
EVERY WOMAN
EVERY CHILD
FOR HEALTHY AND EMPOWERED WOMEN,
CHILDREN AND ADOLESCENTS
PROGRESS IN PARTNERSHIP
2017 PROGRESS REPORT
on the Every Woman Every Child Global Strategy
for Women's, Children's and Adolescents' Health
The Partnership
for Maternal, Newborn
& Child Health

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PROGRESS IN PARTNERSHIP

2017 PROGRESS REPORT

on the *Every Woman Every Child Global Strategy for Women's, Children's and Adolescents' Health*

In a time of complex development challenges, the investments we make today in women's, children's and adolescents' health and well-being will help build the peaceful, sustainable and inclusive societies we have promised to achieve through the Sustainable Development Goals. All that we strive for as a human family—dignity and hope, progress and prosperity—depends on peace. Peace cannot exist without development and development cannot exist without health and well-being, for healthy and empowered women, children and adolescents can bring about the change needed to create a better future for all.

António Guterres
UN Secretary-General

FOREWORD

There is no equality without empowerment. There is no empowerment without knowledge. Our job is to foster the opportunities so that every woman, child and adolescent can understand – and demand – their rights.

In 2015, when the *Every Woman Every Child Global Strategy for Women's, Children's, and Adolescents' Health* was launched, we knew achieving something extraordinary called for a transformative approach in how we worked together as partners to accelerate progress on the Sustainable Development Goals (SDGs).

Every Woman Every Child is increasingly uniting stakeholders across sectors for collective advocacy and action. It has created a surge of support to ensure women, children and adolescents are at the heart of the SDGs. One year on, this inaugural *Global Strategy* progress report serves as a critical tool for alignment, advocacy and accountability.

This report showcases how multisectoral and multistakeholder partnerships are working across the life-course to ensure equitable access to quality and affordable care. Around the world, and across sectors, we are coming together to deliver together on a shared vision for, and of, women, children and adolescents as critical agents of change. We see that, around the world, citizens are getting mobilized to ensure their voices are heard. Many of the poorest countries are investing more in the health and well-being of their citizens. We must continue to work together across sectors building on strategies and interventions that we know work, while broadening our horizons to harness the power of innovation to deliver the next generation of solutions for complex development challenges.

I urge all partners to reflect on the findings and messages in this first annual progress report on the *Every Woman Every Child Global Strategy*. While future reports will compile even more data against emerging baselines, this report sets out our expectations of doing more together, more effectively and more efficiently. We will keep working until every woman, child and adolescent attains their human rights – the health, freedom and opportunities we all deserve – and reaches their full potential.

Graça Machel
Chair, Board of the Partnership for Maternal, Newborn & Child Health
Member, High-Level Steering Group for *Every Woman Every Child*

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EXECUTIVE SUMMARY

Globally, the health and well-being of women, children and adolescents are improving faster than at any point in history, even in many of the poorest nations. The transformation is due in great measure to one of the most successful global health initiatives in history: *Every Woman Every Child* (EWEC). Since its launch by the United Nations in 2010, partners worldwide have made nearly 650 commitments, and more than US$ 45 billion has been disbursed to scale up evidence-based interventions. Greater momentum has been building over the past two years, with more than 200 commitments made since September 2015, when the UN together with governments, the private sector and civil society launched the updated *Every Woman Every Child Global Strategy for Women's, Children's and Adolescents' Health* (EWEC *Global Strategy*). This human rights-based strategy is a detailed roadmap for countries to reduce inequities, strengthen fragile health systems and foster multisector approaches in order to end all preventable deaths of women, children and adolescents and ensure their well-being.

The EWEC movement puts the EWEC *Global Strategy* into practice through country-led, multistakeholder engagement and collaboration, and mutual accountability for results, resources and rights. Its core partners include the H6 Partnership (UNAIDS, UNICEF, UNFPA, UN Women, WHO and the World Bank Group), the Partnership for Maternal, Newborn & Child Health (PMNCH) and the Global Financing Facility in support of EWEC.

This report details the current situation in relation to the EWEC *Global Strategy*'s targets and objectives, analyses commitments, implementation and impact between September 2015 and December 2016, and presents the agreed priorities and milestones for further coordination and action from 2018 to 2020. Further progress reports will be produced annually to underpin the Independent Accountability Panel's recommendations and to support annual reporting to the World Health Assembly and the High-Level Political Forum on Sustainable Development.

"SURVIVE, THRIVE AND TRANSFORM": PROGRESS TOWARDS THE EWEC *GLOBAL STRATEGY*'S OBJECTIVES

Data and estimates show that, despite general progress, major challenges persist around each of the EWEC *Global Strategy*'s three objectives. Across all 60 indicators, major disparities within countries and across regions hinder progress towards the universal agenda of the EWEC *Global Strategy* and the Sustainable Development Goals (SDGs).

To help monitor progress an open-access online data portal was created, publishing the latest available country data on the 60 relevant indicators. This portal was launched in May 2017 on WHO's Global Health Observatory website (http://www.who.int/gho/en/).

Under "survive", there still is a high toll of preventable deaths among women, children and adolescents, and also of stillbirths.

For example, since 1990, the world's maternal death rate has fallen by 44%. However, in 2015, an estimated 303 000 women died from preventable causes during pregnancy and childbirth, with more than half of maternal deaths occurring in sub-Saharan Africa. From 1990 to 2015, death rates of children under age five declined by 53%. Still, in 2015, an estimated 5.9 million children under age five died, mainly of avoidable causes. In 2015, 2.7 million newborns died within 28 days of birth, representing 45% of all deaths among children under age five. Stillbirth also remains a major neglected problem, with 2.6 million stillbirths estimated in 2015.

Under "thrive", multiple barriers to good-quality health care and health-enhancing services prevent millions of women, children and adolescents from realizing their full potential and their human right to the highest attainable standard of health and well-being.

For example, in low- and middle-income countries, 250 million children are at risk of suboptimal development due to poverty and stunting. Additionally, poor-quality health services and inequities in accessing care are major obstacles to improving health outcomes. Gaps are also exacerbated by the worldwide shortage of qualified health workers: global projections to 2030 estimate that an additional 18 million health workers will be needed to meet the requirements of the SDGs. Furthermore, many women and girls do not have access to comprehensive sexual and reproductive health services and rights, including modern contraceptive methods, safe abortion (where legal), treatment and prevention of infertility, and prevention of sexual violence.

Under "transform", issues such as lack of civil registration of children at birth, poverty, gender inequality, lack of education, lack of adequate water, sanitation and hygiene, air pollution, gender-based violence and discrimination constitute both violations of rights and barriers to progress.

For example, the number of out-of-school children of primary school age declined globally from 99 million in 2000 to 59 million in 2013, however, progress has stalled since 2007. Just 1% of the poorest girls in low-income countries complete upper secondary school. Worldwide, almost one third of all women who have been in a relationship have experienced physical and/or sexual violence by their intimate partner; 30% of adolescent girls (aged 15–19) have experienced physical and/or sexual violence by an intimate partner. Issues such as poverty, gender inequality, poor education, discrimination and violence often intersect, leading to even greater vulnerabilities and increased risks of preventable death, illness and injury.

Progress requires action across all the interlinked "survive, thrive and transform" objectives. For example, malnutrition underpins around half of all causes of child mortality; and girls' education is associated with better women's health outcomes.

Adolescent health remains a key concern, particularly because lack of earlier focus on this age group has resulted in less rapid progress compared with areas such as maternal and child health.

Efforts to improve equity of coverage and to reach those most in need of health care and health-enhancing services must continue. In addition, a focus on improving the quality of these services is required. This includes respecting the rights and dignity of those seeking care, as well as a strong focus on multisectoral action.

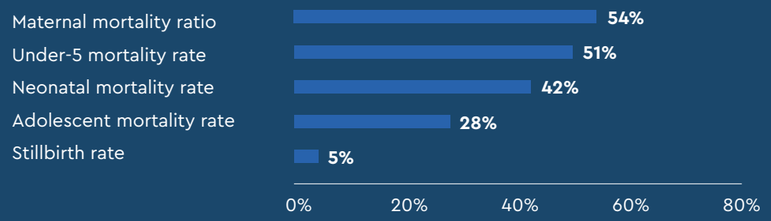
COMMITMENTS TO THE EWEC *GLOBAL STRATEGY*

EWEC has mobilized continued support from governments and a diverse group of nongovernmental stakeholders. Commitments, whether financial, in-kind or shared value interventions (policy, advocacy etc.) have increased since 2015. Between September 2015 and December 2016, 215 commitments were made to the EWEC *Global Strategy*, totalling US$ 28.4 billion (excluding the value of non-financial commitments, which is considerable but hard to quantify). Governments of low- and lower-middle-income countries committed an estimated US$ 8.5 billion – more than half the sum committed by high-income countries.

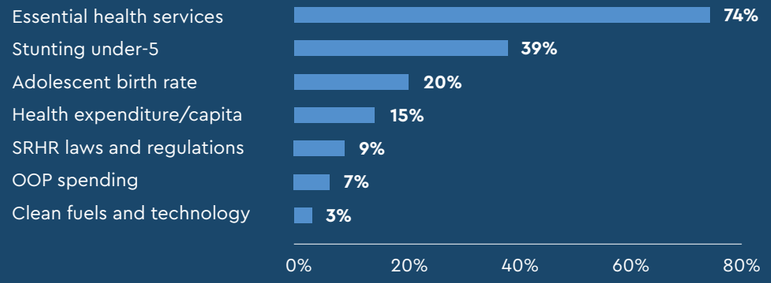
By number of commitments, governments account for 28%; the private sector, 24%; civil society organizations and nongovernmental organizations, 23%; UN agencies, 7%; and joint partnerships, 4%. Private and philanthropic foundations, health-care professional groups, intergovernmental bodies and academic, research and training institutions

Figure 1. Commitments referencing the 16 EWEC *Global Strategy* key indicators

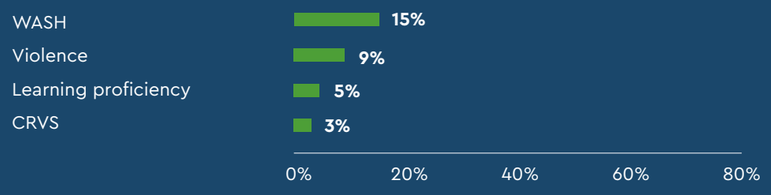
Survive



Thrive



Transform



SRHR: sexual and reproductive health and rights; OOP: out-of-pocket expenditures; WASH: water sanitation and hygiene; CRVS: civil registration and vital statistics.
Source: PMNCH commissioned analysis based on EWEC commitment data.

pledged the balance. Maternal mortality (54%) and under-five mortality (51%) are the two most frequently referenced key indicators under the commitments to the "survive" objectives. Fewer commitments are targeted at adolescent mortality and stillbirths (Figure 1). Commitments covering the "thrive" objective show strong support for essential health services. However, multistakeholder commitments, across and between sectors that address the social determinants of health such as, education and violence against women and children, under the "transform" objectives receive less attention and need further engagement.

Some commitments are coming from countries where the risk of humanitarian crises and disasters is greatest, according to the INFORM risk index. Compiled by global development partners and linked to the WHO's Global Health Observatory, this index is based on assessments of hazards and exposure, vulnerability and lack of coping capacity. The health and well-being of women, children and adolescents are disproportionately affected in these settings. Seven of the 12 countries identified by INFORM as being most at risk in 2017 have made commitments since 2010 to the EWEC *Global Strategy*: Afghanistan, Chad, Democratic Republic of the Congo, Myanmar, Niger, South Sudan and Yemen.

For example, Afghanistan committed in 2015 to improve the quality of education for midwives, and to enhance medical services and supplies in hard-to-reach and insecure areas. It has also committed to creating a multisectoral movement to strengthen gender equity and women's empowerment, improving peace and security in Afghanistan.

Other countries are responding to the EWEC *Global Strategy* with their own commitments. For example, Bangladesh is scaling up programmes in health and health-enhancing sectors, such as education, gender equality and empowerment, water, sanitation, hygiene and nutrition. It plans to increase the number of "family planning mobile workers"; provide free education, meals and stipends to encourage girls to remain in secondary school; and increase efforts to reduce stunting in children. Malawi is combining targeted interventions with a more holistic health system approach to improve health outcomes, and is strengthening government structures to better monitor indicators. As one of nine countries leading EWEC's efforts to improve quality, equity and dignity, Malawi's Minister

of Health hosted the global launch of the Quality of Care Network in February 2017, announcing a goal to halve maternal and newborn deaths in participating health-care facilities by 2022.

Notably, citizens are also driving change and taking action to improve health and accountability. Both the SDGs and the EWEC *Global Strategy* call for accountability frameworks to be inclusive, participatory, transparent and people-centred. Citizens' hearings are increasingly being used to ensure that citizens' voices are heard by decision-makers at all levels of government. However, much more work is needed to engage citizens and inform them of their rights, and to support, and gather evidence of, the citizen-led accountability mechanisms being implemented by a range of partners across countries.

While government leadership plays a major role in implementing the EWEC *Global Strategy*, everyone has a role to play. Nongovernmental stakeholders, including the private sector and civil society, are core EWEC partners, supporting governments with a range of important contributions.

MOVING FORWARD

Accelerated progress, more commitments and better aligned action across sectors and among all partners are needed. A better way to monitor progress among EWEC partners in the short term is also necessary. In response to these needs, partners developed the EWEC Partners' Framework for 2018–2020, which includes six focus areas and five critical enablers ("common deliverables"). This framework does not impose any additional reporting burden on countries; rather, it defines what EWEC partners need to monitor jointly to ensure their mutual accountability.

To support countries in the implementation of their national plans and accelerate progress on the EWEC *Global Strategy* and the SDGs, partners have identified six areas requiring more focused attention and better aligned multistakeholder action: early childhood development; adolescent health and well-being; quality, equity and dignity in services; sexual and reproductive health and rights; empowerment of women, girls and communities; and humanitarian and fragile settings.

The five common deliverables are: political commitment; integrative, sustainable financing; multistakeholder and cross-sectoral partnership; improved management systems and capacities; and strengthened data and information systems and accountability at all levels.

In a time of increased conflicts, refugee and migrant crises, shifting political agendas, widespread human rights violations, and persisting and new dangers, the need to harness the power of partnership and work together with a common vision for change has never been more urgent. The rewards are great: investing in health and well-being of women, children and adolescents produces healthier and more inclusive communities, vibrant economies and more peaceful societies.

ACRONYMS AND ABBREVIATIONS

CEmONC	comprehensive emergency obstetric and newborn care
CRVS	civil registration and vital statistics
CSO	civil society organization
DALY	disability-adjusted life year
ECD	early childhood development
ENAP	Every Newborn Action Plan
EWEC	*Every Woman Every Child*
EWEC *Global Strategy*	*Every Woman Every Child Global Strategy for Women's, Children's and Adolescents' Health*
FP2020	Family Planning 2020
GDP	gross domestic product
GFF	Global Financing Facility in support of *Every Woman Every Child*
H6	UNAIDS, UNICEF, UNFPA, UN Women, WHO and the World Bank Group
HRP	UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction
IAP	Independent Accountability Panel
IPU	Inter-Parliamentary Union
LMICs	low- and middle-income countries
MDGs	Millennium Development Goals
MISP	Minimum Initial Service Package
MMR	maternal mortality ratio
NGO	nongovernmental organization
NMR	neonatal mortality rate
ODA	official development assistance
OHCHR	Office of the United Nations High Commissioner for Human Rights
PMNCH	Partnership for Maternal, Newborn & Child Health
RMNCAH	reproductive, maternal, newborn, child and adolescent health
RMNCAH-N	reproductive, maternal, newborn, child and adolescent health and nutrition
SDGs	Sustainable Development Goals
SRHR	sexual and reproductive health and rights
SRMNCAH	sexual, reproductive, maternal, newborn, child and adolescent health
U5MR	under-five mortality rate
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WRA	White Ribbon Alliance

INTRODUCTION

The investments we make in women, children and adolescents will build a stronger, more resilient world for everyone. That means leaving no one behind. Together, we must reach women, children and adolescents everywhere but especially those who are hardest to reach; they form the last mile in vulnerability but the first mile in our response.

H.E. Elhadj As Sy
Secretary-General, International Federation of Red Cross and Red Crescent Societies
Member of the High-Level Steering Group for *Every Woman Every Child*

The *Every Woman Every Child Global Strategy for Women's, Children's and Adolescents' Health* (EWEC *Global Strategy*)[1] was launched by world leaders in September 2015 alongside the United Nations (UN) General Assembly to build momentum for women's, children's and adolescents' health and well-being and, in so doing, contribute to the achievement of the Sustainable Development Goals (SDGs).[2]

The human rights-based EWEC *Global Strategy* prioritizes meeting the needs of the most disadvantaged and marginalized women, children and adolescents. It takes a holistic approach, focusing on reducing inequities, strengthening fragile health systems and fostering multisectoral approaches to address the wide-ranging determinants of health. In this way the EWEC *Global Strategy* aims to end preventable deaths, illness and injury by 2030 and to unlock the full potential of women, children and adolescents so they can thrive and transform their communities.

The *Every Woman Every Child* (EWEC) movement[3] puts the EWEC *Global Strategy* into practice through country-led, multistakeholder engagement and collaboration. EWEC is a model for transformative and mutually accountable partnership in a complex and evolving development landscape, bridging sectors and strengthening partner alignment in order to support governments and accelerate sustainable progress for all.

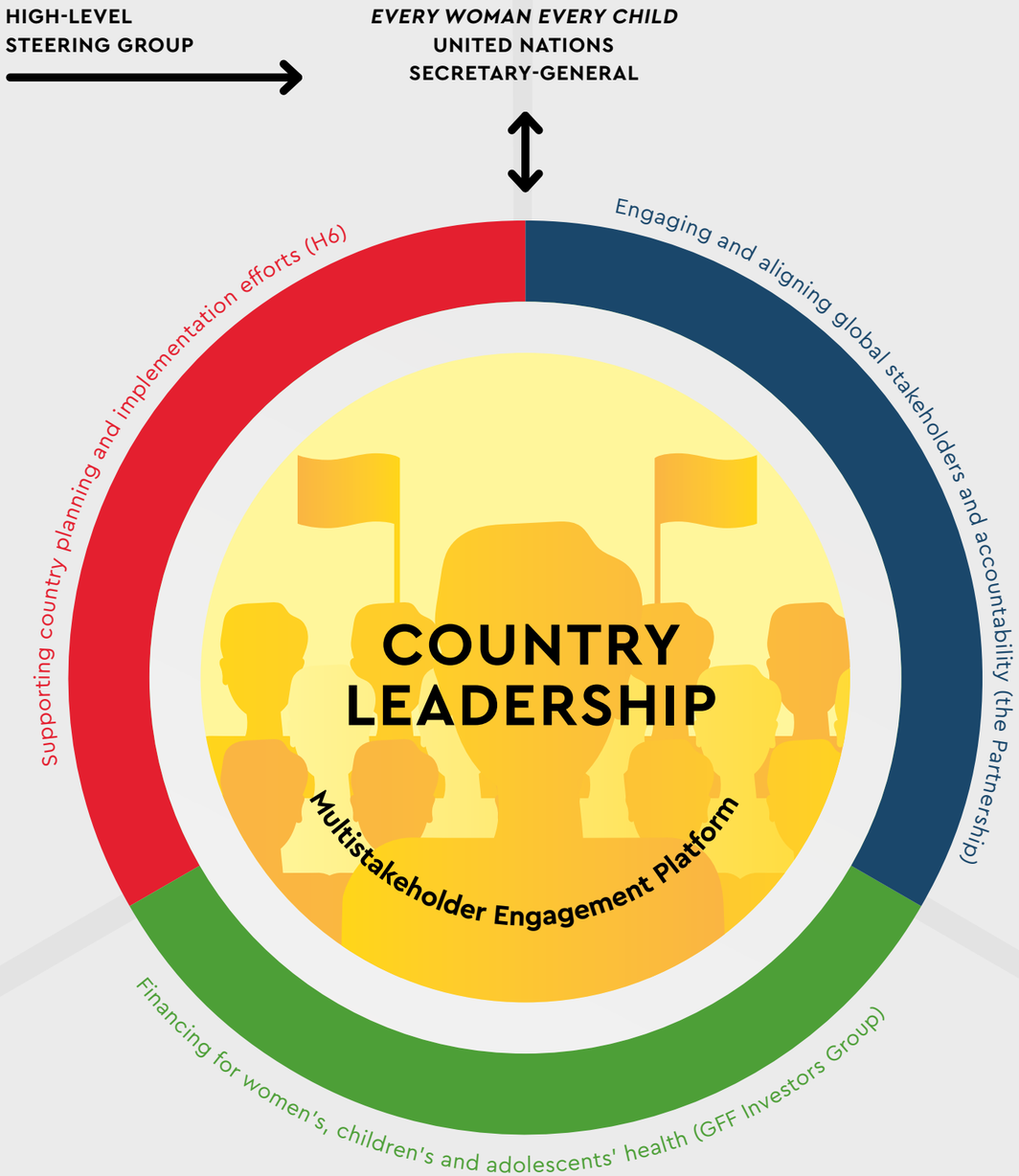
Since the launch of the first EWEC *Global Strategy* in 2010,[4] nearly 650 commitments have been pledged by partners worldwide, and more than US$ 45 billion has been disbursed to target the needs of women, children and adolescents.[5]

Achievements since the launch of the updated EWEC *Global Strategy* in 2015 include 215 concrete, time-bound commitments worth in excess of US$ 28 billion[6] and a World Health Assembly resolution[7] committing to the implementation of the EWEC *Global Strategy* and to reporting regularly on progress to the Assembly. The High-Level Steering Group for EWEC was established in September 2016, co-chaired by the heads of state of Chile and Ethiopia, with the new UN Secretary-General joining as senior co-chair in April 2017. The timeline below lists other milestones.

EWEC is supported by a small secretariat based in the Executive Office of the UN Secretary-General. Its core partners include the H6 Partnership (UNAIDS, UNICEF, UNFPA, UN Women, WHO and the World Bank Group), the Partnership for Maternal, Newborn & Child Health (PMNCH) and the Global Financing Facility in support of *Every Woman Every Child* (GFF) (Figure 1).

This is the first progress report since the launch of the updated EWEC *Global Strategy.* It is the collective effort of multiple partners and serves as a critical accountability tool, complementing country reporting on progress towards the SDGs. Chapter 1 provides a strategic summary of the current status of women's, children's and adolescents' health and well-being, and highlights global progress, gaps and strategic priorities requiring action. Chapter 2 compiles and analyses the commitments made by partners and stakeholder groups to the EWEC *Global Strategy* with examples of commitments and how they are being implemented in countries. Building on the preceding chapters, Chapter 3 presents a prioritized agenda for 2018–2020: it describes how EWEC partners will align themselves more strongly in support of country-led action and the actions planned by each stakeholder group in future.

Figure 1. *Every Woman Every Child* architecture



GFF: Global Financing Facility; **Partnership**: Partnership for Maternal, Newborn & Child Health; **H6**: UNAIDS, UNICEF, UNFPA, UN Women, WHO and the World Bank Group.

This report delivers on EWEC partners' promise to monitor progress and hold each other accountable. To support monitoring, the EWEC *Global Strategy* Indicator and Monitoring Framework sets out 60 indicators across the objectives and targets, with an agreed subset of 16 key indicators to provide a snapshot of progress.[8] The latest available country data and/or regional and global estimates for all 60 indicators are collated from different sources and are available from the open access EWEC *Global Strategy* portal on the WHO Global Health Observatory website[9] (see below for more information). Using data from the portal, Annex 1 provides an overview of the status of the 16 key indicators in 194 countries. EWEC also has an online platform for commitment-makers where commitments can be documented and tracked.

Currently, there are major gaps in data, and a monitoring priorities report reveals that only a handful of the 60 indicators are measured routinely, at scale, and with high quality, adequate frequency and full disaggregation in all countries.[10] Several countries have invested in and strengthened civil registration and vital statistics (CRVS) systems and health information systems, including by implementing the recommendations of the Commission on Information and Accountability for Women's and Children's Health (see Annex 2). Significant further investments in data systems are required that allow country comparisons and provide valid regional and global estimates to monitor progress. The Health Data Collaborative[11] and the GFF[12] are helping countries scale up CRVS and health information systems. With appropriate investments, progress towards the EWEC *Global Strategy* objectives and the SDGs can be monitored more accurately, and better reflected in future progress reports.

EVENTS AND MILESTONES, SEPTEMBER 2015 TO JUNE 2017

September 2015

The EWEC *Global Strategy* is launched at the UN General Assembly in New York. Initial commitments from 140 stakeholders total US$ 25 billion.

January 2016

H.E. Ms Michelle Bachelet Jeria, President of the Republic of Chile, and H.E. Mr Hailemariam Desalegn, Prime Minister of the Federal Democratic Republic of Ethiopia, agree to co-chair the High-Level Steering Group for EWEC. H.E. Ms Tarja Halonen, former President of the Republic of Finland, and H.E. Mr Jakaya Mrisho Kikwete, former President of the United Republic of Tanzania, agree to act as the two alternate co-chairs.

The Independent Accountability Panel (IAP) is established to provide an independent and transparent review of progress towards and challenges to the implementation of the EWEC *Global Strategy* to help strengthen the response from countries and the international health community. The IAP is hosted by PMNCH.

May 2016

A World Health Assembly resolution is adopted on committing to implementation of the EWEC *Global Strategy* and to reporting regularly on progress to the Assembly.

A global dialogue promoting EWEC citizen-led accountability is held at the World Health Assembly.

The EWEC *Global Strategy* indicator and monitoring framework setting out 60 indicators and a subset of 16 key indicators is published.

September 2016

An EWEC report assessing the worldwide state of readiness to begin monitoring progress towards the EWEC *Global Strategy* is launched. The report highlights the need for early investments in countries' civil registration and vital statistics and health information systems, and in local capacity to compile, analyse, disaggregate, communicate and use data, including in humanitarian settings.

The IAP launches its first report, Old Challenges, New Hopes.

February 2017

Nine countries, supported by WHO and UNICEF, establish a government-led Network for Improving Quality of Care for Maternal, Newborn and Child Health. The Network aims to halve maternal and newborn deaths and stillbirths in participating health facilities in 5 years, and to operationalize a common vision for quality of care, starting around the time of birth.

The GFF Trust receives its first contribution from the private sector: MSD for Mothers commits US$ 10 million to the GFF in support of EWEC. This will be used for innovative financing and public-private partnerships worldwide to scale up high-impact interventions to help women and children survive and thrive through critical life periods.

April 2017

UN Secretary-General António Guterres joins the EWEC High-Level Steering Group as its third and senior co-chair. The Steering Group meets in Washington, DC and endorses the EWEC 2020 Partners' Framework to help align action around six focus areas for 2018–2020, and to inspire and facilitate collective political advocacy, accelerate action and streamline efforts across the EWEC movement.

The GFF Investors Group approves the Civil Society Engagement Strategy, which aims to ensure that civil society is meaningfully engaged in the GFF at subnational to global levels.

May 2017

An update on progress towards the implementation of the EWEC *Global Strategy* is discussed by 194 Member States at the World Health Assembly.

An open access EWEC *Global Strategy* portal is launched on the WHO Global Health Observatory website.

The GFF annual report is launched alongside the World Health Assembly and discussed by representatives of governments, the private sector and civil society.

The report of the High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents is launched, calling on governments to: uphold the right to health in national law, protect people who advocate for rights, and strengthen the collection of rights-sensitive data for better monitoring and reporting.

Several tools are launched in support of EWEC at the Global Adolescent Health Conference in Ottawa, Canada, including the Advocating for Change for Adolescents Toolkit and the Global Accelerated Action for the Health of Adolescents (AA-HA!): Guidance to support country implementation, reflecting the increased focus on adolescent health.

July 2017

Policy-makers, donors and advocates from around the world gather at the Family Planning Summit in London to discuss efforts to reach FP2020 goals and ensure that more women and girls around the world are able to plan their families and their futures.

The first annual EWEC *Global Strategy* progress report is launched at the High-Level Political Forum for Sustainable Development in New York.

DATA PORTAL FOR MONITORING PROGRESS ON WOMEN'S, CHILDREN'S AND ADOLESCENTS' HEALTH

The *Every Woman Every Child (EWEC) Global Strategy* indicator and monitoring framework includes 60 indicators: 34 from the Sustainable Development Goals (SDGs) and 26 from related global monitoring initiatives. Of these, a subset of 16 key indicators is highlighted to provide a snapshot of progress. With indicators across health and other sectors, this framework represents a new multipartner, multisector approach to health and SDG monitoring.

