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Chasing Accountability in Global Health: Reflections from Experience on the UN Secretary-General's Independent Accountability Panel on Women's, Children's, and Adolescents' Health

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Abstract

The story of United Nations (UN) efforts to create an independent mechanism to foster greater accountability across global health is one of high hopes, missed opportunities and, ultimately, planned project failure. The creation of the UN Secretary-General's Independent Accountability Panel on Women's, Children's and Adolescents' Health (IAP) in 2016 was born out of the idea that accountability was the missing link to achieve progress on the Sustainable Development Goals related to women's, children's, and adolescents' health. The IAP produced four reports before it was dissolved in 2020. Subsequently, other independent accountability mechanisms have been proposed, such as for antimicrobial resistance. In this paper, I draw on my experience as a member of the IAP to examine the context for the creation of the IAP and share four lessons as to why meaningful accountability has been so elusive in global health and how future efforts might benefit from these insights. These lessons relate to the need for (1) normative grounding; (2) institutional legitimacy; (3) genuine independence; and (4) conceptual clarity with respect to the meaning of accountability. I conclude by arguing that the deeply neoliberal and colonial architecture of global governance for health constrains possibilities for transformative accountability. In telling this story, I do not pretend to represent the views of other IAP members, who may have very different reflections.

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Introduction

The story of United Nations (UN) efforts to create an independent mechanism to foster greater accountability across global health is one of high hopes, missed opportunities, and, ultimately, planned project failure. At the dawn of the Sustainable Development Goals (SDGs) and the implementation of Agenda 2030, accountability-talk in global health was at its apex; "accountability" seemed to be mentioned at every global health summit, paraded as the highest of political virtues, and deemed the long-sought development jackpot. The creation of the UN Secretary-General's Independent Accountability Panel on Women's, Children's and Adolescents' Health (IAP) in 2016 was born out of this enthusiasm for the idea that accountability was the missing link to achieve progress on the SDGs related to women's, children's, and adolescents' health.

The IAP produced four reports while it existed. After its introductory report in 2016, the IAP's reports from 2017 to 2020 focused on accountability in the context of specific areas: adolescents' health in 2017; the private sector in 2018; and COVID-19 and universal health coverage in 2020.[1] At its inception, I was appointed by the UN Secretary-General to the IAP, along with initially eight, and later nine, other experts from diverse disciplines from around the world who each served in our individual capacities. Along with some of the original members, I was reappointed in 2018 and served until the IAP was terminated. In 2020, just as the COVID-19 pandemic began to ravage the world, the IAP was dissolved. It was determined that accountability would be instead centered around the UN High-Level Political Forum, a country-to-country peer review process that differed substantially from the concept of an independent accountability panel.[2] Subsequently, other independent accountability mechanisms have been proposed, such as for antimicrobial resistance.[3]

In this paper, I first set out the context for the creation of the IAP. Thereafter, I share four lessons as to why meaningful accountability has been so elusive in global health and how future efforts might benefit from these insights. These lessons relate to the need for (1) normative grounding; (2) institutional legitimacy; (3) genuine independence; and (4) conceptual clarity with respect to the meaning of accountability. I conclude by arguing that the architecture of global governance for health constrains possibilities for transformative accountability. In telling this story, I do not pretend to represent the views of other IAP members, who may have very different reflections.

Context for the IAP's establishment

The 2008 financial crisis that began in the United States and quickly spread throughout the world shook development finance, as well as domestic resources for health. The International Monetary Fund doubled down on austerity programs, which deeply affected health systems and development financing.[4] By 2010, two-thirds of the way through the Millennium Development Goals (MDGs), lagging progress on MDGs 4 and 5 led then-UN Secretary-General Ban Ki-moon to launch the Every Woman, Every Child Initiative (EWEC) to "intensify national and international commitment and action by governments, the UN, multilaterals, private sector and civil society to keep women's, children's and adolescents' health and wellbeing at the heart of development."[5] As part of this initiative, the UN Secretary-General set out a Global Strategy on Women's and Children's Health, which, among other things, identified accountability deficits as a principal obstacle to progress.[6] That first Global Strategy resulted in a World Health Organization (WHO)-led Commission on Information and Accountability. The commission elaborated a "unified accountability framework" that included "monitor, review, and act," which in turn led to the creation of the independent Expert Review Group on Information and Accountability in Women's and Children's Health (iERG), a *sui generis* "global oversight mechanism to ensure that commitments to women's and children's health were being delivered on time and with impact."[7]

The first Global Strategy focused on 74 low- and middle-income countries, with 49 "priority"

countries that had high burdens of child and maternal mortality.[8] By the end of the MDGs, progress was still highly uneven, and the countries "furthest behind" were largely in Sub-Saharan Africa, where there was the weakest infrastructure.[9] Macroeconomic and structural constraints, however, did not factor into measuring progress in the MDGs. Moreover, while we should applaud progress on these scourges, the plainly colonialist dynamics of the knowledge and governance discourses established in the MDGs presupposed a particular kind of accountability. That is, many of the indicators, such as maternal mortality ratios (MMRs), were calculated using algorithms and monitored at a distance by global institutions as opposed to national statistical offices.[10] Further, arguably, in these highly aid-dependent countries, turning *global* goals and targets—for example, reduce global maternal mortality by 75%—into *national* planning tools (i.e., X country must reduce its MMR by 75%) perverted the meaning of the goals and actually diverted accountability from governments to donors and international institutions, away from their own citizens.

