



EVERY WOMAN
EVERY CHILD
FOR HEALTHY AND EMPOWERED WOMEN,
CHILDREN AND ADOLESCENTS

SURVIVE, THRIVE, TRANSFORM

Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)

2018 monitoring report:
current status and strategic priorities



Special theme:
early childhood development



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ACRONYMS AND ABBREVIATIONS

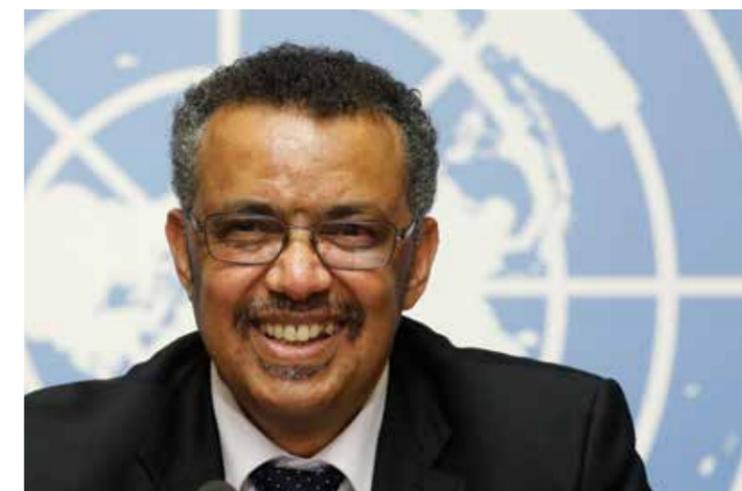
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|---------|--|----------|--|
| AA-HAI | Accelerated Action for the Health of Adolescents | IPA | International Pediatric Association |
| AIDS | Acquired Immune Deficiency Syndrome | LMICs | Low- and Middle-Income Countries |
| ANI | Accelerating Nutrition Improvements | MICS | Multi Indicator Cluster Survey |
| CCD | Care for Child Development | MNCH | Maternal, Newborn and Child Health |
| CRVS | Civil Registration and Vital Statistics | MoNITOR | Mother and Newborn Information for Tracking Outcomes and Results |
| DALYs | Disability-Adjusted Life Years | NCDs | Noncommunicable Diseases |
| DHS | Demographic and Health Survey | PMNCH | Partnership for Maternal, Newborn & Child Health |
| DTP3 | Diphtheria-Tetanus-Pertussis Vaccine | RMNCAH | Reproductive, Maternal, Newborn, Child and Adolescent Health |
| ECD | Early Childhood Development | RMNCH | Reproductive, Maternal, Newborn and Child Health |
| ECDI | Early Childhood Development Index | SDGs | Sustainable Development Goals |
| EQUIST | Equitable Impact Sensitive Tool | STIs | Sexually Transmitted Infections |
| EWEC | Every Woman Every Child | SRHR | Sexual and Reproductive Health and Rights |
| FGM | Female Genital Mutilation | TB | Tuberculosis |
| FIGO | International Federation of Gynecology and Obstetrics | UHC | Universal Health Coverage |
| GFF | Global Financing Facility in support of Every Woman Every Child | UN | United Nations |
| GLAAS | Global Analysis and Assessment of Sanitation and Drinking-Water | UNAIDS | Joint United Nations Programme on HIV/AIDS |
| HDC | Health Data Collaborative | UNESCO | United Nations Organization for Education, Science and Culture |
| HEAT | Health Equity Assessment Toolkit | UNFPA | United Nations Population Fund |
| HIS | Health Information System | UNGA | United Nations General Assembly |
| HIV | Human Immunodeficiency Virus | UNICEF | United Nations Children's Fund |
| HLSG | High-Level Steering Group | UN Women | United Nations Entity for Gender Equality and the Empowerment of Women |
| HPV | Human Papillomavirus | USAID | United States Agency for International Development |
| IAP | Independent Accountability Panel | WASH | Water, Sanitation and Hygiene |
| ICM | International Confederation of Midwives | WGI | Worldwide Governance Indicators |
| ICN | International Council of Nurses | WHO | World Health Organization |
| INFORM | Global Risk Index | | |
| INSPIRE | Implementation and enforcement of laws; Norms and values; Safe environments; Parent and caregiver support; Income and economic strengthening; Response and support services; and Education and life skills | | |

FOREWORD

At the heart of the Every Woman Every Child Global Strategy (EWEC Global Strategy) for Women's, Children's and Adolescents' Health is a simple and profound idea: if every person could unlock their potential for health and well-being at every stage of life, they could realize their rights and contribute to the transformative change envisioned in the Sustainable Development Goals (SDGs). Enabling this transformative change is an immense task, and we all have a role to play with countries in the lead.

I am pleased on behalf of the H6 agencies to present the 2018 monitoring report of the EWEC Global Strategy. The report sets out the status of women's, children's and adolescents' health, and on health systems and social and environmental determinants. Regional dashboards on 16 key indicators highlight where progress is being made or lagging. There is progress overall, but not at the level required to achieve the 2030 goals. There are some areas where progress has stalled or is reversing, namely neonatal mortality, gender inequalities and health in humanitarian settings. The report also highlights new evidence with a special focus on early childhood development as a foundation for health and well-being across the life course. There are new estimates on the causes of death in children older than 5 years; most are preventable. Each section of the report highlights strategic priorities, interventions and approaches that could help countries address challenges and accelerate progress.

Integrating new evidence and evidence-based approaches into policies and programmes is important for continued progress. Universal health coverage is the key to ensuring



equitable access to quality services for sexual, reproductive, maternal, newborn, child and adolescent health. Adopting a life course approach to health, which is central to the EWEC Global Strategy, is a theme throughout the report. Collaboration across sectors is essential to address social and environmental determinants, achieve shared health and sustainable development goals and realize human rights.

It is encouraging to see the work being done through the global EWEC movement to support countries in achieving the objectives of the EWEC Global Strategy and the SDGs.

The findings of this report should serve as a renewed call to action and instil a sense of urgency for action and accountability at all levels. Only if every woman, child and adolescent survives, thrives and contributes to transformative change will we achieve the 2030 SDG vision for people, prosperity and the planet.

Tedros Adhanom Ghebreyesus
Director General
World Health Organization

10 KEY MESSAGES FROM THIS REPORT



This page summarizes 10 key messages based on EWEC Global Strategy monitoring data from 2017 and early 2018. Dashboards in Annex 2 signal where progress is being made or lagging.

CHALLENGES

Some things are not progressing or are getting worse

- 1. Neonatal mortality – limited progress.** Rates of neonatal mortality are not declining as quickly as mortality among children aged 1–59 months. This is a long-standing disparity. Multiple factors contribute to neonatal mortality.
- 2. Gender inequalities – progress is too slow and some gains are being lost.** Gender-based inequalities and violence persist worldwide. Progress is reversing in some areas, such as the number of women in leadership and the economic pay gap. Foster equitable gender norms and address violations of rights across society.
- 3. Humanitarian settings – many more people are now affected by crises.** The world is witnessing the highest levels of displacement on record.¹ Strengthen capacity to reduce vulnerabilities, build resilience and anticipate and respond to health needs in humanitarian settings.

KNOWLEDGE

New evidence and interventions can accelerate progress

- 4. Older children – new evidence about their health and causes of death.** The causes of death of children older than 5 years are mostly preventable.² New global estimates of causes of death among older children indicate areas for action.

- 5. Early childhood development and nurturing care – a foundational role.**

Investments from pregnancy through 3 years of age are the foundation of health and well-being throughout life.³ The new Nurturing Care Framework will help countries to strengthen ECD programmes.

- 6. The life course approach to health – optimizing health throughout life.**

The life course approach helps individuals to optimize their health, well-being and functional ability at and across every stage of life.⁴ It is a connecting theme throughout this report.

- 7. Continual learning and flexibility – innovation promotes change.**

Take note of, and apply, new evidence of good practice in women's, children's and adolescents' health.

ACTION

Build on what works and act in partnership

- 8. UHC and health systems strengthening – essential for progress.**

At least half of the world's population lacks access to essential health services. According to 2017 estimates, investments in UHC and the other SDG targets could prevent 97 million premature deaths globally by 2030.⁵

- 9. Multisectoral action – associated with greater impact.**

Multisectoral action is evident throughout this report as an enabling factor for health. Investments are required to understand how to apply multisectoral approaches effectively in different settings.

- 10. Collaborative effort – everyone has a critical role to play.**

The objectives of the EWEC Global Strategy can only be achieved through sustained collective action and mutual accountability at all levels.

EXECUTIVE SUMMARY



The 2018 monitoring report for the EWEC Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) is based on data from 2017 and early 2018 for the 60 indicators in the EWEC Global Strategy monitoring framework. Dashboards in Annex 2 signal where progress is being made or lagging.

EARLY CHILDHOOD DEVELOPMENT

Early childhood development is the special theme of the 2018 EWEC Global Strategy monitoring report.^{6,7}

Scientific evidence shows that children who lack nurturing care as part of early childhood development may be less healthy, grow poorly, learn less and complete fewer grades at school. They may have difficulties relating confidently to others and earn less as adults.

Recent research confirms that responsive care and opportunities for early learning are essential components for early childhood development. The mental health and well-being of carers are also critical factors.

Strategic priorities

- Implement the new Nurturing Care Framework;
- Observe guidelines on early childhood development;
- Develop early childhood development workforce and capacity, adding newer elements such as support for responsive care, early learning and caregiver health;
- Put in place comprehensive evidence-based policies, information and services;
- Develop and use population-based indicators and a measurement framework for early childhood development;
- Invest in research into the long-term effects of nurturing care interventions.

WOMEN'S HEALTH

Global maternal mortality fell by almost 44% from 1990 to 2015, but about 830 women still die daily in childbirth or as a result of pregnancy or postpartum causes. Evidence points to a range of other health challenges, including: lack of access to modern contraceptive methods; unsafe abortions; HIV/AIDS; cervical cancer; female genital mutilation; stillbirths; and gender-based violence.

Strategic priorities

- Improve women's health across the life course, delivering appropriate care, support and information to women and their families according to needs;
- Ensure a positive pregnancy experience and improve quality of care around childbirth, deploying WHO guidelines on antenatal and intrapartum care;
- Ensure universal access to sexual and reproductive health-care services;
- Address sexually transmitted infections by eliminating mother-to-child transmission of syphilis, controlling antimicrobial resistance of N.gonorrhoea, and researching new diagnostic tests and vaccines against STIs;
- End violence against women, deploying WHO clinical and policy guidelines and the companion manual for health system managers;
- Address causes of cervical cancer by supporting introduction of the HPV vaccine and HPV testing, and increasing access to treatment;
- Eliminate female genital mutilation, introducing and enforcing legislation, adopting a health systems approach to ending the medicalization of FGM and addressing social and cultural dimensions.

CHILDREN'S HEALTH

The relative lack of global progress on neonatal mortality remains a major challenge. The global under-5 mortality rate declined by 56% from 93 deaths per 1000 live births in 1990 to 41 in 2016. However, an estimated 5.6 million children (including newborns) died in 2016 before age 5. Globally, only 71% of under-5s in reporting countries had their births registered between 2010 and 2016.

Strategic priorities

- Deploy and scale up proven interventions to improve survival and health of newborns and children;
- Ensure quality care during pregnancy, childbirth and the postnatal period, deploying care packages known to have the greatest impact on ending preventable neonatal deaths, stillbirths and long-term disability;
- Strengthen sectors that enable improvements in newborn and child health, such as nutrition and WASH;
- Strengthen governance and invest in well-coordinated policies and services.

ADOLESCENTS' HEALTH

Global adolescent death rates have fallen by approximately 17% since 2000 but remain highest in LMICs in Africa. Main causes of death are very different between younger (10–14 years) and older adolescents (15–19 years) and between males and females. Early marriage and early childbirth are associated with a range of maternal and neonatal health complications.

Strategic priorities

- Implement the multisectoral Accelerated Action for the Health of Adolescents (AA-HA!) guidance;
- Engage adolescents as agents of change;

- Provide comprehensive sexual and reproductive health and rights information and counselling for adolescents;
- Prevent and treat anaemia and improve assessment across age groups;
- Target adolescents with HIV prevention and treatment programmes;
- Support girls' menstrual health needs, ensuring menstruation is seen as healthy and normal and providing education about menstruation;
- Prevent child marriage by introducing and enforcing relevant legislation, empowering adolescents, fostering equitable gender norms and promoting girls' education.

UHC, HEALTH SYSTEMS, MAJOR DISEASES AND HUMANITARIAN SETTINGS

At least half of the world's population still lacks access to essential health services, 800 million people spend more than 10% of their household budget on health care, and 65.6 million people around the world have been forced from home.

Strategic priorities

- Accelerate progress towards universal health coverage, ensuring UHC packages are locally designed to provide high-impact, cost-effective interventions, and include cross-sectoral approaches;
- Invest in health systems strengthening and the health workforce, for example through the education and training of midwives, nurses and other health professionals;
- Integrate a life course approach to health, optimizing health, well-being and functional ability throughout life;
- Strengthen capacity to reduce vulnerabilities and to anticipate and respond to emergencies, including humanitarian crises, based on emergency risk assessments.

MULTISECTORAL ACTION

In 2017, 88% of countries that supplied data reported serious problems with malnutrition. Disparities in wealth and education, and environmental challenges, are barriers to health. Multisectoral action benefits health and improves communities, infrastructure and the environment.

Strategic priorities

- Adopt multisectoral approaches, such as early childhood development programmes and nutrition interventions that also help children take advantage of education;
- Improve food systems, including production, distribution, marketing and use and efficient food waste disposal;
- Address environmental determinants of health through initiatives such as the BreatheLife Campaign, the Climate and Clean Air Coalition, and Global Analysis and Assessment of Sanitation and Drinking-Water (GLAAS);
- Promote girls' education, achieving equity of opportunity between boys and girls;
- Provide comprehensive sexual and reproductive health and rights information and counselling as part of health and multisectoral action, in school and in wider society.

EQUITY, GENDER, RIGHTS AND GOVERNANCE

Persistent health, economic, gender, social, racial and educational inequities worldwide are barriers to achieving the 2030 Agenda. The implementation of human rights and good governance are central to its aims.

