Committing to implementation of the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)

Technical Report

1. Pursuant to resolution WHA69.2[1] (2016) on committing to implementation of the Global Strategy for Women's, Children's and Adolescents' Health, the present report highlights progress and stagnation, and programmatic response in the area of women's, children's and adolescents' health. It also presents the progress made in the implementation of the following resolutions: WHA67.10[2] (2014) on the newborn health action plan; WHA63.17[3] (2010) on birth defects; WHA58.31[4] (2005) on working towards universal coverage of maternal, newborn and child health interventions; WHA45.25[5] (1992) on women, health and development; and WHA45.22[6] (1992) on child health and development: health of the newborn. This report explores the continued challenges brought on by coronavirus disease (COVID-19), climate change, conflict, harmful marketing practices directed at pregnant women and children, and threats to reproductive rights, and describes actions to address these threats to the health of women, children and adolescents. It also discusses the importance of a life course approach to health and overall well-being. Finally, it reflects on data gaps and recommendations to fill these gaps, as well as suggesting evidence-based strategic priorities for achieving the objectives of the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) – survive, thrive and transform – for every

[1] WHA 69.2 https://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_R2-en.pdf

[2] WHA 67.10 https://apps.who.int/gb/ebwha/pdf_files/WHA67/A67_R10-en.pdf

[3] WHA 63.17 https://apps.who.int/gb/ebwha/pdf_files/WHA63/A63_R17-en.pdf

[4] WHA 58.31 https://apps.who.int/gb/ebwha/pdf_files/WHA58/WHA58_31-en.pdf

[5] WHA 42.25 https://apps.who.int/iris/bitstream/handle/10665/175805/WHA45_R25_eng.pdf?sequence=1&isAllowed=y

[6] WHA 45.22 https://apps.who.int/iris/bitstream/handle/10665/199126/WHA45_R22_fre.pdf?sequence=1&isAllowed=y

woman, child and adolescent as part of the Thirteenth General Programme of Work, 2019–2025. The data underpinning this report are available from the WHO website.[1]

GLOBAL TRENDS

Trends in mortality and morbidity for women, children and adolescents

1. Between 2016 and 2020, the global maternal mortality ratio remained stagnant: in the year 2016 it was estimated to be 223 maternal deaths per 100 000 live births, while the global figure in the year 2020 was also 223. During this period, only one WHO region (South-East Asia) recorded a significant decline in maternal mortality. In two WHO regions (African and Eastern Mediterranean) neither an increase nor a decrease in maternal mortality were recorded. In three WHO regions (European, the Americas and Western Pacific) there were statistically significant increases in the maternal mortality ratio between 2016 and 2020 (1).

2. Unsafe abortion is a leading – but preventable – cause of maternal deaths and morbidity. Around 73 million induced abortions take place worldwide each year. Six out of 10 (61%) of all unintended pregnancies and three out of 10 (29%) of all pregnancies end in induced abortion (2). According to data for the period 2010–2014, around 45% of all abortions are unsafe, of which 97% take place in developing countries (3).

3. The stillbirth rate is an important marker of quality of care in pregnancy and childbirth. In the year 2021, almost 1.9 million babies were stillborn at 28 weeks' or more of gestation, with a global stillbirth rate of 13.9 stillbirths per 1000 total births. The burden of stillbirths is highest in sub-Saharan Africa and southern Asia, with the two regions accounting for three quarters of all stillbirths. In sub-Saharan Africa, the stillbirth rate was 21.0 stillbirths per 1000 total births, which was seven times higher than the lowest regional rate of 2.9 stillbirths per 1000 total births found in Europe, Northern America, Australia and New Zealand. Sub-Saharan Africa's share of the global number of stillbirths has increased from 26% in the year 2000 to 45% in the year 2021 (4).

4. Neonatal deaths are associated with causes of death related to antenatal care and the birth process. The leading causes of neonatal death are premature birth and birth complications (birth asphyxia/trauma), lower respiratory infections, congenital anomalies, and neonatal sepsis and meningitis. Congenital anomalies form a higher percentage of neonatal deaths in countries with low levels of neonatal mortality, whereas in countries with high levels of neonatal mortality, neonatal infections constitute a higher percentage of neonatal deaths (5).

5. In the year 2023, WHO, UNICEF and the London School of Hygiene and Tropical Medicine released updated global, regional and country estimates of preterm births for the period 2010–2019. The rate of preterm births is 9.8 per 1000 births, with an estimated total of 13 204 235 preterm births in the year 2020. This figure is similar to the estimates of 13 693 986 preterm births in the year 2015 and 14 936 700 preterm births in the year 2010, demonstrating no significant change in the number of preterm births over the last decade. In addition, the number of preterm births is driving the estimates of low birth weight and slowing progress towards low birth weight targets. More countries

[1] See the Maternal, newborn, child and adolescent health and ageing data portal at https://platform.who.int/data/maternal-newborn-child-adolescent-ageing/global-strategy-data, and the Global Health Observatory at https://www.who.int/data/gho

now have good-quality data for the estimation process, but there remain data gaps, especially around gestational age measurement. With the WHO antenatal and intrapartum recommendations published in the years 2016 and 2018, respectively, more should be done to prevent preterm births. In addition, the current emphasis on scaling up care for small and sick newborns means that more can be done to improve care for preterm babies.

6. Care for small and sick newborns (SSNBs) is defined as care for the small newborn who is born preterm (less than 37 weeks) or with low birth weight (less than 2.5 kg) and care for the newborn who becomes sick with any medical or surgical condition (6). SSNBs are particularly vulnerable to impaired respiration, difficulty feeding, growth failure, poor body temperature regulation, and infection. SSNBs have a higher risk of developmental disabilities including cerebral palsy and retinopathy of prematurity, hearing and visual impairment, nutritional deficit, malnutrition, anaemia and long-term adult-onset chronic conditions such as cardiovascular disease (7). Globally, more than 40% of SSNBs under 5 years of age have neurodevelopmental problems resulting in social, emotional and educational functioning deficits into adulthood. The survival, health, growth and neurodevelopment of SSNBs remains concerning in many countries and the pace of improvement has been slow. This is due to the complexities of caring for these vulnerable infants and preventing complications (8).

7. In the year 2021, 2.7 million deaths occurred among children aged 1–59 months. Globally, the mortality rate of children aged 1–59 months is 21 deaths per 1000 children aged 28 days. Children aged 1–59 months in sub-Saharan Africa face the greatest risk, with a mortality rate of 48 deaths per 1000 children, more than twice the global rate and 32 times higher than in Australia and New Zealand. Based on a hypothetical target for mortality among children aged 1–59 months of 13 deaths per 1000 children aged 28 days by the year 2030, 42 countries are currently off track and need urgent assistance to meet this proposed target. If countries were to meet both this hypothetical target for children aged 1–59 months and the neonatal mortality rate target of 12 deaths per 1000 live births, the under-5 mortality rate target would also be met. The leading cause of death worldwide in post-neonatal children (aged 1–59 months) continues to be acute respiratory infections (including pneumonia), diarrhoea and malaria (5).

8. In the year 2019, it was estimated that anaemia affects 40% (269 million) of children aged 6–59 months, 37% (32 million) of pregnant women and 30% (571 million) of women of reproductive age (15–49 years), with the WHO African and South-East Asia Regions being most affected.[1] Trends in the prevalence of anaemia for the years 2000–2019 indicate a slower decline in anaemia prevalence since the year 2010 compared with the period 2000–2010. These trends also indicate that few countries are likely to meet the global nutrition target on halving the prevalence of anaemia in women of reproductive age by the year 2025 or 2030 (indicator 2.2.3 of the Sustainable Development Goals (Prevalence of anaemia in women aged 15 to 49 years, by pregnancy status (percentage)) and greater efforts are needed to reduce anaemia globally.

9. Undernutrition, especially wasting, puts children at greater risk of dying and stunting and is associated with poor cognitive development impacting a child's future life prospects. Although the global prevalence of stunting declined from 33.1% in the year 2000 to 22% in the year 2020, around 149 million children under the age of 5 were stunted in the year 2020. Over 45 million children (6.7%) under 5 years of age were wasted in the year 2020, and 13.6 million of these children were

[1] For further information, see the website of the Global Health Observatory (https://www.who.int/data/gho/data/themes/topics/anaemia_in_women_and_children, accessed 9 March 2023).

affected by severe wasting. Children living in rural settings and poorer households, and whose mothers received no formal education are more vulnerable to stunting and wasting (9).

