



PRIVATE SECTOR: WHO IS ACCOUNTABLE?

for Women's, Children's and
Adolescents' Health

2018 Report



In September 2015, the United Nations Secretary-General launched the Global Strategy for Women's, Children's and Adolescents' Health 2016-2030 (the Global Strategy) to help further the achievement of the 2030 Agenda for Sustainable Development. The Strategy builds on 15 years of progress under the Millennium Development Goals and the Every Woman Every Child (EWEC) movement. A key strategic priority for the EWEC is to ensure strong implementation of the Sustainable Development Goals (SDGs).

To this end, the United Nations Secretary-General appointed the Independent Accountability Panel for Every Woman, Every Child, Every Adolescent (IAP). The Panel provides an independent assessment of progress and challenges to help strengthen the response from the international health community and countries worldwide.

The IAP is comprised of distinguished panellists from diverse regions and backgrounds—from human rights and health experts to statisticians. They command attention from the global community to promote accountability across the Global Strategy's spectrum of issues addressed under its three pillars: survive, thrive, transform.

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2018 report: Private sector: who is accountable? for women's, children's and adolescents' health

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ACRONYMS AND ABBREVIATIONS

2030 Agenda	2030 Agenda for Sustainable Development
AMC	Advance Market Commitment
ARV	antiretroviral drug
CSR	corporate social responsibility
DHS	Demographic Health Survey
EOSG	Executive Office of the Secretary-General, United Nations
EWEC	Every Woman, Every Child initiative
FCTC	Framework Convention on Tobacco Control
Gavi	Gavi, The Vaccine Alliance
GFF	Global Financing Facility
GHO	WHO Global Health Observatory
Global Strategy	Global Strategy for Women's, Children's and Adolescents' Health 2016-2030
GPEDC	The Global Partnership for Effective Development Cooperation
HPV	human papillomavirus
IAP	Independent Accountability Panel for Every Woman, Every Child, Every Adolescent
IFPMA	International Federation of Pharmaceutical Manufacturers
IHME	Institute for Health Metrics and Evaluation
ILO	International Labour Organization
MICS	Multiple Indicator Cluster Survey
NCDs	non-communicable diseases
NGO	non-governmental organization
ODA	official development assistance
OECD-DAC	Development Assistance Committee of the Organisation for Economic Co-operation and Development
PMNCH	Partnership for Maternal, Newborn and Child Health
PPPs	public-private partnerships
RMNCH	reproductive, maternal, newborn and child health
SDGs	Sustainable Development Goals
The Global Fund	The Global Fund to Fight AIDS, Tuberculosis and Malaria
TRIPS	Agreement on Trade-Related Aspects of Intellectual Property Rights
UHC	universal health coverage
UK	United Kingdom
UN	United Nations
UN H6 Partnership	United Nations H6 Partnership (comprising the WHO, UNAIDS, UNFPA, UNICEF, UN Women and the World Bank)
UNCTAD	United Nations Conference on Trade and Development
UNFPA	United Nations Populations Fund
USA	United States of America
USAID	United States Agency for International Development
WHO	World Health Organization



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OVERVIEW

At this point in the roadmap to 2030, it is essential to get it right regarding the private sector's accountability for women's, children's and adolescents' well-being, and for public health.

The 2030 Agenda for Sustainable Development (2030 Agenda) will not be achieved without the active and meaningful involvement of the private sector. In a context of instability, uncertainties and budget constraints in many parts of the world, governments, bilateral donors and the United Nations (UN) system increasingly look to the private sector to help meet global challenges and fund the Sustainable Development Goals (SDGs), with their price tag of US\$ 5.7 trillion. The health SDG alone will require nearly three times the current level of investment in low- and middle-income countries—as much as US\$ 371 billion annually by 2030.

The current proliferation of public-private partnerships (PPPs) is expected to accelerate under the SDGs. The Joint Fund for the 2030 Agenda was launched in 2018 by the UN Deputy-Secretary-General to facilitate scaling up SDG implementation through PPPs. Increasingly, corporations feature prominently in international policy circles and CEOs mingle regularly with the world's decision makers in Davos and at UN headquarters. Yet at the same time, tax avoidance by multinationals—estimated at US\$ 500 billion annually—undermines policy coherence and drains money from the countries most in need.

Can the private sector be held accountable for protecting women's, children's and adolescents' health? And if so, who is responsible for holding them to account, and what are the mechanisms for doing so? This report explores this theme, asking the key questions: Who is checking to see if businesses are aligned with people's rights to health? Are adequate standards and oversight systems in place under the 2030 Agenda and the Addis Ababa Action Agenda? Just how much so-called corporate blue washing is going on?

The UN Secretary-General's Independent Accountability Panel for Every Woman, Every Child, Every Adolescent (IAP) has set out to answer

these questions in fulfilment of our mandate: provide a snapshot of progress on the Global Strategy for Women's, Children's and Adolescents' Health 2016–2030, using the specific lens of accountability: Who is accountable to whom, for what, and how?

Getting accountability right

The IAP is well aware that this report ventures into hotly contested terrain, riddled with misconceptions and mistrust. We hope that it will mitigate some unnecessary polarization and facilitate meaningful dialogue, transparency and accountability. It comes at an important moment, a year away from the first review of the 2030 Agenda by heads of state and government. It is especially relevant given the private sector's role in universal health coverage (UHC), the growing privatization of health services, and the steady growth of business engagement in health. The powerful influence that corporate interests wield in setting public policy agendas and in democratic elections, through political lobbying on the domestic front or through trade negotiations and involvement in the G20 and World Trade Organization processes, makes it increasingly important to address the questions set forth in this report.

At this point in the roadmap to 2030, it is essential to get it right regarding the private sector's accountability for women's, children's and adolescents' well-being, and for public health more broadly. Private sector engagement in health cannot be treated as largesse or charity. Accountability, beyond answering to shareholders and investors, must include the public: the individuals and families that rely upon equitable, quality and efficient health systems; the workers that make up the backbone of health systems; and the people deeply affected by private sector operations within and across borders—including the environmental and gender impacts of these operations.

The private sector's role in health is not new. Its members—who have saved and improved countless lives—include family doctors; creators of vaccines, medicines and medical breakthroughs;

advertising firms behind public health campaigns (to combat, for example, HIV/AIDS or violence against women); and developers of information and communications technologies (for instance, m-health and telemedicine for remote communities), to name but a few.

The challenges of harnessing the innovations and potential contributions of such an important sector are both ethical and practical. The private sector's bottom line is primarily financial profitability, which does not necessarily mean putting people's well-being first. This inevitably poses serious dilemmas and possible conflicts when attempting to put in place a global agenda founded on principles of human rights, dignity, equity and leaving nobody behind. Concerns around the privatization of development and the abdication of responsibilities by states and global institutions are central to the thinking of the IAP and are shared by many.

Governments are the guardians of private sector accountability

The responsibility for ensuring oversight of the private sector lies first and foremost with the public sector. Health is a human right and is interdependent with other human rights that affect the social determinants of health. These rights are enshrined in international law. Governments—from the national and local to the international level—are responsible for safeguarding the right to health, within their own countries and through fulfilment of extraterritorial obligations. It is their task to oversee that all involved, including the private sector, are held answerable for how their actions impact on people's health.

Accountability governing the private sector's engagement in the area of health, however, is particularly vague and undocumented. The concept of accountability is often narrowly understood as the application of civil and criminal measures to sanction corruption and tax evasion, labour and environmental abuses, or human rights violations. These are, of course, fundamental functions of accountability. This report, however, espouses the IAP's comprehensive, constructive, learning

approach to accountability—one in which remedy is a sine qua non component, underscoring how accountability can be corrective and preventative as well. In so doing, we hope the report will be beneficial to for-profit, private sector actors in guiding their future engagement and performance.

When the public sector is strong and government is responsive to its citizens, the private sector can thrive, enhance growth and well-being and accelerate innovation to achieve the 2030 Agenda. Major challenges arise when the public sector is weak and lacks the capacity for effective regulation, as is particularly true in low-income countries where unchecked business interests are prone to produce adverse consequences in affected communities. Moreover, global rules related to trade, intellectual property, and other forms of economic governance may hamper national abilities to effectively regulate private sector actors, especially transnational corporations. In the absence of strong government oversight in the countries where companies operate, and multinational corporations are headquartered, people—especially poor, rural and marginalized communities—may lack the education or means to avert harm. They may fall victim to quack services and treatments they can barely afford. Or they may be exposed to the risks of non-communicable diseases (for example, to obesity as a result of aggressive marketing of low-cost junk food and sugary drinks). Or simply, they may not be able to afford essential, life-saving services and medicines—often made available by the private sector to society's well-off and well-insured, while fractured public health systems and failure to uphold the rights of the have-nots leave the poor and marginalized without access to quality health care.

Of course, even in democratic countries with robust institutional capacities there is a need for continuous vigilance, within their own borders as well as over corporate entities that fall under their effective control. An active civil society and the protection of freedom of information can help to counter the risks of misdirected motives and conflicts of interest in the for-profit sector. Yet self-reporting and self-regulation are often the sole forms of accountability practiced by business sector entities engaging in health and the SDGs. While the IAP welcomes the commitment

of many private sector actors to these accountability mechanisms, we recognize that they lack validation by independent sources and are not sufficient on their own. Accountability must go beyond self-regulation. The UN Global Compact, for instance, is a mechanism created to bring businesses on board as partners for development. Yet the challenge remains of balancing the carrots (which abound for UN Global Compact members in terms of corporate visibility and privileged access to policy-makers) with the sticks (which are all too thin from the perspective of meaningful accountability).

Which private sector?

The landscape of private sector actors is vast and complex. It is characterised by great diversity in the aspects of health covered; types of engagement; types of entities and country settings; and motives and degrees of willingness to be subjected to meaningful accountability and the rule of law.

While acknowledging the diversity of private sector involvement in health, we narrow the scope of our analysis in this report to: *for-profit actors operating in the health sector and/or having significant impact on women's, children's and adolescents' health across the pillars of the Global Strategy—survive, thrive and transform.*

In the context of achieving universal health coverage to attain the SDGs, this report looks at three key areas of private sector engagement:

- health service delivery, from small providers to large hospital networks
- the pharmaceutical industry, from local pharmacists to multinational manufacturers
- the food industry and its significant influence on health and nutrition, with a focus on non-communicable diseases (NCDs) and rising obesity.

Without robust oversight mechanisms, independent review and adequate remedies, accountability can be just lip service.

All parties involved in health and in achieving the 2030 Agenda must be held to account. This applies also to private actors not covered directly by this report, including non-governmental organizations and secular charities, as well as faith-based institutions, which provide a considerable share of care in some settings; and foundations established and funded by corporations, with diverse objectives and degrees of independence—including some that shape the landscape of global health, such as the Bill & Melinda Gates Foundation. Although the extraordinarily influential role of the private sector in financing health, including health systems, is also outside the scope of this report, the IAP acknowledges its relevance. Some major private sector enterprises that affect people's health are also outside the focus of this report, for instance: the extractive industry, which has been well-covered from a human rights and accountability perspective; or the marketing and advertising industry, which shapes gender and other social norms.

Without the full cycle of accountability the SDGs will not be achieved

Under international law, accountability standards apply equally to all actors, public and private, whose activities impact on people's health and rights. Governments have a duty to establish accountability systems that are adequately resourced, in financial and human terms, to oversee compliance with these standards. Only in this way will we be able to achieve the Global Strategy and the 2030 Agenda. Thus, it is fundamental that multilateral institutions and donors invest in effective, accessible and transparent institutions, pursuant to SDG 16. Furthermore, inter-governmental bodies, expert jurists and courts increasingly realize that the governments responsible for exercising effective control over transnational corporations headquartered in their territory also have an obligation to promote accountability for the actions of these entities beyond their borders, directly and through multilateral institutions.

Without robust oversight mechanisms, independent review and adequate remedies, accountability can be just lip service. The public and civil society have the right to an active voice in drafting the laws and regulations that structure private sector activity and accountability, and to participate in implementing and monitoring them.

The IAP approach captures the full cycle of accountability—monitor, review, act and remedy—building on the approaches of the Commission on Information and Accountability for Women’s and Children’s Health, and of the Independent Expert Review Group. This year, we have adapted our accountability framework to focus on the private sector (see Panel 1).



PANEL 1. APPLYING THE IAP’S CONCEPTUAL FRAMEWORK TO PRIVATE SECTOR ACCOUNTABILITY

For this report, the IAP’s accountability framework—monitor, review, act and remedy—is applied to state obligations to hold the private sector accountable. Emphasis is placed on the right to health, its social determinants, and on service delivery—all of which are deeply influenced by private sector actions. Given the global nature of the influence some private sector actors have on health—for example, the pharmaceutical, food and tobacco industries—both national and extraterritorial accountability are stressed. The circle of accountability also encompasses the ways in which businesses wield economic and political influence over policy-making, affecting the health of women, children and adolescents.

Monitor refers to gauging, based on adequate data, whether progress is being made, with a focus on revealing inequities. This requires using and monitoring the right indicators. It also involves putting systems in place to compare the performance of institutions, both public and private, in terms of health service quality, equity and other aspects. However, monitoring private providers is challenging, as the necessary data is not always integrated into public systems. Adequate monitoring of some major actors within the health system, such as pharmaceutical companies, is also difficult because of changing regulations, transfer pricing practices and other cross-border issues.

Review refers to the function of independent oversight institutions such as courts, parliaments, national human rights institutions, auditors and national statistics offices; as well as the role of the media and civil society, enabled through public access to findings of review processes. Currently, review of private sector actors within the health system and of commercial actors that influence health is particularly weak, due to deregulated markets and limited legal enforcement.

Act and remedy refers to the actions ordered by an independent body, which generally have both direct effects on a specific group of people and broader indirect effects on policy, legal and institutional reforms. Without effective access to remedies, prompted by the functions of independent review and oversight, the conditions that prevent people from thriving cannot be transformed.

Key accountability measures that can be applied by countries include:

- **legislation**, including tax, labour and environmental law, and to manage conflicts of interest, among other reforms to establish standards and responsibilities aligned with public health objectives, even when these may limit profits;
- **regulation**, including to specify the terms under which private services, insurance companies and other industries are contracted, licensed and accredited to operate and price services and products;

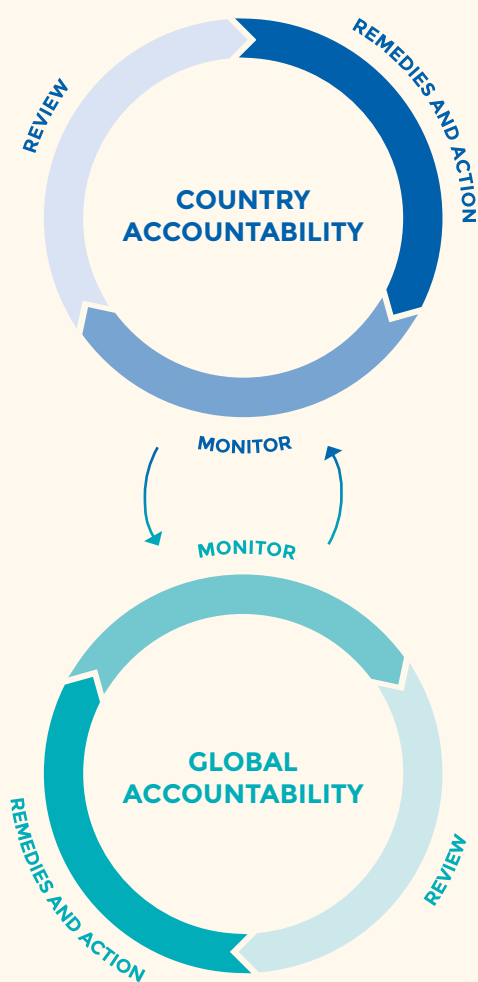
- **monitoring and evaluation** of private sector performance, in terms of both material and indirect impacts (such as in relation to positive or negative social norms and behaviours) of actions affecting women's, children's and adolescents' health and well-being;
- **independent review and effective judicial and other remedies**, including by international tribunals, such as the International Centre for Settlement of Investment Disputes and supranational human rights forums, to ensure compliance with legal and human right standards, and to mandate transformative actions to align industry operations and performance with public health, as well as issue sanctions when need be; and,
- **extraterritorial obligations of states** where transnational corporations are headquartered or over which they exert effective control relating to, among other things: taxation and accounting practices; equitable and non-discriminatory labour practices, including fair compensation, working conditions and unionization of workers; environmental practices; lobbying practices; advertising practices; and intellectual property claims, including carve-outs for public health in accordance with the DOHA Declaration and international human rights law.

The IAP's Unified Accountability Framework

The IAP's Unified Accountability Framework for the Global Strategy shows how levels of monitoring and review are layered and intertwined, from the national to the global.

First and foremost, governments are accountable for making progress on the Global Strategy and the SDGs, and for ensuring oversight of all services and industries operating within and across their borders. At the global level, the High-level Political Forum on Sustainable Development, the World Health Assembly and the Universal Periodic Review of the UN Human Rights Council are key global fora for monitoring progress.

Specific to the private sector, the OECD Guidelines on Multinational Enterprises, the Maastricht Guidelines on Extra-Territorial Obligations, the UN Committee on Economic, Social and Cultural Rights Business and Human Rights General Recommendation from 2017; and the Human Rights Council resolutions on Business and Human Rights, together with the International Labour Organization (ILO) Conventions, are among the relevant standards. The requirements set by independent industry and professional associations also provide useful guidance, but are not sufficient in and of themselves, as accountability requires independent review according to standards agreed through legitimate public processes. The UN Forum on Business and Human Rights, the UN Global Compact, and the World Economic Forum, in addition to the EWEC private sector constituencies, are among the key platforms for strengthening dialogue, and action, on accountability.



The structure of the report

This report draws on the IAP's public call for evidence, intensive research, and consultations with private sector leaders and the range of stakeholders involved in the Every Woman, Every Child (EWEC) initiative. These were extraordinary learning opportunities for gathering the insights that have made this report possible.

Chapter 2 begins by offering a snapshot of progress in advancing the Global Strategy across the three dimensions of rights, results and resources, with a focus on equity gaps and on whether we are measuring who and what really matters. We offer our observations on current global monitoring efforts and also highlight promising developments since our last report, in 2017, on accountability to adolescents. Particular attention is given this year to commitments made by private sector actors to the EWEC initiative, which showcase companies' leadership in support of women's, children's and adolescents' health. While they represent merely a small sampling of what businesses worldwide are doing, these examples also demonstrate what many more should be pursuing. We examine how the contributions of these initiatives are tracked and their performance is measured, and we look at the monitoring and accountability gaps that still need to be filled. We also review the due diligence and accountability standards that Global Strategy partners have in place for their engagement of the private sector, as well as those of the UN Global Compact.

In Chapter 3, we take a more in-depth look at private sector engagement and accountability in women's, children's and adolescents' health across our three focus areas: health service delivery in the context of achieving universal health coverage; the role of pharmaceutical companies and access to essential medicines; and food-industry impacts on rising obesity and NCDs. We ask ourselves: What do we know? What works for accountability? What are the gaps? Throughout, we review the obligations of states and the international human rights standards that govern the private sector, which should be used by executive and legislative branches of government and the range of stakeholders as guideposts to strengthen accountability. We identify how parliaments and judicial systems can help to build stronger checks and balances for women's, children's and adolescents' health by providing effective oversight; and we look at the role of citizen-led and independent accountability.

In Chapter 4 we present our recommendations, addressed to the range of stakeholders: UN Member States, the UN system, private sector actors, development cooperation partners, the EWEC global partners, the UN Global Compact, as well as civil society, including adolescents and youth.

The stakes are highest for the younger generations. What world will they be inheriting in 2030—will it be business as usual, or the transformative change they have been promised?

The IAP recommendations

1. **Access to Services and the right to health:** To achieve universal access to services and protect the health and related rights of women, children and adolescents, governments should regulate private as well as public sector providers. Parliaments should strengthen legislation and ensure oversight for its enforcement. The UHC2030 partnership should drive political leadership at the highest level to address private sector transparency and accountability.
2. **The pharmaceutical industry and equitable access to medicines:** To ensure equitable, affordable access to quality essential medicines and related health products for all women, children and adolescents, governments and parliaments should strengthen policies and regulation governing the pharmaceutical industry.
3. **The food industry, obesity and NCDs:** To tackle rising obesity and NCDs among women, children and adolescents, governments and parliaments should regulate the food and beverage industry, and adopt a binding global convention. Ministries of education and health should educate students and the public at large about diet and exercise, and set standards in school-based programmes. Related commitments should be included in the next G20 Summit agenda.
4. **The UN Global Compact and the EWEC partners:** The UN Global Compact and the EWEC partners should strengthen their monitoring and accountability standards for engagement of the business sector, with an emphasis on women's, children's and adolescents' health. They should advocate for accountability of the for-profit sector to be put on the global agenda for achieving UHC and the SDGs, including at the 2019 High-Level Political Forum on Sustainable Development and the Health Summit. The UN H6 Partnership entities and the GFF should raise accountability standards in the country programmes they support.
5. **Donors and business engagement in the SDGs:** Development cooperation partners should ensure that transparency and accountability standards aligned with public health are applied throughout their engagement with the for-profit sector. They should invest in national regulatory and oversight capacities, and also regulate private sector actors headquartered in their countries.



2

MONITORING THE GLOBAL STRATEGY

Since the 2017 IAP report on *Transformative Accountability for Adolescents*, various positive developments have given impetus to the Global Strategy's implementation. H.E. Michele Bachelet, former president of Chile, was named Board Chair of the Partnership for Maternal, Newborn and Child Health (PMNCH), following on from the leadership lent by Ms. Graça Machel. Her appointment bodes well for navigating the challenges of today's political and financial environment for women's, children's and adolescents' health. These challenges include crackdowns on freedom of speech among civil society, journalists and other human rights defenders; as well as threats to women's and girls' sexual and reproductive health and rights, fuelled by the relatively small but powerful conservative groups that foster extremist interpretations of various religions. At the same time, however, the She Decides movement continues to thrive, with US\$ 450 million in resources—and US\$ 200 million raised in 2017 alone; there have also been massive demonstrations in many countries by women resisting assaults on their rights.

This chapter looks at the progress of the Global Strategy and asks if we are measuring and monitoring what really matters. It also focuses on the participation of the private sector in the EWEC initiative, examining how its contributions are tracked and what accountability gaps need to be closed.

2.1. Snapshot of progress

The IAP's annual snapshot of progress draws on the four reports issued in 2017 and 2018 that focused on monitoring progress in implementing the Global Strategy: the Countdown to 2030 report; the report by the UN H6 Partnership on progress towards 2030 targets; the report prepared by the World Health Organization (WHO) for the World Health Assembly; and the PMNCH brief on commitments made by stakeholders to the EWEC initiative. The data and findings from these reports are cited throughout this section. We also drew on a range of other

new reports, as well as the Global Strategy data portal. As always, we focus our analysis on the equity, gender and human rights dimensions.

The EWEC commitments

The EWEC movement continues to grow in terms of dedicated commitments and resources. The total number of commitments increased from 215 in 2016 to 302 in 2017—a growth rate of 40% in just one year, largely prompted by the Family Planning 2020 summit in 2017. It is worth noting that the first-ever EWEC commitments at the sub-national level (3 in total) were made in 2017.