The architects of the Sustainable Development Goals sought to learn from some of the identified problems in the MDGs.[11] The SDGs addressed inequality, not just extreme poverty; explicitly noted intersectionality and links across goals; and applied universally to all countries. SDG 3 focused on health broadly, and on universal health coverage and health systems, as opposed to top-down siloed approaches to maternal health, child health, and certain infectious diseases.[12] In preparation for the SDGs, in 2015, the UN Secretary-General set out a second, bolder "Global Strategy on Women's, Children's *and Adolescents'* Health," through which the iERG mechanism was succeeded by the IAP.[13] The revised Global Strategy went beyond setting out goals with respect to "surviving" and "thriving" and in its third pillar called for "transforming" conditions that would allow women, children, and adolescents to enjoy the fruits of sustainable development.[14]

In its last report, the time-limited iERG had set the stage for the IAP, arguing for a more robust independent accountability mechanism and asserting that

> *there is vigorous debate about the details. Where should this group be hosted? What should be its exact terms of reference? Who will fund it? Who should it report to? How should its recommendations be acted upon? These details matter. But, much more importantly to us, the idea of independent accountability seems secure, at least in this one sphere of global health and in the short term.*[15]

In retrospect, those concerns were far from logistical details, and the idea of independent accountability was not so secure, even in this one area of global health.

Lesson 1: Accountability cannot be merely instrumental; it must have some normative *raison d'être*.

It was apparent from the outset that while, in global health, accountability was seen in instrumental terms—i.e., to address lagging progress and "improve the oversight of results and resources"—the capacious and somewhat slippery concept had to "earn adequate normative traction."[16] The technocratic, results-based management approach to the goals, targets, and indicators that permeates global health institutions was simply not going to be sufficient to meet the moment. As Danielle Rachad writes, accountability alone is merely "an empty container that structures and explicates a bilateral or multilateral power-relationship. Some substantive normative view, thus, must flesh out this skeleton."[17] The proverbial flesh that was to imbue the instrumental skeleton of accountability with life, and to make it desirable and attractive for its own sake, was good governance based on human rights, which had been highlighted in both Global Strategies. Moreover, Agenda 2030 itself was "to be implemented in a manner that is consistent with the rights and obligations of States under international law," which includes international human rights law.[18] Accountability has long been seen as the *sine qua non* of human rights, converting identified problems into violations to be remedied through

standard setting and the creation of institutions and procedures to implement those standards.

In 2003, in light of the top-down approach of the MDGs, which contrasted sharply with the human development emphasized in the trans-sectoral UN development conferences of the 1990s, the UN Development Group had set out a "Common Understanding on Human Rights-Based Approaches to Development Cooperation and Programming," which highlighted accountability and rule of law among its pillars.[19] That Common Understanding subsequently led to efforts to set out intergovernmental agreements on human rights-based approaches to health at the UN Human Rights Council, the first two of which related to maternal health (2012) and child health (2014).[20]

The IAP drew heavily on these experiences, noting throughout our reports the relevance to accountability of human rights norms related to equality and nondiscrimination, meaningful participation of affected communities, freedoms of information and expression, and other democratic ideals necessary for social and legal accountability. However, we had neither the capacity nor the authority to assess specific countries' legal and policy frameworks, budgets, public policies, monitoring and evaluation standards, and remedies for violations, as these rights-based approaches had set out.

Moreover, while we rooted our normative legitimacy in human rights law, we were operating within a global health architecture that profoundly imbricated the unaccountable private power of transnational corporations, philanthropic foundations, and other private actors.[21] Further, the economic political power relations in the global order were structured through other bodies of international law; by the 2010s, neoliberal globalization had shaped international investment law, trade and intellectual property law, and tax law, among others.[22] The "obligations of States under international law" that were meant to guide actions under the Global Strategy included those set out under these other binding legal frameworks. This, in turn, stymied the implementation of many of our recommendations regarding, for example, curbing the power of pharmaceutical monopolies in order to ensure access to medicines, and stemming illicit financial flows in order to preserve domestic resources for health systems.

Far from oblivious to this context, from the very first report in 2016, the IAP attempted to leverage our status as experts to highlight what the 2014 Lancet–University of Oslo Commission on Global Governance for Health had labeled "global political determinants of health: The norms, policies, and practices that arise from global political interaction across all sectors that affect health."[23] Importantly, in our reports we addressed issues in high-income as well as lower-income countries, as well as systemic forces structuring global governance for health. For example, we included discussion of the taxation of corporate actors, both in terms of products harmful to health (such as sugary beverages) and in terms of international tax evasion.[24]

Yet, as a tiny panel of volunteers with a drastically underfunded secretariat, we had no way in which to foster allegiance to a set of normative expectations that often conflicted either with these other binding legal frameworks or with the growing conservative populist backlash to sexual and reproductive health and rights that was emerging forcefully at the time.[25]

Lesson 2: An independent accountability mechanism requires institutional legitimacy.