The findings and analysis contained in this report are based on the latest data viewable on the EWEC Global Strategy portal of the Global Health Observatory: <http://apps.who.int/gho/data/node.gswcah>

Strategic priorities

- Foster equitable gender norms and attitudes, and promote gender equity through appropriate channels;
- Adopt rights-based approaches to health in health policies and programmes, prioritizing those most in need;
- Strengthen health governance, focusing on whole-of-government responses to ensure greater coordination and coherence of health plans and policies with other areas of government.

DATA MATTERS

There is an urgent need to extend and strengthen data collection and analysis for women's, children's and adolescents' health, ensuring clarity and consistency of definitions and interpretations. Improve monitoring and evaluation and disaggregated data and equity analysis.

Strategic priorities

- Enhance countries' technical capacity to address data challenges and to identify and analyse health inequalities or observed differences between subgroups;
- Consider deploying the WHO Health Equity Assessment Toolkit (HEAT), the WHO Health Equity Monitor database and the UNICEF Equitable Impact Sensitive Tool (EQUIST), in tandem with country health information systems;
- Strengthen country data systems and use. Invest in civil registration and vital statistics, health information, and local capacities to analyse and use data.

INTRODUCTION



This is the 2018 monitoring report for the EWEC Global Strategy for Women's, Children's and Adolescents' Health (2016–2030). It highlights the latest available data through 2017, and to May 2018, for the 60 indicators in the EWEC Global Strategy monitoring framework. Dashboards signal where progress is being made or lagging (Annex 2), and the report flags priorities for policy, investment and implementation in 2018 and beyond. More detailed data for all countries is available on the EWEC Global Strategy portal of the Global Health Observatory at: <http://apps.who.int/gho/data/node.gswcah>

In addition to reporting on women's, children's and adolescents' health overall, each monitoring report has a special theme based on priorities identified by Member States at the World Health Assembly and by the multistakeholder EWEC community. This year the special theme is early childhood development (ECD) – one of the six focus areas highlighted in the 2020 EWEC Partners Framework (Annex 1). In 2019 the theme will be midwifery care.

Early childhood is a critical phase in life, when evidence-based interventions that target risk factors can improve human capital across the life course.⁸ Investing in these interventions can result in a triple dividend – with health, social and economic benefits – for people now, for their future and for the next generation. Investments in newborn care, early childhood, child and adolescent health and development, and family planning, pregnancy and childbirth care can yield benefit-to-cost ratios of at least 10-to-1.^{3,9,10}

To achieve these transformational benefits, it will be necessary to develop innovative and collaborative approaches that reflect the Survive, Thrive and Transform objectives of the Global Strategy and its nine action areas:

1. Country leadership
2. Individual potential
3. Humanitarian and fragile settings
4. Financing for health
5. Community engagement
6. Research and innovation
7. Health system resilience
8. Multisector action
9. Accountability.

These action areas are key to making progress across a core set of interlinked areas and maximizing synergies in the provision and utilization of information, goods and services.

This approach dovetails with the latest scientific evidence,³ which confirms that early childhood development is foundational to the improvement of health and human capital across the life course, especially when delivered in an enabling environment through integrated, multisectoral programmes and at the right critical stage.⁸

While this report provides an overview of progress towards EWEC Global Strategy targets and indicates how they relate to SDG monitoring and baselines, the latter are still being finalized for some SDG targets so comparison is not always possible.

The next section summarizes the latest evidence for early childhood development and highlights the importance of nurturing care. Subsequent sections present the status of action on the objectives of the EWEC Global Strategy. Each section begins with an overview, and then outlines new developments and strategic priorities for action.

SPECIAL THEME:

EARLY CHILDHOOD DEVELOPMENT

The foundation of improved health and human potential for current and future generations



OVERVIEW

Over the last three decades, scientific findings from a range of disciplines have confirmed that early childhood development lays the foundation for health, learning, productivity and well-being throughout a person's life.³

An optimal environment supports children's brain development, while an adverse environment harms development, in the short term and in the long term. The period from pregnancy to 3 years is when children are most susceptible to environmental influences.

Negative factors reduce the capacity of families and other caregivers to protect, support and promote young children's health and development. Moreover, threats to early childhood development tend to cluster together, often in conjunction with social exclusion and lack of services.¹¹

However, children who face early adversity need not fall further and further behind. Commitment to early childhood development can be the catalyst to enable children to thrive, and thereby transform health and human potential.

Effective investments in the early years are the cornerstone of human development and are essential to reduce inequities in health and economic achievement. Failure to so invest has profound economic and social costs that aggregate across society and into the next generations.¹²

WHAT'S NEW?

The 2016 Lancet series, Advancing Early Childhood Development: from Science to Scale, proposed a set of recommendations for promoting, protecting and supporting early childhood development at scale.

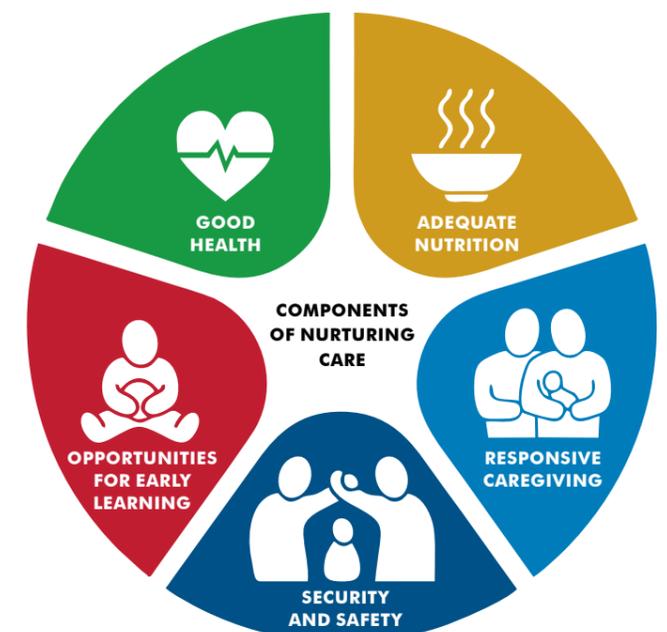
The series emphasized "nurturing care", especially from pregnancy to 3 years, and the important role of the health sector and multisectoral interventions.

What is nurturing care?

Nurturing care refers to the conditions created by public policies, services and programmes to enable communities and caregivers to ensure children's good health and nutrition, protect them from threats, and give young children opportunities for early learning, through interactions that are emotionally supportive and responsive.

Nurturing care promotes young children's health and development and protects them from the worst effects of adversity by reducing stress and boosting emotional and cognitive coping mechanisms. It is especially important for children with developmental difficulties and disabilities, as well as for prevention of child maltreatment.

Figure 1
The components of nurturing care



The science behind nurturing care

Babies are born with almost all the neurons they will ever have. By 2 years, massive numbers of neuronal connections have been made in response to stimulation from caregivers. This rapid brain development is an established genetic pattern, but it is shaped by the young child's experiences.

Children acquire basic learning and social skills at an early age. These competencies make it easier to learn new skills, and build confidence and the motivation to learn more. Long-term studies in countries across the socioeconomic spectrum show that nutritional and psychosocial programmes, implemented from pregnancy, have significant benefits for adult health and well-being, schooling and earnings, personal relationships and social life.¹²

Early intervention is effective and also makes later essential interventions more cost-effective and more likely to succeed. Estimates show that some countries spend less on health now than they will lose in future from poor growth and development in early childhood.¹²

Protecting, promoting and supporting nurturing care

Caregivers need knowledge, time and resources to provide nurturing care. Laws, policies, services, community activities and social relationships create enabling environments, support caregiving, and strengthen caregiver-child relationships.

Nurturing care also requires engagement across a range of sectors – including health, nutrition, education, child protection, social protection, labour and finance. It calls for concerted effort by many stakeholders – including governments, civil society, academic institutions, the private sector, families and others providing care for young children – at the local, national, regional and global levels.

CURRENT STATUS

Risk factors to early childhood development and children at risk

Many things can threaten the development of young children, beginning in and even before pregnancy. These include inadequate maternal nutrition, exposure to environmental pollutants, HIV infection, poor caregiver mental and physical health, suboptimal breastfeeding, malnutrition, illnesses, injuries, limited stimulation, neglect and maltreatment. Adversity in pregnancy leads to low birthweight and preterm birth, which raises the risk of developmental difficulties and chronic diseases in adulthood. Care given to women and men to ensure they are in good health before they conceive a child is also essential.

It is estimated that at least 250 million children younger than 5 years of age (or 43%) are at risk of suboptimal development in LMICs,³ due to risk factors of poverty or stunting alone. Globally, 25% of children are living in extreme poverty, with prevalence as high as 72.3% in sub-Saharan Africa and 46.5% in South Asia.¹³ While stunting is declining in almost every region, progress varies considerably; 22% of children under-5 worldwide suffer from moderate and severe stunting, representing 151 million stunted children. Two out of five stunted children in the world live in Southern Asia.¹⁴

Many health and nutrition interventions for women, children and adolescents affect young children's brain development. This report shows ample data to illustrate critical gaps in coverage.

Comparable data on children's developmental status, using the early childhood development index (ECDI) are currently available for 66 LMICs (UNICEF multi indicator cluster surveys).

The proportion of children who are developmentally on track overall varies widely across countries.¹⁵ It is important to note that the ECDI is currently under review and a stronger metric will become available in the near future to cover children aged 0–59 months.

PROGRESS IN INVESTMENT AND COUNTRY PROGRAMMING

Uptake of the key messages of the Lancet ECD series

Since the launch of the Lancet ECD series on 5 October 2016, early childhood development – and the nurturing care agenda in particular – has attracted the attention of a range of stakeholders interested in disseminating and applying the new evidence.

Seventy-two events and academic presentations have been held worldwide since October 2016 to discuss the series' key messages (Figure 2). Twenty-four countries hosted a national event, while five regional conferences and six global events reached many more national policy-makers and other stakeholders.

Follow-up to document the impact of these events on policies and programming in countries and at global level is underway. An example is the decree of the Government of Mexico, fully endorsing the Nurturing Care framework as the basis for initial education in Mexico.¹⁶

Global institutions – including UNICEF, the World Bank, UNESCO and WHO – have prioritized early childhood development in their future global programmes of work. The launch of the Early Moments Matter report by UNICEF in September 2017 was a milestone.¹³

Figure 2

Disseminating and applying the new evidence (number of global events to launch the Lancet ECD series)



Source: WHO, 2018

A global framework for nurturing care

To provide a roadmap for action, WHO and UNICEF – supported by the Partnership for Maternal, Newborn & Child Health and the ECD Action Network – started to develop a Nurturing Care Framework in 2017. Two global online consultations and face-to-face consultations in several regions were held to elicit inputs from stakeholders. The Framework was due for launch during the 71st World Health Assembly in May 2018. It will be accompanied by an online service through which relevant guidelines, operational guidance, indicators and a measurement framework, country profiles and stories can be accessed.¹⁷

Countries with comprehensive policies for ECD

An updated assessment in December 2017 indicated that 75 countries had a multisectoral early childhood development policy instrument in place (up from 48 in 2007 and 68 in 2014), either as a national policy, a strategic plan, or a law.¹⁸ These provide a basis for promoting a comprehensive agenda for early childhood development addressing services across the life course to age 8, increasingly with a strong emphasis on the critical period from preconception through age 3.

Scaling up interventions

Many health-care and nutrition services, as well as some provisions for security and safety, are already in place in countries, though their coverage and quality must be improved.

What is new is the understanding that responsive caregiving and opportunities for early learning are essential components of daily care for young children. Responsive caregiving is also the basis for supporting families of children with developmental difficulties and disabilities, for preventing maltreatment, and for protecting children against stress and injury.²⁰

Good mental health and strong motivation are important for caregivers to be able to empathize with a young child's experiences. Up to a third of women who are pregnant or who have recently given birth experience depression. Effective interventions to reduce depression and promote maternal mental health have been developed and tested in LMICs where there are very few mental health specialists, and are generally implemented by trained community health workers under professional supervision.²¹ Interventions designed to improve maternal mental health have a positive impact on infant health and development, and interventions to promote infant health and development positively impact maternal mood. They have the greatest effect when implemented together.

Monitoring progress

There is a need for more population-based, comparable data to assess global progress in early childhood development. For the first time, a subgroup of the Lancet ECD Steering Team in collaboration with the Countdown to 2030 has developed country profiles for 91 countries. They bring together data on demographics, prevalence and inequality of risk factors, support for enabling environments through policies and services, and coverage of essential interventions for nurturing care.¹⁷

STRATEGIC PRIORITIES

The EWEC Global Strategy and the SDGs provide the impetus for governments and the global community to step up smart investments for early childhood development. The Nurturing Care Framework calls upon governments and other stakeholders to take action in five areas:

1. Provide leadership, create commitment and invest;
2. Place families and communities at the centre;
3. Strengthen existing systems and services;
4. Monitor progress;
5. Strengthen local evidence and innovate to achieve scale.

Implementing the Nurturing Care Framework to strengthen country programmes for early childhood development is a top priority. In order to support the translation of the Framework into country actions, WHO, UNICEF and a host of experts and partners are working together to expand resources and stimulate investments. Activities include the provision of guidelines, operational guidance, new population-based indicators and a measurement framework, and support for workforce capacity and new research.

The nurturing care framework and additional information on ECD are available from: http://www.who.int/maternal_child_adolescent/child/nurturing-care-framework/en/.

An interactive online service is in preparation at www.nurturing-care.org to enable easy access to relevant resources and new information, including tools and experiences from countries.

Care for Child Development

WHO and UNICEF developed the materials of Care for Child Development (CCD). They include age- and developmentally appropriate recommendations on play and communication that guide counsellors in helping caregivers interact with their children. By 2014, CCD had been introduced in more than 25 countries using multiple contact points in health, nutrition, pre-school education, social welfare and child protection programmes. In no country was a new cadre of worker created; rather the intervention was integrated into existing services.¹⁹ Other countries have since built capacity for CCD, in particular in sub-Saharan Africa and the Americas.