10. Rheumatic heart disease is the most commonly acquired heart disease in people under 25 years of age and mostly affects children and adolescents in low- and middle-income countries (LMICs). In the year 2019, the disease claimed 288 348 lives worldwide. It also accounts for about 2% of deaths from cardiovascular diseases. Although the disease has been eradicated by effective treatment in many parts of the world, it remains prevalent in sub-Saharan Africa, central and south Asia, the Middle East and the South Pacific (10).

11. Global child and adolescent mortality rates peak among children aged under 5 years, fall to a low among adolescents between 10 and 14 years of age and then increase again. In the year 2021, global mortality rates were 38 per 1000 live births for children aged under 5 years, 3 per 1000 children aged 5 years and per 1000 young adolescents aged 10 years, respectively, and 5 per 1000 adolescents aged 15 years. Between 1990 and 2021, mortality rates decreased among all child and adolescent age groups, with the older adolescent age group (15–19 years) seeing the smallest rate of reduction (5).

12. Levels of HIV infections and AIDS-related deaths among adolescents have declined; however, there continue to be disparities between the sexes. Globally, new HIV infections in young people aged 15–24 years declined by 46% between 2000 and 2019. However, the decline varies by sex: among adolescent boys aged 10–19 years, the decline in new HIV infections was by 28% and by 36% among adolescent girls between 2010 and 2019 (11).

Trends in well-being of women, children and adolescents

13. Inequalities in early childhood development are widespread around the world. A recent analysis of household survey data from 95 LMICs, for example, shows that the percentage of children who are not developmentally on track (based on the early childhood development index that is used to assess progress towards indicator 4.2.1 of the Sustainable Development Goals (Proportion of children aged 24–59 months who are developmentally on track in health, learning and psychosocial well-being, by sex) across those 95 countries is over 20 percentage points higher in low-income countries compared with upper-middle-income ones (38.7% versus 18%) (12). The greatest inequalities in early childhood development exist among children living in rural areas in the poorest countries. Globally, an estimated 37% of children are exposed to risk factors of extreme poverty and stunting, mostly concentrated in south Asia and sub-Saharan Africa. Because of a poor start, affected individuals are estimated to suffer a loss of about one quarter of average adult income per year, while countries may forfeit up to twice their current gross domestic product expenditures on health and education (13).

14. Over 820 000 children’s lives could be saved every year among children aged under 5 years if all children aged 0–23 months were optimally breastfed. Breastfeeding improves intelligence quotient (IQ) and school attendance and is associated with a higher income level in adult life (14). Exclusive breastfeeding for six months has many benefits for the infant and mother; however, less than half (about 44%) of infants aged 0–6 months are exclusively breastfed. This practice varies widely among regions. The prevalence of early initiation of breastfeeding in eastern Europe and central

Asia (70%) and in eastern and southern Africa (64%) is twice as high compared with the Middle East and North Africa (34%).[1]

15. On average, 736 million (almost one in three) women who were aged 15 years or older in the year 2018 have experienced physical and/or sexual violence by an intimate partner and/or sexual violence by a non-partner at least once in their lifetime. Intimate partner violence and non-partner sexual violence are the most common and pervasive forms of violence in the lives of women and girls across the world. Intimate partner violence starts early, with almost one in four ever-partnered/married adolescent girls (aged between 15 and 19 years) estimated to have been subjected to physical and/or sexual violence at least once in their lifetime. The rates of intimate partner violence and non-partner violence vary across regions and countries, with the highest prevalence of intimate partner violence over the lifetime and last 12 months occurring in the Pacific island countries, sub-Saharan Africa and southern Asia. The variations in prevalence highlight that violence against women is not inevitable and is preventable. However, there continue to be major gaps in the availability of prevalence data, particularly from the Middle East and North Africa (15).

16. It is estimated that over 200 million women and girls have undergone female genital mutilation (FGM) in 31 countries where data are available. Treatment of the health consequences of this harmful practice are estimated to cost health systems US$ 1.4 billion each year and this figure is expected to rise to US$ 2.3 billion if no change in incidence occurs over the next 30 years due to population growth. There has been a steady decline in FGM prevalence among girls aged 15–19 years in 18 countries over the past 30 years, from about one half of girls undergoing FGM (49%) down to one third (34%). Progress is being achieved most rapidly in Burkina Faso, Egypt, Kenya, Liberia and Togo. In 23 of the countries with representative data, the majority of girls and women think the practice should end, an important precursor to FGM abandonment.[2]

17. In large part due to contraceptive use, the levels of adolescent pregnancy and childbearing have declined, although progress has been slow and uneven. Globally, adolescent birth rates have declined from 52.0 births per 1000 girls in the year 2010 to 42.7 births per 1000 girls in the year 2020. Sub-Saharan Africa remains the region with the highest rates among all regions, at 101 births per 1000 women aged 15–19 years in the year 2021. Latin America and the Caribbean was the region with the second highest level of adolescent fertility, at 53 births per 1000 women aged 15–19 years. In the year 2021, the contribution of adolescent fertility to total fertility was the highest in Latin America and the Caribbean with 14% – a level about 30% higher than in sub-Saharan Africa (16).

18. The levels of child marriage have declined; however, progress has been slow and uneven. Globally, child marriage has declined markedly over the last 25 years from 31% in the year 1995 to 19% in the year 2020 (a 12% decrease). The declines in child marriage have been uneven across regions and between countries. Progress has been more marked in some regions, notably in south Asia. Despite the declines, levels of child marriage remain high in sub-Saharan Africa (34%) and south Asia (28%) as of the year 2020 (17).

[1] For further information, see the United Nations Children's Fund website (https://data.unicef.org/topic/nutrition/breastfeeding/, accessed 9 March 2023).

[2] For further information, see the WHO webpage on FGM (https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation, accessed 9 March 2023).

19. Mental health issues are of great concern among adolescents. Some of the main causes of the non-fatal disease burden in the year 2019 included childhood behavioural disorders and anxiety disorders among young adolescents (aged 10–14 years), as well as depressive disorders among older adolescents (aged 15–19 years) in both males and females.[1] The COVID-19 pandemic increased the prevalence of these conditions.

20. In the year 2022, WHO published the Global status report on physical activity 2022. While over three quarters of all countries reported conducting national surveillance of physical activity among children and adolescents, over 80% of adolescents are estimated as not meeting WHO guidelines on physical activity for health. Uneven implementation of relevant policy actions across WHO regions and income levels results in inequities in people's access to opportunities and environments that support being regularly and safely active (18).

Trends in coverage of interventions and services

21. The universal health coverage service coverage index measures progress on indicator 3.8.1 of the Sustainable Development Goals (Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)). The reproductive, maternal, newborn and child health subcomponent of the service coverage index improved the fastest in low-income countries from 2000 to 2019. [2]

22. Examination of 16 key interventions in sexual, reproductive, maternal, newborn and child health[3] using data from 136 LMICs for the period 2017–2022 indicates that the world is far from achieving universal coverage for these interventions, with larger gaps for family planning services, breastfeeding and treatment of childhood illnesses. LMICs, on average, are reaching coverage levels of 80% or higher for certain interventions, such as skilled attendant at birth, postnatal care for mothers and for babies, immunization services and basic drinking water services. However, average coverage levels across the LMICs with available data hover at or below 50% for indicators on early initiation of breastfeeding, exclusive breastfeeding, vitamin A supplementation, demand for family planning satisfied, and diarrhoea treatment (19).

23. The proportion of women of reproductive age (15–49 years) who have their need for family planning satisfied by modern contraceptive methods increased from 76.8% in the year 2016 to a projected 77.6% in the year 2022. The increase is projected to be fastest in sub-Saharan Africa, from 49.2%

[1] For further information, see the WHO webpage on global health estimates (https://www.who.int/data/global-health-estimates, accessed 9 March 2023).

[2] For further information, see the website of the Global Health Observatory (https://www.who.int/data/gho/data/indicators/indicator-details/GHO/uhc-sci-components-reproductive-maternal-newborn-and-child-health, accessed 9 March 2023).

[3] The 16 interventions include: treatment of pregnant women living with HIV; postnatal visit for babies; immunization with rotavirus vaccine; four skilled attendants at delivery; neonatal tetanus protection; antenatal care (at least four visits); postnatal visit for mothers; population using at least basic drinking water services; care-seeking for children under 5 years of age with symptoms of pneumonia; early initiation of breastfeeding; exclusive breastfeeding (for up to six months); demand for family planning satisfied with modern contraceptive methods; oral rehydration solution treatment for diarrhoea for children under 5 years of age; continued breastfeeding (for the first year); immunization with the first dose of a measles-containing vaccine; and immunization with the third dose of diphtheria-tetanus-pertussis vaccine among 1 year olds.

to 54.3% over this time period, and slowest for northern Africa and western Asia (61.9% to 63.8%) (20).