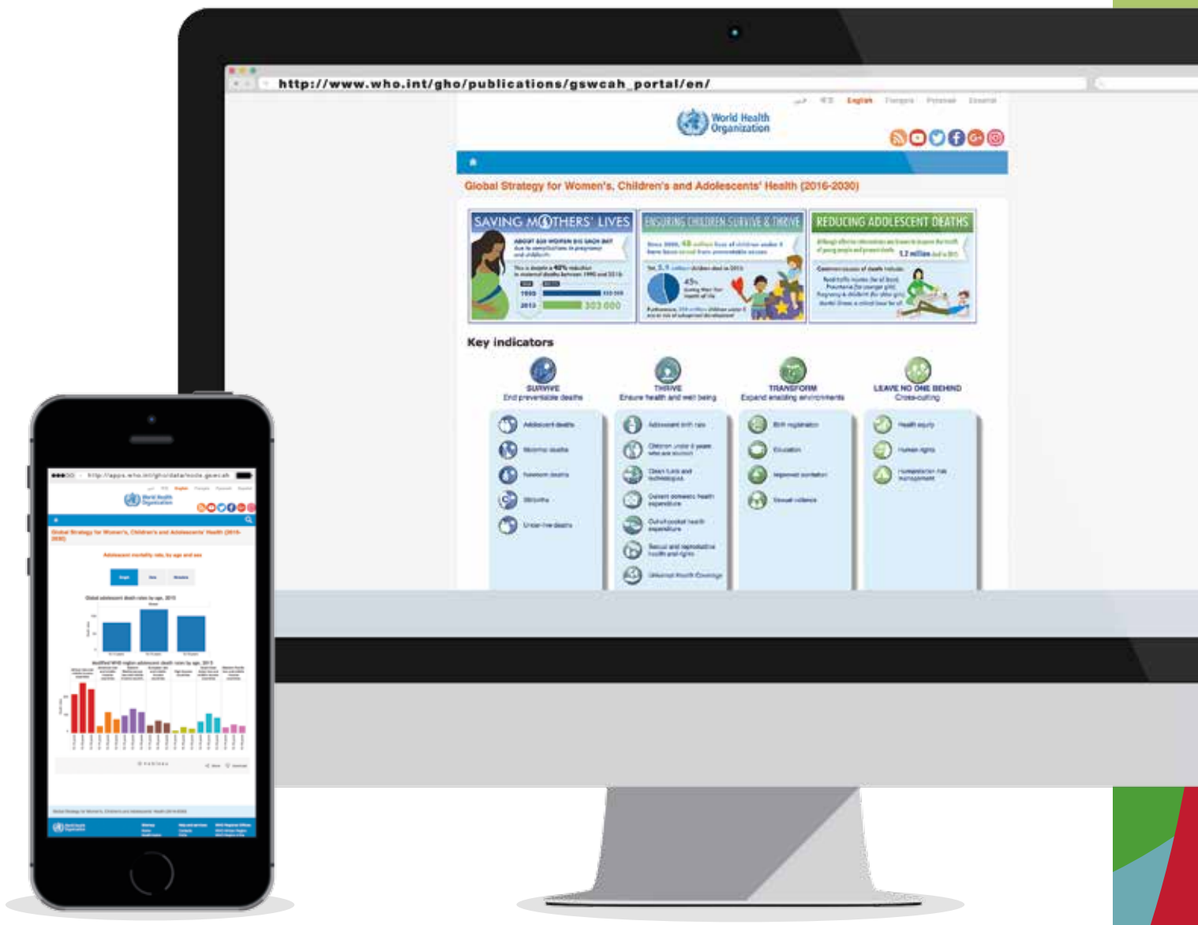
60 INDICATORS

34 INDICATORS FROM THE SUSTAINABLE DEVELOPMENT GOALS

26 INDICATORS FROM RELATED GLOBAL MONITORING INITIATIVES

16 OF THESE INDICATORS PROVIDE A SNAPSHOT OF PROGRESS

WHO has built a dedicated EWEC *Global Strategy* portal linked to the Global Health Observatory to provide public access to the latest available data and estimates – across all countries and for all the EWEC *Global Strategy* indicators. Development of the portal, and updating of the associated data, has involved collaboration across WHO departments, United Nations and multilateral organizations (the UN Statistics Division, H6 agencies – UNAIDS, UNFPA, UNICEF, UN Women, WHO and the World Bank Group – UNESCO and others) and global monitoring partnerships, including Countdown to 2030 and academic institutions. The portal can be accessed at: http://apps.who.int/gho/data/node.gswcah.



Regular monitoring and accountability are vital to assess progress and to assure that all people at all ages are getting the quality care they need for their health and well-being. We must find where gaps exist and act to ensure universal health coverage. If we collectively invest the amount that is needed, we can save and improve the lives of millions of women, children and adolescents by 2030.

Dr Tedros Adhanom Ghebreyesus
Director-General of the World Health Organization

1.

WOMEN'S, CHILDREN'S AND ADOLESCENTS' HEALTH:

status update and strategic priorities

Country data and global estimates for women's, children's and adolescents' health are most complete in areas that attracted particular attention during the Millennium Development Goal (MDG) era, such as child and maternal mortality and reproductive health. With the enlarged compass of the *Every Woman Every Child Global Strategy for Women's, Children's and Adolescents' Health* (EWEC *Global Strategy*) and the SDGs, data now need to be strengthened on mortality, morbidity and well-being, as well as on services, systems and social and environmental determinants related to progress towards the targets for 2030 (Figure 2).

This chapter provides an overview of the current state of women's, children's and adolescents' health and well-being globally, and highlights strategic gaps and priorities.

Figure 2. EWEC *Global Strategy* objectives and related SDG targets

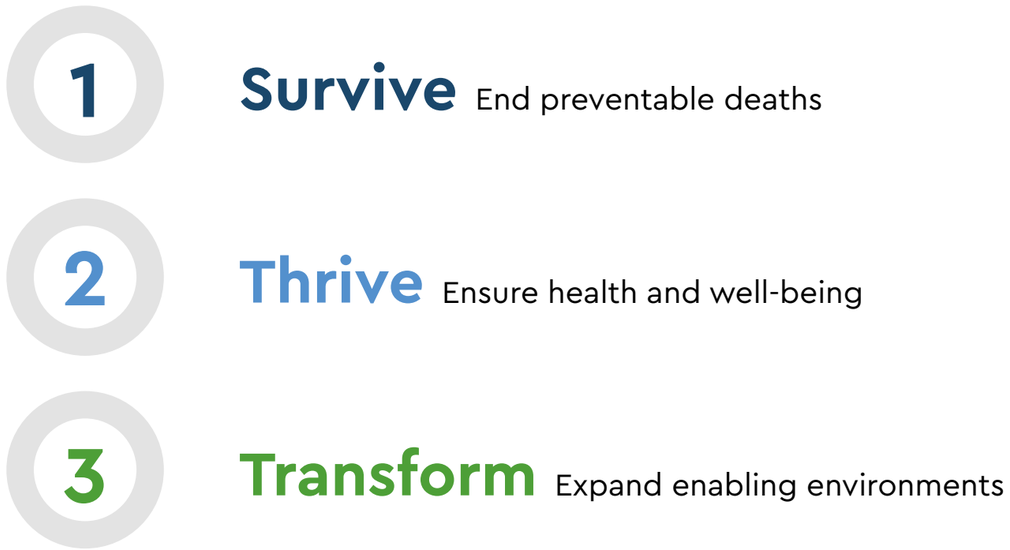


Figure 2. EWEC *Global Strategy* objectives and related SDG targets

Figure 2. EWEC *Global Strategy* objectives and related SDG targets

Thrive

Ensure health and well-being

End all forms of malnutrition and address the nutritional needs of children, adolescent girls, and pregnant and lactating women (SDG 2.2)

Ensure universal access to sexual and reproductive health-care services (including for family planning) and rights (SDGs 3.7 and 5.6)

Ensure that all girls and boys have access to good-quality early childhood development (SDG 4.2)

Substantially reduce pollution-related deaths and illnesses (SDG 3.9)

Achieve universal health coverage, including financial risk protection and access to good-quality essential services, medicines and vaccines (SDG 3.8)

Figure 2. EWEC *Global Strategy* objectives and related SDG targets

Transform

Expand enabling environments

Eradicate extreme poverty (SDG 1.1)

Ensure that all girls and boys complete primary and secondary education (SDG 4.1)

Eliminate all harmful practices, discrimination and violence against women and girls (SDG 5.2 and 5.3)

Achieve universal access to safe and affordable drinking water and to sanitation and hygiene (SDG 6.1. and 6.2)

Enhance scientific research, upgrade technological capabilities and encourage innovation (SDG 9.5)

Provide legal identity for all, including birth registration (SDGs 16.9 and 17.19)

Enhance the global partnership for sustainable development (SDG 17.16)

1.1 Women's health and well-being

STATUS UPDATE

Survive

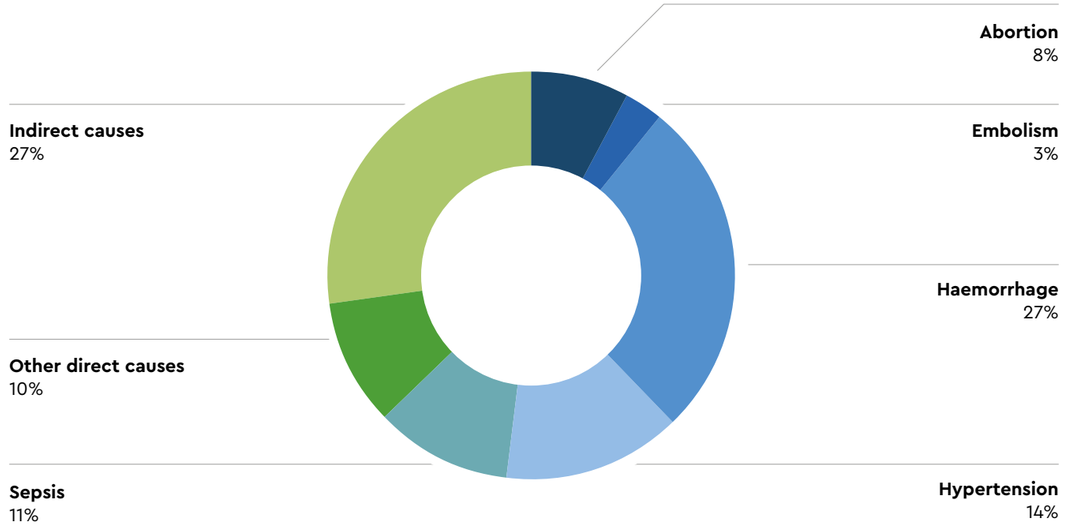
Women's chances of surviving childbirth improved significantly during the MDG era. After 1990, the global maternal mortality ratio (MMR: maternal deaths per 100 000 live births) fell by about 44%, with progress accelerating after 2000.[13,14] However, global progress fell far short of the 75% reduction target set by MDG 5a.[15] The death toll remains high – in 2015, an estimated 303 000 women died from preventable causes during pregnancy and childbirth, with a global MMR of 216 deaths per 100 000 live births. Ninety-nine per cent of all maternal deaths still occur in low- and middle-income countries, with more than 50% in sub-Saharan Africa and almost one third in South Asia.[16,17] The SDG target is a **global** ratio of less than 70 deaths per 100 000 live births by 2030.[18]

The most frequent causes of maternal death are postpartum haemorrhage, hypertensive disorders, infection and complications from childbirth and abortion (Figure 3). Although abortion is safe when performed in accordance with recommended guidelines, many women undergo unsafe procedures. Nearly 7 million women in developing countries are treated for complications from unsafe abortions annually.[19]

Other women die from the interaction between pregnancy and pre-existing health conditions that could have been addressed and managed during pregnancy, for example communicable diseases such as HIV/AIDS, tuberculosis and malaria, and noncommunicable diseases such as cardiovascular diseases. Millions more suffer complications from pregnancy that continue after childbirth. The list of such morbidities is long and diverse, and includes infection, obstetric fistula and depression.[20]

Additionally, in 2015, there were an estimated 2.6 million stillbirths: 18.4 for every 1000 births. The Every Newborn Action Plan target is 12 or fewer stillbirths per 1000 births in every country by 2030.[21] Half of the stillbirths occurred during labour and birth, mostly from preventable conditions, and mostly in low- and middle-income countries.[22] There are huge inequities. At the present rate of change, it will be 160 years before a pregnant woman in Africa has the same chance of carrying her pregnancy through to a live birth as a woman in a high-income country.[23] Stillbirth rate is one of the 16 key indicators to be monitored for the EWEC *Global Strategy*. However, being absent from the MDGs and still missing from the SDGs, stillbirth has received relatively little attention.

Figure 3. Estimates for main causes of maternal deaths



Source: Say L, Chou D, Gemmill A, Tunçalp Ö, Moller AB, Daniels JD, et al. Global causes of maternal death: a WHO systematic analysis. Lancet Glob Health 2014;2:e323–e333.

Good-quality care during pregnancy and childbirth is essential to prevent maternal mortality and stillbirths. Globally in 2016, an estimated 78% of women were attended by a skilled health worker during childbirth[24] and only 58% of pregnant women had four or more antenatal care visits.[25] Based on data from 79 countries, only 52% of women globally received postpartum care in 2016.[26] Many more lives could be saved, and illness and disability prevented, by improving the quality of antenatal care, care at the time of childbirth, and postnatal care for mothers and newborns, and by improving coverage of and tackling inequities in access to and quality of health services, including basic infrastructure.

Thrive

Statistics on mortality and disease burden are a vital source of information. However, they often fail to give a complete picture of women's progress, beyond survival, to enjoyment of health and well-being. While some health factors threaten women's lives, others profoundly affect their physical and mental health and overall well-being. Examples are the estimated 200 million girls and women alive today who have undergone female genital mutilation,[27] the 15 million girls who marry before age 18 each year,[28] and the nearly one in three women subjected to physical or sexual violence by an intimate partner.[29]

15

MILLION GIRLS
MARRY BEFORE THE AGE OF 18 EACH YEAR

The data show that, in many places, women are taking control of these and other areas of their health. Increasingly they are claiming their sexual and reproductive health and rights, for example by using modern contraceptive methods for family planning. Usage rose from 48% to 58% between 1990 and 2015 among married or in-union women aged 15–49. While contraceptive prevalence has improved globally, this figure has plateaued and needs to be scaled up to achieve universal access.[30] Increased contraceptive use prevents unintended pregnancy, which in turn reduces the rate of induced abortion. Globally, there were 35 abortions per 1000 women aged 15–44 each year from 2010 to 2014, down slightly from 40 per 1000 in 1990–1994. The decline has been uneven, with the abortion rate having declined markedly – by 41% – in developed countries since 1990, but remaining roughly the same in developing countries.[31] Current evidence suggests abortion rates do not differ in countries where abortion is highly restricted and those where abortion is broadly legal.[32]

Despite progress, data from 45 countries show that only one in two women aged 15–49 years (married or in union) makes her own decisions regarding sexual relations, contraceptive use and health care.[33]

Cervical cancer is another consideration for women's sexual health. An estimated one million-plus women worldwide, the majority (more than 80%) in low- and middle-income countries, are currently living with cervical cancer, many with no access to services for prevention, curative treatment or palliative care. The human papilloma virus, which is transmitted sexually, is one of the main causes of cervical cancer. A safe and effective vaccine exists, which when provided to girls between 9 and 13 years old protects against this virus, and technologies to screen and treat women living with cervical cancer are becoming more available but still serve only a minority of affected women. This highlights the importance of taking a life-course approach to health.[34]

3

Transform

Socioeconomic factors are important determinants of women's health. Conversely, women's health and empowerment, including through their political, sociocultural and economic participation, can effect transformative socioeconomic improvements. For example, higher levels of education for girls and women's political participation are both associated with better health for women and children, which in turn contributes significantly to socioeconomic development.[35] With respect to political participation, although the number of countries with a female head of state increased from 8 in 2005 to 17 in January 2017, women's representation in politics overall is stagnating.[36]

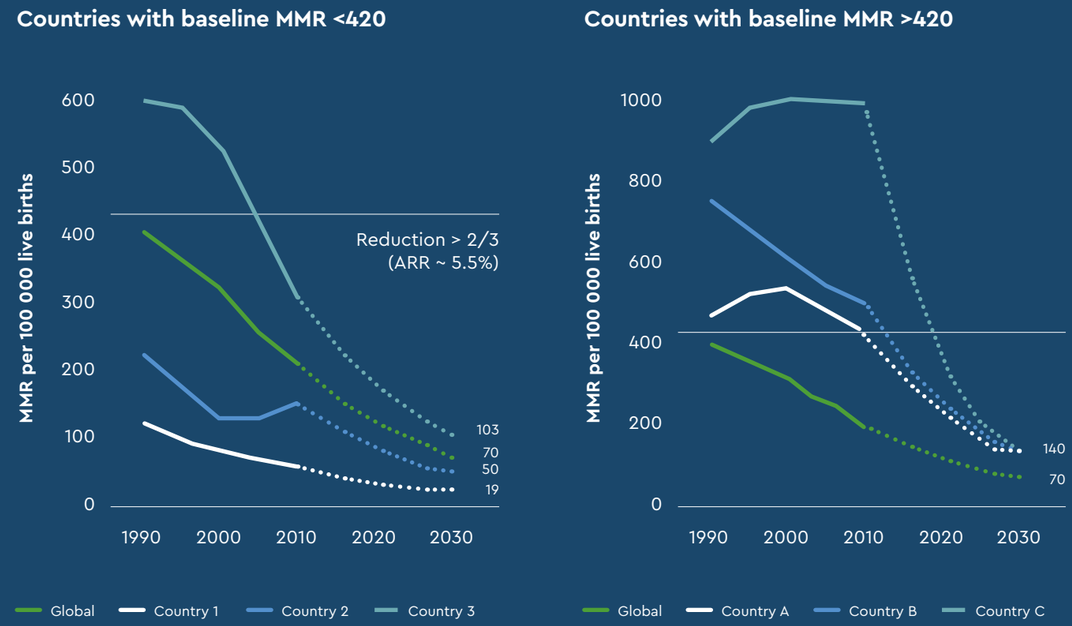
Inequities in access to adequate health services and rights are also significant determinants of women's health and well-being. These inequities may be shaped by social norms on gender inequality, and/or by laws that limit women's autonomy over their health and their participation in society, the labour force and politics. Another barrier in some countries is the lack of supportive legislation for specific subgroups, such as migrants and indigenous women, who are often underserved and marginalized. Access to clean energies in the home will also decrease the burden of disease and death.

COUNTRIES WITH A FEMALE HEAD OF STATE INCREASED FROM ***8 IN 2005 TO 17 IN JANUARY 2017***

Accelerate action to reduce maternal mortality

SDG 3.1 includes a target to reduce the global MMR to 70 per 100 000 live births; no country should have an MMR greater than 140. The Ending Preventable Maternal Mortality initiative has developed strategies, including projections, to help countries chart their required progress towards the 2030 targets (Figure 4).[37]

Figure 4. Recommended MMR reduction rates in different countries



MMR: maternal mortality ratio

ARR: annual rate of reduction

Notes:

- For countries with MMR less than 420 in 2010 (the majority of countries worldwide): reduce the MMR by at least two thirds from the 2010 baseline by 2030. For all countries with baseline MMR greater than 420 in 2010: the rate of decline should be steeper so that in 2030, no country has an MMR greater than 140. For example, in the graph on the right, Country C needs about a 12% annual rate of reduction to get to an MMR of 140, which is 2.5 times faster than the progress required in the MDG era.
- For all countries with low baseline MMR in 2010: achieve equity in MMR for vulnerable populations at the subnational level.

Source: Strategies towards ending preventable maternal mortality. Geneva: World Health Organization; 2015.

Improve quality, equity and dignity of care during pregnancy and childbirth

Efforts to improve equity of coverage and to reach those most in need of health care and health-enhancing services must continue. In addition, a focus on improving the quality of these services is required. This includes respecting the rights and dignity of those seeking care, as well as a strong focus on multisectoral action (e.g. to ensure access to water, sanitation and hygiene and electricity). Supporting this approach are new antenatal care guidelines,[38] standards for improving quality of maternal and newborn care in health facilities,[39] and processes for audit and review of maternal, stillbirth, perinatal and newborn deaths.[40,41] The Quality of Care Network,[42] supported by WHO, UNICEF and UNFPA and led by nine countries, is leading the way on institutionalizing quality of care within health systems, with the aim of reducing maternal and newborn mortality in participating health-care facilities by 50% in 5 years.

Implement recommendations on stillbirths

The Lancet Ending Preventable Stillbirth series in 2016 recommended five priority actions: intentional leadership; increased voice, especially of women affected; implementation of integrated interventions; indicators to monitor progress; and research on knowledge gaps.[43]

Realize sexual and reproductive health and rights

In order for women and girls to realize their sexual and reproductive health and rights, they need access to comprehensive sexual reproductive health and rights (SRHR) education and services, including modern contraceptive methods, safe abortion (where legal), treatment and prevention of infertility, and prevention of sexual violence. Available data suggest that restrictions by marital status, requirement for third-party authorization and age are the most common legal barriers preventing access to sexual and reproductive health services,[44] and therefore access to justice mechanisms is crucial. The recently released report of the High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents calls for all States to strengthen legal recognition of human rights "to health and through health", including sexual and reproductive health and rights, in their national constitution and other legal instruments. States should implement legal, policy and other measures to monitor and address harmful social, gender and cultural norms and to remove structural and legal barriers that undermine sexual and reproductive health and rights.[45]

1.2 Children's health and well-being

Many issues and shortcomings in health care that lead to death or illness for women around the time of childbirth also affect the health of newborns and young children. Other factors that affect the health and life chances of women – including poverty, inequity, malnutrition and adverse social norms – also profoundly affect their children.

1

STATUS UPDATE

Survive

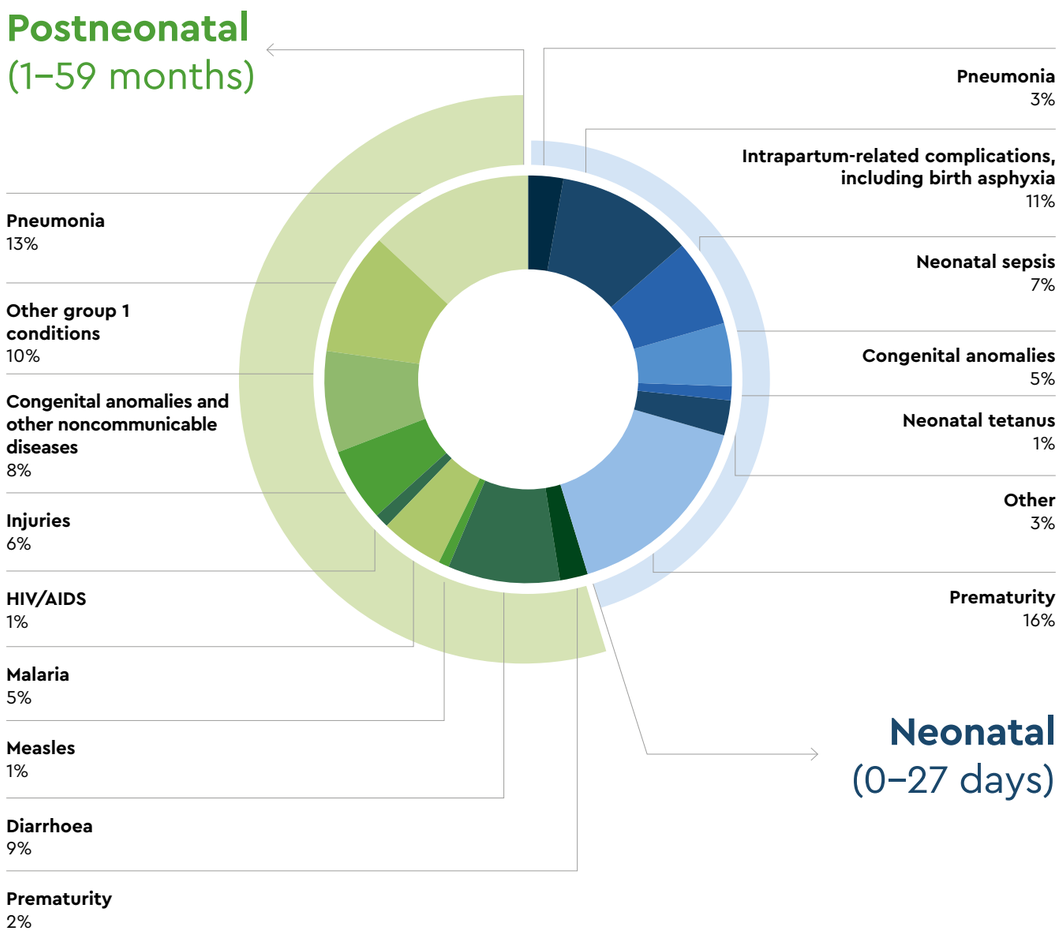
The link between maternal health and child health is seen most starkly in the neonatal mortality rate (NMR), which is still both too high and declining too slowly. In 2015, 2.7 million newborns died within 28 days of birth, representing 45% of all deaths among children under five and an NMR of 19 deaths per 1000 live births (down from 36 deaths per 1000 live births in 1990).[46] The SDGs and EWEC *Global Strategy* target an NMR of no more than 12 deaths per 1000 live births in any country.[47]

More progress was made in reducing the under-five mortality rate (U5MR) than the neonatal mortality rate in the MDG era, with declines of 53% and 47% respectively between 1990 and 2015. However, this fell short of the MDG 4 target of a 66.6% reduction. There still is a high death toll: 5.9 million children died in 2015, largely from preventable causes.[48] The smallest relative declines occurred in the WHO Eastern Mediterranean Region (48%) and the WHO African Region (54%). The SDG target is a U5MR of no more than 25 deaths per 1000 live births in any country.[49] Currently, 79 countries worldwide do not meet the SDG target for under-five mortality.

More than half of the decline in the U5MR since 2000 has been achieved by addressing the major causes of deaths in childhood (Figure 5). A 75%

reduction in measles deaths among children under five was achieved, and significant progress made against other major killers such as pneumonia, diarrhoea and malaria, including by substantially scaling up vaccine coverage, addressing environmental factors such as water, sanitation and hygiene, and using insecticide-treated nets.[50] Malnutrition underlies around half of all child mortality.[51]

Figure 5. Causes of deaths in newborns and children under age five



Source: WHO Global Health Observatory data.

2

Thrive

Beyond mortality and morbidity, current monitoring systems are generally poor at capturing data about the health and development of children. This makes it difficult to assess whether children are thriving through childhood and into adolescence. However, indirect data clearly indicate several risk factors, such as poverty, undernutrition, lack of access to education and exposure to violence.[52] The Early Childhood Development (ECD) Lancet series (2016) indicates that 250 million children in low- and middle-income countries are at risk of suboptimal development due to poverty and stunting (Figure 6).[53] The effects of undernutrition and stunting can include diminished cognitive and physical development, poor educational performance and reduced resistance to disease.

