHENING INSTITUTIONS – Achieving the transformative changes that the Global Strategy envisions also requires institutions, with appropriate mandates, capacity and sustained financing, including accountability and oversight institutions. Mechanisms that need to be strengthened include national statistical offices, administrative data collection entities, independent judiciaries, national human rights institutions and regional and global human rights bodies. The many different actors in the private sector, professional associations and accreditation boards should also be engaged in moving forward collaboratively. Civil society activities, such as citizen hearings, should be supported and enabled through freedom of information and association protections.

The international community has the opportunity to operate under the most comprehensive agenda. An opportunity to renew the way we work, to involve all countries, from the global North and South. But to achieve the desired outcomes, we need to change our working methods. Our ambition should know no bounds. We must be creative in the way we tackle the problems that drive poor health.

We have an opportunity. We must take it.

CHAPTER ONE
**A WORLD OF
CHANGE, A
WORLD OF
OPPORTUNITY**

These are challenging times for the global community. The economic, political and social landscape is much changed in recent years, with far-reaching consequences for the health of women, children and adolescents. We live in a world of tightened resources, where competition for reduced funds is intense across all development sectors and countries in the global North and South are tasked with greater responsibility for their own health and development needs. A world of rising humanitarian crises demands action.

THE LAST 15 YEARS HAVE SHOWN IT IS POSSIBLE TO REDUCE MATERNAL MORTALITY DRASTICALLY. WE NOW NEED MUCH FASTER PROGRESS TO AVOID UNNECESSARY DEATHS, AND TO ALLOW WOMEN, CHILDREN AND ADOLESCENTS NOT ONLY TO SURVIVE, BUT TO THRIVE AND TRANSFORM.

Politicians, our media, regulatory sentinels and civil society – all of us are challenged to face these times head on, to ensure they are changing for the better. And we can make changes for the better. The picture is not all doom and gloom. Amid fiscal constraints and changed political and social agendas lies an incredible opportunity, an opportunity borne of crisis that can enable us to go beyond business as usual to adopt bold responses to our global challenges. We enter this exciting era armed with the Sustainable Development Goals (SDGs), which provide a roadmap, and the inspiration to ensure women, children and adolescents achieve the highest attainable standards of health, that they not only survive, but thrive. The SDGs respond to this global landscape with a sweeping universal agenda, one that emphasizes the urgent need to tackle scandalous inequalities and inequities within and between countries, and one that rightly acknowledges the urgent need for effective, transparent and accountable institutions to oversee this work.

The 2030 Agenda for Sustainable Development is coupled with the new, more robust Global Strategy to address the health of women, children and adolescents via multiple sectors, through coordinated strategies that are anchored in universal human rights. Improved health outcomes require action from within and beyond the health sector. We are not in the last mile. We may have run the last mile on the old track, but we are now entering a new race, one that demands renewed energy, determination and stamina to ensure success when we cross the finish line in 2030.

The Independent Accountability Panel (IAP) has a critical role to play in this quest for better health outcomes. We have a mandate from the UN Secretary-General, through the updated Global Strategy for Women's, Children's and Adolescents' Health 2016–2030, to report annually on progress and to use our combined expertise to ensure the strategies of the Sustainable Development Goals are being carried out



in the most effective ways. While we are primarily focused on the Global Strategy, that Strategy was never intended to be interpreted in isolation from the 2030 Agenda and its 17 SDGs, which set out an indivisible and universal development framework. Therefore, we see our accountability mandate for the Global Strategy as needing to be performed in the spirit of that agenda.

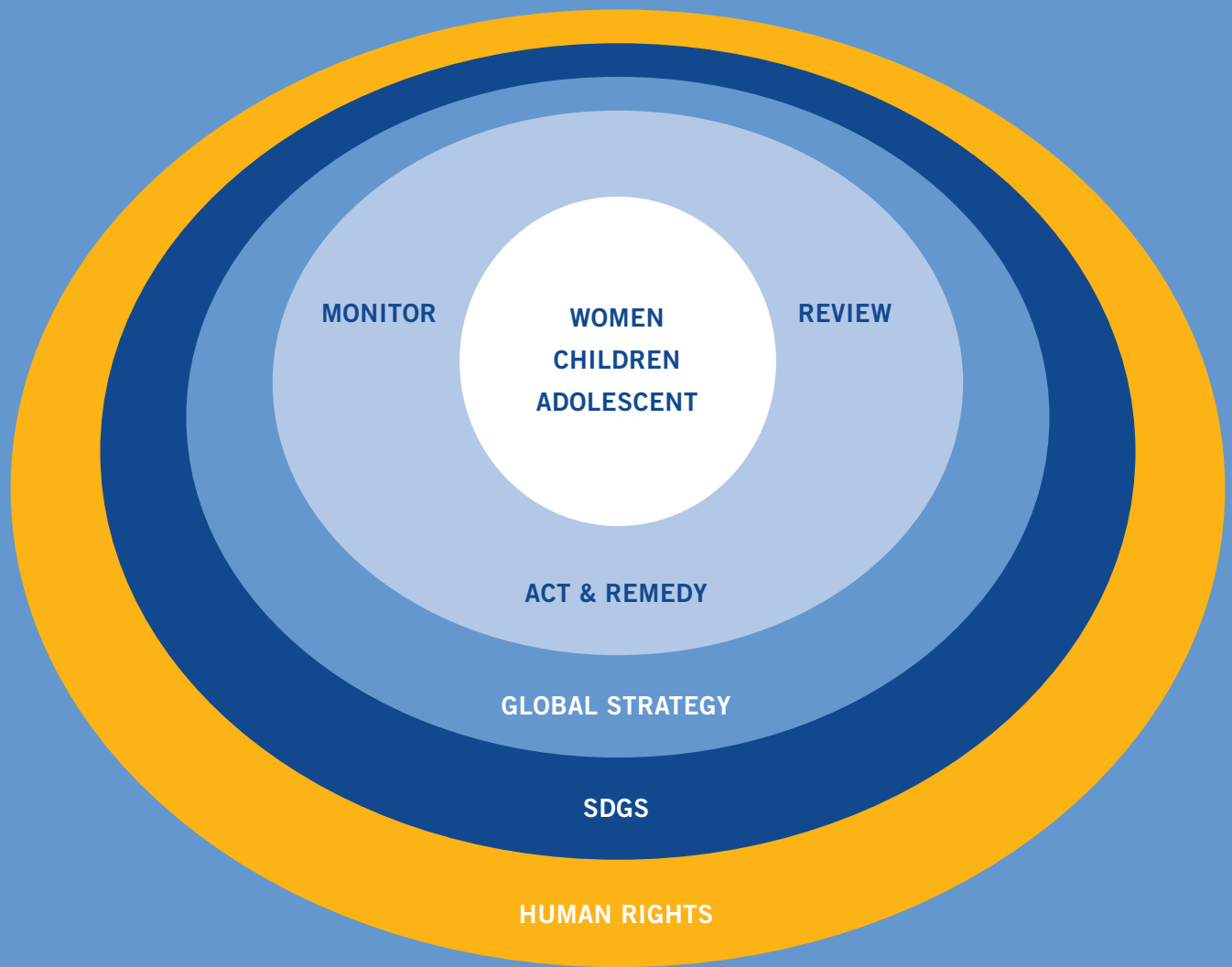
There is a huge thirst in civil society for accountability. Forums around the world have repeatedly demonstrated that people want governments and international institutions to be held to account in a meaningful way, a way that produces real remedies to the inequalities that persist. Witness the Women Deliver conference in Copenhagen in May of this year, when almost 6,000 people gathered in solidarity to demand the ambitious goals set by the international community be effectively implemented.¹ This global clamour for accountability demands that the IAP provides a comprehensive review

of the actions of governments, international agencies and the private sector, and reports without prejudice the deficiencies that demand redress, and the efficiencies that might be emulated in other settings.

The objectives of this report are to lay out the IAP vision of accountability in the context of the Every Woman Every Child global movement, provide a snapshot of indicators across the themes of the Global Strategy, and highlight action areas to promote greater accountability and better health outcomes.

We are submitting it to the Secretary-General with the expectation that our recommendations to stakeholders will help accelerate progress towards the Global Strategy objectives aligned with the Sustainable Development Goals. We also expect that this and our future reports will help the High-level Political Forum on Sustainable Development, and we encourage their discussion at the World Health Assembly, meetings of human rights treaty bodies, civil society assemblies and political events where remedial action can be considered.

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CHAPTER TWO

CONCEPTUAL FRAMEWORK

The Global Strategy is grounded in human rights.

First, its focus on reducing the mortality of women, children and adolescents directly relates to the promotion of the right to life. Second, going beyond their mere survival, it calls for women, children and adolescents to thrive, which requires they be able to freely exercise an array of human rights, including the right to health, to education, to bodily integrity and to control over their reproduction. Third, in aspiring to transform societies and our world, the Global Strategy seeks to guarantee that women, children and adolescents everywhere and for generations to come have the conditions necessary to live with dignity, including achieving the highest attainable standards of health. It enshrines the indivisibility of all human rights, evidenced in the call for multisectoral strategies that encompass education, water and sanitation, for example. The Global Strategy upholds the right to participation, the principle that no one should experience discrimination, and that everyone is “born equal in dignity and rights”,² the bedrock of human rights.

In keeping with the updated Global Strategy, the IAP has adopted a human rights accountability framework that recognizes both preventive and corrective functions. Accountability enables us to identify regulations and policies that are functioning well, so they can be

strengthened, and those that must be improved. Accountability enables collective and individual grievances to be addressed, and laws and policies to be enforced to ensure abuses are not repeated.³ The continuous learning and improvement necessary to achieve the Global Strategy goals is thereby fostered through a circle of accountability – in the health sector and beyond.⁴

The IAP framework builds on the framework previously used by the Commission on Information and Accountability (CoIA)⁵ and the independent Expert Review Group (iERG)⁶, but draws on international human rights law, which lies at the core of the Global Strategy and is set out in instruments accepted by states through intergovernmental processes. The IAP extends the monitor, review and act framework articulated by CoIA to monitor, review, act and *remedy*. This framework recognizes existing legal accountability mechanisms at national level (e.g. courts and national human rights institutions, and others already listed in the revised Global Strategy, such as parliamentarians, civil society organizations, development partners and private sector actors) and international level (e.g. UN treaty-monitoring bodies, regional bodies and the UN Human Rights Council’s Universal Periodic Review).

The graphic (opposite) illustrates the central role of accountability in efforts to achieve the Global Strategy’s aims for women, children and adolescents. The Global Strategy is embedded in the universal and indivisible 2030 Agenda and its Sustainable Development Goals. It is not just the Global Strategy that explicitly states that it is rooted in human rights, but the emancipatory aspirations of the 2030 agenda to eradicate extreme poverty and “leave no one behind” require a “social and international order in which all of the rights” in the Universal Declaration of Human Rights can be enjoyed by everyone.¹⁵ The outer circle is labelled human rights, recalling that across the sectors and issues the Global Strategy and SDGs address – from food security and inclusive economic growth, to gender equality and climate change – a commitment to realizing universal rights and treating people with equal dignity should inform our strategies and our measure of success.

CHAPTER TWO

Including act and remedy makes the accountability framework consistent with the 2030 Agenda for Sustainable Development, which notably sets out the importance of rule of law and access to justice to achieve sustainable peace and development (Sustainable Development Goal 16). This includes equal access to justice for all, and developing effective, accountable and inclusive institutions at all levels.

The IAP is not a supranational court. Its legitimacy lies not in passing judgment on individual countries but in explicating these components of the accountability framework and catalysing their use by states and other international actors charged with advancing the sustainable development agenda. The rest of this report more fully explains the concepts of “monitor, review, act and remedy;” here we introduce the elements of the accountability framework.

Monitor

Accountability cannot be an afterthought in health systems or governance. Monitoring should ensure legal and policy frameworks enable the effective enjoyment of rights related to reproductive, maternal, newborn, child and adolescent health. The call for multisectoral planning and monitoring in the Global Strategy acknowledges that sectors outside health, such as education, can contribute significantly to the health of women, children and adolescents. Expenditures and budgets call for monitoring, and the IAP is tasked with explicitly focusing on resource flows. The lack of appropriate action

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towards realizing universal health coverage and reproductive, maternal, newborn, child and adolescent health due to low social spending, including health spending, can often be traced, at least in part, to insufficient tax revenues at the macroeconomic level.

It is well-known that a significant portion of health resources are wasted through outright corruption as well as ineffectual programmes. Accountability requires improved tracking and accountability for such wastage. However, the IAP has chosen to focus this first report on less discussed structural limitations on resource availability, which relate both to revenue-collection and budgeting in low- and low-middle- income countries, and to cross-border tax evasion and aid policies in high-income countries as well.⁷

Monitoring in the updated Global Strategy is concerned with equity, not just aggregate advances. Effective monitoring should enable

disparities to be assessed based on axes of identity that may reflect discrimination, such as age, gender, race and class. Where data are lacking, on people with disabilities, for example, there should be plans to address such gaps so that no one is left behind, the ethical imperative of the new development agenda.

Review

Review by multiple actors, and at various levels, is crucial to making progress in the Global Strategy. The IAP's accountability framework recognizes that health sector reviews, financial audits, assessments of human rights and gender compliance, parliamentary inquiries and social accountability mechanisms such as citizens' hearings, all play a role in independent reviews. At the global level, these can be done by agencies and networks alongside multilateral agencies. The IAP will analyse the circumstances in which these diverse forms of review can be practised most effectively.

A fundamental part of human rights accountability is converting passive beneficiaries into active agents; that is, people who participate meaningfully in decisions that affect their well-being. Engagement by civil society is necessary for effective action by governments and international organizations, and for holding them to account.⁸ Similarly, the Global Strategy calls for a world where women, children and adolescents are able to fully participate in shaping sustainable and prosperous societies.⁹

Act and remedy

In a democratic society, the executive branch and parliament are expected to act based on monitoring and independent review findings. Adding oversight institutions to the accountability framework, including independent judiciaries and national human rights institutions, acknowledges that these not only apply sanctions against those who violate rights in practice, but also provide incentive for political branches of governments to answer for the commitments made in health.

The judicial enforcement of health-related rights should not be understood as encouraging malpractice or punitive claims against front-line workers. Rather, that the health system is subject to the rule of law, and encodes normative commitments as well as technical decisions. Courts have required the executive and legislative branches of government to reform discriminatory laws, policies and practices affecting health and to provide access to health-related information. They have also required public justification for the reasonableness of their policies and practices in relation to health.^{10,11} Such judgments can lead to actions from the executive and legislature, and mobilization from civil society, that produce transformative changes in the health sector that transcend discrete remedial action and feed back into the circle of learning and improvement.¹²

In summary, the IAP will use its reports to more broadly encourage 'spaces' and opportunities for answerability to rights-holders, through promoting social account-

ability and effective oversight institutions at national, regional and international levels. It seeks to reinforce the legitimacy and capacity of national and international institutions and oversight bodies, not to substitute them. Drawing on the sustainable development agenda and international human rights law, and the Global Strategy, the IAP sees its mandate in a truly universal accountability framework as an opportunity to:

clarify responsibilities of various actors; promote incentives for duty-bearers to answer the demands and concerns of rights-holders, civil society organizations and other actors; and catalyse action to remove systemic deprivations of health-related rights for women, adolescents and children, at national and international levels.¹³ We call for all stakeholders to provide advice and inputs to our process, and to help us communicate our findings and advocate for remedial action to ensure healthy living for

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CHAPTER TWO

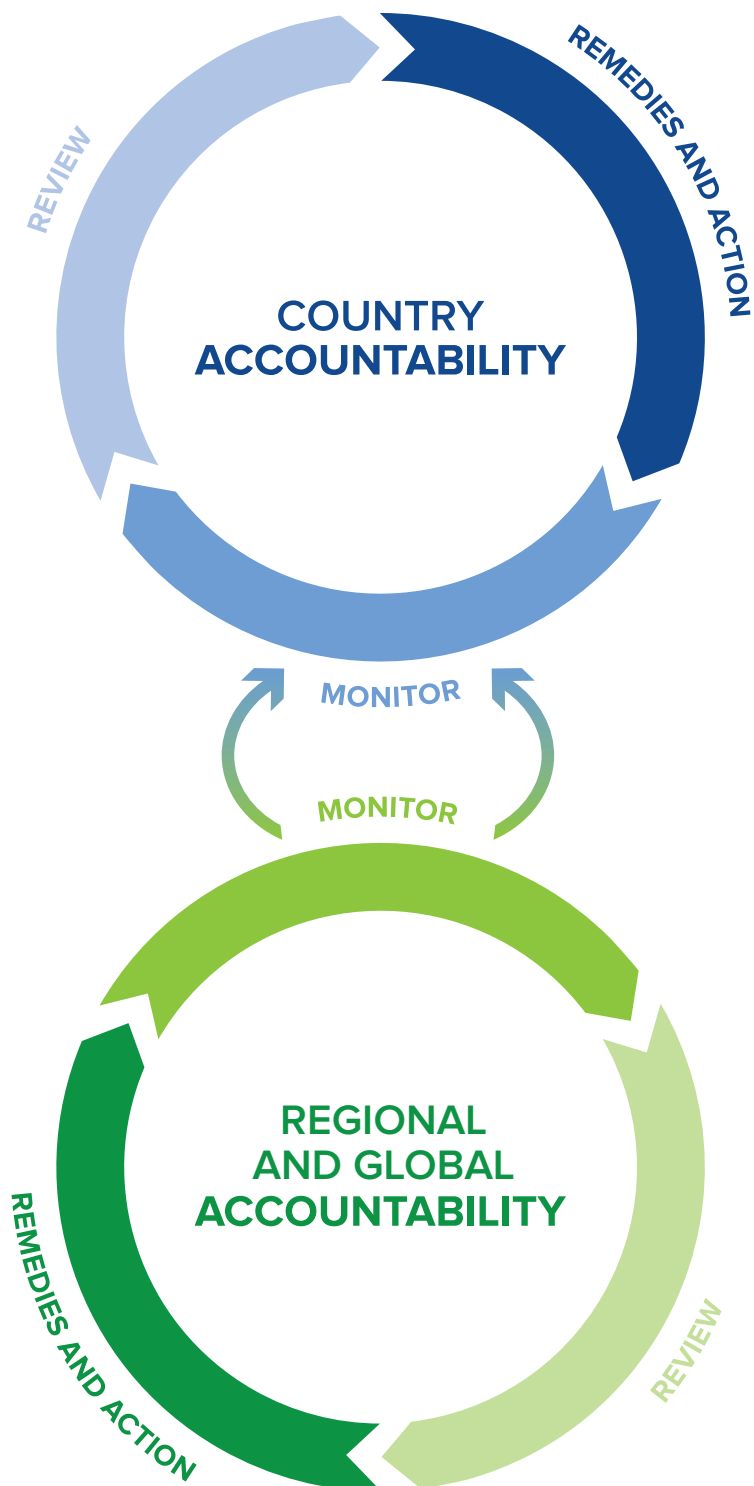
women, adolescents and children everywhere.¹⁴

Accountability framework

The following graphics show the way accountability functions in a circle: monitoring performance through data and other ways to identify problems and areas for improvement, as well as successes; reviewing the evidence to identify causes and solutions, taking into account the voice and perspectives of civil society; and taking action and remedying problems in accordance with actors' responsibilities within and beyond the health sector.

At global level, the circle mirrors the national level, beginning with monitoring frameworks, which are then subject to independent review by the IAP and other supranational bodies, as well as global civil society; and action and remedies by development partners, the private sector, agencies and national institutions.

Regional institutions, such as the Pan-American Health Organization, the Economic Commission on Latin America and the Caribbean (ECLAC) and the Inter-American System of Human Rights in the Americas, as well as subregional governance structures, such as the East African Community, play a critical role between the two levels, setting priorities, adapting standards and conducting peer reviews, as well as providing monitoring, oversight and remedies.



A woman wearing a white hijab and a green long-sleeved shirt is sitting at a desk in a library. She is smiling and looking towards the camera while holding a blue pen over an open book. The desk is cluttered with papers, a blue folder, and other writing instruments. In the background, there are bookshelves filled with books.

CHAPTER THREE

MONITOR: SOLID DATA FOR EFFECTIVE DECISION-MAKING

Photo: Graeme Robertson/Eyevine/Redux

The availability and effective use of information is a cornerstone of progress on the Global Strategy and the Sustainable Development Goals. The IAP applauds the renewed energy with which monitoring is being undertaken at global, regional and national levels, as part of the Global Strategy and the SDGs.

**IT IS A SCANDAL THAT
IN AN ERA OF RAPID
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It is imperative that these monitoring exercises, some of which are discussed below, are coordinated in ways that promote transparency and accountability of all stakeholders, rather than leading to fragmentation or duplication of efforts, and unnecessary burdens on national governments. In the coming years, the IAP will look closely at whether the monitoring activities of various actors are working in harmony, and if necessary make recommendations on how greater harmonization can be achieved. Such harmonization should not, however, dilute the richness of the data being gathered.

We also recognize that a set of global indicators used to compare progress across time and space, as objectively as possible, will differ in important respects from the – probably larger – array of indicators that national governments use for programme planning. However, both kinds of indicators and monitoring require reliable information, which in turn depends on institutional capacity. When the original data are not collected or compiled in a reliable manner, or are not analysed according to appropriate statistical methods and practices, all these monitoring exercises become hollow.

The IAP considers it essential that the renewed emphasis on monitoring progress under the Global Strategy

goes hand-in-hand with strengthening health management information systems as well as the capacities and independence of national statistical agencies, and agencies collecting and analysing administrative data.

Meaningful accountability that underpins the Global Strategy goals of survive, thrive and transform requires going beyond monitoring data. Other information, including legal and policy information, and institutional frameworks, is necessary to understand and modify the underlying drivers of morbidity and mortality in women, children and adolescents. Quantified indicators that are meant to measure laws and policies – such as those for sexual and reproductive health and reproductive rights information (SDG target 5.6) – are necessary but not sufficient. The effective enjoyment of rights that lies at the heart of the Global Strategy also requires knowing whether legislation and regulations have been fairly and effectively implemented.

Access to data and other information and review by civil society, as well as independent oversight institutions, is critical. The dissemination and communication of data should aim at closing the gaps in access and use of data, providing the highest quality information for all, in the

most easily understood format, and making it available at the time when decisions are being made or the opportunity for influencing outcomes is there.¹⁶

Key monitoring efforts

In monitoring progress towards the Global Strategy and the Sustainable Development Goals, various initiatives rely on data collected at country level. The UN agencies track progress in countries and develop estimates of coverage and outcomes, to be able to compare data sets between countries. There have been efforts to reduce the reporting burden on countries and harmonize reporting, although much more needs to be done in this area. Some of the key monitoring and accountability efforts used for the Global Strategy, in addition to the UN estimates, are highlighted and commented on below. The IAP was prevented from commenting on monitoring efforts that were being conducted simultaneously with the production of this report, especially the *Global Strategy monitoring readiness report* due to be released in September 2016, and a more comprehensive one to be launched in May, the *Global Strategy progress report*. The *Global Strategy progress report* is part of the UAF and will be the only member-state driven reporting process for the Global Strategy. WHO and other H6 members will provide the technical leadership and they will be supported by the Partnership for Maternal, Newborn & Child Health (PMNCH). The IAP welcomes the plan for launching the *Global Strategy report* in May in future years, which will give the IAP the opportunity to review and comment on the progress report in its annual reports.

Indicator and monitoring framework for the Global Strategy

The Global Strategy's Indicator and Monitoring Framework¹⁷ is an important step towards reducing the burden on countries for reporting on progress. The IAP welcomes its alignment with the SDG indicators, and the inclusion of coverage indicators for monitoring progress. Data availability and disaggregation is challenging, especially in countries with less developed health information systems. Gaps in indicators include quality of care, child illness treatment coverage, causes of death, governance and accountability, and those shared with other sectors (e.g. early child development and air pollution). Research to develop indicators needs funding. The Indicator and Monitoring Framework includes a commendable list of recommendations, and the IAP will monitor how far these are supported and implemented.