24. The levels of contraceptive use by adolescents have risen. In LMICs, the proportion of adolescent girls aged 15–19 years whose needs for family planning were satisfied by modern contraceptive methods rose from 36% to 60% between 1995 and 2020 (17).

25. Coverage of reproductive and maternal health services shows patterns of inequities across countries as well as within countries, with poor and other disadvantaged groups of women much less likely to receive these services than their wealthier counterparts (21,22). For example, nearly all (97%) unsafe abortions occur in developing countries, with the highest proportion of least safe abortions and highest fatality rates occurring in Africa, where access to services is limited (23).

26. The latest available estimates also show a continued drop in coverage of immunization services during the second year of the COVID-19 pandemic. An estimated 25 million children under 1 year of age did not receive basic vaccines in the year 2021, which is the highest number since the year 2009. Additionally, in the year 2021, the number of completely unvaccinated children increased by 5 million compared with the year 2019 (24).

27. Home care practices to support early childhood development remain inadequate in many countries that have collected population-based data (25). For example, fewer than half of the children received the benefits of early stimulation and responsive care by adults in their home in one third of the countries and more than three quarters of children aged 1–4 years experienced violent discipline by their caregivers in almost half of the countries. However, new cohort data have illustrated that the IQ score of pre-school children who were living in impoverished communities and were raised in a nurturing home environment was on average 6 points higher by the time they became adolescents compared with children who did not benefit from a nurturing environment (26).

28. Human papillomavirus vaccination of adolescent girls, which prevents cervical cancer, the fourth most frequent cancer in women, has now been introduced in 116 countries. However, vaccine coverage decreased in the year 2021 in many countries, and global coverage of the first dose of the vaccine among girls is now estimated at 15% compared with 20% in the year 2019 (24).

29. The quality of services for adolescents is substandard across both health and social systems. Although high-quality, person-centred care requires having a regular doctor or place of care, adolescents are less likely than adults to report having a usual source of care. Across 17 LMICs, between 7% and 47% of adolescent respondents agreed that their health system worked well and that only minor changes were needed to improve it, compared with 59% of adolescents across 11 high-income countries. Compared with adolescents in high-income countries, far fewer adolescents in LMICs reported being somewhat or very confident in their ability to receive the care they needed from their health system (27).

Threats to the health and well-being of women, children and adolescents

30. For nearly three years, the COVID-19 pandemic and the early response aimed at controlling it has negatively impacted the health and well-being of women, children and adolescents in many ways and resulted in disruptions in health, education, social protection and economic systems. For

example, as mentioned in paragraph 26 above, there has been a decrease in routine immunization coverage of children.

31. Between 1 March 2020 and 1 May 2022, it was estimated globally that 10.5 million children (younger than 18 years of age) lost a parent or caregiver to COVID-19 (28). Orphanhood increases the likelihood that a child will experience poverty, abuse, delayed development, reduced access to education and institutionalization. Adolescents who are orphaned also face an increased risk of sexual violence, exploitation, HIV infection, suicide and pregnancy (29).

32. A positive development is that disruptions to essential sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) services lessened in duration and frequency starting in the year 2021. Results from the third round of the WHO national pulse survey on continuity of essential health services during the COVID-19 pandemic, which reflected the period November–December 2021, showed that about two thirds of countries reported either no disruptions or fewer disruptions in selected SRMNCAH services (30).

33. However, mental health has suffered as a result of the COVID-19 pandemic. Estimates for the year 2020 show a global increase in major depressive disorders among the general population of 27.6% and of anxiety disorders of 25.6% since the pandemic began compared with rates prior to its start. Although data are mixed, younger age and females were at greater risk for these disorders (31).

34. Several countries affected by COVID-19 saw increases in levels of violence occurring in the home, including violence against children, intimate partner violence and violence against older people. Countries also faced increasing challenges in maintaining support and care for survivors of violence. WHO compiled a scientific brief to highlight key actions that the health sector can undertake within a multisectoral response to prevent or mitigate interpersonal violence based on existing WHO guidance (32).

35. The COVID-19 pandemic has brought into sharp focus the increase in the risk of and exposure to violence in the home that women and girls face during crises such as outbreaks. There was an increase in reports of violence to police, shelters and hotlines during the COVID-19 pandemic in a number of countries and settings. While the exposure to and severity of violence in the home linked to lockdown measures increased, there was also a reported decrease in access to and disruption of formal support services (e.g. health services for those affected by intimate partner violence). Similarly, the COVID-19 pandemic decreased the level of informal support from friends and families due to lockdown measures. Therefore, it is critical that services responding to violence against women and girls are maintained as essential services during outbreaks (33).

36. School closures during the COVID-19 pandemic lockdowns have resulted in great educational loss for many children. The longer the duration of a school closure, the greater the time needed to make up for the lost learning, and the greater the risk that some students will never return. There is a direct relationship between the length of time a school is closed and children's reading capabilities. However, learning is not the only area impacted and reason for concern: these closures and connectivity issues have increased inequalities in access not only to quality education but also to the wider range of important health and well-being services often available in schools such as school meals and counselling services (34, 35).

37. The ongoing impact of the COVID-19 pandemic in terms of the material deprivation (i.e. education, health, housing, nutrition, sanitation and water) experienced by children will continue to be a serious concern in most societies. It was estimated that around 100 million more children could be living in

multidimensional poverty and around 60 million more children could be living in monetary-poor households by the end of 2021 compared with the pre-COVID-19 situation (36).

38. The maternal mortality rate is an indicator for gender equality. The reasons why women and girls ultimately die or suffer injury during pregnancy and childbirth are often classified as the "three delays": (1) delays in seeking appropriate medical care; (2) delays in reaching an appropriate health facility; and (3) delays in receiving appropriate care once at a facility. Multiple human rights concerns fuel these delays, and discriminatory practices feed the root causes which prevent women from accessing the services they require.

39. Since early 2022, the conflict in Ukraine has exposed some of the perils of the interconnectedness of global food chains and the fragility of food systems in many LMICs. As prices for goods have increased around the world, so have the costs of providing emergency food assistance. However, even before the COVID-19 pandemic and the conflict in Ukraine increased the risk of food insecurity and famine, globally around 618 million people in the year 2019 were facing hunger, and world hunger has risen since the COVID-19 pandemic started, with around 150 million more people experiencing hunger in the year 2021 compared with the year 2019. Around 2.3 billion people were moderately or severely food insecure in the year 2021, and 11.7% of the global population faced food insecurity at severe levels. Food insecurity and hunger disproportionately impacts women, children and adolescents.

40. The number of humanitarian crises is increasing around the world. Gender-based violence against women and girls has been shown to increase in a number of humanitarian settings, including conflict-related sexual violence. Survivors of gender-based violence in humanitarian contexts need a comprehensive response that includes medical, psychosocial and legal services and safe spaces. The humanitarian organizations working in health and protection clusters need to maintain coordination and ensure that health services for survivors of gender-based violence are included as life-saving care.

41. Mounting evidence shows that women's empowerment is directly related to improvements in maternal and child survival, increased coverage of maternal and child health interventions, improvements in early childhood development, and the creation of more equitable and peaceful societies (37, 38). However, this empowerment is under threat due in part to threats to women's reproductive rights.

42. Only 55 % of married or in-union women aged 15–49 make their own decisions regarding sexual and reproductive health and rights, based on data from 57 countries, the majority of which are in sub-Saharan Africa. Data thus far also reveal large disparities among regions, from less than 40 % of empowered women in central and western Africa to nearly 80 % in some countries in Europe, south-eastern Asia, and Latin America and the Caribbean. Analysis of the three sub-indicators shows that while women seem to have the most autonomy in deciding whether to use contraception, with 91 % empowered, only three in four women can decide on their own health care or say no to sexual intercourse (39).

43. Even as top national courts in countries including India, Mexico and Nepal have issued rulings in favour of women's reproductive rights in the past couple of years, policies protecting these rights are under threat in many other places. For example, recent rulings in the United States of America and Poland have had a severe impact on women's access to abortion.

44. It is important to note that in all countries, indicators for noncommunicable diseases reveal differences between men and women among socioeconomic groups and across the life course in

terms of health outcomes, exposure to main risks, adoption of healthy behaviours, access to and use of services, responses from health providers, and the use of formal and informal health care. Biology is important in shaping these differences, but it does not explain them all. Gender norms, stereotypes and inequalities influence exposure to risk and heath-seeking behaviour; gender biases also influence the provision of services. Overall, health professionals' competence in understanding gender-specific health care-seeking patterns is weak. The selection, design and organization of services do not consider gender norms, roles and power relations between men and women in responding to the health needs of women (40).