WOMEN'S HEALTH



OVERVIEW

A primary target of the EWEC Global Strategy and SDG 3 is the reduction of preventable maternal mortality. Based on the latest available estimates, there were 303 000 maternal deaths in 2015, and a decline in the estimated ratio of maternal deaths per 100 000 live births from 385 in 1990 to 216 in 2015 (SDG 3.1.1). Sub-Saharan Africa remains the region with the highest ratio, at 555 per 100 000 live births – almost triple that of the next highest.²²

Of the more than 830 women who daily die in childbirth or as a result of pregnancy and delivery,²² most die from postpartum haemorrhage, hypertensive disorders, infection and complications from delivery or abortion.²³ Others die from the interaction between pregnancy and pre-existing health conditions, or suffer complications from pregnancy that continue after childbirth, including health conditions such as infection and depression.²⁴

Stillbirths are also a major concern, with an estimated 2.6 million in 2015. Half occurred during labour and birth, mostly from preventable conditions, and mostly in LMICs.²⁵ In 2015, the stillbirth rate per 1000 live births was 18 globally, and was highest in sub-Saharan Africa at 29/1000.

In other areas of sexual and reproductive health, an estimated 214 million women of reproductive age in LMICs who want to avoid pregnancy are not using a modern contraceptive method.²⁶ According to a study published in the *Lancet* in September 2017, an estimated 25 million (or 45%) of all abortions every year worldwide between 2010 to 2014 were unsafe.²⁷

AIDS-related illnesses remain the leading cause of death among women of reproductive age (15–49 years) globally, and they are the second leading cause of death for young women aged 15–24 years in Africa.²⁸

In 2012, 528 000 new cases of cervical cancer were diagnosed and 266 000 women died of the disease, nearly 90% of them in LMICs. Many women have no access to services for prevention, curative treatment or palliative care. The primary cause of cervical pre-cancer and cancer is human papillomavirus (HPV), which is a vaccine-preventable infection and the most common sexually transmitted infection (STI).²⁹

Violence against women remains one of the major threats to women's health and well-being (SDG 5.2.1). Global estimates published by WHO in 2013 indicate that 35% of women worldwide have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime. Most of this was intimate partner violence.³⁰ Intimate partner violence often persists into or can start during pregnancy. The global prevalence of physical and/or sexual intimate partner violence among all ever-partnered women is estimated at 30%.³⁰ During pregnancy, the prevalence of intimate partner violence ranges across countries from 2–57%.^{31–33}

At least 200 million girls and women have undergone female genital mutilation (FGM), including about one in three of girls aged 15–19 years in 30 countries in which the practice is concentrated.^{15,34} Only half of all women aged 15–49 years (married or in union) in 45 countries reporting data, make their own decisions regarding sexual relations, contraceptive use and health care.³⁴ More girls are likely to undergo FGM every year over the next 15 years due to population growth.³⁵

WHAT'S NEW?

Contraception – In 2018, an estimated 77% of women of reproductive age who are married

or in-union have their family planning needs met with a modern contraceptive method.³⁶ Achieving universal access to sexual and reproductive health services by 2030 will require intensified support for family planning, including through the implementation of effective government policies and programmes.³⁷ Access to emergency contraception remains limited.³⁸

Antenatal and intrapartum care – In 2017, an estimated 62% of pregnant women received four or more antenatal visits.³⁹ In 2013, 59% sought care early in pregnancy.⁴⁰ In 2015, more than 95% of women in 49 countries were screened for syphilis. However, in high-morbidity countries in sub-Saharan Africa the percentage of pregnant women screened and treated for syphilis was only <50%. Syphilis remains a major cause of preventable stillbirths and neonatal death.⁴¹ Between 2012 and 2017, 79% of pregnant women received care from a skilled health provider at the time of delivery.^{15,42}

Safe abortion – Over 75% of abortions in Africa and Latin America were unsafe, and in Africa nearly half of all abortions were performed by untrained persons using traditional and invasive methods.²⁷ To raise standards worldwide, a new open-access Global Abortion Policies Database was launched in June 2017, containing abortion laws, policies, health standards and guidelines for all WHO and United Nations Member States.⁴³

HIV prevention and testing – New data from a study in eastern and southern Africa has highlighted the importance of HIV prevention and testing for pregnant and postpartum women. The research found that a woman's risk of acquiring HIV through sex with a male partner living with HIV increases during pregnancy and is highest during the postpartum period.⁴⁴

Improving monitoring of obstetric care – Monitoring of emergency obstetric care is essential to improve the provision and quality of care. WHO, UNFPA and other partners

are in the process of revising the indicators and approaches for tracking emergency obstetric care, given that the majority of births now take place in health care facilities.

STRATEGIC PRIORITIES

Improve women's health across the life course – Delivering appropriate care, support and information to women and their families according to needs throughout the life course is critical to achieving health goals. Priorities for strategic reframing of health systems and health-care delivery include: 1) promoting a healthy lifestyle (including adequate nutrition); 2) prevention, testing and management of health conditions such as HIV, diabetes and hypertension; 3) family planning/contraception counselling and services; 4) care and support for women experiencing intimate partner violence; 5) preventing diseases through immunization or detection.

Ensure a positive pregnancy experience and improve quality of care around childbirth – Lack of skilled care, including emergency obstetric and neonatal care, is a major obstacle to better health for women. Strengthened health systems and a fully staffed, qualified health workforce – particularly midwives educated and regulated to international standards – are required to provide quality care around childbirth. WHO guidelines on antenatal and intrapartum care are available.^{47,48}

Ensure universal access to sexual and reproductive health-care services – All women and adolescent girls have the right to freely access sexual and reproductive health services. Freely available information and services are essential to informed decision-making for sexual and reproductive behaviours and practices, including birth spacing. Women's autonomy

and rights to make decisions about their own health should be respected, promoted and protected.^{49,50}

Address sexually transmitted infections – Eliminate mother-to-child transmission of syphilis, control antimicrobial resistance of N.gonorrhoea, and research new diagnostic tests and vaccines against STIs. WHO has set targets for achievement by 2030: 1) a 90% reduction of syphilis incidence; 2) a 90% reduction in gonorrhoea incidence; and 3) 50 or fewer cases of congenital syphilis per 100 000 live births in 80% of countries.⁵¹

End violence against women – Prevention of and response to violence against women remains an ongoing priority and is critical to achieving women's and children's health goals. Governments have recognized this as an urgent public health priority and are updating their protocols and training of health providers.^{52,53}

Address causes of cervical cancer – Support introduction of the HPV vaccine and HPV testing and increase access to treatment. The core principle of a comprehensive approach to cervical cancer prevention and control is to act across the life course to deliver age-appropriate and effective interventions. A comprehensive programme includes primary, secondary and tertiary prevention.^{29,54}

Eliminate female genital mutilation – FGM can result in health complications that affect obstetric, gynaecological, psychological and sexual health. Momentum exists towards the complete abandonment of the practice, including legislation adopted in 26 of 30 high-prevalence countries. Primary prevention of FGM includes preventing medicalization of the practice and addressing social and cultural dimensions.^{55,56}

Saving lives, improving estimates – confidential enquiries into maternal deaths in Kazakhstan

Kazakhstan is one of several countries to have introduced "confidential enquiries" into maternal deaths. Enquiries are designed to improve maternal health and health care – and the accuracy of maternal-mortality estimates – by collecting data, identifying any shortfalls in care and recommending improvements. The approach involves identifying and investigating the causes of all deaths of women of reproductive age using multiple sources of data – including interviews with family members and community health workers, and reviews of CRVS data, household surveys, health-care facility records and burial records. Kazakhstan introduced the system after the Central Confidential Audit Commission audited the officially reported maternal deaths for 2009–2010⁴⁵ and 2011–2013.⁴⁶ The audit identified 29% more maternal deaths than were initially recorded in the CRVS system and resulted in recommendations to revise clinical guidelines.



CHILDREN'S HEALTH



OVERVIEW

The relative lack of global progress on neonatal mortality is one of the most significant challenges identified in this report. Children face the highest risk of dying in their first month of life, with the majority of deaths in the first week of life.² The global neonatal mortality rate fell by 49% from 37 deaths per 1000 live births in 1990 to 19 in 2016 (SDG 3.2.2). Sub-Saharan Africa and Central and South Asia remain the worst affected regions, at 28/1000 and 27/1000 respectively.

The main causes of newborn mortality are prematurity and intrapartum-related complications, including birth asphyxia and birth trauma. The main killers of children under-5 in 2016 included preterm birth complications, pneumonia, intrapartum-related events, diarrhoea, neonatal sepsis and malaria.²

The global under-5 mortality rate declined by 56% from 93 deaths per 1000 live births in 1990 to 41 in 2016 (SDG 3.2.1). Sub-Saharan Africa remains the worst affected region, at 79 deaths per 1000 live births. The majority of regions in the world (and 142 out of 195 countries) at least halved their under-5 mortality rate.²

When they survive beyond 5 years, older children in LMICs face long-term health risks, including infectious diseases and suboptimal development due to poverty and stunting. The global prevalence of under-5 stunting is 22% (SDG 2.2.1) representing 151 million stunted children. Two out of five stunted children in the world live in Southern Asia.^{14,57} The Lancet series on early childhood development (2016) indicates that in LMICs in 2010, 250 million children, or 43%, were at risk of suboptimal development due to poverty and stunting.³ This proportion increases if other risk factors such as low maternal education or violence are considered.

A legal identity is a fundamental human right. Not having a legal identity affects an individual's ability to access basic health care, education and employment and is a major factor contributing to poor health outcomes in children. The proportion of children under-5 whose births have been registered is the indicator that captures progress towards providing a legal identity for all by 2030 (SDG 16.9.1). Globally, only 71% of under-5s in reporting countries had their births registered between 2010 and 2016.⁵⁸ According to global UNICEF figures (based on DHS, MICS, other national household surveys, censuses and CRVS systems) sub-Saharan Africa had the lowest percentage of births registered (43%) followed by South Asia (60%) and East Asia and Pacific (excluding China) (84%). Western Europe and North America, Australia and New Zealand had 100% of births registered for the same reporting period.¹⁵

WHAT'S NEW?

Mortality in early childhood – In 2016, an estimated 5.6 million children (including newborns) died before reaching their fifth birthday, mostly from preventable diseases. Approximately 80% of these deaths occurred in two regions: sub-Saharan Africa and Southern Asia. All six countries with an under-5 mortality rate above 100 per 1000 live births are in sub-Saharan Africa.²

Globally, 2.6 million children died in the first month of life in 2016 with most occurring in the first week, representing 47% of mortality in children under-5. Neonatal mortality declined globally in 2016 but more slowly than mortality among children aged 1–59 months. The decline in the neonatal mortality rate from 1990 to 2016 was slower than the decline in mortality

among children aged 1–59 months (49% compared with 62%). This pattern is consistent across regions with sub-Saharan Africa and Oceania (excluding Australia and New Zealand) having a decline in neonatal mortality that was slower than other regions.

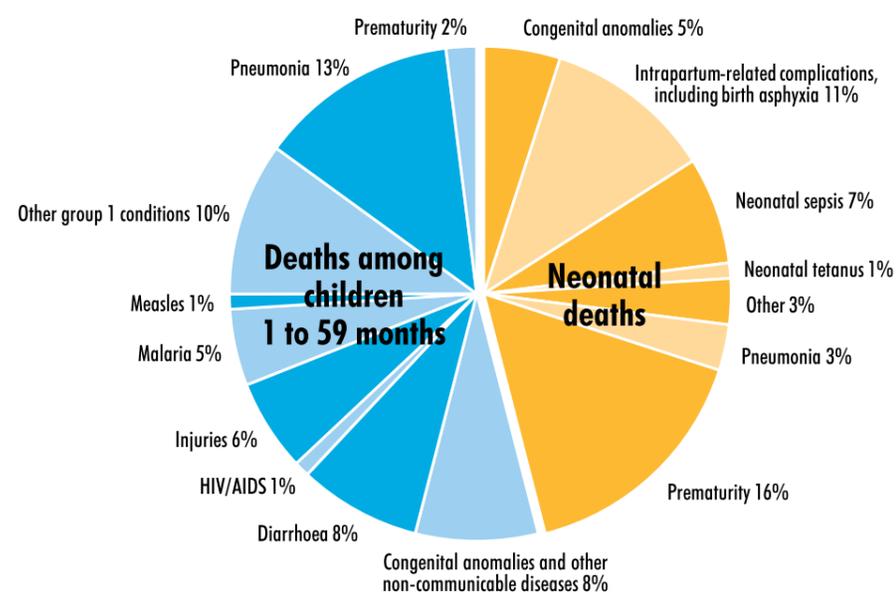
Eighty per cent of all neonates (under 28 days) die from prematurity, birth asphyxia and neonatal sepsis (Figure 3).⁵⁹ For children aged 1–59 months, acute respiratory infections and diarrhoea remain the biggest killers. Ending preventable child deaths can be achieved by: providing immediate and exclusive breastfeeding; improving access to skilled health professionals for antenatal, birth and postnatal care; improving nutrition; promoting knowledge of danger signs among family members; improving access to water, sanitation and hygiene; and providing full immunization coverage. Many of these lifesaving interventions are not fully implemented in the world's poorest communities.

Mortality in older childhood – An analysis of deaths of children aged 5–9 years shows that infectious diseases such as lower respiratory infections, diarrhoeal diseases and meningitis remain among the leading causes of death globally, but that injury-related causes such as drowning and road traffic injury are increasing.²⁸

Recent estimates include, for the first time, deaths for children aged 5–14 years.² In 2016, 1 million in this age group died mainly from preventable causes.²⁸ This translates into 3000 older children dying every day. There are very few global analyses of levels of the causes of death among older children. These estimates are needed if we are to achieve the same level of reductions in mortality and burden of disease among older children as for children under-5.