The majority of commitments fall under the *survive* and *thrive* pillars (77% and 89% respectively), with the *transform* pillar bringing in only 27% of all commitments. Women, children and adolescents living in humanitarian situations received only modest support—19% of all commitments since 2015—despite urgent needs and the largest-ever global refugee crisis in history: 65.6 million people forced to leave home and 535 million children living in countries affected by emergencies.

Under the *survive* pillar, maternal and adolescent mortality were the lead issues (50% and 44% of all commitments, respectively), followed by under-five child mortality (41%); newborn mortality and stillbirths (35% and 5%, respectively) trailed behind. Under the *thrive* pillar, coverage of essential health services received by far the strongest support, referenced in 80% of all commitments. Adolescent birth rate was covered by 76% of new commitments, especially from governments and civil society organizations, a significant increase in attention compared to commitments made in 2015 and 2016 (only 22%). Under the *transform* pillar, commitments primarily addressed water, sanitation and hygiene (12%), as well as violence against women (12%), with a few on learning proficiency (4%) and civil registration and vital statistics (2%).

Financial commitments

New financial pledges to the EWEC initiative totalled US\$ 5.8 billion in 2017, contributing to a significant increase in total resources from

US\$ 29.3 billion in 2015 to US\$ 35.1 billion; these pledges were primarily under the Global Strategy's *survive* and *thrive* pillars. Since 2015, high-income countries have pledged US\$ 14.9 billion (42% of all financial commitments); they are followed closely by low- and middle-income countries, with US\$ 12.9 billion (37% of the total), and by civil society organizations (US\$ 4.7 billion), philanthropic donors (US\$ 1.5 billion) and businesses (US\$ 1 billion).

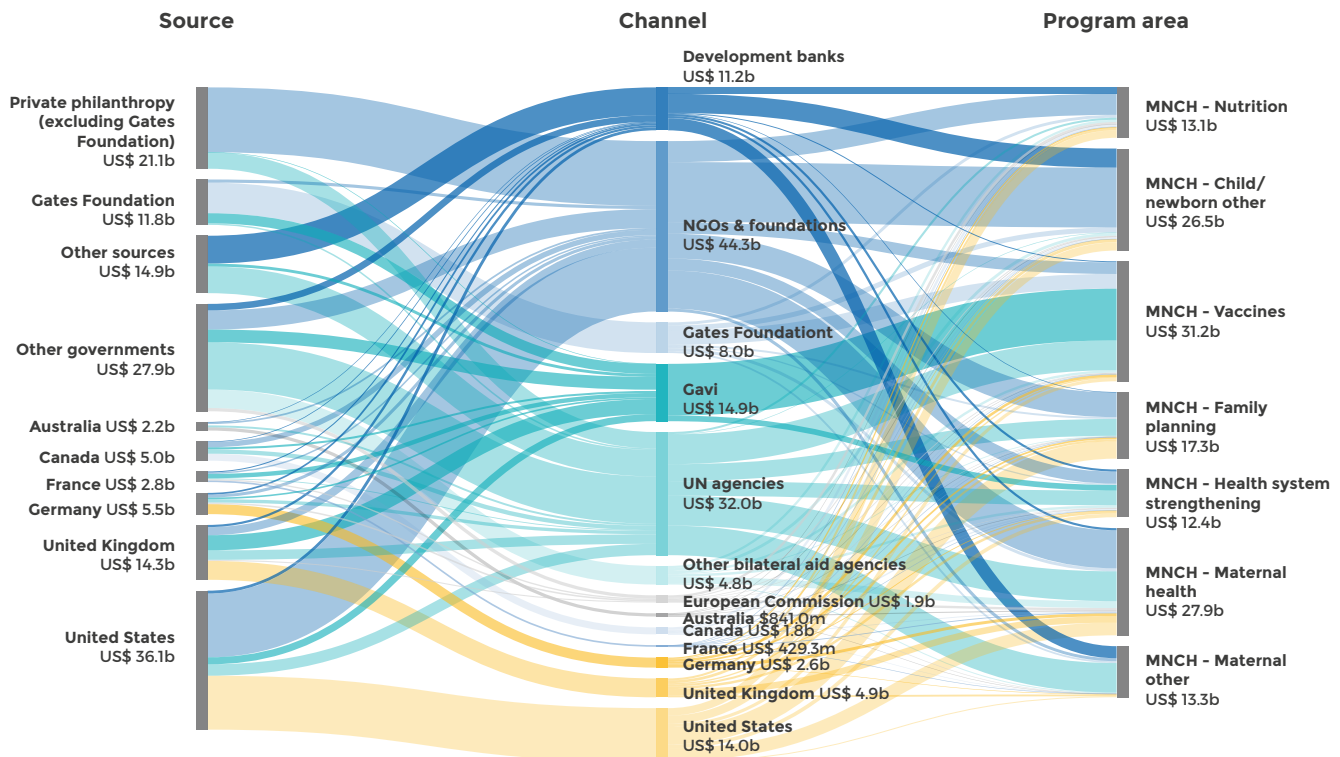
Beyond these financial contributions to the EWEC initiative, there are many other sources of support for Global Strategy implementation, from national public budgets and donors, to earmarking for new initiatives. For example, Japan announced US\$ 2.9 billion to achieve UHC and also became the first donor to the Fund to End Violence against Children, with US\$ 5.9 million earmarked for humanitarian settings. The Bill & Melinda Gates Foundation launched its gender strategy for women's economic empowerment,

allocating US\$ 170 million. A new €18.2 million programme addresses violence against women and girls in the Pacific, primarily funded by the European Union (EU). The Utkrish Impact Bond, launched by the UBS Optimus Foundation with support from the United States Agency for International Development (USAID) and Merck for Mothers, is the first bond in the world focused on maternal and newborn health. These are but a few highlights of the developments since our last report in 2017.

Development assistance for reproductive, maternal, newborn, child and adolescent health

Development assistance for maternal, newborn and child health actually increased between 1990 and 2017, totalling some US\$ 11.6 billion in 2017, while the earlier trend of significant growth

Figure 1. Flows of development assistance for maternal, newborn and child health (MNCH) by source, channel and program area, 2000-2017



Source: Prepared for the IAP by the Institute for Health Metrics and Evaluation, 2018. Financing Global Health Database 2017.

in official development assistance (ODA) for health in general plateaued. Figure 1 shows the flows of development assistance for these issues. In addition, many other donor investments are critical for enabling Global Strategy implementation, such as support for access to food, water, sanitation, electricity and education; and for poverty alleviation and infrastructure.

Important efforts are underway by the Financial Tracking Working Group, convened by the PMNCH and Countdown to 2030, to improve the methodology for tracking ODA and domestic financing for women's, children's and adolescents' health. This will help to overcome the discrepancies in current approaches and findings, while improving transparency and accountability at the country level. The IAP especially welcomes the efforts to incorporate tracking of resources for adolescents, as called for in our report last year. We encourage similar action for resources targeted at gender-based

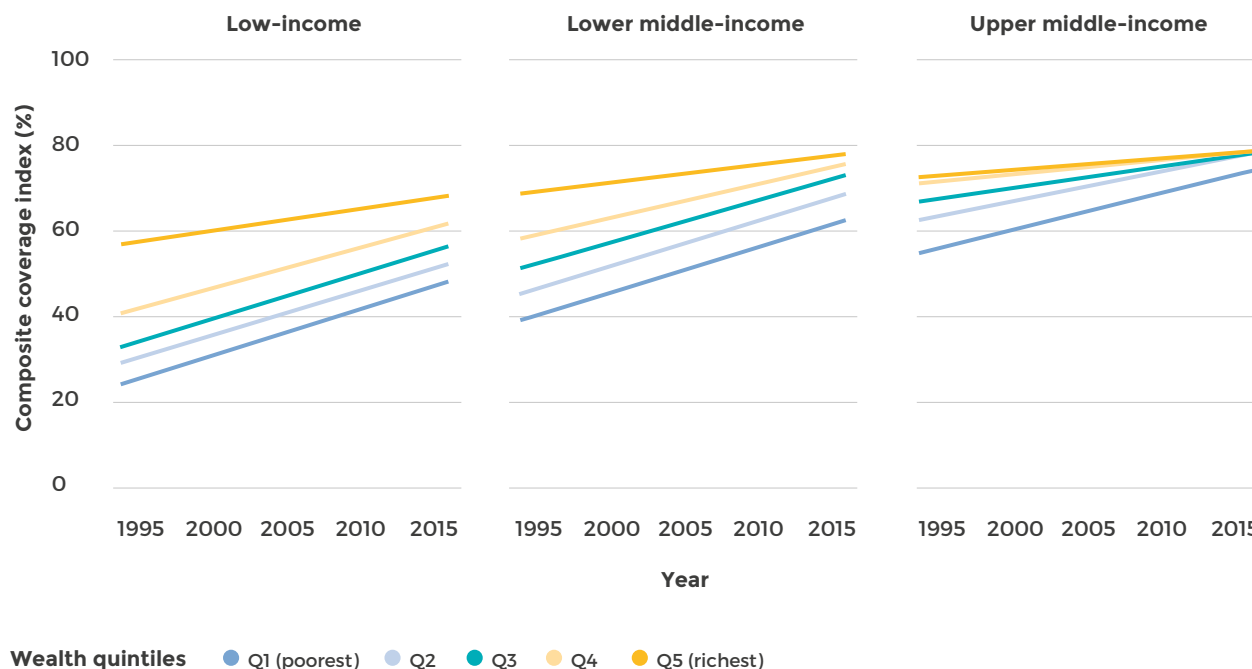
violence against women and girls, and at violence against children.

Is the implementation of the Global Strategy on track?

Progress on women's, children's and adolescents' health is uneven, with both significant achievements and major shortfalls, and is characterized by equity gaps within and among countries.

Coverage of essential services: As reported by Countdown to 2030 for 81 low- and middle-income countries, the coverage of interventions for women's, children's and adolescents' health has improved, particularly in access to new vaccines, malaria prevention, treatment for pregnant women living with HIV, and post-natal care for mothers. However, the slow progress in expanding access to modern

Figure 2. Coverage of essential reproductive, maternal, newborn and child health services, by income levels, within and across countries



Source: Prepared by Countdown to 2030 equity technical working group based at the International Center for Equity in Health, Federal University of Pelotas for the IAP, 2018. Based on available DHS and MICS surveys for 52 low- and middle-income countries ranging from 1993-2015. Note: Composite coverage index measures select reproductive, maternal and child health services.

contraceptives, post-natal care for babies, exclusive breastfeeding and treatment of childhood illnesses (e.g. pneumonia, diarrhoea) is discouraging. For Countdown countries with data available since 2013, the median per cent national coverage for many of these indicators is below 50%, as it is also for access to basic sanitation. Importantly, rural-urban disparities in access to services are narrowing in some countries, such as Malawi, Swaziland and Turkmenistan; however, in others, the divide between rich and poor remains vast, with inequalities across age, education and ethnicity. In Latin America, for example, the coverage of skilled attendance at birth for indigenous women in Guatemala and Nicaragua was 48% and 50%, respectively, versus 83% and 80% for non-indigenous women.

Trends in service coverage (Figure 2) evidence faster progress for the poorer quintiles compared to the richest; there is also some narrowing of equity gaps between quintiles—although to a much lesser degree in low-income countries. However, the composite coverage index among the poorest quintiles in the poorest countries is still below 50%.

Children's health: Globally, progress has been made on reducing under-five mortality: nonetheless, some 5.6 million children still died in 2016, 2.6 million of them in the first month of life and most from preventable causes. Neonatal mortality continues to decline, but at a slower rate than mortality among children ages 1 to 59 months. Children from the poorest quintiles are nearly twice as likely to die before the age of five than those from the richest quintiles. Available for the first time, data on the mortality of 5-14 year olds reveals that 1 million also died in 2016 mostly from preventable causes, with injuries such as drowning and road traffic accidents becoming important causes of death in this age group. It is also alarming to note that at least 43% of children under five face poor chances of optimal development. While stunting in children has been reduced globally, 151 million children are still affected, with 2 out of 5 living in Southern Asia. Once again, inequities are marked by income status: 35% of all stunted children live in low-income countries,

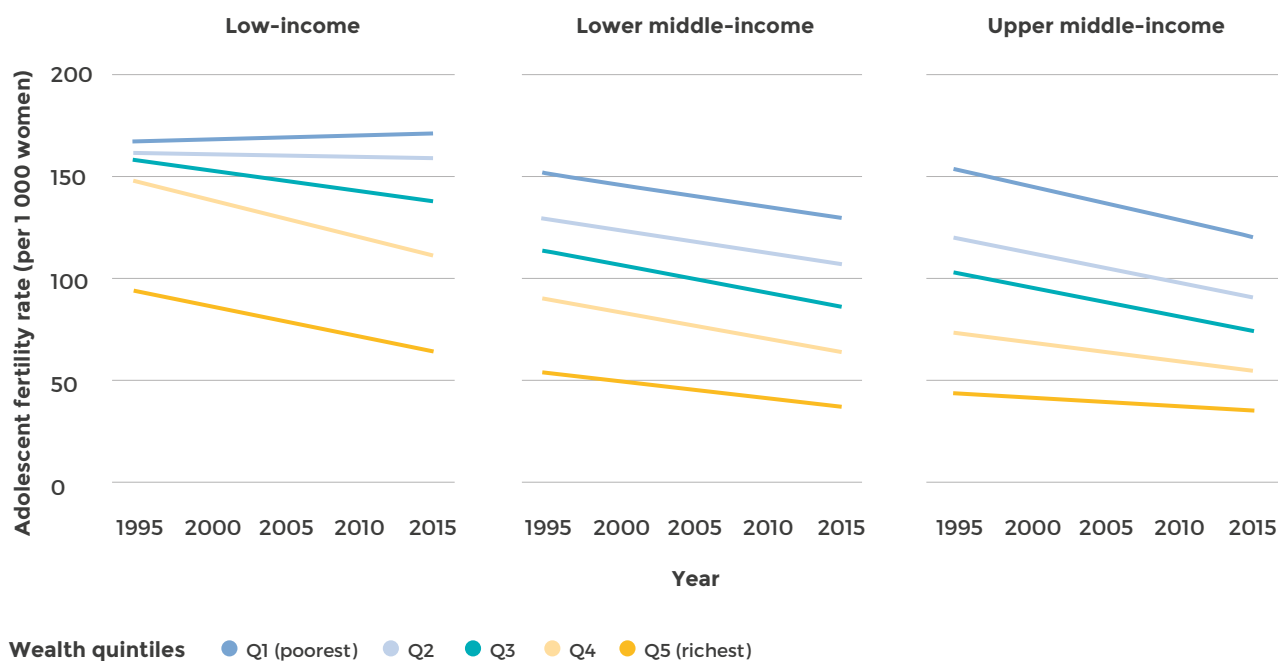
whereas only 2.5% live in high-income countries. New evidence on the transformative effects of investment in early childhood development should help to leverage the crucial investments needed to reverse these trends.

Impressive gains have been made in reducing HIV: new infections among children aged 0-14 dropped by 5% globally between 2015 and 2016, often thanks to their mother's access to antiretroviral medicines during pregnancy and breastfeeding—though without further decreases in 2017. Nonetheless, in 2017 alone, several countries achieved significant reductions in childhood HIV infections, including Namibia (55%), Burundi (34%), South Africa (31%), the Democratic Republic of the Congo (25%) and Malawi (23%).

Adolescents' health: Overall progress in well-being for this age group is inadequate, despite advances in some areas; gender and income inequalities also remain unacceptably high. Globally, 1.2 million adolescents died in 2015, nearly all from preventable causes, and 200 million were not in secondary school in 2016.

Knowledge of how to prevent HIV has improved and in high-burden countries, gender gaps between young women and men (15-24) on this indicator are closing. Nonetheless, gender discrimination and violence limit girls' ability—as compared to young men—to negotiate condom use. In roughly 50% of sub-Saharan Africa countries, where adolescent girls represent 87% of all adolescents living with HIV, there is an alarmingly restrictive policy environment in terms of adolescents' access to condoms.

Drops in child marriage have been achieved globally—from 1 in 4 girls a decade ago, to 1 in 5 today, with gains in South Asia in particular. Rates in Latin America and the Caribbean, however, have stagnated at around 25% and are especially high among indigenous, rural and lower-income groups. Progress is still too slow for the 12 million girls married every year before they turn 18; countries' laws and policies are often complex and even contradictory, undermining efforts to end child marriage.

Figure 3. Trends in adolescent fertility rates by income levels, within and across countries

Source: Prepared by Countdown to 2030 equity technical working group based at the International Center for Equity in Health, Federal University of Pelotas for the IAP, 2018. Based on available DHS and MICS surveys for 52 low- and middle-income countries ranging from 1993-2015.

While gradual progress has been made in preventing adolescent pregnancy, in low- and middle-income countries some 21 million girls between the ages of 15 and 19 became pregnant in 2016. Globally, about half of these pregnancies were unintended, while the proportion was 74% in Latin America and the Caribbean—this region, along with sub-Saharan Africa, has the highest adolescent pregnancy rates in the world. Figure 3 shows trends in adolescent fertility across income levels. Despite an overall trend towards lower adolescent fertility, inequality among wealth quintiles persists; in low-income countries, the two poorest quintiles have shown little to no decrease in adolescent pregnancy since 1995. Low-income countries also continue to have much higher adolescent fertility rates than lower-middle and upper-middle income countries.

Women's health: The IAP welcomes the growing attention to ensuring positive experiences for women in childbirth, and to

maternal mental health and depression. Yet while steady progress has been made globally, with almost 80% of pregnant women receiving skilled care during childbirth between 2012 and 2017, only half of these were in low- and middle-income countries. According to the latest data, 830 women still died from pregnancy-related complications every day in 2015, most of them in sub-Saharan Africa. There are also marked inequities in some high-income countries: about half of the rural counties in the United States, for example, have no hospitals where women can give birth. New analysis of trends also reveals that only 62% of women worldwide had four or more antenatal visits in 2013. During the same period, coverage of early antenatal care was only 23% in low- and middle-income countries, compared to 82% in the high-income countries. Similarly, while it is encouraging that in 49 developing countries, over 95% of pregnant women were screened for syphilis in 2015, in sub-Saharan Africa less than 50% were screened and treated.

Stepped up efforts are also needed to address conditions such as overweight and obesity during pregnancy, which increase the risks of complications.

Unwanted pregnancy is a key factor in maternal mortality. Between 2010 and 2014, 25 million unsafe abortions occurred every year, with young women (ages 20-24) having the highest abortion rates. In 45 countries, mainly in sub-Saharan Africa, only half of the women married or in a union have a say about their sexual and reproductive health and lives—a key factor in explaining why 44% of young women worldwide become pregnant without intending to. And although the number of women and adolescent girls using modern contraception in the 69 poorest countries increased from 270 million in 2012 to 309 million in 2017, the pace of progress is still too slow. In low- and middle-income countries, 214 million women and adolescent girls who want to avoid pregnancy are still not using modern contraception. Marital and educational status widen the gaps: in low- and middle-income countries, young single women have higher rates of unmet needs for contraception than married ones; only 37% of women with no education have their demands for family planning satisfied, compared to 53% with higher education. These figures illustrate the barriers women and adolescent girls face.

There are also major lags in addressing gender-based violence. Between 2005 and 2016, one in five women and adolescent girls worldwide were subjected to physical and/or sexual violence by an intimate partner—yet in 49 countries, related legislation is lacking. While abuse during pregnancy is not uncommon, it is often ignored in maternal health care. Worldwide, 1 in 4 children under five are exposed to violence against their mothers at home, with traumatic effects on their health, including drug and alcohol use, as well as suicide among teenagers. And despite the global surge of attention to sexual harassment in the workplace, 59 countries lack legislation against it.

EWEC monitoring efforts

As mentioned earlier, this chapter draws largely on four main reports that monitor progress in implementing the Global Strategy. The IAP appreciates these efforts and welcomes the coordination among the partners who produced them to ensure complementary, added-value reporting; we also acknowledge the many organizations working to improve data collection on Global Strategy indicators.

The Countdown to 2030 report is a model of meaningful monitoring, using disaggregated data to analyse trends in service coverage and to reveal inequities. Efforts are underway to expand the analysis of service coverage across the continuum of care by improving the tracking of issues relating to quality of care, adolescent girls, nutrition, and women's, children's and adolescents' health in conflict-affected situations.

The 2018 EWEC Global Strategy monitoring report, prepared by the UN H6 Partnership, provides an overview of progress on the Global Strategy's 16 core indicators, with welcome emphasis on early childhood development and multisectoral action. The regional dashboards introduced this year show the distance to go before meeting the SDG targets; however, making country dashboards available would better serve accountability purposes. Including more sources of qualitative data would also strengthen the report's analysis of the inequality, gender and human rights dimensions.

The brief on the EWEC commitments prepared by the PMNCH not only covers new pledges made this past year, but also analyses trends since 2015—across commitment-makers, geographic regions, substantive areas of focus, and resources. But as with the UN H6 report, tracking of quality of care, equity, gender equality and human rights issues could be enhanced by requiring improved reporting on these aspects in the future.

The report on the Global Strategy prepared by the WHO for the World Health Assembly provides a useful overview of data and findings, and of the various critical efforts underway to improve data availability and measurements. However, the report tends to focus on the activities and tools of the WHO and other UN agencies, offering relatively thin reporting. Because the World Health Assembly is the only global body formally entrusted with monitoring the implementation of the Global Strategy, this represents a missed opportunity for meaningfully reporting on the progress of WHO Member States.

Only 23% of adolescent refugees are in secondary school, compared to 84% worldwide.

2.2. Measuring what matters, revealing inequities

Revealing inequities is essential to enable interventions to be targeted at those most in need. However, disaggregated data across age, gender and other critical markers of exclusion and discrimination is still lacking. New analyses, metrics and tools, a few of which we highlight below, are of particular relevance to the Global Strategy, and should serve to prompt increased policy attention and investments—as well as action on accountability.

Tracking children's well-being: OECD's Child Well-being Data Portal offers access to data on children and the settings in which they grow up. To improve policy responses, it measures facets of their life satisfaction, exposing disparities by income, gender, family status and parents' origins. Nonetheless, UNICEF reports that roughly over half a billion

(520 million) children live in countries with huge data gaps which make tracking their progress towards global targets for health, nutrition and education especially difficult.

Children and adolescents in

humanitarian settings: Data disaggregated by age is available for only 60% of the refugees under the UN Refugee Agency (UNHCR)'s mandate. Only 61% of refugee children and adolescents are in primary school, compared to over 90% of children globally; and only 23% of adolescent refugees are in secondary school, compared to 84% worldwide. Gender inequalities among refugee children and adolescents are also alarming: compared to boys, only half as many refugee girls attend secondary school because of fears for their safety from rape and kidnapping, or lack of proper hygiene facilities.

Discrimination in schools: Discrimination on grounds of pregnancy and motherhood is depriving many girls of their right to education. The *Leave No Girl Behind in Africa* report by Human Rights Watch delves into the application of discriminatory return-to-school policies in several countries, appealing to African Union countries to comply with their SDG commitments.

Sexual and reproductive health and rights: The seminal report of the Commission on Sexual and Reproductive Health and Rights, convened by the Lancet and the Guttmacher Institute, finds that 4.3 billion people will lack access to at least one essential sexual and reproductive health service in their lifetime. It recommends a holistic package of services against which governments can be held to account, highlighting that for just US\$ 9 per person per year, the glaring gaps in access to contraception, maternal and newborn health care, and abortion in developing regions could be closed. It also points out the dearth of data for many groups with specific sexual and reproductive health needs, including adolescents and marginalized communities.