45. Climate change represents one of the greatest challenges the world faces today. Between 2030 and 2050, the climate crisis is expected to cause approximately 250 000 additional deaths per year, with substantial and long-term impacts on the health of populations (41). These weather extremes are happening simultaneously, causing cascading effects that are increasingly difficult to manage. The contribution of Working Group II to the Sixth Assessment Report of the Intergovernmental Panel on Climate Change focused on impacts, adaptation and vulnerability and highlighted how the vulnerability of ecosystems and people to climate change differs substantially among and within regions, recognizing the heightened risks to pregnant women, newborns, children and the elderly (42). A growing body of knowledge links climate change to adverse maternal, newborn and child health outcomes, which threatens to worsen levels of mortality. Pregnancy heightens vulnerability to heat, infectious diseases and air pollution (43). In addition, infants and children have unique pathways of exposure and sensitivity to climate hazards, given their immature physiology and nutritional needs (44, 45). Further, the impacts of climate change on household food access, dietary diversity, nutrient quality and water access are particularly problematic for pregnant women, newborns, children and older people. The existence of physiological vulnerabilities, compounded by intersecting patterns of inequity and marginalization, highlights how climate change has the potential to undermine many of the gains in maternal, newborn and child survival and widen existing health inequities. Strategic planning to mitigate climate change-derived health impacts and to design options for adaptation is urgent and requires coordination between ministries, implementing partners, civil society organizations, the private sector and the wider community. WHO, in collaboration with UNICEF and UNFPA, is committed to taking action to strengthen the integration of maternal, newborn, child and adolescent health needs into climate change responses.

Actions taken to counter threats to the health and well-being of women, children and adolescents

46. A life course approach recognizes that people are living longer lives and that societies must invest in every life stage to ensure human development resulting in each person having the ability to be or do what they value. Reflecting WHO's definition of health, a life course approach does not equate health with the absence of disease. Rather, it focuses on actions that can optimize health trajectories: this recognizes that there are critical stages to human development, and that ensuring opportunities for health and mitigating exposures to harmful practices and environments will reduce inequalities and put people on a better health trajectory throughout their lives (46). For example, early risks to health and well-being in pregnancy, childhood and adolescence are associated with around 70% of mental illness and noncommunicable diseases in later years (47, 48). The life course approach in practice requires a paradigm shift and reorientation of the health system to promote healthy development and healthy ageing with a person-centred and multisectoral approach. To this end, WHO is promoting actions to build capacities (for the mind and body), including physical, cognitive and psychological capacities, maintain them at an optimal level for as long as possible and reduce the rate of potential decline. Examples of WHO and other United Nations initiatives that align with this life course approach include the Nurturing Care Framework for Early Childhood Development

(49), the Framework for Adolescent Well-being (50) and the United Nations Decade of Healthy Ageing (2021–2030).[1]

47. To holistically integrate well-being into policy and programmes for adolescents, WHO and the Partnership for Maternal, Newborn & Child Health (PMNCH) published a definition and framework for adolescent well-being. In addition, a *British Medical Journal* collection covering the five domains and 27 sub-domains of well-being was published in 2022 (51). The collection contains policy and programmatic recommendations in support of multisectoral action for adolescents.

48. An emphasis on maternal, child and adolescent health remains critical to a life course perspective, specifically by targeting interventions and services that set people up to optimize their capacities and reduce the burden of disease throughout their lives Examples of the life-course approach can be found in the Nurturing Care Framework for Early Childhood Development, the Framework for Adolescent Well-being and the United Nations Decade of Healthy Ageing (2021–2030) target actions not only in the health sector but also across sectors, such as education, social protection and labour. Additionally, addressing structural determinants related to gender inequalities, including violence against women, harmful gender norms and practices, and the higher burden on women of formal and informal care work, can alter the life course trajectory of women and girls.

49. WHO is committed to increasing the evidence base and making recommendations to operationalize a life course approach to health and engage multiple sectors that contribute to human development and well-being. A review of intervention packages in 284 WHO global guidelines found that only two guidelines contained recommendations on improving people's capacities across the life course. Recent WHO guidelines have started to include the life course in their good practice statement and overall guiding principles, with more progress to be made in this area in the future. Ultimately, this is part of an overall drive for a whole-of-society approach to produce health outcomes.

50. In the year 2022, WHO, as the Inter-Agency Standing Committee Global Health Cluster lead, coordinated humanitarian health action in 29 crisis-affected countries, targeting 97.8 million people. Emergency health support reached 40.3 million people in the first half of 2022; as at September 2022, 5.2 million maternal health consultations had been provided. In the fourth quarter of 2022, the Global Health Cluster established the Sexual and Reproductive Health Task Team to further consolidate efforts to ensure that sexual and reproductive health (SRH) priorities are systematically addressed in all phases of humanitarian response and that SRH coordination is consistently included in cluster coordination at both the global and country levels. The Task Team is co-chaired by UNFPA and the International Rescue Committee (Inter-Agency Working Group on Reproductive Health in Crises partners). A workplan is being finalized.[2]

51. WHO and UNFPA gathered a collection of 36 case studies of nimble adaptations to organizational responses to the SRH needs of adolescents in the context of the COVID-19 crisis from 16 countries in the year 2022. Each case study describes how organizations proactively and cleverly adapted the provision of one or more of the following SRH interventions to circumvent local barriers created by the COVID-19 pandemic: SRH information and education provision; contraceptive provision; abortion and post-abortion care provision; HIV care provision; sexual and gender-based violence

[1] For further information, see the WHO webpage on the United Nations Decade of Healthy Ageing (2021–2030) (https://www.who.int/initiatives/decade-of-healthy-ageing, accessed 9 March 2023).

[2] For further information, see the Humanitarian Action webpage on global achievements (https://humanitarianaction.info/article/global-achievements-0, accessed 9 March 2023).

care provision; menstrual products distribution; and human papillomavirus vaccine administration (52).

52. To address family planning method safety, initiation, use and discontinuation and to provide technical information for policy formulation, programme design and implementation, WHO has issued several guidelines and tools, including *Family planning: A global handbook for providers (2022 update)* (53); *Community and provider-driven social accountability intervention for family planning and contraceptive service provision: experiences from the field* (54); a Medical eligibility criteria app; a statement on the nomenclature for levonorgestrel-releasing intrauterine devices; the Digital Adaptation Kit (DAK) for Family Planning; and an implementation brief on integration of HIV testing and linkage in family planning and contraception services.

53. To improve implementation, decrease barriers to accessing contraceptives and increase service integration and accountability, WHO developed and launched commitments to FP2030 in respect of specific actions to increase use of voluntary, rights-based contraception worldwide; provided specialized technical support to 14 countries under the WHO FP Accelerator project (2019–2022); supported South–South learning exchanges between six countries; and leveraged the Implementing Best Practice Network to disseminate and support implementation of WHO guidelines, reaching over 20 500 participants in 116 countries and 145 different organizations.

54. To strengthen implementation for impact and address equity barriers through a primary health care approach, WHO is developing microplanning guidance for service delivery organizations and managers at the subnational level. The guidance will use planning and implementation of maternal, newborn and child health services as a pathfinder for the development of strategies that adopt a people-centred and integrated care approach across programmes, providers and sectors to address equity barriers related to availability, access, acceptability and quality.

55. Under the leadership of national governments and with technical support from the Secretariat and partners, 10 countries that are part of Network for Improving Quality of Care for Maternal, Newborn and Child Health have strengthened their national strategies, policies and implementation packages, using a systems approach. The Network has galvanized the development or update of national quality of care policy and strategies in all Network countries, where the WHO maternal, newborn and child health quality of care standards have also been adopted and adapted. The Network countries are also engaged and leading other maternal and newborn health and quality of care initiatives such as: service redesign, private sector engagement, maternal and perinatal death surveillance and response (MPDSR) and midwifery. Impact data from implementing sites in three of the Network countries showed an improvement in caregiving practices and a decrease in newborn mortality rates in learning sites (where the national package of interventions has been implemented) since the start of implementation of quality improvement initiatives. Capitalizing on the implementation experience of the Network countries, WHO developed an implementation guide which provides practical guidance for establishing and implementing quality of care programmes for maternal, newborn and child health at the national, district and facility levels (55).

