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

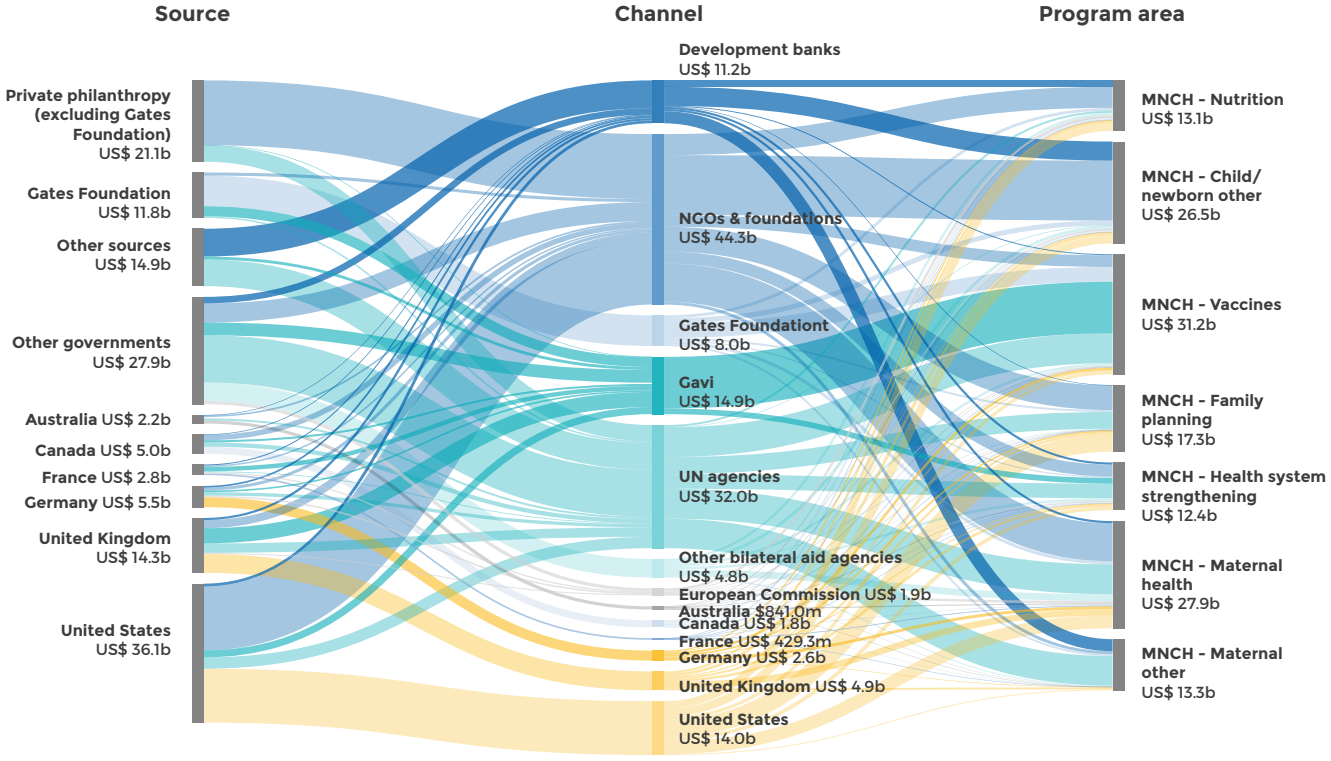
US$ 29.3 billion in 2015 to US$ 35.1 billion; these pledges were primarily under the Global Strategy's *survive* and *thrive* pillars. Since 2015, high-income countries have pledged US$ 14.9 billion (42% of all financial commitments); they are followed closely by low- and middle-income countries, with 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.

