

PROTECT

the Promise



**2022 PROGRESS REPORT ON THE
EVERY WOMAN EVERY CHILD
GLOBAL STRATEGY FOR WOMEN'S,
CHILDREN'S AND ADOLESCENTS'
HEALTH (2016–2030)**



EVERY WOMAN
EVERY CHILD

Protect the promise: 2022 progress report on the Every Woman Every Child Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)

ISBN (WHO) 978-92-4-006010-4 (electronic version)

ISBN (WHO) 978-92-4-006011-1 (print version)

ISBN (UNICEF) 978-92-806-5377-9 (electronic version)

ISBN (UNICEF) 978-92-806-5378-6 (print version)

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Creative direction, layout and design: Future by Design Studio

Data visualization: Future by Design Studio; Fig 2.4 (via Flourish)

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EVERY WOMAN
EVERY CHILD

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Foreword



A more equitable world is one of the most important promises of the Sustainable Development Goals. Sadly, this report shows that with regard to the health and rights of women and children, that promise is not being kept. Far from a progress report, this document describes a reversal. Women's and children's health and rights are threatened to a degree not seen in more than a generation.

At the core of our unkept promise is the failure to address the gaping inequities at the root of global crises, from the COVID-19 pandemic to conflicts and the climate emergency. The report describes the impacts of these crises on women, children and adolescents, from maternal mortality to malnutrition and wasting.

If these inequities persist, we will not keep our promise for a healthier, safer and more just world for all by 2030. Nor will we be equipped to manage the next pandemic, prevent the next conflict, or adapt to the mounting loss and damage from climate-related disasters.

The recommendations in this report fall into four broad categories: increased investment in health, including primary healthcare systems; improvements to food supply; collaboration across sectors and partnerships with the private sector; and the protection and promotion of women's rights across the board. Taken together, these steps can address losses and build concrete progress for women, girls, and young people around the world.

I call on leaders to be resolute in implementing these solutions, honouring their commitments, and safeguarding the rights and wellbeing of every woman, child and young person.

A handwritten signature in black ink, which appears to be 'António Guterres'. The signature is written in a cursive style and is positioned above a long, thin horizontal line that tapers to a point on the right side.

António Guterres

Secretary-General
United Nations

Message from the Global Advocate for Every Woman Every Child



The outlook was bleak when we last presented a progress report on the United Nations Every Woman Every Child Global Strategy for Women's, Children and Adolescents' Health. In 2020, in the early days and months of the global COVID-19 pandemic, many massive and far-reaching consequences were predicted of shutdowns and containment measures that were then happening all around the world. In many ways women, children and adolescents fared worse than anticipated.

I write to you now as the United Nations Secretary-General's Global Advocate for Every Woman Every Child. I was appointed to this role in 2021 and have strived to use the position as a platform to restore women, children and adolescents to a priority place in the global health agenda.

Now, in 2022, we are calling on all to think and act to protect the promise. This promise refers not only to the commitments made in the Sustainable Development Goals (SDGs) and all of the campaigns that followed, but also to the larger promise of potential that everyone is born with. Too often this promise remains unclaimed, or even denied due to geography, economics, race, ethnicity, or gender.

While challenges persist and progress continues to be too slow to achieve the goals set out for 2030, there are reasons to be optimistic. The backsliding in outcomes shows that commitments, when delivered on, can be effective and life-changing. Conversely, in a void of will, attention and action, the results are devastating. This report should be seen as an urgent appeal to get on track to meet the ambitious but achievable goals.

This is our wakeup call. We can be certain that even as barriers continue to grow, healthier and empowered women, children and adolescents are the key to achieving a better world. But we cannot move in the right direction – toward a world where the most vulnerable are prioritized and reached – without concerted and collaborative efforts.

It is not an option to give up on the vision of a world in which all have the opportunity to reach their fullest potential. This is a promise we must all unite to protect fiercely and without compromise.

H.E. Kersti Kaljulaid

United Nations Secretary-General's Global
Advocate for Every Woman Every Child
President of Estonia (2016–2021)

Acknowledgements

This report was developed in support of the Every Woman Every Child Global Strategy for Women's, Children's and Adolescents' Health (2016 –2030). Contributing organizations include the United Nations Children's Fund (UNICEF), World Health Organization (WHO), United Nations Population Fund (UNFPA), Partnership for Maternal, Newborn & Child Health (PMNCH) and Countdown to 2030 for Women's, Children's & Adolescents' Health.

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Abbreviations

2030 Agenda	2030 Agenda for Sustainable Development
FAO	Food and Agriculture Organization of the United Nations
Global Strategy	Global Strategy for Women’s, Children’s and Adolescents’ Health
HPV	human papillomavirus
IFAD	International Fund for Agricultural Development
LIC	low-income country
LMIC	low- and middle-income country
MMR	maternal mortality ratio
MNCAH	maternal, newborn, child and adolescent health
ODA	official development assistance
SDG	Sustainable Development Goal
SRMNCAH	sexual, reproductive, maternal, newborn, child and adolescent health
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
WASH	water, sanitation and hygiene
WFP	World Food Programme
WHO	World Health Organization

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Introduction

The year 2015 saw the launch of the 2030 Agenda for Sustainable Development (1), followed shortly thereafter by the 2016–2030 Global Strategy for Women’s, Children’s and Adolescents’ Health (Global Strategy) (2), which was developed to translate the Agenda into concrete guidance on how to accelerate progress through a multisectoral approach¹. These launches came near the end of a period of dramatic improvements in most countries in maternal and child survival, and optimism was high about the future health and well-being of the world’s women, children and adolescents.

But nearly halfway through the 2030 Agenda, the outlook in 2022 is less promising despite the unprecedented gains and lives saved over the past decade or more. For nearly three years, the COVID-19 pandemic has damaged the world in numerous ways, including by destabilizing access to and availability of health services, and recovery has been slow, intermittent and uneven. Yet the pandemic is not solely to blame for the world falling behind in achieving key global targets because progress had already been too slow or had halted before its onset. For example:

- The global share of pregnant women living with HIV who had access to antiretroviral treatment (ART), a vital intervention that can keep them healthy while also preventing their infants and young children from contracting the virus, surged from 46% in 2010 to 81% in 2015, but six years later in 2021 it was the same at 81% (3).
- Although the global maternal mortality ratio (MMR) declined by 38% from 2000 to 2017, that translated into an average annual rate of reduction of just 2.9% – less than half the 6.4% annual reduction rate needed to achieve the global Sustainable Development Goal (SDG) target of 70 maternal deaths per 100 000 live births (4).
- Global coverage of immunization services has stalled for many years, leaving millions of children unprotected. For example, coverage for the third dose of diphtheria-tetanus-pertussis (DTP) stagnated for a decade before declining from 86% to 81% during the first two years of the pandemic (5).
- After several years of slow adoption and scale-up, global coverage of the first dose of vaccination against human papillomavirus (HPV) also declined by five percentage points, from 20% in 2019 to 15% in 2021, leaving millions of adolescent girls at risk of cervical cancer later in life (6).

1 The Global Strategy for Women’s, Children’s, and Adolescents’ Health includes a monitoring framework with 60 indicators to help countries and their partners promote accountability in ending preventable deaths (survive), ensuring health and well-being (thrive), and expanding enabling environments, so that all women, children, and adolescents can reach their potential (transform).

A variety of factors are behind such disappointing trends and results, including that significant progress toward any target often cannot be sustained close to attainment because the remaining gaps typically comprise the hardest-to-reach individuals. In general, though, the results point to underlying concerns about political commitment to achieving the SDGs, including those so crucial to women's, children's and adolescents' health such as SDG 1 ("no poverty"), 2 ("zero hunger"), 3 ("good health and well-being") and 5 ("gender equality").

The impact of the "three C's": COVID-19 pandemic, conflict and climate change

Hope for an upswing in political commitment to and accelerated progress for women's, children's and adolescents' health has been further eroded since the COVID-19 pandemic began shaking the world in 2020. Today, the "three C's" – COVID-19, conflict and climate change – represent distinct yet overlapping challenges to the health and well-being of women, children and adolescents.