56. The MPDSR system is an essential quality of care intervention for improving maternal, perinatal and neonatal survival, and is key in understanding the number and causes of deaths (56). MPDSR can continuously guide improvements in the quality of care for maternal and newborn health and, in certain contexts, can reduce maternal death by 35% and newborn death by 30% (57). Globally, from 2018 to 2019, 82% of countries reported that maternal death reviews were implemented in health facilities, while neonatal death and stillbirth reviews in facilities were implemented in 63% and 47% of countries, respectively (58). MPDSR contributes to improving the validity and reliability of the data collected on maternal mortality and establishes a system of accountability (59).

However, there are issues, as health providers may be blamed for deaths and may be prosecuted (60). Therefore, there needs to be a protecting environment for health care professionals institutionalizing MPDSR as a separate system from any form of legal procedure. This is being addressed by the Secretariat with the pilot testing of a legal toolkit in support of accountability mechanisms.

57. Implementation of maternity protection policies is a critical step countries can take to improve maternal and newborn health and empower women. Progress towards institutionalizing such policies has been slow, however: as of August 2022, only 43 countries had ratified the International Labour Organization Maternity Protection Convention.

58. The joint Every Newborn Action Plan–Ending Preventable Maternal Mortality (ENAP–EPMM) Management Team, co-led by WHO, UNFPA and UNICEF, has aligned ENAP–EPMM work planning to jointly advance the common agenda to end preventable maternal and newborn deaths and stillbirths and improve health outcomes. Firstly, a combined ENAP–EPMM results framework for the period 2022–2025 was developed. Endorsed by the Management Team, the results framework aims to guide action towards the ENAP and EPMM coverage targets and milestones by the year 2025 that are essential to meet in order to improve maternal and newborn health and survival and prevent stillbirths. Successful implementation of the results framework requires prioritized actions at the global, regional and country levels, such as the development of key global guidance, coordinated technical support across partners and implementation of the prioritized actions in countries. A selected number of countries were prioritized to initiate the joint ENAP–EPMM implementation and intensify support and collaboration with the respective governments and existing stakeholder platforms, as applicable in countries. To develop country-specific action plans, WHO, UNICEF and UNPFA worked with the health ministries develop maternal and newborn health action plans for the period 2023–2025 in seven countries: Bangladesh, Burundi, Kenya, Liberia, Nigeria, Pakistan and Sierra Leone. Opportunities were availed through existing regional platforms, such as the H6 Partnership and the Muskoka Initiative for Maternal Newborn and Child Health, to orient and facilitate the development of joint action plans in these and an additional 30 countries in the African Region.

59. The postnatal period, defined here as the period beginning immediately after the birth of the baby and extending up to six weeks (42 days), is a critical time for women, newborns, partners, parents, caregivers and families. Yet, during this period, the burden of maternal and neonatal mortality and morbidity remains unacceptably high, and opportunities to increase maternal well-being and to support nurturing newborn care have not been fully utilized. Postnatal care services are a fundamental component of the continuum of maternal, newborn and child care, and key to achieving the Sustainable Development Goals on reproductive, maternal and child health, including targets to reduce maternal mortality rates and end preventable deaths of newborns. WHO released global guidelines (61) to improve the quality of essential, routine postnatal care for women and newborns with the ultimate goal of improving maternal and newborn health and well-being. The guidelines provide a comprehensive set of recommendations for care during the postnatal period, focusing on the essential package that all women and newborns should receive, with due attention to quality of care; that is, the provision and experience of care. WHO is developing implementation tools to support countries in adapting the recommendations and in reviewing their services to determine how to strengthen care for women and newborns.

60. In the year 2022, WHO developed 27 recommendations to substantially improve SSNB outcomes. The recommendations include: medicines (tocolytics and corticosteroids) to assist with labour and delivery; immediate skin-to-skin care (known as kangaroo mother care); early initiation of exclusive breastfeeding; micronutrients; emollients for skin care; continuous positive airway pressure;

methylxanthines for breathing difficulties; and family involvement and support, including home visits and parental leave and entitlements (62). WHO has also shown, for the first time, that immediate skin-to-skin care can save almost one third (28%) of lives in trials in 19 countries (Bangladesh, China, Colombia, Ecuador, Ethiopia, Gambia, Ghana, Madagascar, India, Indonesia, Kenya, Malawi, Malaysia, Nepal, Nigeria, Sweden, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania and United States of America) (63). WHO now advises skin-to-skin contact immediately after birth for all preterm babies without any initial period in an incubator. WHO estimates that over 144 000 babies can be saved each year globally through this simple cost-effective intervention (64).

61. To scale up SSNB care across LMICs, WHO is focused on achieving the ENAP target of a functional special care unit for SSNBs in at least 80% of districts in each country.[1] The 2019 WHO and UNICEF report *Survive and thrive: transforming care for every small and sick newborn* (65) articulates the importance of strengthening care for SSNBs and defines the scope of care and range of interventions that can be delivered at different levels to accelerate progress. It highlights the need for transforming hospital care for 30 million vulnerable newborns, if the world is to achieve the Sustainable Development Goals, including universal health coverage, by 2030. WHO has developed a model for scale up which includes all health system building blocks from financing, infrastructure, commodities, the workforce (including WHO's new essential newborn care training course), service delivery, information, technology and governance (66). This model describes how countries and programme managers can build and organize systems and deliver services for implementing SSNB care in health facilities.

62. Appropriate medicines to save and improve the lives of infants and children to address the world's most pressing health priorities often do not exist, are unavailable or are not quality assured, especially in low-resource settings. Created to respond to these paediatric treatment gaps, the Global Accelerator for Paediatric Formulations (GAP-f) is a WHO network hosted within the Research for Health department of the WHO Science Division. Working in partnership with 30 organizations and WHO's technical departments, GAP-f aims to shape and accelerate the global innovation and access landscape for better paediatric medicines by work via three main strategic pillars – prioritize and align, accelerate, and intervene – across the product life cycle and different disease areas. GAP-f and partners are working to ensure the age appropriateness of paediatric formulations of essential medicines for children in the upcoming revision of the Essential Medicines List for Children as well as future paediatric drug optimization (PADO) processes across the spectrum of essential medicines. GAP-f also works and aligns with the WHO Paediatric Regulatory Network, which aims to facilitate regulatory pathways for essential paediatric medicines and formulations as a key step to ensure access to these products as early as possible.[2]

63. All children need to receive nurturing care and caregivers need to be supported to provide it. Nurturing care encompasses good health, adequate nutrition, safety and security, early learning and responsive caregiving. Following the launch of the Nurturing Care Framework in the year 2018, WHO has worked with more than 40 countries to review their governance and implementation plans

[1] For further information, see the WHO webpage on the Every Newborn Action Plan (https://www.who.int/initiatives/every-newborn-action-plan, accessed 10 March 2023).

[2] For further information, see the WHO webpage on Gap-f (https://www.who.int/initiatives/gap-f, accessed 10 March 2023), the WHO webpage on the Model List of Essential Medicines (https://www.who.int/groups/expert-committee-on-selection-and-use-of-essential-medicines/essential-medicines-lists, accessed 10 March 2023) and the WHO webpage on the WHO Paediatric Regulatory Network (https://www.who.int/initiatives/gap-f/who-paediatric-regulatory-network, accessed 10 March 2023).

and build capacities to support caregivers in providing nurturing care. A progress report highlighting achievements and challenges is expected to be made available by May 2023.

64. WHO and UNICEF developed a nurturing care handbook and a practice guide to strengthen nurturing care in health and nutrition services as tools to facilitate programme planning. A virtual platform of resources is maintained to facilitate learning across stakeholders and share information. The importance of a healthy physical, social and emotional environment for early childhood development has been highlighted in a series of briefs (67) that aim to guide the related actions. One example is the country consultations held in five settings in the Eastern Mediterranean Region to strengthen policy and programming based on the brief on nurturing care for children living in humanitarian settings.[1]

65. The imperative to address caregiver mental health as part of programming for child and adolescent health and well-being is well recognized. One in six women are estimated to experience mental health problems in the perinatal period. The WHO operational guide on integration of perinatal mental health in maternal and child health programmes provided an impetus for accelerated actions (68).

66. The relevance of nurturing care for children beyond the early years has also been recognized and is reflected in the WHO report *Investing in our future: A comprehensive agenda for the health and well-being of children and adolescents* (69). As a consequence, WHO is now elaborating a well care approach to support optimal development of children and adolescents in the first two decades of life. Aligned with this effort is the Global Initiative to Support Parents, borne out of the parenting crisis that marked the COVID-19 pandemic. Spearheaded by UNICEF and WHO in collaboration with partners, the aim is to support countries in scaling up evidence-based parenting interventions that support optimal child development, prevent violence against children and reduce the inequities that the youngest generations face in realizing their human potential. The initiative is supporting the new WHO guidelines on parenting (70).