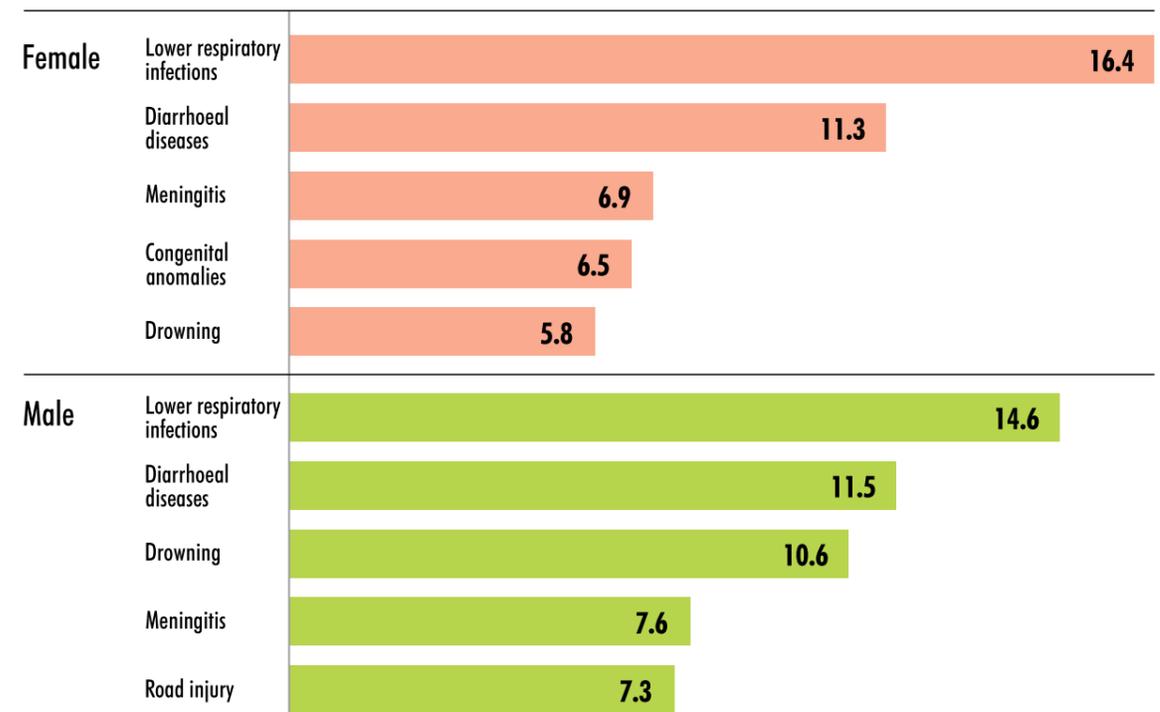
The largest number of older children died in LMICs in Africa, where the death rates for both boys and girls are significantly higher than in any other region. However, there are regional differences in both magnitude and

Figure 3
Main causes of child mortality under 5 years



Source: WHO-MCEE methods and data sources for child causes of death 2000–2016 (Global Health Estimates Technical Paper WHO/HMM/IER/GHE/2018.1)

Figure 4
Estimated top five causes of death for older children aged 5–9 years by sex (rates per 100 000), 2015²⁸



Source: WHO – Global Health Estimates 2015²⁸

cause of death. Drowning is the leading cause of death in LMICs in South-East Asia and Western Pacific, while collective violence and legal intervention (war and terrorism) are the leading causes of death for older children in Eastern Mediterranean LMICs.

STRATEGIC PRIORITIES

Deploy and scale up proven interventions – A variety of evidence-based interventions are known to be effective to reduce child mortality, and remain an ongoing priority for implementation. Effective interventions for improving survival and health of newborns and children are part of the packages of integrated services for reproductive, maternal, newborn, child and adolescent health (RMNCAH).

Ensure quality care during pregnancy, childbirth and the postnatal period – Deploy the packages of care known to have the greatest impact to prevent more than 1.9 million maternal and newborn deaths and stillbirths by 2025 with universal access. Postnatal care provides the delivery platform for promotion of healthy practices, routine care of mother and newborn, and detection of problems requiring additional care. An example is the Baby-Friendly Hospital Initiative to support breastfeeding.⁶⁰

Strengthen sectors that enable improvements in newborn and child health – Invest in sectors related to health, such as nutrition, WASH, education, energy and child and social protection.

Strengthen governance – Invest in well-coordinated policies and services.

ADOLESCENTS' HEALTH



OVERVIEW

The 1.2 billion adolescents (10–19 years) in the world today represent more than 18% of the global population. In 2015, more than 1.2 million adolescents died.⁶¹

Main causes of adolescent deaths include road injury, lower respiratory infections, self-harm, diarrhoeal diseases, drowning, interpersonal violence and maternal conditions.^{28,61} Leading risk factors differ between younger and older adolescents. Younger adolescents globally are at risk from unsafe water and sanitation, inadequate hand washing and household air pollution. For older adolescents, the main risk factors are alcohol use, unsafe sex and unsafe water and sanitation.⁶²

Global adolescent mortality rates have fallen by approximately 17% since 2000 to 101 per 100 000 in 2015. Rates remain highest in LMICs in Africa, at 243 per 100 000. Eastern Mediterranean LMICs are second-highest at 115 per 100 000. The lowest rates are in Western Pacific LMICs (40 per 100 000) and high-income countries (24 per 100 000).⁶¹

According to the latest UNICEF estimates, 25 million child marriages were prevented in the last decade due to accelerated progress to eliminate the practice. However, about 12 million girls still marry each year before the age of 18.^{15,63} An estimated 21 million girls aged 15–19 years become pregnant each year in developing regions; about half of these pregnancies are unintended. The birth rate for women aged 15–19 years is 44 per 1000 globally, and highest in sub-Saharan Africa at 101 per 1000 (SDG 3.7.2).

Early childbirth is associated with a range of maternal and neonatal health complications.^{64,65} There were 25.1 million unsafe abortions each year between 2010 and 2014.²⁷ An estimated 15% of all unsafe abortions are in girls aged 15–19 years.⁶⁶

Demand for family planning satisfied by modern methods is generally lower among girls aged 15–19 years compared to older women.⁶⁷

Globally, 260 000 adolescents aged 15–19 years became newly infected with HIV in 2016, contributing 12% to all 2.1 million adolescents living with HIV.¹⁵ About 80% of the global total is in sub-Saharan Africa.⁶⁸ Compared to children and adults, adolescents living with HIV have poorer retention in care, lower rates of viral suppression and higher rates of mortality.⁶⁸

Gender-based violence against adolescents is a major problem, and the lifetime prevalence of intimate partner violence among girls aged 15–19 years is 29%.³⁰

Iron-deficiency anaemia is the leading cause of disability-adjusted life years (DALYs) lost for girls and boys aged 10–14 and for girls aged 15–19.²⁸

Both younger and older adolescents suffer the burden of mental health problems. Self-harm is a leading cause of death for older adolescent girls and boys worldwide.⁶¹

Risk factors for noncommunicable diseases (NCDs), the leading cause of premature adult deaths, are often acquired in adolescence. They include tobacco use, unhealthy diet and physical inactivity, which lead to an increased risk of overweight and obesity, diabetes and raised blood pressure, and ultimately to a higher risk of NCDs across the life course.⁶⁹

An estimated 60 million young adolescents of lower secondary school age and 142 million of upper secondary age are out of school, based on 2016 figures. The children who are not enrolled in school are often those from the most socially marginalized communities and backgrounds.⁶¹

WHAT'S NEW

Global Accelerated Action for the Health of Adolescents (AA-HA!) – Implementation of the guidance is being rolled-out to countries across all WHO regions, and policy dialogue has taken place with 45 country teams. Fifteen countries have followed up with national AA-HA! processes.

For example, Barbados, Belize, Botswana and Sudan are developing national adolescent health strategies. The Republic of Moldova is renewing its national school health programme using the principles of AA-HA!.

Adolescents are among the most vulnerable in humanitarian settings, but also agents of change

Studies published in 2017 have again highlighted the vulnerability of adolescents in emergency situations – and the value of targeted measures to protect them.

An estimated 28 000 women required post-rape care services after the Nepal earthquake of April 2015.⁷² The multi-agency response to the disaster included adolescent-friendly service corners in 132 reproductive health outreach camps. These were run by trained adolescent facilitators and volunteers, 56% of them female, who conducted awareness-raising activities and encouraged girls to utilize SRH services in a safe environment.

A separate literature review of violence against adolescent girls globally identified an urgent need for more evidence to guide the programming of services to offer protection in humanitarian settings.⁷³

A report on sexual violence against displaced men and boys found they are frequently affected by violence and abuse.⁷⁴ For example, the authors detailed sexual torture and rape against men and adolescent boys in the Syrian Arab Republic, and sexual exploitation of unaccompanied boys aged 14–17 years in Athens, Greece. While the health and humanitarian sectors have been slow to acknowledge these issues fully, there are notable exceptions – such as a referral system for male and transgender survivors in Beirut, Lebanon.

These findings reflect the priorities of the United Nations-backed Compact for Young People in Humanitarian Action, which include “strengthen young people’s capacities to be effective humanitarian actors” and “increase resources to address the needs and priorities of adolescents and youth”.⁷⁵



School health services – There is no international standard for school health programmes. Often they are not evidence-based and lack follow-up and referrals for detected health problems and nutrition. New guidelines are in preparation.

Gender norms – There is growing recognition of the importance of building gender norms in young adolescents to promote health, well-being and gender equality. Gender socialization shapes adverse health and social outcomes, especially those related to sexual and reproductive health, so early adolescence (aged 10–14 years) is an important window of opportunity to address gender socialization.⁷⁰

Adolescent health in humanitarian settings – Work to identify gaps in adolescent health-care services in humanitarian settings is focused on measuring quality of care of existing services. The first steps are to develop indicators for data collection.

Adolescent mental health – Worldwide 10–20% of children and adolescents experience mental disorders. Half of all mental disorders begin by the age of 14 and three-quarters by the mid-20s.⁷¹

STRATEGIC PRIORITIES

Implement the multisectoral AA-HA! guidance – To engage adolescents as agents of change and to address positive health and development and risk factors such as: unintentional injury; violence; HIV; communicable and noncommunicable diseases; nutrition; physical activity; mental health; substance use; and self-harm. Pay special attention to the needs of adolescents in fragile and humanitarian settings.

Provide comprehensive sexual and reproductive health and rights information and counselling for adolescents – Adolescents should have at least a basic

knowledge of sexual and reproductive health and rights, including the right not to be subject to early marriage. Provision of information, such as comprehensive sexuality education and counselling, should be strongly linked to the provision of adolescent-friendly health services, including in humanitarian settings.

Prevent and treat anaemia and measure its impact – Efforts towards improving nutrition of adolescents require assessment of anaemia across a broader range of ages, and programmes to prevent and treat anaemia. Data on girls aged 10–14 years and 15–19 years are largely missing for LMICs.

Target adolescents with HIV prevention and treatment programmes – The population of adolescents (aged 10–19 years) living with HIV is increasing. Since 2010, AIDS-related deaths have been increasing among older adolescents (aged 15–19) but decreasing among younger adolescents (aged 10–14).¹⁵

Support girls’ menstrual health needs – Girls need to grow up in a context where menstruation is seen as healthy and normal, they feel well supported and have access to all the information and facilities they need.⁷⁶ Provide education about menstruation and make sanitary products, water and soap easily and safely accessible, including at school.⁷⁷

Prevent child marriage – It has been estimated that a 10% reduction in child marriage could contribute to a 70% reduction in maternal mortality rates and a 3% decrease in infant mortality in some countries.⁷⁸ There is an urgent need to implement proven interventions and approaches against child marriage and to support creation and implementation of legislation.⁷⁹ Legislation should be combined with efforts to empower adolescents, build equitable gender norms at individual and community levels, and promote girls’ educational attainment.

UHC, HEALTH SYSTEMS, MAJOR DISEASES AND HUMANITARIAN SETTINGS



OVERVIEW

According to 2017 estimates, coverage of selected essential health services increased by roughly 20% between 2000 and 2015. However, at least half the world's population still lacks access to essential health services.⁸⁰ Population groups continue to have highly variable levels of access to health services. For example, in many countries, laws and policies support access to contraceptive services for married or in-union adolescents, but not unmarried adolescents.⁸¹

Globally, the UHC service coverage index stands at 64 on a scale of 0–100 (SDG 3.8.1). The regions with the lowest scores are sub-Saharan Africa (42) and Oceania (excluding Australia and New Zealand) (45).

In 2015, the average per capita domestic general government health expenditure was US\$ 684 globally, and was highest in Australia and New Zealand (US\$ 3482) and Europe and Northern America (US\$ 2077).

The share of out-of-pocket health spending in health expenditures has been gradually decreasing over the past 15 years in all income groups.⁸² In 2015, the average per capita out-of-pocket health spending was US\$ 214 globally, and was highest in Australia and New Zealand (US\$ 802) and Europe and Northern America (US\$ 517). 800 million people globally spend more than 10% of their household budget on health care, and almost 100 million are pushed into extreme poverty each year by out-of-pocket health expenses.⁸⁰

WHAT'S NEW

Universal health coverage – An analysis published by WHO in 2017 estimated that investments in UHC and the other SDG targets could prevent 97 million premature deaths globally by 2030 and add as much

as 8.4 years of life.⁵ Under an “ambitious” scenario modelled for the analysis, achieving the SDG health targets would require new investments increasing over time from an initial US\$ 134 billion annually to US\$ 371 billion, or US\$ 58 per person, by 2030. The analysis shows that 85% of these costs can be met with domestic resources, although as many as 32 of the world's poorest countries will face an annual gap of up to US\$ 54 billion and will continue to need external assistance.

An analysis using the UHC service coverage index identified a “strong association” between life expectancy and the index, after controlling for gross national income and mean years of adult education, with a difference of 21 years over the observed range of country values.⁸³

Country health expenditure – Public funding has increased slightly over the past 15 years from an average of 48% to 51% of current health spending in middle-income countries and from 66% to 70% in high-income countries. In low-income countries, domestic government sources have declined from 30% to 22% as aid increased from 20% to 30%, and there is evidence of fungibility, i.e. development assistance is spent in the health sector, but the recipient government re-allocates its own resources to fund other priorities. It also appears that there is a positive trend in providing on-budget support – external funds channelled through government mechanisms – suggesting increased alignment of donor funding with country priorities and systems.⁸²

In 2017, WHO added estimates on reproductive health (limited to maternal health, family planning, antenatal care and skilled birth attendance) to its global health expenditure database for the first time.⁸⁴

Per capita public domestic sources of spending on reproductive health averages US\$ 9 across 24 LMICs. This spans from less than US\$ 0.5 in Democratic Republic of Congo and Lao People's Democratic Republic, to US\$ 58 in Namibia. By contrast, average per capita external funding on reproductive health is estimated at US\$ 1.3 – and up to US\$ 12 in Democratic Republic of Congo. WHO is working with countries to improve collection of relevant reproductive health data to enable more detailed analysis in future.