Young people: The Youth Progress Index, launched in 2017, tracks how young people are faring under the SDGs; it shows that overall, countries do not perform well in providing them with opportunities for education, for influencing policies and decision-making, and facilitating their inclusion in society. The uncertain futures young people face are underscored in the *Sustainable Development Goals Report 2018*—with three times higher chances of being unemployed than adults.

Gender equality and violence against women: The inaugural *Global Health 50-50 Report*, which uses a set of gender indicators to rate 140 leading international health organizations—including EWEC global partners and private sector companies—finds that overall, the global health community is still gender-blind. UN Women finds that only 10 out of the

54 indicators for monitoring SDG progress on gender issues can be scrutinized at the global level, and that the availability of country data is inadequate for global monitoring. Nonetheless, new tracking tools on gender-based violence have been launched for European Union countries and the first global data portal on human trafficking has also been established.

Other rights-based accountability tools: The IAP welcomes other key reports and novel tools to strengthen rights-based accountability. These include the Inter-Parliamentary Union's report on the role of parliamentary oversight; the guidance for national audit institutions, issued by Women Deliver and Canadian partners to improve how executive branches are held to account for achieving gender equality; a database linking the recommendations of the Human Rights

Council's Universal Periodic Reviews to the SDGs; a toolkit for women with disabilities and their advocates, to help them navigate UN human rights mechanisms and access remedies for rights violations produced by Women Enabled International; and the Girls' Rights Platform, a first-of-its-kind global database promoting advances in legal protections. To track progress on SDG 3, the IAP especially welcomes the addition of an indicator on human papillomavirus (HPV) vaccination for girls—a critical concern highlighted in our 2017 report. Finally, we applaud the long overdue removal of so-called gender incongruence from the category of mental health disorders in the WHO International Classification of Diseases.

2.3. Spotlight: The private sector EWEC commitments

Each year, the IAP zeroes in on specific aspects of how the EWEC accountability ecosystem could be strengthened. This year, we put the spotlight on the business sector's commitments to the EWEC, the leading global initiative engaging the private sector to achieve the SDGs for women, children and adolescents. The findings below emerged from a review of 54 of the total 68 commitment-makers that are from the private sector.

The process: Companies wishing to make a commitment to the EWEC initiative submit a form, in which they are requested to briefly describe the commitment, the results expected, the beneficiary populations, and their plans and indicators for tracking progress. Historically,

approval of business sector commitments has been imparted by the EOSG, with the UN Foundation providing support in eliciting and managing relationships with commitment-makers. There is no formal process involving due diligence or exclusionary criteria.

Reporting on progress takes place through an annual survey managed by the PMNCH. The questionnaire, which was revised in 2017, includes Global Strategy indicators, among which companies select those of most relevance. It also asks whether quality and equity issues are addressed, but commitment-makers are not required to report against these indicators. Companies are encouraged to have monitoring and evaluation plans in place, but are not explicitly asked about key accountability parameters—such as third-party validation, or how beneficiaries and communities are involved in reviews and decision-making.

The commitment-makers: Most EWEC pledges are made by multinationals, but a good number of these businesses are locally-owned or based in low- and middle-income countries, namely in India, Nigeria, the Philippines, Sierra Leone and South Africa. The majority are companies involved in the health industry: pharmaceutical companies, manufacturers of nutritional products, developers of medical technology, health insurance providers, and enterprises focused on water, sanitation, and environmental health. There are major industry federations among them, for example, the International Insurance Society and the International Federation of Pharmaceutical Wholesalers. EWEC commitment-makers also include industries not traditionally associated with health, for instance, from the mining, electronic, textile and beauty sectors.

The commitments: Companies' commitments take the form of financial or in-kind contributions, or involve financing or partnering with a non-profit organization. The majority focus on areas that resonate with companies' and shareholders' business interests—for example, in countries where the company

This year, we put the spotlight on the business sector's commitments to the EWEC, the leading global initiative engaging the private sector to achieve the SDGs for women, children and adolescents.

already operates—or that are relevant for their own workers' health. A few companies focus exclusively on innovative health technologies—such as B&D Technologies and Embryo Technologies, which are developing low-cost solutions for maternal and newborn survival.

The commitments also include some PPPs, such as Saving Mothers, Giving Life, developed by Merck for Mothers together with partners. The Kenya Private Sector Health Partnership—which includes the Kenya Health Care Federation and the United Nations Population Fund (UNFPA)—is engaging private sector companies (GlaxoSmithKline, Huawei, Merck, Royal Phillips East Africa and Safaricom) to lend expertise and resources to the counties in which 98% of the country's maternal deaths occur. The Zinc Alliance for Child Health is a partnership between the Government of Canada, Nutrition International, Teck (a nutrition company) and UNICEF focused on reducing childhood deaths from pneumonia and diarrhoea. Several countries where this initiative operates have established public-private sector five-year plans. Johnson & Johnson is participating in a PPP with Canada, World Vision and others to save babies in India and Ethiopia.

Survive, thrive, transform: Most private sector commitments fall under the *survive* and *thrive* pillars of the Global Strategy (48% and 44%, respectively), and some apply to more than one. Under the *survive* pillar, many focus on newborn mortality (85%), followed by child mortality and maternal mortality (both at 50%). Only one company (Discover) addresses adolescent mortality; another has pledged to combat cervical cancer (AmorePacific). Commitments under the *thrive* pillar show strong support for essential health services, particularly sexual and reproductive health (37%) and to combat malnutrition (29%); others address quality of care. Some companies focus on women's sexual and reproductive health—six of them through services for their employees, some of which cover global supply chains. Five companies also committed to providing parental leave. One of the few commitments to adolescents is made by Sustainable Health Enterprises (SHE) in the form of low-priced menstrual pads for girls in Rwanda who might otherwise miss days in school. Bayer

promotes adolescents' access to contraceptives as well as unbiased sexuality education as part of World Contraception Day. The *transform* pillar has received less attention, with only 19 commitments (35%); ten of these address gender equality, with only one on combatting violence against women (Business for Social Responsibility).

Financial contributions and leveraging business assets: The level of financial support provided ranges widely, from US\$ 150 000 to Merck for Mother's US\$ 500 million ten-year pledge to reduce maternal mortality. Johnson & Johnson's US\$ 30 million contribution focuses on maternal and newborn health. The level of financial contribution, however, is not necessarily indicative of the ambition and reach of a commitment. For example, Unilever's Sustainable Living Plan aims to reach one billion people with improved hand washing and Philips has pledged to reach 300 million people, including through its Community Life Centers that provide comprehensive solutions (medical devices, solar power, training, services, etc.) to strengthen the local primary health care delivery system and enable social and economic empowerment in poor communities in Kenya and beyond; both are being leveraged through the companies' core assets.

Monitoring companies' EWEC commitments

Despite the limited requirements of current reporting forms, promising monitoring and accountability practices emerge from the information companies volunteer. In terms of transparency, a total of 31 companies (58%) plan to make their results available to the public via social media, websites, annual or stakeholder reports, newsletters and brochures. The majority of these (29) release information once a year, in annual reports, and about half of them (15) do so on a quarterly basis. Ten companies report results internally through newsletters or through formal reports to company boards. Companies with strong corporate social responsibility (CSR) governance structures tend to be more systematic in internally disseminating findings on progress, which is also a way of fostering employees' ownership of the EWEC commitment.

Companies are asked no explicit question on external evaluations, and there is no requirement to make the findings of such evaluations public.

Without data on beneficiaries' socio-economic background, and in the absence of external evaluations, there is no way to assess if underserved populations are being reached.

Of the 54 private sector commitment-makers reviewed, only 5 indicated plans to conduct external evaluations (Johnson & Johnson, Merck for Mothers, MTV, Mylan and Unilever). These and a few other companies have fairly robust monitoring processes. Johnson & Johnson, for example, works with evaluation firms to improve data collection and reports that they have reached over 5.3 million newborns since 2016. Merck for Mothers, which reports having reached 6 million women in 2015 with quality maternal health care and contraceptives, has country focal points tracking progress on their EWEC commitment. Unilever's Sustainable Living Plan has a multi-faceted monitoring system. It reports that by 2017, 337 million people had been reached with education on improved hand washing across Asia, Africa and Latin America. Unilever's EWEC commitment is reviewed at their annual shareholders' meeting, and a corporate responsibility committee monitors progress and regularly reports to the company's board. A panel of independent experts in corporate responsibility and sustainability guides the strategy and external reporting.

Commitments that entail partnerships, such as those supported by Bayer Health Care, the Kenya Private Sector Health Partnership, Royal DSM, Teck and United4Oxygen, are often monitored through collective, transparent and structured processes. AmorePacific conducted an impact study on its commitment, finding that 47% of participants obtained job certifications after graduating from the program and 28% obtained jobs. The BORN Project, carried out by Masimo and the Newborn Foundation, has developed mobile

app-based technology for early detection of the major causes of newborn mortality; it uses robust data collection to drive quality and infrastructure improvements for low-resource settings. They report that by April 2018, 300 000 newborns were screened; the initiative has expanded to eight countries from the initial two.

A few companies (such as Lindex, MTV and World Health Partners) also report having participatory and community feedback processes although, as mentioned above for evaluations, companies are not asked explicitly to report on these aspects. Together with the White Ribbon Alliance, Bayer supports a self-care programme for impoverished women for which needs assessments were undertaken and women participated in designing the interventions and shaping local policies on provider training. All the companies supporting sexual and reproductive health services for their workers conduct satisfaction surveys. For example, Lindex, a Swedish textile company based in Bangladesh, involves employees in shaping the services provided and produces a scorecard on results every year. Jaipur Rugs conducts case studies to learn how people benefit from the interventions. Companies developing contraceptives and related supplies report that they regularly conduct acceptability studies with potential users. MTV, which created a very popular youth-focused TV show in Africa called Shuga, conducts viewer acceptability studies to fine-tune messaging.

While the achievements reported are often impressive, only 17 of the commitments mention a focus on marginalized populations. This low number may be explained in some cases by companies' tendency to focus on issues rather than on specific populations (for example, diarrhoea, which is high-risk for underserved poor children—but who may not be identified as such). On the other hand, World Health Partners, which supports telemedicine services for remote communities in Kenya, makes efforts to assess equitable access and quality.

To track progress, roughly 90% of the companies use the number of target beneficiaries reached.



Some track expenditures for each intervention and each population group targeted. While these features are consistently reported, the value of this information on its own is limited. Without data on beneficiaries' socio-economic background, and in the absence of external evaluations, there is no way to assess if underserved populations are being reached. Overall, the IAP analysis found limited evidence of monitoring and reporting frameworks that adequately link companies' contributions to Global Strategy indicators. There is ample room for systematically building-in improved accountability standards and practices from the early stages of EWEC commitments, nudging companies through enhanced management of the system and providing supportive guidance.

2.4. The private sector, the EWEC architecture and the UN Global Compact

Beyond companies' dedicated commitments to the EWEC initiative, business engagement is embedded across the Global Strategy's architecture of lead partners. In this respect, the key issues involve determining how best to leverage private sector contributions while ensuring alignment with public health objectives; and assessing whether the due diligence standards and systems in place are adequate. This review focuses on the EWEC partners supporting

the implementation of the Global Strategy at the country level—the global funds and UN H6 entities—as well as the UN Global Compact, which has the potential to strengthen support and accountability for women’s, children’s and adolescents’ health going forward.

The global funds

All the global funds have strategies in place on business engagement, and all have private sector seats on their boards. Over the years, the Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund) and Gavi The Vaccine Alliance (Gavi), in particular, have made their policies and due diligence processes increasingly sophisticated.

The Global Fund has many initiatives involving corporate contributions, both in-kind and financial. The HER-HIV Epidemic Response, launched at the 2018 World Economic Forum in Davos, addresses HIV among women and girls in Africa; it involves The Coca-Cola Company, Standard Bank, Unilever and ViiV Health Care. Project Last Mile, launched in 2010, is a public-private partnership that leverages Coca Cola’s global supply chain expertise to improve the delivery of medicines and supplies to the hardest-to-reach communities. Product (RED), an innovative consumer marketing approach, has also mobilized over US\$ 500 million to fight HIV in Africa.

The Global Fund has an evolved system of governance and risk management policies, covering restricted financial contributions, codes of conduct for the Fund’s officials and suppliers, a sanctions panel, and whistle-blowing procedures. Specific guidance on private sector engagement and conflicts of interest aims to ensure that accepting contributions from businesses is consistent with the Fund’s principles and does not translate into undue influence on decision-making. Exclusionary criteria bar the Fund from partnering with companies from the arms, tobacco and pornographic sectors. The due diligence process categorizes industries by risk and extra care is taken in the review process, including more extensive consultation with

stakeholders and use of external data sources. The Country Coordinating Mechanisms, which may involve business representatives alongside other stakeholders, are the main mechanisms for participatory planning and monitoring, as well as for managing conflicts of interest at the national level.

Gavi is in itself a new business model, launched in 2000 in Davos to overcome market failures and the high cost of vaccines and related commodities, which were keeping the world’s poorest children from being immunized. As with the Global Fund, Gavi’s innovative private sector partnerships also abound; for example, the Zipline company is enabling the use of drones to deliver life-saving vaccines to remote areas; and DHL, UPS and other logistics services are lending support to improve countries’ supply chain management.

In preparation for its 2016-2020 strategy, Gavi conducted an internal review to strengthen its policies and risk management processes. Prior to accepting a corporate partnership, Gavi undertakes an assessment, aligned with country needs and equity principles, in consultation with national stakeholders; in addition, it brings on board independent, third-party organizations to conduct due diligence on the social, financial, environmental and human rights dimensions. The criteria for exclusion from partnering include: tobacco and arms companies; those that are not signatories to the Extractive Industries Transparency Initiative; violators of the Universal Declaration of Human Rights and international child labour standards; and companies that generate more than 10% of their revenues from vaccines or immunization products. Gavi reviews private sector partnerships annually, and independent evaluations may be commissioned to assess their results.

The Global Financing Facility (GFF) adopted its private sector strategy in 2016 with the aim of catalysing innovative financing mechanisms and leveraging business expertise to support countries in implementing the Global Strategy. For example, the Innovation Challenge in Nigeria draws on the private sector to strengthen health systems in areas such as civil registration and vital statistics, human resources for health, and service delivery.

Business engagement is embedded across the Global Strategy's architecture of lead partners. The key issues involve determining how best to leverage private sector contributions while ensuring alignment with public health objectives.

Private sector donors to the GFF undergo a due diligence process. In 2017, Merck for Mothers became the first corporate donor, committing US\$ 10 million. Multi-stakeholder coordination platforms led by the national government serve as the main accountability mechanisms at the country level. Under the Civil Society Engagement Strategy and its youth addendum (pending adoption), these constituencies are expected to participate in reviews of country progress alongside private sector representatives.

The GFF is working to reinforce countries' capacities to steward private sector engagement in women's, children's and adolescents' health, involving this sector in ten of its countries of operation. This includes, for example, a programme in Kenya to strengthen national accreditation systems through regulatory boards and licensing; and assessments of the private sector's role in delivering services and health products in countries such as the Democratic Republic of the Congo and Uganda. In addition, a Managing Markets for Health training course, adapted from HANSHEP's work, was launched in 2018 in response to demands for skills-building among public sector officials on strategic engagement of the private sector. Other efforts focus on enabling countries to use contracting and performance-based financing, including in conflict-affected areas of Cameroon, the Democratic Republic of the Congo and Nigeria; as well as improving PPPs focused on the health and nutrition of women, children, and adolescents in Vietnam.

In Cameroon, district health teams are being contracted to support facility regulation and to supervise and ensure quality control; community-based organizations are also being contracted to validate the findings gained through patient feedback regarding facility

performance and quality of care. Private facilities are obliged to report data to the Ministry of Health's management information system. Similarly, in north-eastern Nigeria—an area affected by the Boko Haram insurgency—communities are being involved in tracking access to services and quality of care as part of the strategic purchasing of private sector services. While these efforts are in their early stages and not yet evaluated, they are areas of much-needed support and investment.

The UN H6 Partnership

As with the global funds, all the entities that comprise the UN H6 Partnership—UNICEF, UNFPA, UNAIDS, UN Women, WHO and the World Bank—engage with the private sector. However, due diligence policies and practices, and institutional capacities to comply with them, vary considerably among them; these are among the issues the UN Secretary-General's reform proposals on partnering with the private sector aim to address.

The World Bank accountability mechanisms are particularly evolved (and resourced), as there has been pressure from civil society and donors to do so since the 1990s in response to harmful community impacts. The systems in place include independent mechanisms and compliance and social safeguard officers who support projects; these systems are considered to be very robust and to have significant impact on operations. While evaluations are a regular feature, the assessments of health programmes involving the private sector, including PPPs, have found weaknesses in the monitoring frameworks and limited evidence of impact on health, equitable service use, and reach in the poorer sectors. In addition, people are not always aware of how to avail themselves of grievance procedures.

The policies and exclusionary criteria applicable to private sector engagement vary considerably among the other UN H6 entities. Egregious violations of human rights, as well as of environmental and social standards, are common criteria for not partnering. Other exclusionary criteria naturally reflect institutional mandates.

The WHO's Framework for Engagement with non-State Actors (FENSA), adopted in 2016, does not allow private sector support for its work in norm-setting, nor funding from food and beverage manufacturers for work on NCDs (though exclusionary criteria do not explicitly refer to violators of the International Code of Marketing of Breast-milk Substitutes). The WHO does not engage with the tobacco or arms industries. It will only collaborate with research and development companies if the agreement ensures that the resulting health products will be available to developing countries at preferential prices. Collaboration to advocate WHO norms is allowed only if companies commit to implementing them—though how and by whom that compliance is validated is unclear in the FENSA.

UNICEF and the UNFPA refuse to collaborate with violators of breast-milk substitute marketing norms. Along with UN Women, they exclude collaboration with companies involved in gambling, pornography, alcohol, arms and tobacco, as well as violators of UN sanctions. The UNFPA, as some other EWEC global partners, categorizes high-risk sectors, such as the pharmaceutical and extractive industries. UN Women's positive criteria are centred on companies' records on gender equality—largely absent in others' policies—and businesses are encouraged to sign on to the Women's Empowerment Principles. Some of the entities, such as UN Women and UNICEF, have developed tools to guide companies in aligning with their mandates. UNICEF is also developing a strategy for protecting children across the food and beverage industry supply chains, adding to its body of CSR-related resources.

UN due diligence processes commonly involve research on companies' records through publicly available sources. Some policies require that all new partnerships (not just those involving for-profits) undergo an internal screening process. Yet ascertaining the assiduousness of these processes, carried out by regular staff with unknown degrees of thoroughness or skills, is problematic; in general, agencies acknowledge the need for training. Conflicts of interest may also arise when authority for approvals lies with the

very departments responsible for fundraising and amplifying private sector engagement, or is left to executive directors who may have similar biases. UN reform proposals are expected to grapple with these issues and streamline screening and risk management processes across the UN System.

Limited transparency is also an issue. The public can access information about the activities companies are engaged in with the EWEC partners, but the criteria for partnering and the due diligence policies are not always available online. The WHO's framework is relatively extensive and is considered to be stringently applied, yet it has been criticised for not doing enough to prevent undue conflicts of interest. In 2018, the Global Fund rescinded plans to partner with Heineken after facing similar critiques. Even the strongest safeguards are not foolproof, underscoring the need for ongoing scrutiny by all EWEC partners.

The UN Global Compact

The UN Global Compact, with over 10 000 members, is the leading entry point for businesses to engage with the UN on the SDGs. While its areas of focus extend well beyond the health sector, it holds major potential for leveraging support for the Global Strategy and aligning its network of companies with the right to health, particularly in light of its role in operationalizing the UN Secretary-General's system-wide reforms on private sector partnerships.

Overall, there has been a 43% increase in the number of companies joining the UN Global Compact since the SDGs were launched. Although health has been a largely neglected area, 1 425 companies (14% of all UN Global Compact signatories) fall under health-related industries. The EWEC is part of the new Health is Everybody's Business Platform, which aims to involve companies, civil society and academia in advising businesses to address health impacts across their value chains and to integrate health as part of their sustainable business management—the same way they do for environmental concerns. Among the key issues of focus are social

determinants of health problems, including NCDs and childhood obesity; mental health and well-being in the workplace; and women's health across global supply chains. For all these reasons, the IAP reviewed the UN Global Compact's current policies and accountability standards.

The UN Global Compact Board is co-chaired by the UN Secretary-General and its members represent the business sector, civil society and labour. To join, CEOs send a letter to the UN Secretary-General committing to the UN Global Compact's 10 Principles, which centre on human rights, anti-corruption, labour and the environment. Criteria for joining and related policies are publicly posted. Those making profits from the arms or tobacco industries, facing UN sanctions, or with unethical procurement records cannot be accepted, forming the basis for checks on company records in global databases before accepting new applicants. Third-party verification and external consultations are not required to determine if a company should be accepted, but the Office reserves the right to reject applicants.

Companies participating in the UN Global Compact are required to report annually through an on-line questionnaire, indicating their activities, policies and plans, and how their performance is monitored and evaluated. It prompts companies to disclose violations or grievances arising from lapses in compliance with the 10 Principles, and how these are being handled. Non-reporting two years in a row results in expulsion and over 8 000 companies have been suspended under this strictly enforced policy. Self-reporting, however, without external validation or assessment by the UN Global Compact Office, is the sole form of assessing whether businesses are living up to their pledges. Thousands of reports are received, presenting a challenge, and the reports submitted are not systematically reviewed beyond confirming that members have completed the questionnaire. Self-reporting, therefore, can translate into non-disclosure of unethical corporate practices, with the outbreak of scandals once harm has been done.

The UN Global Compact Office has developed several tools to guide companies in planning and reporting on their SDGs activities; but while welcome and on target on key accountability messages, these tend to be light on substantive aspects. Efforts are being undertaken to promote more rigorous processes, better align companies with international human rights and other standards, and enhance the transparency and credibility of reporting under the SDGs through guidance, such as that issued with the Global Reporting Initiative in 2018. Incentives have also been introduced, such as the creation of a category of LEAD companies—some of which are active in the EWEC initiative. These companies are expected to step up their contributions to the SDGs, generating examples of good practice, and providing a higher order of performance and reporting on outcomes.

The Integrity Measures were updated in 2016 to institute greater scrutiny of UN Global Compact signatories and manage allegations of abuses. While the policy encourages companies to handle and resolve matters on their own, it leaves the door open for suspending or expelling companies when egregious abuses and improper conduct have been detected—for instance, if a court has found wrongdoing. Random reviews of existing members are reported to be undertaken in an effort to better detect and address cases of abusive practices.

The UN Global Compact affirms that it is a voluntary initiative, established to engage the business sector in advancing its 10 Principles, and is therefore “not designed, nor does it have the mandate or resources, to monitor or measure participants' performance.” It does “not aspire to become a compliance based initiative”, and thus has been soft on requirements and the demands it makes on companies. Ultimately, despite the efforts and incentives introduced to improve business practices, self-reporting has proven to be inadequate and does not appease the criticisms and concerns of so-called blue-washing, and of corporate misuse of this UN system platform.



3

PRIVATE SECTOR ENGAGEMENT AND ACCOUNTABILITIES

Private sector engagement in health takes many forms. Companies provide services, medicines, and technologies that save lives, as well as the food that underpins our daily nourishment. Many industries also affect the underlying social determinants of health as employers, by advancing women's economic empowerment; through their impact on the environment; or by shaping societal values through media and advertising.