The pandemic itself and early responses aimed at controlling it resulted in disruptions in health, education, social protection and economic systems, all of which have had especially negative impacts on women's, children's and adolescents' lives (7-10). People who were already poor and marginalized – categories in which women and children are disproportionately represented – have fared the worst in most societies during the pandemic (11-13). These trends that greatly harm women and children seem certain to continue while COVID-19 persists as a serious public health problem even as many wealthier countries, which have been able to vaccinate more of their residents, have tried to put the pandemic behind them.

People who were already **poor and marginalized** – categories in which women and children are disproportionately represented – have fared the worst in most societies during the pandemic.



The World Bank's recently established Financial Intermediary Fund (FIF) for Pandemic Prevention, Preparedness and Response (14) and proposals developed by the World Health Organization (WHO) and partners to strengthen the architecture for health emergency preparedness, response and resilience (HEPR) (15) are promising signs that the global community is uniting to act in response to the lessons learned from the COVID-19 crisis. These developments suggest a growing recognition that if the world fails to come together, the same or even more devastating impacts will occur in future pandemics and ongoing efforts to confront other existing epidemics such as HIV and malaria will be less successful.


Rebounding from setbacks to women's, children's and adolescents' health and well-being caused by COVID-19 is being constrained by the growing number of humanitarian crises resulting from conflict and climate change. Millions of children and their families are experiencing poor physical and mental health from recent humanitarian disasters in Afghanistan, Ethiopia, Somalia and Yemen, to name just a few places. By the end of

2021, a record 89.3 million people worldwide – 8% more than the previous year – had been driven from their homes by war, violence, persecution and human rights abuses (16,17).

The number of displaced people had surged even higher by mid-2022 due to other ongoing crises in places such as Myanmar and the Russian invasion of Ukraine, which has also worsened an emerging food insecurity emergency affecting many countries. The World Food Programme (WFP) has estimated that if the war in Ukraine continues and supplies of food products from Russian Federation and Ukraine are constrained, the number of people around the world facing acute hunger could rise by 47 million people this year, adding to the 276 million people already estimated to be in that category at the beginning of 2022 (18,19). Wherever they live, children are the most vulnerable to food crises, with malnutrition putting them at high risk of death, poor physical growth and potential cognitive impairments with long-term implications.

Reigniting optimism might seem impossible at a time of so much destruction, human misery and uncertainty. But history shows that countries do rebound from wars, pestilence and environmental destruction. Through collective action, health and social protection systems can be strengthened and the underlying determinants of women’s, children’s and adolescents’ health can be addressed, creating a more just, resilient and secure world.

This global progress report attempts to lay the groundwork for the kind of accelerated action needed. Section 1 presents key data, trends and developments in women’s, children’s and adolescents’ health and well-being. That is followed in Section 2 by a deeper dive into the impact of the COVID-19 pandemic, which has created and contributed to many threats and challenges to progress for women, children and adolescents. In Section 3, the report concludes with recommendations for accelerating progress towards the achievement of the 2030 Agenda even in such challenging times, with an emphasis on partnership and clear-eyed recognition of the consequences of failing to do better. In this report, childhood is defined as encompassing ages 0–9 years, and adolescence covers ages 10–19 years.

Wherever they live,  children are the most vulnerable to food crises, with malnutrition putting them at high risk of death, poor physical growth and potential cognitive impairments with long-term implications.



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Section 1

**The state of women's,
children's and adolescents'
health and well-being**

1.1. The 2030 Agenda in the current and evolving global context

The 2030 Agenda sets out an ambitious road map for human development, recognizing that success depends on remedying entrenched patterns of inequality and poverty and that early life experiences influence later outcomes with potential intergenerational effects. The SDGs extend well beyond survival, and include targets for nutrition, child development and education. They also encompass health determinants such as economic and environmental goals and an emphasis on multisectoral and partnership-based approaches to achieving progress. Threaded throughout the SDGs is the principle of equity, including in regard to gender equality and women's empowerment.

The 2030 Agenda was introduced in 2015 as major epidemiological and demographic transitions were underway at different paces around the world. Although communicable and infectious diseases continue to be leading causes of death in children under the age of 5, noncommunicable diseases and injuries are making a larger relative contribution to child morbidity and mortality (20,21). Child mortality is increasingly concentrated in the newborn period, specifically in the first seven days of life when the risk of death is highest (21). This trend is important because early newborn deaths and stillbirths are closely associated with the health of the mother and to her access to quality antenatal and childbirth services. Countries with high maternal mortality tend to have high neonatal mortality and lower coverage levels of maternal health care (22-24).

The United Nations Children's Fund (UNICEF) and WHO have responded to growing evidence that a woman's health before conception and during pregnancy lays the foundation for child health, and that early life exposures and experiences can have both immediate and longer-term developmental effects, by structuring their health programmes to support a continuum of services starting with antenatal care and extending throughout the first 19 years of life (25-27). Both organizations helped develop the adapted nurturing care framework shown in **Figure 1.1**, which covers the period from preconception through adolescence and is consistent with the holistic SDGs framework that extends throughout the life course (28,29). It shows that children and adolescents are likely to flourish when they grow up in stable and clean environments that provide them with opportunities to learn, access to quality health services and adequate nutrition and protection from threats, and where they are surrounded with supportive and enriching relationships (28).

With all these shifts and developments – and in this third year of the COVID-19 pandemic and recent rising levels of food and economic insecurity – it is important to take stock of how the world is doing in fulfilling the promise of the SDGs and the lofty

In 2020,
5 million
children died
before they
reached their fifth
birthday.



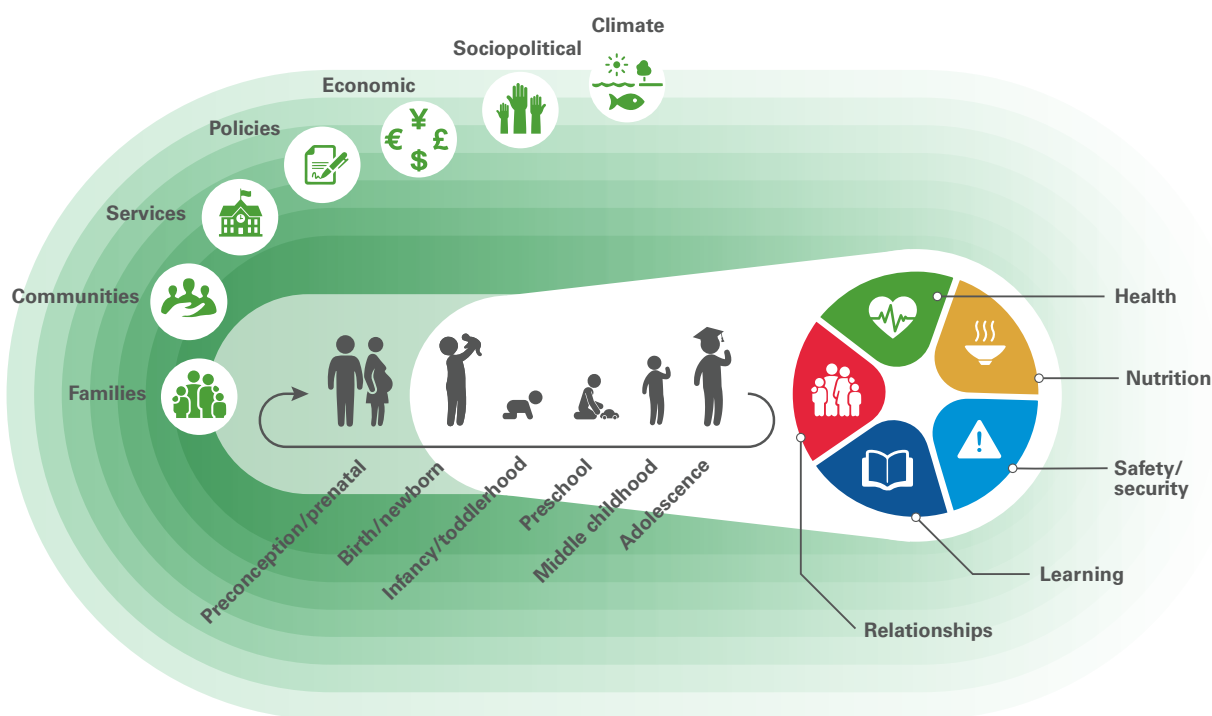
aspirations of the Global Strategy. Although great strides have been achieved in the reduction of child mortality in the past few decades, as illustrated in **Figure 1.2**, around 5 million children died before they reached their fifth birthday in 2020. Almost half of those deaths occurred among newborns in the first month of life, and a large proportion were preventable (21). Nearly 1 million adolescents died in 2020, most from injuries, violence, self-harm, infectious causes and maternal conditions (21). According to the most recent official global data, approximately 295 000 women died from complications of pregnancy and childbirth in 2017 (4) and nearly 2 million babies are stillborn every year (22). These estimates are a stark reminder of the major threats to their survival that too many women, children and adolescents continue to face.