67. In low-, middle- and high- income countries, parenting interventions programmes are a strategy that has been shown to have major and long-lasting benefits in preventing child maltreatment, reducing violence both to and by young people, and improving a host of health, well-being and socioeconomic outcomes for children and adolescents now and into their futures. These intervention programmes typically aim to strengthen caregiver–child relationships through play and praise to help manage child and adolescent behaviours through effective, age-appropriate positive-discipline strategies. WHO played a leading role in the establishment of the Global Initiative to Support Parents to prevent child maltreatment and optimize child development. This multi-agency consortium aims to ensure that all parents and caregivers have access to quality, evidence-based parenting support interventions according to their needs by the year 2027. In addition, WHO guidelines on parenting interventions to prevent maltreatment and enhance parent–child relationships in children aged 0–17 years were published in early 2023, and recommends that evidence-based parenting interventions should be made readily accessible to all parents who need them, in low-, middle- and high-income countries, including in humanitarian settings.[2]

[1] For further information, see the website of Nurturing Care for Early Childhood Development (https://nurturing-care.org/nurturing-care-in-humanitarian-settings-workshops-in-arab-countries/, accessed 10 March 2023).

[2] For further information, see the WHO webpage on parenting for lifelong health (https://www.who.int/teams/social-determinants-of-health/parenting-for-lifelong-health, accessed 10 March 2023).

68. A report published by WHO and partners in April 2021 documented the uptake, adoption and implementation of the INSPIRE framework, a set of seven evidence-based strategies for ending violence against children, over the previous five years (71). The report showed extensive translation of the INSPIRE technical package, with the core document available in a total of 14 languages and the handbook available in three languages. It also showed uptake and implementation of the INSPIRE strategies in at least 67 countries. During the virtual Leaders' Event of the Together to #ENDViolence global campaign, held on 14 June 2022, ministerial-level statements were issued by 15 countries summarizing progress on ending violence against children and identifying key actions necessary to scale up priority programmes in line with national action plans and the INSPIRE framework.[1]

69. To increase the technical capacity of governments, partners and WHO country offices to prevent and respond to violence against children, several initiatives have been implemented: a guidance document (71) published in September 2021 highlights the decisions that need to be made in the selection, adaptation and scaling up of interventions within the multisectoral INSPIRE approach; a free online course on the INSPIRE framework, developed jointly with the Care and Protection of Children (CPC) Learning Network and Columbia University, was launched in mid-2022; a handbook was published and used to inform the training of 50 trainers on the INSPIRE framework across all WHO regions in late 2021; a policy brief was published on the burden, consequences and preventability of online violence against children; and a systematic review was conducted of what works to prevent such violence (72).

70. WHO is supporting countries through a resource package (73) for strengthening countries' health systems to respond to violence against women that includes guidelines and implementation tools including for addressing gender-based violence in humanitarian settings. The audience for this resource package includes health policy-makers, health providers and health managers. Support for implementing the guidelines and tools is provided through three modalities: direct support to health ministries, partners in the United Nations system and joint initiatives (e.g. essential services for violence against women and girls), and through the Global Health Cluster during health emergencies. Preventing violence against women requires a multisectoral approach. In the year 2021, WHO, together with the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women), published the RESPECT implementation package (74) that operationalizes the RESPECT women: preventing violence against women framework for policy-makers endorsed by 14 agencies)75).[2] The implementation package was rolled out in 12 countries in the period 2021–2022 to strengthen the capacities of policy-makers across sectors. RESPECT women has been included as part of a collective commitment for scaling up prevention in at least 25 countries with a high prevalence of violence against women by the year 2026 as part of the Generation Equality Forum Action Coalitions on Gender-Based Violence (76).

[1] The countries are Armenia, Cambodia, Canada, Finland, Georgia, Guinea, Mongolia, Montenegro, Nigeria, Philippines, Romania, South Africa, Uganda, Zambia and Zimbabwe, and the statements are available at: https://www.end-violence.org/sites/default/files/2022-06/National%20Policy%20Dialogue%20%282%29.pdf (accessed 10 March 2023).

[2] The 14 agencies are, United Nations Entity for Gener Quality and the Empowerment of Women (UN Women), International Labour Organization (ILO), United Nations Development Programme (UNDP), United Nations Educational, Scientific and Cultural Organization (UNESCO), United Nations Population Fund (UNFPA), Office of the United Nations High Commissioner for Human Rights (OHCHR), World Health Organization (WHO), United Nations Office on Drug and Crime (UNDOC), Ministry of Foreign Affairs of the Netherlands, Australian Government, UKAid, USAID, SIDA, World Bank Group

71. An increasing number of countries are implementing a health sector response to violence against women and girls. A baseline assessment of the implementation of the WHO global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children, showed that approximately 48% of countries have clinical guidelines and/or protocols for responding to violence against women. While nearly three quarters of 174 countries include provision of psychological support to women survivors of violence, only 35% of countries include mental health assessment and referrals and only 45% include all three elements of post-rape care (i.e. emergency contraception, sexually transmitted infection prophylaxis and HIV post-exposure prophylaxis) in their policies. The assessment report highlights the need for the health sector to step up efforts in putting in place and implementing evidence-based policies for responding to violence against women (77).

72. WHO has developed a comprehensive package of resources to support the health sector in ensuring that women and girls who have undergone FGM receive the highest quality care to manage associated health complications and that health workers have the knowledge and skills to communicate with their patients about preventing FGM. In the year 2022, WHO launched a new package to build health workers' skills on person-centred communication for FGM prevention following positive findings from a multicountry study testing this approach. In addition, WHO launched a guide for integrating FGM content into pre-service training of nurses, midwives and other health workers as well as an online resource kit for the health sector compiling resources related to training health workers, planning health sector programming, advocacy, research and clinical care. WHO is also supporting countries to adapt, implement and scale up these resources within the health sector.

73. WHO has published a variety of reports highlighting the continuing problem of the promotion of commercial milk formula and increasing rates of child morbidity and mortality due to inadequate breastfeeding. A study carried out in Bangladesh, China, Mexico, Morocco, Nigeria, South Africa, the United Kingdom of Great Britain and Northern Ireland and Viet Nam (78) documented the pervasive nature of such marketing. The study demonstrated that exposure to marketing undermines women's confidence in their ability to breastfeed, creates a perceived need for formula milk and positions formula milk as a better alternative in the face of anxieties around feeding. A report on digital marketing of breast-milk substitutes (79) demonstrated how digital technologies have become the dominant form of promoting formula and are highly effective. The 2023 Lancet Series on Breastfeeding described the marketing playbook used by industry to target parents, health professionals and politicians to undermine breastfeeding. As shown in the 2022 report on national implementation of the International Code of Marketing of Breast-milk Substitutes, countries are strengthening their protection against inappropriate marketing of breast-milk substitutes, but still only 32 countries have legislation substantially aligned with the International Code of Marketing of Breast-milk Substitutes. The Region of the Americas and the European and Western Pacific Regions have the lowest percentage of countries with legislation aligned with the Code (80).

74. In collaboration with UNICEF and the Global Breastfeeding Collective, WHO assesses policies and programmes to protect, promote and support breastfeeding through the global breastfeeding scorecard (81). New data analysed in the year 2023 demonstrated that only one in five countries comply with International Labour Organization's recommendations on the provision of nursing breaks and facilities for breastfeeding or milk expression. Maternity leave entitlements are inadequate in nearly every country. Just over one quarter of countries routinely provide counselling on infant and young child feeding and only 17% of countries include training on infant and young child feeding support in pre-service medical curricula. In spite of these ongoing challenges to breastfeeding, some countries have made substantial headway in increasing breastfeeding rates.

Between 2017 and 2022, 22 countries, mostly in Africa and Asia, have increased the percentage of infants under 6 months of age who are exclusively breastfed by at least 10 percentage points.

75. WHO continues its work on advocacy, evidence generation, tool development and capacity-building, while working with partners within and outside the United Nations system to support countries to address adolescent pregnancy effectively in the context of their national programmes. WHO also contributes to efforts of global initiatives, such as the UNFPA–UNICEF Global Programme to End Child Marriage, which supports the implementation of national strategies to accelerate action to end child marriage in 12 high-prevalence or high-burden countries. WHO also works with UNESCO, UNFPA and other partners to strengthen the provision of comprehensive sexuality education within and outside the school context. Further, building on the work done with the FP2020 initiative, WHO works with the FP2030 initiative in developing bold country commitments to improve adolescents' access to and uptake of modern contraception, and to translate these commitments into action.