The essential needs of people living in poverty—of women, children and adolescents—cannot be subordinated to profit margins and financial interests.

Many express scepticism about the very notion of business engagement in health. Distrust abounds and there are very good reasons for this. Health is not a commodity. The human right to health is fundamental. The essential needs of people living in poverty—of women, children and adolescents—cannot be subordinated to profit margins and financial interests. Purchasing health coverage or paying for services is not comparable to buying auto insurance or other commercial goods. If businesses are to engage in health, they must abide by ethical and legal standards, including in relation to human rights, labour and the environment.

Today, the participation of the private sector in health is a reality. The question, therefore, is not *if*, but *how* they should engage. This is where accountability comes in.

This chapter looks at what is needed, in practice, to protect the right to health of women, children and adolescents. It reviews the forms of accountability governing the for-profit sector's involvement as health service providers and health insurance companies; the role of the

Today, the participation of the private sector in health is a reality. The question, therefore, is not if, but how they should engage. This is where accountability comes in.

pharmaceutical industry and access to essential medicines; and the food industry and the impacts it has on rising obesity and the NCDs. The IAP found, however, that the literature often does not distinguish the for-profit health sector from the broader private sector (which includes non-governmental and faith-based organizations, as well as charities). This in itself points to large gaps in the information needed for enhancing this sector's accountability. Due to these data limitations, "private sector" in the following sections refers to the category broadly, including for-profit entities.

Incentives under the 2030 Agenda: What's in it for me?

Corporations and businesses, large and small, are increasingly recognizing the compelling business case for engaging in health. Supporting community health is good for workers' health and productivity, and therefore for business. It enhances a company's institutional image and reputation; helps to capture and sustain customer loyalty and gain new markets; and provides companies with a competitive edge for attracting employees—especially young workers who are socially conscientious. Brand and reputation represent a huge share of companies' market capital, especially in today's mass-media world where bad—as well as good—corporate behaviour can be immediately exposed and disseminated.

But private sector actors face challenges for engaging in women's, children's and adolescents' health. These include a lack of know-how; the scarcity of dedicated institutional brokers to connect business with health investment opportunities; the lack of a common language between the uninitiated business community, on the one hand, and health and development practitioners on the other; bureaucratic inefficiencies and the diverse requirements for partnering with United Nations and other institutions; mistrust of the private sector by civil society, local communities and other stakeholders; and lack of policy, legislative and regulatory measures to level the playing field (which puts do-gooders practicing genuine self-regulation at risk of losing out when others don't play by the same rules).

Alignment with international legal standards, including human rights

Gradually, companies are committing to social development goals. Standards have evolved that encourage this alignment. These include the UN Guiding Principles on Business and Human Rights; the UN Global Compact 10 Principles; the OECD Guidelines for Multinational Enterprises; the Human Rights Council resolutions on business accountability and remedies; and related work by treaty bodies and the Office of the High Commissioner for Human Rights, among others discussed in this report. A working group was also established by the Human Rights Council to elaborate a treaty on transnational corporations and human rights. The Guiding Principles on Business and Children's Rights, together with the recommendations of the Committee on the Rights of the Child, bring added specificity on protections for children and adolescents. UNICEF's Children's Rights and Business Atlas offers practical guidance for businesses on how to go about implementing these principles.

Businesses engaging in the context of universal health coverage must be aligned with one central objective: improving people's health.

Performance against these and other international human rights standards and inter-governmental agreements, however, shows a mixed picture. Although across the SDGs there are numerous instances where business leadership is moving in the right direction, there are still too many cases of private sector actors undermining human rights and the aspirations of the 2030 Agenda. This often includes the very principles these businesses purport to stand for in their public relations campaigns.

Businesses engaging in the context of universal health coverage must be aligned with one central objective: improving people's health. They may also reap rewards and some profits. Political leadership and corporate will, together with

much trust-building among civil society and other stakeholders, can help to ensure that both of these objectives are achieved.

3.1. Accountability, its promises and challenges

The private sector is largely assumed to offer key advantages, and often does; these include cost-effectiveness and efficiency; and know-how in problem-solving, addressing bottlenecks and going to scale. But because states are the primary answerable parties, accountability frameworks, including for the SDGs, are often developed with only the public sector in mind. The World Bank and the World Health Organization position governmental accountability as a pillar of UHC. Private sector accountability, however, has been largely absent from policy-makers' mindsets and actions—and the sector is absent in global monitoring of UHC.

States have an obligation to ensure private sector entities operating within their boundaries or under their effective control are held to the same standards as the public sector—for their participation in service delivery and for ensuring effective price regulation, for example. They must also make sure that they are subjected to independent review and oversight. Furthermore, protecting the right to health and other related rights means addressing threats to public health resulting from the actions of state as well as non-state actors, such as marketing of unhealthy foods and exposure to contaminants.

If we take seriously that health is a human right, the social and institutional arrangements that support its universal and effective enjoyment must be put in place. In this view, health systems cannot be reduced to marketplaces. Rather, we must acknowledge that they function as “core social institutions”. They are part of the social contract in democratic societies, and are expected to be just and fair in ensuring equitable access to health goods and services, regardless of people's ability to pay.

Health status is deeply influenced by underlying social, political and legal determinants, and by unequal power dynamics; these factors particularly affect population groups discriminated against on the basis of their income, race, ethnicity, gender, age, migrant, disability, HIV, LGBTQI or other status. The oversight role of the judiciary is, thus, indispensable in ensuring that executive branches of government fulfil their obligations to safeguard equitable health service delivery and financing; to carry out effective private sector regulation; and to step in when needed to provide remedies that can catalyse improved performance and protect the right to health, a hallmark of the IAP's accountability framework.

Health systems cannot be reduced to marketplaces.

Challenges for accountability

The complexity and range of private sector actors in health makes it especially challenging to track and synthesize related accountability issues. The challenges include the diverse ways in which the private sector engages in health; the contexts businesses operate in, from the local to national and global levels; the specific health issues they address; and the diverse forms of accountability that apply. The lack of common definitions and limited understanding of—and experience with—many aspects of private sector accountability make matters more difficult. In addition, the issues about which people care most, such as quality of care and equity, often receive limited attention in monitoring.

When it comes to regulating the private sector, both companies and governments face challenges. Private sector actors can be reluctant to accept external regulation. Many commit to self-regulation as part of their business plans, but participatory monitoring with community involvement, external evaluations and independent accountability are often lacking. Governments are challenged in striking the right balance, since overregulation can turn away private sector engagement when it results in

high costs for companies. They may be reluctant to impose regulations fearing that companies might take their business and CSR initiatives—and the prospects of boosting the local economy and employment—elsewhere.

With transnational corporations, accountability challenges are compounded because they operate within multiple and sometimes overlapping jurisdictional boundaries, and have long supply chains with many actors and transactions along the way. Companies and multinationals may also provide health services to their workers without standards, oversight or grievance mechanisms in place to ensure quality or compliance with clinical guidelines and human rights standards. The ILO is considering developing a new convention on violence and harassment and the IAP welcomes this initiative, as it would provide the opportunity to put related services and accountability standards in place for working women and older adolescents.

Governments have an obligation to regulate businesses' existing workplace services and incentivize others to provide them, especially to address the sexual and reproductive health and rights of millions of low-income women employed across global supply chains. The countries that exert effective control over transnational corporations headquartered or managed within their borders must also do their part to ensure that these companies are complying with all relevant national and international standards.

Checks and balances for good outcomes

Various forms of accountability apply to the private sector—from legally binding ones with powers of enforcement, to voluntary measures, social accountability and consumer pressures—with varying degrees of effectiveness and authority. Standards that are cross-cutting to private sector activity include compliance with taxation laws and regulations; protection of workers' rights, health and occupational safety; advancement of gender equality (including in relation to sexual harassment in the workplace); supporting the availability, accessibility, acceptability and quality of health facilities, goods and services; environmental protection



PANEL 2. TYPOLOGY OF MEASURES AND MECHANISMS FOR PRIVATE SECTOR ACCOUNTABILITY

Legislation, regulation and government regulatory functions	<p>Legislation and regulations, such as health insurance laws that mandate minimum coverage for sexual, reproductive, maternal, newborn, child and adolescent health; requirements for licenses, certification and accreditation; and authority for government regulators to inspect, audit, and impose penalties.</p> <p>Relevant legislation also encompasses:</p> <ul style="list-style-type: none"> • public health laws, such as prohibitions against alcohol and tobacco advertising, food labelling • criminal laws and sanctions for falsified medicines • laws on prevention of sexual and gender-based violence and harassment in the work-place • taxes on bad foods; subsidies and incentives for healthy food markets • enabling new forms of corporations (such as social enterprises) to incentivize the pursuit of social objectives.
Health finance systems	<p>National public and private health finance approaches that set coverage minimums, maximum out-of-pocket payments and co-payments, quality standards, and accreditation requirements for health insurance (such as URAC in the United States).</p>
Contract law	<p>Contracts between donors, governments, health providers or insurance entities, with clear objectives—such as the supply of services to poor women and rural areas, or compliance with quality standards—and consequences for failure to comply.</p>
Judicial review	<p>Administrative, constitutional and other forms of redress, such as the Brazilian Supreme Court sanctions on food industry marketing to children.</p>
Review by non-judicial bodies	<p>Administrative and other non-court review mechanisms, such as review of cases and complaints by hospital complaint boards, ministry of health internal review bodies, national human rights institutions, alternative dispute resolution mechanisms and other informal justice systems.</p>
Human rights reviews	<p>Human rights reviews by regional and international human rights treaty bodies, which sometimes have been translated into national human rights bodies or courts; human rights impact assessments.</p>
Self-governance and quasi-regulatory	<p>Internationally accepted guidelines and standards, such as the UN Global Compact 10 Principles, the Human Rights Guidelines for Pharmaceutical Companies in relation to Access to Medicines, and the UN Guiding Principles on Business and Human Rights, on Children's Rights, or those of the International Standards Organization (ISO), the Joint Commission International or the Codex Alimentarius.</p> <p>Corporate social responsibility standards.</p> <p>Standards set by professional associations, and disciplinary and supervisory oversight by health professional and industry associations.</p>
Data, indices and transparency	<p>Assessments and external evaluations, voluntary or mandatory and made publicly accessible, such as the Indices on Access to Medicine and to Nutrition.</p> <p>National statistics and health information systems.</p> <p>Open government meetings and records; participatory decision-making involving affected communities and stakeholders during PPP negotiations; procurement transparency (for example, in Georgia).</p>
Political/National policies	<p>National policies and health strategies that guide parliamentary and executive branch actions.</p> <p>Formal processes that provide civil society participation in policy-making, such as membership in government committees.</p>
Social accountability and the media	<p>Civil society advocacy, research and documentation, public awareness-raising and campaigning, such as through public rankings of companies or scorecards.</p> <p>The investigative role of the traditional and new media, including social media and hashtag activism (e.g. #MeToo).</p> <p>Socially responsible investing, such as shareholder activism proposing annual meeting resolutions.</p>

Source: Prepared by Michele Forzley for the IAP, 2018.

and sustainability; and having effective complaint and redress mechanisms in place.

Panel 2 presents an illustrative typology of forms of accountability, by categories and with selected examples, which can be applied to the diverse actors in the private sector. These tools can help to achieve one or more elements of the IAP's accountability framework—monitor, review, act and remedy (presented in Panel 1 of the Overview). This accountability framework requires more than voluntary measures. However, by mapping gaps and assessing opportunities for strengthening accountability, policy-makers, legislators, civil society, development cooperation partners and the private sector itself can identify ways in which oversight can be strengthened.

3.2. Delivering health services: From local providers to hospital networks

To ensure the protection of rights to health, all public and private service providers must be regulated, in all countries, and at all levels. While some profit-driven providers and corporations may object, this can also bring benefits for enhancing private sector performance. Governments with weak regulatory and enforcement capacities, and fragile rule of law, will need political leadership and support to overcome the challenges, including from multilateral institutions and the governments that host transnational corporations. The bottom line is that markets will not self-regulate for equity and people's care.

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If left unregulated, providers have too much decision-making power to determine what services and medicines they offer to their clients. This, in turn, influences demand, as clients, especially those less-educated or less empowered, may be unaware of the options available and therefore cannot make informed choices. There are additional risks in settings where countless informal private practitioners operate without medical credentials, promoting ineffective or dangerous cures.

Conflicts of interest are pervasive among both private and public service providers within health systems in many countries. For instance, public officials may sell illicit drugs or leave health posts unattended to earn extra income in for-profit facilities; or providers may accept gifts from pharmaceutical companies in return for promotion of their medical products. Corruption also remains stubbornly ingrained in both rich and poor countries, and among both government and private sector actors. It takes many forms, from influencing elections and distorting public health policies, to bribing health officials in order to secure licenses or skirt regulations. It is estimated that in the health sector, corruption accounts for a major share of the US\$ 300 billion in losses every year.

The increasing use of digital technologies for health poses additional challenges for accountability. Digital health can make significant contributions to achieving UHC, for example, by strengthening health information systems and transparency, making preventive information and services available through mobile technologies, or expanding training for providers. But digital health approaches have not been properly evaluated—particularly when it comes to their equity and gender aspects—nor regulated. With artificial intelligence and health-care-delivering robots looming on the horizon, now is the time to think through regulation in the digital age.

Who provides health services?

Globally, the private sector provides a significant share of health services. There is great diversity, however, in the public-private service delivery mix across countries. In some—for example, Canada (100%) or Thailand (85%)—nearly all services are run by the public sector. Other countries fall in the other extreme, with the private sector providing most services—for example, the Netherlands, or Georgia (at nearly 100%). The rest fall somewhere in between; in Tanzania, 40% of all primary care visits are to private providers and in several Asian countries, private hospitals account for up to half of all health services.

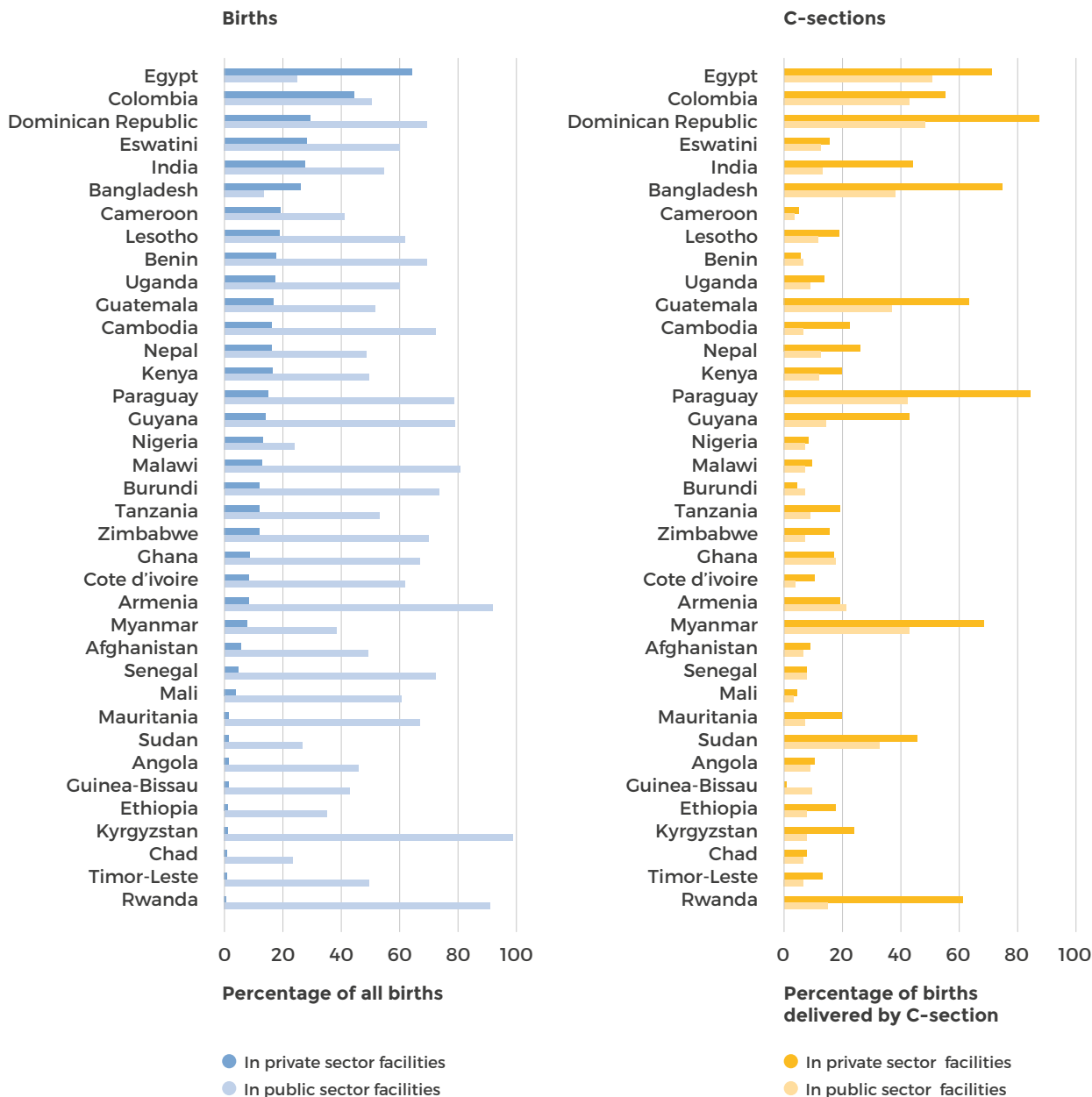
Recent findings (funded through the Merck for Mothers programme) reveal that in low- and middle-income countries across regions, the private sector covers a large share of sexual and reproductive services for women and adolescent girls: 37% of family planning services, 44% of antenatal care, and 40% of delivery care.

Health system governance models vary too. Most OECD countries have integrated approaches: regardless of whether the services are public or private, regulation and financing mechanisms cover all. This contrasts with the situation in many low- and middle-income countries, where the private and public sectors largely operate in parallel systems. Health insurance schemes also vary across countries—for example, they

can be primarily publicly financed, with the private sector only coming in to supplement coverage (for example, in Malta, Rwanda, the United Kingdom); or schemes may be limited to specific categories of beneficiaries (for example, government employees). As consumer demand for choice in providers grows with rising middle-income status (for example, in the People's Republic of China), governments may relax regulations to allow for expansion of the private health-insurance market to supplement public options.

The diversity in the public-private service mix also relates to the delivery of specific services, within and across countries. As Figure 4 shows, more births occur in public facilities than in private ones, with the exception of Egypt and Bangladesh. The proportion of births in private facilities varies widely, from under 1% in Rwanda to over 60% in Egypt. In some countries, births occurring in public and private facilities combined are less than 50% of the total, indicating that home delivery is still common. The percentage of C-sections performed, however, tends to be higher in private facilities—as high as 87% in the Dominican Republic. This reflects the alarming rise of over-medicalization (potentially driven by a range of factors including profit motives) in many low- and middle-income countries. On the other hand, in some countries the low rate of C-sections in both sectors (for example, only 3% in Mali) raises concerns for limited access by women to this vital need.

Figure 4. Births and C-section deliveries in private and public sector facilities



Source: Prepared in 2018 for the IAP by Countdown to 2030 coverage technical working group based at the Johns Hopkins University. Based on DHS and MICS survey data available as of 2014 for 37 low- and middle-income countries, for births and C-section deliveries in the past two years preceding the surveys. Note: Home deliveries are not included.

Achieving universal health coverage

Half or more of the world's population lacks access to quality essential health services. Almost 100 million people fall into extreme poverty every year as a result of out-of-pocket health expenditures and 800 million spend

10% or more of their household budgets on health care. Experts consider that the gaps between the haves and have-nots may actually increase unless equity is put at the forefront of national decision-making. It is no surprise that the latest global stocktaking on the state of UHC concluded that progress is "too slow".

Grappling with accountability will be essential for directing and aligning private sector contributions to achieve UHC. This means ensuring responsiveness to what UHC stands for: equitable access for all to quality essential services, without this resulting in financial ruin or impoverishment. The privatization of health services in many countries; ballooning health care needs; the high costs to public budgets of service provision; and the fact that many people are without even minimally acceptable conditions of access have made it all the more urgent to ensure that checks and balances are in place. Service costs for users (even when covered by health insurance) are of major concern in many countries, posing high-risk barriers for people's health and compounding inequitable service provision and cycles of poverty.

Figure 5 shows how, in sub-Saharan Africa where the private sector is a major source of health care, the richer segments of the population access established hospitals, pharmacies and medical doctors, while those living in poverty are more likely to rely on informal, often unregulated health care providers.

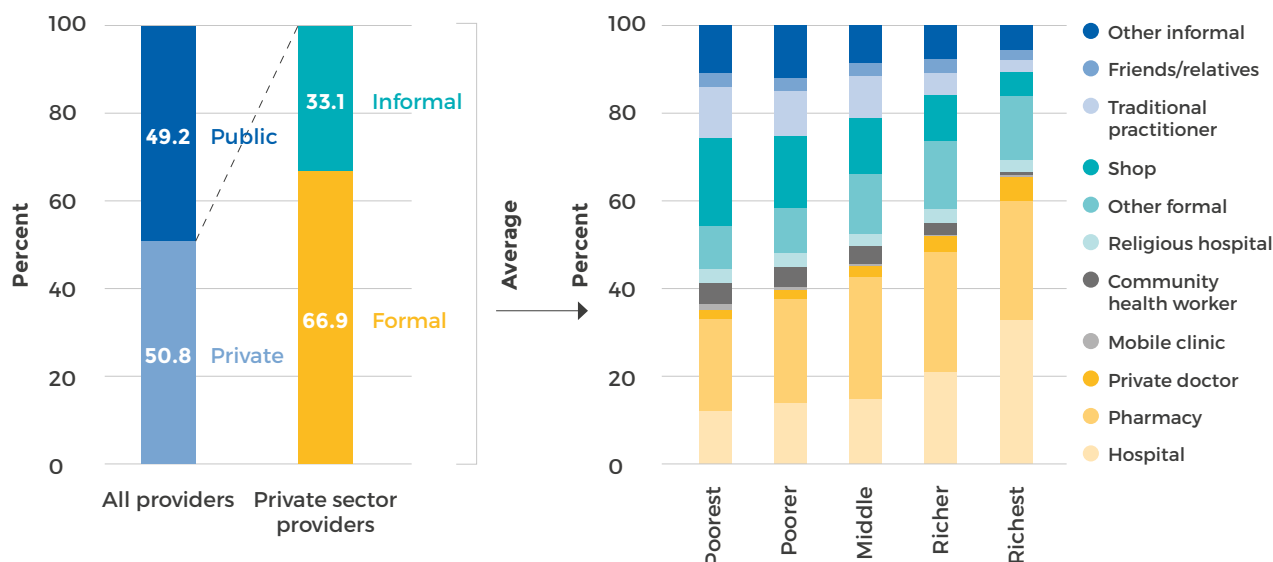
Private sector accountability within national health systems

In many settings, there are serious challenges associated with strategically engaging the private sector while closing equity gaps and upholding standards of quality performance.

To begin with, many governments do not have adequate registries of and data on private sector providers and facilities in their countries; only six of 45 countries in Africa reported having them. Even where registries exist, informal health providers are rarely included, although in some countries they outnumber formal practitioners. In addition, public health officials are not always held accountable for monitoring private sector services because their funding source is not government budgets.