1.2 Inequalities in progress and prospects for children

Global figures mask huge inequalities in progress and vulnerability. Most maternal, child and adolescent deaths and stillbirths are concentrated in low- and middle-income countries (LMICs) and in two regions, sub-Saharan Africa and South Asia. Of the 54 countries that are off track for achieving the SDG target for under-5 mortality (SDG 3.2.1), which is 25 or fewer deaths per 1000 live births, 40 (nearly 75%) are in sub-Saharan Africa (21).

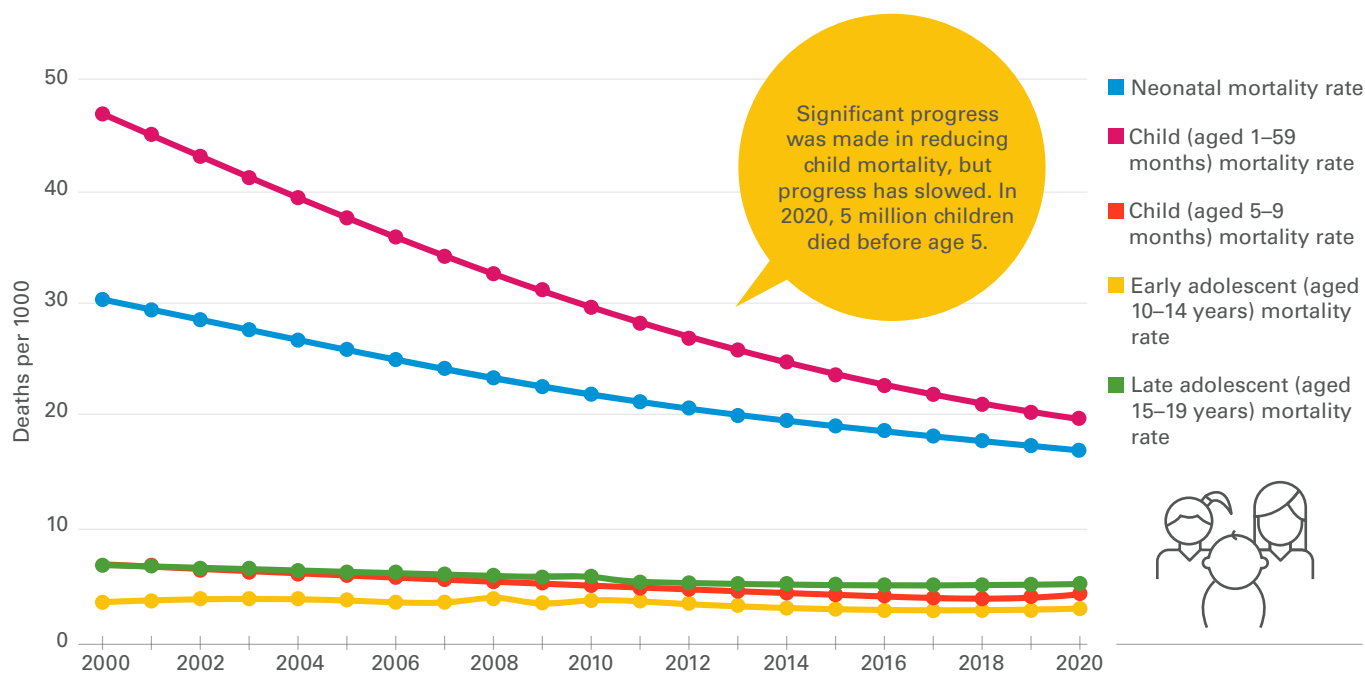
Pneumonia, diarrhoea and malaria – all diseases that are largely preventable and treatable with low-cost interventions – comprise a large share of child deaths occurring in those

Fig. 1.1. Nurturing care framework, from preconception to adolescence



Source: Black MM (28); Black RI (29).

Fig. 1.2. Global neonatal, child and adolescent mortality rates, 2000–2020



Definitions:

Neonatal mortality rate: probability of dying between birth and exact age 28 days (expressed per 1000 live births)

1-59 months mortality rate: probability of dying between age 28 days and exact age 5 years (expressed per 1000 children aged 28 days)

5-9 years mortality rate: probability of dying between age 5 years and age 10 years (expressed per 1000 children aged 5 years)

10-14 years mortality rate: probability of dying between age 10 years and age 15 years (expressed per 1000 children aged 10 years)

15-19 years mortality rate: probability of dying between age 15 years and age 20 years (expressed per 1000 children aged 15 years)

Source: UN IGME (21).

countries (30). Similarly, 34 of the 36 countries with extremely high, very high and high maternal mortality are in sub-Saharan Africa, as indicated in **Figure 1.3**. A woman’s lifetime risk of a maternal death is 1 in 37 in sub-Saharan Africa compared with 1 in 4800 in Europe and North America (4).

Maternal and child deaths are likely to be further concentrated in just one region in the next generation. Demographic trends show that although most of the world’s children and adolescents live in Africa and Asia, Africa is the only region where the child and adolescent population is projected to increase throughout the SDGs period and beyond (21,31,32).

This estimated increase in Africa’s child population has serious implications for countries in the region already facing resource challenges to provide every pregnant woman with essential maternal care and every child with needed health, nutrition, education, water and sanitation, and social protection services.

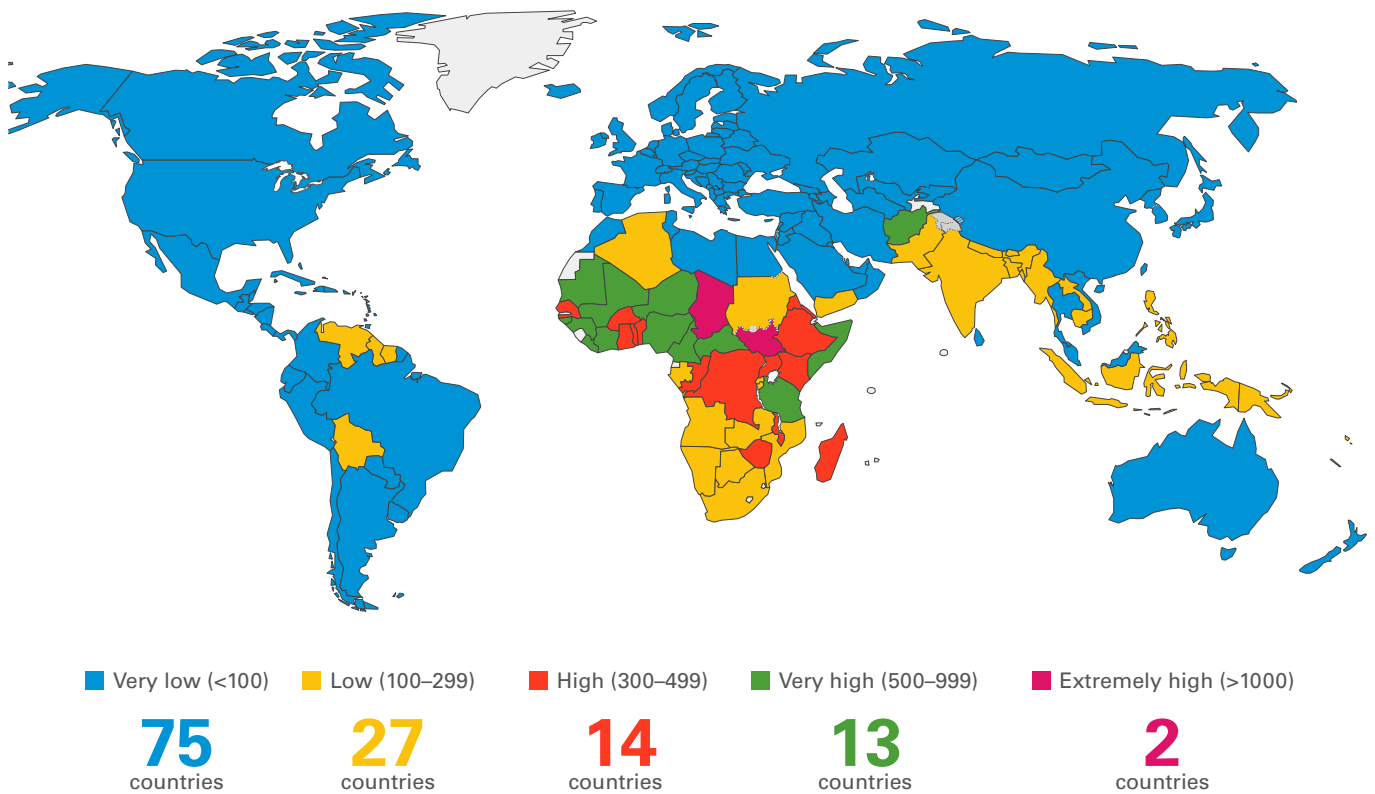
Regional inequalities in mortality levels are consistent with patterns in other key development indicators. Children are not all