Significant improvements were made to childhood nutrition during the MDG era. A 44% reduction was achieved between 1990 and 2015 in the proportion of children under age five who were underweight. Globally, stunting declined by 41% in the same period, although the condition still affected an estimated one in four children in 2015.[54]

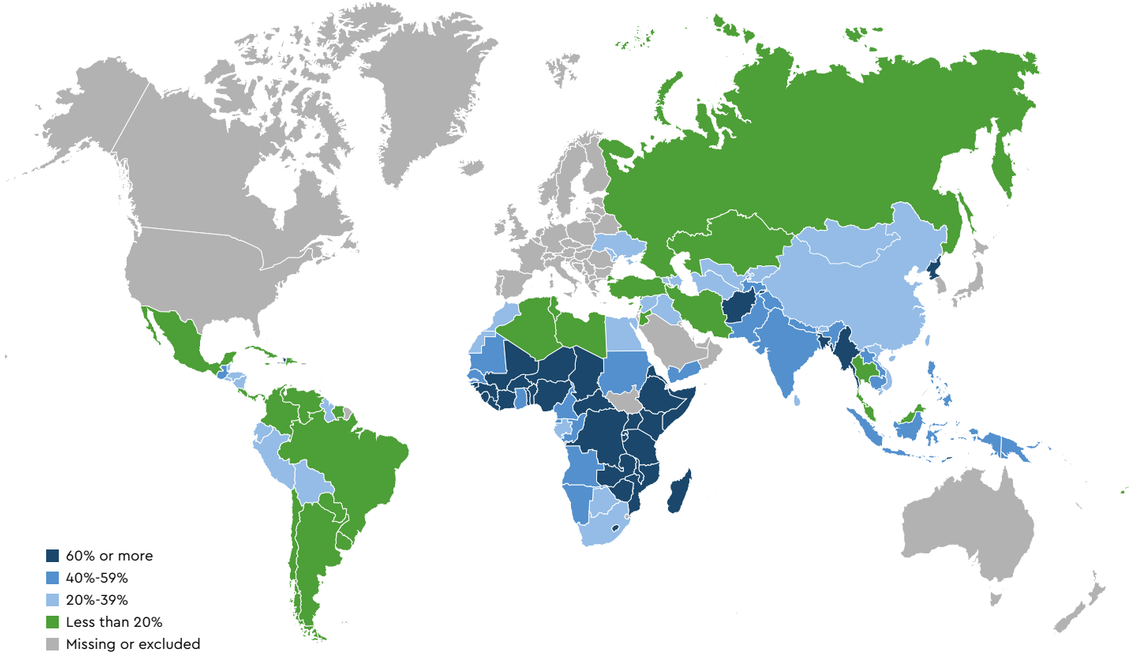
A poor start in life also affects future generations. It is estimated to cause adults to lose about one quarter of average adult income per year, causing a loss for some countries of twice their current GDP expenditures on health and education.[55]

250

MILLION CHILDREN
IN LOW- AND MIDDLE-INCOME COUNTRIES

are at risk of suboptimal development due to poverty and stunting

Figure 6. Percentage of children at risk of suboptimal development due to extreme poverty and stunting



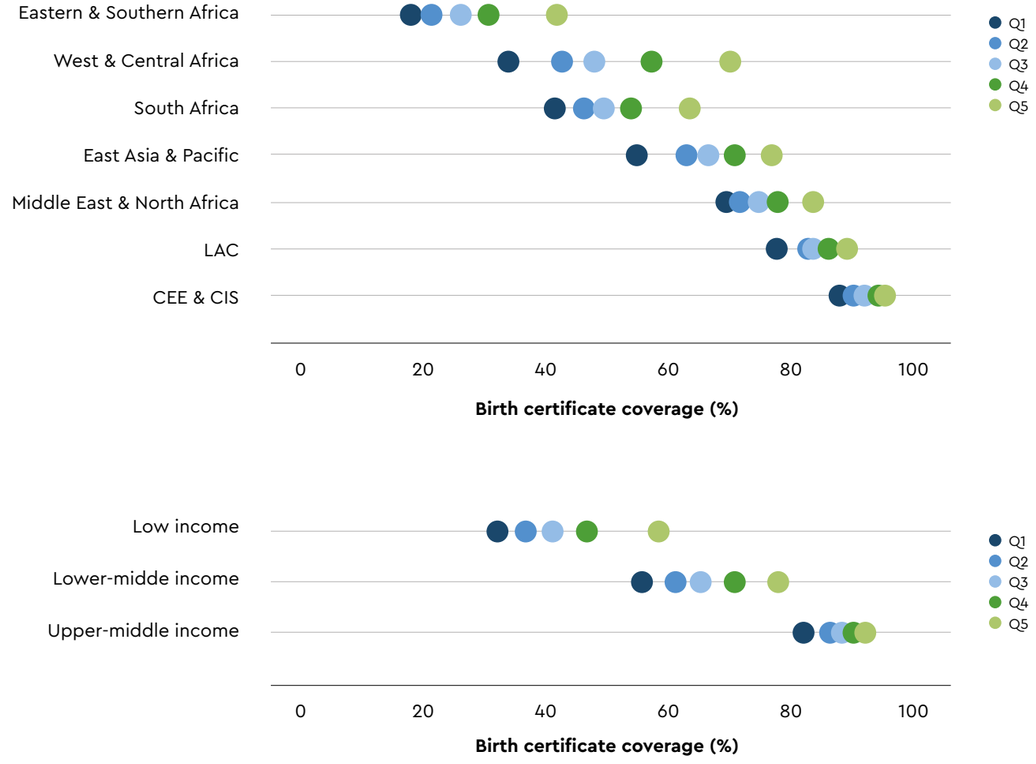
Source: Daelmans B, Darmstadt GL, Lombardi J, Black MM, Britto PR, Lye S, et al. Early childhood development: the foundation of sustainable development. Lancet 2017;389(10064): 9–11.

3

Transform

The human right to a legal identity is violated for many children: worldwide, one in four children under age five has not had their birth registered.[56] Data from national surveys carried out since 2005 in 94 countries show that birth registration coverage varies substantially between different world regions, with the lowest coverage in Africa and South Asia, and the highest in Eastern Europe/Central Asia and in Latin America/Caribbean (Figure 7). Coverage is also higher in middle-income than in low-income countries. Within every regional or country income grouping, coverage increases with family wealth. The widest gaps are seen in West/Central Africa and in low-income countries, where birth certification is over twice as high in the wealthiest families (fifth quintile) as in the poorest families (first quintile).[57]

Figure 7. Inequalities in birth registration coverage



Q: wealth quintile; **LAC:** Latin America and the Caribbean; **CEE & CIS:** Central and Eastern Europe & the Commonwealth of Independent States.

Notes: Mean wealth quintile inequalities in birth certificate coverage among children under the age of five years by UNICEF region and World Bank income group. Q1 to Q5 represent five wealth quintiles, from poorest to wealthiest.

Source: Bhatia A, Ferreira L, Barros A, Victora C. Int J Equity Health, under review.

The most transformative influences on young children come from nurturing care provided by parents, other family members, caregivers and community-based services. Nurturing care is characterized by a stable environment that promotes early childhood development (ECD) and children's health and nutrition, protects children from harm, and gives them opportunities for early learning, through affectionate interactions and relationships. The benefits of such care and early development are lifelong, and include improved health and well-being, and greater ability to learn and earn.

National policies and legislation are important for providing a long-term stable environment for childhood development. This includes policies such as paid parental leave, and population-based services in a range of sectors, including health, nutrition, education and child and social and environmental protection.

Education delivers recognized benefits, and is a core element of the overall empowerment of girls. Between 1990 and 2015, the average time girls spent in education increased globally from 4.7 years to 7.0 years; however, only 1% of the poorest girls in low-income countries completed secondary school education.[58] Although the number of out-of-school children of primary school age, both boys and girls, declined globally from 99 million to 59 million between 2000 and 2013, progress has stalled since 2007.[59]

Equality, empowerment and participation for women, adolescents and children: it is their right, and our responsibility. I am committed to make this a reality, and to transform and sustain our communities. I support the* Every Woman Every Child *movement.

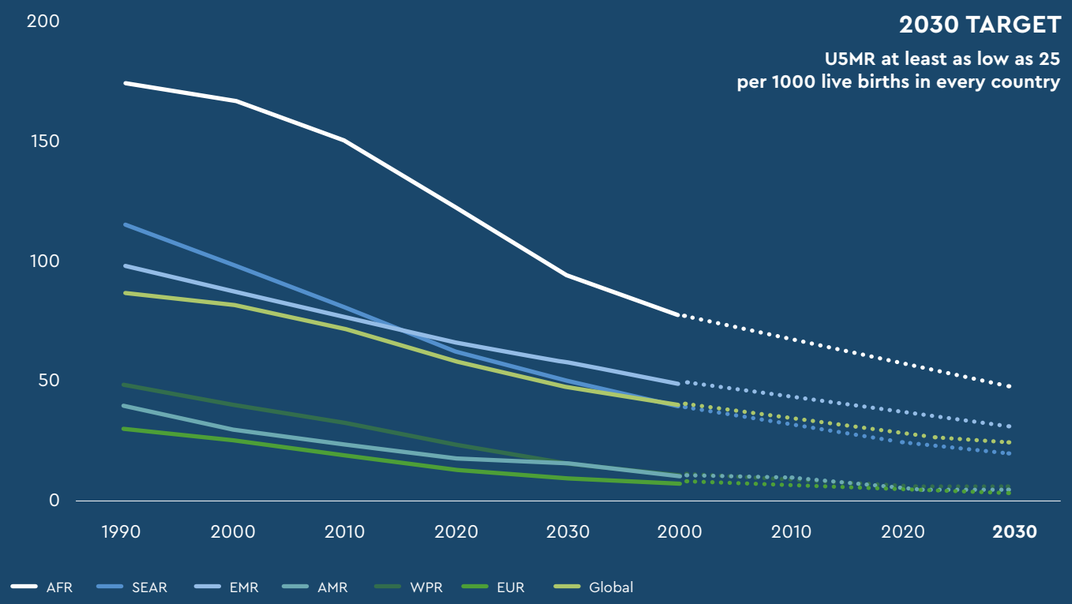
H.E. Dame Meg Taylor, DBE
Secretary-General, Pacific Islands Forum
Member of the High-Level Steering Group for *Every Woman Every Child*

ONLY
1%
OF THE POOREST GIRLS IN LOW-INCOME COUNTRIES
COMPLETED SECONDARY SCHOOL EDUCATION

Accelerate action to reduce child mortality

For every country to meet the SDG child mortality target of at least as low as 25 per 1000 live births, much more rapid progress is needed in many low-income countries. Projections of regional U5MRs to 2030 offer an indication of the different rates of progress needed by countries to reach the SDG target (Figure 8).[60]

Figure 8. Projection of under-five mortality rates from 2015 to 2030 by WHO region, based on the annual rate of reduction in countries, 1990–2015



Key: AFR: African Region, SEAR: South-East Asia Region, **EMR:** Eastern Mediterranean Region, **WPR:** Western Pacific Region, **AMR:** Region of the Americas, **EUR:** European Region.

Source: Calculations based on estimates and ARR provided in: UNICEF/WHO/World Bank/UN. Levels & trends in child mortality report 2015. Estimates developed by the UN Inter-agency Group for Child Mortality Estimation. UNICEF, September 2015.

Prioritize reducing newborn mortality

With newborn mortality reducing at slower rates than child mortality, a specific emphasis is required. Many of the vital interventions for women during childbirth, such as skilled birth attendance, are also key to newborn survival. Implementation of the Every Newborn Action Plan (ENAP) should be prioritized to reduce the NMR.[61] The Quality of Care Network,[62] described in the preceding section on women's health strategic priorities, also works to strengthen the provision of essential care for newborns and children.

Address inequities in child mortality within countries

High-income and some low- and middle-income countries will achieve child mortality rates of well below 25 per 1000 by 2030. However, there are large inequities in child mortality within many countries that need to be addressed. For example, in the United States, babies born to African American mothers in Wisconsin are nearly three times more likely to die before their first birthday than babies born to Caucasian mothers there.[63]

Accelerate implementation of the Global Vaccine Action Plan 2011–2020

This is essential to reach the 20% of children globally who do not currently receive at least a basic set of vaccinations against the major causes of childhood illness and death. This requires allaying concerns causing vaccine hesitancy, where they exist, to prevent the resurgence of diseases such as measles.[64]

Emphasize early childhood development

Countries should develop integrated, multistakeholder and cross-sectoral plans to ensure equitable access to good-quality ECD. Families need support to provide nurturing care for young children, including material and financial resources, national policies such as paid parental leave, and population-based services in a range of sectors, including health, nutrition, education and child and social protection.[65] WHO and partners are working on a new set of metrics and a development framework for ECD.

Expand the breadth of investment

As under-five mortality declines, congenital anomalies, accidents and injuries, overnutrition and childhood obesity, and other noncommunicable diseases are playing a more prominent role among the causes of deaths in childhood. Tracking the incidence of these causes of morbidity and mortality and addressing them with effective interventions providing access to essential services like water, sanitation and hygiene and clean energy will achieve important health benefits.[66]

Focus on empowering girls, including through education

The Lancet series on ECD identifies lack of access to education as one of the risk factors for suboptimal development in childhood.[67] Countries should commit to providing equal educational opportunities as part of their overall support for the empowerment of girls and women.

Cross-cutting priorities, including social and environmental determinants and birth registration and data, are addressed later in this chapter.

1.3 Adolescents' health and well-being

Until recently, adolescent health was a neglected topic. However, that changed with the recognition, in the EWEC *Global Strategy* and elsewhere, that adolescents occupy a pivotal position in global public health and could play a transformative role within the 2030 Agenda for Sustainable Development. By investing in their health and well-being, countries can achieve a "triple dividend" – immediate benefits for adolescents now, and future benefits in their adult lives and for the next generation.[68] The benefit–cost ratio of selected investments in adolescent health has been estimated to be 10-fold in terms of health, social and economic benefits.[69]

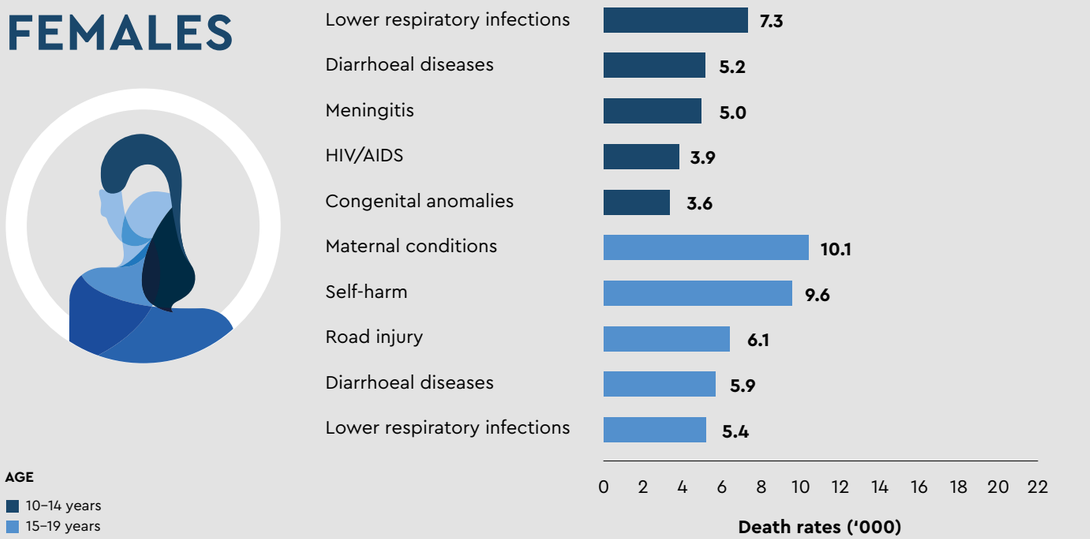
STATUS UPDATE

Survive

Although global adolescent death rates are estimated to have fallen by approximately 17% since 2000, 1.2 million adolescents died in 2015, largely from preventable causes (Figure 9).[70] Deaths remain highest in African low- and middle-income countries (LMICs) at 243 per 100 000, followed by Eastern Mediterranean LMICs 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).[71] The transition from childhood to adulthood is also a dangerous time for adolescents living with HIV: treatment adherence is low and treatment failure is high.[72]

The earlier lack of focus on this age group has resulted in less rapid progress here than in areas such as maternal and child health. In addition, there are large gaps in adolescent health data, and few points of comparison across time. However, there has been intense focus in

Figure 9. Main causes of deaths: younger and older adolescents, and males and females



Source: Global health estimates 2015: deaths by cause, age, sex, by country and by region, 2000–2015. Geneva: WHO; 2016.
Global accelerated action for the health of adolescents (AA-HA!): guidance to support country implementation. Geneva: WHO; 2017.

recent years, with the launch of the EWEC *Global Strategy*, the Lancet Commission on adolescent health and well-being,[73] and a special focus on and requests for related technical support from countries at the World Health Assembly.[74] This has resulted in rapid accumulation of knowledge about the diverse causes of adolescent mortality and morbidity, and support for country investment and implementation. This knowledge, summarized in the 2017 report *Global accelerated action for the health of adolescents (AA-HA!): guidance to support country implementation*,[75] will inform countries' targeting of multisectoral interventions for adolescents of all ages, using gender-, equity- and rights-based approaches to ensure no one is left behind.

2

Thrive

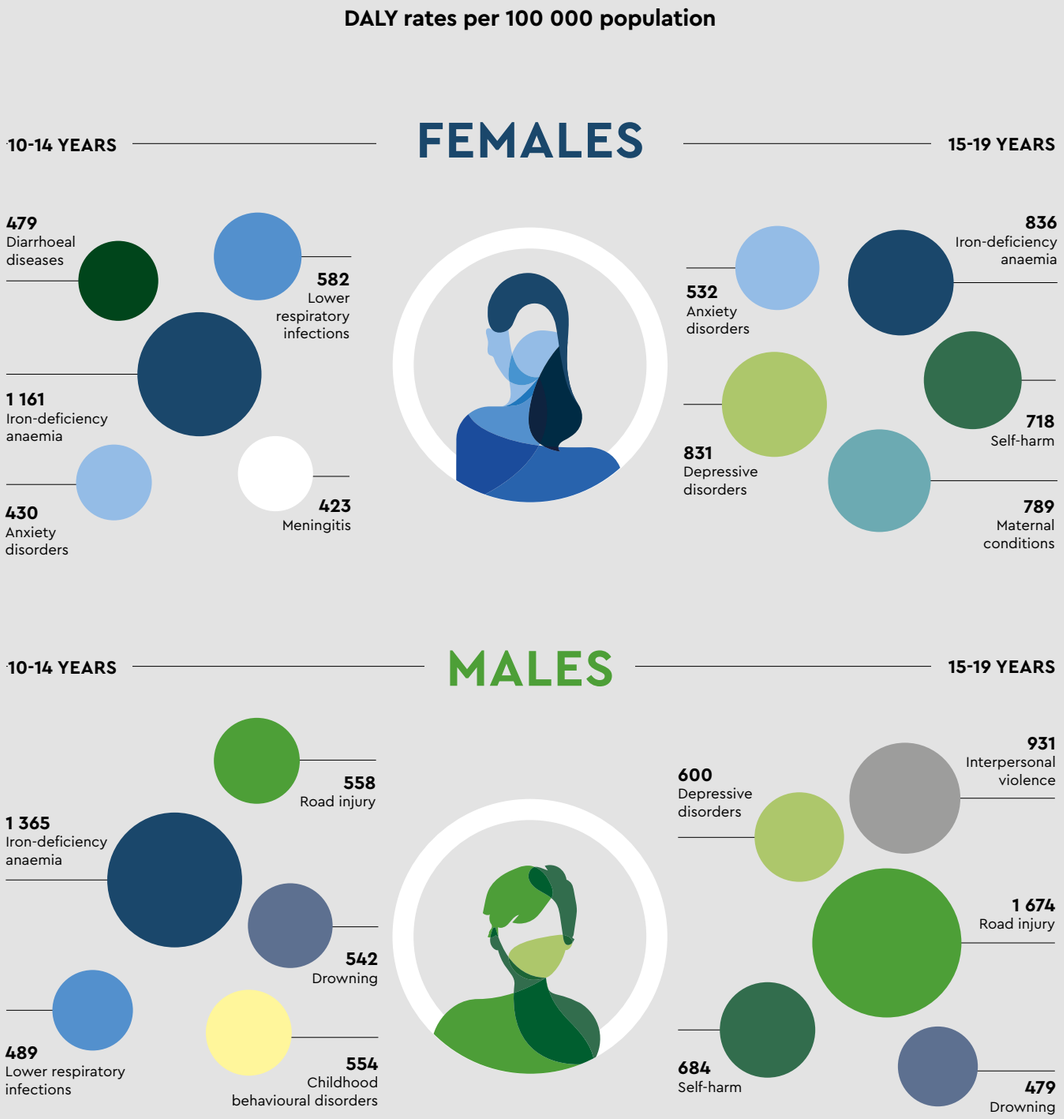
Adolescence should be a time of rapid physical, mental and social development. Any health-related factors that restrict this growth also inhibit young people's ability to thrive and achieve their full potential.

Adolescents' ability to thrive is influenced by a wide range of largely preventable diseases and injuries, which vary according to age and sex (Figure 10).

For example, self-harm is slightly more common among females, while road traffic injuries are much more common among males. Lower respiratory infections are more common among younger adolescents, while interpersonal violence and self-harm are more common among older adolescents.[76] This shows the need for disaggregated data and diverse multisectoral interventions to improve adolescents' health and well-being.

Changing lifestyles mean that an increasing number of adolescents are vulnerable to the health risks associated with poor diet, tobacco, alcohol and substance abuse, malnutrition including anaemia and obesity, and noncommunicable diseases such as diabetes and cancer. In turn, these risks are associated with preventable mortality from noncommunicable diseases in adulthood.[77]

Figure 10. Adolescent disability-adjusted life years (DALYs) lost by age and sex, 2015



Source: Global health estimates 2015: deaths by cause, age, sex, by country and by region, 2000–2015. Geneva: WHO; 2016.

Mental health issues, ranging from childhood behavioural disorders to anxiety, depression and self-harm (including suicide), are among the top five causes of adolescent disability-adjusted life years (DALYs) lost. Over 75% of mental illnesses originate before age 24.[78]

Intimate partner violence often starts early in the lives of women, with 30% of adolescent girls (aged 15–19) having experienced physical and/or sexual violence by an intimate partner.[79] In the WHO South-East Asia Region the estimate is 43% of adolescent girls; in the WHO African Region it is 40%.[80]

Progress is being made in preventing adolescent pregancies and child marriage, but there still are gaps in their access to sexual and reproductive health services and rights. Partly as a result of this, about 19% of young women in developing countries become pregnant before age 18. Girls under age 15 account for 2 million of the 7.3 million births to adolescent girls under age 18 every year in developing countries.[81] And maternal mortality is the leading cause of death for older adolescent girls, with self-harm being the second (Figure 9).[82]

Although declining globally, marriage in childhood (before age 18) is still linked with poor health outcomes for women and girls. Between the early 1980s and 2014, the proportion of young women married in childhood declined from one in three to one in four. In the same period, the proportion of young women married before age 15 declined from 12% to 8%.[83]

OVER
75%
OF MENTAL ILLNESSES
ORIGINATE BEFORE AGE 24

3

Transform

Legal frameworks and cultural and social norms may hinder some countries' efforts to transform the health prospects of their adolescent populations. For example, some adolescents, such as young women who have experienced violence or have been refused health care, are denied access to justice due to their legal status as minors, which impairs their right to health. Among others, disabled adolescents and adolescents from marginalized groups face particular challenges in this regard.

Traditions of child marriage remain strong in some settings, while some countries have a legal age of marriage that is lower than the legal age at which contraception and family planning services can be provided. Female genital mutilation is also still condoned in some settings. In these and similar cases, gender inequality, harmful gender norms and stereotypes and unequal power relations may create barriers to health that seriously undermine efforts to empower women and girls.

Strong and consistent national political leadership – not only in the ministry of health but across all of government – is needed to ensure that adolescent health priorities are promoted nationally, in legislation, planning, investment in services and through public awareness initiatives.[84]

STRATEGIC PRIORITIES[85]

Adopt an intersectoral approach to adolescent health

Coordinated intersectoral action should include, but not be limited to: education, social protection, roads and transport, telecommunications, housing and urban planning, energy, water and sanitation, environment and the criminal justice system.

Conduct national adolescent health situation assessments

Undertake a systematic national review of the health status and well-being of adolescents and a landscape analysis of what is being done, and reassess adolescent health priorities at least every five years to ensure they remain relevant to adolescent needs.

Prioritize adolescent health in national planning

Develop or update inclusive, multisectoral, rights-based national plans and programmes for adolescents.

Listen to adolescents' voices

Ensure that adolescents' expectations and perspectives are properly addressed in national programming processes.

Promote adolescents' agency and empowerment

Take action to ensure adolescents have the skills and knowledge to exercise their rights to make informed choices about their mental and physical health and well-being.

Improve monitoring and data analysis

Disaggregate health data to identify the health needs and intervention priorities for different groups of adolescents.

1.4 Creating an enabling environment for progress

The EWEC *Global Strategy* advocates simultaneous action on women's, children's and adolescents' health across nine interconnected and interdependent areas. It also recommends that action should be guided by a set of 10 core principles, including human rights, equity, partnership, universality and accountability.[86] These action areas and principles amount to an agenda for co-ordinated multisectoral action at country level.

The H6 partnership has developed a toolkit to support country implementation of the EWEC *Global Strategy* that includes a wide range of tools and technical resources for multisectoral action.[87] Key resources include the health in all policies framework and training manual, gender tools, and specific guides to multisectoral implementation, both general and for specific policy areas. Analytic tools such as LiST, EQUIST and Innov8 provide some scope for multisectoral analysis, but this could be expanded. Overall, however, there is a need for greater support for countries to implement multisectoral action. This having been said, global partners themselves need to address their own limitations in working across sectors, tackling silos within and between organizations, and most importantly, genuinely engaging people from non-health sectors in efforts to achieve the objectives of the EWEC *Global Strategy*. Priority areas such as adolescent health and early child development, which by definition require multisectoral action, could provide a focus for this.

The 2030 Agenda for Sustainable Development's call to "leave no one behind" echoes the EWEC *Global Strategy*'s emphasis on rights, equity and universality. It links strongly to the need for better health information: more and better-quality data are urgently needed to identify women, children and adolescents who are underserved or marginalized. As further discussed in Chapter 2, international law obliges governments to help their citizens realize their human rights, including the right to health.[88] This requires the creation of an enabling environment for health and well-being by ensuring that the necessary services, polices, legislation and administrative structures are in place.

Priorities for delivering this agenda are discussed thematically in the next three sections.

THE HEALTH SECTOR: SUPPORTING SYSTEMS, STANDARDS AND TOOLS

The people-centred focus of the EWEC *Global Strategy* has implications for the whole health system, and for all actors, structures and processes that support health, such as a country's health policies, financing, workforce and health infrastructure.

A primary implication is that national governments need a detailed understanding of the health needs of women, children and adolescents and of the population overall. This is necessary to identify those being left behind and to generate data to inform evidence-based policy-making and programmes in priority areas.

Civil registration and vital statistics (CRVS) and health information systems are central to these aims, although in most low- and middle-income countries these need to be strengthened, or in some cases created.[89]

NATIONAL GOVERNMENTS NEED A DETAILED UNDERSTANDING OF THE HEALTH NEEDS OF ***WOMEN, CHILDREN AND ADOLESCENTS AND OF THE POPULATION OVERALL***

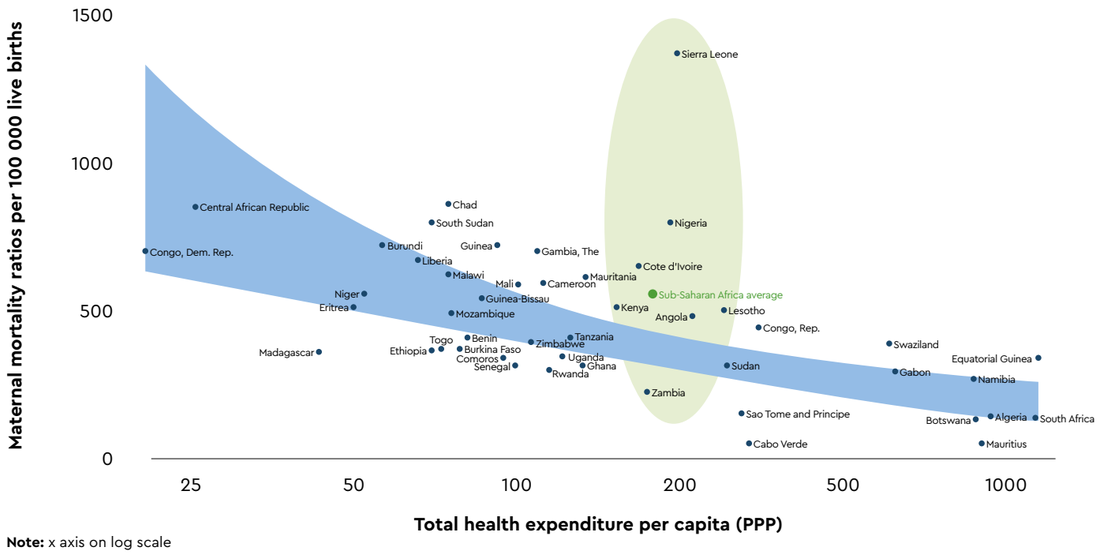
Efforts have also been made to strengthen the frontline capacity of health systems to capture data for accountability across the monitor, review and act functions. A leading example is Maternal Death Surveillance and Response, a monitoring and review system enabling countries to capture detailed information about maternal mortality, and take remedial action.[90,91]

Another priority is the design and financing of resilient health services and facilities that are fit for purpose to sustain and accelerate progress and "achieve universal health coverage, including financial risk protection and access to quality essential services, medicines and vaccines" (SDG 3.8).