From the outset, the IAP struggled with institutional legitimacy, understood broadly as the perception that an institution rightfully exercises authority and can command obligations. The exceptionally broad remit given to the IAP by the Executive Office of the UN Secretary-General (EOSG) was explained to us at our first face-to-face meeting: "The Independent Accountability Panel (IAP) … is empowered to command attention from the global community across the full range of the updated Global Strategy's accountability framework … across the spectrum of issues that comprise the Global Strategy's 'Survive, Thrive, and Transform' themes."[26] From the start, it was unclear what "command attention from the global

community" really meant, given that the IAP had no ability to sanction governments, global institutions, or private actors for poor performance—or to confer rewards for progress. Indeed, Agenda 2030, on which the SDGs drew, had called for a "robust, *voluntary*, effective, participatory, transparent and integrated follow-up and review framework," and it was immediately apparent that states understood compliance with the IAP's follow-up and review mechanism to be voluntary.[27]

The legitimacy stories of accountability institutions within states, even when contested or dismissed in practice, are reasonably well accepted in theory. However, accountability in global health is far more complex than in a domestic sphere with well-established institutions. As Ruth Grant and Robert Keohane note, without a centralized government, there are a variety of power-wielders who relate to one another in non-hierarchical ways.[28] For this very reason, in such a domain, "there is no single 'problem of global accountability'; there are many."[29] Given that, the lack of a clearly defined remit and legal authority posed a major problem for the efficacy of the IAP in holding states, global institutions, and private actors to account.[30]

States are generally the subjects or principals of international law, and international institutions, such as WHO, act as their agents.[31] Human rights law alters this relationship insofar as it sets out individuals as subjects of international law and asserts that sovereign authority cannot be exercised wholly independently from international standards. However, the institutional legitimacy of an international institution, such as a supranational human rights body, to issue judgments regarding a country's performance is based on the consent of states to be bound by specific treaties or membership in specific organizations. The rules regarding signature, ratification, and accession to human rights treaties, as well as interpretation of the permissible scope of reservations, understandings that are established under international law, did not exist with regard to the IAP.[32]

In our case, there was no formal consent from states and other duty bearers to be held to account, and the follow-up and review mechanism had explicitly been stipulated to be "voluntary."[33] Endorsing Agenda 2030 or the Global Strategy was a far cry from consent from a particular country to be judged by the IAP for (in)actions under specific treaties that it had ratified, or based on our interpretation of the *corpus juris* of international human rights law. We of course made efforts to socialize our reports with human rights treaty monitoring bodies, including the Committee on the Rights of the Child. However, the IAP, just as was the case with the iERG before it, did not have the authority to "name and shame" specific states for violations of human rights related to women's, children's, and adolescents' health. Likewise, despite holding civil society hearings and emphasizing the importance of civic space and freedoms of assembly and information, we did not have the authority to receive individual or group complaints from affected people and communities, as is possible through complaint procedures in human rights mechanisms, with all their limitations.

Our reports were limited to invoking standards, citing other well-established human rights authorities as well as reputable indexes, and using data to illuminate important comparisons and trends. Because we had no proverbial sticks, we sought to use carrots, praising certain countries for legislative, regulatory, judicial, and other efforts. For example, we praised Thailand's National Health Security Office for accountability in its strategic purchasing, including of benefits for women and children; Brazil's Supreme Court for banning corporate contributions to parliamentarians to influence food and other policies; and multiple countries' legislatures for instituting sugary beverage and alcohol taxes.[34]

Additionally, the IAP faced particular legitimacy challenges due to the subject matter that was a central domain of our work: sexual and reproductive health and rights. While extraordinary advances in gender equality and sexual and reproductive health and rights had been made in international human rights law and some domestic constitutional law since the 1990s, a growing conservative backlash was apparent during these years, which associated human rights guidance with

illegitimate ideological global governance agendas.[35] Across our reports, we made evidence-based recommendations that aligned with emerging consensuses in international law. Nevertheless, in the context of growing conservative movements that used contestation in reproductive rights around abortion and LGBTQ+ rights to attack the broader legitimacy of global human rights institutions writ large, our inability to stand on firm institutional legitimacy proved challenging.

Holding donor states and global institutions to account proved equally difficult. When we attempted to act as a "monitor of monitors"—for example, pointing out major gaps in data availability across the 60 indicators for the second Global Strategy—and questioned whether the right indicators were being used to enable meaningful action, global health institutions were not always receptive.[36] This resistance to our independent review extended to arguing that the IAP's "dashboards" of indicators were duplicative of work that was already being done, which ignored the fact that the data were set out for quite a different purpose, such as delineation of responsibilities or concern for intersectional inequalities, which were key to accountability in the SDG framework. For example, the Institute for Health Metrics and Evaluation and Countdown to 2030 prepared special visualizations based on its own database as well as Demographic and Health Survey and Multiple Indicator Cluster Survey databases, which enabled us to show equity gaps in the financing of essential reproductive, maternal, newborn, and child health services.[37] While we were able to promote broad general agreement regarding the need for more disaggregated data and actionable information to address equity gaps, it is not clear to what extent sustained changes were made across these institutions' data collection and review processes, or in development financing, as a result of issues the IAP identified.