Woman’s risk of maternal mortality

1 in 37
Sub-Saharan Africa

1 in 4800
Europe and North America

Fig. 1.3. Maternal mortality ratio, 2017 estimates



Notes: The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on this map represent approximate border lines for which there may not yet be full agreement.

Source: WHO (4).

born with equal opportunities, and early life disadvantages have a cumulative effect on a child's life prospects. Life expectancy at birth globally in 2021 was estimated at 71 years (32). However, a child born in Europe and Northern America in 2021 could expect to live, on average, 77.2 years compared with 59.7 years for a child born in sub-Saharan Africa (32,33). Country income status is also a key driver of how long a child born today can expect to live. Children born in high-income countries can expect, on average, to live 80.3 years compared with an average life expectancy of just 62.5 years for children born in low-income countries (33).

Children and adolescents' likelihood of growing up in poverty and their access to education and training opportunities are strongly influenced by where they live. Trends leading up to the pandemic, for example, show an increasing concentration of extreme poverty in sub-Saharan Africa and much slower progress in the region compared with all others in lifting families out of impoverishment (34). Meanwhile, recent estimates show that only 64% of children in sub-Saharan Africa completed primary school and 27.1% completed upper secondary education in 2021 compared with 99.8% and 89.6% of children, respectively, in

Europe and North America². School completion rates also vastly differ across country income categories. In 2021, approximately 99.8% of children living in high-income countries completed primary school and 90.2% completed upper secondary school; the comparable completion rates in low-income countries were 57.2% and 18.2% of children, respectively (35).

Children’s nutritional status varies substantially by country income grouping and region. Childhood stunting is the condition of being too short for one’s age according to international standards, which is correlated with a combination of poor nutrition and insufficient dietary diversity, limited access to safe drinking water and basic sanitation services, lack of access to health care, and inadequate child care. Latest estimates show that stunting prevalence levels are over 30 percentage points higher in low-income countries compared with high-income countries (34.6% vs. 3.4%). Similarly, nearly three quarters of all children affected by wasting – the condition of being too thin for one’s height, resulting from poor child care, insufficient nutrient intake and/or disease – live in lower-middle-income countries compared with only 1% in high-income ones (36).

Most children affected by malnutrition, a category that includes stunting, wasting or overweight, live in Africa and Asia. In 2020, 53% of all children affected by stunting, 70% of all children affected by wasting and 48% of all children who were overweight lived in Asia. The percentages were lower for children living in Africa compared with Asia for these three forms of malnutrition: 41% of all children worldwide affected by stunting, 27% affected by wasting and 27% experiencing overweight. However, Africa is the only region where the numbers of children affected by stunting increased over the past 20 years, from 54.4 million in 2000 to 61.4 million in 2020 (36).

2 The estimates cited in this report are modeled time series estimates. Note: Primary school completion rate is defined as the total number of children who are 3 to 5 years older than the intended age for the last grade of primary education who completed primary education, expressed as a percentage of the total number of children who are 3 to 5 years older than the intended age for the last grade of primary education. Upper secondary education completion rate is defined as the total number of children who are 3 to 5 years older than the intended age for the last grade of upper secondary education who completed upper secondary education, expressed as a percentage of the total number of children who are 3 to 5 years older than the intended age for the last grade of upper secondary education. Upper secondary education programmes are typically designed to complete secondary education in preparation for tertiary education (university level) or provide skills relevant to employment or both. The age range for upper secondary school is about 15 to 17 years old.



Stunting prevalence levels

34.6%
low-income countries

3.4%
high-income countries

Inequalities in early childhood development are also 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 toward SDG 4.2.1) across those 95 countries is over 20 percentage points higher in low-income countries compared with upper-middle-income ones (38.7% versus 18%) (37).

These and other gaps are reflected in this report's annex, which presents the distribution of values for each of the 16 Global Strategy indicators for survive, thrive and transform by country income groupings. The data show a clear social gradient for all 16 indicators, with women and children living in high-income countries consistently faring better on them than those living in poorer countries.

In addition to income status, a country's stability shapes women's and children's lives. Children who have the misfortune of living in countries affected by conflict or who have been displaced by conflict are at much greater risk of dying, experiencing malnutrition and missing out on the services they need to flourish compared with children residing in stable contexts (38) (see **Panel 1 on Afghanistan**). Women and children who are forced to cross borders or who are internally displaced because of conflict, other forms of instability or natural disasters increasingly related to climate change are also at high risk of poor health and developmental outcomes (see **Panel 2 on migration**).

Inequalities that negatively impact women's, children's and adolescents' health are not only pervasive across regions and countries, but within countries as well and go beyond household wealth. Ethnic and racial minorities and those living in remote, rural settings or in urban slums are among the marginalized population groups falling the furthest behind and with the least access to maternal, newborn, child and adolescent health (MNCAH) services (39-42). The factors contributing to inequalities among population groups are complex and context specific, including a mixture of deeply rooted experiences of discrimination, government and political decisions and policies, differences in economic livelihoods, and variances in cultural practices and beliefs.

The remaining sub-sections in Section 1 take a closer look at key driving factors of widespread inequalities and insufficient progress towards the Global Strategy and 2030 Agenda goals and targets. Section 1.3 starts with a focus on primary health care and the ability of health systems to deliver basic essential services to women, children and adolescents. This analysis is followed in Section 1.4 by an exploration of the importance of women's empowerment for improving maternal and child survival, access to health and social protection services, and child development and adolescent participation in addition to helping