Government spending on health is essential to build resilience throughout the health sector and is one of the EWEC *Global Strategy's* 16 key indicators. In the 2001 Abuja Declaration, African Union heads of state pledged to allocate at least 15% of their annual public expenditures to health; since then most African governments have increased the proportion of that allocation. However, spending the recommended amount is not sufficient to guarantee good health outcomes, especially if decisions about health spending are not evidence-based.[92] Although better outcomes are associated with greater health expenditure per capita, for any given level of spending there can be a wide range of outcomes, depending on efficiencies within the health sector. For example, the green oval in Figure 11 highlights the wide range of maternal mortality outcomes between countries that have the same level of health expenditure.[93]

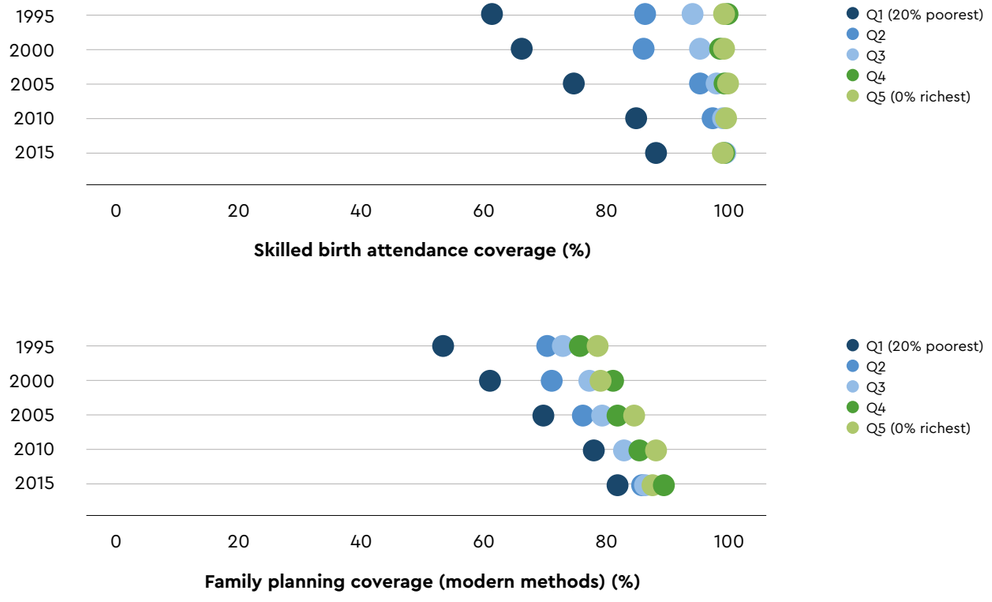
Investments also need to be targeted to areas and populations in greatest need. An example of how targeted policies and investments can result in more equitable access to health services, especially for women, children and adolescents living in poverty, comes from Colombia. Coverage of skilled birth attendance there has increased, particularly for the poorest 20% of the population. Even more remarkable has been the increase in the proportion of reproductive-age women whose family planning needs were met by modern contraceptives. By 2015, coverage was over 90% across the whole population, and inequalities were markedly reduced (Figure 12).[94]

Figure 11. Maternal mortality ratio and total health expenditure per capita in Africa, 2014



Note: x axis on log scale
PPP: purchasing power parity.
Source: Public financing for health in Africa: from Abuja to the SDGs. Geneva: WHO; 2016.

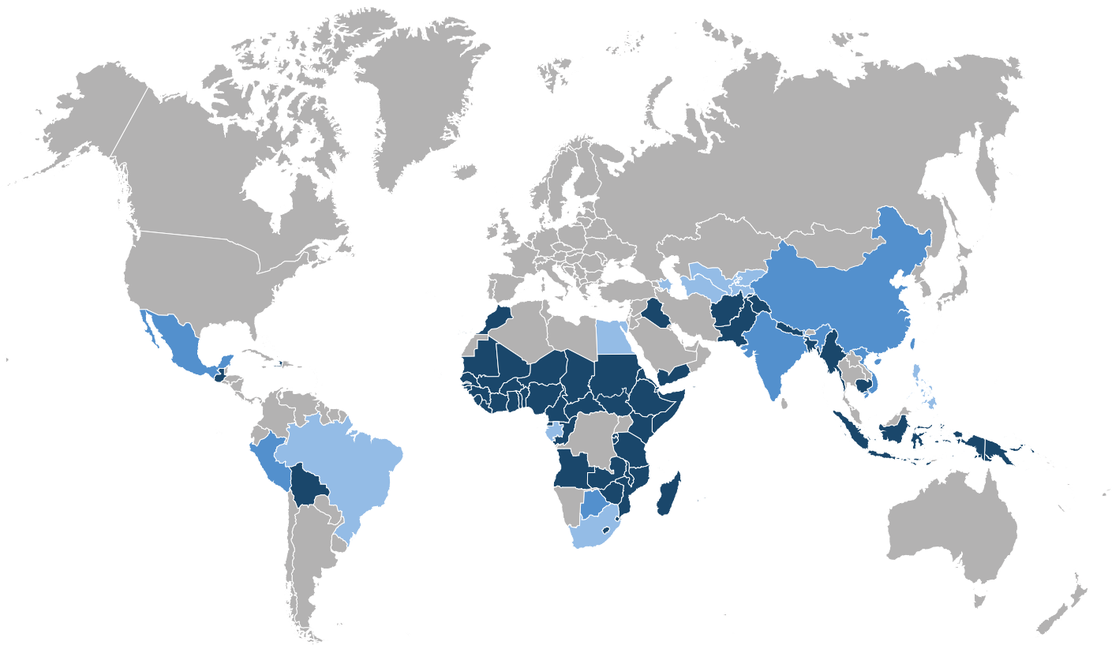
Figure 12. Colombia increases coverage of essential services and reduces inequalities, 1995–2015



Source: Countdown to 2030 analysis based on DHS data.

Central to the achievement of universal health coverage and health systems resilience is a skilled, motivated and well-supported health workforce, including in fragile settings. There has been substantial progress: 27 out of 53 countries with data have shown growth in health worker availability.[95] However, a huge global shortage remains (Figure 13).

Figure 13. Mapping of 74 countries based on the established health worker density thresholds, most recent available year



< 22.8 skilled health professionals per 10 000 population
≥ 22.8 but < 44.5 skilled health professionals per 10 000 population
≥ 44.5 skilled health professionals per 10 000 population

Source: Pozo Martin F, Nove A, Castro Lopes S, Campbell J, Buchan J, Dussault G, et al. Health workforce metrics pre- and post-2015: A stimulus to public policy and planning. Hum Resour Health 2017;15:DOI: 10.1186/s12960–017–0190–7.

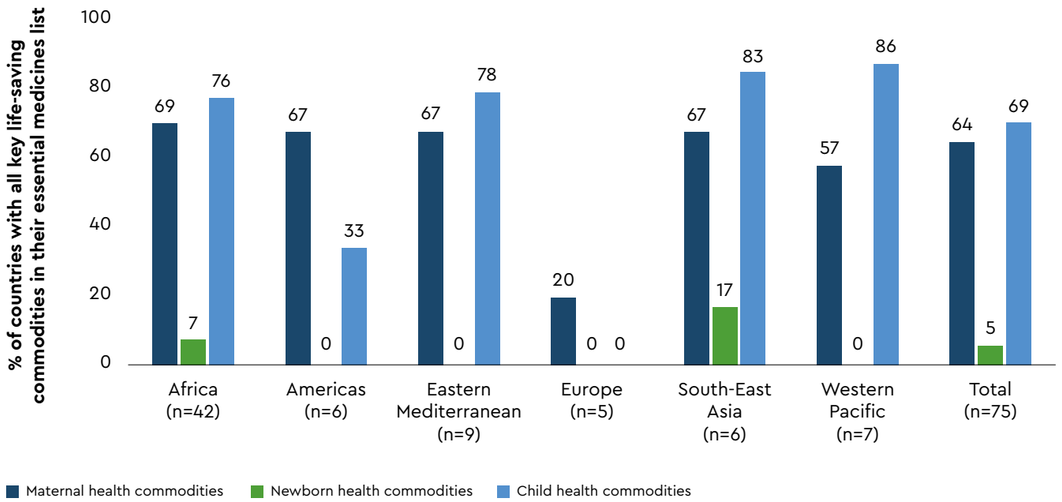
Global projections to 2030 estimate that an additional 18 million health workers will be needed to meet the requirements of the SDGs.[96] A diverse skills mix, involving community-based and mid-level health workers, operating as part of integrated primary health-care teams, will help to address shortages and misdistribution in a cost-effective and sustainable manner. Midwives are a vital part of the health workforce. If fully qualified and working within a functioning health system, they can provide 87% of the essential care needed for women and newborns.[97] By improving the education, regulation, deployment and retention of midwives, governments can reap an immediate return on investment.[98]

Investment in health services and infrastructure, workforce and facilities should be accompanied by improvements to quality of care.[99] This requires health-care services to be safe, effective, timely, efficient, equitable and people-centred. Patient safety is a challenge everywhere: even in developed countries an estimated one in 10 patients is harmed while receiving hospital care. The challenge is not limited to the medical aspects of care: a growing body of research on women's experiences worldwide presents disturbing evidence of disrespectful or neglectful treatment during childbirth.[100] Quality of care is a strategic priority, as noted in preceding sections.

Many countries have identified the lack of a properly functioning supply chain for products and goods as a major bottleneck to providing high-quality care (Figure 14). Coordinated efforts to implement recommendations by the UN Commission on Life-Saving Commodities for Women and Children[101] have strengthened relationships between global systems, countries and markets, but more work is needed.[102]

Nearly all countries report having a set of health services for women and children that are intended to be available to all and free at the point of access. However, few of these countries include the full range of recommended life-saving interventions for women's and children's health in their set of services.[103] Furthermore, assuring access does not preclude out-of-pocket expenses.

Figure 14. Percentage of countries in each WHO region with all key life-saving commodities in their essential medicines list, by commodity classification, 75 countries, 2015



Source: Analysis based on country profiles in: A decade of tracking progress for maternal, newborn and child survival: the 2015 report. Countdown to 2015. Geneva: UNCEF and WHO; 2015.

One of the EWEC *Global Strategy's* targets is to "enhance scientific research, upgrade technological capabilities and encourage innovation". The quest to do things better and more effectively should shape all efforts towards the EWEC *Global Strategy*.

The health research agenda has tended to be set at the global level, but this is changing. For example, some countries have used the Child Health and Nutrition Initiative Method[104] to identify national and local research priorities.

Some low- and middle-income countries need support to improve their capacity for data collection, research and innovation. Several organizations are working to address this issue. For example, HRP (the UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction) offers long-term grants for individuals and institutions in developing countries working on sexual and reproductive health research.[105] The Wellcome Trust is working with African research institutions to increase the number of people with research skills.[106,107] Early indications are that this type of long-term support increases national capacity for research,[108] but no robust evaluation has yet been carried out.

Decision-makers say that it can be difficult to use research evidence. Sometimes this is because the evidence is not relevant to national or local needs, and sometimes because it is not well communicated or action-focused.[109] Therefore, researchers and policy-makers need to communicate and collaborate more. National bodies can assist. For example, India has recently established a National Knowledge Platform, which aims to make research an essential element of the country's health system.[110]

All government activities involve balancing proven, effective programmes against innovative ways of delivering better results, faster or more cheaply. The EWEC *Global Strategy* calls for integrated innovation, which is the coordinated application of scientific/technological, social and business innovation to develop solutions to complex challenges. This approach does not discount the particular benefits of any of these types of innovation, but rather highlights the powerful synergies that can be realized by aligning all three. The EWEC Innovation Marketplace, described in Chapter 2 (Box 3) offers a pipeline and brokerage mechanism for innovation development, curation, financing and scaling up. Indicators and mechanisms to monitor innovation for women's, children's and adolescents' health are still under development.

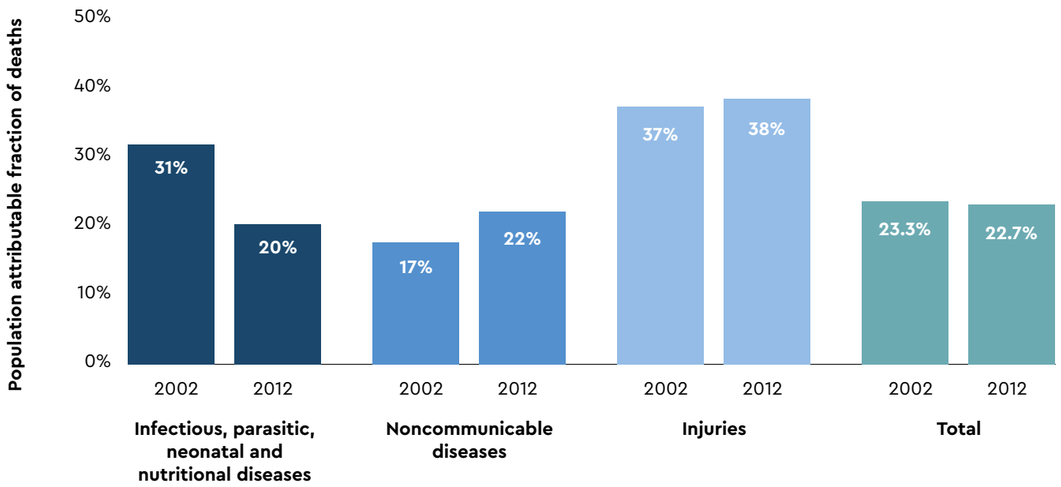
SOCIAL, ECONOMIC AND ENVIRONMENTAL FACTORS

Income status, family background, social norms and numerous other factors are known to shape the health of women, children and adolescents across the life-course, and may increase the risk of people being left behind. Poverty is one of the most damaging factors, not only undermining health by restricting people's access to the necessities of life, such as food and shelter, but also limiting their access to health services. Policies that directly address the root causes of poverty can greatly improve health outcomes across populations.[111,112,113] Data gathered for SDG 10 on inequality suggest that such measures are essential, as income inequality has increased in recent decades in developing countries and in some high-income countries.[114,115]

Many deaths worldwide are associated with adverse environmental factors (Figure 15). Women, children and adolescents are often worst affected. For example, increased exposure to household and outdoor air pollution is associated with increases in noncommunicable diseases and respiratory illness. Ninety-two per cent of the world's population are exposed to air pollution levels that exceed WHO recommendations. Pollutants, such as black carbon, contribute to climate change and to undernutrition due to their related effects on food production, and also to illnesses associated with environmental factors and vectors, including diarrhoea, malaria and respiratory diseases.[116]

An estimated one in four child deaths could be prevented by improving the environment and reducing pollution. For example, children are known to suffer acute poisoning from the widespread use of pesticides in agriculture; and lead in the environment has particularly toxic affects for children and can cause permanent damage to the brain and nervous system.[117]

Figure 15. Percentage of deaths attributable to the environment, by disease group, 2002 and 2012



Source: A global assessment of the burden of disease from environmental risks. Geneva: WHO; 2016.

Childhood exposure to chemicals and other adverse environmental factors can lead to disease and death in adolescence or adulthood: the impacts are felt across the life-course. Measures to eliminate environmental risks could significantly reduce the burden of disease among women, children and adolescents, including cancers, cardiovascular diseases and diabetes.[118]

HUMANITARIAN SETTINGS

Nowhere are women, children and adolescents more at risk of being left behind than in humanitarian crises and disasters. In 2015, an unprecedented 65.3 million people around the world were forced from their homes as refugees or internally displaced persons, with all the consequent barriers to their access to good-quality health and multisectoral services.[119] Whether on the move or in temporary camps or accommodation, refugees and displaced persons face a wide range of health risks, from lack of access to routine childhood vaccinations to inadequate sexual and reproductive health services for women.

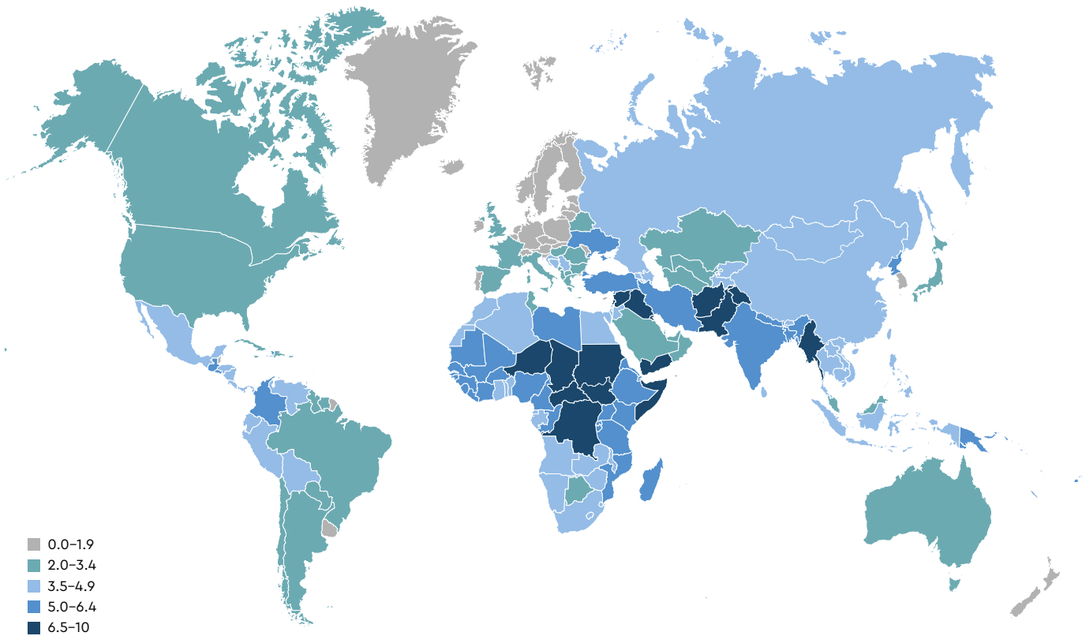
Interagency partners advocate for the deployment of the Minimum Initial Service Package (MISP) for reproductive health in crisis situations to support the needs of girls and women. This package provides clinical care for survivors of rape, makes condoms available to prevent HIV transmission, and ensures availability of skilled birth attendants to prevent maternal and newborn mortality.[120] A range of other packages and kits are available for use in crisis situations, including the Severe Acute Malnutrition Kit, the Interagency Health Emergency Kit and the Interagency Diarrhoeal Disease Kit.[121]

Another useful resource is INFORM, a global, open-source tool to identify and manage humanitarian risks.[122] It provides a way to predict, identify and manage crisis and disaster risk, and to inform decision-making, enabling the reduction of risks, the increase of people's resilience, and improved disaster preparedness and response. In high-income countries, INFORM can support disaster risk and civil contingency applications. The INFORM framework overlaps with the EWEC *Global Strategy*, in that vulnerabilities are assessed using indicators such as child mortality,

prevalence of HIV, TB and malaria, nutrition, gender inequality, poverty, resilience of health and other systems, refugees and displaced people. The need for capacity to ensure progress across the "survive, thrive and transform" objectives applies also to humanitarian risk and related management capacities, including indicators on development and inequality, and governance and health systems access.

Figure 16 shows which countries are most at risk from humanitarian crises and disasters that could overwhelm national response capacity. The assessment of risk level includes three dimensions: hazards and exposure, vulnerability and lack of coping capacity.

Figure 16. Risk of humanitarian crises and disasters



Note: the 12 countries at highest risk are: Afghanistan, Central African Republic, Chad, Democratic Republic of the Congo, Iraq, Myanmar, Niger, Somalia, South Sudan, Sudan, Syria and Yemen.

Source: INFORM 2017 Index. Inter-Agency Standing Committee Reference Group on Risk, Early Warning and Preparedness and the European Commission.

As with other areas of the EWEC *Global Strategy*, there are significant data gaps on women's, children's and adolescents' health and well-being in humanitarian settings. Significant investments in data and information systems are required to monitor progress effectively in humanitarian settings.

A review of progress in women's, children's and adolescents' health since the beginning of the 21st century reveals some remarkable achievements – many delivered through political commitment and smart investments by countries with the highest burdens and fewest resources. However, now that the SDGs have superseded the MDGs, countries need significantly more support to meet their more ambitious health targets. The next chapter examines the country-led, global, multistakeholder partnership forming around the EWEC *Global Strategy*, and the commitments needed to achieve its goals and targets.

NOWHERE ARE WOMEN, CHILDREN AND ADOLESCENTS MORE AT RISK ***OF BEING LEFT BEHIND THAN IN HUMANITARIAN CRISES AND DISASTERS***

2.

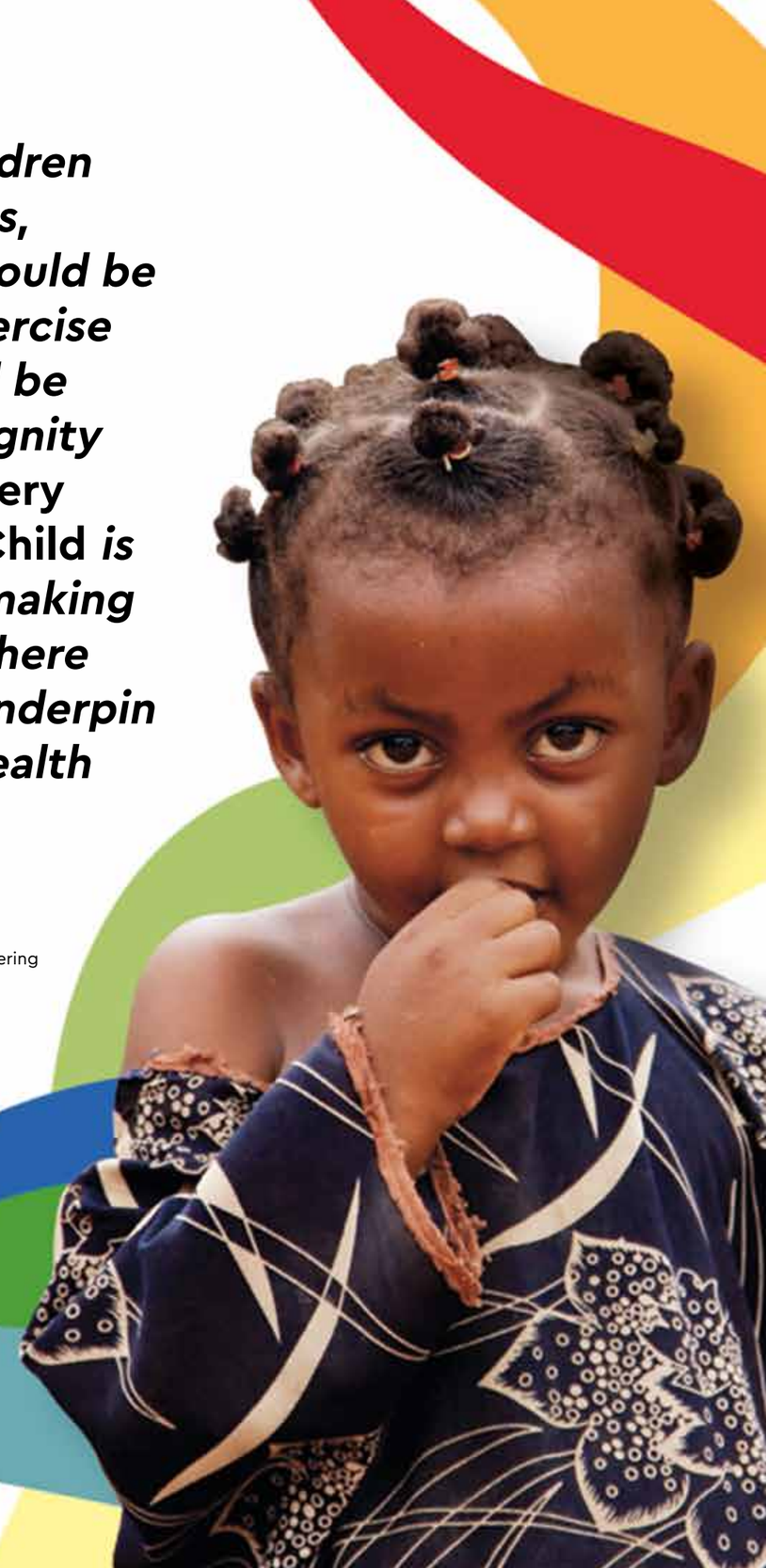
PROGRESS ON COMMITMENTS, ACTION AND ACCOUNTABILITY

Concrete commitments, collective action and mutual accountability (for results, resources and rights) are all needed to harness the power of partnership and to achieve the objectives of the *Every Woman Every Child Global Strategy for Women's, Children's and Adolescents' Health* (EWEC *Global Strategy*). Implementation is country-led and supported by EWEC partners, aligned to drive collective action. This chapter presents an overview of the commitments pledged, the actions taken and the efforts made at the country, regional and global levels to ensure mutual accountability.

International law obliges States to uphold the human rights of their citizens, including the right to health; governments have collective responsibility for doing this. Gender, equity and human rights are critical enablers required to achieve the EWEC *Global Strategy's* objectives. Yet, as a recent report noted, gross violations of human rights are reported from every region of the world, and women, children and adolescents are disproportionately affected (see Box 1).[123]

All women, children and adolescents, everywhere, should be able to fully exercise their rights and be treated with dignity and respect.* Every Woman Every Child *is committed to making this a reality, where human rights underpin all efforts for health and well-being.

H.E. Ms Tarja Halonen
Former President of Finland
Alternate Co-Chair of the High-Level Steering Group for *Every Woman Every Child*



Box 1.

Leading the realization of human rights to health and through health

The High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents released its report in 2017: the first of its kind to be presented to the World Health Assembly and the Human Rights Council.[124] The report cautions that failure to promote and protect the health and human rights of women, children and adolescents will hinder efforts to achieve the goals and targets of the 2030 Agenda for Sustainable Development. The Working Group report calls for leadership at the highest levels for the realization of human rights to health and through health. In nine recommendations, all actors – especially governments – are called upon to reaffirm their commitment to the universal values of health, dignity and human rights for all and to champion the cause of women's, children's and adolescents' health and rights through action, advocacy and activism, including to:

1. **Uphold the right to health in national law**
2. **Establish a rights-based approach to health financing and universal health coverage**
3. **Address human rights as determinants of health**
4. **Remove social, gender and cultural norms that prevent the realization of rights**
5. **Enable people to claim their rights**
6. **Empower and protect those who advocate for rights**
7. **Ensure accountability to the people, for the people**
8. **Collect rights-sensitive data**
9. **Report systematically on health and human rights.**

The report and its recommendations were presented to the 70th World Health Assembly and at the 35th session of the Human Rights Council. Over 100 Member States and dozens of civil society organizations contributed to the discussion, providing examples of a rights-based approach to health. Strong cross-regional statements were made in support of the report, with many Member States calling for a joint programme of work between WHO and the Office of the High Commissioner for Human Rights to strengthen capacity in countries to implement and monitor the Working Group's recommendations.

2.1 Overview of commitments

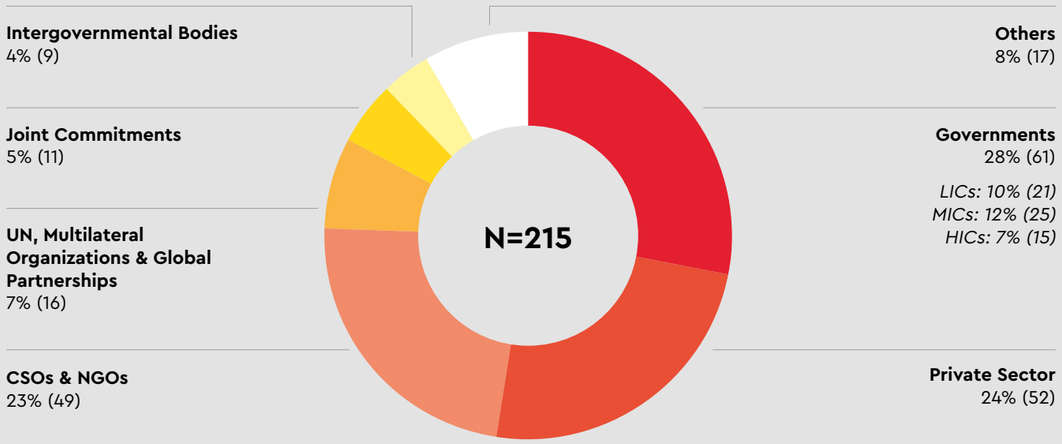
WHO IS SUPPORTING THE EWEC *GLOBAL STRATEGY*?