76. WHO and UNESCO, in collaboration with UNICEF and other United Nations agencies, have developed global standards and indicators for health-promoting schools (82) as well as implementation guidance (83) to support making every school a health-promoting school. Orientations and capacity-building with Member States in the African, South-East Asia, Eastern Mediterranean and Western Pacific Regions were conducted in the period 2021–2022, and work is currently under way with early adopter countries such as Egypt, Kenya, North Macedonia and Paraguay to support governments to build a new generation of school health programmes, aligned with global standards.

77. Many health conditions can be better managed or prevented if detected early, and school health services have an important role to play. In the year 2021, WHO published the WHO guideline on school health services (84), and is supporting countries such as Ghana and Guinea to make their school health services evidence-based and sensitive to students' health and well-being needs. WHO is also working with researchers and policy-makers in a number of Member States (e.g. Armenia, Ghana, Morocco, United Republic of Tanzania and Zimbabwe) to conduct implementation research and effectiveness trials to generate evidence in support of school health and school health services.

78. In the year 2022, the Secretariat continued to provide support to Member States on using the *Global Accelerated Action for the Health of Adolescents (AA-HA!): guidance to support country implementation* to identify priority actions needed for strengthening adolescent health programmes and to implement actions to improve quality of care and strengthen providers' capacity. To advance the AA-HA! recommendations on expanding the use of digital health for adolescents, WHO has published the guidance document *How to plan and conduct telehealth consultations with children and adolescents and their families* (85), which provides practical guidance on organizing teleconsultations with infants, children, adolescents and their families or caregivers. In addition, to operationalize the AA-HA! recommendations on a rights-based approach to adolescent health care, WHO has published a tool for health care providers on assessing and supporting adolescents' capacity for autonomous decision-making in health care settings (86).

79. As we enter the United Nations Decade of Action for the Sustainable Development Goals, WHO, in collaboration with the Partnership for Maternal, Newborn & Child Health (PMNCH) and other partners, is stepping up advocacy efforts in favour of the largest adolescent population ever. Stronger cooperation and joint efforts are needed to address cross-cutting issues that affect the well-being of

adolescents and youth, such as gender inequalities, mental health, child and early marriage, violence including sexual violence, adolescent pregnancy, poverty, hunger, the digital divide, and employability. To this end, preparations of the Global Forum for Adolescents to be held in October 2023 are under way, which is organized by PMNCH in collaboration with WHO and partners, co-produced and co-owned by young people, and aligned with the Our Common Agenda initiative. It will unite adolescents and young people with policy-makers and 1250 PMNCH partner organizations from more than 130 countries and aims to accelerate progress towards the Sustainable Development Goals related to adolescent health and well-being. Adolescents and young people and their advocates will be equipped and supported to demand greater policy and financing commitments for adolescent health and well-being. The Global Forum for Adolescents will be critical to enhancing visibility, political support and momentum for the well-being of adolescents and youth.

80. As part of the WHO Initiative on E-waste and Child Health (87), WHO published the report *Children and digital dumpsites: e-waste exposure and child health* in the year 2021. The report is the first WHO report on e-waste and child health and calls for more effective and binding action to protect children from this growing health threat. WHO estimates that as many as 12.9 million women and 18 million children may be at risk of exposure to hazardous substances released through informal e-waste recycling (88). In the year 2022, WHO contributed to an online course published by PAHO on e-waste and child health.[1] The course aims to upskill health care workers, environmental professionals, policy-makers and medical students on the hazards of e-waste recycling and how to prevent dangerous childhood exposure.

81. Globally, in the year 2019, WHO estimated that 99% of all children under 15 years of age lived in environments with air pollution levels above the WHO guidelines. In the year 2021, WHO released updated air quality guidelines for particulate matter (PM2.5 and PM10), ozone, nitrogen dioxides, sulfur dioxide and carbon monoxide. The air quality guidelines serve as a global target for national, regional and city governments to work towards improving their citizens' health by reducing air pollution.

82. Lead has a profound impact on children's health and development due to the continued use of lead-containing paints and pigments, the presence of unsound recycling of used lead-acid batteries and other lead-containing objects in many countries around the world. Young children are particularly vulnerable because lead targets their developing brains and nervous systems, causing reduced IQ, behavioural problems and reduced educational attainment. In the year 2021, WHO published updated guidelines for clinical management of exposure to lead (89). The guidelines recommend a blood lead concentration of 5 μg/dL as a trigger for clinical intervention. Additionally, WHO and UNEP jointly lead the Global Alliance to Eliminate Lead Paint.[2] The Alliance has the goal of phasing out lead paint through the establishment of lead paint laws in every country. Working with

[1] Further information is available at: https://www.campusvirtualsp.org/es/curso/los-ninos-y-los-basureros-digitales-exposicion-los-residuos-electronicos-y-salud-infantil (accessed 10 March 2023).

[2] For further information, see the WHO webpage on the Global Alliance to Eliminate Lead Paint (https://www.who.int/initiatives/global-alliance-to-eliminate-lead-paint, accessed 10 March 2023).

health ministries, the Secretariat is providing advocacy and technical support to countries in eliminating lead paint. As of the year 2022, 88 countries have legally binding controls on lead paint.[1]

83. The Strategic and Technical Advisory Group of Experts (STAGE) for maternal, newborn, child and adolescent health and nutrition (MNCAHN) was formed in March 2020 with the primary goal of providing recommendations to the Director-General and thew Secretariat and informing and influencing the MNCAHN agenda globally. The core function of STAGE is to provide advice to WHO on matters relating to MNCAHN global priorities and emerging issues for which policies, strategies, recommendations and intervention packages should be developed or updated, with a view to helping Member States in reaching relevant Sustainable Development Goal targets. It is also aimed at creating the much-required coordinated global leadership to reduce the fragmentation, inefficient use of resources and poor accountability for health.

84. In the past six meetings, STAGE discussed and provided recommendations on broad areas such as: impact of the COVID-19 pandemic on MNCAHN; private sector engagement for improving delivery of MNCAHN services; climate change and its impact on MNCAHN; innovations (technical and programmatic) in maternal and newborn health; use of midwifery models of care to improve maternal and newborn care; assessing the impact of preventive adolescent health and well-being check-ups; risk stratification to predict child mortality; an integrated framework to manage anaemia; and SSNB care. Currently, there are two working groups for anaemia and for scale-up of midwifery models of care. Working groups for innovations in maternal and newborn health and for climate change will be formed soon. A position paper on implementation of kangaroo mother care is being finalized.

DATA GAPS AND ACCOUNTABILITY

85. Although there have been advances in data collection and reporting over the past decade in key areas related to women's, children's and adolescents' health, there are still many data gaps. For example, nearly four in 10 of the world's deaths remain unregistered and one in four children under the age of 5 do not officially exist, that is they have no birth registration.[2] Additionally, there are many data gaps related to quality of care indicators for antenatal care, postnatal care, adolescent health, and lack of standardization of health facility registers for maternal, newborn, child and adolescent health.

86. The lack of age-disaggregated data and poor inclusion of women, children and adolescents in early COVID-19 research, testing and surveillance activities hampered a definitive understanding of the direct effects of infection on them. A recommended standard for age disaggregation of health data for use by WHO, other United Nations agencies and key partners was published in the year 2021 (90).

87. In addition, lockdowns due to the COVID-19 pandemic delayed implementation of population-based household health surveys such as the Demographic and Health Surveys and Multiple Indicator

[1] For further information, see the website of the Global Health Observatory (https://www.who.int/data/gho/data/indicators/indicator-details/GHO/legally-binding-lead-controls, accessed 10 March 2023).

[2] For further information, see the website of the United Nations Children's Fund (https://data.unicef.org/topic/child-protection/birth-registration/, accessed 10 March 2023).

Cluster Surveys, resulting in far fewer surveys being conducted in the years 2020 and 2021 in comparison with previous years.

88. WHO, in collaboration with UNICEF, UNFPA and partners, led the development of a joint ENAP–EPMM Tracking Tool to track progress in countries towards the 2025 coverage targets and milestones. The ENAP–EPMM Tracking Tool built on the existing ENAP Tracking Tool and includes further core elements of maternal health, emergency obstetric care, SSNB care and preventing stillbirth to capture and track implementation and progress in countries towards the 2025 coverage targets and milestones. The ENAP–EPMM Tracking Tool has been shared with just over 90 countries including all Countdown to 2030 countries, and data collection and synthesis is under way to develop and publish the first joint ENAP–EPMM progress report by WHO, UNICEF and UNFPA. The report findings will inform the report on the Global Strategy resolution, which includes reporting on resolution WHA67.10 (2014) on the newborn health action plan to the Seventy-sixth World Health Assembly in May 2023.