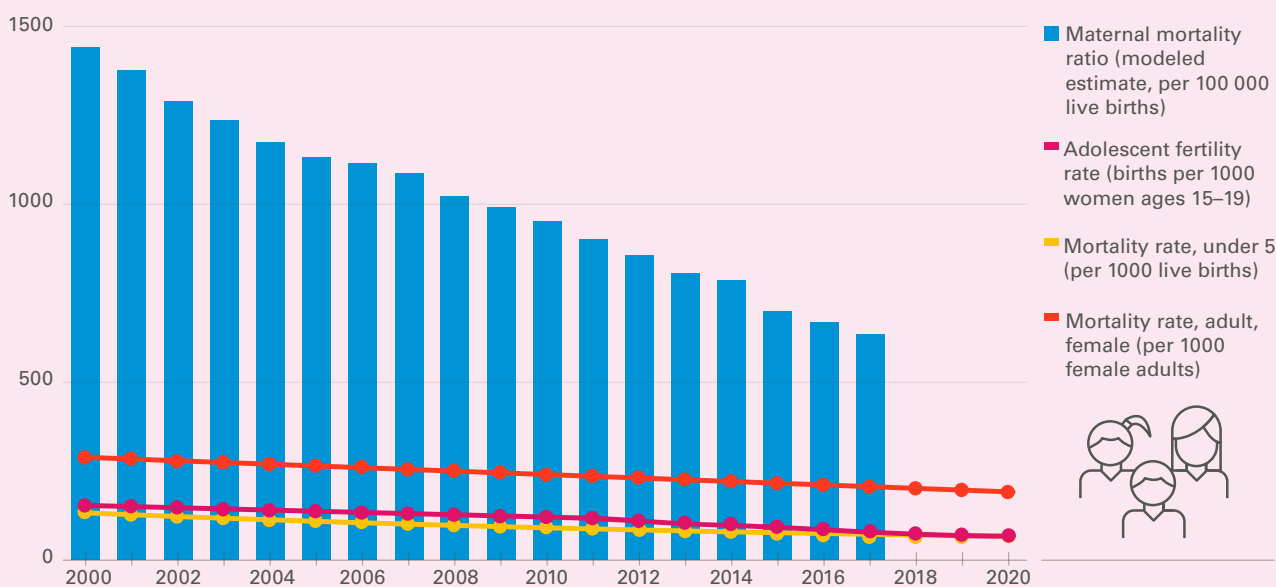
end intergenerational cycles of poverty and gender inequality. Finally, Section 1.5 shines a spotlight on nutrition, a central issue for the Global Strategy because nearly half of all child deaths are attributable to undernutrition (43,44) and strong evidence of the importance of good nutrition for maternal health. At the halfway point of the 2030 Agenda timeframe, rising levels of food insecurity and projected harmful impacts of climate change on food productivity are trends that cannot be ignored.

Panel 1. The "freefall" of women's and children's health and survival in Afghanistan

Despite persistent high levels of poverty and ongoing conflict and instability, Afghanistan saw remarkable gains in health, development and access to essential services over the two decades prior to the Taliban taking power again in 2021. For example, as illustrated in **Figure 1.4**, from 2000 to 2017 the maternal mortality ratio (MMR) dropped almost 60%, from 1450 to 638 deaths per 100 000 live births (4). Over the period 2000–2020, under-5 child mortality declined by more than 50% (from 129 to 58 deaths per 1000 live births), (21) adolescent fertility rates dropped 63% (from 154 to 58 births per 1000 girls aged 15–19 years) (45), and adult female mortality declined by 36% (46).

Key health system factors underlying Afghanistan's progress included improvements in coverage of antenatal care and skilled birth attendance (which nearly doubled from 30% to 60% coverage from 2003 to 2018) through effective implementation of the basic package of health services, essential package of hospital services and community midwifery programmes (48,49). Investments in other development areas, such as nutrition, communications and transport systems, also were beneficial to improved health system responses for women and children (48,50).

Fig. 1.4. Maternal and adolescent health in Afghanistan between 2000 and 2020



Sources: WHO (4), UN IGME (21), UN (45), World Bank (47).

Other drivers of Afghanistan's success since 2001 included improvements in girls' and women's education and political participation. The number of girls in primary school increased from a few hundred to 2.5 million from 2001 to 2018 (48,50), and lower secondary completion rates for girls increased from 8.9% to 43.1% over 2005–2019 (51). Female youth literacy increased from 22% to 42% from 2000 to 2021 (52), and by 2005, about 30% of national parliament seats were held by women, a share that stayed about the same through 2021 and is higher than the world average in 2021 of 26% (53).

Substantial commitment and financial support from the international community, which totalled over US\$ 80 billion over the past two decades (54), was essential for these successes. However, the withdrawal of United States of America troops and the subsequent political upheaval in August 2021 resulted in the country falling into a period of uncertainty (55). Reduced international support and development funding, crippling international sanctions, unprepared new authorities, mass exodus of skilled professionals and the resultant so-called brain drain, recurrent natural disasters, and severe restrictions on girls and women have combined to create an ongoing humanitarian crisis in the country (56).

Today, almost one year after the regime change, the plight of Afghan women and children seems bleak, as illustrated by the following data and estimates:

- Over 24.4 million Afghans need humanitarian assistance, of whom 18.1 million require immediate health care (57). Those needing life-saving care include 3.2 million children aged under 5 years and some 350 000 pregnant women (57).
- Maternal mortality is on the rise, and according to one estimate, the MMR might increase by 50% (from 638 to 963 deaths per 100 000 live births) by 2025 in the absence of serious and comprehensive intervention (58). That increase would translate into a woman dying from childbirth or pregnancy complications every two hours in Afghanistan.
- Many pregnant women remain vulnerable because of relatively low access to antenatal and postnatal care (59) and skilled birth attendance. It is estimated that 20% of deliveries and newborns require lifesaving emergency interventions, yet these are not readily accessible to most women due to restricted mobility, limited capacity of providers and weak referral systems (60).
- Unmet sexual and reproductive health needs have spiralled for women and girls since August 2021 (59). The United Nations Population Fund (UNFPA) estimates that unmet need for family planning could increase to almost 40% and about 4.8 million unintended pregnancies could occur by 2025 (58).

A recent Integrated Food Security Phase Classification analysis estimated that between March and May 2022, about 47% of the population (19.7 million people) was in crisis or experiencing emergency food insecurity (61). The health and nutrition of women and children are undoubtedly further compromised by these pervasive food shortages. Additionally, Afghanistan continues to grapple with multiple disease outbreaks, including COVID-19, measles, acute watery diarrhoea, leishmaniasis, malaria and scabies, which further stress an already strained and broken health system (60).

Afghanistan experienced chronic shortages in health care professionals even prior to the 2021 regime change, with a total of 4.6 medical doctors, nurses, and midwives per 10 000 population (1.2 doctors, 2.1 nurses and 1.3 midwives) (62).

Those 2021 figures are well below the 2.5 medical doctors and 4.5 nursing and midwifery personnel per 10 000 population recommended by WHO, and the situation has only worsened in the past year (63). Humanitarian groups warn of significant shortages of health care workers and health care services in 31 of 34 provinces.

In August 2021, secondary education (above grade 6) for girls in Afghanistan was discontinued, a step that made Afghanistan the only country in the world to prohibit girls from completing their education (64). These restrictions have effectively deprived girls and women of their basic rights and curtailed their life opportunities. Although female teachers, nurses, doctors and civil servants have been allowed to continue working under restricted protocols, cutting education access for girls and young women severs the pipeline of educated women to fill these roles in the future (65). Moreover, gender segregation and shortages of female teachers and health service providers have reduced access to and quality of maternal and child health services and available education for girls (66).

The impact of restrictions on girls and women extends to other facets of life, such as social engagement and employment (67). Many women have lost jobs since August 2021 due to the restrictions on mobility and conditions on public participation. Job losses have been observed across most sectors, with women in particular professions (e.g., media and civil society) reporting additional challenges due to the often-public nature of their work. The combination of restrictions – including women’s right to work, gender segregation in the workplace, clothing regulations, mahram requirements (male accompaniment during travels), and safety and security concerns regarding travelling to and from work – have resulted in most women choosing not to work or to work from home (68). This climate of fear, uncertainty and mobility restrictions inevitably impacts women’s mental health and their ability to work, pursue education, seek vital health services and participate in public and political life (68).

Given the difficult and complex obstacles that women, children and adolescents face in Afghanistan, improving their ability to survive and thrive requires interventions in a range of areas and by key actors nationally and internationally. Recommended actions and focus areas include the following:

- The international sanctions on Afghanistan should be eased for the country’s economy to revert to a sense of normalcy. Restrictions on trade and limited cash liquidity are contributing to catastrophic levels of household poverty, which is the root cause of many health and nutrition challenges affecting families in the country. The Government of the United States of America and allies should prioritize finding a solution
- Immediate reinstatement of health and development funding from Afghanistan’s long-term donors is essential. A full year after the 2021 regime change, the country continues to be in crises mode and the newer government has not managed to secure development funding or establish strong public institutions. Without the international community’s support, Afghanistan’s systems and development achievements could easily crumble within a matter of years. The World Bank and partners have recently committed US\$ 793 million for food, health and livelihoods through the Afghanistan Reconstruction Trust Fund (ARTF), a welcome step in this direction (69).
- Afghanistan’s basic package of health services and essential package of hospital services must continue to be the minimum official standard, and should be revised in light of the changing epidemiology and population migration. The World Bank, European Union and the United States Agency for International Development (USAID) have played prominent roles in funding and scaling these packages country-wide in Afghanistan

since 2001. These actors should now explore innovative financing and contracting mechanisms with nongovernmental organizations to protect health services at all costs.