Perhaps the most disheartening were our efforts to hold actors in the private sector to account for pledges and activities.[38] At the time, the private sector and philanthrocapitalist solutions were being courted by leaders in global health, and championed as responses to the lack of public sector resources and capacity, to, among other things, mobilize "billions to trillions."[39] For our private sector report, given the complexities and diversity of private sector actors involved, we undertook additional efforts: we met with private sector stakeholders both in New York and at the World Economic Forum headquarters; we hired a consultant to conduct background research; and, most importantly, a subset of the IAP panelists, together with the then-director of the secretariat, spent an entire additional week of volunteer time holding meetings with an array of informants and deliberating about key themes.

The 2018 report we produced contained detailed findings and evidence-based recommendations regarding the private provision and financing of services; the pharmaceutical industry and access to medicines; the food industry; the UN Global Compact and EWEC partners; and donor and business engagement in the SDGs.[40] We strongly argued that increased monitoring and regulation of private sector actors across these industries and beyond was critical to ensuring accountability and in turn making progress on women's, children's, and adolescents' health. Indeed, in 2018, we stood out among international panels for arguing for extraterritorial obligations of donor states to regulate private sector actors headquartered in their own countries, given the influence of the transnational food, pharmaceutical, and other industries affecting health.[41] Nonetheless, the lack of institutional legitimacy meant that corporate and private actors were able to ignore or dismiss our conclusions and recommendations, and continue to trumpet discrete actions of voluntary largesse.

Lesson 3: Meaningful accountability requires genuine independence of the oversight mechanism.

In the context of independent judiciaries and other national oversight mechanisms, independence generally refers to two concepts: (1) *autonomy*, which relates to freedom from political influence at the domestic level and (2) decision-making *authority*, which, as noted above, depends on both normative

and institutional legitimacy. These two concepts are equally relevant to the independence of oversight mechanisms at the global level, which is why many global panels (e.g., supranational human rights tribunals) operate within a set of rules intended to safeguard independent judgment.

As noted above, the IAP's authority was challenged from the outset because it was not rooted in a legal framework that would enable the sanctioning of relevant actors. Autonomy was also hindered from the beginning. Structurally, the IAP was created by the EOSG and reported directly to the UN Secretary-General, not WHO as the iERG had done. We presented our reports to the UN Secretary-General at the UN General Assembly, not the World Health Assembly, which underscored that meaningful accountability issues extended beyond the remit of health ministers. However, from the beginning, the IAP faced challenges in terms of its independence from the EWEC ecosystem.

The iERG had not been created to be independent of WHO.[42] From 2012 to 2015, it attempted to assert its small "i" independence from the rest of the EWEC ecosystem with regard to its recommendations. However, noting the lack of independence as a major flaw in the iERG, the IAP was established as independent from WHO from the outset, at least in theory. Nonetheless, in practice the IAP's secretariat was situated within the Partnership for Maternal Neonatal and Child Health (PMNCH), a "partnership" hosted by WHO for which WHO provides a legal, administrative, and fiduciary platform. The IAP received its very small funding as a percentage of the PMNCH budget and was therefore legally accountable not just to the EOSG but also to the Board of PMNCH, which includes 30 members from among the partnership's membership.[43] The initial secretariat staff had even been hired by PMNCH, although we quickly replaced those personnel with direct hires by the IAP and insisted on exclusive control over staffing decisions. Further, despite a theoretical firewall between PMNCH and the IAP secretariat, being physically and administratively hosted by PMNCH frequently meant obtaining budgetary approvals and sharing information.

In addition to funding and physical positioning, another aspect of autonomy relates to the appointment process to the IAP. The EOSG appointed each of us to serve in our individual capacities, based on a diversity of experience, gender, professional background, geographic representation, and age (we had two "youth" representatives who served respectively from 2016 to 2018 and 2018 to 2020). Some members had previously held high positions within the UN system; many if not all of us had participated in WHO, PMNCH, and other panels previously and were well known in that orbit; two of our co-chairs, Carmen Barroso and Joy Phumaphi, had previously served on the iERG. Those backgrounds may be entirely justified for a panel of the nature of the IAP, which had to navigate a complicated global health institutional architecture and also required some institutional continuity with the iERG experience. However, it is not clear what pool of possible candidates was drawn on by the EOSG, nor the role of WHO and PMNCH in the shaping of that pool or the ultimate selection of panelists. Likewise, it was unclear how those actors shaped the selection and remits of the chairs in particular, who exercised substantial control over the IAP's internal governance and external representation, as well as communications with other actors in the EWEC ecosystem.

To be clear: this is not a personal critique of anyone. I greatly admired many of my esteemed co-panelists' commitments to promoting equity in global health, in addition to their formidable technical expertise. It was a privilege to serve with them, and many of us have stayed in touch, united by our shared concern for women's, children's, and adolescents' health. Nonetheless, the processes for appointment—and especially for reappointment in 2018—were not sufficiently transparent to assess the IAP's structural autonomy from other actors in the EWEC ecosystem.