Corporate commercial hospitals have expanded as demand from wealthier segments of society for high-level care and specialized services increases. Some operate as hospital networks within and across countries: examples include Apollo, based in India; the Netcare Group in South Africa; and

Figure 5. Source of health care by wealth quintile and type of service provider for households in sub-Saharan Africa



Source: Analysis of DHS surveys; Montagu 2010 in International Finance Corporation. Healthy partnerships: How governments can engage the private sector to improve health in Africa. World Bank; 2011.

Aster DM, which operates in the Middle East, Far East and India. While these hospitals and clinics fill an important niche in health needs, large segments of the population are often unable to access or afford them. Furthermore, many private sector clinics and hospitals are largely unregulated, offering poor quality of care and overcharging patients. Human rights violations and unethical practices are a major concern, particularly in relation to maternity care; there are cases of families being forced to sell their assets to pay for services, or of at-risk women being discharged to avoid deaths occurring at the facilities. Some of these establishments have been penalized by the courts for egregious violations and neglect.

Knowledge about quality of care is limited, particularly in low- and middle-income countries; there are diverse measurement frameworks and implementation of standards is fragmented (see Panel 3). A new typology developed by researchers from the London School of Hygiene and Tropical Medicine classifies systems for measuring quality of care in the private sector and identifies levers for encouraging providers' participation to improve performance.

Is the private sector a better provider?

The private sector has demonstrated its ability to deliver high-quality services and good health outcomes in many settings. However, there are cases where providers exploit patients or provide poor care. Some private providers have also been known to condone or practice the distribution of counterfeit drugs, overmedication, exorbitant fees for specialist care and the demand for unnecessary tests.

The evidence does not conclusively indicate that, on the whole, private sector services are of better or lesser quality—or higher cost—than those of the public sector. This depends, rather, on how the overall health system is organized. In some cases, the private sector offers higher quality care and is more attentive to clients' needs—especially in terms of stigmatized conditions and populations (such as people living with HIV, or women and adolescent girls with sexual and reproductive health needs). On the other hand, patient preferences may vary according to age or other factors. For example, in sub-Saharan Africa, young women prefer small private sector



PANEL 3. QUALITY OF CARE IN PRIVATE SECTOR SERVICES FOR WOMEN, CHILDREN AND ADOLESCENTS

The Vriddhi project, funded by USAID and implemented by IPE Global and John Snow India, aims to assist India's Ministry of Health and Family Welfare in designing a private sector engagement strategy for reproductive, maternal, newborn and child health (RMNCH) service delivery. A 2016 assessment of private sector facilities in six states found that there was high variability in levels of compliance with established regulations and standards, including clinical guidelines for ensuring patient safety; a majority of in-patient departments lacked legal registration; and very few facilities had the recommended accreditations or renewals from the National Accreditation Board of Hospitals or the International Organization for Standardization. Only one-third of the facilities provided the full package of RMNCH services.

Source: Based on the John Snow Private Limited, India, submission to the IAP 2018 Call for Evidence.

providers for some contraceptive methods, but may turn to the public sector for others. Sometimes, perceptions that public services are of poor quality are borne out by the facts and people prefer to pay for private providers rather than going to public ones for free.

What works for ensuring accountability?

In the context of health care systems, accountability can be defined as measures that ensure that all individual providers, facilities and institutions entrusted and authorized to deliver health goods and services, including medicines and supplies, are answerable for their actions, whether they belong to the public or private sector. This includes ensuring remedial action and instituting timely improvements when problems are detected; mitigating risks of recurrence; and guaranteeing access to justice and redress for neglect and violations of patients' rights. However, while various conceptual frameworks have been advanced by experts, there is no one-size-fits-all approach to accountability because of the very large variance among private sector actors and the contexts in which they operate. Furthermore, government efforts to achieve UHC are often affected by actors beyond their borders.

The following sections look at various approaches and their challenges.

Service providers

Procurement of medicines and supplies, and direct contracting of services—if terms are well defined—can influence private sector performance by building in incentives, agreed standards, oversight mechanisms and penalties for non-compliance. There is no clear evidence, however, that the quality of outcomes from contracted services in low- and middle-income countries is better or worse than that of publicly provided services; the evidence is mixed in high-income countries. Financial or tax incentives, training, social marketing schemes (that increase demand for services) or offers of subsidies are other approaches that provide incentives for improving performance.

Financial mechanisms, such as vouchers and performance-based funding, can enhance accountability, but their effectiveness depends on how private sector service delivery is structured and regulated. Vouchers that allow people to access vaccines, sexual and reproductive health, or other services at free or subsidized prices can serve as a quality-control mechanism, allowing governments to monitor private sector participation and discontinue it in cases of poor performance. However, evidence of their effects on improving the quality of care is limited. Similarly, pay-for-performance approaches have had mixed results: they have had limited effectiveness in improving maternal and child health, quality of care and in reducing out-of-pocket costs, although they have been found to improve the clinical knowledge and availability of trained providers.

Accreditation, licensing and certification are common measures used to align private sector services with quality standards. Many professional organizations—representing general practitioners, hospitals, midwives and other providers—license or certify their members, promoting professional development based on good-practice standards. Depending on the country and legal framework, they may also regulate medical professionals and, in some contexts, investigate malpractice claims. Generally, accreditation by independent organisations (usually an NGO, involving peer reviews) and regulation by government are considered to work best in promoting private sector accountability. While accreditation may be mandated or voluntary, it involves built-in standards, market-entry criteria, inspections, and sanctions in the case of violations. Accreditation is well-established in high-income countries and increasingly so in middle-income countries, where it can be a requirement for participation in national health insurance schemes (for example, in Brazil, Ghana, Kenya, Malaysia, the Philippines and Thailand).

Various accreditation bodies and relevant standards, both national and international, have evolved; they include the International Organization for Standards and the Joint

Commission International, which accredits children's and maternity hospitals. Some specialize in accrediting multinational hospital chains; for example, Accreditation Canada does so globally for ambulatory, child, youth and family care, as well as for obstetrics, based on the standards of the Health Standards Organization. Even in the absence of regulatory requirements for accreditation, providers will often seek out the seal of approval from these highly reputed organizations to provide a competitive edge in gaining clients. However, international accreditation is often too costly or too demanding for many facilities in low- and middle-income countries.

Accreditation has been shown to improve health care provision, but implementation of the associated standards of care by private facilities varies. Accreditation by a health insurance company is sometimes required before a service provider can participate in an insurance scheme, offering a potent financial incentive for compliance with the set standards. This type of accreditation can be more effective in fostering improvements than accreditation by a national organization.

Maternal death surveillance and response systems are in place in many countries and are considered best practice. Nonetheless, success is reliant on government leadership, provider engagement and institutionalization, among other factors. It is important that these reviews include stillbirths and neonatal deaths; in 2015, out of 71 high-burden countries, 51 had systems for maternal death notification yet only 17 had similar policies for stillbirths and neonatal deaths. Research specific to for-profit services is hard to come by and private facilities may not always disclose the cause of death: in East and Southern Africa, for example, deaths due to early pregnancy among adolescent girls are under-reported.

Social accountability mechanisms have proven their potential for promoting improvements in health service delivery and quality of care in a range of countries and settings, including rural and impoverished

areas. These approaches enable clients and communities to rate service providers, expose grievances and exert consumer pressure for improved performance. The mechanisms include the use of scorecards, social audits, digital technologies, Internet platforms and the radio. Many hospitals and facilities also include community feedback on performance as part of their accountability frameworks.

Patients' rights charters have been introduced in various countries in response to neglect and abuses in health care. They emphasize the rights of vulnerable groups—for instance, rights to information, informed consent, confidentiality, transparency regarding costs, access to treatment, a second medical opinion and redress, among others. Charters have historically been adopted voluntarily, especially by non-profit organizations, and those developed by the public sector typically have not covered the private sector. Implementation varies: in many countries, service users are not aware of the charters and providers ignore them. Without the backing of oversight mechanisms, patients' rights charters on their own may not be effective; this is especially true if they are not widely disseminated to inform clients of their rights. Cases such as that of Mexico City—where a public information campaign followed a new law allowing abortion—are rare.

Health insurance companies

Health insurance is critical for achieving UHC. When private sector services are not covered and regulated by the public sector, the poorest are the least able to afford out-of-pocket costs and face the greatest risks of financial hardship. In many countries, even when services are supposedly free at the point of service delivery, it is not uncommon for providers, both public and private, to charge fees under the table. With 33% of global health expenditures funded out-of-pocket—a figure that rises to 38% and 43% in low-income and low-middle income countries, respectively—effective regulation to ensure that insurance schemes offer equitable, quality access for those most in need is all the more pressing.

Evidence on what works in promoting the accountability of private health-insurance companies is limited; it rarely differentiates among public and for-profit schemes, and even less among specific groups, such as children and adolescents. While health insurance is generally associated with improved use of maternal health services—including skilled attendance at birth and delivering at a facility—its effects on quality of maternal health care and on outcomes for women and newborns is understudied. There is also the problem of narrow packages that cherry-pick among the services covered, especially in women’s sexual and reproductive health.

Lack of public access to easily understood information about health coverage entitlements poses major barriers to users’ understanding of their insurance benefits—including with regard to very basic issues, such as what services are covered and for how much. Information about entitlements under insurance schemes, both public and private, may be publicly available in many countries, but it can be too general or too confusing for consumers. One notable exception is the United States’ 2014 Affordable Care Act, a multi-payer system with a mix of public and private sector coverage. It details the package of minimum coverage mandated at the federal level—including maternal and newborn care, contraception, breastfeeding and pediatric services, breast and cervical cancer screening

for women, and immunization and depression screening for children. While challenges to the law since its adoption have resulted in substantial changes, the minimum mandated services remain.

Regulation by national or sub-national authorities is the most common mechanism of accountability for health insurance schemes, including private companies. Governments that set clear standards and obligations can monitor compliance to protect clients from arbitrary or exorbitant charges and ensure that they receive, in a timely fashion, the entitlements and reimbursements they are due. However, as with service delivery, regulatory and legal frameworks for insurance schemes vary greatly across countries, as do powers of enforcement. To protect clients, appeal procedures are required in some countries—such as Germany, Switzerland, the United Kingdom (UK), the United States of America (USA) and the United Arab Emirates—to resolve pricing and reimbursement issues. While less common in low- and middle-income countries, remedy mechanisms are also evolving there.

Thailand’s experience (Panel 4) demonstrates how a national insurance scheme, overseen by a strong regulatory agency, can deliver for women’s and children’s health, using strategic purchasing and contracting to ensure clear service standards and cost requirements.



PANEL 4. EQUITY THROUGH REGULATION AND STRATEGIC PURCHASING: THE THAILAND EXPERIENCE

In Thailand, the National Health Security Office ensures accountability through active purchasing of services to provide a comprehensive benefits package, including services for women and children. The services are offered by private and public providers, representing 15% and 85% of providers, respectively. In addition, the Office maintains a 24/7 complaint line and a conflict resolution system. A decade after the launch of this strategic purchasing approach, babies and women (aged 20 to 30) are healthier. This is attributed to having reduced the financial barriers to accessing services among those who were previously uninsured, particularly the poorest members of society, women and young children. This system has been credited with “erasing the equity gap in infant health”.

Fostering healthy competition among insurance companies can incentivize good performance when provider networks offer competitive quality of care, enabling them to attract more customers. On the other hand, it can produce quality-skimping to cut costs, such as by not offering services that would be medically advisable, but are considered extra. Insurers themselves can hold health providers accountable through their role in accrediting services, establishing the quality standards that constitute the requirements for participation and reimbursement. Detailed contracts with hospitals, clinics, laboratories and other providers can specify the prices and types of services covered, with complaint mechanisms attached. Likewise external organizations can encourage accountability; for example, URAC in the United States, a non-profit organization legally-mandated to provide Health Network Accreditation to insurance companies, monitors compliance with its standards and requirements, which include mechanisms for self-monitoring, dispute resolution, quality assurance and protection of patients' confidentiality and informed consent.

Accountable Care Organizations provide a mechanism for self-regulation and may be a promising approach for improving quality, affordability and efficiency. Networks of service providers work together with health insurance plans to provide integrated health care while ensuring financial savings. Early results for Cigna in the United States are promising in terms of quality and of some cost factors, although not in the scope of services covered.

What makes health services accountability mechanisms effective?

An effective accountability strategy must foster and test over time an ecosystem of measures for improving health-system performance and governance, tailored to the specific context in which it will be applied and involving a broad range of stakeholders, under principles of equitable service provision. No single mechanism

will work in isolation; rather, a combination of government-imposed, self-instituted and citizen-led accountability measures needs to be put in place, facilitated by access to information and transparent reporting.

Many countries need to catch up on regulating the private sector after years of its largely unregulated growth. While private sector stewardship in health is most common in high-income countries, some low- and middle-income countries have also embarked on this trajectory. Afghanistan, for example, launched a stewardship initiative in 2008. In Indonesia, the Expanding Maternal and Neonatal Survival Program deployed a range of measures to strengthen governance of both public and private sector hospitals, as well as community health centres. These measures include clarification of roles, community feedback and convening of public fora, with an emphasis on the providers' social, professional and personal accountability. Early results signal improved quality of care.

The pace and scale of change needed to fill crucial accountability gaps requires fast-tracked leadership from both governments and the private sector, as well as civil society and other actors.

Countries also need to review their existing governance mechanisms, making improvements where needed and adapting to changes in health system developments. The Government of Malta, for instance, in anticipation of expanded private sector provision of hospital services, is applying its concept of clinical governance for ensuring patient-centric care across the whole health system—in line with the country's Charter for Patient Rights and Responsibilities. To underpin stepped up regulation, various initiatives have emerged in support of capacity-building for governments, as well as for the private sector. The pace and scale of change needed to fill crucial accountability gaps requires fast-tracked leadership from both governments and the private sector, as well as civil society and other actors.

3.3. The pharmaceutical industry

The majority of pharmaceutical companies in the world—across the full supply chain—are private sector; they include research companies, manufacturers, exporters, importers and distributors, ranging from the international level through to local retail supply chains and small drug stores. Only a few governments, such as China, Sri Lanka and Thailand, are medicine manufacturers. The role of the pharmaceutical industry in providing universal access to high-quality, affordable, essential medicines—in the context of universal health coverage and SDG target 3.8—is, therefore, indispensable.

Today, 2 billion people lack access to essential medicines, making this one of the most urgent global public health priorities

But today, 2 billion people lack access to essential medicines, making this one of the most urgent global public health priorities. Despite significant progress in immunization rates over the past decades, inequities remain pronounced and the costs of new medicines keep rising. The poor bear the brunt of fractured health systems and persistent market failures: up to 90% of the population in developing countries purchases medicines with out-of-pocket payments, making medicines the largest family budget item after food. For half of all households in low- and middle-income countries, medicines represent 100% of the resources spent on health. In addition, it is particularly alarming that as many as one in ten medical products circulating in low- and middle-income countries are either substandard or falsified.

The availability of medicines, vaccines and equipment for non-communicable diseases is especially poor. For example, in South-East Asia less than 10% of health facilities have a complete

array of essential medicines for treating non-communicable diseases. The supply chain in many countries continues to underperform, leading to stock-outs and the inability to deliver quality, uninterrupted supply. On top of these and many other obstacles, countries face continuously emerging challenges to public health, such as anti-microbial resistance and opioid abuse.

The pharmaceutical market is significant: it represented US\$ 1.1 trillion in global trade in 2016. The generic drug market is projected to rise to US\$ 500 billion by 2021, driven by so-called pharmerging countries; this term refers to the emerging markets in developing countries for both branded and generic drugs. Spending on medicines in these countries has rapidly increased, opening up a growing area of investment for multinational companies. Local production of medicines is also expected to increase, for instance, under the Pharmaceutical Manufacturing Business Plan of the African Union. All this calls for a concomitant increase in regulation and oversight.

Making medicines accessible

Decision-making around research and development of medicines and technologies is central to ensuring equitable access, especially to treat diseases that disproportionately affect the developing world or small patient populations, as well as mothers and children. In 2016, pharmaceutical companies spent US\$ 5.6 billion in research and development for drugs and vaccines targeting the developing world. Governments fund an estimated 30% of total research and development globally—and as much as 60% for diseases predominantly burdening low- and middle-income countries—but may fail to set the pricing conditions attached to their financing to ensure optimal return for the public good on those public investments. The challenge is striking the right balance, ensuring fair pricing that is affordable for national budgets and at the same time satisfying the industry's needs for incentives and profit margins. In this regard, it is important to note that the investments pharmaceutical companies make in search of new cures often end up in failure.

Developing safe, effective, new treatments at affordable prices is a complex, costly operation (for example, getting doses and treatments right for young children). If these investments are properly shaped by actors on all sides, negotiating in good faith in line with public health objectives, major cost-savings can be made for health systems in the long-term, while improving equitable access and people's well-being. For example, preventing and managing the risks of NCDs can help to cut the staggering costs of hospital admissions and care once serious chronic conditions present themselves. Many in the industry, however, use well-known tactics to prolong and maximize profits (extending patents and monopolies, blocking manufacturing of generics, etc.); middlemen and hedge fund investors may also hike prices once medicines are on the market.

Efforts to delink the costs of research and development from end-line prices of medicines have intensified as a means of expanding access to essential medicines, but the volume and pace of progress on this front is still limited. High prices for much-needed medicines make them inaccessible to many countries and population groups, including children. The prices of medicines and health products increase across global chains of production, distribution, marketing and retail, but in many countries mark-ups remain unregulated. While some pharmaceutical companies are gradually converging with the aspirations of the SDGs and aligning with needs-based motives, many actors in the industry are not. The challenge, in the context of aggressive competition for markets and profits, is to align the industry as a whole with public health priorities.

Trade negotiations have been the object of bitter deliberations in the struggle to advance universal access to medicines. Pharmaceutical companies sometimes exert undue influence or claim that they cannot afford to lower prices to produce medicines given the high level of investments. Meanwhile, industry profit margins continue to increase—by as much as 20% in recent years for leading USA-based multinational pharmaceutical companies.

Companies and governments have sometimes threatened countries with retaliation when taking advantage of The Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) flexibilities under the Doha Declaration, which allows countries to legally produce and/or import generic versions of patented medicines to expand access to essential medicines for their populations. Recent evidence finds, nonetheless, that 89 countries across all income levels have availed themselves of the TRIPS flexibilities since their adoption in 2001.

History shows what can be achieved. In 1996, Brazil established HIV/AIDS treatment as a legal right and guaranteed free, universal access to antiretroviral drugs (ARVs)—the first developing country to do so. Local manufacture of generics began in the early 1990s. Throughout the 2000s, the government proactively negotiated the prices of treatment and used threats of issuing compulsory licenses to lower prices. Between 2001 and 2005, it is estimated that using the TRIPS flexibilities saved the country some US \$1.2 billion on ARV costs. In South Africa, early in the millennium, the government refused to back down from developing ARV generics to ensure access to life-saving treatment for its population, despite threats of lawsuits by pharmaceutical companies. Medication prices dropped as public pressure on the pharmaceutical industry grew and the initiative was hailed a success. Likewise, in India, manufacturing of ARV generics began in 1991, with more companies entering the market since and reducing prices through competition. Today, India is a well-known pioneer in the production of generics, supplying 80% of HIV medicines for Africa. These landmark developments began changing the reality of living with HIV and AIDS, rendering it the chronic, manageable condition that it is today.

The advance market commitment (AMC) model, launched by Gavi and partners in 2009, has drastically cut prices and expanded immunization in resource-poor countries. At the time, the very high prices of pneumococcal vaccines meant that the vaccine would not be available to children in low- and middle-income countries for many years after those

in high-income countries. AMC incentivizes pharmaceutical companies to invest in research and development and to expand production capacity by guaranteeing the price of vaccines through advance donor commitments. In exchange, companies agree to sell them to Gavi at considerably reduced prices for use in low- and middle-income countries. This has resulted in many children's lives being saved.

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However, as countries move to middle-income status they lose eligibility for such schemes, as well as donor support. They can face challenges in sustaining immunization programmes, and be hard-pressed to afford the high costs of introducing new vaccines and medicines. To mitigate these risks, efforts have been underway to assist countries in preparing for the transition to self-financing. Nonetheless, further solutions are needed to ensure long-term affordable pricing of vaccines and medicines, and the sustainability of immunization programmes. The manufacturers of the pneumococcal vaccine agreed in 2016 to drop prices for children in humanitarian contexts, who are especially susceptible to dying from pneumonia, yet it remains out of reach for too many living in developing countries.

The WHO and other stakeholders have launched various global plans and initiatives to address the costs of medicines and price gouging, and to expand access to treatments. These include the Fair Pricing Forum, UNITAID (focused on HIV, tuberculosis and malaria) and PAHO's revolving Fund, among others. The challenges of securing affordable, equitable access to medicines are exemplified by the case of hepatitis C. As of 2016, an estimated 69 million people with hepatitis C were untreated, due in good measure to the exorbitant prices of treatment; these prices are

out of reach for developing countries, and even wealthy countries have rationed treatment. In 2017, *Medicins sans Frontiers*, with UNITAID support, secured generic hepatitis C treatment at greatly reduced prices through the Access Campaign for some of the countries where it operates. Governments in countries such as Brazil and the Ukraine have also pushed back on granting patents and in 2017, Malaysia issued a compulsory license.

Stepping up under the SDGs

Pharmaceutical companies are responding to calls for accelerating progress under the SDGs. Multinational companies have undertaken a range of initiatives to expand access to medicines in low- and middle-income countries, including price reductions, special pricing agreements, training in procurement and supply chain management, financing, and donations of medicines and equipment for ministries of health, among others. These actions often have the dual purpose of enhancing their CSR while securing a foothold in emerging markets. Several initiatives, including PPPs, focus on women's, children's and adolescents' health; they include those listed in the World Health Partnerships Directory of the International Federation of Pharmaceutical Manufacturers (IFPMA). The IFPMA also supports Access Accelerated, which involves over 20 biopharmaceutical companies in developing affordable care for NCDs.

Product development partnerships have expanded in recent years, bringing together the public, private, academic, and philanthropic sectors to pool funding and knowledge behind developing new medicines and related supplies as global public goods (for example, the Medicines for Malaria Venture and the International Partnership for Microbicides). These partnerships are gaining importance and are facilitating technology transfer and local production, especially in emerging markets such as Brazil or Indonesia. An example of a win-win public-private sector partnership in Argentina is showcased in Panel 5.



PANEL 5. A WIN-WIN MODEL FOR PUBLIC HEALTH: SINERGIUM BIOTECH S.A.

Sinergium Biotech S.A. was born in response to the 2009 influenza pandemic, when most vaccines were produced in high-income countries. Argentina, as many other low- and middle-income countries, faced supply shortages. With 100% private investment and through a partnership with a multinational for technology transfer (Novartis at the time, now Seqirus/CSL), Sinergium established a new production facility for flu vaccines. In order to provide free vaccines to all at-risk groups, the government granted Sinergium exclusivity for a number of years to sell its production to the Ministry of Health.

Today, Sinergium's alliances with multinational companies is enabling the company to manufacture other vaccines as well, such as the pneumococcal vaccine (with Pfizer) and the HPV vaccine (with MSD). Argentina is among the countries in the world that have the technology to produce influenza vaccines and is one of the more than 50 members of the Developing Countries Vaccine Manufacturing Network, focused on producing quality vaccines in developing countries.

The Government of Argentina established clear requirements in the contract with Sinergium, including setting annual targets in line with public immunization plans, providing vaccination cards, constructing cold chambers at provincial levels, and supplying computers to vaccination centres for registration and follow-up of those vaccinated, among others. Sinergium's good collaboration with regulators is ongoing. The company has also established links with medical associations and civil society organizations to raise public awareness on HPV, HIV and sexual and reproductive health; foster scientific research; and develop training tools for the medical community.