The updated EWEC *Global Strategy* has catalysed ground-breaking support for women's, children's and adolescents' health. A total of 215 commitments were made by 212 commitment-makers between its launch in September 2015 and December 2016.[125] The number of commitments increased from 173 in 2015 to 215 in 2016, demonstrating the EWEC movement's ability to mobilize continuing support from both governments and a diverse group of nongovernmental stakeholders, and reflecting the country-led, cross-sectoral and multistakeholder nature of the EWEC *Global Strategy*. Commitments are listed on the EWEC website having been approved through a formal process.[126]

Making 61 commitments by December 2016, governments form the largest category of supporters, accounting for 28% of all commitments (Figure 17). Nearly 22% of all pledges were made by low-income and middle-income countries. The private sector makes up the second-largest supporter group, with nearly one quarter (24%) of commitments, followed closely by civil society organizations (CSOs) and nongovernmental organizations (NGOs), with 23%.

Of the remaining quarter of commitments, 16 were made by the UN, multilateral and global partnerships, 11 were made jointly by multiple actors, nine by intergovernmental bodies, eight by academic, research and training institutes, seven by philanthropists and foundations, and two by health-care professional associations.

Figure 17. Commitments to the EWEC *Global Strategy* by supporter group, September 2015-December 2016

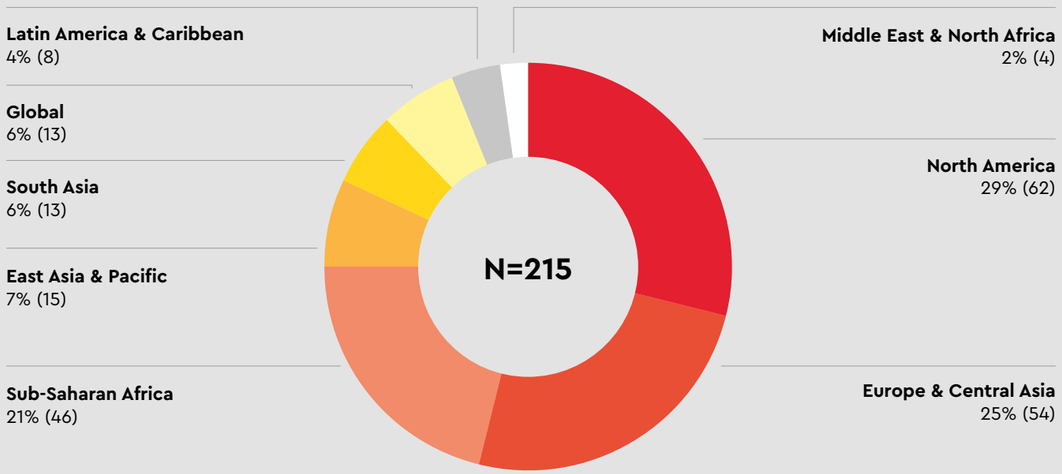


"Others" refers to Research & Academic Institutions(4%); Philanthropists & Foundations (3%); Health-care Professionals (1%). Percentages do not add up to 100% due to rounding.

HICs: high-income countries; **LICs:** low-income countries; **MICs:** middle-income countries.

Source: PMNCH commissioned analysis based on EWEC commitment data.

Figure 18. Commitments to the EWEC *Global Strategy* by geographic region, September 2015-December 2016



Source: PMNCH commissioned analysis based on EWEC commitment data.

Support for the EWEC *Global Strategy* is truly global, with supporters based all over the world (Figure 18). About half of all commitments come from North America (29%) and Europe (25%). Just over one fifth come from sub-Saharan Africa (21%). The remaining quarter of commitments come from four other geographic areas and from global-level stakeholders.

Commitments by the private sector, CSOs, NGOs, foundations and academic institutions are primarily from North America and Europe (78%), representing the need for more engagement by supporters in other regions of the world. Nongovernmental commitments are particularly low from sub-Saharan Africa: although half of commitments by governments come from sub-Saharan Africa, only 8% of private sector commitments, and 14% of CSOs' and NGOs' commitments, come from this region.

Commitments to the EWEC *Global Strategy* have resulted in more than

US$45

BILLION

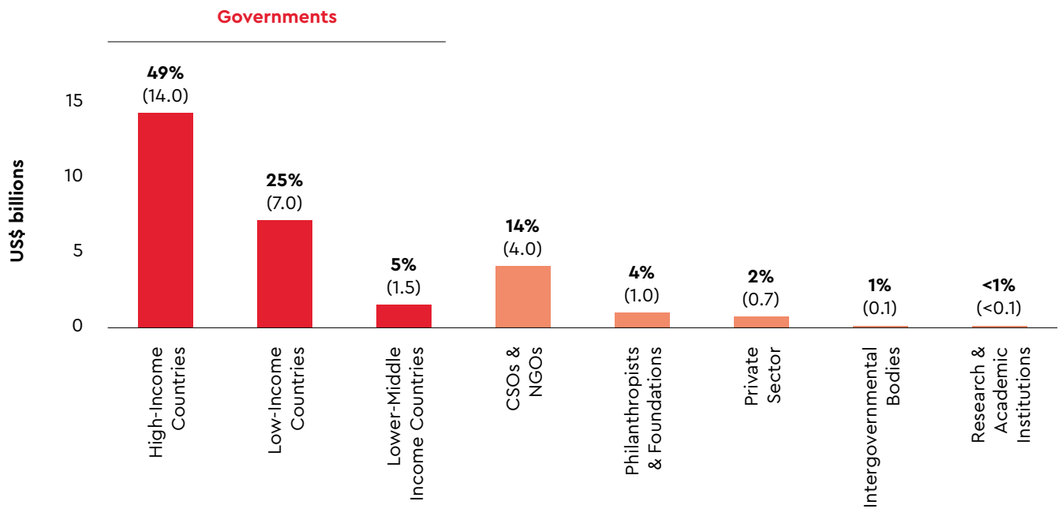
IN TOTAL DISBURSEMENTS SINCE SEPTEMBER 2010

WHAT ARE THE DIFFERENT TYPES OF COMMITMENTS?

Substantial financial commitments have been made to the updated EWEC *Global Strategy* and the funds are being disbursed. Between September 2015 and December 2016, commitment-makers pledged a total of US$ 28.4 billion in financial commitments.[127] Of this amount, donor governments pledged 49%, and low- and lower-middle income countries 30%, with the remainder coming from NGOs, CSOs, foundations, the private sector and intergovernmental bodies (Figure 19).[128] Commitment-makers are on track with their disbursements, with an estimated US$ 6.0 billion disbursed by December 2016.

The magnitude of the financial commitments to the EWEC *Global Strategy* becomes even more impressive when financial commitments to the *Global Strategy* 2010–2015 and related disbursements are taken into account. Disbursements for these commitments amounted to US$ 40 billion, bringing the total disbursements since September 2010 to more than US$ 45 billion.[129]

Figure 19. Financial commitments to the EWEC *Global Strategy* by constituency group, September 2015-December 2016



Total = US$ 28.4 billion.

Note: This graphic refers to the value of financial commitments. It does not include the value of other types of commitments (e.g. policy; in-kind services; products and other resources provided).

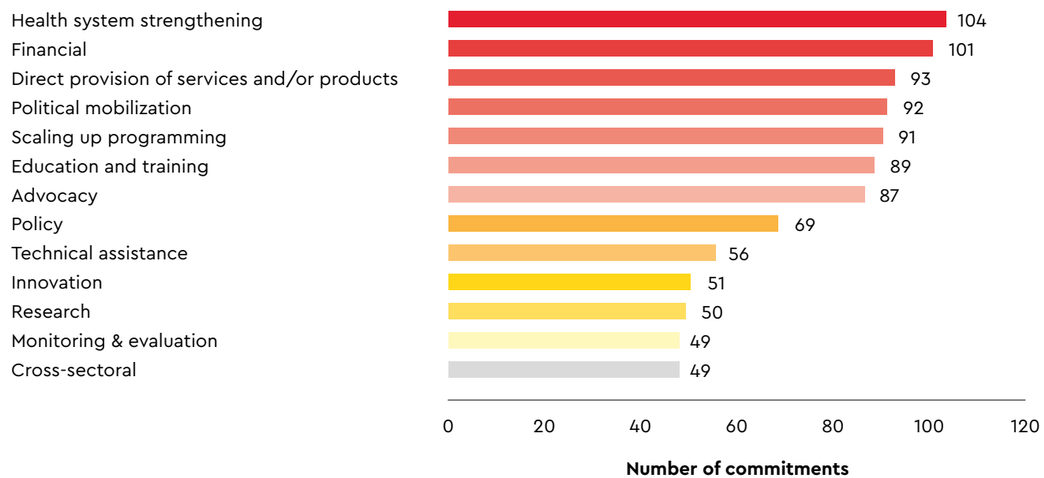
Source: PMNCH commissioned analysis based on EWEC commitment data.

Significant commitments have been made to provide advocacy, policy, service delivery and product development; these are harder to quantify but nonetheless contribute substantially to achieving the EWEC *Global Strategy*'s objectives. For example, supporters were asked to identify which of 14 "types" of activities their commitment related to (Figure 20).[130] The majority referred to health system strengthening (n = 104, 48%), the provision of services and products (n = 93, 43%), political mobilization (n = 92, 43%), and/or advocacy (n = 87, 40%). These pledge in-kind delivery of services, products or innovation, rather than direct financial support.[131]

Some supporters unite around a specific area of activity. Commitments to meet the family planning needs of women and adolescent girls made through Family Planning 2020 (FP2020) are one example (Box 2).

The private sector accounts for one third of all commitments to innovation. It provides substantive in-kind and shared value interventions that leverage the unique functions of business to address social needs in diverse ways, including through market-based business models, rather than making direct financial contributions (Box 3). CSOs and NGOs made strong pledges on service delivery and education and training, while UN organizations, multilateral agencies and global partnerships provide essential policy support.

Figure 20. Commitment types referenced by commitment-makers



Source: PMNCH commissioned analysis based on EWEC commitment data.

Box 2.

FP2020 commitments

Commitment-makers and their formal pledges to expand access to voluntary, rights-based, high-quality family planning are the foundation of FP2020, which is aligned with the EWEC *Global Strategy*. Five of the EWEC *Global Strategy's* 215 commitments are also commitments to the FP2020 partnership, which has grown steadily since its launch in 2012. FP2020 hopes to further expand this partnership and secure new commitments at the Family Planning Summit in July 2017. Led by the UK government in cooperation with the Bill & Melinda Gates Foundation and UNFPA, the Summit is intended to highlight proven strategies, and to generate more political commitments and financial resources.

Box 3.

The Innovation Marketplace

The EWEC Innovation Marketplace is a strategic alliance established to scale up effective health-care innovations. The goal is to scale up 20 innovations by 2020, with at least 10 of these widely available and significantly affecting women's, children's and adolescents' health outcomes by 2030. As of April 2017, 100 innovations had been reviewed, agreements had been completed on two, and discussions with potential partners and investors had begun on others.

The alliance prioritizes innovations that are transformative, sustainable, equitable and backed by a strong team. One example is Every Second Matters for Mothers and Babies' Uterine Balloon Tamponade (ESM-UBT), a device to treat postpartum haemorrhage, a leading cause of maternal mortality and morbidity.[132] It comprises a condom tied to a catheter and inflated with clean water through a syringe and one-way valve. The device and training package, costing less than US$ 5, have been successfully evaluated in 11 countries[133] and the ESM-UBT team intends to scale up operations widely. The alliance includes the Bill & Melinda Gates Foundation, Grand Challenges Canada, the United States Agency for International Development (USAID), the Norwegian Agency for Development Cooperation and the UBS Optimus Foundation.

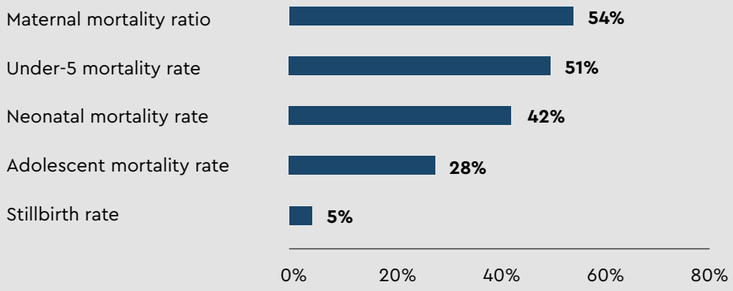
Commitments show strong support for the "survive" and "thrive" objectives of the EWEC *Global Strategy* but could be expanded to better address the social determinants of health reflected by the "transform" objective. While 80% and 70% of the 215 commitments refer to at least one of the 16 key indicators of the "thrive" and "survive" objectives respectively, only 27% reference any of the key indicators measured under the "transform" objective. This reflects the need to further develop connections between the objectives.

Of the commitments under the "survive" objective, maternal mortality (54%) and under-five mortality (51%) are the two most frequently referenced key indicators; fewer commitments are targeted at adolescent mortality and stillbirths (Figure 21). Commitments covering the "thrive" objective show strong support for essential health services. Few commitments address sexual and reproductive health and rights (SRHR) laws or out-of-pocket health expenditure. Key indicators of the "transform" objective, with topics such as education and violence against women and children, receive less attention and need further engagement.

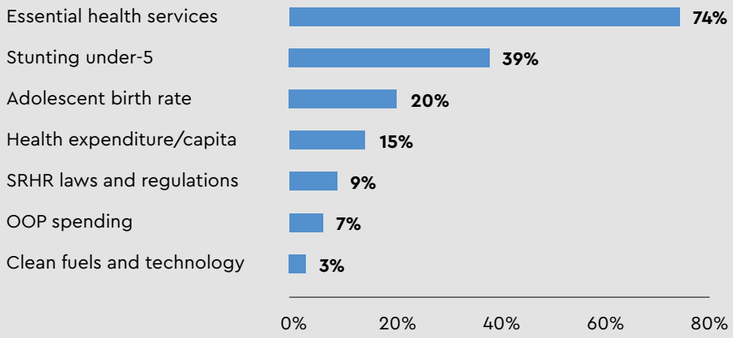
In addition to the 215 commitments made through EWEC's formal process, nine others were made at the World Humanitarian Summit in Istanbul on 23–24 May 2016, expressing support for the world's most vulnerable people. Four of these were made by governments, two each by UN organizations and CSOs, and one by the private sector.[134] All nine commitments were in support of the core responsibility to "leave no one behind". Six of them explicitly commit to ending all preventable deaths of women and adolescent girls in crisis settings. For example, UN Women will work towards this aim by supporting partners in removing structural barriers such as discriminatory policies and practices. Through the Agenda for Humanity Platform for Action, Commitments and Transformation, all stakeholders who made commitments will report on progress annually.[135]

Figure 21. Commitments referencing the 16 EWEC *Global Strategy* key indicators

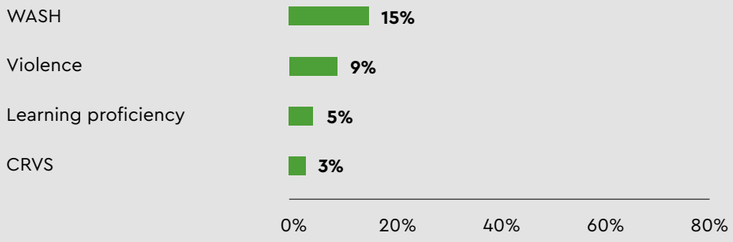
Survive



Thrive



Transform



SRHR: sexual and reproductive health and rights; **OOP:** out-of-pocket expenditures; **WASH:** water, sanitation and hygiene; **CRVS:** civil registration and vital statistics.

Source: PMNCH commissioned analysis based on EWEC commitment data.

2.2 Financing women's, children's and adolescents' health

Domestic resources are by far the biggest source of financing for health services in all countries, regardless of income level. Most low- and lower-middle-income country governments have pledged to increase public expenditure on health as a share of overall public expenditure to 15%. Progress towards this target is vital: government spending on health is below this level in many countries, mostly in Africa and Asia.[136]

The Africa Health Budget Network recently analysed the 2015 Open Budget Survey. Looking at 27 countries in sub-Saharan Africa, it found the majority were reasonably transparent about health budgets, but far fewer were transparent about actual spending – or outcomes. And while half the countries communicated budget information well, only Kenya, Rwanda and South Africa allowed the public to participate in the budgeting process.

The Global Financing Facility (GFF) in support of EWEC was launched in 2015 by the UN, in partnership with the World Bank Group (see Box 4). It is the financing arm of EWEC, and aims to close the financing gap for reproductive, maternal, newborn, child and adolescent health and nutrition (RMNCAH-N) by making more efficient use of existing resources, raising additional domestic resources (public and private) and further mobilizing and better coordinating external assistance. By the end of 2016, 16 of 62 eligible countries were receiving GFF support.

Box 4.

GFF: adding value to countries' efforts to improve the health and well-being of women, children and adolescents[137]

The GFF, using a new financing model, works to reduce preventable deaths and accelerate advancements in the health of women and children through the highest-impact interventions, addressing system barriers and tackling the social determinants of poor health. The GFF is a country-led multistakeholder partnership, and draws on the expertise and resources of the World Bank Group, UN agencies including the H6 Partnership, PMNCH, Gavi, the Global Fund, the Bill & Melinda Gates Foundation, bilateral donors, civil society organizations and private sector partners.

The GFF prioritizes quality and equity issues, such as sexual and reproductive health and rights, nutrition, newborn survival and adolescent health, and populations that have been neglected and underfunded. It also focuses investments in fragile settings: four of the current 16 GFF-supported countries are classified as fragile, one is just emerging from Ebola, and three contain fragile regions.

The GFF's approach involves prioritization, coordinated health financing, and tracking progress and learning, with country leadership. Prioritization involves identifying both key investments needed to improve RMNCAH-N outcomes in an efficient, equitable, feasible and affordable manner (typically through the development of an investment case) and health financing reforms that will result in scaled-up and more sustainable and equitable financing.

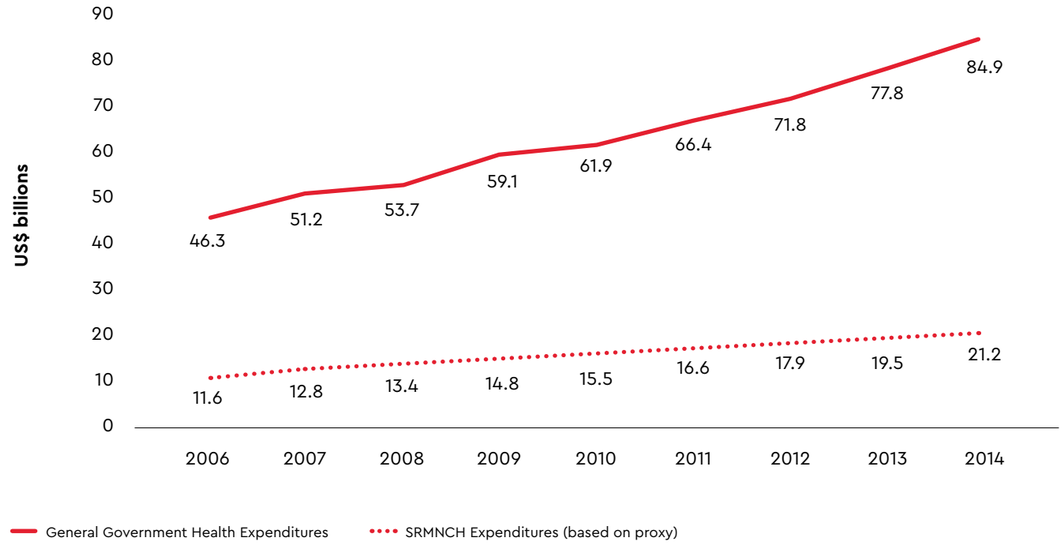
These investment cases are then implemented in a coordinated manner, with GFF catalysing improved efficiency, increased domestic resources, more and better harmonized external assistance, including concessional financing, and leveraged private sector resources.

Finally, the GFF adds value by creating a feedback loop that enables course correction during implementation, by ensuring investment in the systems needed to monitor and evaluate, and so provide reliable data to track progress in, areas such as civil registration and vital statistics systems, health management information systems, and household surveys.

Independent analysis commissioned by PMNCH for this report found that overall spending by the 62 countries eligible for GFF financing has increased continuously since the launch of the first EWEC *Global Strategy* (the latest year available is 2014).[138] Previous studies have assumed that 25% of total government health expenditures benefited sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) (see the dotted line in Figure 22).[139,140] While these are substantial increases, they still fall short of the sums needed.

In 2015, the GFF estimated the incremental resource gap for eligible countries, the amount needed to scale up coverage of services from current levels to coverage needed to ensure better health outcomes, at US$ 33.3 billion (US$ 9.42 per capita).[141] This gap needs to be filled by improved efficiency and additional domestic and donor funding to achieve the goals of the EWEC *Global Strategy*.

Figure 22. Government health expenditures in the 62 GFF-eligible countries, 2006–2014

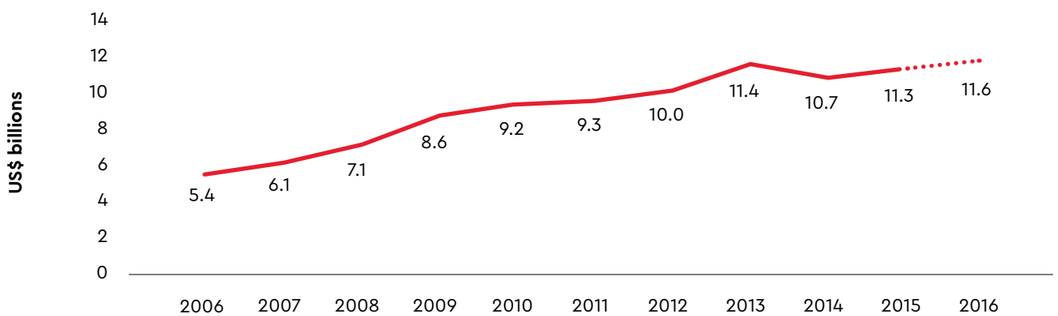


Note: Expenditures in US$ billions, constant 2010 prices.
Source: WHO Global Health Expenditure Database.

An analysis of broader SRMNCAH financing trends was conducted to contextualize the financial commitments to the EWEC *Global Strategy*, and to estimate how these commitments affected SRMNCAH financing overall.[142] The analysis shows that official development assistance (ODA) by international donors for SRMNCAH in the 62 GFF-eligible countries increased by 6.6%, from US$ 10.6 billion in 2014 to US$ 11.3 billion in 2015.[143] Compared with 2010, when the first EWEC *Global Strategy* was launched, 2015 donor flows to SRMNCAH were 22% higher.

Provisional financial data collected for this report signal further growth in SRMNCAH financing in 2016, reflecting donors' continued support. These data indicate that a number of key donors increased their SRMNCAH funding in 2016 and that the funding of most others remained stable. Overall, it is estimated that donors disbursed a total of US$ 11.6 to GFF-eligible countries, reaching a new peak in 2016, with an increase of 3% from 2015. Increases were also driven by major commitment-makers to the EWEC *Global Strategy* (e.g. Canada and Sweden) which indicates its positive influence on overall SRMNCAH financing trends (Figure 23). However, funding for some critical intervention areas is stagnating or even declining: after steady increases since the 2012 London Summit, donor country funding for bilateral family planning activities remained flat in 2015 in real terms. However, in current US dollars, 2015 funding was 6% below the 2014 level.[144]

Figure 23. ODA disbursements for SRMNCAH to the 62 GFF countries, 2006–2015, and provisional 2016 spending



Note: Expenditure in US$ billions – constant 2015 prices.
Source: OECD Common Reporting Standard (2006–2015) and 2016 provisional estimate.

2.3 Implementing commitments: government leadership

As stated in the EWEC *Global Strategy*, governments drive the process of achieving national targets by developing investment and implementation plans, establishing a coherent system for monitoring and evaluation and ensuring accountability, and harnessing existing country-level multistakeholder engagement platforms. This requires collaboration with stakeholders across societies and across sectors to create an enabling environment for health and well-being, taking a cue from the holistic spirit and scope of the SDGs (see Box 5).

***We must work together in partnership to move the needle—standing as one for those who need us most. I am committed to* Every Woman Every Child.**

H.E. Mr Jagat Prakash Nadda
Union Minister of Health and Family Welfare of the Republic of India
Member of the High-Level Steering Group for *Every Woman Every Child*

Box 5.

Cross-sectoral approaches to addressing inequalities and social determinants of health

Chile's Crece Contigo (ChCC) is a human rights- and evidence-based social protection system which aims to improve early childhood development by eliminating socioeconomic and health inequalities between children from gestation through pre-kindergarten. A presidential council sought regional, national and international input from experts, civil society and community actors across sectors. In 2007, new initiatives provided benefits and programmes for: people living in poverty and vulnerability, nursery and pre-school facilities, improved prenatal care, birth with paternal participation, and improved care for child health and well-being, with additional support for vulnerable families. This ambitious agenda was realized through multisectoral collaboration across nine government ministries, municipalities, public services and intersectoral networks. By the end of 2016, more than 920 000 pregnant women had engaged with the ChCC, and more than 312 000 home visits were made to families of children with psychomotor development issues. Since 2009, more than one million child care aids, which include materials and information, for example on issues related to parenting and stimulation from birth to two years, have been provided, one for every child born in Chile.[145,146]

As well as making progress in the "survive" agenda, Peru has also achieved significant progress in the "thrive" and "transform" objectives. Peru's focus moved towards implementing social policy and programmes aimed at reducing poverty and extreme poverty, and more recently to inclusion as an indispensible requirement for development. Nutrition and early childhood development targets improved throughout the country. Peru saw unprecedented reductions in poverty, decreased gender disparities between boys' and girls' school attendance, improved civil registration, increased numbers of children completing primary school, better security overall, and improvements in the quality of education. However, ongoing attention is still needed to reduce gender inequality and inequities in high-quality care.[147]

As part of the effort to monitor countries' progress towards implementing the EWEC *Global Strategy*, the Ministers of Health of Bangladesh, India, Malawi and Nigeria were interviewed by PMNCH (see Box 6 for highlights).

Other government leaders are also working together across regions and sectors, and with partners, to implement their EWEC *Global Strategy* commitments and address shared challenges, of which ending child marriage is one example (see Box 7).

Box 6.

Country leadership: highlights of interviews with the Ministers of Health of Bangladesh, India, Malawi and Nigeria

Bangladesh has consistently and substantially increased its health budget over the past few years, and is scaling up programmes in health and health-enhancing sectors, such as education, gender equality and empowerment, water, sanitation, hygiene and nutrition. For instance, it plans to: increase access to its 18 000 primary health-care clinics; increase antenatal and postnatal care coverage; increase the number of "family planning mobile workers"; provide free education, meals and stipends to encourage girls to remain in secondary school; empower women and attain gender parity in the workspace and in politics; increase efforts to lower the current stunting prevalence rate of 38% in children by reaching over 25 million children per year; and ensure no one is left behind by implementing legal reforms, including on child marriage.

India is focusing on improving universal health coverage, with an emphasis on maternal, newborn, child and adolescent health. It has therefore increased its annual health budget by 26%. The Prime Minister of India recently announced the Pradhan Mantri Surakshit Matritva Abhiyan initiative, popularly referred to as "I pledge for 9". This invites the private sector to provide free antenatal services on the ninth day of every month to pregnant women, especially those living in underserved, semi-urban, poor and rural areas. In three months this initiative reached 3.2 million women.

Malawi has made progress in improving the health and well-being of its women, children and adolescents by combining targeted interventions with a more holistic health system approach. Malawi sees country ownership as a critical driver of sustainable progress. The Ministry of Health is working on a number of initiatives to ensure high-quality outputs and deliverables, and is strengthening government structures to better monitor indicators, including the number of women who give birth, the number of women using contraceptives and survival rates of children.

Nigeria has developed a model for universal health coverage that aims to cater to the needs of everyone, leaving no one behind. The government has defined a package of basic health-care services, including tailored interventions addressing the unique needs of children, adolescents, women and men, regardless of location. These bold aspirations are not without their challenges owing to the sheer volume of need. For example, domestic resource mobilization, community ownership and accountability are needed to improve the health and well-being of women, children and adolescents. In line with this approach, the Ministry of Health is strengthening its engagement with civil society, monitoring and evaluation, quality of care, and data reporting lines, in order to initiate evidence-based programmes at the grassroots level and then implement them nationally.