Further, meaningful autonomy also requires being protected from retaliation from powerful stakeholders after critical reports are issued. The IAP was accountable not just to the EOSG, which would have been complicated enough. It was also legally answerable to PMNCH Board, whose mem-

bers represented different constituencies, including donor governments and foundations, "partner governments," UN agencies, the private sector, and nongovernmental organizations. This arrangement placed us in the impossibly complicated position of trying to hold accountable actors that held sway over our financing and continued ability to function. Such a structural arrangement invariably affected the boundaries of our permissible critique.

Genuine independence and institutional legitimacy are closely related. At a minimum, the IAP would have required a direct, clearly articulated mandate and accompanying budget directly from the EOSG that was legally rooted in state consent, with transparent selection processes. Without those conditions in place, the hard-won capital "I" of the IAP compared with the aspirational "i" in the iERG ended up being less of an achievement than we had hoped.

Lesson 4: The concept and implications of accountability remain deeply contested in global health.

What complicates accountability discourses in global health is not only the various contexts they must address but also the multiplicity of concepts they imply and their more or less pronounced normative undertones.[44] Because so much of the global health community viewed accountability in a very narrow limited way of *monitoring* data, much of the IAP's work entailed explaining what *human rights* demanded in terms of accountability. In a 2017 article, Carmel Williams and Paul Hunt explained the importance of going beyond monitoring:

> *if the SDGs are simply monitored, using the agreed indicators, human rights failings can be overlooked, intentionally or otherwise. For example, if a state were to introduce punitive measures against women who fail to give birth in approved facilities, they would likely show improvement on SDG 3.1.2, with an increased number of births taking place under supervised care. However, if this indicator is achieved without women's consent or in the absence of culturally acceptable care being provided, then it breaches women's human rights entitlements.*[45]

The IAP took as a starting point the "monitor, review, act" framework articulated by the Commission on Information and Accountability and used by the iERG, but immediately noted that it would additionally include *remedies*—in other words, monitor, review, act, *and remedy*. Our reasoning in adding judicial and other remedies was that to be consistent with human rights law and meet commitments to the bolder second Global Strategy and the SDGs, national legislation and regulations were required, policies and national plans of action needed to be devised and implemented, and priority-setting mechanisms for universal health coverage needed to be instituted. All of these require the use of law and are issues overseen by courts in democratic societies.

As the High-Level Working Group on Health and Human Rights of Women, Children and Adolescents recognized in 2017, accountability for rights in and through health requires legal review as part of democratic governance.[46] Likewise, General Comment 22 on the right to sexual and reproductive health, which the UN Committee on Economic, Social and Cultural Rights issued in 2016, underscored far more strongly the need for judicial remedies in relation to health than had its earlier General Comment 14 in 2000, noting that it was imperative that

> *the right to sexual and reproductive health … be fully justiciable at the national level, and that judges, prosecutors and lawyers be made aware of that such a right can be enforced. When third parties contravene the right to sexual and reproductive health, States must ensure that such violations are investigated and prosecuted, and that the perpetrators are held accountable, while the victims of such violations are provided with remedies.*[47]

Judicial and quasi-judicial remedies are equally important at the international level for accountability in global health and within efforts to achieve the SDGs. For example, in its 2017 report, the IAP highlighted the International Centre for Settlement of Investment Disputes tribunal case in which Philip Morris had sued the government of Uruguay for plain packaging on cigarette containers, in keeping with the WHO Framework Convention on Tobacco Control, and lost. The tribunal specifically noted the

margin of appreciation (i.e., scope of permissible policy action) afforded to states for the protection of public health.[48] In its 2018 report, the IAP noted the increasing frequency of concluding recommendations from UN treaty monitoring bodies relating to the regulation of private business enterprises, in relation to health and beyond.[49]

The addition of judicial remedies in the IAP framework had a fundamental epistemic purpose as well; it underscored that when they are addressed by courts, failures to address health issues are transformed from being lapses in quality of care to questions of dignity and nondiscrimination, violations of bodily integrity, and the like. This epistemic change was essential to undergirding our normative claim that accountability was about more than improvements in health indicators and required a whole-of-government response, including sanctions, which "independent review" was simply too weak to trigger. In a real-world example, when an estimated 272,000 women were forcibly sterilized in Peru between 1996 and 2000 under Alberto Fujimori's administration, an independent review was performed by the Population Council, which found serious deficiencies in the quality of care and informed consent. By contrast, human rights activists mobilized politically and brought litigation, initially domestically and later internationally, arguing that violations of bodily autonomy had to be understood in the context of systemic discrimination against Indigenous women and the weaponization of the health system under Fujimori.[50]

When supranational tribunals or forums are involved, the institutional response shifts as well. That is, when a supranational forum offers recommendations or a judgment, ministries of foreign affairs, justice, finance, and women and family are involved, not just the ministry of health.[51] For example, Brazil created an interministerial committee when the Committee on the Elimination of Discrimination Against Women found it in violation of rights regarding maternal health in *Alyne da Silva Pimentel v. Brazil*.[52]

At the time, the enormous effort we made to explicate accountability's dimensions seemed an appropriate, even strategic, response to the IAP's lack of capacity and authority.[53] We were committed to using our platform to make meaning out of the ubiquitous disparities and deprivations faced by women, children, and adolescents regarding their health and to explain how such injustices could be legally remedied and not merely lamented. Because we were a tiny volunteer panel, and could not ourselves sanction behavior, our efforts were rightly intended to catalyze the strengthening and implementation of systems at the national level and to reaffirm the importance of existing systems at the international level.