Health workforce – USAID estimates that the lives of 5.6 million children and 260 000 women could be saved by 2020 by training health-care workers in areas such as: maternal and child health and nutrition; reaching newborns with proper care after delivery; treating children for diarrhoea and pneumonia; and vaccinating children against preventable and deadly diseases.⁸⁵ For all countries to reach SDG 3, WHO estimates that the world will need an additional 9 million nurses and midwives by 2030. However, if current trends persist, the predicted shortfall will only decline to 7.6 million by 2030, and could worsen in the African and Eastern Mediterranean regions.⁸⁶

Water, sanitation and hygiene – Lack of WASH services in health-care facilities is a major obstacle to providing safe and quality care, especially during the critical time around childbirth. A global review using data from 71 LMICs indicates that 50% of health care facilities lack piped water, 33% lack improved toilets and 39% lack hand washing with soap.⁸⁷ These figures are similar to those reported in 2015 by WHO and UNICEF.⁸⁸ Approximately 80% of 78 responding countries have a policy for WASH in health-care facilities or infection prevention and control, but less than 25% of these are fully funded and being implemented.⁸⁹

Immunization – In May 2017, the Seventieth World Health Assembly adopted resolution WHA70.14, urging Member States and the Director-General to further strengthen immunization systems to achieve the goals of the Global Vaccine Action Plan (2011–2020).⁹⁰ An analysis of 2016 data showed progress against two major infectious diseases due to immunization: the fewest cases of polio ever reported and the certification of maternal and neonatal tetanus elimination in three more countries. Global DTP3 vaccination coverage increased by 1% to 86%. However, overall progress remains too slow to achieve most of the Plan's goals by 2020, due to factors such as conflicts and natural disasters, displacement and migration, insufficient political commitment and increased vaccine hesitancy. WHO continues to provide technical support to Member States and is supporting pilot implementation of the new malaria vaccine (see below).⁹¹

Communicable diseases

HIV, malaria and TB – In 2016, there were roughly 1.8 million new HIV infections – down from 1.9 million in 2015. A 2017 update estimated an 11% decline in new infections among adults between 2010 and 2016, and 1% in the wider population. In the same period, new infections among children globally declined from 300 000 to 160 000.⁹² Diagnosing and initiating treatment among these children remains a priority and a challenge. UNAIDS highlighted the work still to be done, especially among adolescents and young adults. AIDS-related illnesses are the second leading cause of death for women aged 15–24 years in Africa.⁹³

By end 2016, 53% of all people living with HIV had access to life-saving treatment, with 20.9 million people receiving antiretroviral treatment by mid-2017 – up from 7.7 million in 2010.⁹⁴ In 2016, 76% of all

pregnant women living with HIV accessed treatment to prevent HIV in their babies – up from 47% in 2010.⁹⁵ In 2017, UNAIDS worked closely with key organizations in the framework of the Monitoring Technical Advisory Group to harmonize new HIV indicators with international standards and provide standardized data for comparison across countries.⁹⁵

By the end of 2017, more than 250 cities had signed the Paris Declaration on Fast-Track Cities: Ending the AIDS Epidemic, committing to address the significant disparities in access to basic services, social justice and economic opportunities and to achieve the Fast-Track targets towards ending AIDS by 2030.

There were an estimated 216 million cases of malaria in 2016, about 5 million more than in 2015. Total deaths from malaria declined from 446 000 in 2015 to 445 000 in 2016.⁹⁶ WHO announced that pilot implementation of the first vaccine to provide partial protection against malaria in young children is expected to begin in 2018. Trials between 2009 and 2014 prevented approximately 39% of cases of malaria among children aged 5–17 months, and showed a reduction in the need for hospital admissions and blood transfusions.⁹⁷ WHO supported the launch of a mass antimalarial drug administration campaign in 2017 that reached an estimated 1.2 million children under-5 in Nigeria's Borno State. Early results point to a reduction in malaria cases and deaths in trial areas.⁹⁶

Globally, the TB mortality rate is falling at about 3% per year, and incidence at about 2% per year. A 2017 report highlighted the work that still needs to be done, especially among adolescents and young adults who are generally at a higher risk of new infections. In 2017, there were an estimated 1.3 million TB deaths among HIV negative people, down from 1.7 million in 2000. TB is

the leading cause of death among people living with HIV.⁹⁸

Noncommunicable diseases

The increasing global incidence of NCDs (principally cardiovascular diseases, cancers, chronic respiratory diseases and diabetes) is closely linked to factors such as physical inactivity, diet, poor air quality and exposure to environmental pollution and toxins such as mercury and lead.^{99,100} Preventative interventions introduced from early childhood onwards can be highly effective in reducing the onset of NCDs in later childhood, adolescence and adulthood. These include actions to address known causes of NCDs, such as avoiding tobacco, reducing intake of alcohol and salt, improving dietary habits, increasing physical activity and widening access to preventative therapies.¹⁰¹ A life course approach to health focused on maintaining the highest-achievable standard of functional health at every life stage is also proven to be effective in preventing NCDs.⁴

Humanitarian crises and other emergencies

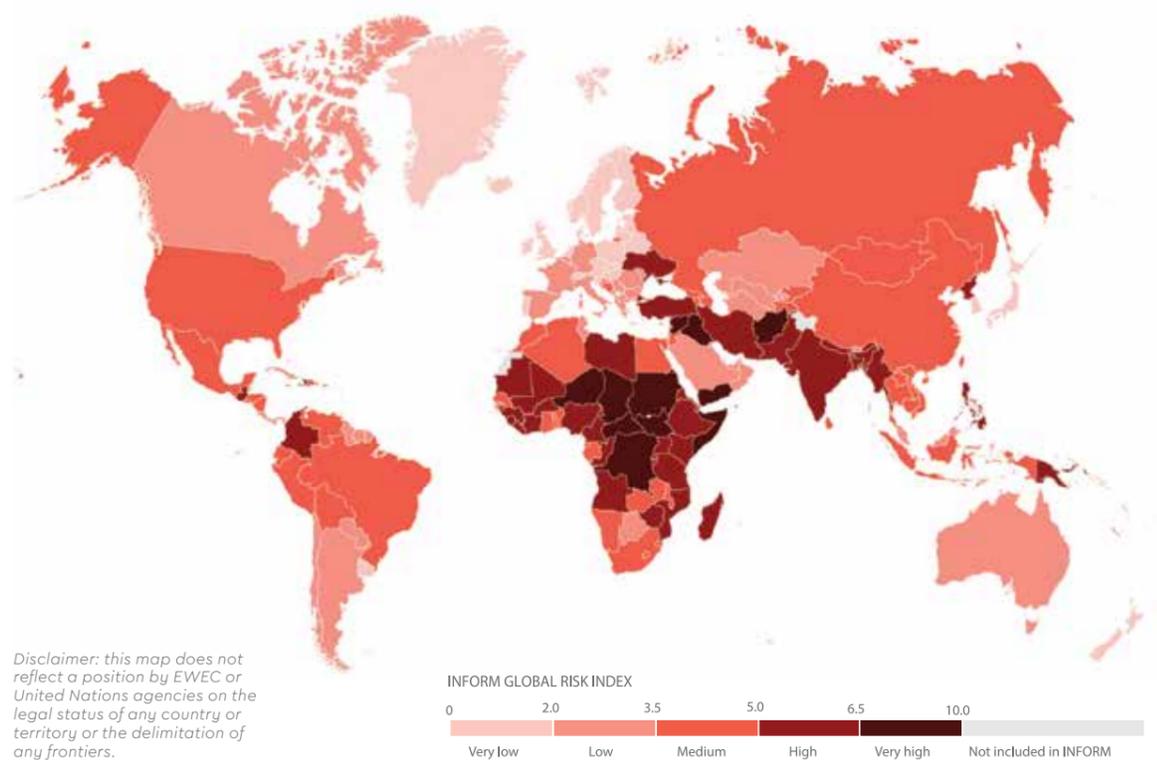
The increasing risk to health in humanitarian crises is one of the most significant challenges identified in this report. Emergency situations such as drought and conflict undermine the effectiveness of UHC and health systems and disproportionately affect the health of women and children;¹⁰² there is a growing realization that adolescents are often similarly affected.⁶¹ In 2017, roughly 535 million children were living in countries affected by emergencies.¹⁰³ An estimated 65.6 million people around the world have been forced from home – in some cases for years or even decades. 55% of refugees worldwide come from three countries: Syrian Arab Republic (5.5 million), Afghanistan (2.5 million) and South Sudan (1.4 million).¹

With the objective of improving health in humanitarian settings, global efforts contributed to improved national and global capacity to measure risk. The Index for Risk Management (INFORM) is designed to promote common understanding of the risk of humanitarian crises and disasters at national and subnational levels. New risk models covering Latin America and the Caribbean region, Central Asia and the Caucasus region and Guatemala are now available.¹⁰⁴ A global INFORM is published, with 2018 results now available.¹⁰⁵ It is a unified emergency risk modeling approach using composite indicators from 191 countries to support more effective prevention, preparedness and response by countries and international partners, leading to better outcomes for people facing risk of disasters and humanitarian crises.

In 2018, the 12 countries at overall highest risk from humanitarian crises and disasters that could overwhelm national response capacity are: Somalia (9.1), South Sudan (9.0), Chad (7.8), Afghanistan (7.7), Central African Republic (7.6), Yemen (7.6), Niger (7.2), Sudan (7.0), Democratic Republic of Congo (7.1), Syrian Arab Republic (6.9), Iraq (6.8) and Myanmar (6.4).

As evidence of improved risk management following the Ebola outbreak of 2014–15 in West Africa, frontline field epidemiology training programmes have since been established in Liberia, Sierra Leone and Guinea. The programme provides 3 months of on-the-job training and supervision for surveillance officers working within the ministry of health.¹⁰⁶

Figure 5
Risk of humanitarian crises and disasters, 2018



Source: INFORM Global Risk Index results 2018. Available from: <http://www.inform-index.org/>

STRATEGIC PRIORITIES

Accelerate progress towards universal health coverage – UHC is a value-based strategy whereby access to high-quality, integrated, people-centred health services are expanded to reach everyone without people incurring financial hardship. UHC packages should be locally designed to provide high-impact, cost-effective interventions and include cross-sectoral approaches where appropriate. UHC service delivery should include population-wide prevention strategies such as road safety, food labelling and smoke-free laws.

Invest in health systems strengthening and the health workforce – Examples include the education and training of midwives, nurses and other health professionals.

Integrate a life course approach to health – A life course approach provides a proven means of optimizing the health, well-being and functional ability of individuals throughout life. It takes full account of the influence of enabling factors outside the health system and provides a framework for implementing multisectoral interventions.⁴

Strengthen capacity to reduce vulnerabilities and to anticipate and respond to emergencies, including humanitarian crises – Take full account of the vulnerabilities and capacities of women, children and adolescents in emergency risk assessments at all levels. Deploy the INFORM Global Risk Index to advocate for action. Increase emergency preparedness and build health system capacity to support women's, children's and adolescents' health in humanitarian and other emergency situations.

MULTISECTORAL ACTION



OVERVIEW

Multisectoral factors have long been recognized as major determinants of health across the life course. Some inhibit health and well-being (such as poverty, hunger and gender discrimination) while others enable it (such as nutrition and education).⁶ They remain among the most intractable in terms of designing and implementing interventions to achieve progress towards the Survive, Thrive and Transform objectives of the EWEC Global Strategy. The need to coordinate the action of multiple actors across sectors is undoubtedly a factor in this.

The SDGs are based on the need for global partnership and reflect the importance of multisectoral action to achieve the 2030 Agenda. The following section highlights progress made in 2017 against some of the SDGs most closely related to women's, children's and adolescents' health.

WHAT'S NEW

Poverty (SDG1)

In 2017, extreme poverty was reduced by an estimated 38 million people – 4 million more than in 2016.¹⁰⁷ Deep disparities remain between and within countries.¹⁰⁸ To provide more accurate and appropriately timed information for countries, the World Bank is to publish estimates for a new reference year every other year. It now reports incidence of monetary poverty for different poverty lines for lower-middle-income countries (US\$ 3.20 and US\$ 5.50 per day) in addition to US\$ 1.90 per day.¹⁰⁹

Nutrition (SDG 2)

According to the 2017 Global Nutrition Report, 88% of countries that supplied data were seriously impacted by either two or

three forms of malnutrition (childhood stunting, anaemia in women of reproductive age and/or overweight in adult women). Effective interventions such as the protection, promotion and support of breastfeeding, nutrition education, subsidies to small family farmers, improvements in food security and the application of taxes to sugary drinks can reverse this situation.¹¹⁰

Education (SDG 4)

Based on the most recently available data, net school enrolment rates worldwide are 91% for primary education, 84% for lower secondary education and 68% for upper secondary education. About 264 million children (of primary, lower secondary and upper secondary age) were out of school in 2015, including 61 million children of primary school age. Sub-Saharan Africa and Southern Asia account for over 70% of the global out-of-school population in primary and secondary education.⁵⁸ Nonetheless, since 2015 many countries have reported an increase in secondary school attendance, fewer drop outs and more children attending early learning centres.¹¹¹ Monitoring for SDG 4.1.1 indicates that 56% of primary and secondary school-aged children and adolescents globally are not achieving minimum proficiency levels (mathematics), with rates highest in sub-Saharan Africa (84%) and Central and Southern Asia (76%).

Environmental health (SDGs 6, 11, 12 & 13)

More than 3 million children die every year due to unhealthy environments and risk factors such as unsafe water, inadequate sanitation and hygiene, air pollution, climate change and harmful chemicals.^{112,113}

Globally, the proportion of the population with access to clean fuels and technology is 59% (SDG 7.1.2). However, it is 13% in sub-Saharan Africa and 17% in Oceania (excluding Australia and New Zealand).

Thirty-seven cities have joined the BreatheLife campaign¹¹⁴ led by WHO and the Climate and Clean Air Coalition. It offers

solutions to help all cities achieve safe air quality levels by 2030 (currently 92% of the world's population lives in places where air pollution levels exceed WHO guideline limits) and thereby protect children's respiratory health. WHO is planning its first air pollution and health conference. In 2018 it is due to publish technical guidance on air pollution and child health and training tools.