Box 7.

Ending child marriage and reducing teenage pregnancy: signs of progress

Ending child marriage globally is central to improving the well-being of society, and is encouraged in the SDG agenda. Child marriage cuts across countries, cultures, religions and ethnicities, and occurs in every region of the world.

Improving opportunities for young women requires a multisectoral approach. Laudably, regional leadership is increasing: for example, both the African Union and the South Asian Association for Regional Cooperation have launched high-profile initiatives to end child marriage in their Member States. Fourteen countries have developed comprehensive national strategies to reduce this practice and so avoid its negative health and social consequences.[148]

In Niger, while the legal age for marriage is still under 18, the government, with the support of UNFPA, has introduced a nationwide programme providing life skills training, literacy, and sexual and reproductive health information and services. The programme has reached more than 25 000 girls aged 10–19, both unmarried and married, and has resulted in a significant uptake of contraceptive services, particularly by married girls.[149]

Zambia has also committed to strengthening access to sexual and reproductive services, reducing teenage pregnancy and eliminating child marriage. The government has sponsored and supported resolutions at the UN General Assembly and the Human Rights Council to end child, early and forced marriage. Its multisectoral country-level actions to address the vulnerabilities that contribute to early marriage include the National End Child Marriage Strategy, launched in April 2016 by the Minister of Gender, and the soon to be finalized National Plan of Action on ending Child Marriage. Together with UNFPA and partners, the government is also implementing evidence-based health and education programmes to help protect girls from child marriage and adolescent pregnancy.[150]

Governments are also increasingly addressing gender inequality because it is a root cause of poor maternal, newborn, child and adolescent health outcomes. For example, in Sierra Leone, with support from H6, the Ministry of Social Welfare, Gender and Children's Affairs worked on a community empowerment project that mobilized traditional birth attendants focusing on issues of gender-based violence and reproductive health. Community Advocacy Groups have engaged in outreach in their respective communities: making referrals, promoting family planning awareness and addressing problems of gender-based violence. In the Democratic Republic of the Congo, with support from H6, community leaders and members, both men and women, have engaged in interventions to improve gender equality. For example, in 2016, women's cooperatives were organized around income-generating activities to improve health insurance coverage, and 72 clubs promoted women's rights, including reproductive rights, reaching 3000 men and boys.[151]

THE ROLE OF PARLIAMENTS

Parliaments have the power to create an enabling legal environment for health and rights, and to ensure that high-quality health services are accessible and affordable, and provided without discrimination on grounds of age, gender, geographical area or socioeconomic status. They approve health budgets and control the purse strings and so can ensure that expenditure is effective and reaches the most needful.

Parliaments have a key role to play to unlock and leverage the full potential of women, children and adolescents. They are the bridge between citizens and their government, prioritize budgetary allocations and ensure accountability for results. Through* Every Woman Every Child *we can and will make a difference.

H.E. Mr Saber Chowdhury
President of the Inter-Parliamentary Union
Member of Parliament, Bangladesh
Member of the High-Level Steering Group for *Every Woman Every Child*

The Inter-Parliamentary Union (IPU) has collaborated with EWEC for some years in advocating to parliaments for increased action on SRMNCAH. Following the launch of the EWEC *Global Strategy*, the IPU committed to renew efforts in support of parliamentary action.

For example, with IPU's support, members of the Health and Budget Committees in the Parliament of Uganda received training on health financing and budgeting, budget analysis and expenditure tracking. As a result, in 2013, the Parliament was able to exercise its prerogative over the government, refusing to approve the budget for the next fiscal year until the President of Uganda increased funding to health workers, especially those in rural areas.

As representatives of the people, members of parliament can increase their constituents' knowledge of existing health legislation and of their health rights, voice constituents' needs and concerns, and facilitate access by citizens to decision-making.

For example, in March 2016, the Rwandan Parliament passed the Human Reproductive Health Law. This recognizes the right of citizens to access reproductive health and family planning services, and enacts provisions for more effective oversight of government action on sexual and reproductive health. Male and female parliamentarians across party lines engaged constituents from all 30 districts of the country, explaining people's health rights and encouraging access to reproductive health services and family planning.

2.4 Nongovernmental supporters: progress on implementation

To track progress on the implementation of nongovernmental commitments since the launch of the EWEC *Global Strategy*, commitment-makers were invited to complete a questionnaire. In total, 134 nongovernmental commitment-makers received the questionnaire, of which 96 (72%) completed it between 2 March 2017 and 16 June 2017.[152]

The self-reported survey results show that nongovernmental commitments have already resulted in the provision of services to at least 273 million women, children, newborns and adolescents. Given that not all supporters reported on progress to EWEC, this is almost certainly an underestimate.[153]

Survey respondents also provided descriptive statistics and responses on implementation to date. Table 1 shows examples of services provided to different age groups, with the estimated numbers of people reached.

Table 1. Services provided under selected areas covered in the online survey of nongovernmental commitment-makers

Focus area	Examples of services provided
Women's health priorities/interventions, including SRHR	• 28 million reached with contraceptives • 3.4 million reached with safe abortion and care services • 1 million reached with family planning counselling • 6000 reached with training for self-detection of breast cancer

Focus area	Examples of services provided
Maternal health priorities/interventions	• 5.5 million mothers reached with hand-washing training • 5 million women reached with activities or products concerning obstetric services • 1.3 million women reached with access to high-quality maternal health care • 29 000 women reached with prenatal services
Adolescents' health priorities/interventions	• 75 million reached with SRHR services • 35 000 reached with sustainable sanitation in schools
Children's health priorities/interventions	• 52 million reached with vaccines, including pneumonia, measles, rubella • 15 million reached with oral rehydration salts and zinc treatment for diarrhoea • 11 million reached with hand-washing training
Newborns' health priorities/interventions	• 1.7 million reached with improved care through training of nurses and midwives • 0.8 million reached with postnatal care efforts, including the use of chlorhexidine for umbilical cord care, neonatal intensive care unit admissions and home visits

The following are a few examples of the services that have been provided by stakeholders to achieve the results summarized in Table 1. Through multiple initiatives, the UN Foundation worked with partners to vaccinate 12 million children. As part of the for "Zinc Alliance for Child Health" partnership, Teck, a Canadian mining company, provided zinc and oral rehydration salts to treat children with diarrhoea. Over one million neonates were reached by Johnson & Johnson through their efforts to train 7000 nurses and midwives in five countries. Restless Development and Bayer collectively reached 0.5 million adolescents with SRHR activities. Pathfinder reached one million women with family planning counselling. PATH and partners reached 4 million pregnant women with improved technologies for the provision of child-birth services. Unilever reached 5.5 million mothers with hand-washing training.

Private-sector commitment-makers often focus on innovations, education and training, and scaling up programming (see Boxes 8 and 9 for two examples).

***The private sector has an important role to play in improving women's, children's and adolescents' health and well-being. We are ready to meet the challenge and boost action in support of* Every Woman Every Child.**

Bob Collymore
Chief Executive Officer, Safaricom Limited, Kenya
Member of the High-Level Steering Group for *Every Woman Every Child*

Box 8.

Kenya's Private Sector Health Partnership

In Kenya the Private Sector Health Partnership (PSHP) was launched in September 2015 to contribute to the EWEC *Global Strategy*. Its partners have committed approximately US$ 2.5 million. PSHP aims to drive improvements in maternal health in the six counties that account for close to 50% of all maternal deaths in Kenya but have only 10% of the population: Mandera, Wajir, Mrasabit, Isiolo, Lamu and Migori. Its partners, notably Huawei, MSD (Merck), Royal Philips, Safaricom and the Kenya Private Sector Healthcare Federation, work in close collaboration with local authorities, UN agencies (with leadership from UNFPA), the Beyond Zero Campaign of the First Lady of Kenya, the GFF and nongovernmental partners.

PSHP has launched several new initiatives, including the development and testing of telemedicine solutions by Huawei and Safaricom. A Community Life Center will be opened by Philips in collaboration with the Mandera County Government and the local community in July 2017 to serve the catchment area of 30 000 people around Dandu. A comprehensive system of electronic medical records for health facilities, to improve data tracking, patient information and commodity supply, is also being tested in Lamu County with support from Huawei. Around 37 000 patients have been registered. PSHP is also exploring resource pooling, social franchising for midwives, and improved civil registration and vital statistics collection methods. Further, it has supported the I AM innovation accelerator, which helps young Kenyans access sexual and reproductive health information. This initiative has reached 830 000 young people through social media, and 139 469 people have used the innovative solutions.

Over 100 high-level decision-makers and influencers from government, the private sector and other constituencies have been engaged through advocacy and policy dialogue to mobilize support for PSHP's efforts.

Box 9.

South Africa: Saving children's lives through a safer road environment

In 2015, Discovery, an insurance provider based in South Africa, made a multifaceted commitment to the EWEC *Global Strategy*. Its Safe Travel to School programme set out to improve safety for schoolchildren, countering South Africa's shockingly high rate of traffic accidents by using Discovery's telematics systems to monitor the driving behaviour of school bus and mini-bus drivers, and encouraging safer practices and greater accountability and ownership across local communities.

The programme was initiated in the greater Cape Town area and recruited 310 school transport drivers working on high-risk traffic routes. All vehicles are checked for roadworthiness, and equipped with devices which record driving behaviour. Drivers receive monthly feedback and gain rewards for driving safely. Safe Travel to School also provides first aid training and wellness checks for drivers, arranges driving training, refers all drivers for eye tests and arranges spectacles as required, thus improving both their personal health and driving techniques. The programme nurtures community ownership by maintaining strong relationships with partners and other stakeholders, including school principals, the Department of Transport and law enforcement representatives. Programme managers reward the safest driver each year. This has contributed to a decrease in unsafe driving, and reached 3720 children and adolescents.

Survey respondents, including those from the business community and academia, also provided examples of progress through innovation. Innovation and research are essential aspects of the work being undertaken to achieve the objectives and targets of the EWEC *Global Strategy*. Two thirds of respondents (60) reported progress on a wide range of innovations. New health technologies, including 18 eHealth and mHealth technologies, were the most frequently reported innovations. Others included advances in education curricula, service delivery approaches, advocacy and policy, and clean energy/climate, water and sanitation.

For example, Plan International is collaborating on the introduction of a cost-saving stainless steel telescopic rod for use in the long bones of children with *osteogenesis imperfecta*, and a smartphone application for skilled birth attendants that provides direct access to evidence-based and updated clinical guidelines on basic emergency obstetric and neonatal care.

Commitments from CSOs and NGOs focus particularly on service delivery, education and training, research, and health system strengthening. Overall, survey respondents reported substantial efforts in the training of health-care personnel: according to the information provided, 0.7 million family planning counsellors, 0.5 million community health-care workers, 11 000 nurses and midwives and 1000 doctors have been trained.

Box 10 highlights the progress made by international NGOs in implementing their commitments, and their impacts. Box 11 describes a partnership between a Nepalese youth-led organization and a local NGO to address identified reproductive health needs through education and advocacy.

Engaging citizens is what will take us from setting goals to actually meeting them.

Dr Aparajita Gogoi
National Coordinator, White Ribbon Alliance India

Box 10.

Examples of international NGOs' commitments: progress and impact

Save the Children committed to invest US$ 250 million in its global health and nutrition portfolio in 2015, but actually spent US$ 338 million, exceeding its commitment by more than 50%. These investments directly reached 36 168 706 children and adolescents (aged 0–18 years) and 18 623 873 women with life-saving interventions across seven primary areas: maternal, newborn and reproductive health; child health; maternal, infant and young child nutrition; water, sanitation and hygiene; HIV; adolescent sexual and reproductive health; and clinical services in crisis settings. In 2016, Save the Children committed to investing US$ 2.25 billion in global health and nutrition work, in both development and humanitarian settings, in the period 2017–2021.

In 2015, Marie Stopes International (MSI) committed to strengthen health systems, remove unnecessary restrictions on access to lifesaving services, and advocate for evidence-based resource allocation and policy formulation. Since 2012, MSI has enabled 3.6 million additional people to use contraceptives in the 69 FP2020-designated focus countries,[154] around 30% of their total pledge of 12 million additional users. MSI also provided 3.4 million women with safe abortion and post-abortion care in 2015.

Women Deliver fulfilled its commitment to the EWEC *Global Strategy* for 2015 to 2016, meeting or exceeding all its targets, by: holding the Women Deliver Conference in 2016; creating a Young Leaders' Programme; running a communications and advocacy campaign, Deliver for Good, that provides a gender lens for the SDGs; and undertaking general advocacy work relating to girls' and women's health, including sexual and reproductive health and rights. The provision of these services was valued at US$ 12.6 million and contributed to significant improvements in the lives of women and girls.

Box 11.

Community-led efforts to improve menstrual hygiene management in Nepal

Menstrual hygiene management remains a major health and social issue in Nepal, where women are ostracized during their periods, and girls drop out of education due to limited access to proper hygiene facilities at school. To address the need for culturally specific interventions that would remove barriers to adequate menstrual hygiene management in their community, Kalyani, a youth-led organization, partnered with KIRDARC, a local NGO working in Surkhet, Nepal. Through a 6-month seed grant project, funded by the Women Deliver Young Leaders programme in 2016, the Kalyani team developed a baseline, and conducted advocacy, awareness and skills training sessions on menstrual hygiene. The baseline showed that only 28% of adolescent girls were aware of menstruation as a normal physiological process, and that 79% of respondents were practising traditional Chhaupadi, whereby women and girls move into sheds during their periods. They conducted 73 menstrual hygiene management awareness sessions for over 1680 people, among target groups including: school-going adolescents, adolescent groups, youth committees, women's and mothers' groups, female community health volunteers, community leaders and other community members. Finally, 22 training sessions taught 311 women and girls to make reusable sanitary cloth pads for use in place of less hygenic practices. The impact of these activities will be assessed in 2017. Importantly, Kalyani's collaboration with KIRDARC has facilitated new partnerships which will continue this work at the community level, including with district health and gender officials.[155]

Health-care professionals play an essential role in providing high-quality care to all women, children and adolescents, and training and educating health workers (see Box 12). However, they have only made 1% of the commitments to the EWEC *Global Strategy.*

Box 12.

Health-care professionals: at the forefront of operationalizing human rights for health

At the request of the UN Human Rights Council, the Office of the High Commissioner for Human Rights and partners prepared two technical guidance documents on how to address preventable maternal mortality and morbidity and under-five mortality and morbidity in all aspects of planning and programming, in accordance with human rights standards. Professional associations have a critical role to play in integrating human rights standards and principles into the design and delivery of health services and interventions and into training and education. For example, as part of its capacity building efforts, the Society of Midwives of South Africa is using the technical guidance to apply a human rights-based approach in the training and regulation of midwives. Based on that guidance, the Society developed a trainers' handbook on applying human rights-based approaches to midwifery, conducted workshops with its executive members and educators to support the introduction of human rights standards and principles into their respective training institutions, and advocated for midwifery. Thus far, the handbook has been piloted with 30 midwives by trained educators. These activities strengthened the Society's collaboration with the National Department of Health and the Ministry of Health, and led to explicit recognition of midwives in the South African Nursing and Midwifery Act 2015.[156]

2.5 Citizens driving change

We must ensure that every woman, child and adolescent is empowered to become what they choose to be. Building partnerships and working at the local level will be key if we are to achieve real results and build a better future for them.

H.E. Ms Marie-Claude Bibeau
Minister of International Development and La Francophonie of Canada
Member of the High-Level Steering Group for *Every Woman Every Child*

EMPOWERMENT AND PARTICIPATION

Progress has also been made by supporting women as autonomous agents and enabling them to drive change for themselves. This includes enhancing their ability to participate in decision-making, investing in them as individuals, building confidence, facilitating collective action and raising awareness of rights.

It is widely acknowledged that the greatest obstacles to better health for women are not medical in nature, but are largely determined by their social, political and economic conditions. Studies have consistently shown that socioeconomic differentials are the clearest indicators of the status of women's health. These factors significantly influence women's ability to participate in their own health-care decision-making, health-care access and health outcomes (Box 13).

Now in Bangladesh, people bear 64% of the expense for health services, which often pushes people below the poverty level.

Dr Arefin Omar Islam
Chair of the Executive Committee of White Ribbon Alliance,
at the National Citizens' Hearing, Bangladesh

Supporting women's empowerment involves fostering an environment that enables them to access resources, through employment opportunities or loans, as well as focusing on the broader multidimensional nature of women's autonomy, including skills development and participation.

Box 13.

Increasing uptake and use of services through women's empowerment

In Cameroon's Far North region, the poorest in the country, H6 has supported efforts to address the root causes of low utilization of health facilities and lack of health-seeking behaviour since 2014. More than 70 women's groups received technical and material support to develop income-generating activities and to promote RMNCAH. The women's groups carried out activities such as awareness-raising on RMNCAH and the importance of accessing services, counselling for women, and financial support to women who cannot afford to access services. This approach catalysed the women's financial empowerment, and also facilitated their access to health services, particularly for childbirth in health facilities.[157]

It is important to involve citizens when addressing their needs, and when implementing plans. They are the ones who know exactly what they need. Involve them.

Senior Chief Somba
at the Blantyre District Citizens' Hearing, Malawi

There is growing recognition of the potential for citizen-led accountability. Both the SDGs and the EWEC *Global Strategy* call for accountability frameworks to be inclusive, participatory, transparent and people-centred. However, for citizen-led accountability initiatives to thrive, deliver results and be incorporated into broader accountability frameworks operating at national and global levels, a concerted effort must be made to engage citizens and inform them of their rights. Such efforts are also essential for ensuring that citizens' voices are heard by decision-makers at all levels of government: local efforts operating in isolation have limited reach and potential, resulting in "a voice without teeth".[158] With the support structures and amplification of voice provided by a wider network, duty-bearers are more receptive to citizens' asks and demands.

World Vision, Save the Children, International Planned Parenthood Federation and White Ribbon Alliance (WRA) formed a partnership in 2015, pooling their social accountability-related networks to reduce duplication and achieve more effective work jointly. This partnership works collaboratively with state and government institutions and decision-makers to foster trust between duty-bearers and rights-holders. The partners have launched a number of highly successful initiatives, including the following.

The partnership has coordinated citizens' hearings around the world, at which thousands of citizens and community groups, including children's, adolescents' and women's rights groups, have engaged with decision-makers and service-providers to discuss health services and identify strategies for immediate improvements in their local area. Citizens' hearings provide opportunities for citizens to shed light on SRMNCAH issues, seek solutions, set priorities, and monitor and review progress.

In 2015 and 2016, citizens' hearings were held in more than 20 countries in Africa and Asia (Afghanistan, Bangladesh, Cambodia, Ghana, India, Indonesia, Kenya, Lesotho, Malawi, Mali, Mauritania, Nepal, Niger, Nigeria, Pakistan, Sierra Leone, South Africa, Sudan, Uganda, Tanzania, Zambia and Zimbabwe). Citizens' hearings have helped to identify priorities for the SDGs and the updated EWEC *Global Strategy*, and to persuade governments to establish accountability frameworks.[159]

In Tanzania, in order to address the lack of investment in comprehensive emergency obstetric and newborn care (CEmONC), WRA Tanzania and its members advocated for an increase in and ring-fencing of the budget allocation for CEmONC. WRA Tanzania worked with member organizations, religious leaders and village health teams to raise awareness among citizens of the CEmONC funding gap. Through media partnerships, WRA Tanzania ensured that health officials and other

If citizens are not given an opportunity to speak, as is being done here at the Citizens' Hearing, leaders will not be able to identify the actual problems facing citizens.

Dr Juma Mfangwa
District Medical Officer, at the Muheza District Citizens' Hearing, Tanzania

government leaders heard the stories and evidence collected from mothers and their families, and that community demands were discussed and addressed. On a regional level, citizen-led efforts in Rukwa region contributed to the creation of five health facilities providing CEmoNC services, each serving between 7000 and 15 000 people.

Similarly, key advocacy and accountability activities at the national level helped to amplify citizens' voices and so increase government officials' awareness of their responsibilities as duty-bearers. Policy-makers responded by increasing the 2017/18 budget for maternal and newborn health by 53% over the previous year, with plans to upgrade 150 health centres to provide CEmONC.

In Uganda, Advocacy for Better Health, a five-year USAID project implemented by PATH and Initiatives Inc, has since 2014 used advocacy capacity building, community mobilization and social accountability to amplify citizens' voices. The project engages communities in the planning and monitoring of health services, and strengthens the capacity of local CSOs to represent citizens' interests and advocate for health policies, budgets and programmes. Advocacy for Better Health and 20 CSO partners have mobilized 429 community groups in 35 districts to hold duty-bearers accountable for health-related goals and commitments.

CITIZENS' HEARINGS PROVIDE OPPORTUNITIES FOR CITIZENS TO SHED LIGHT ON SRMNCAH ISSUES, *SEEK SOLUTIONS, SET PRIORITIES, AND MONITOR AND REVIEW PROGRESS*

Engaged by the programme's partners, the media have provided invaluable help in amplifying the voices of citizens demanding accountability, enabling them to reach decision-makers at subnational, national and global levels. For example, the National Citizens' Hearing in Uganda was broadcast on national television. Print and electronic media have also devoted significant space and attention to citizens' demands. Radio, television and newspapers have provided opportunities for citizens and other stakeholders to highlight key issues and inform citizens of their rights to take action on those issues.

These examples of the partnership's work illustrate the critical impact of citizen-led accountability efforts on improving services and outcomes for women, children and adolescents. However, much more work needs to be done to support, and gather evidence of, successful citizen-led accountability mechanisms, led by a range of partners across countries.

3.

MOVING FORWARD TOGETHER AND LEAVING NO ONE BEHIND

Investing in women, children and adolescents means investing in more sustainable, prosperous, equitable and resilient societies. This is the future we want and what we are working for.

H.E. Mr Børge Brende
Minister of Foreign Affairs, Norway
Member of the High-Level Steering Group
for *Every Woman Every Child*

As Chapter 1 indicates, despite the general progress that has been achieved, major challenges persist around each of the three objectives of *Every Woman Every Child Global Strategy for Women's, Children's and Adolescents' Health* (EWEC *Global Strategy*).

Under "survive", there is still a high toll of preventable deaths among women, children and adolescents, and also of stillbirths. There are continuing epidemics of communicable and noncommunicable diseases, emerging challenges from environmental pollution and climate change, and humanitarian crises that hinder progress: their impact is especially devastating in already fragile settings.

Under "thrive", multiple barriers to good-quality health and health-related services – including for nutrition, early childhood and adolescent health and development, and sexual and reproductive health services and rights – prevent millions of women, children and adolescents from realizing their full potential and their human right to the highest attainable standard of health and well-being.

Under "transform", issues such as children not being registered at birth, poverty, gender inequality, lack of education, weak health systems, lack of adequate water, sanitation and hygiene, air pollution, gender-based violence and discrimination constitute both violations of rights and barriers to progress. These issues often intersect, leading to even greater vulnerabilities and increased risks of preventable death, illness and injury.

Progress requires action across all the interlinked "survive, thrive and transform" objectives. For example, malnutrition underpins around half of all causes of child mortality; and girls' education is associated with better women's health outcomes. Across all areas, inequities within countries and across regions work against the universal agenda of the EWEC *Global Strategy* and the SDGs.

EWEC has mobilized continued support from governments and a diverse group of nongovernmental stakeholders, including many from low-income countries. For example, seven of the 12 countries in the world that are most at risk from humanitarian crises and disasters (see Figure 16 in Chapter 1) have made commitments since 2010 to the EWEC *Global Strategy* to protect women, children and adolescents from these risks: Afghanistan, Chad, Democratic Republic of the Congo, Myanmar, Niger, South Sudan and Yemen. Commitments, whether financial, in-kind or shared value interventions (policy, advocacy etc.) have increased since 2015.

Chapter 2 demonstrates that support for the EWEC *Global Strategy* is truly global, but increased engagement is still needed by supporters from regions outside North America and Europe. The commitments show strong support for the "survive" and "thrive" objectives of the EWEC *Global Strategy*, but multistakeholder commitments across and between sectors that address the social determinants of health under the "transform" objective are lacking. Government leadership is essential in order to address inequalities and realize progress in women's, children's and adolescents' health, with multisectoral collaboration playing a major role in the implementation of commitments.

However, Chapter 2 also shows that everyone has a role to play, with parliamentarians and nongovernmental supporters demonstrating strong commitments to unite efforts across sectors to improve the health of women, children and adolescents. Notably, citizens are also driving change and taking action for improved health and accountability. Clear documentation and evaluation of activities, processes and outcomes are also necessary to build evidence of what works best across the "survive, thrive and transform" objectives.

3.1 EWEC Partners' Framework for 2018–2020

Accelerated progress, more commitments, better aligned action across sectors and among all partners engaged in implementing the EWEC *Global Strategy*, and stronger mutual accountability mechanisms are all needed. In response to these needs, partners developed the 2020 EWEC Partners' Framework, which includes six focus areas: early childhood development; adolescent health and well-being; quality, equity and dignity in services; sexual and reproductive health and rights; empowerment of women, girls and communities; and humanitarian and fragile settings. The Framework includes: five critical enablers ("common deliverables"); political commitment; integrative, sustainable financing; multistakeholder and cross-sectoral partnership; improved management systems and capacities; and strengthened data and information systems and accountability at all levels. This framework was endorsed unanimously by the High-Level Steering Group during their April 2017 meeting. Both the focus areas and the common deliverables will have measurable milestones and will be monitored through the Unified Accountability Framework, and published in this report annually.

This Framework does not add any additional reporting burden for countries; rather, it defines what EWEC partners need to monitor between and among themselves to ensure mutual accountability. The EWEC *Global Strategy*'s 60 indicators are part of monitoring mechanisms that already exist. The Framework sets out what action each EWEC core partner will take in relation to the focus areas and the enablers.[160] By mapping where, how and by when partners can make greater gains, and how those gains can be measured, the Framework will enable future EWEC *Global Strategy* progress reports to show where action is occurring, and where it is lacking. This will improve coherence among partners, enhance impact and encourage greater mutual accountability.

3.2 Everyone has a role to play

Countries, constituencies and partners united in support of the EWEC Partners' Framework and its measurable 2020 milestones can achieve more together than by acting alone. The following actions, by actor group, demonstrate the breadth and interdependence of the effort needed to achieve the aims and objectives of the EWEC *Global Strategy*. It is hoped that these activities will be increasingly evident in future progress reports, with stakeholders identifying specific actions for achieving their intended milestones.

The groups of commitment-makers listed below comprise the 10 constituencies of PMNCH and they work together in support of EWEC for improved action, alignment, advocacy and accountability.[161]

GOVERNMENT AND NONGOVERNMENTAL COMMITMENT-MAKERS

Governments: Increase government commitments to women's, children's and adolescents' health, including through costed and financed plans for integrated SRMNCAH activities, and increase the percentage of domestic financing supporting universal health coverage.

Parliamentarians: Strengthen the capacity of parliaments to move towards universal health coverage, and uphold the right of all women, children and adolescents to the highest attainable standard of health and well-being. Introduce or amend legislation and policies in line with human rights principles, including gender equality and non-discrimination.

Private sector: Increase commitments by supporting government policies aimed at universal health coverage, better nutrition, healthier foods and cleaner energy. Support efforts to improve access to good-quality health services and life-saving commodities. Explore new drugs, technologies and interventions to improve health in resource-limited settings, bringing the most promising innovations to market.

Donors and foundations: Mobilize additional resources to complement domestic investments, and align these resources with country plans and priorities. Provide effective and streamlined technical support for country-identified priorities, while enhancing local capacities to develop, finance, implement and monitor evidence-based national plans and programmes.

Health-care professional associations: Provide the highest possible quality of care and treat all women, children and adolescents with dignity and respect, upholding their human rights. Audit clinical practice, providing information to track progress, and ensuring effective remedy and redress at facility and community levels.

NGOs and CSOs: Advocate for increased attention to, and investment in, women's, children's and adolescents' health, while ensuring that people and communities are meaningfully engaged in shaping high-quality health-care services and health-enhancing interventions. Contribute to strengthening accountability, and to efforts to reach the most vulnerable populations.

Adolescents and youth: Strengthen youth-led networks and use them to demand that young people's voices are heard and valued. Advocate for their rights, motivate and inspire authorities to take necessary action, and become active agents of improvement in their own health and well-being.