This focus on effective systems of democratic governance was a departure from an idea proposed in the final report of the iERG, which called for all countries to "establish and implement transparent, participatory, democratic, and independent national accountability mechanisms to monitor, review, and act on results and resources for women's, children's, and adolescents' health, with special attention to the translation of recommendations into action and reporting to Heads of State."[54] Rather than promoting the creation of mini-IAPs filled with technical specialists, the IAP instead chose to emphasize that accountability in women's, children's, and adolescents' health was a matter of regulating and transforming power through institutional arrangements, which both uphold and require functioning democracies. It was critical for the IAP, both epistemically and politically, to repeatedly break through the tendency to focus on the health sector, and delineate the roles of many institutions—from national statistical offices to health providers, and from parliaments to judiciaries—in protecting and promoting the health and rights of women, children, and adolescents.

On the one hand, it was the IAP's insistence on judicial remedies that, perhaps more than any other change from the iERG, garnered the enormously positive feedback some of us received from human rights advocates who were in the trenches fighting to advance the justiciability of health-related rights and hold their governments and other actors accountable. On the other hand, powerful actors that may have bristled at the possibility of facing sanctions and other legal remedies either

rejected the idea that judicial remedies should play a part in advancing accountability under the SDGs or chose to elide the significance of emphasizing remedies.

Although the IAP hoped to "command the attention of the global community" regarding the normative importance of all of these dimensions of accountability, including remedies, in well-functioning governance, in retrospect the time spent on justifying evolving explanatory frameworks did not prove as helpful as we hoped in attempting to shore up our legitimating toolbox. Despite significant efforts—including the creation of a brief video created at Harvard University on a pro bono basis—in its short existence, the IAP had neither the necessary resources nor the authority to catalyze a broader acceptance of the justiciability of health rights related to women's, children's, and adolescents' health at national and international levels.[55]

Conclusion

In 2019, an independent evaluation of the IAP was commissioned for the EWEC ecosystem. Among the principal recommendations was to evolve the remit of the IAP to include accountability for "who is being left behind, where and why" across health and well-being in the SDGs, with the idea that women, children, and adolescents would be among the most left behind. However, there was no appetite to address the extent to which the global political economy itself perpetuates the exclusion of certain populations in certain countries. Nor was there readiness to acknowledge the dramatically different legal mandate and institutional configuration that such a remit would have required. In early 2020, rather than set up a successor panel, the IAP was dissolved and accountability efforts were centered on the country-to-country peer review High-Level Political Forum for Sustainable Development.[56]

At a time when the Trump administration has upended global governance for health and we are seeing a disastrous retrogression on women's, children's, and adolescents' health, among many concerns, the need to revive discussions of accountability in global health could not be more urgent. However, the questions raised here bear serious consideration before additional panels are set up that are destined to fail. I have argued here that the IAP faced at least four challenges in promoting accountability for advancing women's, children's, and adolescents' health in the SDGs, which involved the lack of effective normative grounding, institutional legitimacy, genuine independence, and conceptual agreement regarding elements of accountability and why they matter.

All of these factors in turn must be understood within a neoliberal global order permeated by enormous economic and political power asymmetries, which constrained transformative accountability. Truly transforming the conditions that perpetuate ill-health for women, children, and adolescents, as the third pillar of the 2015 Global Strategy had set out, calls for changing tax, sovereign debt, investment, and trade and intellectual property rules; adding leaders from the Global South to decision-making multilateral institutions; changing the obsolete model of charity and crisis-based development finance; and curbing the power of private actors in the global health architecture. It is those structural factors and "rules of the game" that consign women, children, and adolescents to being left behind in, if not excluded from, progress in human development.

Even as we need to mitigate the devastation that the Trump administration's shambolic destruction has created, this inflection point also offers an opportunity to consider how we might genuinely transform global governance for health, including the production and distribution of resources, the construction of knowledge and epistemic authority, leadership criteria, control over agenda setting, and possibilities for accountability.[57] Hard-won lessons from the IAP should inform that thinking. There is no room for nostalgia for the status quo ante, nor for the empty invocation of new mantras—such as the newly popular "country ownership"—without situating such calls in the reality of macroeconomic constraints and alignment with technology transfer and other legal reforms. To recover lost trust in institutions and advance global health justice requires nothing less than a radical reimagining

of global governance that addresses the political determinants of global health and reanimates hope for realizing dignity, equality, and well-being for swaths of people across the world.

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References

1. Independent Accountability Panel, *2016: Old Challenges, New Hopes: Accountability for the Global Strategy for Women's, Children's and Adolescents' Health* (World Health Organization, 2016); Independent Accountability Panel, *2017: Transformative Accountability for Adolescents: Accountability for the Health and Human Rights of Women, Children and Adolescents in the 2030 Agenda* (World Health Organization, 2017); Independent Accountability Panel, *Private Sector: Who Is Accountable? For Women's Children's and Adolescents' Health* (World Health Organization, 2018); Independent Accountability Panel, *Caught in the COVID-19 Storm: Women's, Children's and Adolescents' Health in the Context of UHC and the SDGs* (World Health Organization, 2020).