World health statistics

The annual *World health statistics* report for the WHO's 198 Member States has evolved from a simple compilation of data to include analysis of situations and trends. The IAP welcomes the WHO 2016 report,

Monitoring health for the SDGs, which highlights available data, sources and measures of inequity for each indicator. It also focuses attention on the challenges of migration. Data gaps are noted, the sources well referenced and a five-point call to action to strengthen country health information systems with key targets is fully explained. The challenge is to fill the data gaps and address inherent weaknesses in national statistical systems. The IAP would like to see highlighted countries with new data in each of the indicators reported to assess progress.

Institute for Health Metrics and Evaluation

The Institute for Health Metrics and Evaluation (IHME) has produced major reports on estimated maternal and child mortality, global disease burdens, development assistance for health and topical analysis of health issues. Concerns have been raised by countries and researchers about the differences in mortality estimates produced by IHME from those produced by UN agencies, especially for maternal mortality, and there has been much debate and discussion on the uncertainty of such estimates.¹⁸ In June 2016, Global Health Experts published *Guidelines*

International donors should reserve a significant proportion of their international aid to support the development of national capacities and a stronger civil society. The success of the Global Strategy depends on independent national bodies producing and analysing data, and of civil society engendering the political will so that data is used to promote the right to health through more efficient approaches and equitable policy options.

*for accurate and transparent health estimates reporting: the GATHER statement.*¹⁹ GATHER defines best practices for documenting studies that synthesize evidence from multiple sources to quantitatively describe population health and its determinants, including a code of adherence. This will facilitate transparency and trust in the estimates developed. The IAP looks forward to its publications and debate around the data used and estimates produced.

Social monitoring

In the past decade, a significant number of initiatives grouped under the term social accountability have emerged in some countries. Undertaken by civil society organizations, sometimes supported by international agencies, social accountability has focused on citizen participation in governing accountability mechanisms and in establishing citizen-led forums for accountability. These initiatives have produced new data, including by advocating for greater transparency, especially on national and subnational budget information, and by collecting direct observations from community members. The IAP recommends greater support for an expansion of these efforts by national governments, international donors and the private sector.

Humanitarian monitoring

Accountability in humanitarian settings can be markedly improved, but the need for more transparent financing is perhaps the most pressing challenge. Currently, it is not feasible to track funding through the system, a deficiency highlighted by the high-level panel on humanitarian financing in its report to the

UN Secretary-General.²⁰ Being able to track funding is essential to ensure accountability – to the donor and its recipients, the people most in need – and to increase the efficiency and effectiveness of disbursements.²¹ There have been advances. The ALNAP website on the state of the humanitarian system is a model of effective communication²². The IAP also recommends mechanisms such as IATI be strengthened. The IATI Standard does enable funds to be traced through the delivery chain, but this can happen only when all actors provide high-quality data on their contributions and humanitarian activities.²³

The future of monitoring

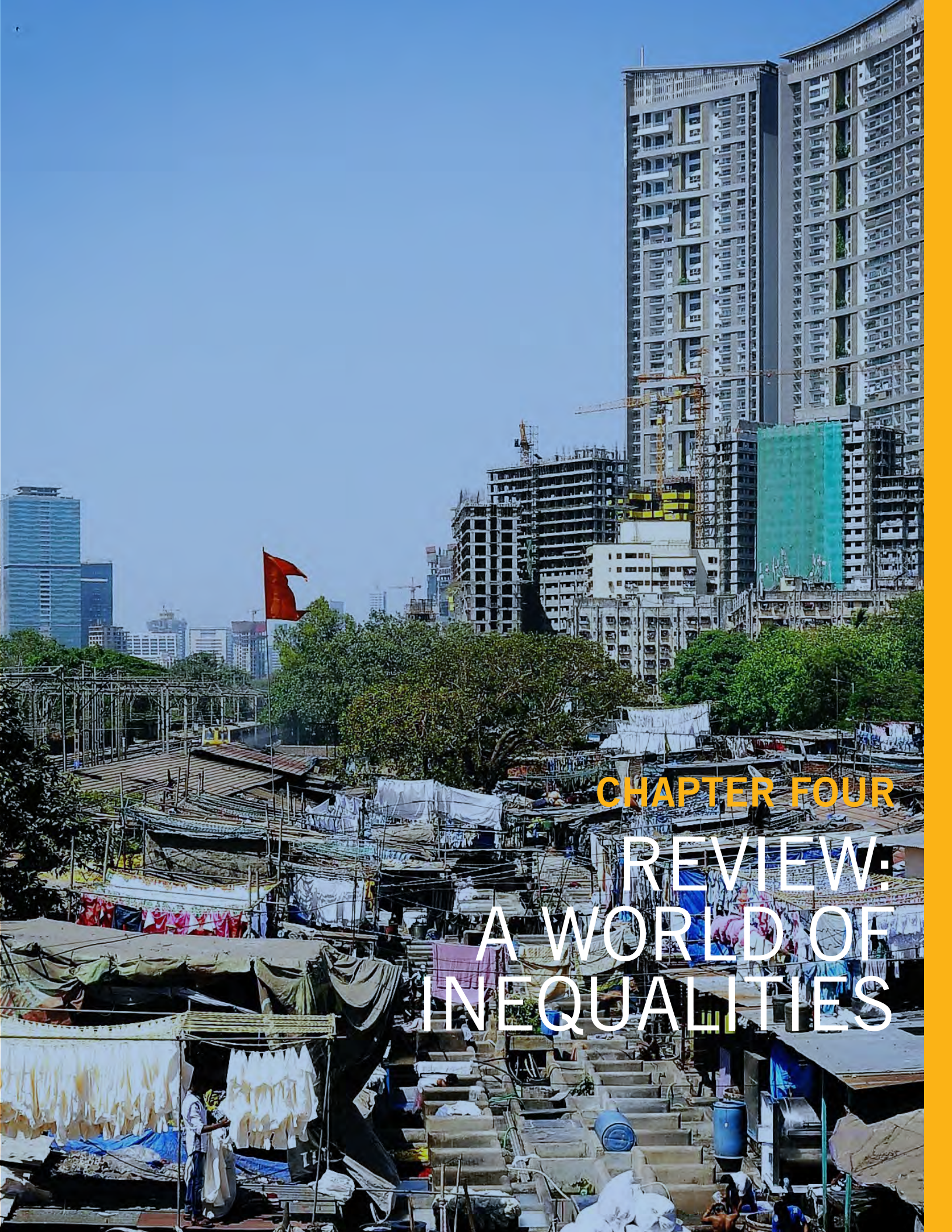
Much progress has been achieved in monitoring some indicators and identifying how existing gaps might be addressed. Yet the gaps remain vast, and the IAP is convinced only a concerted effort from the international community and national governments will adequately address them. This requires strengthening the capacities of independent national bodies producing and analysing data, and of civil society engendering the political will so that data is used to promote the right to health through more efficient approaches and equitable policy options.

The most important gaps for this concerted action include: the need for governance mechanisms where all users and potential users of data, including parliamentarians and young people, have a voice; the need to combine quantitative and qualitative data for a better picture of people's experiences; and the need for further disaggregated data, so

progress can be measured on the impact of policies on groups historically neglected or actively discriminated against.

The IAP believes that meeting these needs is critical for the success of the Global Strategy. But we insist on prioritizing building national capacities and strengthening civil society. National capacity is essential for generating the data that is the raw material of accountability at national, regional and global levels. It is a scandal that in an era of rapid technological progress we do not have hard data and must rely on estimates of basic indicators, such as maternal mortality. In a world where major investments and minor personal decisions rely on a plethora of information, policy-makers still lack the guidance that disaggregated data could supply to redress long-standing inequalities and evaluate programmes aimed at rebalancing societal benefits. A strong civil society can ensure the data are used to hold all stakeholders, including donors and civil society organizations, to account.

International donors have long recognized the merits of recommendations emerging from the monitoring exercises we have analysed, but they have not yet acted with sufficient resolve to make them a reality. Instead of spending resources on multiple evaluations of their own projects, they should reserve a significant proportion of their international aid to support the development of national capacities and a stronger civil society. In this way, their projects – and the health systems and the social determinants of health – will be evaluated from the perspective of users and put to use to promote healthier lives for all.



CHAPTER FOUR

REVIEW:
A WORLD OF
INEQUALITIES

Inequality that produces gross unfairness in life chances is a scourge of the modern world and a major challenge to achieving the Global Strategy and the Sustainable Development Goals. The first Global Strategy and the Millennium Development Goals made significant progress, but the mantra of the new agenda, leave no one behind, acknowledges that inequality remains a deep cause of political and economic instability, and often reflects gross violations of human rights.

**EXPERIENCE WITH THE
MILLENNIUM DEVELOPMENT
GOALS (MDGS) SHOWS
THAT APPROPRIATE METHODS
FOR TRANSPARENTLY
COLLECTING AND REPORTING
CAN BE ACHIEVED WITH
SUFFICIENT POLITICAL WILL.**

Therefore, the IAP has made inequality the centrepiece of its analysis of results. The focus is on economic inequality, but we address gender and age inequalities where appropriate, and where disaggregated data is available. We are aware of the many other inequalities that demand attention – those based on ethnicity, disability, sexual orientation and gender identity, for example – and of the confluence of inequalities faced by many marginalized groups, which may be subjected to multiple forms of discrimination. They may well be the focus of future reports.

IAP subset of results and rights indicators

The IAP does not have a direct monitoring function. Our role is to review and comment on the results of monitoring by others. The objective, therefore, is not to report all the latest data, but to provide a snapshot of progress in the Global Strategy and help harmonize reporting.

We have selected a set of easily understood indicators to illustrate progress in the three Global Strategy objectives of survive, thrive, transform, and for the three population

groups of women, children and adolescents. While the effective enjoyment of human rights underpins all results indicators, specific indicators on legal rights for each group have been added to highlight the importance of legal frameworks for achieving health results.

In keeping with its role to support harmonized reporting, all IAP indicators are aligned with the SDG indicators and the Indicator and Monitoring Framework for the Global Strategy (noting that the latter also includes two non-SDG indicators on stillbirth and adolescent mortality, which have been included for completeness). Availability of data was not a selection criterion, as the IAP seeks to identify indicators that should be monitored even when data are not collected or globally reported on. Experience with the Millennium Development Goals (MDGs) shows that appropriate methods for transparently collecting and reporting can be achieved with sufficient political will. Data on former MDG indicators are available for most countries, but further development of an internationally agreed methodology is required for several SDG indicators.²⁴

Data on inequalities

The IAP has analysed the availability of data on the selected indicators to monitor the reduction of inequalities among countries and along wealth, age, and gender dimensions.

Effective monitoring for equity should assess disparities based on identity that may reflect discrimination. Answerability and accountability demand public access to all information used in monitoring, so that health-system users and civil society are aware of progress and areas of concern.

For each indicator a range of data sources was identified, including from the Sustainable Development

Goal custodian agencies identified by the Inter-Agency and Expert Group on Sustainable Development Goal Indicators (IAEG-SDG) as being responsible for compiling the data at the global level and for global reporting.²⁵ Tables below provide an analysis of the availability of disaggregated data. Disaggregated data are available across a range of sources, though there is no consolidation, and methods are not always aligned.

Current availability of data disaggregated by wealth quintile is poor, in particular on maternal and adolescent mortality and stillbirths. However, disaggregated data by age,

cause of death and wealth quintile on maternal mortality will be available in 2017 from the Maternal Mortality Estimation Inter-Agency Group (MMEIG). Disaggregation of child and neonatal mortality and child nutrition data by wealth quintile is available from UNICEF, the custodian agency for this indicator, but for only 95 low-income countries. UNFPA and Countdown to 2015 have analysed income equity of family planning and the adolescent birth rate in low- and lower-middle-income countries. Some analysis is also done by WHO Health Equity Monitor on several indicators but for a limited set of countries.

TABLE 1. AVAILABILITY OF DATA BY WEALTH QUINTILE

	Women	Children	Adolescents
Survive	1. Maternal mortality (3.1.1)	2a. Child mortality (3.2.1)	3. Adolescent mortality
		2b. Neonatal (3.2.2)	
		2c. Stillbirths	
Thrive	4. Family planning (3.7.1)	5a. Stunting (2.2.1)	6. Adolescent birth rate (3.7.2)
		5b. Child obesity (incl. in 2.2.2)	
Transform	7. Poverty (1.1.1)	8. Education – Attainment of proficiency level (4.1.1)	9. Youth not in education or employment (8.6.1)
Legal Rights	10a. SRH legal rights (5.6.2)	11. Birth registration (16.9.1)	12. Sexual violence (16.2.3)
	10b. Legal protection from domestic violence (proxy for 5.1.1)		

Note: SDGs are presented in parenthesis after each indicator. Grey: disaggregation is not applicable. Green: disaggregated data is available for 75% of countries. Yellow: disaggregated data is available for 40–74% of countries. Red: disaggregated data is available for less than 40% of countries. This is the same classification used by the World Health Statistics 2016. However, while they used only the SDG custodian agency data; we analysed all identified data sources. These can be found in Appendix A.

CHAPTER FOUR

Data disaggregated by age are often available, but through the Institute for Health Metrics and Evaluation rather than the SDG custodian agency. However, several custodian agencies are now preparing this disaggregation. Data on the portion of youth not in education or employment are not available by age group from ILO. Data on adolescent birth rate are available from UN DESA Population Division, but only for the 15–19 age group, and the accuracy of estimates for younger adolescents is poor.

TABLE 2. AVAILABILITY OF DATA BY AGE

	Women	Children	Adolescents
Survive	1. Maternal mortality (3.1.1)	2a. Child mortality (3.2.1)	3. Adolescent mortality
		2b. Neonatal (3.2.2)	
		2c. Stillbirths	
Thrive	4. Family planning (3.7.1)	5a. Stunting (2.2.1)	6. Adolescent birth rate (3.7.2)
		5b. Child obesity (incl. in 2.2.2)	
Transform	7. Poverty (1.1.1)	8. Education – Attainment of proficiency level (4.1.1)	9. Youth not in education or employment (8.6.1)
Legal Rights	10a. SRH legal rights (5.6.2)	11. Birth registration (16.9.1)	12. Sexual violence (16.2.3)
	10b. Legal protection from domestic violence (proxy for 5.1.1)		

Note: see key in Table 1

Availability of gender-disaggregated data is mixed. Data on women living in poverty are not available from the World Bank or main UN agencies. Disaggregated data on sexual violence affecting women exists, but UNICEF, the custodian agency, has data from only 35 countries.

TABLE 3. AVAILABILITY OF DATA BY GENDER

	Women	Children	Adolescents
Survive	1. Maternal mortality (3.1.1)	2a. Child mortality (3.2.1)	3. Adolescent mortality
		2b. Neonatal (3.2.2)	
		2c. Stillbirths	
Thrive	4. Family planning (3.7.1)	5a. Stunting (2.2.1)	6. Adolescent birth rate (3.7.2)
		5b. Child obesity (incl. in 2.2.2)	
Transform	7. Poverty (1.1.1)	8. Education – Attainment of proficiency level (4.1.1)	9. Youth not in education or employment (8.6.1)
Legal Rights	10a. SRH legal rights (5.6.2)	11. Birth registration (16.9.1)	12. Sexual violence (16.2.3)
	10b. Legal protection from domestic violence (proxy for 5.1.1)		

Note: see key in Table 1

A woman wearing a bright yellow sari with a red and green patterned border is sitting on the ground, sorting through agricultural products. She is surrounded by several large white sacks filled with different types of crops, including what appears to be coffee beans and other dried goods. She is holding a small glass cup in her hand, and there are more cups scattered around the sacks. The scene is set outdoors on a paved surface.

WOMEN: PROGRESS
SLOWER THAN EXPECTED

ADOLESCENTS: DO WE
HAVE A FUTURE?

CHILDREN: POSITIVE TRENDS,
BUT NOT FAST ENOUGH

WOMEN: PROGRESS SLOWER THAN EXPECTED

What do the indicators on the four dimensions of survive, thrive, transform and legal rights tell us about the recent trends in women's health? In the following review, we present a snapshot based on the best available evidence.

Ending preventable deaths

Concerted efforts under the Global Strategy helped achieve a remarkable reduction in maternal deaths, down to a global maternal mortality ratio (MMR) of 216 deaths per 100 000 live births in 2015 from 385 in 1990. However, scandalous inequalities between countries still exist, from an MMR of one per 100 000 in Finland to 1360 in Sierra Leone.²⁶ The lifetime risk of dying from pregnancy and childbirth-

related complications, including unsafe abortions, is 80 times higher in low-income countries than in high-income countries, the greatest gap in a major public health indicator.²⁷

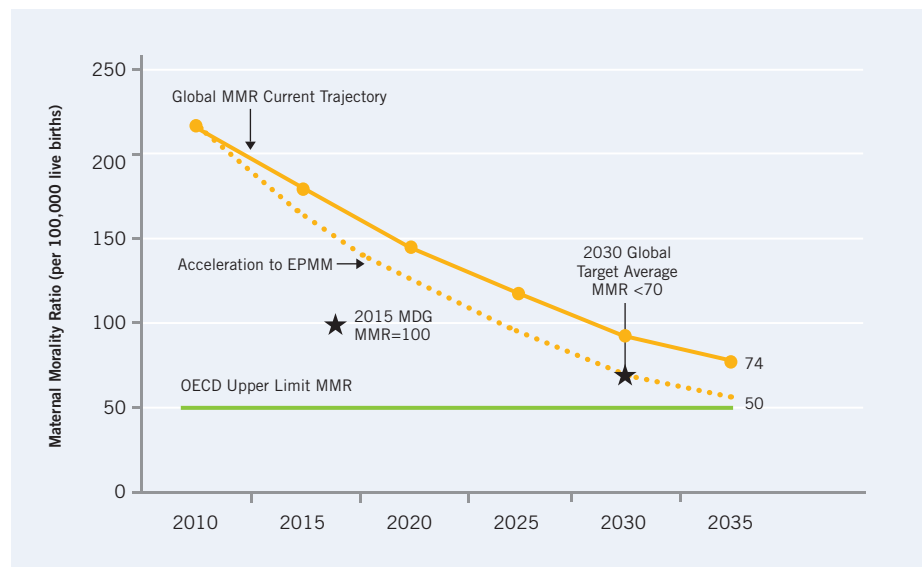
Within countries, studies have shown huge national inequalities, both between the wealthiest and poorest regions and individuals. Ethnic inequalities compound these deprivations of the basic right to life of all

human beings. In the United States of America, for instance, maternal mortality of women of colour is much higher than that of white women. Age inequalities are also significant, as early childbearing poses increased risks to adolescent mothers, and is a leading cause of death among girls aged 15–19 globally.

More rapid progress (three times faster) than that achieved during 1990–2015 is required to reach the

Toward ending preventable maternal mortality (EMPP) Worldwide – Reaching MMR of 70 by 2030 and MMR of 50 by 2035

- Global Current Trajectory
- ... Global Accelerated Trajectory
- OECD Upper Limit MMR (capped at 50)



Source: WHO et al., 2014a

global goal of no more than 70 deaths per 100 000 live births. Reduction in maternal mortality ratios will have to be at least 7.3% annually. Although ambitious, accelerated progress is achievable.²⁸ Just as importantly progress will need to be more evenly distributed than during the first Global Strategy, where a handful of countries accounted for most of the progress. Global leaders need to show real commitment to ending these unacceptable inequalities in both the social determinants of maternal mortality and health-system factors, mobilizing resources and engaging in multisectoral strategies to create the world we want.

Monitoring exercises usually give scant attention to unsafe abortion, one of the major causes of maternal mortality, and one that is almost totally preventable. Abortion rates have declined significantly over the past 25 years in developed

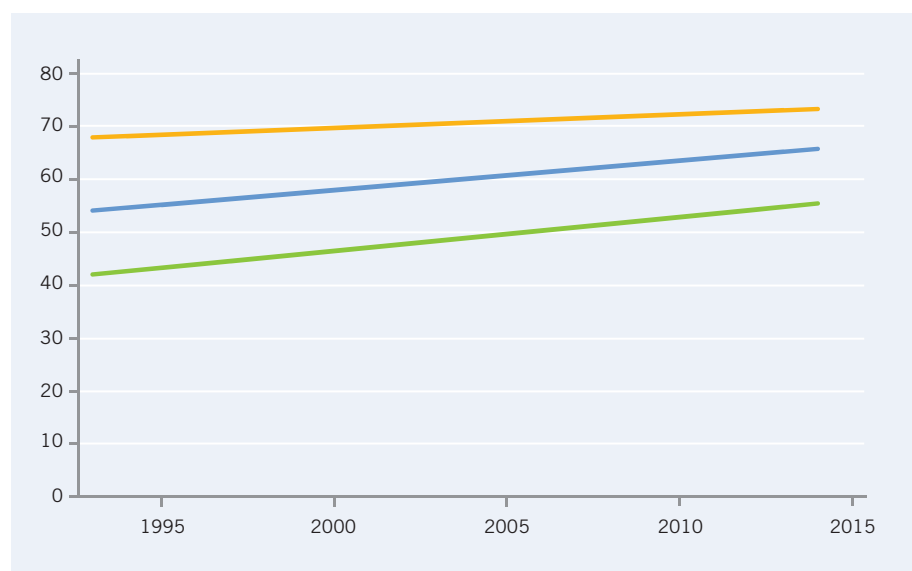
countries, and are at an historic low, with the annual rate per 1000 women of childbearing age (15–44 years) falling from 46 to 27. But in countries where abortions are unsafe due to criminalization or health-system failures that create inordinate barriers, rates are virtually unchanged, down from 39 to 37.²⁹ Importantly, a recent study found that abortion occurred at similar rates, whether legal or prohibited. For example, in Latin America, a region with highly restrictive abortion laws, one in three pregnancies ended in abortion from 2010–2014, higher than any other region.³⁰ Evidence-based laws and policies are needed to prevent the deaths of women and girls, and to recognize their human rights to dignity and equality.

Satisfying demand for contraceptives

Many women who die from causes related to pregnancy and childbirth

did not want to get pregnant. If women are to realize their human rights to health and life, it is imperative they be able to control their own fertility and that this unsatisfied demand for family planning is met, which is why SDG indicator 3.7.1 is worded as the “proportion of women of reproductive age (15–49) who have their need for family planning satisfied with modern methods”.³¹ One component of the Global Strategy is to ensure access to sexual and reproductive health information and services for all who need it, including adolescents.

Inequality in access to contraceptives between countries is also huge, ranging from 1.2% in Somalia to 75.1% in Thailand.³² As the graph below shows,³³ there is a positive trend towards a diminishing gap between rich and poor in satisfying demand for family planning, with faster progress among poorest



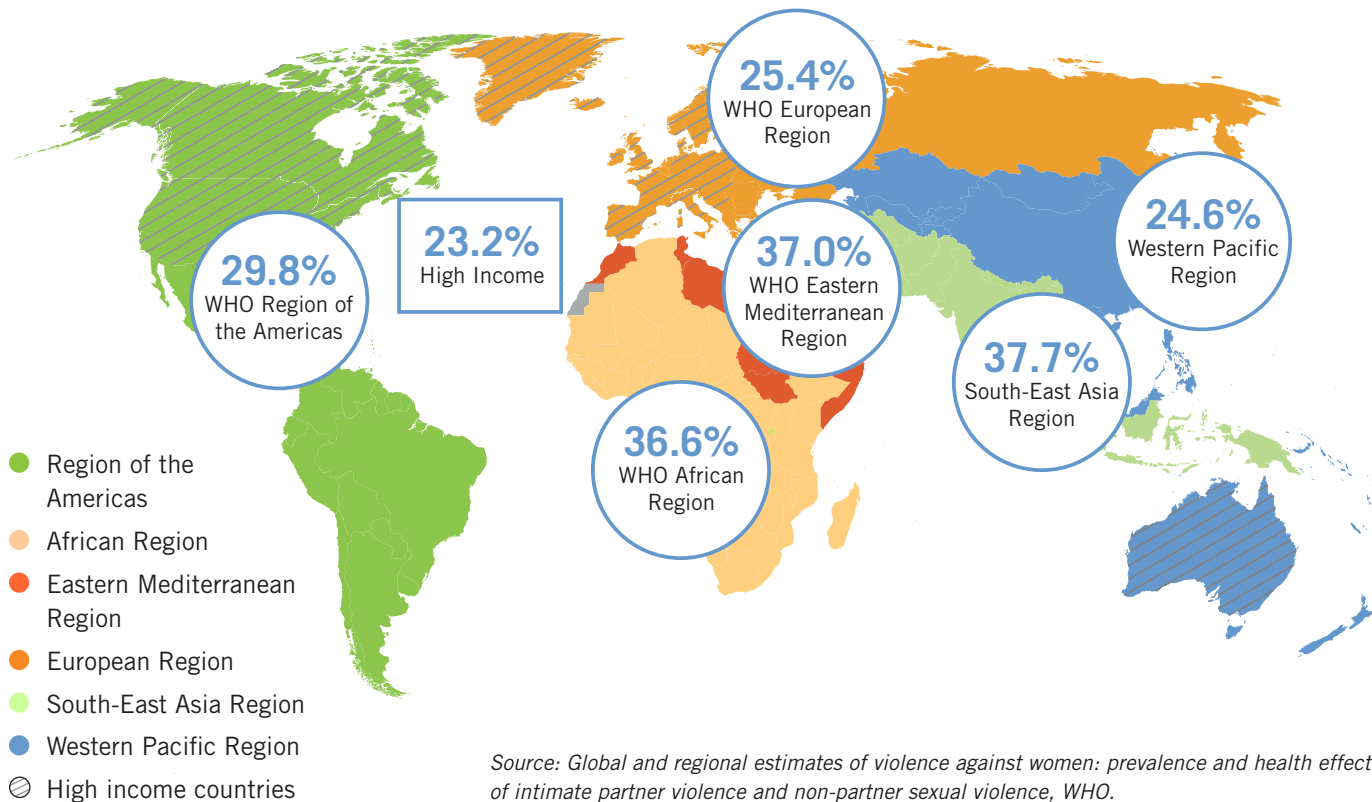
Time trend in proportion of demand for family planning satisfied for all women, and for those in the poorest (Q1) and richest (Q5) wealth quintiles, based on an analyses of 89 countries

Wealth Quintiles:

- All
- Q1 (poorest)
- Q5 (richest)

Source: Special analysis prepared for the IAP by Countdown to 2030 Equity Working Group at the Universidade Federal de Pelotas. Their full report can be accessed in the IAP website.