Academic and research institutions: Generate, translate and disseminate evidence and best practices to shape effective, human rights-based and equity-oriented health policies and programmes that are critical for improving women's, children's and adolescents' health and well-being. Strengthen networks of academics and researchers to promote knowledge exchange, especially relating to cross-sectoral interventions. Increase research capacity in communities and countries where women, children and adolescents have poor health outcomes. Conduct research on relevant, under-addressed priorities, such as implementation and accountability.

EWEC PARTNERS

UN Secretary-General and High-Level Steering Group for EWEC: Build political attention to and momentum for women's, children's and adolescents' health and well-being through targeted opportunities (e.g. at G20, Inter-Parliamentary Union Assembly, African Union summits, G7, United Nations General Assembly, as well as at bilateral meetings and speaking engagements). Disseminate key messages through media, and urge the integration of health care with health-enhancing sectors (e.g. education, water, sanitation, environment and energy) and with humanitarian action.

EWEC and PMNCH secretariats: Support the High-Level Steering Group and partners in their collective and better coordinated action, across the health sector and other relevant sectors, as well as strengthening accountability at global, regional and country levels, including documenting positive systemic changes. Generate commitments to the EWEC *Global Strategy* through increased engagement with constituency groups, including the private sector. Conduct commitment tracking, develop annual EWEC *Global Strategy* progress reports, and analyse financial trends and forecasting for women's, children's and adolescents' health. Strengthen stakeholders' capacity to engage in social accountability processes (e.g. citizens' hearings, scorecards, checklists and death audits, media and parliamentary processes). Support efforts to increase transparency and information flows between country and global partners, which will help strengthen accountability mechanisms.

H6 partnership (UNAIDS, UNFPA, UNICEF, UN Women, WHO and the World Bank Group): Provide technical support for nationally led efforts to develop and cost national plans and to implement them by working with a wide range of stakeholders. Define evidence-based policy options, packages of interventions and best buys for investments to inform prioritization and mobilization of domestic and external SRMNCAH financing. Facilitate technical exchanges (including South-South) and documentation and dissemination of SRMNCAH best practices and lessons learned. Provide guidance and support to strengthen country health information systems.

Global financing mechanisms (GFF, the Global Fund to Fight AIDS, Tuberculosis and Malaria and Gavi, the Vaccine Alliance): Support smart, integrated, scaled, sustainable financing for SRMNCAH, contributing to country development of such financing strategies in support of high-impact, prioritized investments. Support monitoring and evaluation efforts to provide data on financing indicators and targets at country level.

EWEC Innovation Marketplace: Facilitate investments across the six EWEC focus areas, and target innovative financing mechanisms. Foster private sector engagement, including via provider partners and multinational corporations, and build political attention and momentum through targeted Innovation Marketplace events. Incorporate innovations into country plans, in cooperation with global financing mechanisms as appropriate.

FP2020: Generate additional country and nongovernmental commitments to rights-based family planning in support of EWEC, and raise awareness and profile of family planning at national and global levels. Strengthen the focal point system in 38 countries to include civil society and young people, and build family planning linkages across other sectors. Work with partners to ensure that new/renewed costed implementation plans integrate performance management, are based on human rights principles and use up-to-date data for decision-making.

Independent Accountability Panel (IAP): Provide an independent and transparent review of progress towards and challenges to the implementation of the EWEC *Global Strategy* to help strengthen the response from the international health community and countries. Deliver its messages to the widest possible audience, for review and action from diverse stakeholders within the context of SDG review processes, including the High-Level Political Forum on Sustainable Development and the World Health Assembly, as well as annual meetings of the international financial institutions, human rights treaty bodies, the Inter-Parliamentary Union, the African Union, Partners in Population and Development and other high-level political assemblies and events. The IAP's 2017 report focuses on adolescents, providing

the updated evidence, recommendations and guidance on progress towards, and challenges and constraints involved in, achieving the goals.

Countdown to 2030: Strengthen monitoring of and accountability for women's, children's and adolescents' health at global and country levels, focusing on equitable coverage of effective interventions and on the drivers of coverage, including health systems, policies, financial flows and broader contextual factors. Produce global synthesis reports and country profiles for the 81 highest-burden countries, and conduct regular workshops in priority regions to develop country capacity to collect, analyse and use data for decision-making on RMNCAH and nutrition.

The H6 is committed to help implement the* Every Woman Every Child Global Strategy for Women's, Children's and Adolescents' Health. *Aligned and focused action is crucial to achieve the SDGs for all.

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CONCLUDING REMARKS

This 2017 EWEC *Global Strategy* progress report has taken stock of the current state of progress towards the EWEC *Global Strategy's* targets and objectives, analysed commitments, implementation and impact between September 2015 and December 2016, and presented the agreed priorities for further coordination and action through to 2020.

Apart from its analysis of commitments and implementation, the scope of this first progress report was limited by several constraints. The latest available data on health outcomes are from 2014 or 2015, and few countries have recent data (2010 or later) on more than 13 of the 16 key indicators. The lack of disaggregated country-level data makes it difficult to monitor the most disadvantaged and vulnerable populations within many countries. Monitoring progress in humanitarian and fragile settings is also severely constrained. Moreover, it remains a challenge to track progress in other areas, such as realizing human rights, building resilient health systems, improving SRMNCAH policies and strengthening accountability. Finally, monitoring progress should directly inform data use for action and transparent accountability at all levels.

For many countries, and at the global level, the first year of the SDGs and the EWEC *Global Strategy* was devoted to laying the groundwork for implementation (e.g. developing national plans) and for defining progress (e.g. defining indicators and updating methods of monitoring) which are necessary steps on the road to 2030. Several countries are still setting their baselines. Among other consequences, this report could not begin to assess country progress or make projections to 2030.

However, following the recent launch of Global Health Observatory's EWEC *Global Strategy* portal and the agreement of interim 2020 milestones, the next EWEC *Global Strategy* progress report will be better able to capture the pace of progress and to assess whether or not each country is on track to achieve the EWEC *Global Strategy's* targets by 2030. It will also be possible to assess more accurately how successfully partners are aligning and driving collective action.

In a time of increased conflicts, refugee and migrant crises, shifting political agendas, widespread human rights violations, and persisting and new dangers to the health of women, children and adolescents, the need to harness the power of partnership and work together towards a common vision for change has never been more urgent. The rewards are great: investing in health and well-being produces healthier and more inclusive communities, vibrant economies and more peaceful societies.

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125. In 2016, three new commitments were made by supporters who had already made a commitment to the updated EWEC *Global Strategy* in 2015 (Merck, USAID and Save the Children) bringing the total number of commitments to 215.

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127. In line with previous analyses of commitments to the EWEC *Global Strategy*, the amount of committed financing was adjusted to control for double-counting. Double-counting occurs when funding has been committed twice by different stakeholders: for example if a bilateral donor channels funding through an NGO and both of them count this funding as part of their commitment. Determining the exact extent of double-counted funding was challenging due to data limitations; figures are therefore approximations. For more details, please refer to the supplementary materials on the PMNCH website.

128. At least US$ 9.7 billion (range: US$ 9.7–US$ 11.6 billion) of the US$ 28.4 billion in financial commitments to the EWEC Global Strategy is expected to be additional. While most commitments were made for an initial five years, a number of commitment-makers, mostly low-income countries, made longer-term commitments through 2030. US$ 22.4 billion in committed financing is expected by 2020, and the remainder by 2030.

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160. The specific milestones for individual EWEC partners are the subject of further consultation and development, and are expected be agreed by the end of 2017.

161. PMNCH's 10 constituencies are: academic, research and training institutes; adolescents and youth; donors and foundations; global financing mechanisms; health-care professional associations; intergovernmental organizations; nongovernmental organizations; partner governments; private sector; and United Nations agencies.

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ANNEX 1.

Every Woman Every Child Global Strategy for Women's, Children's and Adolescents' Health: country data on the 16 key indicators

This data annex provides a snapshot, as of 28 June 2017, of the country data and/or estimates on the subset of 16 key indicators of the *Every Woman Every Child Global Strategy for Women's, Children's and Adolescents' Health* (EWEC *Global Strategy*) for all 194 WHO Member States. Notes and references on the indicators are shown after the table.

The latest information for the full set of 60 EWEC *Global Strategy* indicators, for all countries, is available from the *Global Strategy* data portal at the WHO Global Health Observatory: http://apps.who.int/gho/data/node.gswcah. The portal will be updated regularly, and therefore the data in this annex may differ from the information on the portal.

Some of the figures presented in this annex are point estimates, and should be interpreted within the context of uncertainty intervals which are available from the original sources provided in the table at the end of the annex. In the data portal the figures for some indicators are shown to 1 or 2 decimal places, whereas this annex rounds nearly all figures to the nearest whole number.

KEY

Grey shaded cell = no country-level data/estimate available on the EWEC *Global Strategy* portal or data/estimate from before 2005

Regular cell = data/estimate from 2010 to date

Regular cell with ( ) = data/estimate for years between 2005 and 2009 inclusive

SDG indicator	Survive					Thrive		
	3.1.1	3.2.1	3.2.2			2.2.1	3.7.2	3.8.1
Global Strategy indicator	Maternal mortality ratio (maternal deaths per 100 000 live births) [1]	Under-5 mortality rate (probability of dying by age 5 per 1000 live births) [2]	Neonatal mortality rate (per 1000 live births) [3]	Stillbirth rate (per 1000 total births) [4]	Adolescent mortality rate (per 100 000 population) [5 a]	Children aged <5 years stunted (%) [6]	Adolescent birth rate (per 1000 women aged 15–19 years) [7]	RMNCH Composite Coverage Index [8 b]
Afghanistan	396	91	36	27	208	59	52	-
Albania	29	14	6	4	30	(23)	20	(87)
Algeria	140	26	16	19	65	12	12	-
Andorra	-	3	1	2	-	-	4	-
Angola	477	157	49	27	346	(29)	(191)	-
Antigua and Barbuda	-	8	5	6	41	-	67	-
Argentina	52	13	6	5	56	(8)	68	-
Armenia	25	14	7	14	37	21	23	86
Australia	6	4	2	3	20	(2)	14	-
Austria	4	4	2	4	20	-	8	-
Azerbaijan	25	32	18	17	37	18	47	(64)
Bahamas	80	12	7	10	46	-	35	-
Bahrain	15	6	1	6	30	14	14	-
Bangladesh	176	38	23	25	64	36	113	-
Barbados	27	13	8	9	36	8	(50)	-
Belarus	4	5	2	3	35	(5)	22	-
Belgium	7	4	2	3	19	-	7	-
Belize	28	17	8	10	91	19	64	80
Benin	405	100	32	30	198	34	94	58
Bhutan	148	33	18	16	121	34	28	-
Bolivia (Plurinational State of)	206	38	20	13	139	(27)	116	(71)
Bosnia and Herzegovina	11	5	4	5	25	9	11	85
Botswana	129	44	22	15	110	(31)	39	-
Brazil	44	16	9	9	80	(7)	65	-
Brunei Darussalam	23	10	4	7	27	(20)	(17)	-
Bulgaria	11	10	6	6	38	9	41	-
Burkina Faso	371	89	27	21	224	35	(130)	65
Burundi	712	82	29	27	277	58	85	67
Cabo Verde	42	25	12	14	46	21	90	-
Cambodia	161	29	15	12	124	32	57	80
Cameroon	596	88	26	20	273	32	119	59
Canada	7	5	3	3	23	6	13	-

SDG indicator	Thrive				Transform				
			5.6.2	7.1.2	16.9.1	4.1.1	16.2.3	6.2.1	
Global Strategy indicator	Out-of-pocket expenditure as a % of total expenditure on health [9]	Per capita government expenditure on health (current US$) [10]	Laws and regulations that guarantee women aged 15–49 access to sexual and reproductive health care, information and education [11]	% of population with primary reliance on clean fuels and technologies at the household level [12]	Civil registration coverage of births (%) [13]	% of girls at the end of lower secondary education achieving at least minimum proficiency in reading [14 c]	% of women aged 18-29 who experienced sexual violence by age 18 [15 d]	Population using improved sanitation facilities (%) [16]	Global Strategy indicator
Afghanistan	64	20	-	17	37	-	-	32	**Afghanistan**
Albania	50	136	-	67	(99)	51	-	93	**Albania**
Algeria	27	263	-	>95	>90	-	-	88	**Algeria**
Andorra	16	2923	-	>95	100	-	-	100	**Andorra**
Angola	24	115	-	48	36	-	-	52	**Angola**
Antigua and Barbuda	24	528	-	>95	>90	-	-	-	**Antigua and Barbuda**
Argentina	31	335	-	>95	100	54	-	96	**Argentina**
Armenia	54	69	-	>95	100	-	-	89	**Armenia**
Australia	19	4043	-	>95	100	91	-	100	**Australia**
Austria	16	4345	-	>95	100	87	-	100	**Austria**
Azerbaijan	72	96	-	>95	>90	-	(0.1)	89	**Azerbaijan**
Bahamas	29	789	-	>95	-	-	-	92	**Bahamas**
Bahrain	23	786	-	>95	>90	-	-	99	**Bahrain**
Bangladesh	67	9	-	10	30	-	-	61	**Bangladesh**
Barbados	30	728	-	>95	99	-	-	96	**Barbados**
Belarus	32	296	-	>95	100	-	-	94	**Belarus**
Belgium	18	3803	-	>95	100	88	-	99	**Belgium**
Belize	23	187	-	87	95	-	-	91	**Belize**
Benin	39	19	-	7	85	-	-	20	**Benin**
Bhutan	25	65	-	68	100	-	-	50	**Bhutan**
Bolivia (Plurinational State of)	23	150	-	79	(76)	-	-	50	**Bolivia (Plurinational State of)**
Bosnia and Herzegovina	28	330	-	40	>90	-	-	95	**Bosnia and Herzegovina**
Botswana	5	227	-	63	(72)	-	-	63	**Botswana**
Brazil	25	436	-	93	96	57	-	83	**Brazil**
Brunei Darussalam	6	899	-	>95	(>90)	-	-	-	**Brunei Darussalam**
Bulgaria	44	361	-	79	100	73	-	86	**Bulgaria**
Burkina Faso	39	18	-	7	77	-	-	20	**Burkina Faso**
Burundi	21	11	-	<5	75	-	-	48	**Burundi**
Cabo Verde	22	130	-	71	91	-	-	72	**Cabo Verde**
Cambodia	74	14	-	13	73	-	2	42	**Cambodia**
Cameroon	66	13	-	18	66	-	16	46	**Cameroon**
Canada	14	3753	-	>95	100	93	-	100	**Canada**

SDG indicator	Survive					Thrive		
	3.1.1	3.2.1	3.2.2			2.2.1	3.7.2	3.8.1
Global Strategy indicator	Maternal mortality ratio (maternal deaths per 100 000 live births) [1]	Under-5 mortality rate (probability of dying by age 5 per 1000 live births) [2]	Neonatal mortality rate (per 1000 live births) [3]	Stillbirth rate (per 1000 total births) [4]	Adolescent mortality rate (per 100 000 population) [5 a]	Children aged <5 years stunted (%) [6]	Adolescent birth rate (per 1000 women aged 15–19 years) [7]	RMNCH Composite Coverage Index [8 b]
Central African Republic	882	130	43	34	361	41	(229)	45
Chad	856	139	39	40	348	40	(203)	27
Chile	22	8	5	3	36	2	52	-
China	27	11	6	7	30	9	6	-
Colombia	64	16	9	8	91	13	(84)	84
Comoros	335	74	34	31	144	32	70	62
Congo	442	45	18	15	173	21	147	73
Cook Islands	-	8	4	9	-	-	56	-
Costa Rica	25	10	6	6	44	(6)	61	90
Côte d'Ivoire	645	93	38	27	429	30	(125)	56
Croatia	8	4	3	2	22	1	12	-
Cuba	39	6	2	6	31	7	53	-
Cyprus	7	3	2	4	8	-	4	-
Czechia	4	3	2	3	19	3	11	-
Democratic People's Republic of Korea	82	25	14	14	73	28	(1)	-
Democratic Republic of the Congo	693	98	30	27	252	43	138	59
Denmark	6	4	3	2	12	-	2	-
Djibouti	229	65	33	35	214	34	21	(64)
Dominica	-	21	16	12	-	-	(47)	-
Dominican Republic	92	31	22	11	71	7	90	82
Ecuador	64	22	11	8	78	25	100	-
Egypt	33	24	13	12	66	22	56	79
El Salvador	54	17	8	12	118	14	72	-
Equatorial Guinea	342	94	33	16	245	26	176	-
Eritrea	501	47	18	23	91	50	(76)	-
Estonia	9	3	2	3	26	-	16	-

Thrive				Transform				SDG indicator
		5.6.2	7.1.2	16.9.1	4.1.1	16.2.3	6.2.1	
Out-of-pocket expenditure as a % of total expenditure on health [9]	Per capita government expenditure on health (current US$) [10]	Laws and regulations that guarantee women aged 15–49 access to sexual and reproductive health care, information and education [11]	% of population with primary reliance on clean fuels and technologies at the household level [12]	Civil registration coverage of births (%) [13]	% of girls at the end of lower secondary education achieving at least minimum proficiency in reading [14 c]	% of women aged 18-29 who experienced sexual violence by age 18 [15 d]	Population using improved sanitation facilities (%) [16]	Global Strategy indicator
46	8	-	<5	61	-	-	22	**Central African Republic**
39	20	-	4	12	-	-	12	**Chad**
32	563	-	>95	99	73	-	99	**Chile**
32	234	-	57	-	-	-	76	**China**
15	428	-	91	97	53	3	81	**Colombia**
45	19	-	7	87	-	3	36	**Comoros**
18	132	-	18	96	-	-	15	**Congo**
10	467	-	80	>90	-	-	98	**Cook Islands**
25	705	-	>95	100	74	-	95	**Costa Rica**
51	26	-	18	65	-	-	-	**Côte d'Ivoire**
11	860	-	94	>90	91	-	97	**Croatia**
4	781	-	87	100	-	-	93	**Cuba**
49	823	-	>95	100	-	-	100	**Cyprus**
14	1165	-	>95	100	89	-	99	**Czechia**
-	-	-	7	(100)	-	-	82	**Democratic People's Republic of Korea**
39	7	-	6	25	-	13	29	**Democratic Republic of the Congo**
13	5479	-	>95	100	90	-	100	**Denmark**
36	122	-	10	(92)	-	-	47	**Djibouti**
28	280	-	92	>90	-	-	-	**Dominica**
21	180	-	92	88	-	1	84	**Dominican Republic**
48	285	-	>95	92	-	-	85	**Ecuador**
56	68	-	99	99	-	-	95	**Egypt**
29	185	-	83	99	-	-	75	**El Salvador**
20	511	-	22	54	-	-	75	**Equatorial Guinea**
54	12	-	14	-	-	-	16	**Eritrea**
21	984	-	92	100	96	-	97	**Estonia**

SDG indicator	Survive					Thrive		
	3.1.1	3.2.1	3.2.2			2.2.1	3.7.2	3.8.1
Global Strategy indicator	Maternal mortality ratio (maternal deaths per 100 000 live births) [1]	Under-5 mortality rate (probability of dying by age 5 per 1000 live births) [2]	Neonatal mortality rate (per 1000 live births) [3]	Stillbirth rate (per 1000 total births) [4]	Adolescent mortality rate (per 100 000 population) [5 a]	Children aged <5 years stunted (%) [6]	Adolescent birth rate (per 1000 women aged 15–19 years) [7]	RMNCH Composite Coverage Index [8 b]
Ethiopia	353	59	28	30	192	40	71	37
Fiji	30	22	10	12	59	8	(28)	-
Finland	3	2	1	2	20	-	7	-
France	8	4	2	5	17	-	6	-
Gabon	291	51	23	14	146	18	(115)	69
Gambia	706	69	30	24	224	25	88	64
Georgia	36	12	7	11	39	(11)	42	-
Germany	6	4	2	2	16	(1)	8	-
Ghana	319	62	28	23	211	19	65	68
Greece	3	5	3	4	19	2	8	-
Grenada	27	12	6	8	37	-	53	-
Guatemala	88	29	13	12	99	47	91	-
Guinea	679	94	31	21	255	31	146	46
Guinea-Bissau	549	93	40	37	249	28	(137)	(52)
Guyana	229	39	23	17	102	12	(101)	(73)
Haiti	359	69	25	25	196	22	66	58
Honduras	129	20	11	13	86	23	101	84
Hungary	17	6	4	4	21	3	20	-
Iceland	3	2	1	1	21	-	7	-
India	174	48	28	23	90	(48)	28	(64)
Indonesia	126	27	14	13	83	36	(47)	80
Iran (Islamic Republic of)	25	16	10	6	42	7	38	-
Iraq	50	32	18	16	158	23	(82)	75
Ireland	8	4	2	3	19	-	9	-
Israel	5	4	2	4	17	-	10	-
Italy	4	4	2	3	16	4	6	-
Jamaica	89	16	12	19	48	6	46	-
Japan	5	3	1	2	15	7	4	-
Jordan	58	18	11	11	42	8	26	84
Kazakhstan	12	14	7	7	51	13	36	87
Kenya	510	49	22	23	207	26	96	(67)
Kiribati	90	56	24	16	113	34	50	-
Kuwait	4	9	3	5	38	6	7	-
Kyrgyzstan	76	21	12	10	48	13	42	77

SDG indicator	Thrive				Transform				SDG indicator
			5.6.2	7.1.2	16.9.1	4.1.1	16.2.3	6.2.1	
Global Strategy indicator	Out-of-pocket expenditure as a % of total expenditure on health [9]	Per capita government expenditure on health (current US$) [10]	Laws and regulations that guarantee women aged 15–49 access to sexual and reproductive health care, information and education [11]	% of population with primary reliance on clean fuels and technologies at the household level [12]	Civil registration coverage of births (%) [13]	% of girls at the end of lower secondary education achieving at least minimum proficiency in reading [14 c]	% of women aged 18-29 who experienced sexual violence by age 18 [15 d]	Population using improved sanitation facilities (%) [16]	Global Strategy indicator
Ethiopia	32	16	-	<5	(7)	-	-	28	**Ethiopia**
Fiji	23	134	-	37	>90	-	-	91	**Fiji**
Finland	18	3473	-	>95	100	95	-	98	**Finland**
France	6	3878	-	>95	100	87	-	99	**France**
Gabon	22	220	-	73	90	-	9	42	**Gabon**
Gambia	17	21	-	<5	72	-	0.4	59	**Gambia**
Georgia	59	63	-	55	100	-	-	86	**Georgia**
Germany	13	4165	-	>95	100	91	-	99	**Germany**
Ghana	27	35	-	21	71	-	(10)	15	**Ghana**
Greece	35	1075	-	>95	100	87	-	99	**Greece**
Grenada	51	235	-	>95	-	-	-	98	**Grenada**
Guatemala	52	88	-	36	(97)	-	-	64	**Guatemala**
Guinea	45	15	-	6	58	-	-	20	**Guinea**
Guinea-Bissau	49	8	-	<5	24	-	-	21	**Guinea-Bissau**
Guyana	37	132	-	61	89	-	-	84	**Guyana**
Haiti	35	13	-	9	80	-	4	28	**Haiti**
Honduras	43	108	-	48	94	-	5	83	**Honduras**
Hungary	27	684	-	>95	100	87	-	98	**Hungary**
Iceland	17	3778	-	>95	100	88	-	99	**Iceland**
India	62	23	-	34	72	-	(1)	40	**India**
Indonesia	47	38	-	57	69	52	-	61	**Indonesia**
Iran (Islamic Republic of)	48	202	-	>95	99	-	-	90	**Iran (Islamic Republic of)**
Iraq	40	176	-	>95	99	-	-	86	**Iraq**
Ireland	18	2800	-	>95	100	94	-	90	**Ireland**
Israel	27	1771	-	>95	100	85	-	100	**Israel**
Italy	21	2463	-	>95	100	87	-	100	**Italy**
Jamaica	28	139	-	93	100	-	-	82	**Jamaica**
Japan	14	3095	-	>95	100	94	-	100	**Japan**
Jordan	21	250	-	>95	99	67	-	99	**Jordan**
Kazakhstan	45	293	-	92	100	53	-	98	**Kazakhstan**
Kenya	26	48	-	6	67	-	4	30	**Kenya**
Kiribati	0	125	-	<5	(94)	-	-	40	**Kiribati**
Kuwait	13	1191	-	>95	>90	-	-	100	**Kuwait**
Kyrgyzstan	39	46	-	76	98	-	0	93	**Kyrgyzstan**

SDG indicator	Survive					Thrive		
	3.1.1	3.2.1	3.2.2			2.2.1	3.7.2	3.8.1
Global Strategy indicator	Maternal mortality ratio (maternal deaths per 100 000 live births) [1]	Under-5 mortality rate (probability of dying by age 5 per 1000 live births) [2]	Neonatal mortality rate (per 1000 live births) [3]	Stillbirth rate (per 1000 total births) [4]	Adolescent mortality rate (per 100 000 population) [5 a]	Children aged <5 years stunted (%) [6]	Adolescent birth rate (per 1000 women aged 15–19 years) [7]	RMNCH Composite Coverage Index [8 b]
Lao People's Democratic Republic	197	67	30	24	107	44	94	61
Latvia	18	8	5	4	29	-	15	-
Lebanon	15	8	5	10	39	17	17	-
Lesotho	487	90	33	20	193	33	94	(72)
Liberia	725	70	24	21	201	32	147	61
Libya	9	13	7	9	69	(21)	(6)	-
Lithuania	10	5	3	3	35	-	14	-
Luxembourg	10	2	1	3	11	-	6	-
Madagascar	353	50	20	18	170	(49)	(148)	(63)
Malawi	634	64	22	22	186	42	143	80
Malaysia	40	7	4	6	46	(17)	13	-
Maldives	68	9	5	8	33	(20)	14	(80)
Mali	587	115	38	33	232	(39)	172	49
Malta	9	6	4	4	14	-	13	-
Marshall Islands	-	36	17	16	-	-	85	-
Mauritania	602	85	36	27	141	22	71	53
Mauritius	53	14	8	10	36	14	29	-
Mexico	38	13	7	6	48	14	71	-
Micronesia (Federated States of)	100	35	19	18	81	-	33	-
Monaco	-	4	2	6	-	-	-	-
Mongolia	44	22	11	7	53	11	27	87
Montenegro	7	5	3	4	24	9	13	78
Morocco	121	28	18	25	30	15	(32)	-
Mozambique	489	79	27	19	279	43	167	60
Myanmar	178	50	26	20	112	35	30	-
Namibia	265	45	16	11	93	23	82	79
Nauru	-	35	23	16	-	(24)	105	-
Nepal	258	36	22	18	90	37	71	69
Netherlands	7	4	2	2	13	2	5	-
New Zealand	11	6	3	2	35	-	19	-
Nicaragua	150	22	10	7	62	(23)	(92)	-

SDG indicator	Thrive				Transform				SDG indicator
			5.6.2	7.1.2	16.9.1	4.1.1	16.2.3	6.2.1	
Global Strategy indicator	Out-of-pocket expenditure as a % of total expenditure on health [9]	Per capita government expenditure on health (current US$) [10]	Laws and regulations that guarantee women aged 15–49 access to sexual and reproductive health care, information and education [11]	% of population with primary reliance on clean fuels and technologies at the household level [12]	Civil registration coverage of births (%) [13]	% of girls at the end of lower secondary education achieving at least minimum proficiency in reading [14 c]	% of women aged 18-29 who experienced sexual violence by age 18 [15 d]	Population using improved sanitation facilities (%) [16]	Global Strategy indicator
Lao People's Democratic Republic	39	16	-	<5	75	-	-	71	**Lao People's Democratic Republic**
Latvia	35	582	-	>95	100	92	-	88	**Latvia**
Lebanon	36	271	-	>95	(100)	-	-	81	**Lebanon**
Lesotho	16	80	-	32	(45)	-	-	30	**Lesotho**
Liberia	31	15	-	<5	25	-	(4)	17	**Liberia**
Libya	26	273	-	-	-	-	-	97	**Libya**
Lithuania	31	722	-	>95	100	90	-	92	**Lithuania**
Luxembourg	11	6830	-	>95	100	82	-	98	**Luxembourg**
Madagascar	41	7	-	<5	83	-	-	12	**Madagascar**
Malawi	11	15	-	<5	6	-	6	41	**Malawi**
Malaysia	35	252	-	>95	>90	57	-	96	**Malaysia**
Maldives	18	913	-	>95	(93)	-	-	98	**Maldives**
Mali	48	14	-	<5	81	-	-	25	**Mali**
Malta	29	1709	-	>95	100	-	-	100	**Malta**
Marshall Islands	12	527	-	41	(96)	-	-	77	**Marshall Islands**
Mauritania	44	24	-	45	59	-	-	40	**Mauritania**
Mauritius	46	237	-	>95	>90	-	-	93	**Mauritius**
Mexico	44	351	-	86	93	65	-	85	**Mexico**
Micronesia (Federated States of)	9	376	-	25	-	-	-	57	**Micronesia (Federated States of)**
Monaco	7	7216	-	>95	100	-	-	100	**Monaco**
Mongolia	42	108	-	32	99	-	-	60	**Mongolia**
Montenegro	43	262	-	74	>90	71	-	96	**Montenegro**
Morocco	58	64	-	>95	94	-	-	77	**Morocco**
Mozambique	9	24	-	4	48	-	8	21	**Mozambique**
Myanmar	51	9	-	9	72	-	-	80	**Myanmar**
Namibia	7	201	-	46	87	-	1	34	**Namibia**
Nauru	2	445	-	>95	(83)	-	-	66	**Nauru**
Nepal	48	16	-	26	58	-	1	46	**Nepal**
Netherlands	5	4954	-	>95	100	89	-	98	**Netherlands**
New Zealand	11	4032	-	>95	100	89	-	-	**New Zealand**
Nicaragua	38	100	-	49	85	-	-	68	**Nicaragua**