Enhanced surveillance underpins progress on nutrition improvements in children and women of reproductive age

An estimated 46 million children under-5 and 66 million women of reproductive age benefited from a WHO-led nutrition initiative that ran from 2013 to 2016 in 11 countries in sub-Saharan Africa. The Accelerating Nutrition Improvements (ANI) project focused on improving nutrition surveillance in Burkina Faso, Ethiopia, Mali, Mozambique, Rwanda, Senegal, Sierra Leone, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.¹¹⁵ Nutrition surveillance is critical because it provides the necessary information to assess the nutritional situation, prioritize programmes to address malnutrition, track improvements to reach national nutrition targets and reorient programmes for more efficient interventions.

The ANI project enabled up to 25% of districts to have a functioning data collection system that feeds into national surveillance systems in the 11 countries. This contributes to improved decision making and ability to measure progress. ANI also supported the scaling up of evidence-informed nutrition actions in Ethiopia, Uganda and United Republic of Tanzania, which are high-burden Scaling Up Nutrition countries.

The ANI project confirmed that nutrition surveillance is an essential component for early warning, prevention and management of all forms of malnutrition. Strengthening nutrition surveillance through the ANI project led to an improvement in tracking global nutrition targets. Among other findings, it demonstrated that involving decision-makers from the district health system in data analysis and use of information was crucial for allocation of resources for nutrition-related activities.



About 30% of the world's population lacks safely managed drinking water services (SDG 6.1.1), and over 50% lacks safely managed sanitation services.¹¹⁶ Globally, the proportion of the population using safely managed sanitation services, including a hand-washing facility with soap and water, is 39% (SDG 6.2.1). As of 2017, 75 countries participated in the UN-Water Global Analysis and Assessment of Sanitation and Drinking-Water (GLAAS) initiative.⁸⁹

More countries have taken action against two major neurotoxins by banning lead paint and joining the Minamata Convention to reduce exposure to mercury.^{117,118}

equitable promotion of girls' schooling in rural areas in low-income countries.

Provide comprehensive sexual and reproductive health and rights information and counselling – As part of health and multisectoral action, while at school and in wider society, adolescent girls need to receive comprehensive sexual and reproductive health and rights information and counselling, including on contraception and the risks associated with early pregnancy – and particularly as a result of early or forced marriage. Boys will also benefit from counselling on their responsibilities in sexual and reproductive health and their role as partners and potential fathers. These services should continue across the life course.⁶¹

STRATEGIC PRIORITIES

Adopt multisectoral approaches – Health and social policy should reflect the close links between major determinants of health and the need for parallel progress and cross-sectoral collaboration in multiple areas to achieve maximum impact. For example, improvements in education, water and sanitation can combine to enhance health outcomes.

Improve food systems – Including production, distribution, marketing and use and efficient food waste disposal.

Address environmental determinants of health – Initiatives and publications such as the BreatheLife Campaign, the Climate and Clean Air Coalition, GLAAS, the Minamata Convention, and the WHO Atlas on Children's Health and the Environment provide guidance for action against environmental determinants of health.

Promote girls' education – Despite progress made over the last 20 years, girls remain less likely than boys to attend school. Poverty is a contributing factor to gender disparities in education and contributes to lack of resources for

EQUITY, GENDER, RIGHTS AND GOVERNANCE



OVERVIEW

Slow progress and reversal of gains in certain areas of gender equality are two of the most significant challenges identified in this report and have significant impact on global health outcomes. Persistent gender inequities are found globally. For example: women spent almost three times as long on unpaid domestic and care work as men, on average, from 2000 to 2016;³⁵ fewer than one in three senior- and middle-management positions were held by women in most of the 67 countries with data from 2009 to 2015;³⁴ the economic gender gap widened in 2017 – back to 2008 levels – and will now take an estimated 217 years to close.¹¹⁹

Examples of health, economic, social, racial and educational inequities that impact health outcomes are also found globally. For example: shortages of health-care professionals were most acute in 2015 in those regions with the greatest need, including most countries in sub-Saharan Africa and other of the world's least-developed countries; almost 10% of people in employment lived with their families on less than US\$ 1.90 per person per day in 2016, while only 22% of the unemployed worldwide received unemployment benefits; in the United States, Native American/Alaska Native and Hispanic women are almost three times as likely as white women to lack health insurance.³⁵

The WHO Constitution (1946) envisages "...the highest attainable standard of health as a fundamental right of every human being". This right, and other fundamental human rights, are central to the 2030 Agenda for Sustainable Development¹²⁰ and to the EWEC Global Strategy.⁶ Good governance, transparency and accountability are also central considerations in both.

WHAT'S NEW

Gender equality (SDG 5) – Evidence from the Global Early Adolescent Study has confirmed that inequitable gender norms and attitudes are geographically widespread and develop early in life, intensifying in early adolescence with the onset of puberty.¹²¹ Separate findings confirmed the interconnectedness of gender-related inequalities with other inequalities. For example, a girl born into poverty and forced into early marriage is more likely to drop out of school, to give birth at an early age, to suffer complications during childbirth and to experience violence than a girl from a higher-income household.³⁵

Several countries highlighted success among indicators related to gender inequality in 2017. For example, the prevalence of child marriage is decreasing globally with some countries seeing significant reductions in recent years. Overall, the proportion of women who were married as children decreased by 15% in the last decade, from one in four to approximately one in five.¹⁵ There has also been positive, although slow, global change in women moving into positions of decision-making and power. In 2017, women's participation in national parliaments was 23.4%, up 10 percentage points from 2000.⁵⁸

Human rights – Monitoring of the proportion of countries that have ratified human rights treaties related to women's, children's and adolescents' health is ongoing. Efforts also are ongoing to develop and collect information on the number of countries with laws and regulations that guarantee women aged 15–49 years access to sexual and reproductive health care, information and education (SDG 5.6.2) and those that have legal frameworks in place to promote, enforce and monitor equality and nondiscrimination on the basis of sex (SDG 5.1.1). Within the terms of

reference of SDG 5.6.2, 57 countries globally have sexual and reproductive health laws and policies; 30 are in sub-Saharan Africa.¹²²

WHO and the Office of the High Commissioner for Human Rights signed a framework cooperation agreement to implement the recommendations of the High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents, issued in 2017.¹²³

Implementation includes building institutional capacity and expertise, and monitoring of progress.

Governance (SDG 16) – The Worldwide Governance Indicators (WGI) were updated in 2017 and are now available for 1996 to 2016: Voice and accountability; Political stability and absence of violence/terrorism; Government effectiveness; Regulatory quality; Rule of law; and Control of corruption.¹²⁴

Turning promises into action: gender equality³⁵

The 2030 Agenda's commitment to gender equality is comprehensive, yet inequalities among women and girls remain pervasive.

In 89 countries, there are 4.4 million more women than men living on less than US\$ 1.90 a day. Violence against women and girls remains widespread, as one in five women have experienced physical and/or sexual violence by an intimate partner in the past 12 months. Despite recent progress, access to education is not universal: 48.1% of adolescent girls in sub-Saharan Africa remain out of school, compared to 44% of boys.

In 2018 alone, 124 countries are expected to cut their budgets – eroding essential services on which many women and girls depend. Currently, only one third of the data needed to assess the status of gender equality in the 2030 Agenda exists.

UN Women's monitoring report identifies four key areas for action:

- Putting gender equality at the center of implementation
- Closing the financing gap for gender equality
- Improving gender statistics, and
- Strengthening accountability for gender equality commitments at all levels.

When women are enabled to participate, where incentives to advance gender equality are in place and where poor performance on women's rights has consequences – better outcomes are possible.



The WGI provide the kind of data that enable citizens to hold their governments and leaders accountable.¹²⁵ Several countries demonstrated improvements in Voice and accountability, including Georgia, Japan, Rwanda and Serbia. Other countries affected by civil war and political disruption, including Yemen and the Bolivarian Republic of Venezuela, witnessed sharp declines in both Government effectiveness and Voice and accountability.¹²⁵

The 2018 World Happiness Report, based on 2017 survey data, ranked 156 countries by their happiness levels, and 117 countries by the happiness of their immigrants. The Himalayan state of Bhutan played a role in popularizing happiness globally as a measure of well-being within populations. The nine domains of the country's long-standing Gross National Happiness Index include Health (physical and mental), Psychological well-being (quality of life, life satisfaction and spirituality) and Good governance (how people perceive government functions).

Well-being is a subjective state that can be evaluated across three domains: 1) perceived life satisfaction; 2) emotions experienced; and 3) self-realization and a sense of purpose or meaning. A meta-analysis of longitudinal studies indicated that subjective well-being is associated with lower mortality.¹²⁶

STRATEGIC PRIORITIES

Foster equitable gender norms and attitudes – Inequitable gender norms are a key underlying determinant of sex differentials in morbidity and mortality of both adolescents and adults, particularly related to SRHR. To foster equitable gender norms and attitudes, there is an urgent need to: engage adolescents in open discussions about gender norms and attitudes that take into account their evolving cognitive capacities;

stimulate critical reflection to change attitudes and norms within peer groups; incorporate content on gender-equitable norms in parenting interventions; strengthen school-based efforts to promote equitable gender attitudes; tap into the reach and influence of media and technology; and change norms by working simultaneously at different levels of the ecological framework.¹²¹

Adopt rights-based approaches to health – A rights-based approach to health requires that health policy and programmes prioritize the needs of those most in need. This will foster greater health equity, a principle that has been echoed in the 2030 Agenda for Sustainable Development. A State's obligation to support the right to health includes allocating "maximum available resources" to progressively realize this goal. In many cases, the right to health has been adopted into domestic law or constitutional law. The right to health must be enjoyed through "meaningful participation" and without discrimination on the grounds of race, age, ethnicity or any other status.¹²⁷

Strengthen health governance – Focus on "whole-of-government" responses to ensure greater coordination and coherence of health plans and policies with other areas of government. This approach is based on the rationale that health is determined by multiple factors outside the direct control of the health sector (e.g. education, income and individual living conditions) and that decisions made in other sectors can affect health and shape disease distribution and mortality. Good governance in the SDG era includes better conflict of interest management and improved co-benefit analysis, planning and financing. In this way action across sectors promotes effective, accountable and transparent institutions at all levels.¹²⁸

DATA MATTERS



OVERVIEW

In order to reflect the progress achieved towards the objectives of the EWEC Global Strategy, there is an urgent need to extend and strengthen data and surveillance systems, and data collection and analysis, including through household surveys and administrative sources, and in the use of data for decision-making at different levels.

Investments are required in civil registration, vital statistics and health information systems, including to establish or improve CRVS systems to ensure that all births and deaths are registered. Action should be prioritized in regions with the lowest percentages of registered births (UNICEF regions): sub-Saharan Africa (43%), South Asia (60%), East Asia and Pacific (excluding China) (84%). The Health Data Collaborative continues to assist countries in using the HDC approach to improve the availability, quality and use of health data.

WHAT'S NEW

Defining indicators – Clarity and consistency of indicator definitions and data interpretations are critical. For example, work was undertaken in 2017 to refine the definition of skilled health personnel (SDG 3.1.2, proportion of births attended by skilled health personnel). Despite increased coverage of births by “skilled attendants”, expected declines in maternal mortality have not been observed in many countries,²² suggesting the possibility of a problem with the indicator (e.g. its metadata), its measurement, or a combination of both. A specialized taskforce of representatives from WHO, UNFPA, UNICEF, ICM, ICN, FIGO and IPA considered comments from a broad stakeholder consultation during 2017 to

inform and refine the definition of the health-care providers who should be counted as skilled health personnel to document progress towards achievement of both SDG 3.1.1 and 3.1.2.¹²⁹

Investments are also needed to better measure the agency of unmarried/non-union women to make decisions concerning sexual relations, contraceptive use and health care. The currently available data is for married/in-union women, as cited elsewhere in this report.

Environmental health data – In 2017, WHO published a new Atlas on Children's Health and the Environment, summarizing actions needed to protect children from environmental hazards.¹³⁰ Updated information on child health and the environment has since been included in the Global Health Observatory, and new training tools and strategies for health professionals are being developed.

Nutrition data – The Decade of Action proclaimed in 2016 reinforces the need for timely and credible data for monitoring countries' progress towards the achievement of the SDG 2.2 target to end all forms of malnutrition. The recently launched Global Nutrition Monitoring Framework operational guidance will help countries to integrate harmonized nutrition indicators into their national monitoring systems. Technical and financial support are required for continued capacity building on nutrition data collection and reporting.¹³¹

Water and sanitation data – In 2017, WHO and UNICEF released a new Joint Monitoring Programme report, presenting a global assessment of “safely managed” drinking water and sanitation services.¹¹⁶

As of 2017, 75% of the 75 countries that participate in the UN-Water Global Analysis and Assessment of Sanitation and Drinking-Water (GLAAS) initiative indicated financial data were available and utilized for decision-making around WASH and health issues.⁸⁹ Of these countries, over two-thirds indicated the existence of a financing plan or budget for WASH, but fewer than one-third reported a financial plan was in place and

consistently followed.⁸⁹ WHO and UNICEF have developed specific WASH indicators for health facilities where births take place, which are being tested at country level.

Disaggregated data and equity analysis – Countries need to enhance their technical capacity to address the challenges outlined above and to identify and analyse health inequalities or observed differences between subgroups. By more accurately and

consistently monitoring health inequalities, they should be able to better identify health priorities for women, children and adolescents. It is also important to recognize that there are clustered deprivations across sex, education, poverty, rural/urban and other dimensions of inequalities. To address these issues there is a need also to cross-disaggregate to identify and address intersecting inequalities.

As part of their efforts to build capacity, countries flagged the need for a new toolkit to help with data disaggregation and analysis. The toolkit would need to display a summary of measures of inequality, and include interactive and customizable features that facilitate interpretation and reporting.

In response, WHO developed the Health Equity Assessment Toolkit (HEAT) between 2014 and 2016, which contains the WHO Health Equity Monitor database.¹³³ The first and only application of its kind, it allows users to assess in-country inequalities against over 30 RMNCH indicators and five dimensions of inequality (economic status, education, place of residence, subnational region and child's sex, where applicable).