Regional prevalence rates of intimate partner violence by WHO region



1 IN 3 WOMEN
THROUGHOUT THE WORLD
WILL EXPERIENCE PHYSICAL
AND/OR SEXUAL VIOLENCE
BY A PARTNER OR
SEXUAL VIOLENCE BY A
NON-PARTNER

women (this has not happened in all countries; for example, in Ethiopia, contraceptive use has increased significantly, but was higher among the wealthiest group). The difference between the wealthier and the poorest quintiles, however, remains large (17.9%). At the current rate, equality would only be reached by 2061. Age inequalities are significant in the majority of countries for which data are available, with a gap in demand satisfied of 55% in India between poorly served adolescents aged 15–17 and adult women. Again, we need the political will to promote legal and institutional changes and to mobilize significant

additional resources to produce a faster rate of progress.

Ending extreme poverty

Extreme poverty can be as limiting to people's life choices as violations of civil rights, and affects every aspect of women's health. Extreme poverty and lack of empowerment reflect and result in women being marginalized and excluded from social and economic policies, and the benefits of education and sustainable development.³⁴ Eliminating extreme poverty will greatly benefit women, who are disproportionately represented

among the poorest. According to the World Bank, in 2015 the number of people living in extreme poverty fell below 10%, a drop of more than two thirds since 1990. Many countries have made good progress in reducing extreme poverty, though global totals tend to be dominated by the two largest countries, China and India. If national growth rates for the past 10 years prevail for the next 15 years, the extreme poverty rate will fall to 4% by 2030, but will still be 20% in sub-Saharan Africa.

In the absence of corrective policies, the wealth gap results in large health-coverage inequalities for women, children and adolescents. The poorest-to-richest quintiles difference is at least 20 percentage points in the composite coverage index in half of countries.³⁵ Nationally, coverage levels of reproductive, maternal, newborn and child health interventions increased over the past decade, accompanied by faster improvements in the most disadvantaged subgroups, with country variations.

Legal rights for gender equality and access to care, information and education

Women's health is closely linked to gender equality. Enabling legislation – and implementing and monitoring it – is necessary to empower women and promote their well-being, but not enough. Laws are important to ensure accountability and access to justice and redress, but not sufficient. At the country level, they can still present barriers to accessing sexual health services. While the UN Human Rights Council has adopted, and WHO has published guidelines

and strategies on how to use human rights concepts to improve programmes and service delivery, most countries have not used these tools to identify or analyse legal, regulatory and policy barriers to sexual and reproductive health.³⁶

Civil society organizations have embraced human rights approaches to women's health for identifying the most vulnerable, promoting empowerment and holding governments to account. Maternal mortality and morbidity, for instance, is now seen not just as a public health issue but a human rights one, too, involving the right to non-discrimination, and other human rights deprivations, and the need for enhanced government accountability.³⁷

As of 2015, 89 countries had laws and policies in place to allow adolescents, regardless of marital status, to access sexual and reproductive health services.³⁸ Data are mostly available on abortion rights. Between 1996 and 2013, the percentage of countries permitting abortion increased gradually for all legal grounds.³⁹ Of 145 countries with available data in 2012, governments in 87 (60%) had implemented measures in the past five years to improve access to safe abortion services to the extent permitted by law. There has been a remarkable growth in the number of countries that have passed legislation on gender-based violence⁴⁰, a serious problem with high incidence all over the world.

For accountability, states must use national judicial systems to enforce laws. National human rights institutions exist as independent bodies

and are uniquely positioned to hold governments accountable to their commitment to respect, protect and fulfil reproductive rights as defined in international law and domestic legislation and policies. They are well placed to help states meet international commitments to human rights in practice, by integrating international standards in national legislation and regulations. The UN treaty-monitoring bodies have, through periodic reporting, also held states to account by publishing their concerns and recommendations, including in relation to sexual and reproductive health.

ADOLESCENTS: DO WE HAVE A FUTURE?

By including adolescents for the first time, the updated Global Strategy makes an important contribution to realizing the full promise of the 2030 Agenda. Engaging this generation of adolescents, using their resourcefulness and determination, will bring tremendous social, political and economic benefits for whole societies. As UN Secretary-General Ban Ki-moon said: “Adolescents can be a key driving forces in building a future of dignity for all.”

The IAP is pleased the new Strategy brings attention to this key, historically neglected group. Two chapters of this report will address adolescents. This section reviews some key indicators that show the challenges faced by adolescents, and section 5.2 calls for actions and remedies to overcome those challenges.

Adolescent's deaths: tragic and catastrophic

The death of an adolescent is a personal tragedy, but also a catastrophe for society. Adolescent mortality declined by a modest 12% from 2000 to 2012, the slowest progress compared with other age brackets. Still, it receives little attention, perhaps because rates are lower than in most groups. But the majority of adolescent deaths are preventable and should be addressed by policy-makers seeking favourable benefit–cost ratios.

The facts are sobering. In 2013, the leading cause of death among 10–14 years-olds was HIV and AIDS.

Among older adolescents (15–19 years), it was road injuries, suicide and interpersonal violence (violence between individuals).⁴¹ Data on wealth inequalities is not available, but the “carnage from injuries experienced by young people is inextricably linked to glaring inequalities in living conditions and political will to regulate exposure to hazards.”⁴² The health needs of young people aged 10–24 are too readily bypassed. Neglect of this group represents a “myopic standpoint” with profound consequences. It denies attention to pervasive inequalities in their health with ramifications for future population health.⁴³

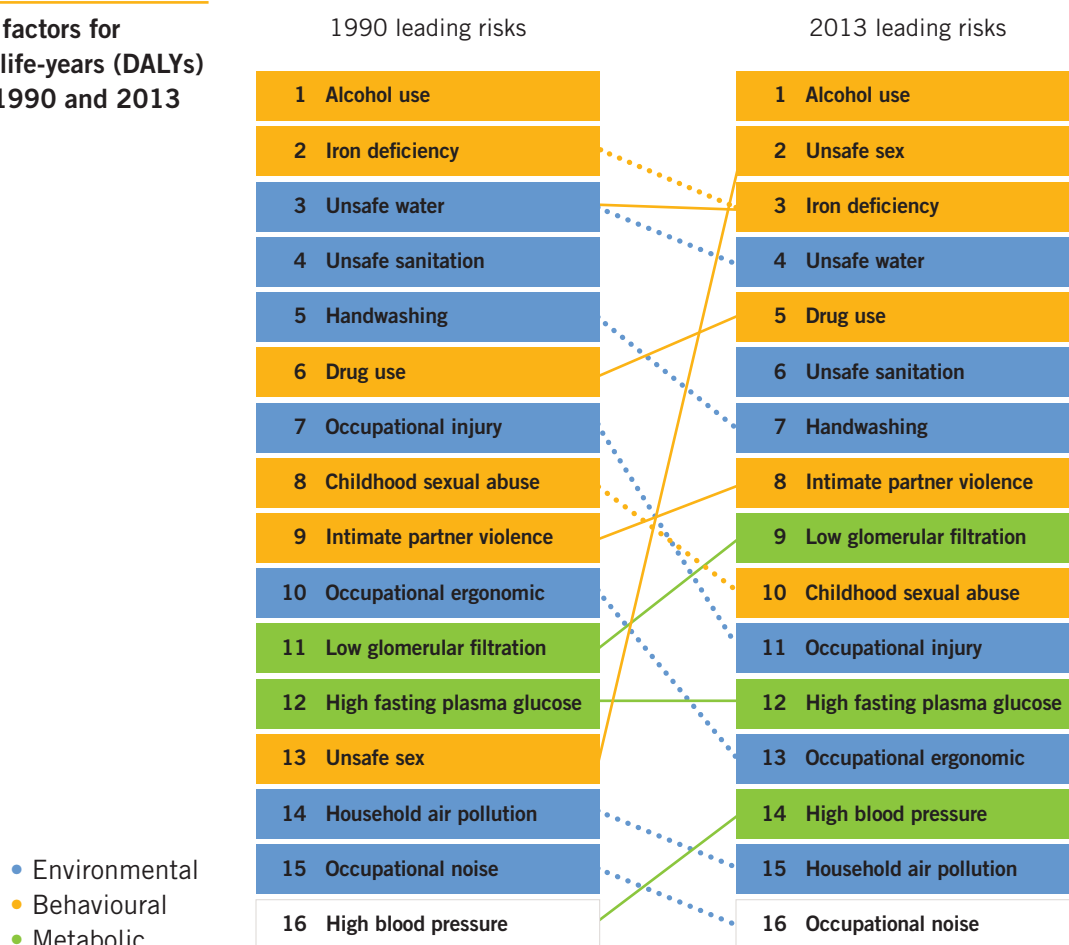
Global burden of disease data show the substantial and increasing burden of unsafe sex, which rose from the 13th ranked risk factor among 15–19 year-olds in 1990 to the second in 2013. Unsafe sex is only partially linked to sexual violence, but both are rooted in gender inequality. The leading cause of death for adolescent girls is suicide, an unknown proportion

of which is linked to unwanted pregnancies, especially for those not married or in a stable union. The stigma surrounding suicide and pregnancy out of wedlock can preclude girls from seeking help, and this is exacerbated for marginalized and discriminated-against groups. In addition, in many facilities in low- and middle-income countries, health workers are not trained in mental health issues and medicines are not available.⁴⁴

Children having children

Childbirth among adolescents is one of best studied indicators of the Global Strategy. As birth rates have fallen sharply among older women, adolescent birth rates have remained relatively stable, down from 59 per 1000 women in 1990 to 51 in 2015. While much is changing around young people's lives, the likelihood of an adolescent girl becoming a mother is about the same as in previous decades. Worldwide, an estimated 16 million 15–19 year-olds give birth each

Leading global risk factors for Disability-adjusted life-years (DALYs) for ages 15–19 in 1990 and 2013



Source: *Our future: a Lancet commission on adolescent health and well-being*. 2016

year. What seems to be an overall stagnation is a glaring case of inequality, with the decline in developed countries more than four times faster than in developing regions.⁴⁵ Nearly one in five adolescent girls in low- and middle-income countries become pregnant before they reach 18.⁴⁶ And poorer girls are more likely to become mothers than the better-off. This gap is big (136 births per thousand women in 2013 for the poorest adolescents, versus 47 for the richest; see graph below)

and likely to become bigger with the trends in reduction of adolescent fertility rates being slightly faster in the richest quintile (reduction of 0.94 points per year) than the poorest (reduction of 0.45).

For an adolescent girl who becomes a mother, the change affects her own life chances and those of her offspring. A cycle of poverty that is perpetuated across generations may result from her increased health risks, lower her prospects of

pursuing an education and cause difficulty in earning a living. The World Bank has calculated the lifetime opportunity costs related to adolescent pregnancy (the young mother's foregone annual income over her life), ranges from 1% of annual gross domestic product in China, where rates are low, to 26% in Nigeria, 27% in Malawi and 30% in Uganda. Around the world, adolescent pregnancies may represent a profound abuse of human rights, with early and forced

CHAPTER FOUR

marriage in some countries and unmarried adolescents denied access to contraceptives in others. Worldwide, 49% of adolescent pregnancies are unintended. This figure reaches 74% in Latin America, where two thirds of 19-year-olds report having had sexual intercourse and 43% are married. In other regions, the proportion of wanted pregnancies is higher, but these frequently result from early and forced marriage and the lack of life alternatives for adolescent girls living in poverty.

Among similar income countries, inequalities are also common, reflecting differences in health and education policies and, importantly, social attitudes to sexuality and gender equality. Even high-income countries differ from one another. For example, in most European countries where an adolescent's right to comprehensive sexuality educa-

tion and reproductive health services is widely accepted, adolescent pregnancies are rare, while in the United States of America, where adolescent sexuality is a subject of political controversy, pregnancies are still common.

Youth not in employment, education or training

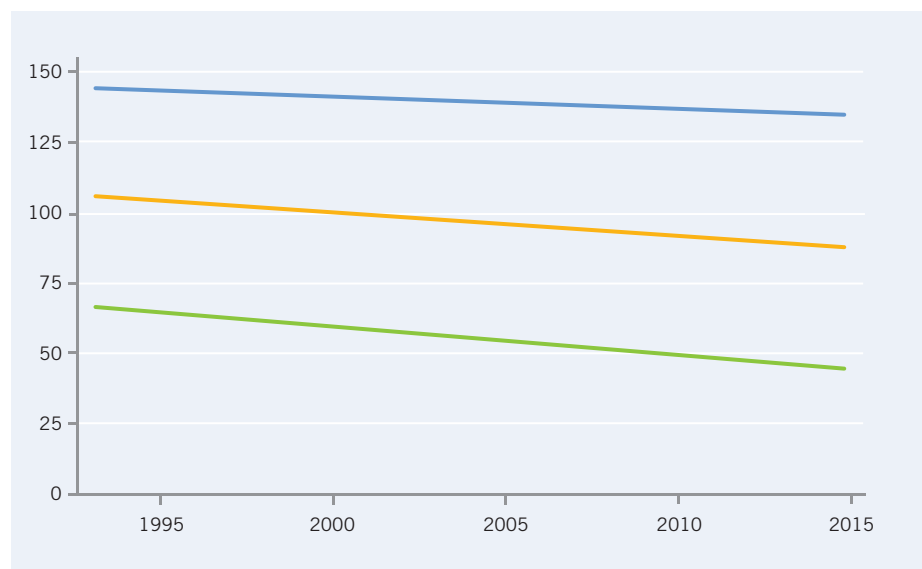
Youth employment and education touch on all aspects of growth and development. Young people aged 16–24 who are not in employment, education or training (they are identified as NEET) at the end of schooling are more likely to have lower earnings, greater unemployment and employment instability throughout their adult lives. Poor mental and physical health in adolescence and difficult transitions into the workplace go hand in hand.⁴⁷ NEET youths have greater odds of psychiatric disorder,

substance use and suicidal behaviour compared with those who exclusively study.⁴⁸ They have, therefore, been included in the Sustainable Development Goals monitoring framework and are monitored by the Global Strategy.⁴⁹ Currently, data from the ILO are available only for 95 countries.

Those who leave school and are unemployed or inactive make up about 13% of the youth population across OECD countries, and up to 30% in rapidly developing low- and middle-income countries, such as South Africa and India.⁵⁰ Young people are almost three times more likely than adults to be unemployed.⁵¹ Gender differentials in youth unemployment rates are decreasing at a global level and in most regions, but remain significant. Males are generally favoured, except in the developed economies and the European Union and East Asia,

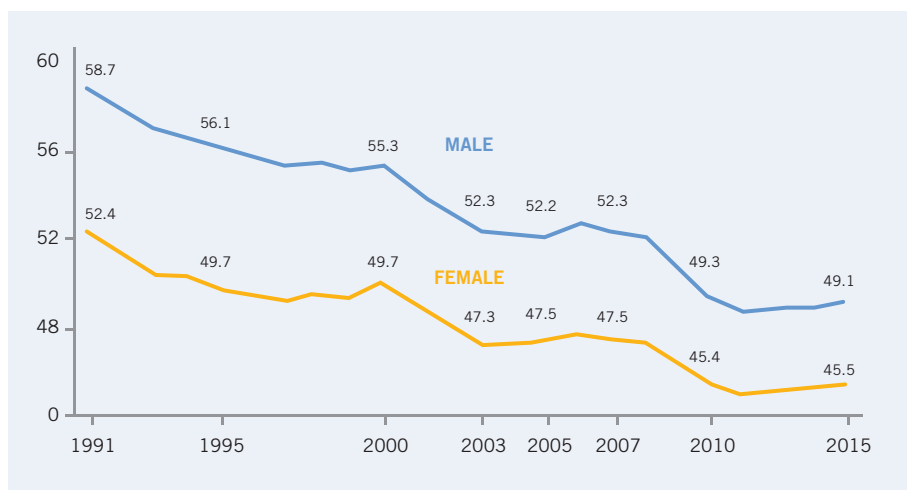
Time trend in adolescent fertility rates (births per thousand women-years, age 15–19 years), global, and for adolescents in the poorest (Q1) and richest (Q5) wealth quintiles, based on analyses of 69 countries

Wealth Quintiles:
— All
— Q1 (poorest)
— Q5 (richest)



Source: Special analysis prepared for the IAP by Countdown to 2030 Equity Working Group at the Universidade Federal de Pelotas. Their full report can be accessed in the IAP website.

Youth labour force participation rates in developed economies and European Union, by sex, 1991–2014



Source: *Global employment trends for youth 2015*, ILO

where unemployment rates for young males exceed those for females.⁵² Even when unemployment rates are higher, young males have a higher rate of participation in the labour force, as can be observed in the graph below. This apparent paradox is explained by the fact that a person is defined as unemployed when he or she is out of work but is actively looking for a job. Young women are working in a much lower proportion, but those who are looking for a job are finding one.

The ILO publication, *Global employment trends for youth 2015*, reports some encouraging prospects for youth employment and education. Yet despite the tendency for more young women and men to engage in secondary and tertiary education, millions in low-income countries still leave school early to take up employment. Young people still face discrimination in the job market and suffer from precarious status.⁵³ More than 47.5 million young people aged 15–17 work in jobs that expose them to environ-

mental hazards, excessive hours or physical, psychological or sexual abuse. Young women are more likely than young men to have difficulty finding safe, stable work in non-hazardous occupations.⁵⁴

Sexual violence

The 2014 UNICEF study, *Hidden in Plain Sight*, estimates that 120 million girls under the age of 20 (about 1 in 10) have been subjected to forced sexual intercourse or other sexual acts at some point of their lives.⁵⁵ It warns that any estimates at global, regional and country level of the prevalence of sexual violence should be interpreted with caution and assumed to be an underestimate of the actual number of children victimized.

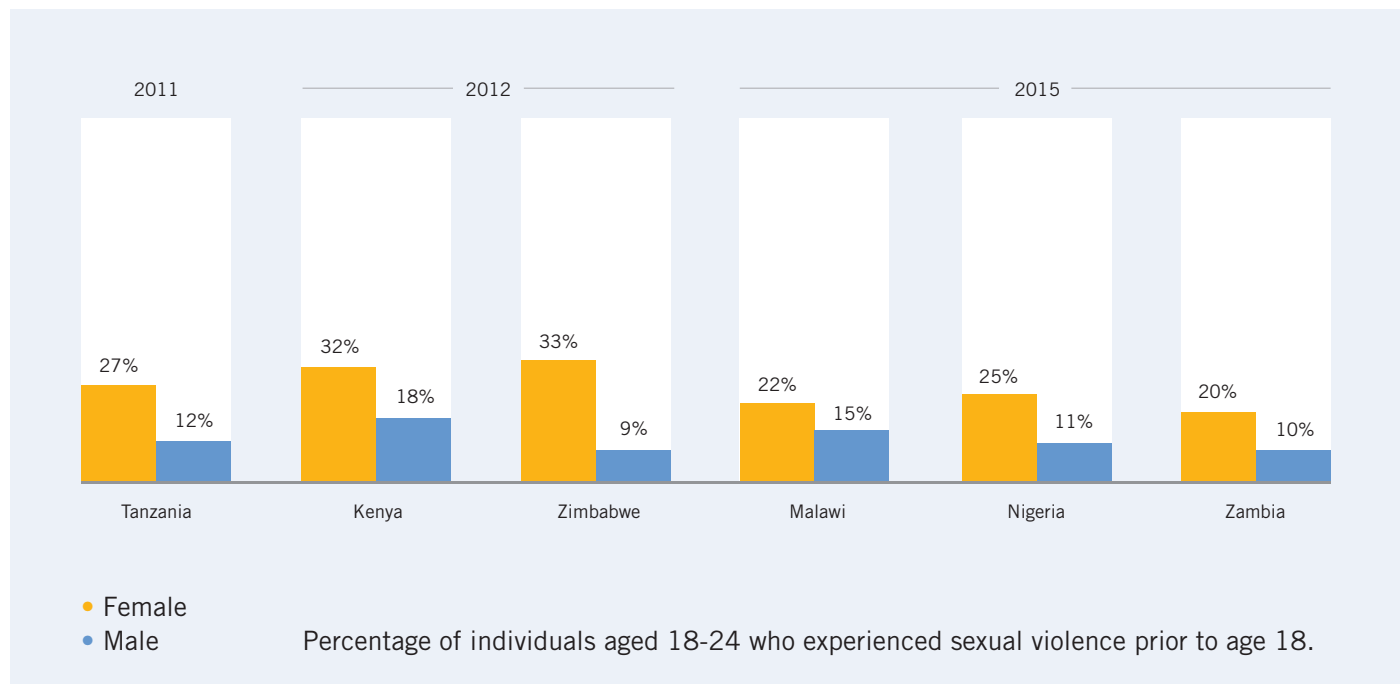
Violence against women is everywhere. Across the world, they are subjected to sexual, physical, psychological and economic violence.⁵⁶ Overall, one in three women experience physical and/or sexual violence by an intimate

partner or sexual violence by a non-partner at some point in their lives.⁵⁷ WHO estimates prevalence of exposure to intimate partner violence is high among young women aged 15–19 (29.4%), suggesting violence commonly starts early in relationships.⁵⁸

Reported lifetime prevalence rates from available Demographic and Health Surveys data were higher across Africa than other regions, with more than half of the 19 countries with data reporting a prevalence of at least 20%.⁵⁹ The health consequences are serious; girls who experience violence are 2.6 times more likely to suffer alcohol abuse and 2.3 times more likely to suffer from depression and anxiety. Girls experience higher rates of sexual violence but boys are victims also.⁶⁰

The IAP recommends that urgent and high priority be given to scaling up efforts to prevent violence in the first place and to provide services for women experiencing violence.

Girls and boys experience high rates of sexual violence before age 18.



Source: *Breaking the cycle of violence – Together for girls stakeholder report 2015–2016*

Governments must implement the WHO clinical and policy guidelines and coordinate efforts across sectors to ensure women's social and economic human rights. The private sector also can play an important role.⁶¹ The horrifying data on sexual violence reflect social norms that perpetuate male control of women, and the lack of effectively implemented laws and policies to protect them from abusive intimate partners. Successful and promising strategies include school initiatives to prevent violence within dating relationships, microfinance opportunities for women combined with gender-equality education, and programmes to reduce alcohol use and abuse.⁶²

Few countries have data for SDG indicator 16.2.3, the proportion of young women and men aged 18–29 who experienced sexual violence by age 18. Efforts are needed to improve the availability of comparable data across countries, a challenge in the absence of a common definition and instruments that measure sexual violence. UNICEF, the custodian agency for this Sustainable Development Goal, and all participating agencies have a mission to harmonize the monitoring of sexual violence.⁶³

As birth rates have fallen sharply among older women, adolescent birth rates have remained relatively stable, down from 59 per 1000 women in 1990 to 51 in 2015.