SDG indicator	Survive					Thrive		
	3.1.1	3.2.1	3.2.2			2.2.1	3.7.2	3.8.1
Global Strategy indicator	Maternal mortality ratio (maternal deaths per 100 000 live births) [1]	Under-5 mortality rate (probability of dying by age 5 per 1000 live births) [2]	Neonatal mortality rate (per 1000 live births) [3]	Stillbirth rate (per 1000 total births) [4]	Adolescent mortality rate (per 100 000 population) [5 a]	Children aged <5 years stunted (%) [6]	Adolescent birth rate (per 1000 women aged 15–19 years) [7]	RMNCH Composite Coverage Index [8 b]
Niger	553	96	27	37	159	43	206	56
Nigeria	814	109	34	43	340	33	122	43
Niue	-	23	13	10	-	-	(14)	-
Norway	5	3	2	2	16	-	5	-
Oman	17	12	5	9	43	14	14	-
Pakistan	178	81	46	43	88	45	44	62
Palau	-	16	9	8	-	-	27	-
Panama	94	17	10	6	82	(19)	91	81
Papua New Guinea	215	57	25	16	116	50	65	-
Paraguay	132	21	11	13	78	11	(63)	-
Peru	68	17	8	9	66	15	65	84
Philippines	114	28	13	11	75	30	57	77
Poland	3	5	3	2	31	-	14	-
Portugal	10	4	2	2	17	-	11	-
Qatar	13	8	4	6	42	12	13	-
Republic of Korea	11	3	2	2	18	3	2	-
Republic of Moldova	23	16	12	8	35	6	27	88
Romania	31	11	6	4	34	13	39	-
Russian Federation	25	10	5	5	50	-	27	-
Rwanda	290	42	19	17	190	44	45	73
Saint Kitts and Nevis	-	11	7	8	-	-	75	-
Saint Lucia	48	14	9	12	66	3	(43)	-
Saint Vincent and the Grenadines	45	18	12	11	49	-	(70)	-
Samoa	51	18	10	11	32	6	(44)	-
San Marino	-	3	1	3	-	-	1	-
Sao Tome and Principe	156	47	17	16	145	17	92	(75)
Saudi Arabia	12	15	8	14	67	(9)	(18)	-
Senegal	315	47	21	25	120	19	80	65
Serbia	17	7	4	6	21	6	22	-
Seychelles	-	14	9	10	30	8	61	-

Thrive				Transform				SDG indicator
		5.6.2	7.1.2	16.9.1	4.1.1	16.2.3	6.2.1	
Out-of-pocket expenditure as a % of total expenditure on health [9]	Per capita government expenditure on health (current US$) [10]	Laws and regulations that guarantee women aged 15–49 access to sexual and reproductive health care, information and education [11]	% of population with primary reliance on clean fuels and technologies at the household level [12]	Civil registration coverage of births (%) [13]	% of girls at the end of lower secondary education achieving at least minimum proficiency in reading [14 c]	% of women aged 18-29 who experienced sexual violence by age 18 [15 d]	Population using improved sanitation facilities (%) [16]	Global Strategy indicator
34	10	-	<5	64	-	-	11	**Niger**
72	30	-	<5	30	-	4	29	**Nigeria**
2	1143	-	91	>90	-	-	100	**Niue**
14	8141	-	>95	100	90	-	98	**Norway**
6	606	-	>95	-	-	-	97	**Oman**
56	13	-	45	34	-	-	64	**Pakistan**
15	833	-	58	-	-	-	100	**Palau**
22	702	-	86	>90	-	-	75	**Panama**
10	75	-	31	-	-	-	19	**Papua New Guinea**
49	213	-	64	85	-	-	89	**Paraguay**
29	217	-	68	97	45	-	76	**Peru**
54	46	-	45	90	-	(3)	74	**Philippines**
23	646	-	>95	100	95	-	97	**Poland**
27	1359	-	>95	100	88	-	100	**Portugal**
7	1806	-	>95	>90	55	-	98	**Qatar**
36	1114	-	>95	>90	96	-	100	**Republic of Korea**
38	118	-	93	100	-	(5)	76	**Republic of Moldova**
19	448	-	82	>90	72	-	79	**Romania**
46	466	-	>95	100	85	-	72	**Russian Federation**
28	20	-	<5	63	-	10	62	**Rwanda**
51	325	-	>95	-	-	-	-	**Saint Kitts and Nevis**
46	268	-	>95	92	-	-	91	**Saint Lucia**
49	292	-	>95	(>90)	-	-	-	**Saint Vincent and the Grenadines**
6	273	-	27	59	-	-	91	**Samoa**
6	3237	-	>95	100	-	-	-	**San Marino**
11	-	-	30	95	-	(3)	35	**Sao Tome and Principe**
14	855	-	>95	-	-	-	100	**Saudi Arabia**
37	26	-	36	73	-	-	48	**Senegal**
37	392	-	71	99	77	-	96	**Serbia**
2	456	-	>95	>90	-	-	98	**Seychelles**

SDG indicator	Survive					Thrive		
	3.1.1	3.2.1	3.2.2			2.2.1	3.7.2	3.8.1
Global Strategy indicator	Maternal mortality ratio (maternal deaths per 100 000 live births) [1]	Under-5 mortality rate (probability of dying by age 5 per 1000 live births) [2]	Neonatal mortality rate (per 1000 live births) [3]	Stillbirth rate (per 1000 total births) [4]	Adolescent mortality rate (per 100 000 population) [5 a]	Children aged <5 years stunted (%) [6]	Adolescent birth rate (per 1000 women aged 15–19 years) [7]	RMNCH Composite Coverage Index [8 b]
Sierra Leone	1360	120	35	24	412	38	125	67
Singapore	10	3	1	3	15	4	3	-
Slovakia	6	7	4	3	26	-	21	-
Slovenia	9	3	1	3	22	-	5	-
Solomon Islands	114	28	12	18	87	(33)	(62)	-
Somalia	732	137	40	36	326	(25)	64	-
South Africa	138	41	11	17	129	(24)	(54)	-
South Sudan	789	93	39	30	292	31	(158)	-
Spain	5	4	3	3	14	-	8	-
Sri Lanka	30	10	5	5	58	15	(20)	-
Sudan	311	70	30	24	189	38	87	50
Suriname	155	21	12	19	76	9	(65)	-
Swaziland	389	61	14	12	189	26	87	80
Sweden	4	3	2	3	17	-	5	-
Switzerland	5	4	3	3	16	-	2	-
Syrian Arab Republic	68	13	7	11	332	(28)	(54)	(77)
Tajikistan	32	45	21	14	48	27	54	74
Thailand	20	12	7	5	51	16	60	-
The Former Yugoslav Republic of Macedonia	8	6	4	8	23	5	19	86
Timor-Leste	215	53	22	18	88	50	50	(59)
Togo	368	78	27	34	225	28	85	57
Tonga	124	17	7	9	35	8	30	-
Trinidad and Tobago	63	20	13	11	57	5	(36)	-
Tunisia	62	14	8	9	37	10	7	85
Turkey	16	14	7	7	75	10	29	-
Turkmenistan	42	51	23	17	82	(19)	(21)	(81)
Tuvalu	-	27	18	14	-	(10)	(42)	-
Uganda	343	55	19	21	223	34	140	65
Ukraine	24	9	6	9	46	4	27	88
United Arab Emirates	6	7	4	7	46	-	(34)	-

SDG indicator	Thrive				Transform				SDG indicator
			5.6.2	7.1.2	16.9.1	4.1.1	16.2.3	6.2.1	
Global Strategy indicator	Out-of-pocket expenditure as a % of total expenditure on health [9]	Per capita government expenditure on health (current US$) [10]	Laws and regulations that guarantee women aged 15–49 access to sexual and reproductive health care, information and education [11]	% of population with primary reliance on clean fuels and technologies at the household level [12]	Civil registration coverage of births (%) [13]	% of girls at the end of lower secondary education achieving at least minimum proficiency in reading [14 c]	% of women aged 18-29 who experienced sexual violence by age 18 [15 d]	Population using improved sanitation facilities (%) [16]	**Global Strategy indicator**
Sierra Leone	61	15	-	<5	77	-	2	13	**Sierra Leone**
Singapore	55	1149	-	>95	>90	94	-	100	**Singapore**
Slovakia	23	1055	-	>95	100	80	-	99	**Slovakia**
Slovenia	12	1550	-	>95	100	89	-	99	**Slovenia**
Solomon Islands	5	94	-	9	-	-	-	30	**Solomon Islands**
Somalia	-	-	-	9	(3)	-	-	-	**Somalia**
South Africa	6	275	-	82	85	-	-	66	**South Africa**
South Sudan	54	12	-	<5	35	-	-	7	**South Sudan**
Spain	24	1884	-	>95	100	87	-	100	**Spain**
Sri Lanka	42	71	-	19	(97)	-	-	95	**Sri Lanka**
Sudan	76	28	-	23	67	-	-	-	**Sudan**
Suriname	11	304	-	91	99	-	-	79	**Suriname**
Swaziland	10	188	-	35	54	-	-	57	**Swaziland**
Sweden	14	5721	-	>95	100	86	-	99	**Sweden**
Switzerland	27	6385	-	>95	100	91	-	100	**Switzerland**
Syrian Arab Republic	54	31	-	>95	(96)	-	-	96	**Syrian Arab Republic**
Tajikistan	62	22	-	72	88	-	0.3	95	**Tajikistan**
Thailand	12	177	-	76	99	79	-	93	**Thailand**
The Former Yugoslav Republic of Macedonia	37	224	-	61	100	-	-	91	**The Former Yugoslav Republic of Macedonia**
Timor-Leste	10	52	-	<5	55	-	1	41	**Timor-Leste**
Togo	46	13	-	6	78	-	4	12	**Togo**
Tonga	12	175	-	63	93	-	-	91	**Tonga**
Trinidad and Tobago	38	608	-	>95	(97)	-	-	92	**Trinidad and Tobago**
Tunisia	38	173	-	>95	99	57	-	92	**Tunisia**
Turkey	18	440	-	-	99	88	-	95	**Turkey**
Turkmenistan	35	122	-	>95	(96)	-	-	-	**Turkmenistan**
Tuvalu	1	628	-	30	(50)	-	-	-	**Tuvalu**
Uganda	41	13	-	<5	30	-	8	19	**Uganda**
Ukraine	46	103	-	>95	100	-	(2)	96	**Ukraine**
United Arab Emirates	18	1165	-	>95	100	77	-	98	**United Arab Emirates**

SDG indicator	Survive					Thrive		
	3.1.1	3.2.1	3.2.2			2.2.1	3.7.2	3.8.1
Global Strategy indicator	Maternal mortality ratio (maternal deaths per 100 000 live births) [1]	Under-5 mortality rate (probability of dying by age 5 per 1000 live births) [2]	Neonatal mortality rate (per 1000 live births) [3]	Stillbirth rate (per 1000 total births) [4]	Adolescent mortality rate (per 100 000 population) [5 a]	Children aged <5 years stunted (%) [6]	Adolescent birth rate (per 1000 women aged 15–19 years) [7]	RMNCH Composite Coverage Index [8 b]
United Kingdom of Great Britain and Northern Ireland	9	4	2	3	16	4	19	-
United Republic of Tanzania	398	49	19	22	228	35	72	71
United States of America	14	7	4	3	28	2	27	-
Uruguay	15	10	5	7	54	12	64	-
Uzbekistan	36	39	20	12	63	(20)	30	(83)
Vanuatu	78	28	12	14	51	29	78	-
Venezuela (Bolivarian Republic of)	95	15	9	7	115	(13)	95	-
Viet Nam	54	22	11	10	57	19	36	88
Yemen	385	42	22	29	146	47	67	52
Zambia	224	64	21	21	202	40	145	76
Zimbabwe	443	71	24	21	204	28	120	81

SDG indicator	Thrive				Transform				SDG indicator
			5.6.2	7.1.2	16.9.1	4.1.1	16.2.3	6.2.1	
Global Strategy indicator	Out-of-pocket expenditure as a % of total expenditure on health [9]	Per capita government expenditure on health (current US$) [10]	Laws and regulations that guarantee women aged 15–49 access to sexual and reproductive health care, information and education [11]	% of population with primary reliance on clean fuels and technologies at the household level [12]	Civil registration coverage of births (%) [13]	% of girls at the end of lower secondary education achieving at least minimum proficiency in reading [14 c]	% of women aged 18-29 who experienced sexual violence by age 18 [15 d]	Population using improved sanitation facilities (%) [16]	Global Strategy indicator
United Kingdom of Great Britain and Northern Ireland	10	3272	-	>95	100	87	-	99	**United Kingdom of Great Britain and Northern Ireland**
United Republic of Tanzania	23	24	-	<5	15	-	6	16	**United Republic of Tanzania**
United States of America	11	4541	-	>95	100	89	-	100	**United States of America**
Uruguay	16	1027	-	>95	100	60	-	96	**Uruguay**
Uzbekistan	44	66	-	90	>90	-	-	100	**Uzbekistan**
Vanuatu	6	141	-	16	43	-	-	58	**Vanuatu**
Venezuela (Bolivarian Republic of)	64	256	-	>95	81	-	-	94	**Venezuela (Bolivarian Republic of)**
Viet Nam	37	77	-	51	96	95	-	78	**Viet Nam**
Yemen	76	18	-	62	31	-	-	-	**Yemen**
Zambia	30	48	-	16	11	-	5	44	**Zambia**
Zimbabwe	36	22	-	31	32	-	13	37	**Zimbabwe**

Notes:

[a] The adolescent deaths per country are from the WHO Global Health Estimates for 2015. These are estimated by WHO based on UN life tables and analyses of death registration data submitted to WHO, using standardized methods intended to maximize comparability across countries. The UN Population Division medium variant population estimates for 10 to 14 years and 15 to 19 years for 2015 are used as denominators to compute the rate.

[b] Until the full UHC service coverage index is available, the Global Strategy uses a composite coverage index of RMNCH interventions as a proxy. The coverage indicator is the weighted average of coverage of a set of eight preventive and curative RMNCH interventions. It gives equal weight to four stages in the continuum of care: family planning, maternal and newborn care, immunization, and case management of sick children. The estimate is calculated as follows: 1/4 (FPS + (SBA+ANC1)/2 + (2DPT3+MSL+BCG)/4 + (ORT+CPNM)/2). Where: FPS = family planning need satisfied; SBA = skilled birth attendance; ANC1 = at least one antenatal visit with a skilled provider; DPT3 = three doses of diphtheria-pertussis-tetanus vaccine; MSL = measles vaccination; BCG = BCG (tuberculosis) vaccination; ORT = oral rehydration therapy for children with diarrhoea; and CPNM = care-seeking for children showing symptoms of pneumonia.

[c] This is one of 12 sub-indicators under the main indicator: "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". Estimates for the remaining sub-indicators are available on the portal.

[d] This is one of two sub-indicators under the main indicator: "Proportion of young women and men aged 18–29 who experienced sexual violence by age 18". Estimates for the other sub-indicator are available on the portal.

REFERENCES AND LINKS TO DATASETS

The latest available country data and/or estimates for all 60 EWEC *Global Strategy* indicators are collated and available from the *Global Strategy* portal on the WHO Global Health Observatory website: http://apps.who.int/gho/data/node.gswcah?lang=en.

All SDG indicators also are available through the Global SDG Indicators Database: https://unstats.un.org/sdgs/indicators/database.

GS indicators (include number if SDG indicator)	References and links to datasets
[1] **Maternal mortality ratio**	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/maternal-mortality-2015/en.
[2] **Under-5 mortality rate**	United Nations Inter-Agency Group for Child Mortality Estimates (UN IGME). Levels and Trends in Child Mortality: Report 2015. New York: United Nations Children's Fund; 2015. Available from: http://www.childmortality.org.
[3] **Neonatal mortality rate**	United Nations Inter-Agency Group for Child Mortality Estimates (UN IGME). Levels and Trends in Child Mortality: Report 2015. New York: United Nations Children's Fund. Available from: http://www.childmortality.org.
[4] **Stillbirth rate**	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.
[5] **Adolescent mortality rate, by age and sex**	WHO. Global health estimates 2015: deaths by cause, age, sex, by country and by region, 2000-2015. Geneva: World Health Organization; 2015. Available from: http://www.who.int/healthinfo/global_burden_disease/estimates/en/index1.html.
[6] **Prevalence of stunting (height for age <-2 standard deviations from the median of the WHO Child Growth Standards) among children under 5 years of age**	UNICEF and WHO. Joint child malnutrition estimates – levels and trends. Geneva: UNICEF, WHO, The World Bank Group; 2017. Available from: http://www.who.int/nutgrowthdb/estimates2016/en.
[7] **Adolescent birth rate (15–19) per 1000 women in that age group**	United Nations. World Fertility Data 2015. United Nations, Department of Economic and Social Affairs, Population Division (2015). World Population Prospects: The 2015 Revision, DVD Edition. http://esa.un.org/unpd/wpp/Download/Standard/Fertility. http://www.un.org/en/development/desa/population/publications/dataset/fertility/wfd2015.shtml.

GS indicators (include number if SDG indicator)	References and links to datasets
[8] **Interim indicator: RMNCH Composite Coverage Index as SDG 3.8.1 is under development.** **Main indicator: Coverage of essential health services (index based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access) [SDG 3.8.1] – Universal Health Coverage Index under development.**	WHO Health Equity Monitor and Countdown to 2030. Available from: http://www.who.int/gho/health_equity/services/rmnch_composite_coverage_index/en.
[9] **Out-of-pocket health expenses as percentage of total health expenditure.**	WHO Global Health Expenditure Database 2017. Geneva: World Health Organization. Available from: http://apps.who.int/nha/database/Select/Indicators/en.
[10] **Current country health expenditure per capita (including specifically on RMNCAH) financed from domestic sources.**	WHO Global Health Expenditure Database 2017. Geneva: World Health Organization. Available from: http://apps.who.int/nha/database/Select/Indicators/en.
[11] **Number of countries with laws and regulations that guarantee women aged 15–49 access to sexual and reproductive health care, information and education**	Currently under development; will be available from UNFPA and UN Women.
[12] **Proportion of population with primary reliance on clean fuels and technology**	WHO. Burning opportunity: clean household energy for health, sustainable develop-ment, and well-being of women and children. Geneva: World Health Organization; 2016. Available from: http://apps.who.int/iris/bitstream/10665/204717/1/9789241565233_eng.pdf?ua=1.
[13] **Proportion of children under 5 years of age whose births have been registered with a civil authority, by age**	UNICEF Global Databases 2017. New York: UNICEF. Available from: https://data.unicef.org/topic/child-protection/birth-registration.
[14] **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**	UNESCO Institute for Statistics (UNESCO-UIS) 2017. Available from: http://www.uis.unesco.org/Pages/default.aspx.
[15] **Proportion of young women and men aged 18–29 who experienced sexual violence by age 18**	UNICEF Global Databases 2017. New York: UNICEF. Available from: https://data.unicef.org/topic/child-protection.
[16] **Percentage of population using safely managed sanitation services including a hand-washing facility with soap and water**	WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation. 2015. Available from: https://www.wssinfo.org/data-estimates.

ANNEX 2.

Implementing the Commission on Information and Accountability's 10 recommendations: lessons learned and summary of progress (2011–2015)

Formed in 2011, the time-limited Commission on Information and Accountability for Women's and Children's Health (CoIA) outlined a vision of accountability for the *Global Strategy for Women's and Children's Health (2010–2015)*, and a series of concrete action steps to monitor commitments and results, especially at country level. To implement this vision CoIA made 10 recommendations for the generation of information to improve results, track resources and enhance oversight for results and resources. The Unified Accountability Framework for the updated *Every Woman Every Child Global Strategy for Women's, Children's and Adolescents' Health* builds on CoIA's principles and recommendations, with a substantial focus on tracking progress in implementing CoIA's recommendations.[1]

LESSONS LEARNED

- By making accountability a central component of the women's and children's health agenda at multiple levels (global, regional and national) the CoIA recommendations initiated a process that continues beyond the lifespan of the recommendations themselves. Facilitating development of country-level accountability frameworks (see table below for a snapshot of progress) and then providing catalytic funding were key steps in initiating this process and helped to institutionalize the practice of planning for accountability.

- The Commission's focus on accountability for RMNCH served as an entry-point for what have turned out to be broad health systems strengthening initiatives. Particularly in the areas of civil registration and vital statistics (CRVS) and maternal death surveillance and response (MDSR), efforts to implement the CoIA recommendations have garnered widespread support and collaboration from multiple partners, since the benefits are salient to multiple sectors beyond RMNCH.

- That said, establishing robust accountability mechanisms – such as comprehensive CRVS, MDSR and health management information systems – is a long-term process with no one-size-fits-all strategy. Countries require extensive and ongoing technical and financial support, as well as capacity building for data quality assurance, management and analysis.

- Given the multiple CoIA recommendations, some were inevitably prioritized more highly than others, by both implementing countries and donors. Those workstreams with outputs that were less defined, less immediately translatable into actions for improving maternal and child health, or politically sensitive, tended to receive less attention from countries and donors.

- Obtaining and maintaining the engagement of diverse groups of stakeholders is challenging and time-consuming, but very necessary, part of developing and implementing accountability mechanisms. Civil society organizations and parliamentarians in particular have a critical role to play in advocating for resource monitoring and transparent dissemination of data, and it is important to ensure that they are equipped with the resources and know-how to do this.

- Utilizing newly available data for advocacy and evidence-based policy making can initiate a positively-reinforcing cycle that prompts further demand for data, but there is a need to strengthen capacity for, and to institutionalize norms surrounding, the use of data in decision-making.

- Ongoing efforts to align and streamline accountability work are also needed. Countries continue to experience significant challenges in dealing with the high volume of requests for reporting from multiple agency partners, fragmentation in data collection efforts, and uncoordinated efforts to strengthen country institutional analytical capacity; these are creating an unnecessary reporting burden, and causing inefficiencies.

[1] Keeping promises, measuring results. Report of the Commission on Information and Accountability for Women's and Children's Health. Geneva: World Health Organization; 2011 (http://www.who.int/topics/millennium_development_goals/accountability_commission/Commission_Report_advance_copy.pdf?ua=1, accessed 3 July 2017).

Snapshot of progress 2011–2015

Work Area	Recommendation	Target	Results as of April 2015
Country Accountability Framework (CAF)	Countries have plans for strengthening national accountability processes	50 countries with CAFs by 2013	68 countries are in the final stages of implementing country accountability frameworks. 17 countries demonstrate results and were awarded additional catalytic funds.
1. Vital events and Maternal Death Surveillance and Response (MDSR)	By 2015, countries improve systems for registration of births, deaths and causes of death and health information systems	50 countries with civil registration and vital statistics (CRVS) assessments and plans by 2015	64 countries have conducted an assessment of their CRVS system, or have an assessment underway.
		50 countries making improvements in MDSR by 2015	51 countries have national policy requiring all maternal deaths to be notified. 55 countries are implementing facility-based maternal death reviews. 30 countries are implementing community-based maternal death reviews.
2. Health Indicators	By 2012, countries using the same 11 indicators on RMNCH, disaggregated for gender and other equity considerations.	50 countries use and have accurate data on the core indicators Global partners have streamlined reporting systems	51 countries using web-based facility reporting (e.g. DHIS 2). The majority of other countries conduct regular household surveys, and 20 countries have introduced data quality improvement mechanisms.
3. eHealth and Innovation	By 2015, countries integrating Information and communication technologies in national health information systems and health infrastructure.	By 2015, 50 countries developed and implementing national eHealth strategies	27 countries have an eHealth strategy. Additional 20 countries set to undertake joint (health and ICT) eHealth planning and implementation in 2015.
4. Resource Tracking	By 2015, countries are tracking and reporting: 1) total health expenditure by financing source, per capita; and 2) total RMNCH expenditure by financing source, per capita.	By 2013, 50 countries have and use accurate data on the two indicators, as part of their monitoring and evaluation systems	New System of Health Accounts 2011 methodology accepted by countries and global partners (GAVI, Global Fund, USAID). 65 countries have adopted the System of Health Accounts 2011 methodology. 33 countries have data on RMNCH expenditure.
5. Country Compacts*	By 2012, "compacts" in place between governments and development partners.	By 2015, 50 countries have formal agreements with donors	51 countries** have compact or similar partnership agreements for the health sector in place. Since 2010, more than one in three of these compacts have been co-signed by civil society or non-state actors.
6. Reaching Women and Children	By 2015, governments have capacity to review health spending and relate spending to commitments, human rights, gender and equity goals and results.	Linked to Recommendations 2 and 4	PMNCH tracks implementation of commitments and spending. Budget advocacy workshops held for 21 country teams of media, civil society and parliaments to better understand national budget expenditures for RMNCH.
7. National Oversight (Health Sector Reviews, Advocacy and Action)	By 2012, countries have transparent and inclusive national accountability mechanisms.	50 countries have regular national health sector review processes	54 countries have reported undertaking an annual, or mid-term review, or a similar process (such as a health summit).
		20 countries are engaging political leaders and financial decision-makers in health	Parliaments in 30 countries have engaged in legislation and/or increased budget allocation to improve the health of women and children.
		50 countries have held a Countdown event	Countdown to 2015 has been providing regular global and country assessments of progress towards the 11 core indicators.
8. Transparency	By 2013, stakeholders publicly sharing information on commitments, resources and results achieved annually, at both national and international levels.	50 countries with mechanisms for sharing and disseminating data Global partners with databases on women's and children's health, and dissemination on core indicators	Global partner databases for 11 core indicators are publicly available through Countdown to 2015. Web-based facility reporting systems (DHIS 2.0) make information publicly available. 27 countries organizing civil society hearings on women's, children's and adolescents' health. OECD-DAC reporting on aid flows for RMNCH.
9. Reporting Aid for Women's and Children's Health	By 2012, OECD-DAC to agree on improvements to Creditor Reporting System (CRS) to capture RMNCH health spending by development partners.	By 2012, development partners agree on the method By 2013, OECD has developed guidance and instruction to support new method, and donors using new method	19 DAC member countries began reporting on the RMNCH policy marker.
10. Global Oversight	2012–2015, an independent Expert Review Group (iERG) reporting to the United Nations Secretary-General on the results and resources related to the *Global Strategy for Women's and Children's Health* and progress on CoIA recommendations.	Members appointed Reports due September 2012 and every year until 2015	Three reports delivered to the UN Secretary-General with recommendations to accelerate progress on the *Global Strategy for Women's and Children's Health.*

Source: Accountability for women's and children's health: 2015 progress report. Geneva: WHO; 2015.

* The Commission suggested a target date of 2012 for this recommendation. However, during the stakeholder meeting that resulted in the original strategic workplan for implementing the recommendations, the date of 2015 was deemed more realistic.

** This includes non-CoIA countries: Bosnia and Herzegovina, Fiji, Seychelles, Tunisia.


World Health
Organization

UNAIDS

unicef

UNFPA
United Nations Population Fund

UN
WOMEN

WORLD BANK GROUP