This experience shows how pharmaceutical companies that exemplify corporate citizenship, and constructive partnership with government regulators, can work for global public health.

Source: Sinergium submission to the IAP 2018 Call for Evidence.

Forms of accountability, challenges and gaps

Government regulators, the private sector, or both working together have a primary responsibility to ensure that effective accountability systems with measurable monitoring frameworks are in place to support universal access to essential medicines. Access to medicines is determined by a range of factors that need to be taken into account in establishing these systems, including policies on medicines, pricing and intellectual property rights; public procurement systems and health financing; the effectiveness of regulation; and the existence of corruption (including illicit pricing and political influence), among others. Policies and regulations

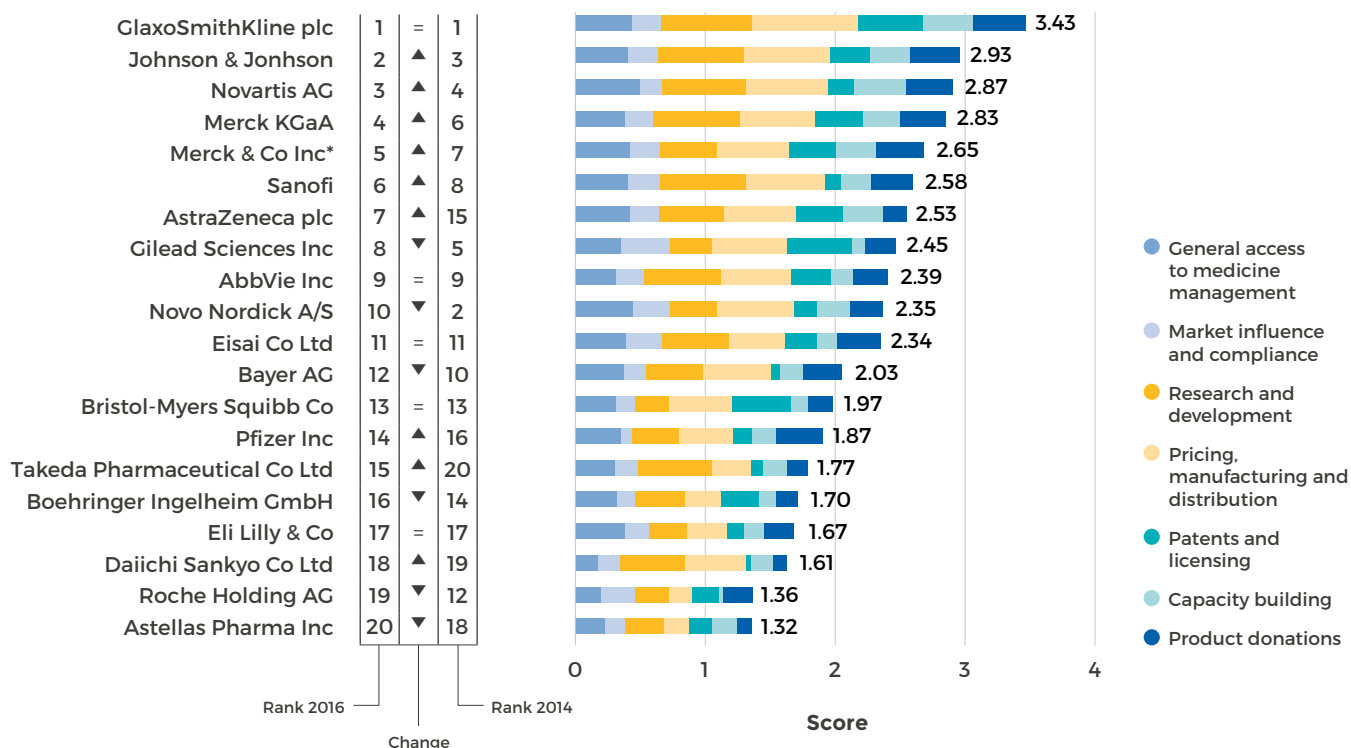
must extend to generic medicines, and to pharmacies—a primary source of care—including on safety and pricing issues.

Access is also influenced by socio-cultural and gender factors, particularly in relation to sexual and reproductive health. To overcome the barriers and facilitate access by women and adolescent girls to reproductive health commodities, some countries no longer require prescriptions for selected contraceptives, making them available over the counter through legislation (scheduling) and standards for administration of products—such as oral and emergency contraceptives, as well as injectables—by trained pharmacists and drug outlet staff.

Self-governance practices, commonly followed by pharmaceutical companies engaged in CSR in the developing world, include self-monitoring and public reporting; internal policies (for example, on anti-corruption); and codes of conduct regarding social, health and ethical principles (such as responsible pricing). The IFPMA, for example, has its own code of conduct and ethical principles. Brazil’s INTERFARMA, the national industry association, actively works on the regulatory environment; it issues detailed guidance on managing conflicts of interest in its Code of Conduct, as do many other national industry associations. However, compliance and internal enforcement of these codes and policies varies across industry actors. Non-disclosure and lack of transparency—such as on costs and investments—are common gaps. Self-governance is not enough. Accountability requires independent review and the existence of effective remedy.

Indices and public rankings incentivize companies to improve over time by pointing them to concrete areas of their operations where course-corrections should be made. The Access to Medicine Index is the leading independent assessment of pharmaceutical companies’ performance in improving access to medicines, ranking 20 of the world’s largest pharmaceutical companies—including some EWEC commitment-makers. The Index covers seven areas of corporate activity, including research and development, pricing, compliance and capacity building (see Figure 6). It is based on self-reported data from companies, which are cross-checked through research using publicly available sources, as well as through external validation and consultations. The latest findings, from 2016, show that while pharmaceutical companies are becoming more sophisticated in getting their products to poor people and are addressing global health priorities,

Figure 6. A race to the top? Access to Medicine Index overall ranking



Source: Access to Medicine Index, 2016. Five is the maximum score.

good practice is limited to a narrow range of products and countries. In terms of affordable and equitable pricing, only 5% of the companies' products satisfied the Index criteria. In 2017, the Access to Medicine Foundation issued the first Access to Vaccines Index, ranking the so-called big-eight vaccine companies on their efforts to improve immunisation coverage, including pricing sensitivity in line with ability to pay, among other issues.

Social accountability and human rights

reviews can, similarly, shape practices by putting pressure on pharmaceutical companies to manage reputational risks in the face of public opinion. In the UK, for example, public and media pressure prompted a retail chain to lower its inflated prices for a generic version of emergency contraception. However, social accountability, like self-governance, is insufficient on its own; it requires going beyond—to effective regulation.

The frailty of regulatory systems does not relieve the business sector from its responsibilities to public health.

Legislation and regulation by governments is ultimately the key for ensuring accountability. All legally licensed operations and all other legitimate players in the pharmaceutical industry supply chain—from manufacturers to distributors, exporters and importers, retail chains and local pharmacies—fall under the regulatory system established by the relevant government agencies. This includes legislative, policy, judicial and contractual mechanisms that can be leveraged to ensure equitable access to essential medicines—for example, legislating pricing transparency for consumers and decision-makers, fixing price ceilings, or directing distribution of pharmacies. Governments have also taken the initiative to enhance collaboration and regulatory frameworks at the regional level, such as CARICOM's Caribbean Pharmaceutical Policy; work is also underway in Eastern Mediterranean countries, including to improve implementation of codes of conduct, establish independent complaints mechanisms, and engage civil society.

Countries, especially those with low institutional capacities, commonly face regulatory challenges. Governments are blind-sided when they lack adequate procurement and regulatory capacities to undertake thorough assessment before granting patents, licenses and market authorization for medicines; and also when they lack access to crucial information for sound decision-making on patents awarded, clinical trial results and prices companies charge for the same products in other countries. These challenges are compounded by the expansion of industry-led initiatives, which has outpaced the ability of developing country governments to effectively engage in their development, implementation and monitoring. In 2018, the WHO issued a policy brief to support governments in assessing industry-led initiatives, including ensuring compliance with national laws and regulations.

Regulators must establish clear rules and standards around promotion and advertising, clinical trials, competition, Internet sales, licensing, and storage, distribution and transport of medicines, among others. The key steps towards effective regulation include ensuring due diligence prior to accepting projects; and establishing clear contractual agreements, including monitoring, evaluation and public disclosure requirements. Taking these steps helps to avert problems governments may run into—such as use of scarce resources for duplicative efforts; accepting drug donations that are not appropriate for country needs or have short expiration periods that end up costing governments to dispose of them; and conflicts of interest arising from, for example, industry tactics to influence doctors' prescription practices by offering training and travels, or decisions concerning what medicines are included in national lists or for reimbursements.

Weak regulatory and enforcement systems remain a major obstacle to securing universal, equitable access to safe, effective, quality essential medicines and related supplies for the populations most in need. While in-country regulatory capacities desperately need strengthening, regulation of transnational pharmaceutical companies in their home countries is also essential. The frailty of regulatory

systems, however, does not relieve the business sector from its responsibilities to public health, as affirmed in the Human Rights Guidelines for Pharmaceutical Companies in relation to Access to Medicines. Ultimately, independent monitoring and external regulation are critical to validate compliance with public health objectives and standards. Improved efforts are also needed to track the CSR and PPP initiatives of multinational pharmaceutical companies, as well as their public health effects in developing countries, and to review how these initiatives are coordinated and aligned with national health systems.

3.4. The food industry and big business impacts on health

Beyond the role of the private sector in health-care delivery, a myriad of global industries impact on the well-being of women, children and adolescents. They shape and influence underlying determinants of health—from the air we breathe and the water we drink, to the food we eat. They improve public health when their operations work to curb pollutants and chemicals; protect land and aquifers; and treat their workers right. But there are also many adverse impacts. The fashion industry, for instance, is one of the largest polluters in the world, in addition to paying notoriously low wages for labour. Advertising and the media play a role in eating disorders among adolescents, which have become a global problem. The lack of gun control (as witnessed with the mass shootings and in schools in the United States) is yet another example of how big business influences people's health—and their very survival.

A major influencer of public health and nutrition is the food industry—the focus of this section. We chose this industry, with an emphasis on sugary drinks and junk food, not only because food is a basic necessity, but also because of the urgent need to address the alarming rise of obesity and non-communicable diseases (NCDs) around the world.

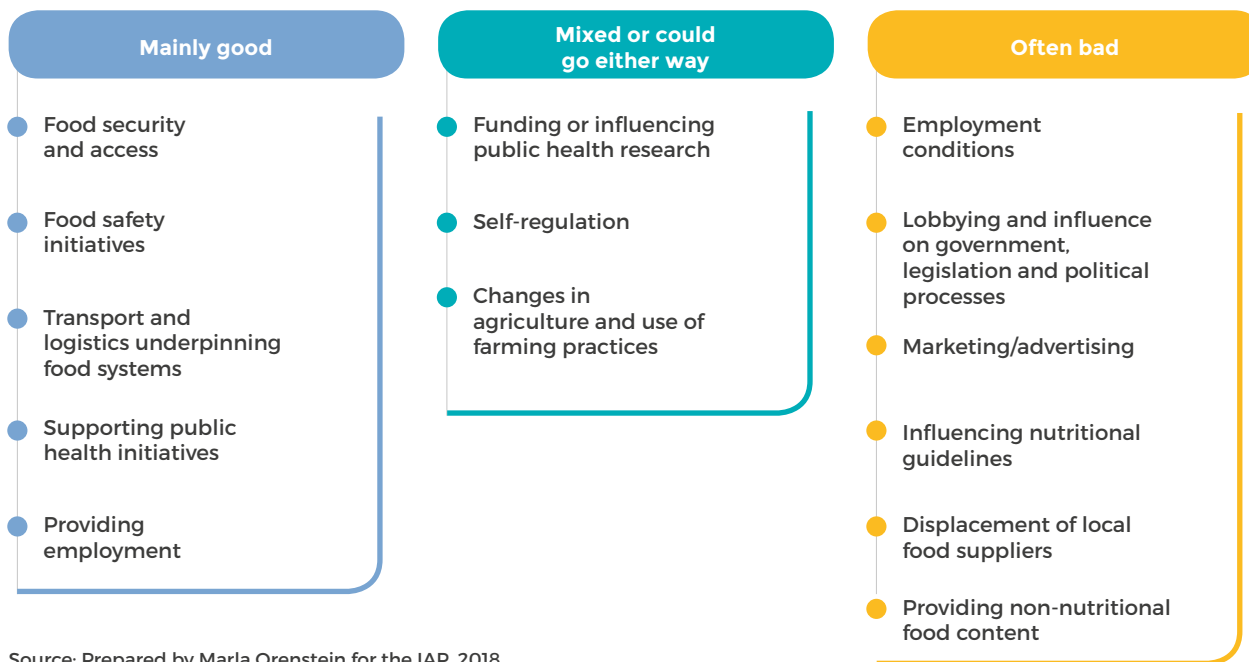
Tackling food industry accountability

The food and beverage industry is enormous, multi-faceted and diverse, comprising all organizations involved in producing, packaging, distributing and marketing foods and beverages. The size of the industry and the complexity of players involved—from small farmers to huge multinational corporations—requires tailored accountability measures across national and global production and supply chains.

We depend on the food industry for the nourishment that sustains us, and for ensuring its nutritious content and safety. Increased public awareness and consumer demand have provided incentives for companies to create new lines of healthier foodstuffs, but too many companies still operate in ways that undermine public health. And while various transnational corporations have committed, through voluntary actions, to minimizing unhealthy food and improving the nutritional value of their products in high-income countries, this may not be the case across the board in low and middle-income countries. Figure 7 illustrates ways in which the food industry influences public health, from the very good and essential to the harmful. It also reflects where public policy and regulatory measures are particularly needed to align industry action with public health.

By comparison to other industries that promote unhealthy consumption patterns (such as tobacco and alcohol), monitoring and regulation of the food industry is lagging. A binding international convention has helped to rein in tobacco companies and has contributed to significant drops in smoking rates in countries where there has been compliance. Standards and national legislation also exist in many countries when it comes to alcohol consumption, including restriction of sales to minors and curtailing times for purchase. Nothing comparable is available when it comes to the impact of the food and sugary beverage industries on obesity and other NCDs, with some notable exceptions—mainly the standards restricting the promotion of breast-milk substitutes and promoting food safety, discussed below.

Figure 7. The good, the bad and the in-between: How the food industry influences public health



Source: Prepared by Marla Orenstein for the IAP, 2018.

Breast-milk substitutes

Breast milk is a unique and nutritious food that boosts infants’ healthy growth and development. Aggressive marketing of baby formula and other substitutes contributes to depriving infants of the benefits of breast milk and thereby increases their health risks. In response to concerns for declining breastfeeding and rising child mortality in developing countries, the International Code of Marketing of Breast-milk Substitutes was adopted in 1981. The Code outlines if and how products can be promoted and marketed, to enable mothers to make informed choices free of commercial influences and biased information. Though voluntary in nature, the Code’s strong language and clarity, the adoption of its provisions in a growing number of countries and the global mobilization of monitoring efforts have served to sustain pressure to improve business practices. In line with the Code, many countries are also taking measures to support breastfeeding among women. Peru, for example, passed a law in 2016 mandating the public and private sectors to provide breastfeeding spaces, including in banks and shopping malls.

However, lapses in monitoring and enforcement are not uncommon and violations of the Code occur in high-income as well as low- and middle-income countries. Sanctions are relatively few and penalties often too small in comparison to the huge budgets of the companies involved (the industry made some US\$ 40 billion in global sales of milk formula in 2013 alone). Conflicts of interest, and public sponsorship and other marketing tactics abound—including misleading women to believe formula is more nutritious.

Even in countries where the Code has been integrated into national legislation, inadequate regulations and weak monitoring render those provisions ineffective. Companies’ internal policies have also been found to be sub-standard and inconsistent with the Code. Nearly 40 years since the Code was adopted, aggressive promotion of breast-milk substitutes remains a major barrier to increases in breastfeeding. As sales drop in higher-income countries, low- and middle-income countries—and poorer, less-educated women—are increasingly targeted. Getting accountability right could have priceless rewards: worldwide, the lives of over 820 000

children under five could be saved each year if breastfeeding were universal; this could also generate US\$ 300 billion in economic savings.

Big business and NCDs

NCDs, such as cardiovascular diseases, cancer, diabetes and chronic lung diseases, cause 70% of all deaths worldwide—almost 40 million every year—particularly affecting poor and excluded communities. Over three-quarters of NCD deaths occur in low- and middle-income countries—that is, the countries with the health systems least able to cope, and where too many people already lack access to essential services. Globally, more than half a million deaths that occur every year are associated with intake of trans fats. In addition, excess sugars are linked to obesity, illness and death from NCDs, and many people living with NCDs and chronic conditions require treatment and care. The financial burden of NCDs is huge, estimated to cost US\$ 47 trillion to the global economy through 2030. Additional health risks regularly emerge, such as the growing threat of antibiotic-resistant bacteria or the potential risks of the use of antibiotics in animal husbandry—banned by the European Union years ago—further burdening health systems.

Though NCDs result from a complex combination of factors, such as environment, genetics and behaviour, the risks can be mitigated. Many

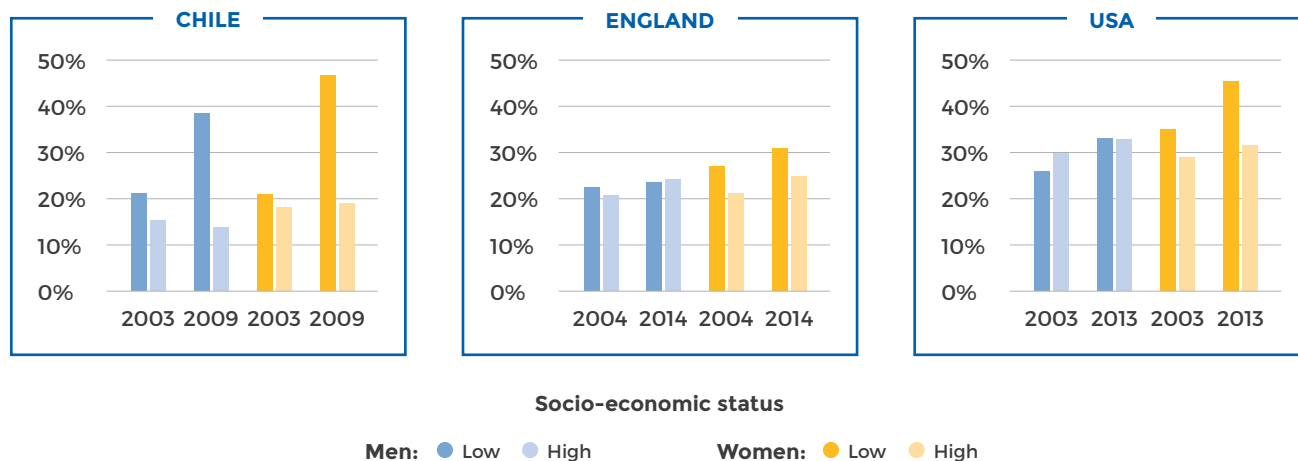
factors linked to NCDs (for example, tobacco use, exposure to second-hand smoke, unhealthy diet, physical inactivity and harmful use of alcohol) begin during adolescence—a critical time for prevention. Women, children and adolescents are particularly at-risk because of their low socio-economic, legal and political status. Women face higher risks of maternal mortality associated with obesity and high cholesterol which in turn, affects their newborns: in 2015, high blood glucose in pregnancy affected some 21 million live births.

The obesity epidemic

Alarming, some two billion adults in the world are overweight or obese. In some countries, the proportion of overweight women is much higher than men. The epidemic is growing alarmingly fast: there has been a tenfold increase in obesity among children and adolescents over the past 40 years. The vast majority of overweight or obese children live in developing countries, where the rate of increase has been more than 30% higher than that of developed countries. Obesity not only increases the risks of diabetes in childhood, but also the likelihood of remaining obese through adulthood, with serious health problems later in life, including diabetes and heart disease.

Obesity and the intake of unhealthy foods affect all countries and are strongly linked to poverty. In OECD countries, low-income groups and

Figure 8. Trends in obesity, by gender and socio-economic status



Source: Prepared by OECD for the IAP, 2018. Based on national survey data. Socio-economic status is defined based on income levels for England and the USA, and on educational levels for Chile.

women are especially affected. Women with less education are up to three times more prone to being overweight than those with higher education in some countries. As Figure 8 shows for three countries, the differences based on gender and socio-economic status are significant, and are increasing in some countries. The increases in obesity among lower-status groups are particularly marked in the case of Chile, among both women and men, as well as among women in the United States.

In addition, the paradox of a double burden has emerged within countries, communities and households where, for example, anaemia in girls and women, or child stunting, co-exists with high rates of maternal obesity and overweight (see Figure 9); or at the individual level, among individuals who have micronutrient deficiencies despite high caloric intake. In sub-Saharan Africa—where countries are torn by conflicts and severe drought, and impoverished populations

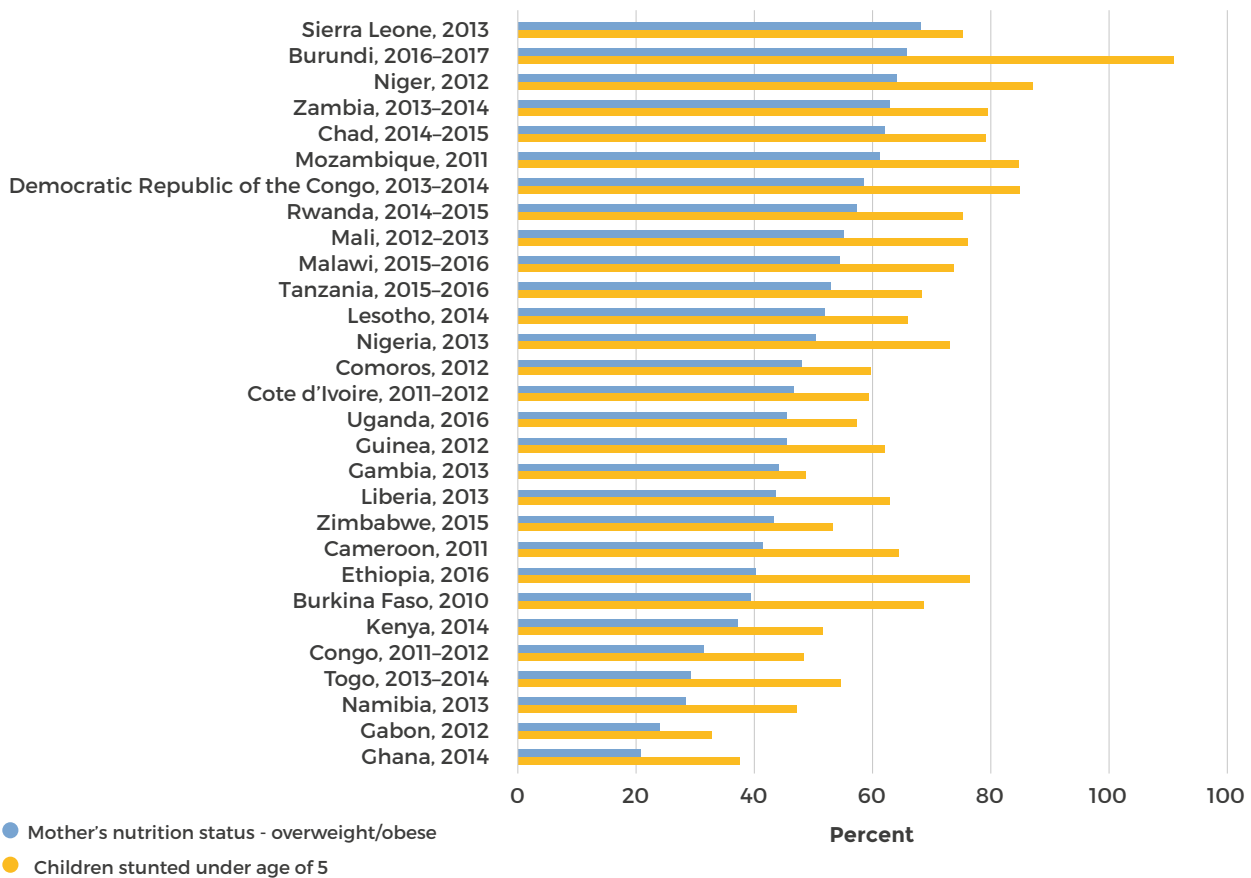
face threats of hunger and famines—increasing overweight and obesity rates among children are linked to cheap imports of food and to urbanization.