89. As facility births increase, monitoring through the use of routine facility data in the District Health Information System (version 2) has potential, yet validation research has mainly focused on maternal recall surveys. The Every Newborn – Birth Indicators Research Tracking in Hospitals (EN-BIRTH) study aimed to validate selected newborn and maternal indicators for routine tracking of coverage and quality of facility-based care for use at the district, national and global levels. The validation was undertaken through a multicountry study of Bangladesh, Nepal and the United Republic of Tanzania, and the final validation was published as a BMC supplement of 14 papers in the year 2021 (91).

90. WHO's violence prevention information system (Violence Info), an interactive online resource with prevalence data on all forms of violence against children and information on causes, consequences, risk factors and the effectiveness of preventive interventions, was updated with new estimates for the prevalence of homicide and non-fatal violence in mid-2022.[1]

91. As mortality rates among children decrease, the proportion of deaths due to congenital anomalies increases. However, the last time an estimate of the burden of congenital anomalies was done was in the year 2006. The Secretariat has created a birth defects technical working group to revise these estimates in the year 2023. Additionally, to improve surveillance of birth defects, a revised birth defects surveillance manual for programme managers and an accompanying new quick reference guide were released in the year 2020, both of which were translated into Spanish in the year 2022, and a digital application toolkit for birth defects surveillance will be released in the year 2023.

92. To make visible the status of child and adolescent health globally and catalyse action around improving children's health and well-being, a dashboard was created with UNICEF and Children in All Policies 2030. This dashboard compares country data on child health and well-being for a specified set of indicators, visually showing the current status of child and adolescent health across

[1] For further information, see the Violence Info webpage (https://apps.who.int/violence-info/, accessed 10 March 2023).

countries, both where progress is being made and where gaps remain, informing planning and policy-making for children's rights.[1]

93. The Global Action for Measurement of Adolescent health (GAMA) Advisory Group, established by WHO in the year 2018 and supported by seven other United Nations agencies, has systematically selected and published a draft set of priority indicators for adolescent health measurement. The indicators are now being assessed for feasibility in 12 countries, further harmonized across data collection tools and initiatives, and will be finalized over the course of the year 2023 (92).

94. Following the 2019 adolescent well-being call to action endorsed by United Nations agencies, civil society and youth-led organizations, and national governments, a global expert consultative group was established in the year 2022 to develop a measurement approach for adolescent well-being. The approach will be closely linked with the efforts of the GAMA Advisory Group, and draft indicators will be presented at the Global Forum for Adolescents in October 2023 (93).

95. At least 50 country profiles were developed in the year 2021 capturing the sexual and reproductive health of adolescents, entitled *Contraception within the context of adolescents' sexual and reproductive lives* using data from national household surveys and United Nations databases. The country profiles have been introduced and discussed in various national meetings and conferences and have been used to drive evidence-informed and rights-based commitments from countries for the FP2030 initiative, including recommendations on how to make bold and transformative commitments to improve adolescent and youth sexual and reproductive health (95).

96. Home-based records have a long history, initially used to record proof of smallpox vaccinations in the mid-1800s. Today, more than 163 countries use a form of home-based record, such as antenatal notes, vaccination-only cards, child health booklets or integrated maternal and child health handbooks. These documents are used to record an individual's history of health services received and can also provide basic health promotion messages. WHO recommends home-based records to contribute to improved care-seeking behaviours, men's involvement and support in the household, maternal and child home care practices, infant and child feeding, and communication between health workers and women and caregivers. Despite the wide use of home-based records, implementation challenges persist, such as stock outs, incorrect use of home-based records by health workers or low retention by women, parents and caregivers. To support countries to address these issues, WHO, UNICEF and the Japan International Cooperation Agency have developed an implementation guide targeted at programme managers within health ministries, as well as key implementation partners involved in making decisions and taking action to strengthen the implementation and use of home-based records for improved maternal, newborn and child health outcomes. The guide was released in English and in French in January 2023. The guide includes activities and decision-making tools, as well as many examples from countries and links to existing resources that can be used to strengthen planning, design, implementation and monitoring processes with the goal of maximizing the benefits of home-based records for women, parents, caregivers, health workers and programme managers (96).

97. *Analysis and use of health facility data: guidance for RMNCAH programme managers* (97), a module of the WHO toolkit for routine health information systems data (98), recommends a list of maternal, newborn, child and adolescent health indicators that can be reported through routine health

[1] See the Child health and well-being dashboard at: https://platform.who.int/data/maternal-newborn-child-adolescent-ageing/child-health-and-well-being-dashboard

information systems, including recommended metadata and suggested analyses for the data. The guidance was developed as a working document in the year 2019 and will be updated and officially published with accompanying capacity-building materials for analysis, interpretation and use of maternal, newborn, child and adolescent health data for decision-making.

98. The WHO global SRMNCAH policy survey will be updated in the year 2023. The survey, which was last completed by 150 Member States in the period 2018–2019, helps to monitor country progress in adopting or adapting WHO global recommendations into national laws, policies and guidelines related to SRMNCAH. A document detailing the methodology used to conduct the 2018–2019 survey is available online (99). Survey response data from 2018–2019 and a repository of national source documents are available through the WHO maternal, newborn, child and adolescent health and ageing data portal[1] and will be updated when the 2023 survey has been completed.

99. The Global Abortion Policies Database established in the year 2017 is a tool to expand knowledge related to abortion laws and policies, encourage transparency and promote accountability. The database is regularly updated as new information about country-specific law or policy reform becomes available, but a systematic update of all data contained in the database was undertaken in the year 2022, whereby additional source documents were added. A new interface with expanded search functions and other features will be launched in the year 2023.[2]

100. An online indicator toolkit is under development based on advice from the following WHO measurement advisory groups: Mother and Newborn Information for Tracking Outcomes and Results (MoNITOR); the Child Health Accountability Tracking technical advisory group (CHAT); Global Action for Measurement of Adolescent health (GAMA); the Technical Advisory Group for Measurement of Healthy Ageing (TAG4MHA); and the Life course Quality of Care Measurement (LCQM) technical working group. The purpose of this online indicator toolkit is to provide countries with a suite of priority indicators and their metadata to promote standardized measurement, monitoring, reporting and data use at different levels and by different stakeholders to monitor health outcomes for women, newborns, children, adolescents and older people. The first version, which includes maternal newborn and child health indicators, has been released.[3]

101. Amid the rapidly growing global demand for normative and implementation guidance around maternal, newborn, child and adolescent health quality of care measurement, since the year 2021 WHO has convened and serves as the secretariat for the Life course Quality of Care Measurement technical working group, established in the year 2021, to develop and promote the use of a harmonized methodology, framework, guidance and tools for quality of care measurement across the life course, and to support the roll-out and operationalization of these technical products at the country level. WHO has developed indicators and measures of quality of care in health facilities, namely in the areas of intrapartum care, care for SSNBs and paediatric care. Workstreams to develop core effective coverage measures and guidance on their operationalization at the country level have also just started. The long-term goal is to work with countries in a phased approach to produce periodic global maternal, newborn, child and adolescent health quality of care reports on the state of the quality of care in health facilities, starting with early adopters.

[1] See the Maternal, newborn, child and adolescent health and ageing data portal at https://platform.who.int/data/maternal-newborn-child-adolescent-ageing/global-strategy-data

[2] See the Global Abortion Policies Database at https://abortion-policies.srhr.org

[3] MoNITOR online indicator toolkit (https://monitor.srhr.org/, accessed 10 March 2023); and CHAT online indicator toolkit (https://chat.srhr.org/)

102. The Partnership for Maternal Newborn & Child Health (PMNCH) is an alliance, hosted by WHO, of more than 1300 member organizations in 192 countries. The PMNCH Accountability Working Group provides advice to strengthen coordinated accountability efforts for women's, children's and adolescents' health. To streamline global reporting on women's, children's and adolescents' health, PMNCH works with partners such as WHO, UNICEF and Countdown to 2030 and coordinated the production of the 2022 progress report entitled *Protect the promise* (19), which was launched at the World Health Summit 2022 in Berlin. The report is also used by the Every Woman Every Child Global Advocate for reporting to the United Nations Secretary-General. PMNCH is working with partners on the Accountability Portal to be launched in the year 2023. This online portal will bring together key accountability resources and will facilitate capacity-building and learning on women's, children's, and adolescents' health.

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