CHILDREN: POSITIVE TRENDS, BUT NOT FAST ENOUGH

As we did in the previous sections on women and adolescents' health, we now turn our attention to the results for children on four dimensions of survive, thrive, transform and legal rights.

Ending preventable neonatal and child mortality – and preventing stillbirths

Under-five mortality fell in all countries between 1990 and 2015, with some of the most substantial reductions in the least developed countries. Today, fewer than 6 million children die before their fifth birthday, less than half the number in 1990. The UN report, *Levels and trends in child mortality 2015*, indicates that a third of countries (62) have achieved or exceeded the targets of Millennium Development

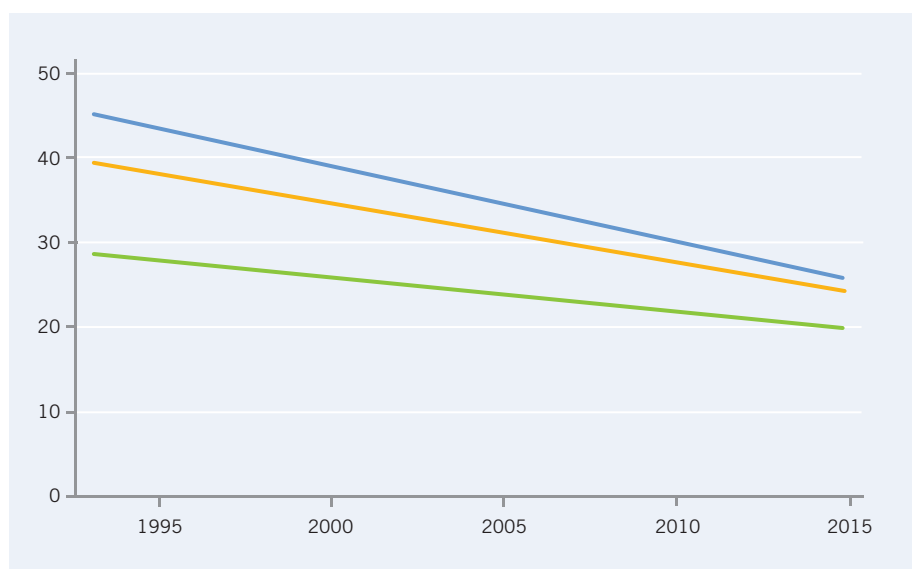
Goal 4, including 12 low-income countries and 12 lower-middle income countries, and a further 75 have reduced their under-five mortality by at least half. Yet this is short of the global target of a two thirds reduction set, and masks inequities between and within countries.

This global figure also masks the change in epidemiology over the past 15 years, as more attention to preventing and managing postneonatal mortality (e.g. through immunization, malaria control, prevention and

management of pneumonia and diarrhoea) has led to a steadily increasing proportion of deaths in the neonatal period,⁶⁴ which now accounts for 45% of under-five mortality. The overall ratio between the developed and developing regions has stayed at 6.6, but the gap between the developed countries and those of the sub-Saharan Africa region has increased, from a ratio of 12 to 13.8. The gap between countries of the same region has also increased, with 21-plus countries in sub-Saharan Africa tripling their

Time trend in neonatal mortality, global, and for births in the poorest (Q1) and richest (Q5) wealth quintiles, based on an analyses of 69 countries

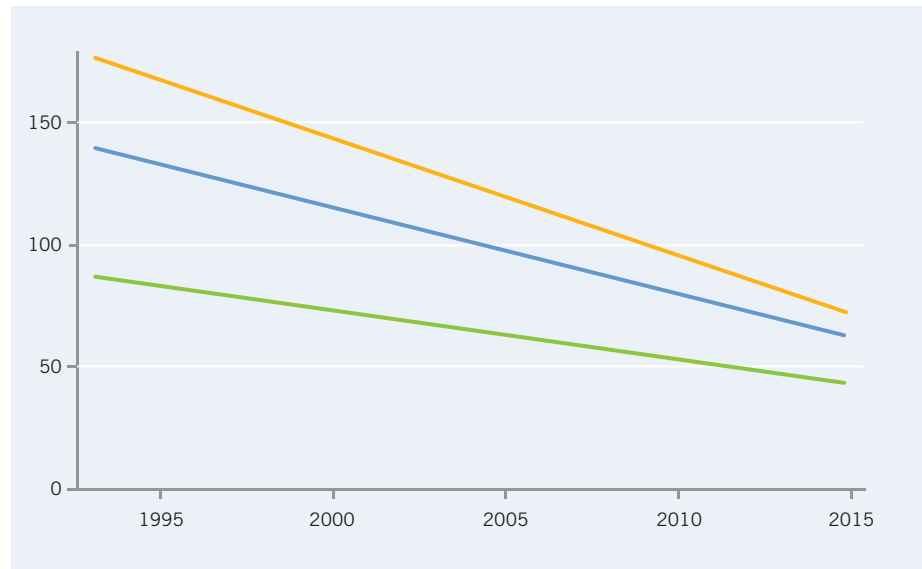
Wealth Quintiles:
 — All
 — Q1 (poorest)
 — Q5 (richest)



Source: Special analysis prepared for the IAP by Countdown to 2030 Equity Working Group at the Universidade Federal de Pelotas. Their full report can be accessed in the IAP website.

Time trend in under-five mortality, global, and for births in the poorest (Q1) and richest (Q5) wealth quintiles, based on an analyses of 69 countries

Wealth Quintiles:
 — All
 — Q1 (poorest)
 — Q5 (richest)



Source: Special analysis prepared for the IAP by Countdown to 2030 Equity Working Group at the Universidade Federal de Pelotas. Their full report can be accessed in the IAP website.

annual rate of reduction of under-five mortality, while others have less than doubled their rate.

In all countries, the rate of reduction in neonatal mortality has been lower than the rate for postneonatal mortality, with one third of all neonatal deaths occurring on the day of birth, a close correlation to maternal mortality.

For both neonatal and under-five mortality the top quintile does better than the poorest quintile, although coverage has increased more rapidly for the poor than for the rich, shrinking the equity gap⁶⁵.

In order to reach the SDG target of 25 or fewer under-five deaths per 1000 live births, 47 countries need to accelerate their reduction in under-five mortality from current rates, and 63 countries need to accelerate their rates to achieve the target of 12 or fewer neonatal deaths per 1000 live births.

So where are the stillbirths?⁶⁶ The Global Strategy has included a stillbirth reduction target of 12 or fewer per 1000 total births, though this is not reflected in the SDG targets. This recognizes the importance of counting stillbirths and its impact on women and their families. The Lancet series on stillbirths, published in March 2016, gives the latest levels and trends in stillbirths from 2000–2015. It makes for sobering reading. Countries with the highest rates⁶⁷ have 47 and 43 stillbirths per 1000 total births, almost three times the global average of 18.4, and 12.6 times that in developed countries. The countries with the highest number of stillbirths have the least data, and although there has been an overall decline in numbers over the past 15 years, in 2015 there were still 2.4 million stillbirths, 98% of which occurred in low- and middle-income countries, with 77% occurring in

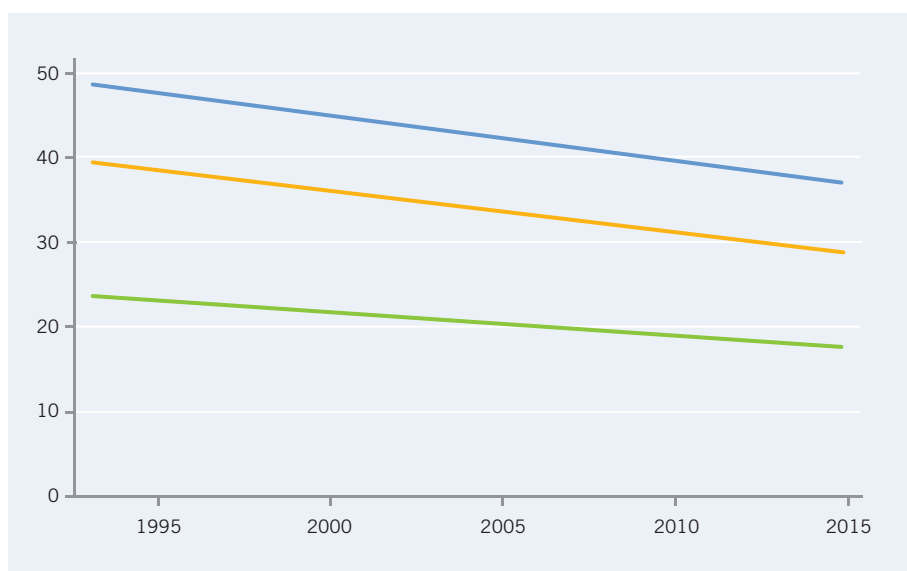
sub-Saharan Africa and South-East Asia. Recognizing stillbirths as a fundamental marker of inequity, and counting and reporting them, will focus attention on the need for access to quality services during pregnancy and childbirth for all, not just for those than can afford them.

The double burden of malnutrition: stunting and obesity

Key headlines in the 2015 UNICEF, WHO and World Bank Group report on child malnutrition are 159 million children with stunted growth in the world, 41 million overweight (10 million more than two decades ago), and 50 million children's lives threatened by wasting. These alarming figures demonstrate the stark inequity within and between countries and across regions of the world. Stunting declined from 39.6% in 1990 to 23.8% in 2015, representing 96 million fewer stunted children. But the decline

Time trend in stunting for children under five years of age, and for those in the poorest (Q1) and richest (Q5) wealth quintiles, based on an analyses of 62 countries.

Wealth Quintiles:
 — All
 — Q1 (poorest)
 — Q5 (richest)



Source: Special analysis prepared for the IAP by Countdown to 2030 Equity Working Group at the Universidade Federal de Pelotas. Their full report can be accessed in the IAP website.

remains too slow and variable across countries.

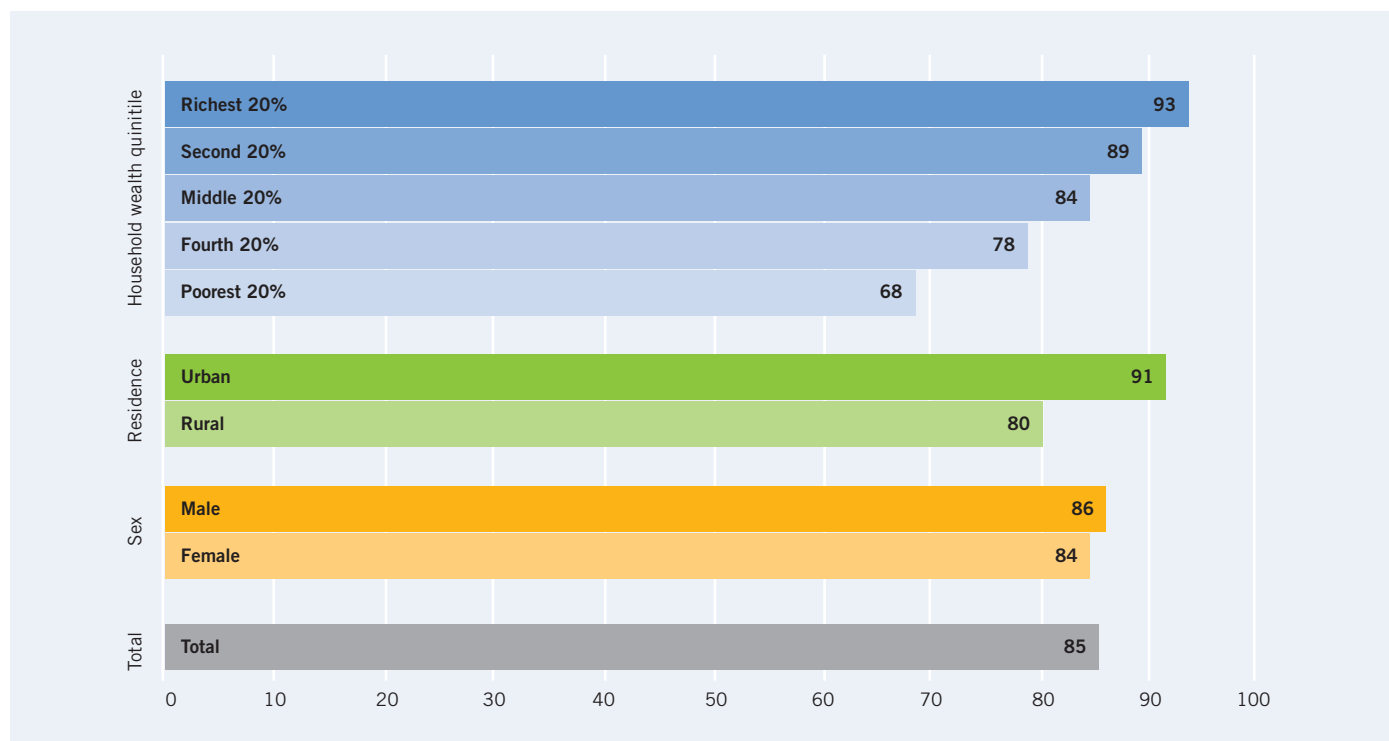
Of the 50 million children wasted, 16 million – 2.4 children for every 100 – were severely wasted. Conversely, 6.1% of children were overweight, up from 4.8% over the same period. Most regions have experienced a decrease in stunting; for example, there has been more than a 50% decrease in Asia and Latin America, alongside an increase in those overweight. However, inequity within regions is considerable, with Eastern Asia having reduced stunting twice as fast as Southern Asia (82% versus 41%). The lifetime impact of stunting on physical and cognitive development and future capital, along with the impact of being overweight on developing noncommunicable diseases, will place a huge burden on countries, especially the lowest income countries.

An analysis of trends in reducing stunting shows increasing inequity between countries, with the low-income countries reducing stunting much more slowly than upper middle-income countries (32% versus 77%). Equity analysis shows stunting to be more prevalent in rural areas, poor households and where mothers are denied basic education. Within countries, there has been a reduction of wealth inequality as shown in the graph at top right.

Achieving the SDG target of all children being free from malnutrition in all its forms requires countries to accelerate reduction of stunting as they work towards the 2025 target to reduce waste and maintain childhood wasting to less than 5%. The 2025 target also requires the current trend in overweight children to be reversed to a zero increase in overweight childhood. These

challenges require policies and strategies targeted at the poor, including conditional cash transfers and supplementary feeding, as well as broader policies and strategies that address the total population. Such initiatives include promoting exclusive breastfeeding and adequate complementary feeding, regulating the marketing of complementary foods to children, taxing unhealthy processed food and sugary drinks, and promoting physical activity. The IAP commends Mexico for its legislation, as initially conceived, to introduce a sugar tax on soft drinks, and the United Kingdom for doing likewise, along with Chile for its comprehensive labelling of unhealthy foods. We urge all national governments to implement the World Health Assembly resolution on the marketing of complementary foods and to adopt the necessary legislative measures.

Primary school net attendance rate (percentage), by household wealth quintile, sex, and residence, 2009–2014



Source: UNICEF global databases, 2016

Education: quality is the big question

Education is a way out of poverty and the key to child survival, yet current indicators on education mainly look at school enrolment rather than educational quality or attainment. A quantum shift is required in data collection and measurement, which is why the preliminary SDG indicator 4.1.1 proposes, instead, the proportion of children and young people: in grades 2/3; at the end of primary school; and at the end of lower secondary achieving at least a minimum proficiency level in reading and mathematics, by sex.

Even focusing on enrolment, the world failed to reach Millennium Development Goal 2 of achieving universal primary education by 2015. Globally, 91% of primary school-age children were enrolled in 2013, but there is still a long way to go before universal primary education is achieved in some regions. This challenge is most acute in the West and Central Africa region, where the net enrolment rate stood at 74% in 2013. Although the number of out-of-school children of primary school-age declined globally, from 99 million to 59 million between 2000 and 2013, progress has stalled since 2007.

In many countries, children from the poorest 20% of the population are less likely to attend school than those who are from better-off backgrounds, with each successive quintile having a higher average attendance. The largest disparities are in West and Central Africa. In Guinea, for example, nearly 90% of children from the wealthiest households attended primary school in 2012, compared with less than one third of children from the poorest quintile. Children in rural areas are, in general, more disadvantaged, being almost twice as likely to be out of primary school as their urban counterparts. In Niger, 83% of children in urban areas attended

primary school in 2012, compared with 45% of rural children.

Gender parity has improved, with more than two thirds of countries and areas having attained it (a gender parity index, or GPI, of between 0.97 and 1.03) in primary education. However, girls remain at a disadvantage in many countries, particularly in Africa, the Middle East and South Asia. In South Sudan, for example, the GPI is 0.66, meaning that 66 girls are enrolled in primary school for every 100 boys.

While more children are attending school worldwide, many of them drop out or fail to meet minimum standards of learning. Of the world's 650 million children of primary school age, 120 million do not reach grade 4; a further 130 million reach grade 4 but fail to achieve a minimum level of learning. Measuring learning achievement, starting in the early grades, will

help to identify where schools are failing to meet their commitments to children and to formulate appropriate remedial action. For example, data for 2013 from 15 Latin American countries show that in six countries, fewer than 50% of third-grade children have a minimum level of proficiency in mathematics; in three countries, fewer than half were proficient in reading.

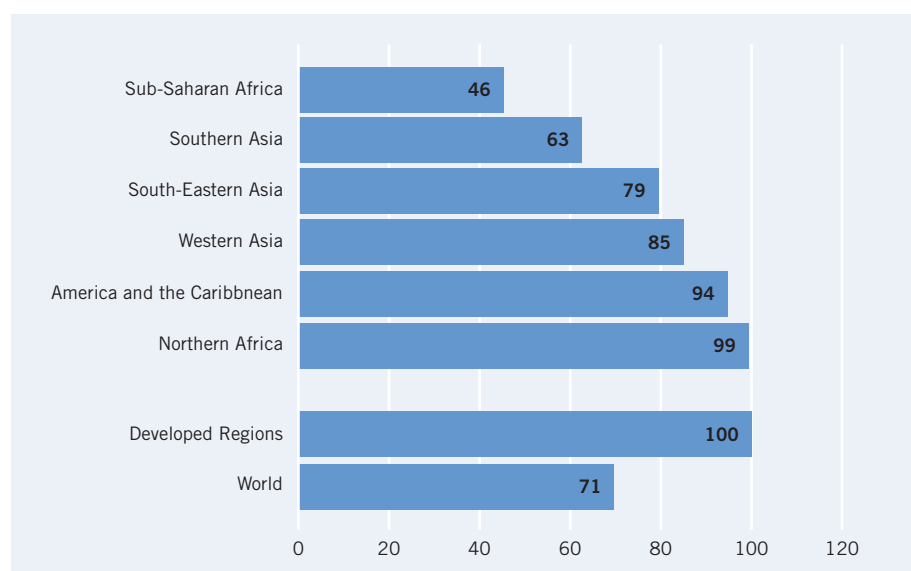
And again, enrolment does not guarantee quality education. UNESCO states that at the end of primary school, children should be able to read and write, and to understand and use basic concepts in mathematics. In 2014, between 40% and 90% of children failed to achieve even minimum levels of proficiency in reading in 10 African countries; in nine of those, between 40% and 90% of children failed to achieve minimum levels of proficiency in mathematics. This is a sad indictment of the level of education,

and reflects poor opportunities for adolescents and those entering adulthood. The IAP calls for better measuring of educational quality and attainment – not just school attendance – as a measure of progress towards transforming children's lives, and in turn our collective future.

Birth registration as a right

Equity is at the heart of the Sustainable Development Goals, which demand no one be left behind. But we can only know that if we have recorded their existence; at birth and subsequent life events, namely marriage, divorce, possibly migration and ultimately death. Such record-keeping has long been practised in developed countries but is yet to be initiated or significantly scaled up in many developing countries in Africa, Asia, Latin America and the Arab states, where more than 60% of the world's

Estimated proportion of children under 5 whose births were registered, 2010-2015 (percentage)



Note: Estimates are based on a subset of 144 countries covering 92 percent of the global population of children under age of 5. Data coverage was insufficient to calculate regional estimates for Eastern Asia, Oceania, and the Caucasus and Central Asia.

Source: The Sustainable Development Goals Report, 2016.

CHAPTER FOUR

population lives. When the birth of a child is not registered, how are their rights to be met? How does a government plan for their needs, including health services and education? How does a child gain access to supplementary food? And how can a child's death be recorded if their birth is unknown and unregistered? Hence, the proportion of children under five whose births have been registered with a civil authority, by age, is the proposed SDG indicator 16.9.1.

In 2016, little more than half (59%) of infants younger than 12 months

had their births registered, with only 33% registered in South Asia and sub-Saharan Africa. UNICEF's global database on birth registration shows the disparity between regions and countries of the same region, and socioeconomic and geographic disparities within countries. Differences tend to favour the urban and higher socioeconomic groupings. However, in some countries where about 50% of births are registered, there is little difference either in urban-rural or socioeconomic disparities. In Chad, for example, only the top quintile has a leap to 39% of births registered; the

other four quintiles have only 6–8% registered, while the urban-rural difference is 6–36%. India, Pakistan, Rwanda, Sierra Leone and South Sudan all show similar patterns.

There is more to consider than the wealth of a country, and the wealth and education status of the people. When the system is available, people choose to register their children's births, so countries need to adopt policies that encourage them to do so, and to uphold the right of every child to be counted and to count.

Making everyone visible?

Revived by the African Centre for Statistics at the UN Economic Commission for Africa (UNECA) in 2009, through the African Programme on Accelerated Improvement of Civil Registration and Vital Statistics (APAI-CRVS), there has been steady progress in African efforts to leave no one behind. At a political level, an institutional framework was developed through the African Ministers responsible for Civil Registration, supported by African statisticians and civil registrars. Through the slogan of making everyone visible in Africa, the APAI-CRVS has provided tools and materials, including guidelines and digitization manuals, on how to utilize information technology. The initiative gained ground rapidly in Asia, where the ministers responsible for CRVS declared the decade from 2015 one of “getting everyone in the picture.” In Latin America, through the Inter-American Development Bank, a similarly strong initiative has been in operation, with crucial tools and materials developed and shared. The Arab region embracing Maghreb has also begun a programme for civil registration. Based on such initiatives, the ethical imperative to leave no one behind and Sustainable Development Goal 16 on peace, justice and strong institutions will be well served, but only if crucial impediments such as complacency and lack of leadership are urgently addressed.

CHAPTER FIVE
**REMEDIES AND
ACTION FOR THE
WORLD WE WANT**

The Global Strategy recognizes the crucial role of country leadership in efforts to improve the health of women, children and adolescents. It also acknowledges the critical role of civil society, academia, diverse actors in the private sector, media, funders in holding each other, government and others to account for health outcomes. That being the case, the Global Strategy recommends accountability and oversight at country level be the responsibility of all stakeholders, and calls for them to join together to develop plans and programmes, and to monitor and review their implementation.

CONCERTED EFFORTS
ENERGIZED BY THE
GLOBAL STRATEGY
ACHIEVED A REMARKABLE
REDUCTION OF THE
GLOBAL MATERNAL
MORTALITY RATIO WHICH
NOW STANDS AT
216 PER
100,000
LIVE BIRTHS.

The IAP concurs that independent and adequately resourced new national mechanisms are crucial to this process of accountability in the pursuit of better health outcomes. But it does not believe they should duplicate the work of existing national institutions such as parliaments, the various branches of government, the judiciary and human rights institutions, which have the primary responsibility for accountability. Rather, multis-takeholder mechanisms, the executive and legislative arms of government and the legal system should complement and reinforce each other, to ensure a strong independent judiciary and autonomous regulatory mechanisms, including measures to protect whistleblowers.