Being overweight or obese is a factor in many NCDs, such as diabetes, cancer, and cardiovascular and respiratory disease. The financial costs of obesity are staggering as well: the global obesity epidemic is currently estimated to cost US\$ 2 trillion annually, or 3% of GDP. This makes strengthening the accountability of the food industry and transnational corporations, which serve as “vectors for the global spread of NCD risks”, all the more urgent.

The rising tide of non-communicable diseases

Why have NCDs risen so fast? While there is no easy answer, they have increased in tandem with the globalization of food processing, distribution and

Figure 9. Under one roof: the obesity-stunting conundrum



Source: Prepared by Marla Orenstein for the IAP, 2018. Based on latest data available for 29 sub-Saharan African countries from DHS surveys, 2010-2017.

marketing, and the trade of unhealthy products. In many developing countries, this has translated into a shift from fresh produce in open markets to supermarkets stocked with processed, unhealthy foods produced by large multinationals. Shifts in the locus of power for decision-making mirror this trend—away from national governments, local producers and farmers, to traders, retailers and international conglomerates.

These trends also exacerbate inequalities: fresh produce and healthy options become financially out-of-reach for low-income households; but inexpensive, non-nutritious, high-calorie foods are accessible almost everywhere. As with tobacco, producing unhealthy foods is hugely profitable for companies given the low production costs and other advantages offered by long-lasting, packaged goods. This creates perverse incentives for businesses to aggressively seek out new markets, especially in low- and middle-income countries, where consumption of unhealthy commodities is rising fastest and is projected to continue.

Policy-makers have adopted international agreements to tackle the fast rise of NCDs, namely the 2011 UN Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and its follow-up reviews, SDG Target 3.4, and the Montevideo Roadmap 2018-2030 on NCDs as a Sustainable Development Priority (which also calls for private sector accountability). However, limited progress has been made in implementing these agreements. In 2018, to accelerate the global response, the WHO launched the High-Level Commission on NCDs; it proposes solutions, building on recommended cost-effective “best buys”.

Aggressive marketing and tactics

The food industry landscape is riddled with power-shaping tactics, conflicts of interest and unethical practices—from aggressive marketing and outright bribery to more nuanced tactics that distort policy-making and scientific research, and derail regulatory efforts that could protect public health. Lobbying by corporations in trade negotiations compounds the global challenge of addressing malnutrition. Equipped with

sizable budgets, companies apply tactics learned from the worst offenders, such as the tobacco industry, driving consumer behaviour in ways that perpetuate harm.

Over the past decade in the United States, the food and beverage industry spent, on average, close to US\$ 30 million each year on lobbying; since 2009 it has spent US\$ 107 million to fight taxes on sodas and warning labels alone. Also in the United States, US\$ 2 billion per year was spent on marketing food and beverages to children between 2006 and 2009, targeting those as young as two years old. One major beverage company spent US\$ 4 billion worldwide in advertising in 2017. With some US\$ 350 billion per year in global sales of carbonated soft drinks, the beverage industry has a lot of incentive to derail regulatory efforts.

Marketing to children

The onslaught of aggressive marketing targeting children is a critical concern. Consumption of unhealthy foods and beverages shapes their eating preferences, beginning with added sugars in breast-milk substitutes. Children are more susceptible to marketing, lured by playful cartoons and similar promotional tactics that provide businesses with potentially life-long, loyal customers for their products.

Several industry-driven initiatives have arisen to address childhood obesity, improve nutrition and curb advertising of fast foods, as well as PPPs, such as the EPODE network. But while very welcome, these initiatives on their own are not enough to combat the large scale of the problem. Industry-led efforts are not always accompanied by independent validation to assess whether companies are staying true to their public pledges. Furthermore, some companies put the onus on individuals for their unhealthy consumption habits to deflect attention from their own responsibilities for public health.

In studies in the United States, the overwhelming majority of foods marketed to children were found to be of poor nutritional quality; three-quarters of the advertised foods comprised fast foods and sweets, in particular breakfast cereals and carbonated beverages. Advertising was also found to specifically target black and

Hispanic youth, who face higher risks of obesity and related diseases. In the UK, one study found that the food industry spent nearly 30 times more on advertising junk foods than the amount spent by the government to promote healthy eating. In China, a study on food industry advertising on television channels that are popular with children found that 25.5% of all advertisements were for food, of which 48.1% were for unhealthy foods.

In 2010, WHO Member States adopted recommendations on marketing foods and non-alcoholic beverages high in saturated fats, trans fats, sugars or salt to children and adolescents. Their implementation is limited, however, and meaningful monitoring and enforcement are lacking. In the absence of effective accountability systems, the standards on ending inappropriate promotion of foods to infants and young children, endorsed by the World Health Assembly in 2016, may meet with the same fate.

Overall, as with the International Code of Marketing of Breast-milk Substitutes, voluntary frameworks largely rely on industry self-regulation, which is too often driven by profit interests rather than by concern for protecting children's rights to nutrition and health. Fast food restaurants are especially notorious: in the United States, a study from 2013 found that only 3% of kids'-meal combinations met the industry's own nutritional standards. The WHO Commission on Childhood Obesity calls on states to actively engage the industry in transparent partnerships, with clear accountability mechanisms in place to align their activity with public health priorities and standards. Under legally binding international conventions and human rights standards, governments have an obligation to ensure that legislation and regulations curb marketing of unhealthy foods to children, including in schools.

International codes of practice to keep food safe

Food safety and packaging are well covered by existing laws and accountability regimes, notably the long-standing Codex Alimentarius initiated by the WHO and FAO in 1963. This collection of thousands of international standards for

international food trade ensures safety and quality. The Codex Commission proceedings, in which most countries in the world participate, actively engage industry representatives—who have a voice, but no vote.

While the Codex is not legally binding, it is very effective: incentives for compliance by both governments and the industry are built in. Codex standards are a leading reference point for settling World Trade Organization disputes—thus powerfully dissuading potential violators. Companies face very damaging reputational risks and plummeting sales of their products if scandals arising from loose compliance result in public health emergencies or massive product recalls. Such was a recent case in South Africa, where an outbreak of listeria (an infection that can be lethal, caused by contaminated food), prompted public outcry and a class-action lawsuit against a major food company that is pending court ruling. Because pregnant women are particularly vulnerable to listeria and can pass it on during gestation, some 40% of the fatalities were newborns.

The Codex holds up as a very positive accountability system—and a very rare one when it comes to the food industry. It has increased food safety globally by mediating and guiding public health and industry interests for improved outcomes. However, its scope is narrow and does not comprehensively address the harms of industry conduct.

Where to on food industry accountability?

The gaps in independent monitoring and accountability of the food and beverage industry contrast sharply with the auditing companies routinely undergo of their financial, environmental and social welfare performance. The challenge of balancing public health concerns with for-profit motives is becoming even more acute as the industry increasingly becomes involved in public-private partnerships to reduce obesity. Moreover, small and medium-sized food producers that share the commitment to improving nutrition do not always receive the technical assistance and support they need.

A combination of voluntary standards, strict regulatory measures and legislation (both in countries where corporations operate and where they are headquartered), and consumer demand for healthier products serve as key levers for shaping industry alignment with public health. Building constructive dialogue across stakeholders, including civil society, is also essential to overcome the polarization that has been fuelled by years of industry breaches of existing standards, such as those pertaining to tobacco and breast-milk substitutes.

Legislation and judicial enforcement are increasingly utilized by countries to govern the food industry in order to address rising obesity and NCDs among women, children and adolescents. In Brazil, for example, in response to the influence of food and beverage industry donations on regulatory efforts, the Supreme Court banned corporate contributions to parliamentarians during elections as unconstitutional.

Bold new measures are needed to govern food industry conduct. This can level the playing field, ensuring that all those in the industry doing good can do more, and that others can be brought in line with the protection of women's, children's and adolescents' health.

Fiscal policies, such as taxation of sugary foods and drinks, are effective, much in the same way increasing tobacco prices deters smoking; this is one reason why the WHO issued its recommendation of a 20% tax on sugary drinks in 2016. Soda taxes are increasingly being implemented in a range of countries, including among OECD members. Norway, for example, has taxed added sugar since 1922, and hiked the tax significantly in 2018. Mexico's 2014 tax on sweetened beverages reduced consumption by over 7% within two years.

Public rankings of food companies, as with pharmaceutical companies, incentivize improvements in policies and practices to support better nutrition. The Access to Nutrition Index, developed by a non-profit organization

based in the Netherlands together with industry and other stakeholders, ranks 25 leading global food and beverage manufacturers on their nutrition-related commitments. The 2018 report shows that, while some companies are making improvements—such as new policies, or commitments to address undernutrition—progress is too slow, particularly in providing affordable, healthy foods for people living in poverty. Fewer than a third of the products analysed were found to be healthy. All companies were in need of improving responsible marketing, especially aimed at children. A nutrition index dedicated to tracking performance of the leading companies involved in the production and marketing of breast-milk substitutes is also available.

Self-regulation and voluntary codes of practice have resulted in some achievements in some countries, particularly around reducing dietary salt, limiting marketing to children, and improving menu labelling, as well as the beverages made available in schools. Self-regulation has benefits: it conserves government resources, and is less adversarial and more flexible—and can be timelier—than government regulation. But self-regulation is meaningless when companies publicly commit to promoting nutrition, which enhances their reputation, but in effect do the opposite. And as noted elsewhere, lack of external validation and evaluations undermines the credibility of industry self-regulation.

Clear principles and international standards

The current global landscape of food industry accountability is fragmented and limited. States have an obligation to protect people's rights to health and adequate food under international human rights laws and treaties that have been ratified by most countries in the world. Bold new measures are needed to comprehensively govern food industry conduct and ensure that it aligns with public health. This can level the playing field, ensuring that all those in the industry doing good can do more, and that others can be brought in line with the protection of women's, children's and adolescents' health.



4

RECOMMENDATIONS

THE IAP RECOMMENDATIONS

1

Access to services and the right to health

To achieve universal access to services and protect the health and related rights of women, children and adolescents, governments should regulate private as well as public sector providers. Parliaments should strengthen legislation and ensure oversight for its enforcement. The UHC2030 partnership should drive political leadership at the highest level to address private sector transparency and accountability.

2

The pharmaceutical industry and equitable access to medicines

To ensure equitable, affordable access to quality essential medicines and related health products for all women, children and adolescents, governments and parliaments should strengthen policies and regulation governing the pharmaceutical industry.

3

The food industry, obesity and NCDs

To tackle rising obesity and NCDs among women, children and adolescents, governments and parliaments should regulate the food and beverage industry, and adopt a binding global convention. Ministries of education and health should educate students and the public at large about diet and exercise, and set standards in school-based programmes. Related commitments should be included in the next G20 Summit agenda.

4

The UN Global Compact and the EWEC partners

The UN Global Compact and the EWEC partners should strengthen their monitoring and accountability standards for engagement of the business sector, with an emphasis on women's, children's and adolescents' health. They should advocate for accountability of the for-profit sector to be put on the global agenda for achieving UHC and the SDGs, including at the 2019 High-Level Political Forum on Sustainable Development and the Health Summit. The UN H6 Partnership entities and the GFF should raise accountability standards in the country programmes they support.

5

Donors and business engagement in the SDGs

Development cooperation partners should ensure that transparency and accountability standards aligned with public health are applied throughout their engagement with the for-profit sector. They should invest in national regulatory and oversight capacities, and also regulate private sector actors headquartered in their countries.

1

Access to services and the right to health

RECOMMENDATION 1

To achieve universal access to services and protect the health and related rights of women, children and adolescents, governments should regulate private as well as public sector providers. Parliaments should strengthen legislation and ensure oversight for its enforcement. The UHC 2030 Partnership should drive political leadership at the highest level to address private sector transparency and accountability.

As licensed operators, private sector service providers must be subject to the same standards and regulations as public providers. Emphasis should be placed on ensuring that the health system as a whole offers equitable access to essential goods and services for women, children, adolescents and all those living in poverty and exclusion, including protection from catastrophic expenditures and impoverishment. Governments should establish clear standards of minimum financial coverage, mandated by legislation; compliance with these standards should be enforced through monitoring and oversight of public and private providers, including private health insurance companies. Due attention must be placed on addressing NCDs and mental health conditions, as well as on adolescents and people living with HIV and disabilities, among other marginalized communities.

To transform mindsets and overcome resistance and mutual distrust among ministry of health officials, private sector and civil society actors, governments should establish multi-stakeholder platforms for planning, implementation and monitoring. These can build bridges of mutual understanding for constructive accountability processes. Resource-poor countries will need support from the international community to overcome gaps in regulatory capacities.

1.1. Ministries of health should integrate for-profit providers into national health governance systems by developing private sector stewardship and accountability strategies.

KEY MEASURES

Require private sector providers and facilities to register and report to the ministry of health's management information systems; include them in system-wide performance monitoring and review processes; and harmonize quality of care standards across private facilities. The purpose is to ensure that all services and health education comply with national policies and clinical protocols. This extends to private providers of immunization coverage. Particular attention should be paid to monitoring compliance in delivery of evidence-based sexuality education and sexual and reproductive health services.

Ensure that both public and private health providers comply with international human rights obligations for the protection of patients' rights, and establish effective complaint and redress mechanisms. Governments, as well as private providers, should ensure that the public is made aware of patients' rights and the grievance mechanisms available. The Government of Mexico, for example, has established a call-in system (CALIDATEL) that receives complaints covering both public and private providers; an arbitration mechanism has also been set up to resolve disputes over quality and costs. Human rights violations, including those stemming from disrespect and abuse in maternity care, should be sanctioned.

Engage civil society—including women, youth and community groups—in monitoring compliance with quality standards and health coverage entitlements in both public and private facilities. Brazil, for example, established health councils at all levels to monitor both public and private services, with representation specified at half from civil society, one-quarter from providers, and another quarter from government. An enabling context of good governance is required to ensure the effectiveness of such participatory review mechanisms. Social accountability platforms for health professionals and civil society can help drive improvements (see Panel 6).

Extend private sector stewardship to multisectoral planning and monitoring systems addressing nutrition, NCDs, environmental health and other social determinants of health. This should cover both domestic and transnational business operations, and be undertaken through inter-ministerial collaboration.



PANEL 6. SOCIAL REGULATION OF THE PRIVATE SECTOR FOR PATIENTS' RIGHTS

SATHI is a civil society organization based in India that leads the Accountability of the Private Medical Sector Thematic Hub of COPASAH (Community of Practitioners on Accountability and Social Action in Health). This network was established in 2017 to protect patients' rights in developing countries, with a focus on South Asia.

In Maharashtra State, SATHI is spearheading social regulation through coalition-building among doctors, civil society activists and public health professionals who have exposed malpractice, campaigned for patients' rights and demanded effective regulation, grievance and redress mechanisms. A public hearing was convened, focusing on rights violations by public and private healthcare providers. The state government formulated a bill to regulate private clinical establishments, which includes a charter to protect patients' rights to information, access to their records, confidentiality, informed consent, non-discrimination and mandatory complaint mechanisms. Similarly, advocacy by the People's Health Movement has led to the inclusion of a charter of patients' rights in the national standards for clinical establishments, which applies to private hospitals.

Source: SATHI, India, based on submission to the IAP's 2018 Call for Evidence.

1.2. Parliaments should enact and strengthen legislation governing the parameters for private sector engagement in health, and ensure meaningful oversight and enforcement.

Under various international conventions and standards, “business respect for human rights is not a choice, it is a responsibility”. States and corporations have the responsibility to protect and respect human rights, and to remedy violations. Without remedy and independent review and oversight by the judiciary, parliaments, ombuds offices and other national human rights institutions, and auditor generals to uphold the rule of law, there can be no meaningful accountability (see Panel 7).

In addition to adopting legislation—governing both for-profit providers and multinational corporations in countries where they are headquartered—parliamentarians have a responsibility to actively defend and monitor budgetary appropriations for women’s, children’s and adolescents’ health; this includes providing the oversight mechanisms required. Strong, well-financed national human rights institutions would be positioned to effectively protect rights to health, covering both public and private sector actors.

Parliamentary committees should be tasked with reviewing legislation and adopting reforms to regulate the private sector’s role in health care delivery as well as business impacts on health. This includes setting standards for government monitoring, contracting and licensing of private sector health goods and services, including through PPPs, and for managing conflicts of interest.





PANEL 7. LEGISLATION AND OVERSIGHT FOR PUBLIC HEALTH AND WELL-BEING

Protecting patients' rights: Independent focal points to receive and investigate patients' grievances should form part of any meaningful accountability system. Canada, for example, has a well-resourced ombuds office in the Province of Ontario that has positioned patients' rights as a health system issue, beyond individual grievances. Finland's Act on the Status and Rights of Patients mandates all health care facilities, public and private, to have an ombuds officer. Similarly, New Zealand's Code of Health and Disability covers the private sector.

Setting standards for procurement of private sector services: Legislative measures should regulate the terms for partnering with the private sector and managing conflicts of interest. For example, in the USA PPPs are legally registered as non-profits if they are to benefit from tax exemptions; thus they have to comply with reporting and can face fines for political activities. In Georgia, the law on procurement standards, its accompanying public electronic system and the role of the State Procurement Agency have contributed to making the country one of the highest-ranked by the Open Budget Survey.

Addressing supply chains: The Duty of Vigilance Law in France (2017), considered a landmark in business and human rights circles, obliges multinational companies to establish mechanisms to prevent human rights violations and negative environmental impacts across their supply chains. The private sector can also take the initiative: Sanofi, a pharmaceutical company, has committed to establishing an alert system against child labour across its supply chain, as well as complaint and early warning systems for non-compliance with its policies, including on workers' and patients' rights. Such corporate initiatives should be incentivized, while ensuring external validation of implementation.

Regulating the regulators: Legislation should ensure that public sector regulators' conduct is free of undue influence from both policy-makers and corporate interests. India's Supreme Court passed an order in 2011 on managing conflicts of interest among parliamentarians and policy-makers. Romania's Criminal Code goes further, making public officials liable for violations of conflict of interest standards. It applies broadly to all public sector institutions and private sector actors with government-delegated functions, including doctors and pharmacists.

Mandating corporate giving: India's amendment of the Companies Act requires large national corporations and foreign multinationals operating in the country to donate at least 2% of the past three years' average net profits to development initiatives. Companies can choose from one of nine focus areas, including three especially relevant to the Global Strategy: improving maternal and child health; eradicating hunger, poverty and malnutrition; and promoting education. Two years after the adoption of the amendment in April 2014, companies' charitable donations increased from 34 billion rupees in 2013 to around 250 billion rupees in 2016. However, 52 of the country's largest 100 companies failed to spend the required 2% in 2015. Even so, while still in its early stages, the experiment represents an innovative practice.

KEY MEASURES

Mandate independent accreditation of private health providers and require independent audits of facilities and insurance companies to ensure compliance with quality of care standards and entitlements under UHC schemes. These measures should be applied as part of licensing, renewals, regular inspections and other regulatory mechanisms, and as a pre-condition for participation in health insurance schemes. Facilities and insurers should have transparent monitoring and reporting systems in place, and should make user-friendly information about service prices and entitlements publicly accessible. Regulation should extend to digital health technologies and data (for example, Internet sales of medicines and health products; provision of remote counselling and services; and to protect patient confidentiality).

Establish or extend patients' rights charters to explicitly cover for-profit private providers, and require private sector facilities and insurance companies to have effective complaint and redress mechanisms. Patients' rights charters and information on grievance and remedy procedures should be made publicly accessible and visible in health facilities, in user-friendly language. Independent oversight mechanisms should be designated to receive and investigate grievances (for example, ombuds offices and judicial, parliamentary, and professional associations with related mandates). Parliamentarians should convene public hearings on patients' rights in collaboration with national human rights institutions.

Strengthen the mandate, authority, independence and capacity of the judicial system to enforce national legislation and human rights standards with respect to the private sector. Courts play a critical role in ensuring compliance, by both national for-profit actors and multinational corporations in countries where they are headquartered. In Brazil, for instance, the Inter-American Court of Human Rights affirmed the state's constitutional duty to regulate private health actors in a case concerning a private psychiatric clinic. In Colombia, the Constitutional Court established jurisprudence on conscientious objection, ensuring women's rights to access abortion services in all public and private facilities.

Establish legal measures to incentivize business sector contributions aligned with public health priorities. This includes: creating a legal persona for social enterprises, if one does not yet exist, whereby the built-in incentives place health goals above, or at least on a par with profit motives; putting in place tax incentives for contributions to health; and mandating CSR financial contributions from large companies and multinational corporations.

1.3. The UHC2030 partnership should drive political leadership and action at the highest level to ensure comprehensive national policies and transnational collaboration to address private sector accountability. It should position women, children and adolescents—and accountability for their health and rights—at the forefront of the global UHC agenda, and of decision-makers' mindsets at all levels.

A comprehensive approach is warranted, including but going beyond the roles of ministries of health, to involve a range of sectors in holding industries to account for their impacts on nutrition, environmental and other social and economic determinants of health. This should be achieved through close collaboration with other mechanisms and partnerships, especially those focused on NCDs and nutrition. This proposal is timely in light of the partnership's formalization of private sector engagement, including through representation on its Steering Committee and the establishment of a private sector constituency.

2

The pharmaceutical industry and equitable access to medicines

RECOMMENDATION 2

To ensure equitable, affordable access to quality essential medicines and related health products for all women, children and adolescents, governments and parliaments should strengthen policies and regulation governing the pharmaceutical industry.

Many factors influence the fact that millions of people around the world lack access to essential vaccines, medicines and diagnostics. High costs—to people's pockets, national budgets and the pharmaceutical industry itself (for research and development)—are among them. The monopolies held by pharmaceutical companies keep out competitors and constrain governments' policy space to negotiate fair prices. This is compounded by global trade and investment rules that traditionally are focused on economic growth, rather than on outcomes for people's health and well-being; and by trade agreements that enhance patent protections beyond the TRIPS requirements, undermining governments' ability to protect public health and regulate prices.

Strengthening the accountability of the pharmaceutical industry to align it with public health should involve a mix of effective self-regulation in compliance with policies, laws and robust internal codes of conduct, alongside policies that offer incentives for companies to delink costs from the end-line prices of medicines. Governments also need to ensure that adequate policies and funding are available to support investments in research and development, create fair-pricing mechanisms, and improve protection from high out-of-pocket costs. The IAP lends its voice—from an equity and right-to-health perspective—to various expert findings and proposals, including from the WHO, civil society, and the UN Secretary-General's High-Level Panel on Access to Medicines.