2. United Nations High-Level Political Forum on Sustainable Development, "High-Level Political Forum," https://hlpf.un.org/.

3. United Nations General Assembly, Political Declaration of the High-level Meeting on Antimicrobial Resistance, UN Doc. A/79/L.5 (2024).

4. J. Stiglitz, *Freefall: America, Free Markets, and the Sinking of the World Economy* (W.W. Norton, 2010); Center for Economic and Social Rights, *Assessing Austerity: Monitoring the Impacts of Fiscal Consolidation* (Center for Economic and Social Rights, 2018).

5. Sustainable Development Goals Knowledge Platform, "Every Woman Every Child," https://sustainabledevelopment.un.org/sdinaction/everywomaneverychild.

6. United Nations Secretary-General Ban Ki-moon, *Global Strategy for Women's and Children's Health* (2010).

7. Commission on Information and Accountability for Women's and Children's Health, *Keeping Promises, Measuring Results* (World Health Organization, 2011); International Expert Review Group, *Every Woman, Every Child: From Commitment to Action: The First Report of the Independent Expert Review Group (iERG) on Information and Accountability for Women's and Children's Health* (World Health Organization, 2012), p. 2.

8. Commission on Information and Accountability for Women's and Children's Health (see note 7).

9. World Bank Group and United Nations Development Programme, *Transitioning from the MDGs to the SDGs* (2016).

10. A. E. Yamin and V. M. Boulanger, "Why Global Goals Matter: The Experience of Sexual and Reproductive Health and Rights in the MDGs," *Journal of Human Development and Capabilities* 15/2 (2014), pp. 218–231; A. E. Yamin, "Power, Politics and Knowledge Claims: Sexual and Reproductive Rights in the SDG Era," *Global Policy* 10/Suppl 1 (2019).

11. J. Waage, R. Banerji, O. Campbell, et al., "The Millennium Development Goals: A Cross-Sectoral Analysis and Principles for Goal Setting After 2015," *Lancet* 376/9745 (2010); M. Langford, "A Poverty of Rights: Six Ways to Fix the MDGs," *IDS Bulletin* 14/1 (2010).

12. United Nations Department of Economic and Social Affairs, "The 17 Goals," https://sdgs.un.org/goals.

13. United Nations Secretary-General Ban Ki-moon, *The Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)* (2015).

14. Ibid.

15. International Expert Review Group, *Every Woman, Every Child, Every Adolescent: Achievements and Prospects: The Final Report of the Independent Expert Review Group (iERG) on Information and Accountability for Women's and Children's Health* (World Health Organization, 2015), p. V.

16. D. H. Rached, "Doomed Aspiration of Pure Instrumentality: Global Administrative Law and Accountability," *Global Constitutionalism* 3/3 (2014), p. 342.

17. Ibid.

18. United Nations General Assembly, Transforming Our World: The 2030 Agenda for Sustainable Development, UN Doc. A/RES/70/1 (2015).

19. HRBA Portal, "The Human Rights Based Approach to Development Cooperation: Towards a Common Understanding Among UN Agencies," https://hrbaportal.org/the-human-rights-based-approach-to-development-cooperation-towards-a-common-understanding-among-un-agencies/.

20. Office of the United Nations High Commissioner for Human Rights, *Human Rights-Based Approach to Reduce Preventable Maternal Morbidity and Mortality: Technical Guidance* (2012); Human Rights Council, Technical Guidance on the Application of a Human Rights-Based Approach to the Implementation of Policies and Programmes to Reduce and Eliminate Preventable Mortality and Morbidity of Children Under 5 Years of Age, UN Doc. A/HRC/27/31 (2014).

21. D. McCoy, A. Joshi, R. Khosla, et al., "Global Health Governance and the Challenge of Holding Power to Account," United Nations University International Institute for Global Health Working Paper (2024), https://collections.unu.edu/eserv/UNU:9659/Power___Accountability_Working_Paper__June_24.pdf; O. P. Ottersen, J. Dasgupta, C. Blouin, et al., "The Political Origins of Health Inequity:

Prospects for Change," *Lancet* 383/9917 (2014).

22. See, e.g., A. E. Yamin, *When Misfortune Becomes Injustice*, 2nd edition (Stanford University Press, 2023).

23. O. P. Ottersen, J. Dasgupta, C. Blouin, et al., "The Political Origins of Health Inequity: Prospects for Change," *Lancet* 383/9917 (2014).

24. Independent Accountability Panel (2016, see note 1); Independent Accountability Panel (2018, see note 1).

25. Yamin (see note 10).

26. Office of the UN Secretary-General and Partnership for Maternal Newborn and Child Health, Background Note and Agenda for First Face-to Face IAP Meeting, Johannesburg, South Africa, March 2016 (on file with author); United Nations General Assembly (see note 18).

27. United Nations General Assembly (see note 18) (emphasis added).

28. R. W. Grant and R. O. Keohane, "Accountability and Abuses of Power in World Politics," *American Political Science Review* 99/1 (2005), p. 41.