- The humanitarian needs for food, clean water and sanitation, health and education are monumental. Humanitarian players on the ground such as WFP and UNICEF require immediate and generous funding to continue protecting the lives and welfare of women, children and families in Afghanistan.
- The health and well-being of Afghan girls and women lies in the hands of Afghanistan's new government, and its officials must think responsibly and holistically about how to protect and support this critical mass of Afghan society. In particular, the government should recognize that educating girls and permitting women to have an equal standing in society advances economic growth, improves public health, reduces conflict and enhances environmental sustainability. The status of girls and women in Afghan societies today is dismal. Despite challenges, the international community should continue advocating for and promoting gender-sensitive programming in all efforts.

Panel 2. **The growing urgency to support displaced, refugee and migrant women and children**

Migration is a complex issue with both positive and negative implications for women and children. It can open new life possibilities or it can be destabilizing and traumatic, leaving women and children poorer, more isolated and insecure, and less healthy physically and mentally than before they moved. Situations such as conflict or humanitarian disasters can force people and families to move, with many ending up as refugees living in settlements or camps for indefinite periods.

In recent years, millions of people have been internally displaced or have fled across borders to escape armed conflict in the Democratic Republic of the Congo, the Syrian Arab Republic, Ukraine and Yemen, among several other countries, with millions of others being displaced by droughts, floods, wildfires, land degradation and severe storms that are increasing in intensity due to climate change. These crises can compound and exacerbate problems such as economic stress and food insecurity that in turn prompt more migration, creating a vicious circle. In places such as Afghanistan, all three of these existential challenges (conflict, climate change and severe economic stress) have converged at once, as discussed in Panel 1 of this report.

Recent data show that the overall situation is getting worse. At the end of 2021, an estimated 89.3 million people worldwide had been forcibly displaced as a result of conflict, fear of persecution, violence and human rights violations (70). That was more than double the number a decade ago in 2012 (42.7 million) and the most since the Second World War (70,71). With some 6 million or more Ukrainians having fled their homes since the beginning of 2022 and major displacements in places such as Burkina Faso and Myanmar, the total global forced displacement was assumed to exceed 100 million by the middle of the year (72).

Children and women are often disproportionately affected by forced migration. One reason is pure numbers: Children make up over half of the world's refugees (73) and accounted for about 41% of the 89.3 million forcibly displaced people at the end of 2021 (70), both of which are substantially higher percentages than their 30% share of the world's population. The number of displaced children almost certainly has increased in

2022 because the vast majority of those fleeing their homes in Ukraine are women and children, as most men below the age of 60 are not permitted to leave the country (74). Women and children are heavily represented in refugee settlements; in the Za'atari refugee camp in Jordan, for example, home to 80 000 people who fled the Syrian Arab Republic, more than half the refugees are children and 30% are female-headed households (75).

Children and adolescents experiencing displacement face numerous risks to their health and well-being, especially if their families are destitute and living in overcrowded conditions. Threats range from malnutrition to diarrhoeal illnesses due to poor sanitation to sexual and other forms of violence to post-traumatic stress symptoms (71). Preventing and treating these and other conditions can be difficult due to lack of access to health services, including for mental health. Children's and adolescents' education is often disrupted or ended altogether by displacement and long periods living in refugee settlements, with girls and young women particularly likely to miss out on or drop out of school (71). Women's ability to work, travel or seek support for themselves and their families is often constrained by restrictive policies and fears of violence or detainment by authorities.

The COVID-19 pandemic complicated the plight of migrants and refugees in several ways. Country measures to limit internal mobility and to tighten borders to fight the virus's spread left many migrants and refugees stranded, often in precarious situations. Cramped conditions in many refugee settlement camps also increased the risk of rampant spread of the virus that causes COVID-19. (See Section 2 for a more detailed discussion of COVID-19's impacts.)

Improving the life conditions and prospects of migrant and refugee women and children is important for achieving progress towards the 2030 Agenda. One approach relevant for all stakeholders is to strengthen commitment to the twin global compacts on migration and refugees adopted by the United Nations General Assembly in 2018 (73,76). At the core of the Global Compact on Safe, Orderly and Regular Migration are 23 objectives for better managing migration at local, national, regional and global levels. Its child-sensitive overlay includes this pledge: "We further commit to uphold the best interests of the child at all times, as a primary consideration in situations where children are concerned, and to apply a gender-responsive approach in addressing vulnerabilities, including in responses to mixed movements." In practice, among other things, this means that signatories commit to provide migrant children with access to education, to include them in child protection schemes, to enable family reunification, and to prevent child labour and exploitation.

The Global Compact on Refugees commits signatories to "adopt and implement policies and programmes to empower women and girls in refugee and host communities, and to promote full enjoyment of their human rights, as well as equality of access to services and opportunities." This commitment includes a vow to "contribute resources and expertise towards policies and programmes that take into account the specific vulnerabilities and protection needs of girls and boys, children with disabilities, adolescents, unaccompanied and separated children, survivors of sexual and gender-based violence, sexual exploitation and abuse, and harmful practices, and other children at risk."

Another action beyond strengthening commitment to these compacts is to invest in data systems on migrants and refugees to inform analysis and decision-making. More information is needed on how, why, and where children migrate and who they are. Gathering data on migrants and refugees that can be disaggregated by age and sex would also help with planning services for women and children. Providers and funders of services for internally displaced persons, refugees and other migrants also should build on and expand digital-based innovations, including those introduced during COVID-19, to reach and support women and children on the move (77).

1.3 Reaching women, children and adolescents through primary health care

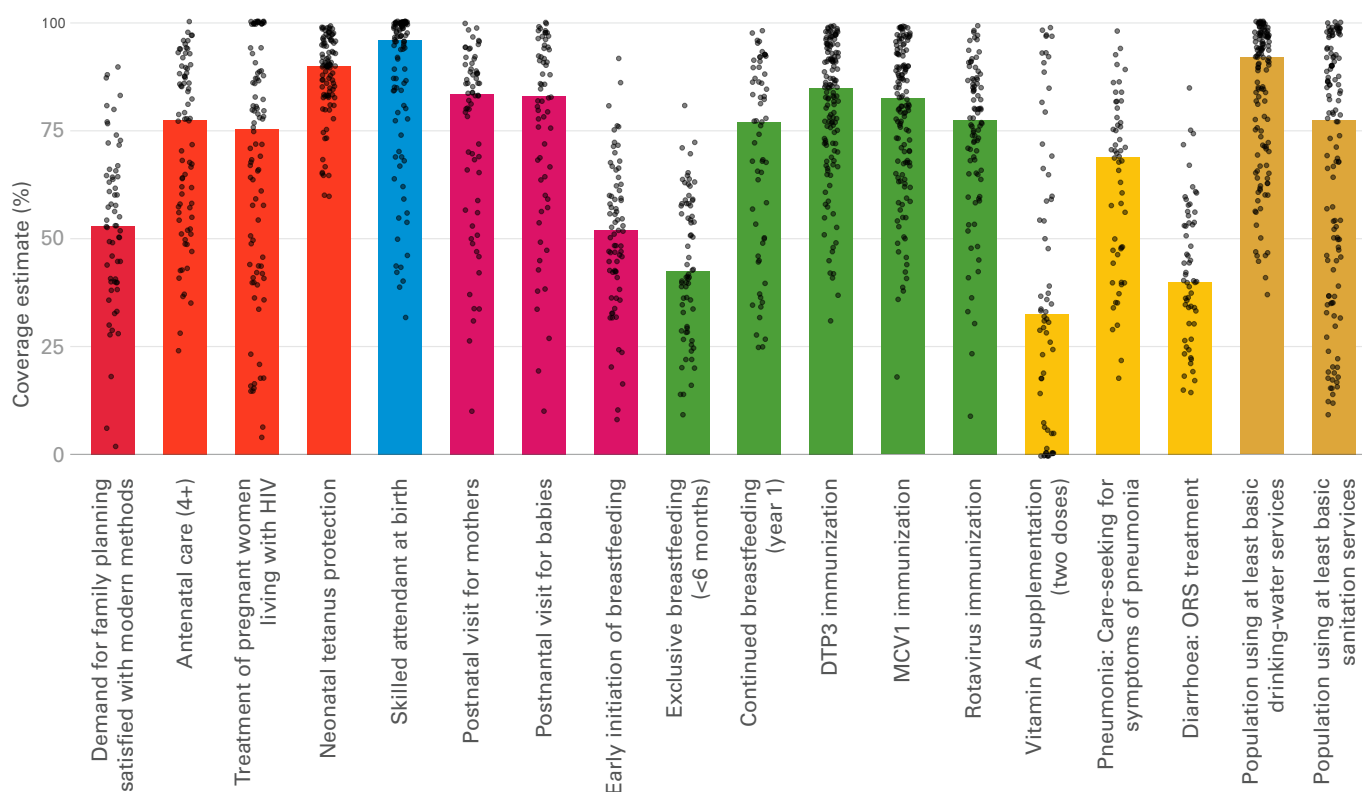
Forty years after the 1978 Alma-Ata Declaration, some 2000 delegates from more than 120 countries convened in Astana, Kazakhstan at a similar global meeting to develop a new declaration and renew their political commitment to primary health care (78,79). The 2018 Astana Declaration promotes the primary health care model, which is consistent with the nurturing care framework (Figure 1.1) and encompasses three broad pillars: empowered people and communities, multisectoral policy and action, and health systems that can deliver primary health care services throughout the life course (80).