Meaningful accountability that makes a difference

When systematic monitoring and independent review identify problems or areas for improvement, accountability requires they be remedied to enable women, children and adolescents to survive and thrive. To transform the conditions

that drive ill-health and mortality, accountability cannot be an afterthought. Throughout this report, the IAP has stressed the need for multisectoral strategies and planning that address historically marginalized or discriminated groups, along with adequate and equitably allocated resources, and strong national institutions to collect and interpret data. It also requires clearly delineated responsibilities. Additionally, meaningful accountability requires investment in the oversight and review institutions, including auditor- and inspector-general offices, accreditation and professional associations, national human rights institutions and independent judiciaries. It also requires citizen engagement and social accountability, including freedoms of association and information.

The IAP notes that remedies are not merely remedial actions that re-establish the state of affairs prior to an alleged violation: remedies go beyond reparations or redress. Nor should remedies be principally punitive, and especially not directed at making health workers scapegoats for systemic problems. On the

contrary, remedies should be key instruments in transforming the underlying situation and dismantling entrenched institutional dynamics resistant to change.

The IAP wants to stress that remedies take a variety of forms, from administrative to political, from legal to social. Moreover, diverse remedies should work in synergy. For example, administrative remedies that include health facilities having their accreditation conditionally suspended might be accompanied by reforms to regulations as an incentive to higher standards of care. Public and private health insurance funds can also provide remedy by setting criteria for reimbursement based on good practices, such as not promoting formula for newborns.

Delineating responsibilities within the health system: who is accountable for what?

Delineating responsibilities and gaps at every level of a health system and beyond is a first step in establishing accountability and in enabling appropriate action to be taken if monitoring and review indicate the need for improvement.

At the facility level, for example, staff need to be overseen for quality of services and how they manage supplies, medicines and funds, and to be shown leadership when it comes to values. Whether a patient is an adolescent, or a member of an ethnic or racial minority, a sex worker, a person living with HIV or AIDS, a man who has sex with men, a transgender person or someone living with disability, no one trying to access care should be denied on discriminatory grounds. Public or private, health institutions invariably

need to be accredited and regulated by governments, and, therefore, can and should be held accountable for compliance with relevant laws and policies.

Health professionals have individual accountability through licensing procedures, medical and nursing boards and other professional bodies. These are vital. Without professional accountability it would be difficult to uphold reasonable standards of ethical and scientific conduct by health workers.

There is accountability at health-system level. As part of good governance, the health system should build processes that support a culture of transparency and justification from initial situation analysis to the development of health-sector reviews and national policies and action plans, budgeting, programme implementation, monitoring and evaluation.

Country contexts and health systems vary enormously, as do the roles of private funding, provision of care and decentralization, which can sometimes mean overlapping or unaligned responsibilities at different levels of devolution. The IAP regards delineating responsibilities for progress on the Global Strategy as a key prerequisite to establishing meaningful accountability. It will use its reports, and other opportunities, to refine and clarify who is accountable to whom and for what in the health system, in meeting the aims of the Global Strategy. And it will highlight good practices in creating functioning divisions of responsibility and their transparent communication to the public.

Accountability for women's, children's and adolescents' health, beyond the health system

There is also accountability beyond the health system, at executive and parliamentary levels, to ensure sequencing and coordination within and between systems, including appropriate alignment of laws and policies, with budgets, and budgets with programmes.⁶⁸ Courts have a role to play in holding political branches of government to account and in upholding constitutional and legal norms.

Political action

The legislative and executive branches of government are inherently responsible for political actions to remedy problems and improve performance, and ultimately elections serve as accountability mechanisms in representative democracies. In the case of the legislature, remedial action may require enacting new legislation, making budgetary appropriations and tax laws to provide sufficient revenues for health, including reproductive, maternal, newborn, child and adolescent health. The legislature should also rescind legislation that proves discriminatory in practice, or fails to achieve a legitimate government objective; for instance, restrictions to services based on marital status or age.

In the case of the executive, remedying poorly managed or functioning health systems frequently requires alignment of laws and policies, better regulations or more effective oversight of public and private actors. The Constitutional Implementation Commission of

Kenya, for example, oversaw a five-year process integrating constitutional principles and values into legislation and the management of county health facilities in three of Kenya's 47 counties.⁶⁹ Remedies may also require better coordination among ministries, such as finance and health, or between federal-level policy-making and subnational programme implementation in decentralized or federalist states.

One such example of the political branches of a government collectively taking action to protect the health of its population – in particular, to inhibit children and adolescents from taking up smoking – occurred in 2006, when Uruguay's legislature passed cigarette packaging laws that contained explicit warnings and removed brand identifiers, an initiative praised by WHO and anti-smoking activists.⁷⁰

The judiciary

When the health system is understood to be essential to good governance, as opposed to merely an apparatus to deliver goods and services, it is clear that independent judiciaries also have an important role to play in ensuring the political branches uphold constitutional and legal norms in the design, funding and management of that system. Access to justice is as important to health as it is to other pillars of a democratic society. The judiciary's role is primarily not a punitive one, although courts can sanction wrongdoing. Rather, an independent judiciary that takes the health and well-being of women, children and adolescents seriously enables an external check on the reasonableness of government actions to ensure

that the framework in place for achieving the Global Strategy, and universal health care, is aligned with fundamental human rights and constitutional principles.

So, for example, courts from South Africa to the United States have insisted upon evidence-based and non-discriminatory policy-making in areas from HIV to abortion.⁷¹ Colombia's Constitutional Court insisted that all children, including adolescents up to age 18, no matter whether their parents had formal employment or not, had access to equal benefits.⁷² In India, courts have found that procedures to determine indigence to receive benefits⁷³ were being applied inappropriately, in ways that excluded poor women and children. In Kenya, the Nairobi High Court has found unconstitutional an anti-counterfeit law, where the wording was vague and threatened to adversely affect access to generic medications, such as those for HIV.⁷⁴ Courts do not set health policies, but they can and should play a role in ensuring that health systems are designed, and services delivered, in accordance with normative commitments to equal dignity and rights made under constitutions and domestic law, and international law.

Social accountability

The IAP wants to highlight that all remedies and action require social accountability and engagement by those whose rights and well-being are at stake.⁷⁵ The updated Global Strategy includes community engagement as one of its nine areas of action.⁷⁶ Helping citizens become more aware of their rights and involving them in setting priorities, reviewing action and calling for

change is vital to achieving this. The relationship between social accountability and good governance in health is cyclical: citizen-led accountability is, to some degree, dependent on the extent to which there are functional democratic systems and rule of law, and at the same time, citizen engagement enhances democratic systems. The IAP is concerned with the shrinking space for civil society in many countries.

People from traditionally disadvantaged or marginalized communities have shown extraordinary capacity to have an impact on health outcomes by their collective action to monitor health systems. This type of cooperation leads to better policy, leadership, investment and preventive actions, and can help citizens assert their rights and entitlements,⁷⁷ and produce better health outcomes.

New technologies, particularly mobile phones, enable not only access to social services and broadening financial systems, but also provide an important mechanism for crowdsourcing and social accountability. Through these technologies, citizens are documenting conditions and making demands on health systems, serving the cause of accountability in communities around the world. However, new technologies also bring a risk that those in the most precarious circumstances will be left behind, and of increasing vulnerability to persecution and invasions of privacy when information divulged through these technologies is used to enforce unjust and harmful policies.

For social accountability to lead to sustained and meaningful action,

Nuestro Texas

The *Nuestro Texas* (Our Texas) campaign in the United States illustrates how effective social accountability can be, and how it can work with other remedies to spur political action and ensure care for women. *Nuestro Texas* advances the right to affordable reproductive health care in the Rio Grande Valley of Texas, which has provided opportunities for Latinas and immigrant women, including undocumented immigrants, to participate in political decision-making on the distribution of health resources. In 2011, the state of Texas reduced funding to family planning clinics by two thirds, prompting the closure of rural clinics and severe cuts in services at those remaining. In the Rio Grande Valley, volunteer *promotoras de salud* (health outreach workers serving rural communities) teamed with two national organizations – the Center for Reproductive Rights and the National Latina Institute for Reproductive Health – to mobilize women to form a Texas Latina Advocacy Network, which grew to include thousands of women. The network built these women's capacity to engage in local, state and national advocacy, and in global accountability processes, advocating for core human rights principles of transparency and freedom from discrimination, and the right to health. The Texas state legislature created a commission to study the impact of its cuts and accepted civil society submissions, allowing *Nuestro Texas* leaders to testify and submit qualitative and quantitative data.

The campaign increased pressure by submitting shadow reports and testifying at two UN human rights treaty review processes (Human Rights Committee and CERD Committee), and by hosting a Women's Human Rights Hearing. Campaign leaders played a key role in prompting the Texas legislature to restore funding to family planning services in 2013 and substantially increase allocations in 2015. One also provided expert testimony about lack of access to reproductive health care in a legal challenge to HB2, Texas' restrictive abortion law passed in 2013, which was found unconstitutional by the US Supreme Court in *Whole Woman's Health v. Hellerstedt* (2016).

there needs to be freedom of information, and mechanisms that enable people to access information about service delivery and outcomes, and budgets. Citizen engagement cannot be a tokenistic consultation. It needs to be integrated across the policy cycle, from preparation, planning and implementation, through to accountability for health planning, budgeting and service delivery.

The global level

The Global Strategy also contemplates accountability and remedial action at the global level: of multilateral institutions, states, development partners, intergovernmental organizations and private actors, such as multinationals. Some of these actors, such as states that are development partners, have extraterritorial obligations under international human rights law, which include 'doing no harm' to the health rights

of women, children and adolescents in other countries through their policies, including their financial and trade policies.

Human rights treaty-monitoring bodies, regional adjudicatory and other governance bodies, together with the UN Human Rights Council's Universal Periodic Review process, are important supranational oversight mechanisms to ensure policy coherence and alignment with the normative commitments states have

made under international law, both domestically and extraterritorially.

The responsibilities of stakeholders other than national governments – from intergovernmental organizations to multilateral institutions, private actors and development partners – could not be more dramatic than in the humanitarian settings and refugee crises that afflict the world today. In failed states and humanitarian settings, the institutions and forums for accountability invariably seem non-existent. Yet these most vulnerable people must be treated as human beings with rights as well. The well-being and lives of these women, adolescents and children – and men – cannot be written off as casualties of global politicking and power renegotiations, or treated simply as the beneficiaries of humanitarian largesse. Refugees and those in humanitarian settings are entitled to the same rights and dignity as all other human beings,

and must be able to participate in decisions on policies and programmes that impact on their lives.

A systemic approach

The IAP believes it is not enough to recognize that problems exist through monitoring and review; accountability demands the institutions and conditions that drive those problems must be modified. The urgent need for meaningful action to remedy obstacles to the ideals and goals of the Global Strategy requires greater coordinated attention by governments, international organizations and other stakeholders. Funding and mandates for accountability mechanisms, including administrative mechanisms and independent judiciaries, must be contemplated systemically. Accountability is a work in progress. Remedies added to broken systems are not enough to solve systemic inequities. For instance, it is important to have

some form of complaints system for local citizens, but it does not necessarily mean citizens utilize it or that political authorities take notice of the suggestions.

At both national and global levels, citizen-led accountability mechanisms, such as citizen hearings, symbolic tribunals and the like, should be promoted, and findings integrated into the monitoring of progress towards commitments. Strengthening the capacity of civil society organizations – their management and leadership as well as their technical and advocacy skills – is critical to meaningful social accountability. Information and transparency are key prerequisites to social accountability as well. The IAP believes citizens are entitled to know the commitments, resources and results of all stakeholders, at national, regional and international levels.



A close-up photograph of two hands, one with dark skin and one with light skin, clasped together in a supportive grip. The hands are positioned over a fabric with a bold, black and white geometric pattern. The lighting is soft, highlighting the textures of the skin and the fabric. The overall mood is one of solidarity and care.

HUMANITARIAN SETTINGS
ADOLESCENTS: THE
FUTURE BEGINS NOW
HUMAN RESOURCES
FOR HEALTH

HUMANITARIAN SETTINGS

The world is experiencing its greatest period of human need since the Second World War, with forced displacement exceeding 60 million for the first time, and 125 million people requiring life-saving assistance.⁷⁸ Although services are targeted at everyone in a humanitarian emergency, women, children, adolescents and the elderly suffer most as they are less able to flee, less able to access resources and most susceptible to violence and risk. Today, 60% of preventable maternal deaths and 53% of child deaths take place in settings of conflict, displacement and natural disaster.⁷⁹ Despite evidence that empowering women and ensuring their human rights accelerates humanitarian recovery, their needs, and those of children and adolescents, are still not being met.

This is a complex environment, covering fragile states and humanitarian, conflict, protracted crisis and post-conflict settings, each requiring a different approach but with the lines often blurred. In recent years, though the number of emergencies has decreased, they have become more complicated, requiring longer-term assistance. In 2014, 84% of countries receiving humanitarian assistance had been receiving it for the previous five years, 69% for 10 years.⁸⁰ Though a nuanced response is demanded, in practice it is frequently fragmented and involving a plethora of agencies. Adequate provision of health and human rights for this increasingly affected population requires cooperation between emergency health and humanitarian response mechanisms and a com-

mitment by humanitarians, development actors and stakeholders to work together in a cohesive, comprehensive manner.

Everyone, everywhere

Today's generation of youth is the largest the world has ever known, accounting for many of those affected by armed conflict, including as refugees and displaced persons. Recognizing this, and the threat to stability and development posed by the rise of radicalization among young people, the UN Security Council has urged Member States to consider ways to give youth a greater voice in decision-making at local, national, regional and international levels.⁸¹

This is welcomed by the IAP, who believes it is time to turn promises into action for this generation, time to curb violence against women, children and adolescents in refugee camps, and time to stop the negligence of poor local host populations. It is also time to address the absence of accountability – the data and monitoring gaps – in these settings.

The need for a changed approach is recognized in the updated SDG-centred Global Strategy. The

IAP welcomes that new attention is given to the vulnerable conditions in which too many women, children and adolescents live, with humanitarian and fragile settings named as one of its nine priorities. The Strategy calls for its objectives to be addressed everywhere, and urges humanitarian and development actors to redouble efforts to work together to better build health and resilience among the women, children and adolescents who live in the most fragile and volatile circumstances.

Concerted effort is needed to achieve these goals, and to resource them, and partners in the sector met in Abu Dhabi in April 2016 to put together a five-year plan to implement the Global Strategy so that its targeted reproductive, maternal, newborn and adolescent health outcomes can be secured even in these complex settings.⁸²

The IAP notes this will require a transformative shift, and it endorses the Abu Dhabi recommendations for clarity on responsibilities for monitoring, improved resources, better data and the need to disaggregate data. The commitment to uphold rights will require a monitoring

Today, 60% of preventable maternal deaths and 53% of child deaths take place in settings of conflict, displacement and natural disaster.

framework and links to human rights bodies and country mechanisms, such as independent monitoring bodies. The Abu Dhabi report calls for such links, likewise affirmed by the Panel.⁸³ The IAP recommends these points form a coherent package under a high-level recommendation on how WHO and partners should deliver this plan.

The IAP urges that the selection process for the new Secretary-General of the United Nations considers candidates' commitment to do everything possible to prevent humanitarian crises and to mobilize support for concerted action and adequate resources to:

- put women, children and adolescents at the centre of humanitarian actions;
- uphold the principles and standards of international human rights, and in particular protect those seeking and those providing health care;
- support the meaningful engagement of civil society, first respondents and the affected communities themselves;
- enhance accountability from the onset of a humanitarian crisis using innovative approaches, adapting social accountability models and citizen monitoring.

The IAP also urges Development Initiatives in the 2017 edition of its Global humanitarian assistance report to provide a comprehensive overview on the health of women, children and adolescents in humanitarian settings, such detail being absent from its 2016 report.

The IAP also welcomes the proposal from delegates who signed the Abu Dhabi Declaration in February 2015⁸⁴ to include a case study on humanitarian settings in its annual review reports, and commits to a theme of accountability in fragile states and humanitarian settings, with a particular focus on women, children and adolescents, in its report for 2017 or 2018.

A brave new world?

We must do better for humanity; this was the overriding ambition of the first World Humanitarian Summit in Istanbul, in May 2016. The UN Secretary-General's background report for the summit, *One humanity, shared responsibility*, calls on global leaders to commit to core responsibilities to change lives, with an approach that truly engages communities, civil society and youth and equal participation of women in leadership roles and peace-building processes.⁸⁵ Building on the agenda, the Summit considered how best to improve the way aid is given in the years to come and how the world reacts to crises.

As the Global Strategy recognizes with its everywhere message, in fragile settings every woman, child and adolescent is at grave risk. Emergencies and protracted crises deepen gender inequalities, marginalization and exclusion. The Abu Dhabi document acknowledges that women, though especially vulnerable, could be great assets in dealing with emergency situations. And in Istanbul, there were widespread calls for gender equality, women's empowerment and women's rights to become pillars of humanitarian

action. New methods and financial support for accountability to gender equality programming were announced, including enabling adolescent girls to stay in school and escape gender-based violence, and commitments made to ensure the rights to sexual and reproductive health care for all women and adolescent girls.⁸⁶ The IAP would like to see these commitments implemented and reported so that it can review progress.

The fight to eradicate sexual and gender-based violence, a constant around the world, is endorsed by the IAP. The UN itself needs to put in place stronger mechanisms to ensure that its peacekeeping forces do not become perpetrators. There is a need to address the systemic weaknesses exposed by the UN-appointed High Level External Independent Review Panel on Sexual Exploitation and Abuse by International Peacekeeping Forces in the Central African Republic. Concerned with the increase of new allegations of sexual abuse lodged against UN peacekeeping personnel, the UN Secretary-General Ban Ki-moon has appointed Jane Holl Lute as special coordinator to support him in "reviewing and advancing implementation of the Panel's recommendations and in strengthening our response to such abuse."⁸⁷ The IAP supports plans to end all tolerance of abuses, and would like to see the work of the special coordinator fully supported.

CASE STUDY:

Acute shortage of health workers to serve Syrians

The extract is from a report presented by the Syria Public Health Network at the 2016 Syria donors conference in London, and illustrates the patent need to better engage refugee communities themselves in emergency and transition situations. The crisis in Syria has been described as “the biggest humanitarian emergency of our era.”⁸⁸

“At least half of health-care workers have left Syria. Of the remaining, more than half are nurses, and few experienced physicians or surgeons remain. For Syrian health-care workers in Jordan, Lebanon and Turkey, there are limited opportunities for ongoing training, while restrictions with strict penalties apply to those found working or providing health care, even to fellow Syrian refugees. There are particular challenges in mental health: prior to the conflict there were fewer than 100 psychiatrists across Syria and no psychiatric nurses. There are just 71 psychiatrists in Lebanon today, mostly in Beirut, and provision in rural and poorer urban areas is fragmented. Some organizations are providing inappropriate care using poorly trained workers. There are various mechanisms by which improved health-care access could be achieved in neighbouring countries; for example, placing clearer conditions on aid to those countries for development and humanitarian needs relating to the crisis. The drive for universal health coverage offers an opportunity to remove legal and financial barriers to access to care, with population-wide benefits. Support for health workers’ rights to train and work in neighbouring countries (even on a restricted basis) is essential at policy level, both to provide for Syrian refugees but also to train and maintain the skills of the health-care workers who would form the future of Syria’s health service. Failure to capitalize on the availability of skilled Syrian health professionals is a major lost opportunity, one that must be rectified.”

Leading the way

Advocating for greater focus on contexts, settings, risks and crises, the Global Strategy’s Everywhere Workstream brings together key actors from the humanitarian and development sectors, to identify conceptual, policy and programming opportunities to better support the health of women, children and adolescents in all settings everywhere. The IAP encourages the Workstream to expand its efforts of advocacy for greater engagement of the humanitarian system with the Global Strategy. The Istanbul summit, and the Abu Dhabi Everywhere report, highlight the enormity and urgency of the task, and the need for strong political will to address multiple humanitarian crises in powerful and innovative ways. It is the IAP’s belief that a strong, committed UN Secretary-General can give it the leadership and the direction required.

Zika response: More funding, human rights focus required

According to WHO, the Zika virus and its complications represent a new type of public health threat, and one that requires a unique and integrated strategy.⁸⁹ It is a humanitarian emergency, different from the majority caused by armed conflicts and natural disasters. The Zika epidemic has long-term consequences for families, communities and countries, especially for women, adolescents and children living in poverty, who are at the centre of the epidemic.

WHO declared a public health emergency in February 2016. And the epidemic is spreading: in July this year, 63 countries reported transmission, with more than 1500 cases of related microcephaly or central nervous system malformations confirmed in 2016.⁹⁰ Initial attention to the virus, first suspected to be linked to an increase in birth defects in Brazil in July 2015,⁹¹ was slow and mostly focused on mosquito eradication and advice to women to delay pregnancies, but with no remedy to their lack of access to basic reproductive health services and restrictive abortion laws. This approach was criticized by civil society and later revisited. In April 2016, the Pan American Health Organization (PAHO) issued a guidance document on the key ethical issues raised by the epidemic.

Zika has received considerable global attention. In July 2016, WHO/PAHO and partners revised their Strategic Response Framework, placing greater focus on preventing and managing medical complications caused by Zika virus infection, and on integrating mosquito management, sexual and reproductive health (SRHR) counselling, and health education and care within social and legal contexts. The plan provides the basis for collaboration among partners so that countries' response capacities are supported.⁹²

The IAP applauds this move to better coordination, a lesson from the Ebola response, and welcomes the emphasis on prevention, the attention to SRHR, which goes some way to answering civil society criticisms. However, the Panel regrets that indicators do not include SRHR and the failure to recommend revised legislation on abortion, which was included in the PAHO guidance issued earlier.

As a Lancet editorial, The right(s) approach to Zika, suggests, controlling vectors is an essential step, but will be ineffectual without a rights-centred approach: "... sound recommendations, duly relayed by health authorities, but they certainly don't resonate in the poorest neighbourhoods of Brazil and other affected countries, where the availability, practicality, and affordability of protective items are doubtful and where safe sex is not always negotiable."⁹³ While we are grateful Zika is being treated comprehensively, following an initially slow response that failed to address women's rights, the IAP calls for more proactive efforts to address underlying issues, rather than reactive ones. For this it recommends new financing, a revision of indicators and a review of legislation.

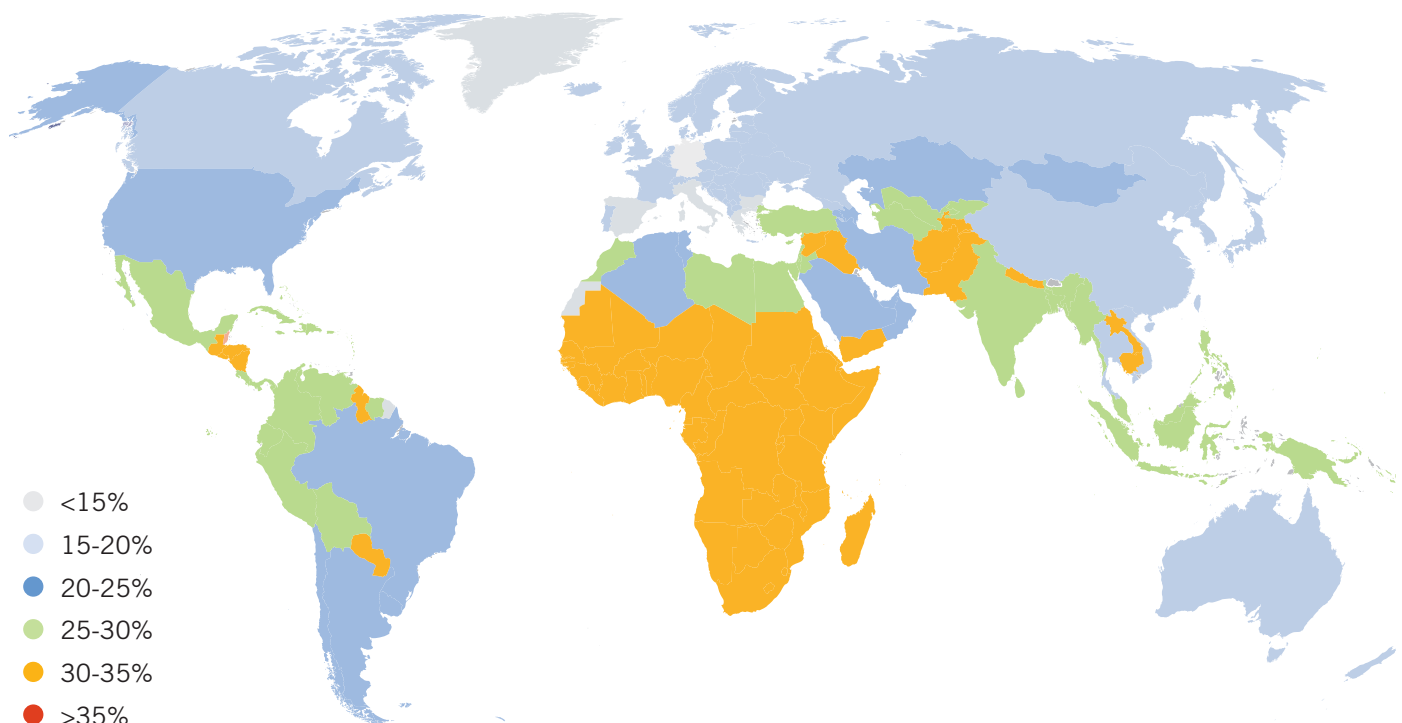
ADOLESCENTS: THE FUTURE BEGINS NOW

Today's generation of adolescents is the largest in history, with 1.2 billion people aged 10 to 19 years world-wide. Their unprecedented numbers, particularly in less developed countries, means this generation will not only be among the primary beneficiaries of the new international development agenda, but also a key force driving it.