29. Ibid.

30. Ibid., p. 40.

31. P. W. Kahn, "Speaking Law to Power: Popular Sovereignty, Human Rights, and the New International Order," *Chicago Journal of International Law* 1/1 (2000), p. 1; L. Henkin, "That 'S' Word: Sovereignty, and Globalization, and Human Rights, Et Cetera," *Fordham Law Review* 68/1 (1999).

32. Vienna Convention of the Law of Treaties, United Nations Treaty Series Vol. 1155 (1969), arts. 19–23.

33. United Nations General Assembly (see note 18).

34. Independent Accountability Panel (2018, see note 1), pp. 38–52.

35. See, e.g., *Cynthia Rothchild, Written Out: How Sexuality Is Used to Attack Women's Organizing* (International Gay and Lesbian Human Rights Commission and the Center for Women's Global Leadership, 2005), pp. 118–119.

36. Independent Accountability Panel (2017, see note 1), p. 11.

37. Independent Accountability Panel (2018, see note 1), pp. 11–12.

38. Independent Accountability Panel (2016, see note 1); Independent Accountability Panel (2018, see note 1).

39. J. Y. Kim, "Billions to Trillions: Ideas to Action" (speech at Third International Conference on Financing for Development, July 13, 2015), https://documents1.worldbank.org/curated/en/144851468190446079/pdf/101985-WP-Box393267B-PUBLIC-2015-07-13-JK-Billions-To-Trillions-Ideas-to-Actions.pdf.

40. Independent Accountability Panel (2018, see note 1).

41. Ibid.

42. C. Williams and P. Hunt, "Neglecting Human Rights: Accountability, Data and Sustainable Development Goal 3," *International Journal of Human Rights* 21/8 (2017); see also P. Hunt, "SDG Series: SDGs and the Importance of Formal Independent Review: An Opportunity for Health to Lead the Way," Health and Human Rights (September 2, 2015), https://www.hhrjournal.org/2015/09/02/sdg-series-sdgs-and-the-importance-of-formal-independent-review-an-opportunity-for-health-to-lead-the-way/.

43. International Expert Review Group (2012, see note 7); Global Strategy for Women's, Children's and Adolescents' Health Strategy and Coordination Group, Independent Accountability Panel: Scope of Work and Terms of Reference for Panelists (World Health Organization, 2015).

44. A. E. Yamin, "Accountability in Global Health and the Sustainable Development Goals (SDGs)," Global Health Education and Learning Incubator at Harvard University in partnership with Independent Accountability Panel (September 30, 2019), https://www.youtube.com/watch?v=5XR1duSlJUM.

45. Williams and Hunt (see note 42), p. 1116.

46. High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents, *Leading the Realization of Human Rights to Health and Through Health* (World Health Organization, 2017), p. 46.

47. United Nations Economic and Social Council, General Comment No. 22, UN Doc. E/C.12/GC/22 (2016), para. 64.

48. *Philip Morris Brands Sàrl, Philip Morris Products S.A. and Abal Hermanos S.A. v. Oriental Republic of Uruguay*, ICSID Case No. ARB/10/7, award of July 8, 2016.

49. Independent Accountability Panel (2018, see note 1).

50. Yamin (see note 23), pp. 113–116.

51. Ibid., ch. 6.

52. *Alyne da Silva Pimentel v. Brazil*, Committee on the Elimination of Discrimination Against Women, Communication No. 17/2008, UN Doc. CEDAW/C/49/D/17/2008 (2011).

53. In addition to the reports, see, e.g., A. E. Yamin and E. Mason, Elizabeth Mason, on behalf of the UN Secretary-General's Independent Accountability Panel, "Why Accountability Matters for Universal Health Coverage and Meeting the SDGs, *Lancet* 393/10176 (2019), pp. 1082–1084; E. Mason, G. Sen, and A. E. Yamin, on behalf of the UN Secretary-General's Independent Accountability Panel, "Universal Health Coverage Provisions for Women, Children, and Adolescents," *Bulletin of the World Health Organization* 98/2 (2020), pp. 79–79A.

54. International Expert Review Group (see note 15).

55. "Accountability in Global Health and the Sustainable Development Goals (SDGs)" (video for the Global Health Education and Learning Incubator at Harvard University, September 30, 2019), https://www.youtube.com/watch?v=5XR1duSlJUM.

56. United Nations High-Level Political Forum on Sustainable Development (see note 2).

57. J. Holst, "Global Health: Emergence, Hegemonic Trends and Biomedical Reductionism," *Globalization and Health* 16/42 (2020); U. Ngwaba, "Taking 'Third World' Lives Seriously: Decolonising Global Health Governance to Promote Health Capabilities in the Global South," *Trans-*

national Human Rights Review 10/2 (2023); S. Abimbola, J. Van de Kamp, J. Lariat, et al., "Unfair Knowledge Practices in Global Health: A Realist Synthesis," *Health Policy and Planning* 39/6 (2024); M. Pai, S. Bandara, and C. Kyobutungi, "Shifting Power in Global Health Will Require Leadership by the Global South and Allyship by the Global North," *Lancet* 404/10464 (2024).