2.1. Ministries of health and public regulatory and procurement agencies should strengthen the policies and regulations governing the pharmaceutical industry and other actors involved in delivering medicines, in collaboration with ministries of finance and trade, among others.

KEY MEASURES

Undertake national assessments and reviews of progress in ensuring access to essential medicines for women, children and adolescents through inter-ministerial collaboration and with the participation of civil society. This includes reviewing the implementation and impacts of related policies, legislation and regulations on out-of-pocket costs and fair pricing. Pharmaceutical companies should annually report on their efforts to facilitate equitable, affordable access to essential medicines. They should ensure public transparency regarding their policies and their implementation (including pricing), as well as their lines of accountability.

Set standards and minimal requirements to regulate pharmacies and drug retail outlets on quality and safety, as well as on pricing of medicines, including sharing savings from manufacturers' discounts with consumers to reduce out-of-pocket expenditures. This should extend to pharmacy benefit managers. For essential vaccines and medicines, fee-waiver and subsidy programmes for women, children, adolescents and other vulnerable population groups should be established.

Ensure adherence to standards and transparency in procurement processes, and set clear contractual stipulations when negotiating PPPs with pharmaceutical companies, including on monitoring and reporting, and with an emphasis on the negotiation of fair prices.

Make full use of TRIPS flexibilities in trade and investment negotiations, refusing provisions that restrict governments' ability to protect public health. This should be buttressed by legislation that fully integrates TRIPS flexibilities, including compulsory licensing. Health and human rights impact assessments should be undertaken to inform decision-making, and these should be made publicly available.

2.2. Parliamentarians should strengthen legislation and oversight to ensure that public and private actors involved in the provision of essential medicines are aligned with rights-to-health and fair-pricing principles.

In considering legislation specific to any industry, existing corporate legislation, as well as any laws that cut across the business sector relating to financial disclosure, investment, trade, competition and others, may warrant revision from a public health perspective and to ensure coherence with new reforms undertaken.

KEY MEASURES

Require transparency on costs across the research and development, production, distribution and marketing of medicines and treatments; mandate reporting and disclosure by pharmaceutical companies to regulatory and procurement bodies, including prior to granting licenses, contracts or marketing authorization. This includes requiring companies to justify setting high prices for medicines (such as legislation adopted in Vermont, USA). Regulations on market authorization should also be strengthened, including prohibiting unethical marketing practices by pharmaceutical companies and imposing sanctions, such as the suspension of licenses.

Ensure strict standards and enforce patent legislation from a public health needs perspective to avoid companies seeking to unduly extend monopolies (such as the regulations adopted in Argentina and India). Patents should only be awarded for innovations in the production of priority medicines (noting that an estimated 70% of medicines currently available are non-essential or duplicative). Mechanisms should be put in place to ensure that ministries of health weigh in on decision-making by patent offices; and for civil society and other third parties to present grounds for opposing patent applications (such as the legislation adopted in India).

Require pharmaceutical companies to make clinical trial data publicly accessible in order to ensure the best possible outcomes for people's health and to enable health providers to access the latest findings on the safety, effectiveness and side effects of treatments they prescribe. The European Medicines Agency, for example, adopted a policy in 2014 to this end.

Leverage financial and other incentives for pharmaceutical companies to invest in research and development aligned with public health priorities. For example, the priority voucher review programme in the USA fast-tracks regulatory review for treatment of neglected diseases (e.g. tuberculosis, rare pediatric conditions), an approach that could be adapted to essential medicines for women, children and adolescents, taking into account the lessons learned.

Set standards of conduct for managing conflicts of interest. Prevent lobbying by pharmaceutical companies against fair pricing regulations, as well as their undue influence on both public officials and for-profit service providers. Require full disclosure of financial expenses and other contributions for political lobbying and to research centres, patient advocacy groups and health professionals, as well as of public funds or tax breaks received by companies.

Standardize the prices of medicines, including by establishing price controls and caps for out-of-pocket expenses; ensure public awareness of price ceilings and of reimbursements for out-of-pocket costs. For example, European Union countries reduced prices for consumers by capping prices for generic medicines and setting standards for reimbursements. Similarly, in 2003 Norway set caps on retail prices for a selection of drugs that were subject to generic competition, resulting in lower prices for consumers. This should be done for essential medicines for women, children and adolescents.



3

The food industry, obesity and NCDs

RECOMMENDATION 3

To tackle rising obesity and NCDs among women, children and adolescents, governments and parliaments should regulate the food and beverage industry, and adopt a binding global convention. Ministries of education and health should educate students and the public at large about diet and exercise, and set standards in school-based programmes. Related commitments should be included in the next G20 Summit agenda.

While we acknowledge the commitments of various companies aligning with public health, the food and beverage industry must be held to account for its role in contributing to obesity and NCDs. So too must UN Member States that have fallen short of fulfilling their international human rights obligations and commitments under the 2011 Political Declaration and the 2014 Outcome Document of the General Assembly. This slow response has occurred despite repeated alerts over the years from health experts regarding the once-looming burden of obesity and NCDs, which has now become a full-fledged global health crisis, projected to increase even further and undermining progress on the SDGs.

The IAP builds on the findings and recommendations of the High-Level Panel on Food Security and Nutrition (2017) and the Commission on Ending Childhood Obesity (2016), as well as various international agreements and guidelines adopted by the World Health Assembly. We welcome the recommendations of the WHO Independent High-Level Commission on Noncommunicable Diseases and its call for governments to increase regulation (2018). Yet our recommendations go some steps further.

3.1. UN Member States should develop a binding global convention to promote healthy diets and restrict marketing of unhealthy commodities by the food and beverage industry, with particular attention to women, children and adolescents.

The IAP is not convinced that a voluntary international code of conduct aimed at restricting the marketing of unhealthy products aimed at children, as proposed by the High-Level Commission on NCDs, will significantly shift the accountability scenario beyond business as usual—especially given the poor compliance with already existing standards. Instead, we call for a binding convention, as proposed in 2014 by the World Obesity Federation and Consumers international and endorsed by the UN Special Rapporteur on the right to food.

KEY MEASURES

UN Member States should undertake consultations to design and commit to a comprehensive international binding convention, with the support of the WHO, other UN agencies, civil society, and parliamentarians. The convention, to be negotiated after broad public consultation, should:

- **Establish minimum legal requirements** to guide governments in their development of national food and beverage regulations.
- **Bring together existing international standards**—including the International Code of Marketing of Breast-milk Substitutes—as well as guidelines on marketing to children and adolescents. It should be modelled after the Framework Convention on Tobacco Control (FCTC), which was adopted and ratified by governments in record time. As with the FCTC drafting process, rent-seeking interests should be excluded from the negotiations.
- **Require reporting by member states, and invite independent reports** by the UN, civil society and academic coalitions, as well as by the food and beverage industry, making these publicly accessible.
- **Establish an independent global review** mechanism in addition to participatory reviews at the country level.

Lessons should be drawn from the OECD Guidelines for Multinational Enterprises, a leading government-recommended framework, and its mechanisms for compliance. These include OECD Watch, a network of NGOs that advises civil society on grievance mechanisms and issues independent reports, including on access to remedy for victims of corporate misconduct. This model should be strengthened by ensuring attention to health in the application and monitoring of the guidelines, and by fortifying extraterritorial controls over transnational corporations, as well as over the actions of donor countries engaging with the private sector through multilateral institutions.

3.2. National governments, parliaments and the judiciary should enact and enforce regulations and legislation to curb the food and beverage industry's production and marketing of unhealthy products, with particular attention to women, children and adolescents.

In considering the legislative reforms proposed below, parliaments should consult with ministries of health, other government agencies, health professionals, civil society, women's and youth groups, and food industry representatives aligned with values of corporate citizenship.

KEY MEASURES

Ban televised marketing of unhealthy food and beverages during hours when children are prime audience viewers and restrict promotional tactics targeting them through social media.

Tax unhealthy foods and beverages—including sugary drinks.

Require reductions in unhealthy contents of foods and beverages (such as trans fats, added sugar, salt, empty calories).

Mandate clear labelling for informed decision-making by consumers, which should be easily understood by children (for example, use of traffic lights).

Require nutritious menus in school meal programs and design these in consultation with children to ensure that healthy options appeal to them.

Make large restaurant chains display calorie counts and nutritional information about their products, especially those providing non-nutritious fast food.



PANEL 8. LEGISLATION AND THE POWER OF THE COURTS IN CURBING AGGRESSIVE INDUSTRY TACTICS

Chile: With the highest levels of child obesity in Latin America, and 60% of its population overweight or suffering from related health problems, Chile passed a groundbreaking law in effect since 2016. The law requires clear signage—resembling stop and warning signs—to be included on the front of packaged foods that are high in sugar, calories, sodium or saturated fat. Among the rules it sets for the industry: these products may not be advertised to children under 14, nor appear in media where at least 20% of the target audience is under 14; and they may not be sold or promoted in schools.

Brazil: A law in place since 1990 prohibits abusive advertising aimed at children. Nonetheless, because the law was not specific in defining what this meant, companies continued their promotional activities. A new law in 2014 changed that, calling on businesses to reform their conduct or face sanctions, including suspension of their operating licenses. For the first time, in 2016 the Supreme Court found a food company guilty of illegally marketing to children.

Colombia: When a government agency censored an NGO for producing a public-health TV announcement on the risks of sugary drinks, the Constitutional Court ordered the agency to desist from squelching science-based information. The complaint against the NGO had been lodged by a company opposed to a soda-tax bill that was under consideration in Congress. The court's ruling affirmed freedom of speech on all matters of public health, setting an important precedent and signalling expectations for business conduct aligned with rights to health.

Harmonize national legislation with the International Code of Marketing of Breast-milk Substitutes, in line with its comprehensive approach, and establish sanctions for violations.

Panel 8 showcases groundbreaking legislation in Latin American countries, as well as the role of the courts in its enforcement. The IAP appeals to parliamentary networks at the global and regional levels, in particular the Inter-Parliamentary Union, to facilitate advocacy, knowledge-sharing and capacity-building for legislators in this regard.

3.3. Ministries of education and health should educate and empower students and the public at large to avoid unhealthy products and improve diet and exercise. Ministries of education should set standards in school-based programmes.

Governments should complement legislative measures by leveraging a range of underutilized policy options, including programmes to raise public awareness and significant scaling-up of educational programmes for prevention of obesity and NCDs.

KEY MEASURES

Ensure the good nutritional content of students' meals and implement health education programmes that equip pupils, as well as their parents and caretakers, with information and critical thinking skills for decision-making, including around marketing. India's award-winning HealthSetGo, a private sector programme promoting health and nutrition in schools, including obesity prevention, offers an example for other countries.

Develop innovative policies and fiscal incentives—in collaboration with ministries of finance—to encourage the food and beverage industry to produce healthier foods and snacks, and to expand access to nutritious food, for example, by reducing the costs of these foods and making healthy outlets available in low-income communities.

3.4. Governments and companies should ensure that socially responsible commitments to women's, children's and adolescents' health are included in the agenda of the next G20 Summit, with a focus on tackling obesity and NCDs.

KEY MEASURES

Ensure clear targets and independent monitoring mechanisms to track implementation of the commitments.

Establish minimum do-no-harm standards on public health for companies joining the B20 (representing the G20 business community); these should extend across the borders of corporate operations, including through extraterritorial enforcement mechanisms.

4

The UN Global Compact and the EWEC partners

RECOMMENDATION 4

The UN Global Compact and the EWEC partners should strengthen their monitoring and accountability standards for engagement with the business sector, with an emphasis on women’s, children’s and adolescents’ health. They should advocate for accountability of the for-profit sector to be put on the global agenda for achieving UHC and the SDGs, including at the 2019 High-Level Political Forum on Sustainable Development and the Health Summit. The UN H6 Partnership entities and the GFF should raise accountability standards in the country programmes they support.

In the context of the UN Secretary-General’s proposals for system-wide reform of partnerships with the private sector, our recommendations reflect standards that are common practice among development and UN agencies—but currently are not necessarily expected of, nor applied, when it comes to the for-profit sector.

4.1. The UN Global Compact Board and Office should strengthen accountability standards to protect the right to health among women, children and adolescents.

Building on the UN Global Compact’s efforts to improve companies’ engagement in the SDGs, including more recently in the area of health, accountability standards must be strengthened. This, in turn, can reverberate across the wider UN system’s practices and those of corporations becoming increasingly involved. Strengthening business sector accountability is also strategic for UN Member States: UN Country Teams are poised to play an important role in facilitating private sector engagement at the national level, including through the UN Global Compact’s Local Networks.

KEY MEASURES

Bolster due diligence standards and practices for accepting and retaining members to ensure that the health impacts of their operations are addressed, and to better align these with the SDGs. This should include scrutiny of company records regarding, for example, the provision of healthy working conditions and insurance coverage for employees, as well as the impacts of their operations on community health. The review should also comprise positive criteria, such as whether health services are provided for employees, and if their quality is monitored.

Encourage corporations wishing to join to undergo health impact assessments, and to do so periodically thereafter. This should include improvements in the transparency of reporting, as well as the disclosure of potential causes or actual incidents of harm, and how these are being remedied.

Prompt companies to coordinate and collaborate with national and local authorities to ensure alignment of their CSR initiatives and operations with the country's public health priorities and standards.

Proactively encourage corporate members to undertake external evaluations of their health-focused initiatives, in particular those addressing women's, children's and adolescents' well-being, and to make the results publicly available.

Commission an external thematic evaluation of corporate policies, initiatives and impacts on health in a cross-section of companies. This would serve as a baseline for developing more robust guidance and standards to support companies' learning and improvements.

Open a space on the UN Global Compact website for independent parties, including civil society and academia, to publicly post evidence and assessments of industry performance, a practice that already exists for some inter-governmental UN processes.

In relation to UN system-wide reforms, the UN Global Compact's Board and its Chair (the UN Secretary-General), as well as the UN H6 Partnership Heads of Agency, should:

- **Ensure that the issue of business engagement and accountability for women's, children's and adolescents' health and rights is made an explicit agenda item and work stream of the UN system's inter-agency platforms addressing private sector engagement, at both the principals and working levels.**
- **Involve civil society in processes to determine due diligence and accountability standards for qualifying corporations as partner-ready for engagement with the UN**, ensuring inclusion of organizations specialized in women's, children's and adolescents' health and gender equality. For purposes of transparency, criteria for participation should include public disclosure of funds received from the business sector by civil society organizations.

4.2. The EWEC global partners should ensure systematic application of robust monitoring and accountability standards with relation to engagement of the business sector, including to the support they provide governments for implementing the Global Strategy.

The EWEC global community is well-positioned to play a leadership role in innovating and modelling private sector accountability for women's, children's and adolescents' health at the global as well as the country level, where many of the partners have a presence. The strategic positioning of the PMNCH Private Sector Constituency and the for-profit EWEC commitment-makers as EWEC champions should be leveraged to this end, including through cross-constituency collaboration and support from the UN H6 and other EWEC partners. Global partners can also advocate for civil society organizations to systematically incorporate explicit attention to the for-profit sector into their work, and can support them in doing so.

The EOSG should enable the PMNCH Secretariat to assume full responsibility for coordinating and managing improvements across the full cycle of EWEC commitments, including those of governments and corporations. Building on PMNCH efforts to strengthen standards, improvements in the management and processing of all EWEC commitments are required. While gaps in accountability standards are not unique to the commitments of business partners, extra care is warranted in engaging this sector to preserve the integrity and credibility of the EWEC initiative. The capacities of the PMNCH Secretariat will need to be strengthened to adequately manage private sector commitments.



The PMNCH should build in accountability standards from the start of private sector EWEC commitments.

This should be achieved by facilitating the establishment of publicly accessible exclusionary criteria, as well as a due diligence process, governing EWEC private sector commitments; and by revisiting the submission and reporting questionnaires to strengthen accountability standards and requirements (for example, on data disaggregation, monitoring plans, external impact evaluations and civil society participation).

The EWEC High-Level Steering Group should help put accountability of the for-profit sector on the global agenda for achieving UHC and the SDGs, including at the 2019 High-Level Political Forum on Sustainable Development and the Health Summit during next year's UN General Assembly. The IAP appeals to UN Member States, the UN Secretary-General (also in his function as Co-Chair of the EWEC High-Level Steering Group) and the Government of Japan—as the G20 Presidency in 2019 and a champion of UHC—to support achieving this. This should form part of the Steering Group's broader strategy, which includes placing private sector accountability for women's, children's and adolescents' health on its own agenda, in fulfilment of its role in stewarding implementation of the Global Strategy.

The UN H6 Partnership entities and the GFF should apply due diligence and accountability standards to the technical advice and country programmes they support involving the private sector.

KEY MEASURES

The UN H6 Partnership entities and the GFF should assist governments in establishing meaningful mechanisms for planning private sector engagement and tracking performance, such as complaint and grievance mechanisms, and community involvement in monitoring. This should include strengthening implementation of the GFF Civil Society Strategy, in collaboration with the PMNCH, to ensure its even application across country settings.

The UN H6 Partnership should facilitate the development of technical guidance on monitoring and accountability standards for business engagement in women's, children's and adolescents' health, in support of companies as well as UN Country Teams and Global Compact Local Networks, among other national partners. The process should fully involve academics and civil society, as well as consultation with companies.

The WHO and the World Bank should ensure that global monitoring of UHC captures for-profit providers.

The WHO should facilitate and strengthen the provision of legal advisory services to support governments in regulating the pharmaceutical and food industries.

5

Donors and business engagement in the SDGs

RECOMMENDATION 5

Development cooperation partners should ensure that transparency and accountability standards aligned with public health are applied throughout their engagement with the for-profit sector. They should invest in national regulatory and oversight capacities, and also regulate private sector actors headquartered in their countries.

Development cooperation partners—including bilateral donors, the development banks, global health foundations such as the Bill & Melinda Gates Foundation, and the UN system—should ensure that their engagements with the for-profit sector are guided by the same standards that they regularly apply to recipients of their technical and financial support.

Expanded business engagement is being pursued as a means to achieve increased development financing, but without adequate strategies and requirements in place. Impact assessments of PPPs—with regard to human rights, inequality and social development issues—are rarely undertaken. Bilateral donors should also fulfil their extraterritorial obligations for regulating the transboundary health impacts of corporate operations, in line with the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, among other standards.

5.1. Bilateral donors should systematically apply accountability standards to private sector engagement in order to protect the right to health, especially for women, children, adolescents and left-behind groups. This includes all vehicles for mobilizing private sector investments in health—including blended finance and PPPs.

In line with the Paris Declaration and the aid effectiveness principles, bilateral donors have a responsibility to ensure that private sector engagement aligns with public health priorities. Our recommendations below apply to all ODA-supported initiatives involving the business sector. They draw on the OECD Development Assistance Committee's (OECD-DAC) thematic review of private sector engagement and on their donor peer reviews, among other sources.

KEY MEASURES

*Ensure transparency on **additionality** and include it as part of the rationale and evidence for decision-making on partnering; communicate the information to external stakeholders.*

*Undertake **impact assessments on health, human rights and equity** before concluding a partnering agreement, and in assessments of the results of implementation.*

Ensure meaningful civil society and community involvement in decision-making and reviews of implementation, to inform decisions by governments and donors, including on whether poor communities are benefitting.

Make independent evaluations obligatory and their reports publicly accessible. Set clear reporting requirements, including on equity and service-coverage issues (for example, out-of-pocket costs), which are often masked in PPP reporting. At the global level, reports on and evaluations of the business engagements of UN agencies should be included in reporting to their Executive Boards.

Encourage governments to make planned PPPs open to public consultation, especially those impacting on health; involve women's groups, other civil society organizations and health professionals in designing and monitoring them.

5.2. The Global Partnership for Effective Development Cooperation (GPEDC) should ensure that health—with particular attention to women, children and adolescents—receives adequate attention in the guidance (currently under development and expected in 2019) for bilateral donors and development banks regarding the effective use of modalities of private sector engagement, including PPPs.

Such guidelines are often centred on environmental, infrastructure and financing issues, with limited attention to health, gender equality and human rights issues. Bilateral donors and the OECD-DAC, however, need not await adoption of the GPEDC recommendations to act on the suggestions above.



5.3. Development cooperation partners should invest in national regulatory and participatory accountability systems to hold private sector partners to account for women's, children's and adolescents' health.

Many low- and middle-income countries will require support to overcome weak institutional monitoring and regulatory capacities. Attention should also be paid to providing technical assistance to small private sector health providers and local food industry enterprises that are committed to public health priorities, but face challenges in aligning their engagement with them.

KEY MEASURES AND INVESTMENT AREAS

Update national health information management systems to capture for-profit private sector providers, as an essential step in monitoring and regulation.

Strengthen public sector capacity to regulate the private sector, purchase services, negotiate contracts and manage PPPs, building-in clear standards, roles and responsibilities, as well as public disclosure agreements (including on taxes).

Build government capacity to negotiate international trade agreements and regulate the operations of multinationals to protect public health (for example, to navigate TRIPs provisions and secure access to affordable medicines, or in relation to the food industry).

Develop standards and measurement frameworks to track results from a public health and human rights-based perspective, with clear plans for addressing these dimensions throughout planning, monitoring and evaluation.

Develop guidance for governments and parliamentarians on model legislation for effective regulation of private sector engagement in health, with a focus on women's, children's and adolescents' health.

Strengthen independent accountability and oversight mechanisms, such as the judiciary and legal systems, as well as civil society organizations that carry out social accountability functions.



5

LOOKING AHEAD

The IAP centres its approach to accountability on the promise of *transformation* to achieve the world we want. Rather than looking at accountability strictly as a measure of penalization, we prefer to think of it as a fundamental means of getting us there. By taking the right steps in a spirit of collaboration—and remedying missteps—accountability can help ensure the best results for everyone—for the public, as well as the private good.

The IAP's mandate targets universal aspects of well-being that are in urgent need of increased attention: women's, children's and adolescents' rights to health. This year, we zeroed in on the role of the private sector in helping to fulfil these rights. While many in the private sector already make vital contributions to public health, there is still a lot of ground to cover in shaping and leveraging its full potential. Accountability is—in this sense—more than an obligation; it serves to incentivize and evidence the extent to which for-profit enterprises are producing benefits aligned with social, environmental and good governance principles, while calling attention to private sector activity that is actually perpetuating harm.

Our report next year will take these issues a step further, focusing on the theme of health financing—strategically set in the context of the 2019 high-level review of the 2030 Agenda for

Sustainable Development and the financing for development agenda. These debates are crucial to any discussion of private sector accountability.

Let us be clear: the private sector is not the only target of debates on accountability. All parties must be held accountable for upholding health standards for women, children and adolescents. We will only reach our goals by building up ecosystems of accountability for all sectors—public and private. We must do so based on constructive, open dialogue and cooperation, spearheaded by governments and with solid support from the EWEC partners, parliamentarians, civil society, development cooperation actors—and the private sector.

We have often heard our private sector partners say, in the context of development discussions: “Why do you always talk about us—you need to talk *with us*.” Now is the time.

It is not a question of private or public, but of the role each plays. We salute the private sector champions who are investing in demonstrating that doing good and doing well can, indeed, be compatible. Without them—and without growth in their ranks—we will never reach our goal of creating the healthiest, fairest world possible for all, in particular for women, children and adolescents.

2018 Report

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for Women's, Children's and Adolescents' Health



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