HEAT has been designed work alongside country health information system and to assist technical staff (e.g. in ministries of health and statistical offices), public health professionals, policy-makers, researchers, and students. The 2018 Health Equity Monitor release will include disaggregated data from 111 countries on different inequality dimensions. Age disaggregation will be added for reproductive health interventions.

UNICEF developed the Equitable Impact Sensitive Tool (EQUIST) as a tool for organizing, analysing, storing, and presenting key health data, and to help decision-makers develop equitable strategies to improve

health and nutrition for the most vulnerable children and women.¹³⁴ A web-based analytical platform, it identifies cost-effective interventions, prioritizes key bottlenecks that constrain their coverage and targets the most effective and equity-focused strategies to increase MNCH intervention coverage and accelerate the reduction of maternal and child mortality, especially among deprived populations.

STRATEGIC PRIORITIES

Enhance countries' technical capacity – To address the data challenges and to identify and analyse health inequalities or observed differences between subgroups.

Consider deploying HEAT, the Health Equity Monitor database and EQUIST – In tandem with country health information systems.

Strengthen country data systems and use – There is a continued need for strong country systems for CRVS and health information. Countries also need to invest in local capacities to analyse and use the data in a timely manner to inform decision-making at all levels.

Indonesia study makes case for health inequality monitoring

A major study into the state of health inequality in Indonesia identified high socioeconomic inequalities and pressing areas for action in maternal, newborn and child health – despite progress in this area in the country over recent decades.¹³² The study, conducted in 2016 and 2017, aimed to improve understanding of health inequalities across MNCH and other health topics and dimensions of inequality, and to identify health priorities and their policy implications.

Key recommendations for MNCH included: universal improvements in exclusive breastfeeding; and equity-oriented improvements in antenatal care coverage, births attended by skilled health personnel, and postnatal care coverage for both mothers and newborns. The findings confirmed the importance of ensuring services are of high quality and reliably accessible to all. Analysis by subnational data highlighted the need to build capacity in under-performing geographies.

Other findings included: low national coverage for complete basic immunization and large inequality, especially by subnational region and economic status; insufficient progress on child malnutrition, with pronounced inequalities, especially by subnational region, economic status and mother's education level; and stagnation in reductions of neonatal mortality. To address preventable child mortality, the report recommended diverse approaches across health and non-health sectors, supported by adequate resources.

The report strengthens the case for improved country health inequality monitoring as a key step in determining how to advance health equitably. It also showcases the work of an emerging network of stakeholders that monitor health inequality in Indonesia.



CONCLUSION



The concept of unlocking human potential across the life course through improvements to health and well-being is central to the EWEC Global Strategy, and is one of its nine action areas. By eliminating preventable determinants of death and disease – and providing integrated services, in innovative ways, at critical phases across the life course – countries can support the efforts of women, children and adolescents to improve their health and life chances. This builds human capital within individuals, families and communities, which pays forward across generations.

Recent scientific evidence has confirmed early childhood development as a critical early intervention for improving health, realizing human potential and creating a strong foundation for human capital. But children have to survive before they can thrive. An estimated 5.6 million children (including newborns) still die each year before reaching their fifth birthday, mostly from preventable diseases. Many of the persistent health challenges that threaten the lives of children under-5, and hinder their development, could be ameliorated or eradicated if early childhood development and good-quality health services were available to every child as part of UHC – underpinned by a life course approach to health.

The process of self realization and fulfilment through good health and well-being enters a new phase with the onset of adolescence. At this time of unique health challenges and new behaviour patterns, an individual who thrived as a child can too easily suffer health setbacks that may threaten their well-being and affect the rest of their lives. Specialized interventions, based on the AA-HA! guidance on global accelerated action for the health of adolescents, are needed to support adolescents.

Barriers to sustaining good health multiply for many girls and women as they approach adulthood. High rates of death and chronic disease from maternal causes continue to affect women globally, while social, economic and cultural factors – including gender-based violence and discrimination – prevent many women from realizing their full potential. By addressing these pressing health challenges, and actively promoting positive gender norms across society, countries can support women's endeavours to take charge of their health.

To accelerate progress towards the objectives of the EWEC Global Strategy, improvements to the health of women, children and adolescents should be implemented through comprehensive evidence-based policies, information, services and multisectoral action, informed by human rights and underpinned by good governance and accountability. The design and implementation of universal health coverage systems, and health systems strengthening, give countries the opportunity to embed these principles into their health and social care systems, at scale. In parallel, improved monitoring and data analysis are needed to identify and address inequities in access to services.

Three years may seem of little consequence during adulthood, but their value at the beginning of life is almost without measure. As part of an integrated, holistic approach to women's, children's and adolescents' health, early childhood development begins the process of unlocking human potential and sustaining good health and human capital across the life course.

ANNEXES

ANNEX 1:

COUNTRY SUPPORT THROUGH EWEC AND THE EWEC ECOSYSTEM

EWEC HIGH-LEVEL STEERING GROUP (HLSG)

In April 2017, the HLSG welcomed the United Nations Secretary-General, António Guterres, as its Senior Chair. Also in April, the HLSG endorsed the EWEC 2020 Partners Framework to facilitate collective advocacy and action for results against the 2030 targets of the EWEC Global Strategy.

The framework is underpinned by principles of human rights, equity, equality and universality. It places particular focus on the following areas: 1) early childhood development; 2) adolescent health and well-being; 3) quality, equity and dignity in services; 4) sexual and reproductive health and rights; 5) empowerment of women, girls and communities; 6) and humanitarian and fragile settings. It also serves to ensure greater alignment across the robust EWEC platform by identifying a set of common deliverables to bring partners together for collective action in support of country-level implementation.

Leveraging their unique platforms and voices, various HLSG members have helped to take forward the framework. Working with partners and leveraging existing mechanisms, they have led advocacy work across the respective focus areas through the development and promotion of advocacy roadmaps. In an evolving landscape, the HLSG continues to help weave the focus areas together and ensure a common narrative for women's, children's and adolescents' health in the SDG era.

H6 PARTNERSHIP SUPPORT FOR IMPLEMENTATION

The H6 partnership of UNAIDS, UNFPA, UNICEF, UN Women, WHO and the World Bank Group continued to provide technical support during 2017 to help countries implement the EWEC

Global Strategy, and to advance regional and global initiatives.

Country level

- H6 provided functioning coordination mechanisms in 46 high-burden countries, with one of the six agencies serving as chair on a rotating basis;
- By 2017, 60 governments had made commitments to the EWEC Global Strategy: 31 mobilized by H6 country teams;
- H6 is progressing towards its goal to help all countries strengthen health systems and services in relation to reproductive, maternal, newborn, child and adolescent health (RMNCAH).

Global and regional

- H6 developed and disseminated several knowledge products in the public domain to enhance evidence-informed, rights-based, client-centred and results-oriented practices for RMNCAH;
- H6 contributed to the development of several innovative global efforts for improving RMNCAH: the GFF business plan; Every Newborn Action Plan; Ending Preventable Maternal Mortality; and Global Accelerated Action for the Health of Adolescents;
- H6 technical teams provided technical support to countries for the development and implementation of national RMNCAH plans and investment cases. H6 received collaborative funding from the Muskoka Initiative;
- The Network for Improving Quality of Care for Maternal, Newborn and Child Health began implementation of its strategic objectives in the months following the launch of the network in February 2017.¹³⁵ The Network sets out to achieve a vision where every pregnant woman and newborn receives good-quality care throughout pregnancy, childbirth and the postnatal period. The 10

countries (Bangladesh, Côte d'Ivoire, Ethiopia, Ghana, India, Malawi, Nigeria, Sierra Leone, United Republic of Tanzania and Uganda) of the network, supported by WHO, UNICEF, UNFPA and other partners, established quality of care coordination structures that involve all implementing partners.

An independent evaluation of the H6 Joint Programme¹³⁶ highlighted the added value of the H6 partnership in supporting the operationalization of the EWEC Global Strategy, especially through improvements in quality and access of RMNCAH services, policy engagement, advocacy, and health system strengthening.

GLOBAL FINANCING FACILITY (GFF) IN SUPPORT OF EVERY WOMAN EVERY CHILD

To support countries, a multidonor trust fund – the GFF Trust Fund – has been established at the World Bank Group. It provides flexible financing for the preparatory work and technical assistance required to identify priorities, supports the process of bringing partners together, and makes modest grants to address key bottlenecks. The GFF Trust Fund is not intended to fill the financing gap on its own but rather to crowd in additional resources from the broad set of partners that are part of the facility and to ensure that the available resources are aligned and working smoothly together.

The broad set of GFF partners includes governments, civil society organizations, the private sector, UN agencies, Gavi the Vaccine Alliance, and the Global Fund to Fight AIDS, Tuberculosis and Malaria. They come together through the GFF Investors Group, which convenes several times a year to discuss progress and how to strengthen collaboration across the partnership.

The GFF has to date supported 16 countries (Bangladesh, Cameroon, Democratic Republic of Congo, Ethiopia, Guatemala, Guinea, Kenya, Liberia, Mozambique, Myanmar, Nigeria, Senegal, Sierra Leone, United Republic of Tanzania, Uganda and Viet Nam) to develop investment cases, all of which include some

aspects of health systems strengthening. A new group of 10 countries (Afghanistan, Burkina Faso, Cambodia, Central African Republic, Côte d'Ivoire, Haiti, Indonesia, Madagascar, Malawi and Rwanda) initiated the preparation of GFF investment cases in early 2018. A focus on results is central to the GFF approach. This means that the GFF strongly supports strengthening systems to track progress, learn, and course-correct, in three main ways: 1) ensuring clarity around results; 2) supporting capacity building for results measurement and the use of data to inform programming; and 3) supporting cross-country learning.

As part of the Investment Case process, the GFF supports countries to undertake an assessment of monitoring and evaluation (M&E) capacity, so that required investments can be included. The GFF recommends that 5–10% of budget of Investment Cases go to M&E, including to strengthen CRVS and health information systems and population and facility surveys. The latest GFF annual report is available at: <https://www.globalfinancingfacility.org/global-financing-facility-annual-report>.

EWEC INNOVATION MARKETPLACE

The EWEC Global Strategy identifies innovation as the starting point of a process that translates new ideas and scientific evidence into effective, widely used interventions and commodities to improve the health of women, children and adolescents. However, a significant bottleneck exists at the step of “critical testing and transition to scale.”

The EWEC Innovation Marketplace¹³⁷ aims to tackle this bottleneck as a strategic alliance of development innovation organizations, including the Bill and Melinda Gates Foundation, Grand Challenges Canada, the United States Agency for International Development, the Norwegian Agency for Development Cooperation and UBS Optimus Foundation. The objective is to facilitate 20 investments by 2020, and by 2030 to see at least 10 of these innovations widely available and having significant impact.

As of April 2018, 228 innovations have been sourced from the anchor partners and external sources. Innovations are curated by a College of Curators and reviewed by a Review Panel, both constituted by experts. The Marketplace has undertaken three rounds of curation and catalyzed \$6.943M USD investment in 9 of the most promising innovations: six critical testing deals and three transition to scale deals.

The EWEC Innovation Marketplace also uses high-profile events to catalyze investments in prioritized innovations, create brand awareness, and support country-level uptake and advocacy.

PARTNERSHIP FOR MATERNAL, NEWBORN & CHILD HEALTH (PMNCH)

PMNCH provides a platform for organizations to align objectives, strategies and resources, and agree on interventions to improve maternal, newborn, child and adolescent health. Its role complements the work and accountability processes of its more than 1000 member organizations in 77 countries. PMNCH plays a lead role in operationalizing the unified accountability framework of the EWEC Global Strategy.

Since the launch of the first Global Strategy in 2010, PMNCH has led the tracking and analysis of commitments made by stakeholders to the EWEC Global Strategy. An overview of the commitments pledged, progress on implementation, and the efforts made by partners at country, regional and global levels are accessible on the EWEC website at www.everywomaneverychild.org.

The GFF Civil Society Coordinating Group, convened by PMNCH, brings together more than 150 representatives from civil society organizations at the national, regional and global levels in joint planning and advocacy concerning the GFF. The Group is an example of PMNCH's greater focus on aligning partner efforts for

more effective action, especially at national and subnational levels, and of its country work to strengthen multistakeholder platforms.

INDEPENDENT ACCOUNTABILITY PANEL (IAP)

The UN Secretary-General appointed the Independent Accountability Panel Adolescent (IAP) to provide an independent and transparent review of progress and challenges on the implementation of the EWEC Global Strategy to help strengthen the response from the international health community and countries.¹³⁸ The IAP is composed of an expert group of nine internationally-recognized leaders in the field of health and human rights who serve in their individual capacities. PMNCH hosts the secretariat of the IAP and provides financial support.

The IAP conceptual framework is “monitor, review, act and remedy” and through its reports, the IAP aspires for incisive insights and solution-oriented recommendations for action. The IAP's 2017 report explored opportunities for fast-tracking implementation of the Global Strategy, and focused on adolescents. It presented six major recommendations: lock in accountability; make adolescents visible and measure what matters; foster whole-of-government accountability to adolescents; make UHC work for adolescents; boost accountability for investments, including for adolescents' health and well-being; unleash the power of young people and move away from tokenism. The IAP's 2018 Report will be on the theme of private sector accountability for women's, children's and adolescents' health.