The importance of adolescents is further highlighted by the demographic dividend, resulting from the decline in the ratio of dependents (children and the elderly) to those in the active workforce. This offers countries the potential to expand their economies and reduce poverty. But for this demographic dividend to materialize it is imperative to urgently invest in the education,

health, livelihoods and participation of adolescents. Such investments will not only help adolescents achieve their full potential, they will be crucial for achieving a more sustainable and just world, as health gains among adolescents result in social, demographic and economic benefits for all, and help break the intergenerational transmission of inequities.

Adolescents and young adults as a proportion of country population in 2013. Percentage of total country population aged 10–24 years



Source: *Our future: a Lancet commission on adolescent health and well-being*. 2016

Moving from words to action in all sectors

Currently, there is significant international energy to move forward with a new agenda on adolescent health. Not only has the Global Strategy been expanded to recognize adolescents as a group with unique health needs that must be addressed to achieve sustainable development, many initiatives that recognize the importance of adolescents have also emerged, such as the Adolescent and Youth Constituency of the Partnership for Maternal, Newborn and Child Health (PMNCH), the WHO Global Framework for Accelerated Action for the Health of Adolescents (AA-HA) and ALL IN to #EndAdolescentAIDS. In addition, initiatives to scale up programmes that have proven to be effective in addressing adolescent needs are also emerging, such as the UNFPA-UNICEF Global Programme to Accelerate Action to End Child Marriage.

This welcome momentum at the global level, however, needs to be

translated into concrete actions at the national level. It is key that the well-being of adolescents becomes an integral component of national development plans. These plans must be developed in consultation with adolescents, be adequately funded, effectively implemented and incorporate a comprehensive approach to address the complex and multifaceted challenges that affect this age group. They need to encompass all aspects of adolescent health and address its social determinants. In the past we have seen countries develop and adopt initiatives to prevent adolescent pregnancies, but many of these have failed to produce the desired results due to inadequate funding, lack of involvement of all the sectors that affect adolescents, and poor design and implementation.

For these reasons, the IAP strongly recommends supporting local civil society organizations (CSOs), particularly youth-led networks, so that they are better positioned to advocate for increased national

investments in adolescents, while they build the political will needed to translate the good intentions expressed at the international level into concrete and well-funded interventions in countries. National governments' ownership and commitment to the international agenda is crucial for success. It needs to be fostered and cannot be taken for granted.

In addition, to further strengthen and capitalize on the momentum that exists at the international level, the IAP recommends a high-level UN commission on adolescents be created to help coordinate efforts, increase attention to adolescents and youth in the 2030 Agenda, and identify people-centred and cross-sectoral interventions that can ensure adolescents reach their full potential. Member States, UN agencies, CSOs, young leaders, researchers, donors and the private sector should be part of this commission, which should build on the successful experiences of the Global Strategy and have close links with it.

England's success in reducing adolescent pregnancy

Research⁹⁷ shows that the British Teenage Pregnancy Strategy (TPS), launched in 2000, has helped to dramatically reduce the rates of adolescent pregnancy in women younger than 18 and social exclusion among young parents. The strategy provides high-quality education on sex and relationships, together with youth-friendly contraceptive services. It guarantees coordination between the different levels of government, being nationally led and locally implemented, with local implementation grants allocated according to teenage pregnancy levels. As a result, pregnancy rates in under-18 adolescents have fallen by 51% to their lowest level since the 1970s. This case highlights that initiatives with national reach, that are grounded in good science and good management, sustained throughout time, adequately funded and provide equal access to high-quality education and contraception are crucial to reducing adolescent pregnancy and its consequences.

A multisectoral approach to adolescent pregnancy in Mozambique

Mozambique's adolescent health initiative grew from a pilot launched in 1999 into a programme that has national coverage and reached millions of adolescents with information on sexual and reproductive health and rights, making quality sexual and reproductive health services available to all young people. One of the strengths of the programme has been its multisectoral approach, which allowed for close collaboration between various ministries, each of which had specific responsibilities: the Ministry of Health coordinated all clinical activities; the Ministry of Education implemented school-based activities; and the Ministry of Youth and Sports spearheaded community-based activities to reach out-of-school youth. UNFPA and Pathfinder International provided technical support.

Continued government leadership and support, training and sensitizing of health professionals, and the active involvement of adolescents as peer educators also contributed to the success. The programme helped reduce adolescent fertility, although much remains to be done; rates remain high, with young women continuing to initiate sexual activity early, and the knowledge that condoms can protect one from HIV not fully translated into consistent use.

A transformative approach to address adolescent pregnancy

There seems to be some fatigue in the international community on the subject of adolescent pregnancy, and a perception that because it has featured in the international development agenda for some time, it has already been dealt with. Unfortunately, this is far from true, as shown in section 4.2 of this report.

Traditionally, many countries have tried to prevent adolescent pregnancy with simplistic approaches that have focused disproportionately on changing the attitudes and behaviour of adolescents without recognizing underlying factors such as “gender inequality, poverty, sexual violence and coercion, child marriage, social pressures, exclusion from educational and job opportunities and negative attitudes and stereotypes about adolescent girls, as well as neglect-

ing to take into account the role of boys and men.”⁹⁴ Adolescents continue to face deep social and psychological barriers that are rooted in the denial of their sexual rights. In most societies, there is a deep resistance to recognize young people as having rights, and an equally strong resistance to recognize them as sexual beings. Equally, or perhaps even more damaging, many young people acutely feel a lack of entitlement to education and services. The lack of recognition of their sexual rights, and the absence of public policies to fulfil those rights, makes it inconceivable for many young people to know their rights, much less demand comprehensive sexuality education and access to adequate services.

A new approach is needed to deal with adolescent pregnancy and make it a problem of the past. The IAP

fully endorses the Global Strategy and UNFPA recommendation of multisectoral policies and initiatives that can unburden girls “from the economic and social pressures that too often translate into a pregnancy and the poverty, poor health and unrealized human potential that come with it.”⁹⁵

These multisectoral approaches must include universal access to contraception and to comprehensive sexuality education that is age-appropriate and scientifically accurate. Young people need and have a right to comprehensive and non-discriminatory sexuality education to make informed decisions before they become sexually active, as established in different international agreements and documents.⁹⁶

HUMAN RESOURCES FOR HEALTH

In May 2016, the World Health Assembly adopted the Global Strategy on Human Resources for Health: Workforce 2030 to address health workforce challenges post-2015.⁹⁸ It brings together national, bilateral and multilateral stakeholders to enhance availability, accessibility, acceptability and quality of human resources for health. With this momentous step, the international health community acknowledged that realizing the right to health and universal health care depends on a skilled, motivated workforce.

In an earlier development, in March 2016, the UN Secretary-General appointed a High-Level Commission on Health Employment and Economic Growth, co-chaired by French president François Hollande and South Africa president Jacob Zuma, to guide the creation of health and social sector jobs as a means of advancing inclusive economic growth, with specific consideration of the needs of low- and middle-income countries.⁹⁹

Together, these events signal unprecedented political support for investment in the health workforce. The IAP considers the HRH strategy a significant improvement, and we urge each country to develop its own specific strategy aligned with these milestones, including outcomes related to the number and qualifications of professionals to be recruited, trained and retained, with clear, well-resourced plans to make them happen.

GLOBAL STRATEGY ON HUMAN RESOURCES FOR HEALTH: WORKFORCE 2030

Adopted by the 69th World Health Assembly 2016

GLOBAL MILESTONES 2020

1. All countries have inclusive institutional mechanisms in place to coordinate an intersectoral health workforce agenda.
2. All countries have a human resources for health unit with responsibility for development and monitoring of policies and plans.
3. All countries have regulatory mechanisms to promote patient safety and adequate oversight of the private sector.
4. All countries have established accreditation mechanisms for health training institutions.
5. All countries are making progress on health workforce registries to track health workforce stock, education, distribution, flows, demand, capacity and remuneration.
6. All countries are making progress on sharing data on human resources for health through national health workforce accounts and submit core indicators to the WHO Secretariat.
7. All bilateral and multilateral agencies are strengthening health workforce assessment and information exchange.

GLOBAL MILESTONES 2030

1. All countries are making progress towards halving inequalities in access to a health worker.
2. All countries are making progress towards improving the course completion rates in medical, nursing and allied health professionals training institutions.
3. All countries are making progress towards halving their dependency on foreign-trained health professionals, implementing the WHO Global Code of Practice.
4. All bilateral and multilateral agencies are increasing synergies in official development assistance for education, employment, gender and health, in support of national health employment and economic priorities.
5. As partners in the United Nations Sustainable Development Goals, to reduce barriers in access to health services by working to create, fill and sustain at least 10 million additional full-time jobs in health and social care sectors to address the needs of underserved populations.
6. As partners in the United Nations Sustainable Development Goals, to make progress on Goal 3c to increase health financing and the recruitment, development, retention and training of the health workforce.

No workforce, no health care

An essential building block of health systems,¹⁰¹ health-care delivery and public health are not possible without adequate human resources that include health professionals,¹⁰² allied professionals¹⁰³ and community health workers. In 2006, WHO recommended a minimum of 2.28 skilled professionals (physicians plus nurses/midwives) per 1000 population for a high coverage of deliveries by skilled birth attendants.¹⁰⁴ The Global Health Workforce Alliance in 2014 reported that almost half of the countries did not meet this modest norm of availability.¹⁰⁵

The current global health workforce is estimated to be slightly more than 43 million.¹⁰⁶ Although the density globally is 2.29 per 1000 population, in the populous African and South-East Asia regions it is a depressing 1.31 and 1.51 respectively. Besides, there are vast geographic and rural-urban differentials in all parts of the world.

Several low- and middle-income countries face the malady of migration of their scarce health workforce to wealthier nations. The problem remains despite the WHO Global Code of Practice on the International Recruitment of Health Personnel, adopted by the World Health Assembly in 2010.¹⁰⁷ For instance, in Oman, United Arab Emirates and Saudi Arabia, 80% of physicians are foreign-trained, in England the figure is 35%.¹⁰⁸ Implementation has been suboptimal except in one WHO region.¹⁰⁹ Poor countries can ill afford to lose the precious skills of these professionals, but many do not offer adequate working conditions. Donors can compound the problem by forbidding their aid be used for salary adjustments or construction of

facilities. The IAP urges donors to revise this practice.

The consequences of the workforce shortage are serious, and inadequate HRH hampered attainment of the health Millennium Development Goals in many countries. In 2013, more than 40% of births in the Africa and South-East Asia regions were not attended by skilled health personnel.¹¹⁰ Globally, 5 billion people lack access to safe, affordable surgical, obstetric and anaesthesia care.¹¹¹ HRH shortages are compromising the health and human rights of people in all continents.

New thinking for the SDG era

The 2006 workforce 'norm' of 2.28 personnel to 1000 people at child-birth is outdated. The Sustainable Development Goals encompass a broad agenda of health services plus an integrated health system, and the IAP endorses the new WHO index based on a composite of SDG tracer indicators.¹¹² An aggregated density of 4.45 physicians, nurses and midwives per 1000 population is now the needs-based threshold,¹¹³ and shapes recommendations of WHO's human resources for health strategy.

Using this threshold, shortages in 2013 amounted to 2.6 million physicians, and 9 million nurses and midwives. Given present trends, the deficits in 2030 will persist to the tune of 2.3 million physicians, and 7.6 million nurses and midwives.¹¹⁴ In addition, 4.6 million other cadres would be deficient, a projected shortfall of 14.5 million health workers. A Lancet Commission estimated an additional worldwide requirement of 2.28 million surgical, obstetric and anaesthesia specialists by 2030.¹¹⁵

The problems of the HRH are not limited to shortages. Health workers often do not have the working conditions necessary for maintaining their motivation and delivering services of quality. Of particular importance for the Global Strategy is the fact that many workers have not had the opportunity to develop skills and be sensitized to their patient's right to be treated with dignity and respect. The IAP urges governments to address both the quantity and the quality of the workforce.

Given the enormous deficit, nothing less than a transformational global effort to augment and equitably deploy a competent and client-respecting health workforce would be required to meet the 2030 ambition of healthy lives and well-being for all ages.¹¹⁶ Enabling and motivating working conditions are critical to retain health staff.

Critical pathways

The health sector is also a phenomenal source of employment. The global economy is expected to create about 40 million new health sector jobs by 2030, mostly in middle- and high-income countries. This is based on labour market analyses that project the demand for health workers in 2030 to be 80.2 million in 165 countries, with 2.4 million in the WHO African region, 12.2 million in South-East Asia and 25.9 million in Western Pacific. Such enormous demand can only be met by investing in capacity building, faculty development and curricular innovation.

There is increasing feminization of the health professional workforce as nurses, midwives, doctors, community health workers and allied health professionals. Some experts are

concerned that without women, the medical profession could become depleted. However, analysts have pointed to gender power relationships within the workforce that can be unfavorable to women. The IAP recommends human resources policies be adopted to ensure a level playing field, so that the full potential of women in the workforce can be tapped.

Community health workers have demonstrated great effectiveness at basic health tasks, such as immunization. They have also been trained to undertake some health interventions for women and adolescents, and there is ample evidence of their effectiveness. Strengthening the health workforce for reproductive, maternal, newborn, child and adolescent health, if done in a gender equitable way, is a critical pathway to equality, and another compelling reason to invest in HRH.

Imperatives for every woman, every adolescent, every child

Health workforce requirements for the Global Strategy cannot be seen only through the lens of maternal and child health or the former Millennium Development Goals 4 and 5. Women's and adolescents sexual and reproductive health requires more than a maternal and child health worker system. There should be strong links to workers in social services, including the judicial system, to provide comprehensive services. Especially neglected is adolescent health, which requires special efforts that are integrated with life skills, education and employment opportunities, in addition to the new skills of the

health workforce. In the course of 2016–2030, progress on the Global Strategy mandates accompanying progress on Sustainable Development Goal 3 on good health and well-being, as a whole, and on the connecting indicators in other goals.

Stakeholders of Every Woman Every Child should pledge to reach the SDG index-based workforce threshold of 4.45 physicians and nurses/midwives per 1000 population in all countries for all people, including rural populations. In this holistic approach, IAP considers that meeting shortages of health professionals who work primarily with women, children and adolescents¹¹⁷ must be a high priority, and all possible efforts must be made to achieve the desired density, distribution and quality over the next five to seven years.

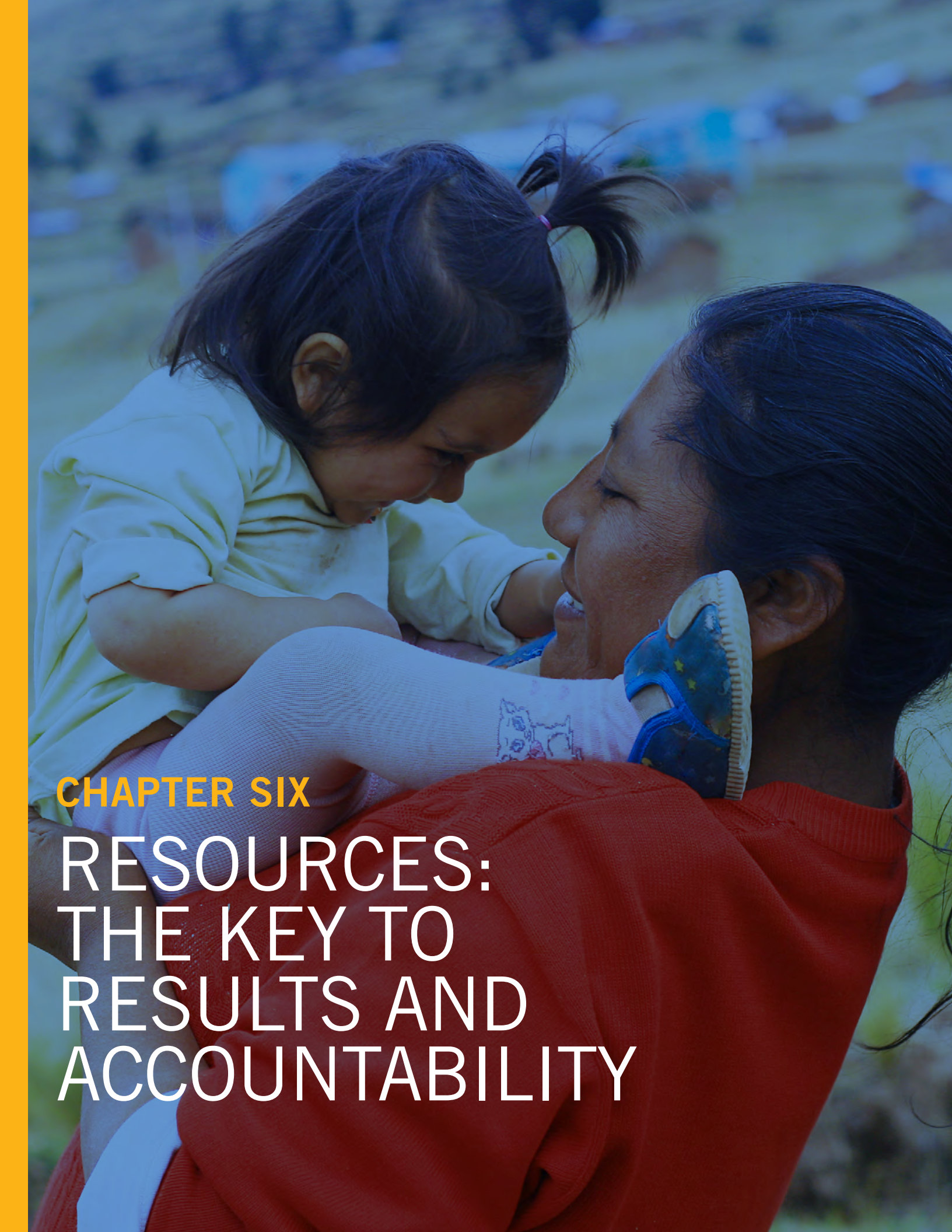
Looking to the future

In order to achieve the Global Strategy's goal of survive, thrive and transform, there needs to be a dramatic expansion and rethinking of the health workforce, which advances the rights of all patients to access quality care and the rights of health workers. The IAP expresses its deep concern at the workforce shortages facing low- and middle-income countries, and lack of efforts to address the problem of migration of health professionals from low resource nations. Inadequate access to competent health workers exacerbates the risk of ill health and mortality, and poverty, for a huge number of women, children and adolescents. Problems faced by the poor and those living in rural and inaccessible areas are even more

acute, with millions unable to get essential health care, jeopardizing their human rights.

The IAP welcomes linking grants and loans for health by partners with impact assessments of workforce implications and a deliberate HRH strategy on how specific programming contributes to strengthening capacity-building efforts. We also appreciate the incorporation of specific indicators to be attained by 2020 and 2030 in its accountability and monitoring framework.¹¹⁸

The IAP will follow progress on strategy milestones, and action at national and subnational levels, through the prism of equity and universal coverage. In particular, the Panel will critically observe trends in production, density, distribution, equity, quality and mix of human resources for health, and policies that impact on the quality, motivation, retention and rights of workers. And it welcomes the establishment of the High-Level Commission, trusting it will give an impetus to meeting health workforce challenges and advise on leveraging health employment as a means to income, well-being and women's empowerment.

A photograph of a woman with dark hair, wearing a red sweater, holding a young child with dark hair in a ponytail. The child is wearing a light green long-sleeved shirt and white socks with a cat design. They are outdoors, with a blurred background of greenery and a blue sky. The image has a blue tint and a semi-transparent dark blue overlay on the right side.

CHAPTER SIX

RESOURCES: THE KEY TO RESULTS AND ACCOUNTABILITY

Without resources, accountability is just empty rhetoric. To achieve the results the Global Strategy sets out – the outcomes on human rights, the innovations necessary to achieve better health outcomes for all – requires resources. And it demands that they be also allocated to accountability mechanisms, ensuring that all resources are deployed for maximum efficiency and equity.

In the previous chapter, the IAP discussed human resources for health, acknowledging that the right to health and universal health coverage depends on a skilled, motivated workforce. Here we turn our attention to financial resources for health, drawing on several sources including the draft report *Analysis of commitments to the global strategy for women's, children's and adolescents' health* prepared for the Partnership for Maternal, Newborn and Child Health (PMNCH).¹¹⁹

That report outlines the various sources of public health resourcing, the number and type of new commitments to the Global Strategy, financial and non-financial, since September 2015, and looks at those who have and have not made commitments.

Significant general support for Global Strategy

The Global Strategy has attracted significant general support and attention to critical issues in the health of women, children and adolescents. By July 2016, 177 commitments had been made to the Global Strategy, 100 from those who had also committed to the first Global Strategy (2010–2015) and

77 by new commitment-makers.¹²⁰ Governments represented the largest group of commitment-makers, most of these from low-income countries. About half of all commitments were from stakeholders in North America and Europe, the remainder from Africa, Asia and Latin America. However, commitments from nongovernmental organizations, foundations, academia and the private sector were overwhelmingly made by stakeholders from North America and Europe, indicating a potential for additional nongovernmental commitments from elsewhere.¹²¹

Commitments reflected strong support for the Global Strategy's survive and thrive objectives, but could better recognize the social determinants of health and the value of cross-sector collaboration reflected in the transform objective. Analysis revealed stillbirths and neonatal health remain insufficiently targeted. Commitment-makers showed broad support for improving lives at all stages, although further attention on adolescents was seen as warranted, and for health system strengthening as an important factor in improving sexual, reproductive, maternal, newborn, child and adolescent health. Humanitarian and fragile settings were largely overlooked. Commitments reflect strong

ALL COUNTRIES NEED TO ADDRESS THE ISSUE OF FISCAL SPACE, TAX EVASION AND MORE EQUITABLE TAXATION AND EQUITABLE ALLOCATION OF RESOURCES.

support for a partnership-driven, country-led, people-centred approach, but comparatively few explicitly refer to human rights.

Donor commitments

Substantial financial commitments have been made to the Global Strategy.¹²² As of June 2016, 89 commitment-makers had pledged a total of US\$ 25.5 billion. Some of these are double-counted.¹²³ Excluding instances of double-counting, the total amounts to US\$ 20 billion.¹²⁴

The PMNCH-commissioned report found that almost 90% of financial resources were pledged by governments. High-income countries pledged US\$ 11.4 billion and committed exclusively to improving health in developing countries through development cooperation. Low-income countries pledged almost US\$ 5 billion, with commitments from middle-income countries remaining modest. Some of the largest commitment-makers of the first strategy have made only small commitments to date, or have yet to make any at all.

Another key finding of the report was that donor financing for reproductive, maternal, newborn and child health (RMNCH) rose substantially in the three years after the launch of the first Global Strategy, but fell in 2014 for the first time since 2006.¹²⁵ Overall government expenditure for sexual, reproductive, maternal, newborn and child health (SRMNCH) in the 75 so-called Countdown countries increased by US\$ 30 billion (37%) since 2010, reaching a total of more than US\$ 110 billion in 2014.¹²⁶ However, 88% of this was in the large middle-income countries

Brazil, China, India, Indonesia, Mexico and South Africa.