By further raising the profile of this important model, the renewed commitment was seen as a way to encourage greater and more consistent efforts to overcome gaps in reaching all women and children at all stages of their lives. A recent targeted literature review of how well health and social systems are meeting the needs of children in LMICs found that the quality of services for children are, on average, substandard (81). The review also found that health systems in most LMICs have serious structural deficits such as insufficient health facilities and supply chain bottlenecks, non-functioning referral systems, lack of a trained and well-supervised workforce able to provide high quality and respectful care to women and children, and poor service offerings for adolescents (81). The global shortage of midwives, estimated at approximately 900 000, is particularly concerning for maternal and newborn health (82). As detailed in **Figure 1.5** and **Table 1.1**, examination of average coverage levels of a basic set of essential services across the continuum of care in 136 LMICs confirms that health systems in these settings are failing to deliver the set to all women and children in need.



Fig. 1.5. Gaps persist in access to services essential to women’s and children’s health

Coverage (%) of key interventions across the continuum of care for all low- and middle-income countries*



*The total number of countries included in the analysis is all 136 low- and middle-income countries based on the World Bank classification for fiscal year 2023, based on 2021 gross national income (GNI) per capita, updated in July 2022. For each indicator, only countries with available data from 2017 and later are included in the analysis. Black dots represent national estimates and bar represents the median among all countries with available data.

Sources: WHO/UNICEF (83-85), UN (86), UNICEF (87).

Table 1.1. Median national coverage of interventions across the continuum of care for all low- and middle-income countries*

Indicator	Median	Min	Max	Number of countries with data
Pre-pregnancy				
Demand for family planning satisfied with modern methods	53	2	90	61
Pregnancy				
Antenatal care (four or more visits)	78	24	100	76
Treatment of pregnant women living with HIV	76	4	100	90
Neonatal tetanus protection	90	60	99	99
Birth				
Skilled attendant at birth	96	32	100	97
Postnatal				
Postnatal visit for mothers	84	10	100	66
Postnatal visit for babies	83	10	100	62
Early initiation of breastfeeding	52	8	92	72
Infancy				
Exclusive breastfeeding (<6 months)	42	9	81	70
Continued breastfeeding (year 1)	77	25	98	61
DTP3 immunization	85	31	99	134
MCV1 immunization	82	18	99	134
Rotavirus immunization	78	9	99	86
Childhood				
Vitamin A supplementation (two doses)	32	0	99	64
Pneumonia: Care-seeking for symptoms of pneumonia	69	18	98	55
Diarrhoea: Oral rehydration salts (ORS) treatment	40	14	85	59
Environment				
Population using at least basic drinking-water services	92	37	100	133
Population using at least basic sanitation services	79	9	100	133

Note: DTP3 = third dose of diphtheria-tetanus-pertussis vaccine; MCV1 = measles-containing-vaccine first-dose.

*The total number of countries included in the analysis is all 136 low-and middle-income countries based on the World Bank classification for fiscal year 2023, based on 2021 gross national income (GNI) per capita, updated in July 2022. For each indicator, only countries with available data from 2017 and later are included in the analysis. Black dots represent national estimates and bar represents the median among all countries with available data.

Sources: WHO/UNICEF (83-85), UN (86), UNICEF (87).

As illustrated in the figure and table, 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. The overall message is that although there is a wide range in coverage for each of the interventions in the core set across LMICs, accelerated efforts are needed to close the coverage gaps for them and make greater progress toward the 2030 Agenda goal of universal health coverage.

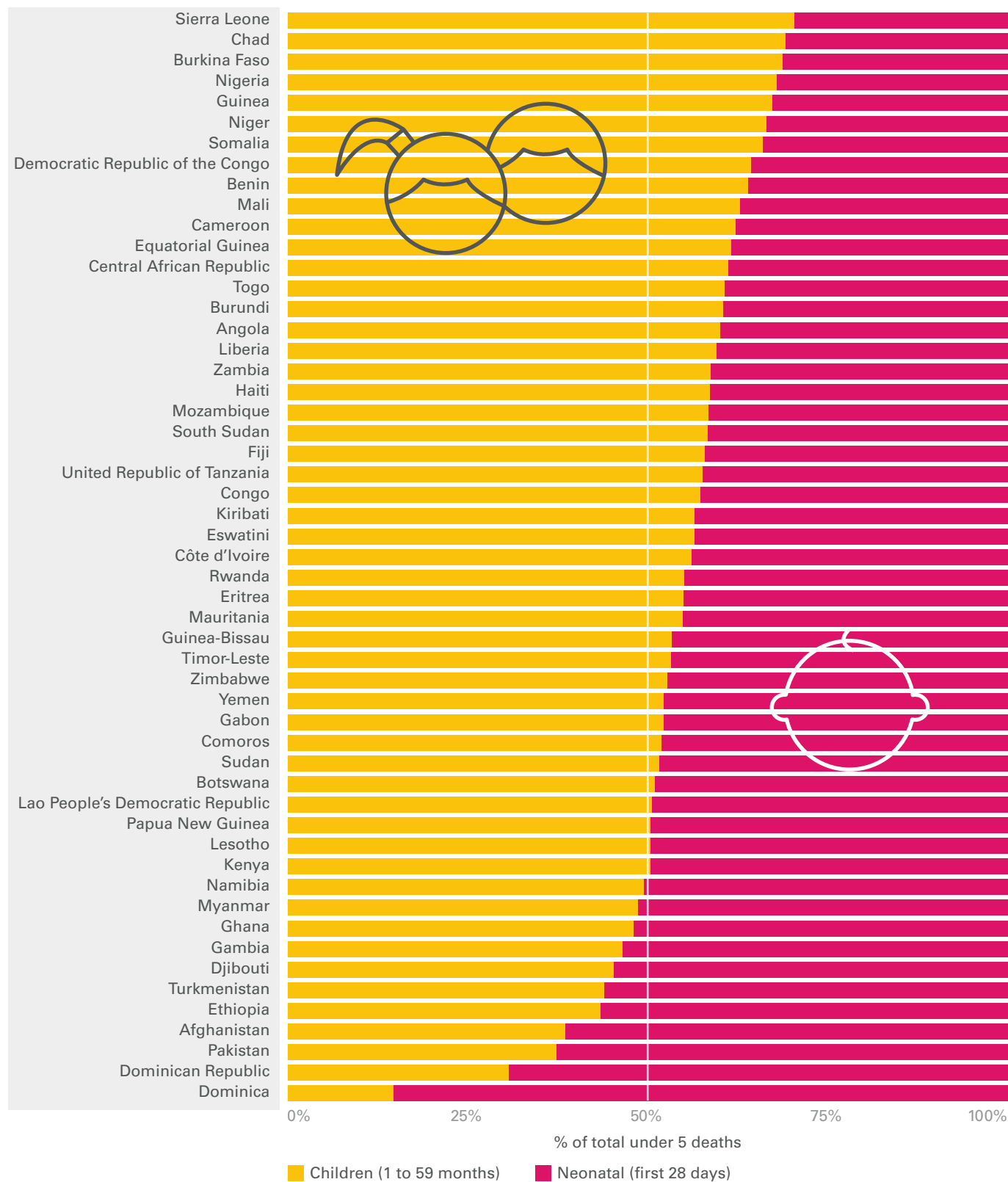
The low coverage levels for vitamin A supplementation, oral rehydration salts (ORS) treatment for diarrhoea and breastfeeding indicators are especially concerning given the high proportion of deaths in children under the age of 5 occurring after the neonatal period (ages 1–59 months) in the 54 countries off track for achieving SDG target 3.2.1 on under-5 mortality. As illustrated in **Figure 1.6**, the share of under-5 deaths after the neonatal period is above 50% in 43 of the 54 countries.