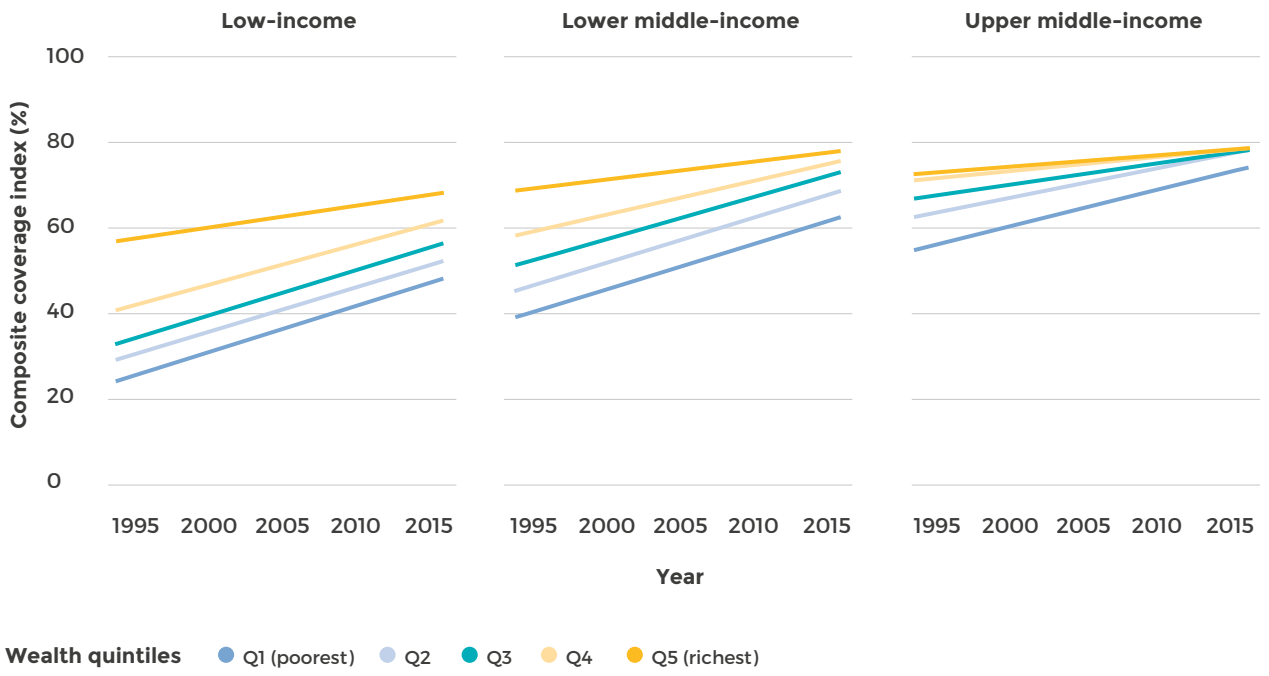
Important efforts are underway by the Financial Tracking Working Group, convened by the PMNCH and Countdown to 2030, to improve the methodology for tracking ODA and domestic financing for women's, children's and adolescents' health. This will help to overcome the discrepancies in current approaches and 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.

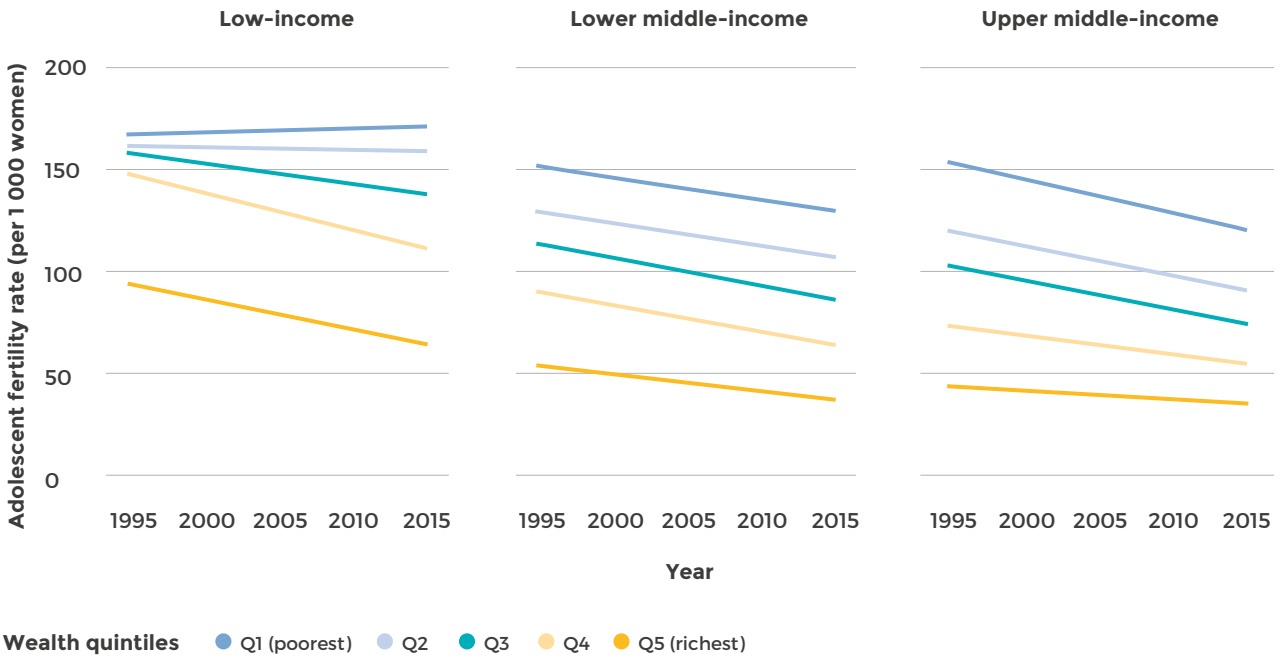
Impressive gains have been made in reducing HIV: new infections among children aged 0–14 dropped by 5% globally between 2015 and 2016, often thanks to their mother's access to antiretroviral medicines during pregnancy and breastfeeding—though without further decreases in 2017. Nonetheless, in 2017 alone, 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.

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.

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

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 Embryyo 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 on line. 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.