Financing trends shows donor aid for the Countdown countries dropped by 6% in 2014, affecting key areas, including HIV and AIDS (as related to SRMNCH), malaria, immunization and nutrition. To reverse the trend, it is key that additional commitments are secured among OECD donors over the coming months. Strong financial commitments to the first Global Strategy were among the principal drivers of a growing awareness of the need for sustained RMNCH financing. Even in this era of fiscal constraints, additional financial commitments from donors are urgently required to support countries now striving for improved results.

Commitments at the highest level are needed, as is aid transparency. Prime Minister Trudeau of Canada set an example by pledging to strengthen aid transparency and including among the top priorities for his new Minister of International Development: ensuring that Canada's focus on Maternal, Newborn, Adolescents and Reproductive Health is driven by evidence, not ideology, including by closing existing gaps in reproductive rights and health; supporting the implementation of the 2030 Agenda for Sustainable Development, championing the values of inclusive and accountable governance, peaceful pluralism, respect for diversity and human rights including the rights of women and refugees; focusing on development innovation and effectiveness, including by supporting better data collection and analysis. At the World Humanitarian Summit in Istanbul, Canada's government said it would allocate an

extra US\$331.5 million in humanitarian aid.¹²⁷

The IAP applauds initiatives to make information on donor commitments and disbursements freely available. It further encourages all donors to provide such information, in accessible formats that ideally permit disaggregation of funding by priorities, including allocations to SRMNCAH.

Domestic budgets

Overall domestic spending (not only as part of Global Strategy commitments) increased markedly since the launching of the first Global Strategy.¹²⁸ Under the updated strategy, almost one quarter of financial commitment-makers are low-income countries, followed by the private sector and nongovernmental organizations. Only 12 middle-income countries pledged money to the Global Strategy to June 2016. According to the World Bank, there are 107 middle-income countries, and further financial commitments from this group should be encouraged. Low- and middle-income countries together account for only 29% of financial commitments, reflecting again the need to mobilize additional financial commitments from them.

Domestic spending must continue to increase overall, especially for reproductive, maternal, newborn, child and adolescent health, and particularly in the poorest countries, many of which spend less than 5% of gross domestic product on health.¹²⁹ Globally, low-income countries have the lowest proportion of health expenditure, and the highest proportion of out-of-pocket expenditure. This can lead to

catastrophic expenditure, furthering impoverishment. Financial protection, especially for the poorest, is important. The IAP will assess progress in protection in future reports.

Fiscal space

A 2010 WHO report¹³⁰ defines fiscal space for health as “additional budgetary resources for health without prejudice to a country’s financial sustainability”. The authors note that low-spending countries suffer from multiple and complex health financing problems, triggered from both inside and outside the national health financing system. The bottom-line, however, is low and inequitable health spending. Household out-of-pocket resources play a predominant role in financing health in these countries. The budgetary share of health is uniformly low among LICs in all WHO regions. Facing multiple inequities, the disadvantaged population groups also received a lesser share of government and private resources. External resources play a crucial role in only a few countries.

The achievement of the Global Strategy calls for significant resource expenditures. In a global context where ‘newly’ middle-income countries are required to shoulder a larger proportion of the health costs, the IAP is concerned that tax avoidance by both individuals and corporations is at a massive scale. This creates a significant deficit in fiscal revenues for many of these governments, and erodes their capacity to finance implementation of the Global Strategy, as it does

other public priorities. Tax avoidance, coupled with the trend toward austerity in donor countries, further limits the resources available for development assistance.

Cross-border tax evasion and illicit financial flows are equally if not more significant to combat than tax evasion within countries. Conservative estimates suggest the total cost of cross-border tax abuse to developing countries far exceeds the amount of official development assistance they receive, which at its height in 2014 was a relatively paltry US\$ 135.2 billion. In Latin America, The Economic Commission for Latin America and the Caribbean estimates that evasion and avoidance of personal and corporate income tax cost Latin America more than US\$ 190 billion, or 4% of GDP, in 2014.¹³¹ Fiscal space needs to be adequate in order for the other goals of the Global Strategy to be met, such as reducing disparities across populations in access to reproductive, maternal, newborn, child and adolescent health care.

The Sustainable Development Goals call for better collection, and transparency, of information regarding tax collection and the allocation of public tax revenues. Although these measures are likely to be imperfect in the near future, as the Millennium Development Goals demonstrated, political determination can promote improved data collection. We encourage these promising efforts to better capture tax evasion, as well as innovative taxation mechanisms to address disparities.

Health aid eligibility

While health aid has increased in the past decade, it still falls short of what is needed. As Sara Davis argues in the *Health and Human Rights Journal*, facing other crises, some donor countries are looking to cut overseas health aid drastically. As a result, controversy has raged over how to equitably distribute diminishing funds. This is of particular importance for middle-income countries, home to 70% of people living in poverty worldwide.¹³²

This raises questions of how countries are rated eligible in the first place. Most donors use the World Bank’s Gross National Income Per Capita (GNIpc) index to determine aid eligibility, but critics have pointed out weaknesses in GNI, including arbitrary quantification measures, lack of commensurate categories and weak data from underfunded statistics bureaus creating bizarre changes in income classification. Some countries have been known to manipulate their GNI to stay aid-eligible, and GNIpc, a national measure, fails to capture internal inequality.

The Institute for Health Metrics and Evaluation suggests aid agencies examine countries’ budgets and expenditures to assess whether they use maximum available resources to fulfil economic and social rights, and the Committee on Economic, Social and Cultural Rights recommends looking at similar countries for comparison, as well as at the past performance of the country. This kind of review will often find that countries are not spending what they could on health. If done transparent-

ly and inclusively, fiscal space review could encourage more civil society and public advocacy for domestic health financing.

The IAP agrees that we cannot keep relying on old tools such as GNI, and that donors and international agencies should determine aid eligibility “in ways that are transparent, inclusive and accountable to the public.”¹³³

Global Financing Facility

The Global Financing Facility (GFF), aiming at accelerating advancements in the health of women, children and adolescents,¹³⁴ is a welcome addition to the health financing land-

scape, with a clear equity focus and results framework, strong support for civil registration and vital statistics (CRVS), and a commitment to upholding transparency and accountability via strong country leadership. Launched in July 2015 in support of Every Woman Every Child, it started operating with US\$ 12 billion in domestic and international, private and public funding aligned to country-led five-year investment plans for the health of women, children and adolescents. It started in four so-called front runner countries of the Democratic Republic of the Congo, Ethiopia, Kenya and United Republic of Tanzania. It is now working in 11.¹³⁵

However, the GFF should not be seen as a cure-all to health financing challenges. The IAP notes that the word global in its title is something of a misnomer, and that it operates in only 11 front runner countries. The Panel believes it is an important component for moving forward with the Global Strategy, but does not solve all funding needs. The indicators for country platforms must include greater civil society participation. The IAP will closely monitor how successful the GFF is in mobilizing domestic financing and whether it is accelerating universal health care.

Civil society engagement in the GFF

The involvement of civil society in the development of Investment Cases¹³⁶ in the four front runner countries varied from one country to the next but common challenges persisted, including poor communication about GFF processes and limited representation of civil society members in consultations.

The GFF Business Plan included a set of minimum standards for country platforms, which outlined basic parameters for enhancing transparency and inclusivity. In response to realized concerns about the engagement of civil society and other stakeholders, a revised, more comprehensive set of minimum standards was developed by civil society leaders and submitted to the Investors' Group in February 2016.¹³⁷ The group has indicated it will include them in the forthcoming operational guidelines for countries. In the meantime, the African Health Budget Network has taken the lead in developing an independent scorecard tool for monitoring the application of the minimum standards in GFF countries.¹³⁸

Experience from other funding mechanisms, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Gavi, the Vaccine Alliance, has shown civil society involvement is critical to fostering national accountability. The IAP welcomes the clear focus of the GFF on equity and accountability with country leadership, and the involvement of civil society. The coming year will be crucial as the front runner countries start to implement the GFF. The IAP is keenly interested in how both the processes and results in the GFF are monitored in order to ensure adherence to transparency and accountability.

Private sector

With resources a major issue, there is a critical need to mobilize the private sector towards achieving the aims of the Global Strategy and the sustainable development agenda's imperative of no one left behind. Moving from the Millennium Development Goals to the Sustainable Development Goals has brought expectations of much greater private sector engagement, and a growing understanding of the positive impact this could have. The private sector could play a big role in achieving the SDGs, and in the updated Global Strategy, and private companies have engaged in many areas relating to the health of women, children and adolescents, including developing and delivering vital commodities, philanthropic donations, public-private partnerships, and service delivery. Yet, the participation is still not what it could be. For instance, of the total amount of financial resources pledged in support of the Global Strategy just 2% came from the private sector.¹³⁹ Further, commitments were overwhelmingly made by companies from North America and Europe, indicating potential for additional from other regions.¹⁴⁰

Private sector companies are accountable to shareholders and to customers, but they also are increasingly recognized to have corporate responsibilities and to society as a whole. The private sector has for years been reporting on their sustainability impacts. With the introduction of the Sustainable Development Goals, the Global Reporting Initiative, UN Global Compact and World Business Council for Sustainable Development

created the SDG Compass, a tool to help companies align their strategies with the SDGs and report on them.¹⁴¹ Importantly, the private sector is also converging on a standardized way to report on all 17 SDGs in their sustainability or integrated financial reports. The IAP encourages the private sector to be guided by the Compass, viewing it as a welcome means of achieving uniform reporting across all companies.

The accountability of the private sector towards the health of women, children and adolescents has been largely neglected. A key challenge is whether it can evolve from primarily self-initiated voluntary activities towards a more systematic approach in which areas of unmet need are identified and aligned with their technologies, competencies and resources. Aligning private sector capabilities around national and global targets within a broader-based planning framework would enhance accountability by defining specific responsibilities for the private sector and engaging their competencies in driving implementation and outcomes. It must also introduce ways that companies can support positive health impacts, such as increased philanthropic giving, corporate social responsibility initiatives, shared value creation and coalition-building around advocacy and policy change.

The need for greater transparency, especially in relation to the involvement of the diverse private sector, takes on greater urgency in the post-aid era when low- and middle-income countries that have had health funding withdrawn must hold an increasingly diverse array of actors, including independently

operating private-sector funders, accountable for health-related impacts.

The future of financing

The Global Strategy has attracted appreciable attention and support for the health of women, children and adolescents. But real progress requires funding, and the overview of existing commitments comes up short. The potential for commitments from all actors – countries, other donors, the private sector – must be pursued, with robust and reliable pledges, sustained over the long-term.

The IAP welcomes progress made towards greater transparency in financial resourcing at all levels and encourages even greater coordination among the various actors, along with better criteria for aid eligibility. Low- and middle-income countries should increase domestic budgeting, and all countries need to address the issue of fiscal space and more equitable taxation and equitable allocation of resources. These issues are particularly difficult to address in low income countries in fragile settings, many of which are facing additional budgetary pressures from increased security risks.

The Panel encourages a more systematic approach to engaging the private sector in pursuit of the Global Strategy and the Sustainable Development Goals, though its own efforts to self-monitor for accountability should continue. In the IAP's opinion, these efforts would stimulate an inflection point in investment towards attainment of the Global Strategy, and SDG, ambitions.



CONCLUSION

TIME FOR
ACTION

The need for action is urgent. It is true we need higher-quality data, which is suitably disaggregated. But there is already enough information available for the broad analysis we present in this report – and to act upon it. Oversight mechanisms are improving in many countries but it is true that there is still much room for improvement at national, regional and global level, and the IAP itself has plans to strengthen its own work. But there is only one clear conclusion that is possible to draw from this report: there is much that can and must be done, starting right now.

Throughout this report, we make many recommendations, some suggestive, indicating where we think stakeholders might take greater action, others more forceful. Some are quite specific, some more general. Now we turn to three overarching conclusions that emerge repeatedly throughout the report, and which we consider of the highest priority.

To enable women, children and adolescents – and their families and communities – to survive and thrive, and to transform the environments that produce poor health, action is required on three fronts: leadership, resources and institutional capacity-building.

Leadership

History shows that taking forward any transformational agenda, such as the Sustainable Development Goals, requires strong institutional leadership. We are at a seminal moment of transition at the United Nations. By early 2017 we will have a new Secretary-General of the United Nations, and a new Director-General of the World Health

Organization. The IAP deeply appreciates that the current Secretary-General has played a key leadership role in positioning the health of women, children and adolescents at the forefront of global efforts towards better health and well-being for all the world's population; it will be one of his signature legacies. Likewise, the current WHO Director-General has led the organization's drive to give its full support to the complex implementation of the new Global Strategy based upon human rights. Both have been champions of accountability, promoting ideas and building mechanisms for making it a reality. They have accomplished a great deal, but there is still much to be done.

We urge the UN Security Council and General Assembly to choose as the next Secretary-General of the UN a candidate who has a clear commitment to vigorously promoting and implementing the Global Strategy; to making sure mechanisms are in place at the global, regional and national level so that accountability can be much more than rhetoric; and to powerfully support the achievement of the Sustainable

Development Goals and the centrality of the health of women, children and adolescents to the 2030 agenda. Similarly, we urge the World Health Assembly to elect a candidate with a strong commitment to the Global Strategy, to advancing meaningful accountability and to robust collaboration across sectors.

Progress on achieving the “highest attainable standard of health” in general, and the goals set forth in the Global Strategy in particular, depends upon improvements in education, employment, water and sanitation, and other social determinants of health. Much has been said about intersectoral partnerships, but without strong leadership at the highest level, collaboration at the scale needed will not happen.

Resources

We know that progress at the scale needed requires more resources than are currently available. However, we need an investment framework with more precise estimates of the costs and potential benefits of various investments. Also needed from our world leaders and UN agencies is a

CONCLUSION

clear plan for tapping additional resources, ones that go beyond the mantra of shifting to domestic resources from governments of middle income countries and having greater collaboration between existing global financing mechanisms. Both domestic resources and greater collaboration are needed, but a clearly defined roadmap is crucial.

The Global Financing Facility (GFF) is an important step to meet the health needs of women, children and adolescents in some of the poorest countries in the world. But we urge the World Bank to enhance partnerships to accelerate its implementation in more countries, and to ensure civil society has a genuine voice in the ways funding is used and in auditing those funds.

We also urge governments from North and South alike, to work together in setting new expectations for policies on tax collection and use, within and between countries. These policies should expand the fiscal space of governments with limited capacity to provide for the needs of their most disadvantaged citizens, as well as create more effective regulation and oversight.

We also call for donors to revisit their aid eligibility criteria, which currently excludes two thirds of the world's poor who live in middle-income countries.

And we urge the manifold and diverse institutions that make up the private sector as a whole to give higher priority to women, children and adolescents, by supporting actions to promote their health, and avoid those actions that might be detrimental to it.

Institutional change

Our report makes clear that accountability has to be based on human rights. The institutional framework and norms of human rights were established after the world emerged from the great human catastrophe of World War II. We now face crises on a grand scale again and we must redouble our commitment to universal human dignity. We have focused our attention on how gross inequalities within and between countries, in major health indicators and beyond the health sector, undermine the possibility of achieving the vision set out in the 2030 Agenda, and all of the Sustainable Development Goals. We are not alone in pointing out that gender equality and overcoming the marginalization of young people are fundamental to the inclusive ideals of Agenda 2030, as is addressing other forms of entrenched inequality and discrimination. And we are not alone in urging the strengthening of national accountability and to point out the need for better, disaggregated data to illuminate patterns of exclusion that require redress.

All this requires the strengthening of global, regional and, in particular, national institutions that promote citizen participation. Achieving the transformative changes that the Global Strategy envisions requires institutions, with appropriate mandates, capacity and sustained financing, including accountability and oversight institutions.

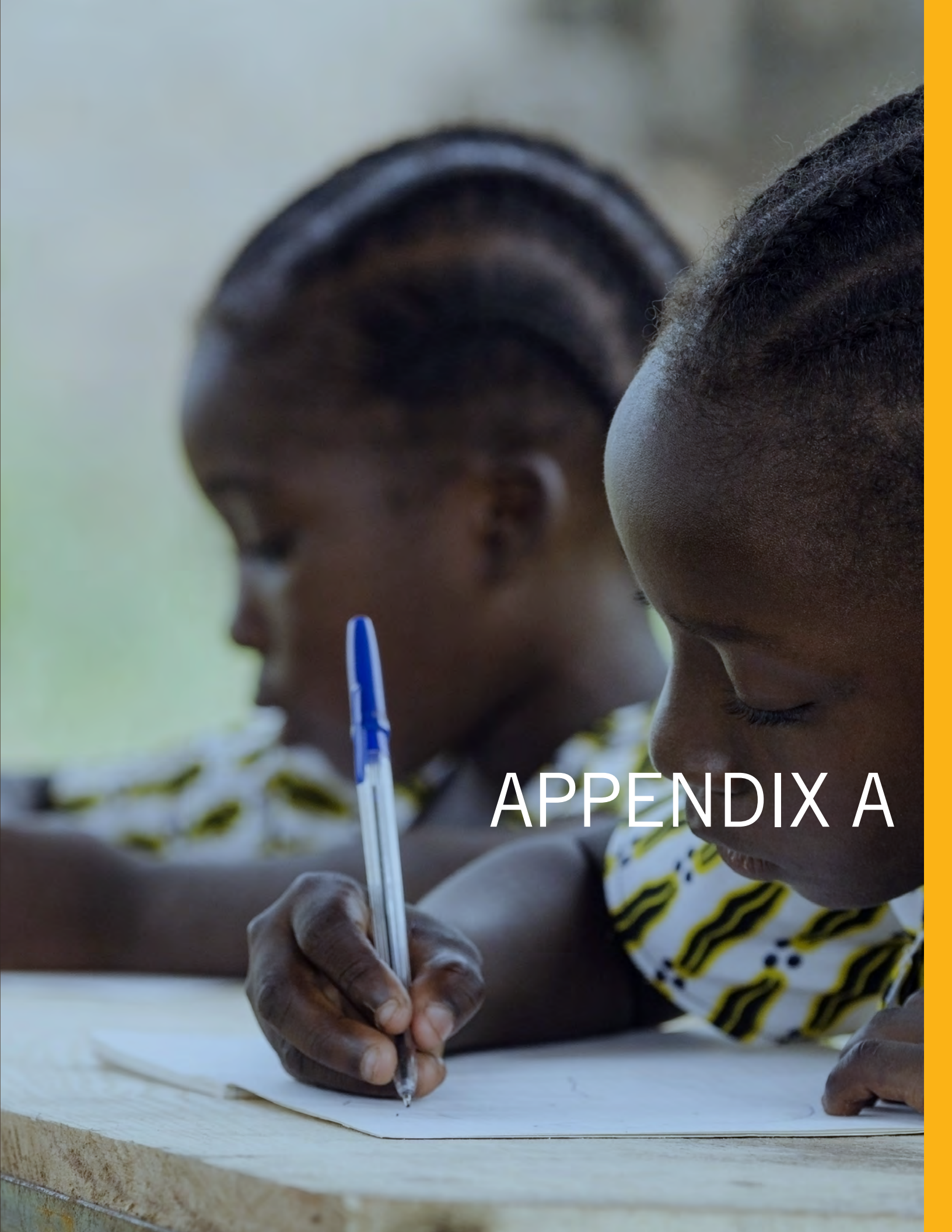
Mechanisms that need to be strengthened include national statistical offices, and administrative data collection entities. They also include independent judiciaries and national human rights institutions,

as well as regional and global human rights bodies. The many different actors in the private sector at multiple levels, as well as professional associations and accreditation boards should also be engaged in moving forward collaboratively. Perhaps most importantly, civil society activities, such as citizen hearings, should be supported and enabled through freedom of information and association protections. We all have a role to play in creating the world we want.

The IAP recommends not only that these mechanisms be strengthened but also that higher priority be placed on the well-being of women, children and adolescents, including aspects that are too often subject to ideological politicking, such as sexual and reproductive health and rights.

There may also be the need to establish new accountability mechanisms, or new initiatives that bridge disciplinary and sectoral silos, and support both technical capacity and focus on the health and rights of women, children and adolescents. The IAP welcomes the High Level Working Group on Human Rights and Women's Health, and pledges to collaborate with it in searching for ways to foster improved health and rights, which are inextricably linked and essential for the future of the world that we desire.

We are all accountable. The IAP welcomes comments on this report from all stakeholders, and we look forward to receiving inputs for the report we will present next year.

A photograph of two young girls with dark skin and hair, sitting at a wooden desk and writing on white paper. The girl in the foreground is in sharp focus, holding a blue and silver pen and looking down at her work. She is wearing a white shirt with a yellow and black pattern. The girl in the background is slightly out of focus, also writing. The background is a plain, light-colored wall. The text 'APPENDIX A' is overlaid in white, sans-serif capital letters on the right side of the image.

APPENDIX A

APPENDIX A: SUMMARY AVAILABILITY OF INDICATORS

TABLE 1 : SCORING KEY, BASED ON TABLE 6 OF THE WORLD HEALTH STATISTICS REPORT, OF THE AVAILABILITY AND DISAGGREGATION OF IAP INDICATORS.

	Scoring	WHS methodology	Adaptation for IAP indicators
Country data availability	Good	Data is available for more than 75% of countries where the indicator is relevant (2010 or after) ¹	WHS assessed based on the availability of data in WHO countries only, so IAP has only assessed against WHO countries, rather than all the UN countries.
	Fair	Data is available for 40-74% of countries where the indicator is relevant (2010 or after)	
	Poor	Data is available for less than 40% of countries where the indicator is relevant (2010 or after)	
Comparable estimates	Annual	Annual data is available	
	Every 2-3 y	Data points for every 2-3 years are available for most countries	
	In preparation	Historical estimates are being prepared	
	Not available	Historical data is not available	

This scoring only deals with presence or absence of data at country level, rather than the quality of that data.

¹ Based on WHO list of 194 countries. 75% =145, 40% =77

TABLE 2. DATA SOURCES OF IAP INDICATORS, AND AVAILABILITY AND DISAGGREGATION OF COUNTRY DATA

Indicator	Data source	Country data availability (since 2010)	Availability of disaggregated data ³					Comparable estimates
			Age	Cause of Death	Location ⁴	Sex	Wealth	
1. Maternal mortality (3.1.1)	UN MMEIG*	Good ²						Annual
	IHME GBD	Good	X	X				Annual
2. Under-5 mortality (3.2.1)	UN IGME*	Good				X		Annual
	UNICEF*	Fair					X	2-3 yr (Survey)
	GHO HEM	Poor					X	2-3 yr (Survey)
	Countdown	Fair					X	n.a.
	GHO	Good		X				2-3 yr (Survey)
	IHME	Good	X	X		X		Annual
2b. Neonatal mortality (3.2.2)	UN IGME*	Good						Annual
	UNICEF*	Fair					X	2-3 yr (Survey)
	GHO HEM	Poor					X	2-3 yr (Survey)
	IHME	Good	X	X		X		Annual
2c. Stillbirth	Lancet article (2016)	Good						Annual
3. Adolescent mortality	WHO GHO	Good	X	X		X		2-3 yr (Survey)
	IHME GBD	Good	X	X		X		Annual
4. Demand for Family planning satisfied with modern methods (3.7.1)	UN Pop Division/DESA*	Fair						Annual
	UNFPA	Fair	X					2-3 yr (Survey)
	GHO HEM	Poor						2-3 yr (Survey)
5a. Stunting among children under 5 (2.2.1)	Countdown	Fair	X					2-3 yr (Survey)
	JME UNICEF WHO WB*	Good						Annual
	UNICEF*	Fair			X		X	2-3 yr (Survey)
	GHO HEM	Poor				X	X	2-3 yr (Survey)
	Countdown	In preparation					X	n.a.
	IHME	In preparation			X	X		n.a.
5b. Overweight among children under 5 (included in 2.2.2)	JME UNICEF WHO WB*	Fair						Annual
	UNICEF*	Fair					X	2-3 yr (Survey)
	GHO HEM	Poor				X		2-3 yr (Survey)
	IHME	In preparation			X	X		n.a.

² This was marked as fair in WHO 2016 World Health Statistics report, but data is available for 183 countries.

This needs to be further investigated with WHO.

³ Grey columns indicate non-applicable disaggregation.

⁴ Location is the classification between rural and urban.