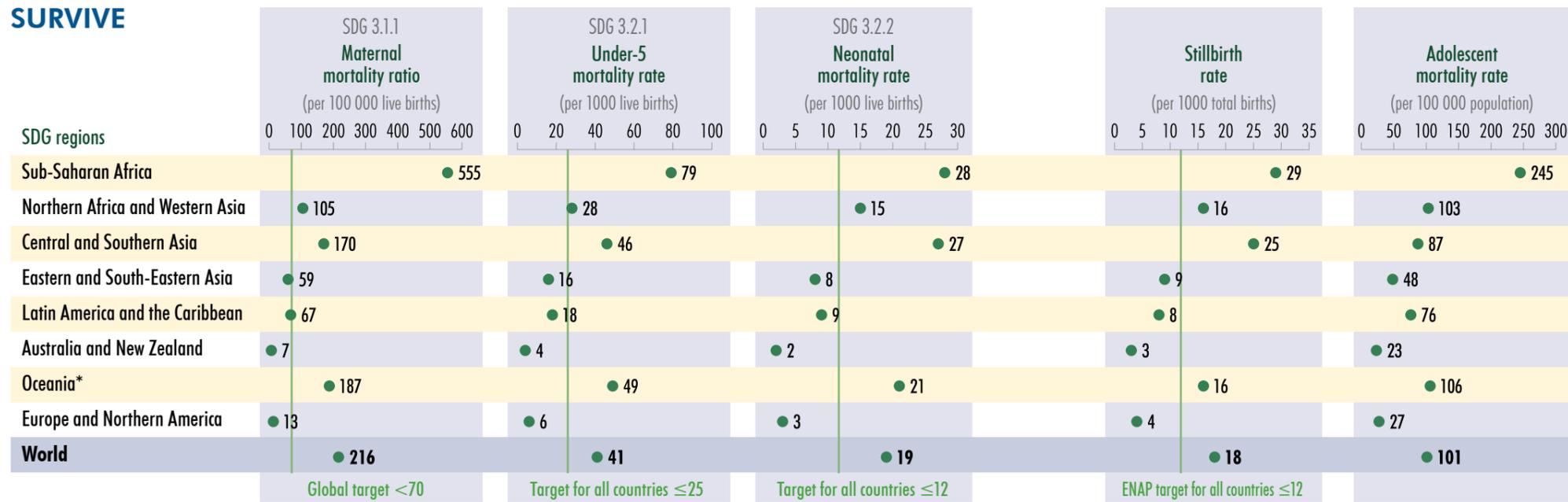
The IAP encourages review of its reports and recommendations by diverse stakeholders at global, regional and national fora and high level political assemblies and events, so that the appropriate actions can be taken.

For more information please see: www.everywomaneverychild.org

ANNEX 2:

REGIONAL DASHBOARDS ON 16 KEY INDICATORS: STATUS IN 2018

SURVIVE



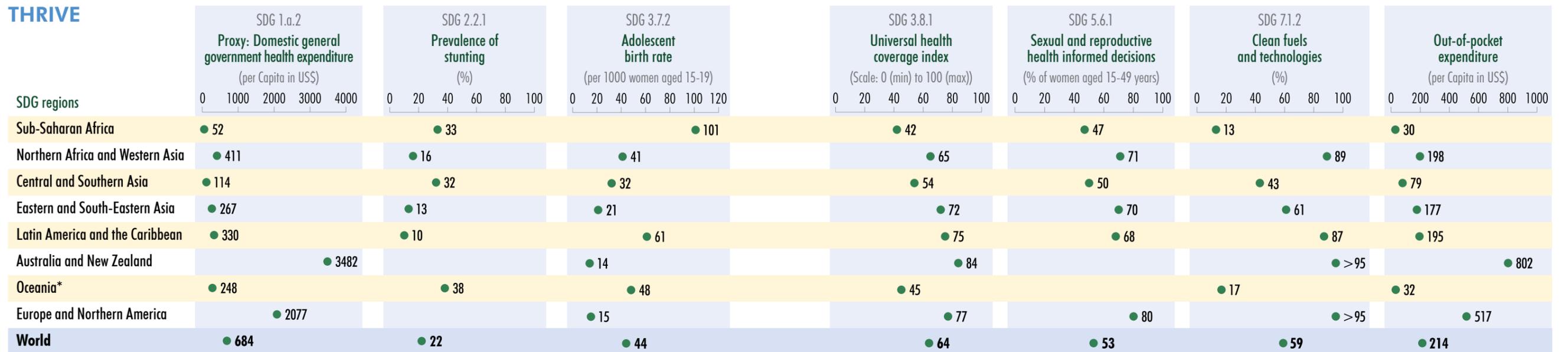
EWEC Global Strategy portal of the Global Health Observatory
<http://apps.who.int/gho/data/node.gswcah>

* Oceania refers to Oceania excluding Australia and New Zealand.

Indicators in each section are first organized by SDG number, and then by additional indicators.

The SDG regions are based on the 2017 SDG regional groupings: <https://unstats.un.org/sdgs/indicators/regional-groups/>
 The assignment of countries or areas to specific groupings is for statistical convenience and does not imply any assumption regarding political or other affiliation of countries or territories by the United Nations or Organizations publishing this report.

THRIVE



SDG 3.1.1 Maternal mortality ratio. Data from 2015. SDG region estimates recalculated from: Trends in maternal mortality: 1990 to 2015: Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Geneva: World Health Organization; 2015.
 Available from: <http://www.who.int/reproductivehealth/publications/monitoring/maternalmortality-2015/en/>.

SDG 3.2.1 Under-5 mortality rate. Data from 2016. SDG region estimates from: United Nations Inter-Agency Group for Child Mortality Estimates (UN IGME). Levels and Trends in Child Mortality: Report 2017. New York: United Nations Children's Fund. Available from: <http://www.childmortality.org>.

SDG 3.2.2 Neonatal mortality rate. Data from 2016. SDG region estimates from: United Nations Inter-Agency Group for Child Mortality Estimates (UN IGME). Levels and Trends in Child Mortality: Report 2017. New York: United Nations Children's Fund. Available from: <http://www.childmortality.org>.

SDG 1.a.2 Proportion of total government spending on essential services (education, health and social protection). Under development. Proxy indicator. SDG region estimates recalculated from: WHO Global Health Expenditure Database (2013-2015). Country estimates of Public domestic sources of spending on HIV/AIDS and Other Sexually Transmitted Diseases (STDs), on Reproductive health, and on Contraceptive management (family planning) are separately available from <http://apps.who.int/riha/database/Home/Index/en>.

SDG 2.2.1 Prevalence of stunting among children under 5. Data from 2017. SDG region estimates recalculated from: Levels and trends in child malnutrition: Key findings of the 2018 edition. UNICEF/WHO/World Bank Group Joint Child Malnutrition Estimates; May 2018. Available from: www.who.int/nutgrowthdb/estimates; <https://data.unicef.org/topic/nutrition/malnutrition/>.

SDG 3.7.2 Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group. Rates are given as the average over a five-year period from mid-year 2015 to mid-year 2020 with 1 January 2018 as the mid-point for 2015-2020. SDG region estimates for aged 15-19 are recalculated from: United Nations, Department of Economic and Social Affairs, Population Division (2017). World Population Prospects: The 2017 Revision, <https://esa.un.org/unpd/wpp/Download/Standard/Fertility/>.

Stillbirth rate per 1000 total births. SDG region estimates recalculated from: Blencowe H, Cousens S, Jassir FB, Say L, Chou D, Mathers C, et al. National, regional, and worldwide estimates of stillbirth rates in 2015, with trends from 2000: a systematic analysis. Lancet Glob Health. 2016;4(2):e98-e108. Available from: <https://www.ncbi.nlm.nih.gov/pubmed/26795602>.

Adolescent mortality rate per 100 000 population. SDG region estimates recalculated for aged 10-19 from: World Health Organization. Global health estimates 2015: deaths by cause, age, sex, by country and by region, 2000-2015 Geneva; 2016. Available from: http://www.who.int/healthinfo/global_burden_disease/estimates/en/index1.html.

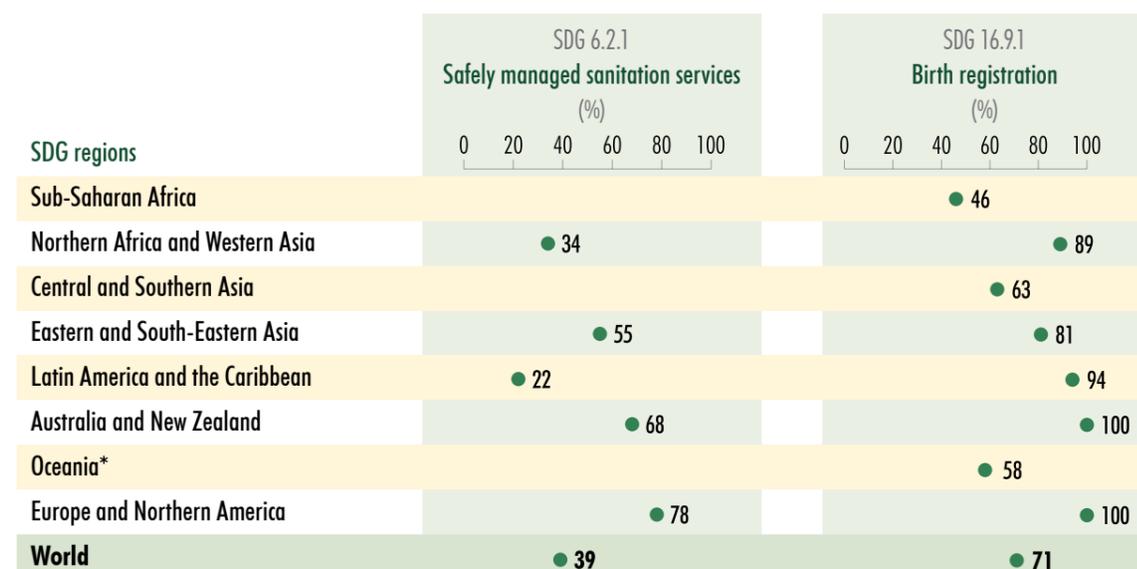
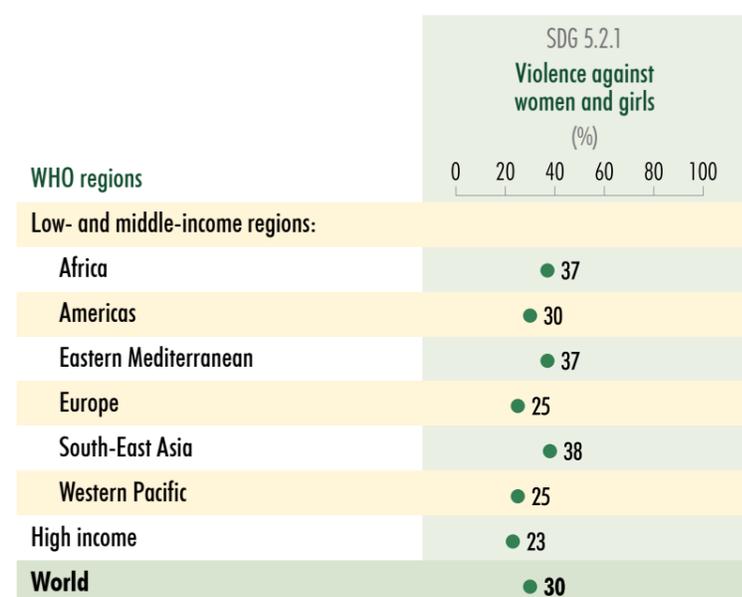
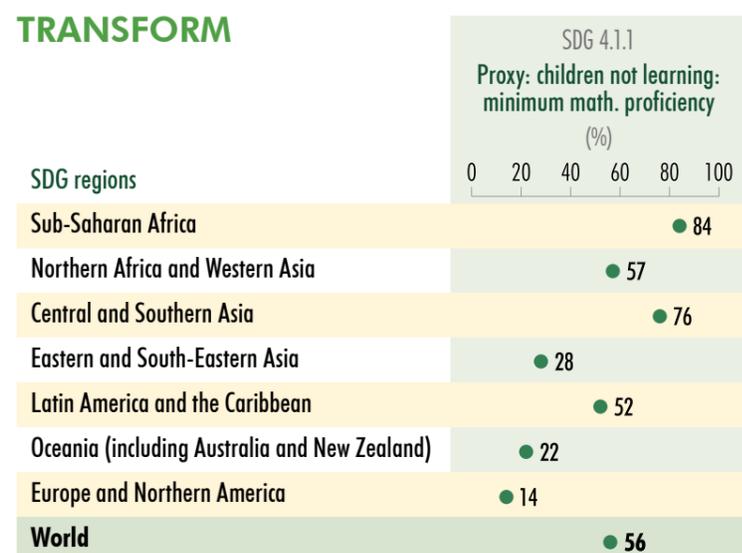
SDG 3.8.1 Coverage of essential health services. The UHC service coverage index is a measure of SDG indicator 3.8.1, which is coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, noncommunicable diseases and service capacity and access, among the general and the most disadvantaged population). Data from 2015. SDG region estimates recalculated from: Tracking universal health coverage: 2017 global monitoring report. World Health Organization and International Bank for Reconstruction and Development / The World Bank; 2017. Available from: http://www.who.int/healthinfo/universal_health_coverage/report/2017/en/.

SDG 5.6.1 Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care. Data from 2013. SDG region estimates from: UNFPA Global Database, 2018. Available from: <http://unfpaopendata.org>.

SDG 7.1.2 Proportion of population with primary reliance on clean fuels and technologies. Data from 2016. SDG region estimates recalculated from: World Health Statistics 2018: Monitoring Health for the SDGs. Geneva: World Health Organization; 2018.

Out-of-Pocket Expenditure per Capita in USD. SDG region estimates recalculated from: WHO Global Health Expenditure Database (2013-2015). Available from <http://apps.who.int/riha/database/Home/Index/en>.

TRANSFORM



SDG 4.1.1 Proportion of children and young people (a) in grades 2/3; (b) at the end of primary; and (c) at the end of lower secondary achieving at least a minimum proficiency level in (i) reading and (ii) mathematics, by sex. Under development. Proxy indicator: Proportion of primary and secondary school-aged children and adolescents not achieving minimum proficiency levels (mathematics). Data from 2015. SDG region estimates from: UNESCO Institute of Statistics.

SDG 5.2.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age. Under development. Subset indicator: lifetime prevalence of physical and/or sexual intimate partner violence among ever-partnered women. Source: Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and nonpartner sexual violence. Geneva: World Health Organization; 2013.

SDG 6.2.1 Proportion of population using safely managed sanitation services, including a hand-washing facility with soap and water. Data from 2015. SDG region estimates from: WHO/UNICEF Joint Monitoring Programme for Water Supply, sanitation and hygiene. 2017. Available from: www.washdata.org.

SDG 16.9.1 Proportion of children under 5 years of age whose births have been registered with a civil authority, by age. The World estimate is based on a population coverage of 80 per cent. The SDG region estimate for the Eastern and South-Eastern Asia region is based on a population coverage of 40 per cent. SDG region estimates recalculated from: UNICEF global databases, 2017, based on DHS, MICS, other national household surveys, censuses and vital registration systems. Available from: <https://data.unicef.org/topic/child-protection/birth-registration/child-protection/birth-registration>.

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