TABLE 2. CONTINUED

Indicator	Data source	Country data availability (since 2010)	Availability of disaggregated data ³					Comparable estimates
			Age	Cause of Death	Location ⁴	Sex	Wealth	
6. Adolescent birth rate (3.7.2)	UN Pop Division*	Good	X					5 yr estimates
	UNFPA	Fair			X		X	n.a.
	GHO HEM	Poor	X				X	2-3 yr (Survey)
7. Poverty (1.1.1)	World Bank*	Good						Annual
8. Education – attainment of proficiency level (4.1.1)	UNESCO IUS*	Poor						(to confirm)
9. NEET (8.6.1)	WB/ILO*	Fair						2-3 yr (Survey)
10a. SRH legal rights (5.6.2)	UNFPA*	In preparation						n.a.
10b. Legal protection from domestic violence (proxy for 5.1.1)	UN Women* (for 5.1.1)	Not available				X		n.a.
	OECD gender Index	Good						2009, 2012, 2014
10c. Public opinion on domestic violence (incl. 5.1.1)	UN Women* (for 5.1.1)	Not available						n.a.
	OECD gender Index	Fair						None
11. Birth registration (16.9.1)	UNICEF*	Good			X	X	X	In preparation
12a. Child marriage (5.3.1)	UNICEF*	Fair	X					In preparation
12b. Sexual violence (16.2.3)	UNICEF*	Poor				X		In preparation
	IHME	In preparation						n.a.

* represents custodian agency, as defined by IAEG-SDGs

Grey columns indicate non-applicable disaggregation.

- 1 6,000 people attending the Women Deliver conference included young people, journalists, private sector representatives, UN agencies, government representatives, including ministers and parliamentarians from more than 50 countries.
- 2 The Universal Declaration of Human Rights (UDHR). New York, United Nations, 1948 (<http://www.un.org/en/universal-declaration-human-rights/>).
- 3 OHCHR and CESR. Who will be accountable? Human rights and the post-2015 development agenda. New York and Geneva: United Nations; 2013;ix.
- 4 UN Human Rights Council. Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal mortality. UN document; 2012 (A/HRC/21/22).
- 5 Commission on Information and Accountability for Women's and Children's Health. Final report: Keeping promises, measuring results; 2011
- 6 Independent Expert Review Group (iERG) Monitoring Framework; 2012 (http://www.who.int/woman_child_accountability/ierg/reports/iERG_onepager_MONITORING_FRAMEWORK_2012.pdf).
- 7 2010 World health report. Geneva: World Health Organization; 2010
- 8 UN Human Rights Council. Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal mortality. UN document; 2012 (A/HRC/21/22); paragraph 6.
- 9 Every Woman Every Child. The global strategy for women's, children's and adolescents' health (2016–2030). Every Woman Every Child; 2015; p36.
- 10 Flood CM, Gross A, eds. The right to health at the public/private divide: A global comparative study. New York: Cambridge University Press; 2014.
- 11 Yamin AE, Lander F. Implementing a circle of accountability: a proposed framework for judiciaries and other actors in enforcing health-related rights. *Journal of Human Rights*; 2015;14(3):312-331.
- 12 Yamin AE, Lander, F. Implementing a circle of accountability: a proposed framework for judiciaries and other actors in enforcing health-related rights. *Journal of Human Rights*; 2015;14(3):312-331. Yamin AE. Suffering, power and courts: reflections on judicialization of the right to health. In Yamin AE, Gloppen S, eds. *Litigating health rights: Can courts bring more justice to health?* Cambridge, MA: Harvard Human Rights Series, Harvard University Press; 2011:333-372. (Also reprinted partially in Grodin M, Tarantola D, Annas G, Gruskin S, eds. *Health and human rights in a changing world*. New York: Routledge; 2013)
- 13 OHCHR and CESR. Who will be accountable? Human rights and the post-2015 development agenda. New York and Geneva: United Nations; 2013;x.
- 14 The process by which stakeholders will be able to provide advice and inputs will soon be outlined on the IAP website.
- 15 Article 28, Universal Declaration of Human Rights.
- 16 A world that counts: mobilizing the data revolution for sustainable development. United Nations Secretary-General's Independent Expert Advisory Group on a Data Revolution for Sustainable Development (IEAG).
- 17 Indicator and monitoring framework for the Global Strategy on women's, children's and adolescents' health (<http://www.who.int/life-course/publications/indicator-monitoring-framework-publication/en/>).
- 18 Dorringtona RE, Bradshawb D. Acknowledging uncertainty about maternal mortality estimates. *Perspectives. Bulletin World Health Organization*. 2016;94: 155–156
- 19 Stevens GA, Alkema L, Black RE, Boerma JT, Collins GS, Ezzati M, et al. (2016) Guidelines for accurate and transparent health estimates reporting: the GATHER statement. *PLoS Med* 13(6): e1002056. doi:10.1371/journal.pmed.1002056. *PLOS medicine* June 2016. IHME, Harvard, JHPU, University of Oxford, LSHTM, University of Ottawa,) and two medical journals *Lancet* and *PLOS* (<http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002056>).
- 20 High-level panel on humanitarian financing report to the Secretary-General (2015) Too important to fail – addressing the humanitarian financing gap (www.un.org/news/WEB-1521765-E-OCHA-Report-on-HumanitarianFinancing.pdf).
- 21 Development Initiatives (2016). Better information for a better response: the basics of humanitarian transparency (<http://devinit.org/#!/post/betterinformation>).
- 22 sohs.alnap.org
- 23 World Humanitarian Summit briefing: Using IATI to improve operational effectiveness in humanitarian assistance; International Aid Transparency Initiative, p2.
- 24 New SDGs requiring international definition or methodology: 8: Education - attainment of proficiency level (SDG 4.1.1); 10a: SRH legal rights - access to SRH services (SDG 5.6.2); 10 b. c. Protection from domestic violence (proxy for SDG 5.1.1); 12 b. Experienced sexual violence by age 18 (SDG 16.2.3).
- 25 IAEG-SDGs. Provisional proposed tiers for global SDG indicators as of 24 March 2016 (<http://unstats.un.org/sdgs/files/meetings/iaeg-sdgs-meeting-03/Provisional-Proposed-Tiers-for-SDG-Indicators-24-03-16.pdf>).
- 26 WHO. World health statistics 2016: monitoring health for the SDGs. Geneva: World Health Organization; 2016.

- 27 Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division.
- 28 USAID. Ending preventable maternal mortality: USAID maternal health vision for action evidence for strategic approaches. Washington DC: USAID; 2015.
- 29 Sedgh G et al. Abortion incidence between 1990 and 2014: global, regional, and subregional levels and trends. The Lancet. Published online 11 May 2016 ([www.thelancet.com/journals/lancet/article/PIIS0140-6736\(16\)30380-4/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)30380-4/abstract)).
- 30 Ibid.
- 31 Although the term family planning does not accurately describe the need for contraceptives, it reflects long-standing use by the global health community. Often 'family planning' and 'contraceptives' are used interchangeably. As with other health services, contraceptives must be offered respecting the dignity of all clients and their rights to autonomy and confidentiality.
- 32 WHO. State of inequality: reproductive, maternal, newborn and child health. Geneva: World Health Organization; 2015.
- 33 Special analysis prepared for the IAP by the Countdown to 2030 Equity Working Group at the Universidade Federal de Pelotas, Brazil. The group's full report can be accessed at the IAP website.
- 34 57th session of Commission on Status of Women, New York, 4–15 March 2013: E/CN.6/2013/L.5.
- 35 State of inequality: reproductive, maternal, newborn and child health. Geneva: World Health Organization; 2016.
- 36 Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality. United Nations Human Rights Council, A/HRC/21/22, 2012 (http://www2.ohchr.org/english/issues/women/docs/A.HRC.21.22_en.pdf, accessed 27 July 2016).
- 37 UNFPA, Center for Reproductive Rights (CRR). ICPD and human rights: 20 years of advancing reproductive rights through UN treaty bodies and legal reform. CRR; 2013.
- 38 UNFPA. Annual report 2015: for people, planet & prosperity. New York: UNFPA; 2016.
- 39 The five legal grounds are: 1) to save a woman's life, to preserve a woman's physical health, 2) to preserve a woman's mental health, 3) in cases of rape or incest, 4) in cases of fetal impairment, 5) for economic or social reasons.
- 40 United Nations Economic and Social Affairs (2015). The world's women 2015, trends and statistics, p160.
- 41 Patton, George C et al. Our future: a Lancet commission on adolescent health and wellbeing. The Lancet; 2016;387(10036):2423–2478 ([http://dx.doi.org/10.1016/S0140-6736\(16\)00579-1](http://dx.doi.org/10.1016/S0140-6736(16)00579-1)).
- 42 Ameratunga S, Denny S. GBD 2013: a window into the world of young people. The Lancet; 2016;387(10036): 2353–2354 ([http://dx.doi.org/10.1016/S0140-6736\(16\)30296-3](http://dx.doi.org/10.1016/S0140-6736(16)30296-3)).
- 43 Ibid.
- 44 WHO. World health statistics 2016: monitoring health for the SDGs. Geneva: World Health Organization; 2016.
- 45 UNFPA. State of world population 2013. Motherhood in childhood: Facing the challenge of adolescent pregnancy. New York: UNFPA; 2013.
- 46 Ibid.
- 47 Hale DR, Bevilacqua L, Viner RM. Adolescent health and adult education and employment: a systematic review. Pediatrics; 2015;136:128–40.
- 48 Benjet C, Hernández-Montoya D, Borges G, Méndez E, Medina-Mora ME, Aguilar-Gaxiola S. Youth who neither study nor work: mental health, education and employment. Salud Publica Mex; 2012;54:410–17.
- 49 Baggio S, Iglesias K, Deline S, et al. Not in education, employment, or training status among young Swiss men. Longitudinal associations with mental health and substance use. J Adolesc Health; 2015;56:238–43.
- 50 Youth neither in employment education nor training (NEETs). Society at a glance 2014: OECD Social indicators. Paris: OECD Publishing; 2014.
- 51 Global employment trends for youth 2013: a generation at risk. Geneva: International Labour Organisation; 2013.
- 52 Global trends of youth unemployment 2015. Geneva: ILO; 2015.
- 53 Ibid.
- 54 Ibid.
- 55 http://www.unicef.org/protection/57929_58006.html.
- 56 United Nations. The world's women 2015: Trends and statistics. New York: United Nations, Department of Economic and Social Affairs, Statistics Division; 2015. Sales no E.15.XVII.8.
- 57 WHO, Department of Reproductive Health and Research, London School of Hygiene & Tropical Medicine, South African Medical Research Council, 2013a. Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva: World Health Organization; 2013.
- 58 Ibid.
- 59 United Nations. The world's women 2015: trends and statistics. New York: United Nations, Department of Economic and Social Affairs, Statistics Division; 2015. Sales no E.15.XVII.8.

- 60 Breaking the cycle of violence. Together for Girls Stakeholder Report 2015-2016 (<http://www.togetherforgirls.org/wp-content/uploads/Together-for-Girls-2015-2016-Stakeholder-Report.pdf>).
- 61 Together for Girls. Breaking the cycle of violence. Together for Girls stakeholders report 2015–2016.
- 62 WHO, London School of Hygiene & Tropical Medicine. Preventing intimate partner and sexual violence against women: taking action and generating evidence. Geneva: World Health Organization; 2010.
- 63 IAEG SDG. Metadata compilation reports Goal 16. New York: UN; 2016; Provisional proposed tiers for global SDG indicators as of 24 March 2016. New York: UN; 2016.
- 64 The first 28 days of life.
- 65 Special analysis prepared for the IAP by Countdown to 2030 Equity Working Group at the Universidade Federal de Pelotas. Full report can be accessed at the IAP website.
- 66 Viable baby born with no signs of life. Viability classified by WHO International Classification of Diseases 10 late fetal death as birthweight 1000 g or more, or gestational age of 28 weeks or more, or length of 35 cm or more. With the increasing survival of very preterm babies, many countries have lowered the weight/gestational age down to 500 g/22 weeks.
- 67 Pakistan, Nigeria.
- 68 UN Human Rights Council. Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal mortality. UN Doc; 2012 (A/HRC/21/22).
- 69 World Bank project appraisal document 1694, May 2016 (<http://documents.worldbank.org/curated/en/215261467995371106/pdf/PAD1694-PAD-P152394-IDA-R2016-0122-1-Box396259B-OUO-9.pdf>).
- 70 Cigarette maker Philip Morris filed a complaint and sued Uruguay for compensation but their challenge was rejected by the International Centre for Settlement of Investment Disputes (ICSID) in July 2016.
- 71 Yamin A. Power, suffering, and the struggle for dignity: human rights frameworks for health and why they matter. Philadelphia, PA: University of Pennsylvania Press; 2016.
- 72 https://www.crin.org/sites/default/files/colombia_access_to_justice_0.pdf
- 73 Janani Suraksha Yojana (JSY), or Mother Security Scheme, is an Indian government scheme launched in April 2005 to lower neonatal and maternal deaths by promoting institutional delivery of babies. It is a safe motherhood intervention under the National Rural Health Mission.
- 74 <https://reprohealthlaw.wordpress.com/2016/06/14/kenyan-high-court-anti-counterfeit-act-threatened-access-to-generic-medicines/>
- 75 See, for example, USAID strategy on democracy, human rights and governance, June 2013, The Global Development Research Center Governance Assessment (http://www.gdrc.org/u-gov/doc-oecd_ggov.html#Participation), Brinkerhoff, D. (2003).
- 76 Concrete actions proposed to improve direct citizens engagement are a) to improve community awareness of their right through improved health literacy, dialogue, learning and action, community engagement strategies and tailored mass-media campaigns; b) to encourage communities to participate in defining their health needs together with political leaders and planners and formalize their contribution within national health systems; and c) to reorient health and development services in response.
- 77 See Yamin A. Power, suffering, and the struggle for dignity: human rights frameworks for health and why they matter. Philadelphia, PA: University of Pennsylvania Press; 2016.
- 78 UNHCR. Mid-year trends 2015; Geneva, UNHCR; 2015 (<http://www.unhcr.org/uk/statistics/unhcrstats/56701b969/mid-year-trends-june-2015.html>). PRMB, OCHA. Global humanitarian overview 2016 (<https://docs.unocha.org/sites/dms/Documents/GHO-2016.pdf>).
- 79 Every Woman Every Child. The global strategy for women's, children's and adolescents' health (2016–2030). Every Woman Every Child; 2015.
- 80 ALNAP. The state of the humanitarian system. ALNAP Study. London: ALNAP/ODI; 2015.
- 81 [http://www.un.org/en/ga/search/view_doc.asp?symbol=S/RES/2250\(2015\)](http://www.un.org/en/ga/search/view_doc.asp?symbol=S/RES/2250(2015))
- 82 <http://www.everywomaneverychild.org/news-events/news/1360-report-implementing-the-global-strategy-for-women-s-children-s-and-adolescents-health-everywhere>
- 83 Implementing the global strategy for women's children's and adolescents' health everywhere. 2016. (http://www.everywomaneverychild.org/images/EveryWhere_AD_Report_for_web-4.pdf)
- 84 Abu Dhabi Declaration. http://www.who.int/pmnch/media/news/2015/abudhabi_declaration.pdf
- 85 One humanity, shared responsibility. Report of the United Nations Secretary-General for the World Humanitarian Summit; New York: United Nations; 2016 (<http://sgreport.worldhumanitariansummit.org/>).
- 86 UN Women website article. At WHS, participants vow to put women and girls at centre of decision-making (<http://www.unwomen.org/en/news/stories/2016/5/whs-participants-vow-to-put-women-and-girls-at-centre-of-decision-making>).
- 87 Secretary-General's remarks to the Security Council meeting on sexual exploitation and abuse (<http://www.un.org/sg/statements/index.asp?nid=9520>).

- 88 Statement by António Guterres, UN High Commissioner for Refugees, August 2014 (www.unhcr.org/53ff76c99.html).
- 89 <http://www.who.int/emergencies/zika-virus/en/>
- 90 Editorial. The right(s) approach to Zika. *The Lancet*. July 2016;4(7)e427 ([http://thelancet.com/pdfs/journals/langlo/PIIS2214-109X\(16\)30109-7.pdf](http://thelancet.com/pdfs/journals/langlo/PIIS2214-109X(16)30109-7.pdf)).
- 91 In October 2015 Brazil reported an association between Zika virus infection and microcephaly. (<http://www.who.int/mediacentre/factsheets/zika/en/>).
- 92 WHO. Zika strategic response plan. Revised for July 2016–December 2017. Geneva: World Health Organization; June 2016 (<http://apps.who.int/iris/bitstream/10665/246091/1/WHO-ZIKV-SRF-16.3-eng.pdf?ua=1&ua=1&ua=1>).
- 93 Editorial. The right(s) approach to Zika. *The Lancet*. July 2016;4(7)e427 ([http://thelancet.com/pdfs/journals/langlo/PIIS2214-109X\(16\)30109-7.pdf](http://thelancet.com/pdfs/journals/langlo/PIIS2214-109X(16)30109-7.pdf)).
- 94 Verbatim from UNFPA report, Motherhood in Childhood.
- 95 Motherhood in childhood. Facing the challenge of adolescent pregnancy. UNFPA State of world population report 2013 (<http://www.unfpa.org/sites/default/files/pub-pdf/EN-SWOP2013-final.pdf>).
- 96 Convention on the Rights of the Child, the International Covenant on Economic, Social and Cultural Rights; the International Covenant on Civil and Political Rights; the Convention on the Elimination of All Forms of Discrimination against Women; and the Convention on the Rights of Persons with Disabilities.
- 97 Implementing the United Kingdom Government's 10-Year teenage pregnancy strategy for England (1999e2010): Applicable Lessons for Other Countries, *The Lancet*, March 2016.
- 98 WHO. Global strategy on human resources for health: Workforce 2030. Draft for the 69th World Health Assembly, May 2016. Geneva: World Health Organization; 2016.
- 99 <http://www.who.int/hrh/com-heeg/en/>
- 100 WHO. Global strategy on human resources for health: Workforce 2030. Draft for the 69th World Health Assembly, May 2016. Geneva, World Health Organization; 2016.
- 101 WHO. The world health report 2000 – health systems: improving performance. Geneva: World Health Organization; 2000.
- 102 Nurses, midwives, general physicians, specialists (surgeons, anaesthesiologists, obstetricians, paediatricians, orthopaedic surgeons, others) etc.
- 103 Pharmacists, physiotherapists, speech therapists, optometrists, special educators, clinical psychologists, dieticians, operation room attendants etc. (sometimes called paramedics).
- 104 WHO. The world health report 2006 – working together for health. Geneva: World health Organization; 2006.
- 105 Global Health Workforce Alliance, WHO. A universal truth: no health without a workforce. Geneva: Global Health Workforce Alliance and World Health Organization; 2013.
- 106 WHO. World health statistics 2016: monitoring health for the SDGs. Geneva: World Health Organization; 2016.
- 107 WHO. Migration of health workers. The WHO code of practice and the global economic crisis. World Health Organization in partnership with MPI and University of the State of Rio de Janeiro, Brazil; 2010.
- 108 Global Health Workforce Alliance, WHO. A universal truth: no health without a workforce. Geneva: Global Health Workforce Alliance and World Health Organization; 2013.
- 109 Siyam A et al. Monitoring the implementation of the WHO global code of practice on the international recruitment of health personnel. *Bulletin of the World Health Organization*; 2013;91:816–23.
- 110 WHO. World health statistics 2016: monitoring health for the SDGs. Geneva: World Health Organization; 2016.
- 111 Meara JG et al. Global surgery 2030: evidence and solutions for achieving health, welfare, and economic development. *The Lancet*; 2015.
- 112 WHO. Global strategy on human resources for health: Workforce 2030. Draft for the 69th World Health Assembly, May 2016. Geneva: World Health Organization; 2016.
- 113 Ibid.
- 114 Ibid.
- 115 Meara JG et al. Global surgery 2030: evidence and solutions for achieving health, welfare, and economic development. *The Lancet*; 2015.
- 116 Sustainable Development Goal 3.
- 117 Such as obstetricians, pediatricians, family physicians, midwives, nurses and community health workers, among others.
- 118 WHO. Global strategy on human resources for health: Workforce 2030. Draft for the 69th World Health Assembly, May 2016. Geneva: World Health Organization; 2016.
- 119 Analysis of commitments to the Global Strategy for Women's, Children's and Adolescents' Health. Prepared for the Partnership for Maternal, Newborn and Child Health by SEEK Development – Strategic and Organizational Consultants. Berlin: 2016.
- 120 Ibid.
- 121 Ibid, p2.
- 122 Ibid, p14–17.

- 123 Double-counting relates to funding committed twice by different stakeholders. For example, there could be a bilateral donor commitment to a global health partnership that is reported as a Global Strategy commitment by both the donor and the partnership. About US\$ 5.4 billion has been identified as referring to commitments that include double-counted funding. This includes primarily NGOs (US\$ 3.3 billion) and LICs who rely to some extent on funding from bilateral donors.
- 124 Analysis of commitments to the Global Strategy for Women's, Children's and Adolescents' Health. Prepared for the Partnership for Maternal, Newborn and Child Health by SEEK Development – Strategic and Organizational Consultants. Berlin: 2016.
- 125 The analysis of SRMNCH financing trends was conducted using the Muskoka method and data from the Organisation for Economic Co-operation and Development's Creditor Reporting System (CRS; <https://stats.oecd.org/Index.aspx?DataSetCode=CRS1>, accessed 20 May 2016/March 2015). The Muskoka method applies percentages to funding reported to the OECD under certain purpose codes and to selected multilateral organizations. The percentages applied vary depending on the intended target group of the respective donor activity. Activities targeting entirely or mostly women of reproductive age and/or children under five are assigned 100%; activities targeting the general population are counted at 40%. Disease-specific interventions are attributed at 18.5% for tuberculosis, 46.1% for HIV/AIDS and 88.5% for malaria. Basic drinking water supply and sanitation is counted at 15.0% (<http://www.g8.utoronto.ca/summit/2010muskoka/methodology.html> accessed 12 July 2016).
- 126 Ibid
- 127 <https://www.thestar.com/news/canada/2016/05/24/canada-announces-extra-3315-million-in-humanitarian-aid.html>
- 128 Analysis of commitments to the Global Strategy for Women's, Children's and Adolescents' Health. Prepared for the Partnership for Maternal, Newborn and Child Health (unpublished) by SEEK Development – Strategic and Organizational Consultants, Berlin, 2016;p16–17.
- 129 World health statistics 2015. Geneva: World Health Organization; 2015.
- 130 Durairaj V and Evans D. Background paper 41, World health report. Geneva: World Health Organization; 2010.
- 131 State responsibility for the impacts of cross-border tax abuse on women's rights & gender equality, p7-8. Submission to the Committee on the Elimination of Discrimination against Women 65th pre-sessional working group, Geneva, 7-11 March 2016. Suggestions for the list of issues: Switzerland to be considered in connection with the combined fourth and fifth periodic reports (CEDAW/C/CHE/4-5). Submitted on 22 February 2016 by: Berne Declaration, Center for Economic and Social Rights Global Justice Clinic, New York University School of Law Tax Justice Network.
- 132 <https://www.hhrjournal.org/2016/05/who-pays-to-fulfill-health-rights-aid-eligibility-accountability-and-fiscal-space/>
- 133 Ibid.
- 134 <http://globalfinancingfacility.org>.
- 135 India not yet confirmed.
- 136 Civil society engagement in the GFF and implications for strengthening national and regional accountability mechanisms. Draft submission for the IAP 2016 report. Global Health Visions. July 2016.
- 137 Recommended minimum standards for RMNCAH country platforms, November 2015. http://www.portal.pmnch.org/pmnch/media/events/2015/cso_min_standards.pdf
- 138 Draft AHBN GFF Regional Scorecard, February 2016. <http://www.mamaye.org/en/evidence/global-financing-facility-update-february-2016> (see downloads).
- 139 Analysis of Commitments to the Global Strategy for Women's, Children's and Adolescents' Health. Prepared for the Partnership for Maternal, Newborn and Child Health by SEEK Development – Strategic and Organizational Consultants, Berlin, 2016; p14–16; p14–16.
- 140 Ibid, p2
- 141 SDG Compass. The guide for business action on the SDGs (http://sdgcompass.org/wp-content/uploads/2015/12/019104_SDG_Compass_Guide_2015.pdf).

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