Latest available estimates also show a continued drop in coverage of immunization services during the second year of COVID-19, with 25 million children unvaccinated or undervaccinated in 2021 (6). Recent reversals in immunization coverage underscore an important message that successes in the child survival agenda can rapidly unravel if political commitment and resources wane or are diverted to other causes, and if concerted efforts are not continuously made to engage with communities to foster trust in the efficacy and safety of public health measures. Reductions in already low global coverage levels of HPV vaccination in the past two years also raise questions about global commitment to reaching adolescent girls and boys with essential services that can protect their health now and as they age (6).



Fig. 1.6. Per cent of under-5 deaths by age group: 54 countries off track for SDG 3.2.1

A substantial proportion of under-5 deaths are among children ages 1 to 59 months



Source: UN IGME (21).

1.4 Women's empowerment: an essential ingredient to improving women's, children's and adolescents' health and well-being

The SDGs framework recognizes the essential role of gender equality and women's empowerment in enhancing women's lives, strengthening families and communities as well as advancing overall social and economic development. Empowerment relies on a woman being able to make informed decisions about her own body, health care and well-being and to act on these decisions, including to get the services and support she or her children need conveniently, affordably and safely whenever she wants. Other important components of women's empowerment are a high degree of social independence or autonomy, ability to participate in politics at local and national levels, and equal access to education and employment opportunities. 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 (88-92).

Although some knowledge gaps remain, clinical evidence indicates a close interlinkage between a pregnant woman's health and her baby's development in utero. Women who begin their pregnancies at a healthy weight and who have access to nutritious food as well as high-quality antenatal, intrapartum and postnatal care services are much more likely to experience positive birth outcomes for themselves and their newborns than pregnant women who are malnourished and miss out on essential care (93,94). Women who live in clean, stable and supportive home and community environments also fare better during pregnancy and childbirth than pregnant women who are exposed to violence, poverty or toxic levels of stress (95-97). In addition, women's experiences of anxiety and depression before, during and after pregnancy have been found to directly impact their well-being as well as that of their children (98).

Globally, women's access to family planning services, antenatal care, skilled birth attendance and postnatal care has substantially increased in the past two decades. However, this progress has been uneven around the world, as indicated in Figure 1.5 and Table 1.1, and some countries experienced declines in availability of these services during the first two years of COVID-19 (as detailed in Section 2). All regions except sub-Saharan Africa and South Asia, for example, have reached universal coverage (95% or higher) of skilled birth attendance (99). As noted in Section 1.2, these are the same two regions where maternal and neonatal mortality are highest. Such data indicate that increasing access to skilled birth attendance will result in improvements in both maternal and newborn survival.



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Coverage of reproductive and maternal health services shows similar 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 (100-103). (The report's annex contains detailed information about access to such services grouped by country wealth quintile and other categories.) Nearly all (97%) unsafe abortions, for example, occur in developing countries³, with the highest proportions of least safe abortions and highest case fatality rates occurring in Africa, where access to services are limited (104). Unsafe abortion is a major cause of maternal mortality (105).

Strengthening health systems so that all women are reached with essential reproductive and maternal health services and greater implementation of maternity protection policies are critical steps countries can take to improve maternal and newborn health. Progress toward institutionalizing such policies has been slow, however: As of August 2022, only 43 countries had ratified the International Labour Organization Maternity Protection Convention (106).

Overall, aiming to better ensure that women survive childbirth and their newborns have a healthy start in life entails actions

³ The designation of “more developed” and “less developed”, or “developed” and “developing”, is intended for statistical purposes and does not express a judgment about the stage in the development process reached by a particular country or area.

beyond health sector reform measures. An important overarching focus should be on breaking intergenerational cycles of poverty, which elevate the risk of poor obstetrical outcomes and the transmission of disadvantage from mother to child. This requires investments in educational and training opportunities for girls and young women of all ages, rectifying patterns of gender discrimination in the workforce, and redressing harmful gender norms that contribute to girls dropping out of school, early marriage and adolescent pregnancy. As highlighted in Panel 3 of this report, creating mechanisms for greater adolescent participation in civic life and in the development of adolescent health programmes is another potentially valuable investment.

During the 15 years prior to the onset of the COVID-19 pandemic, substantial global progress was achieved in improving gender parity in school enrolment rates; by 2018, the out-of-school rates for lower and upper secondary education were nearly identical for girls and boys (107)⁴. The same analysis showed, however, that girls of primary school age were still more likely to be out of school compared with boys, placing them on a disadvantaged trajectory at an early age. In 2018, more than 258 million children and adolescents were out of school, most of them in sub-Saharan Africa and South Asia (108). This figure ballooned during COVID-19, as discussed in Section 2, posing a serious threat to the futures of today's generation of girls and boys unless concerted efforts are undertaken to bring these children and adolescents back to school and to make up for instruction time lost.

In addition to paving a pathway to career opportunities, education is highly associated with MNCAH outcomes. Numerous studies have found that women with higher levels of education are more likely to survive childbirth and to receive reproductive and maternal health services than those with no or low levels of education (109,110). Similarly, their children have a significantly better chance of surviving childhood and receiving essential health services and sufficient nutritious food than children of mothers with no or lesser education (111,112).

SDG 5 includes targets on improving women's political and labour force participation. Research has shown that greater

4 Programmes at International Standard Classification of education (ISCED) level 2, or lower secondary education, are typically designed to build on the learning outcomes from ISCED level 1. Usually, the aim is to lay the foundation for lifelong learning and human development upon which education systems may then expand further educational opportunities. The age range is about 12–14 years. Upper secondary education programmes are typically designed to complete secondary education in preparation for tertiary education (university level) or provide skills relevant to employment or both. The age range for upper secondary school is about 15 to 17 years old.

Research has shown that **greater participation of women** in politics and leadership roles results in increased investments in social protection, health and education policies and programmes.



participation of women in politics and leadership roles results in increased investments in social protection, health and education policies and programmes (113-116). However, women are underrepresented at all levels of decision-making:

- Just 13 of the 193 United Nations member states have a woman head of state, and 15 have a woman head of government (117)⁵.
- Only around 26% of parliamentarians around the world are women, ranging across countries from a low of 0% to a high of 61% (118).
- Data from 133 countries show that women constitute about one third (36%) of elected members in local deliberative bodies such as councils or assemblies (119).

Gender equality in the workforce is also crucial to economic growth, sustainable development and improvements in MNCAH. Yet, globally women continue to earn, on average, 20% less than men; represent only about 28% of managers across sectors; face numerous hurdles to entering and advancing in the workplace; and overwhelmingly undertake unpaid work such as caretaking and household duties (120,121). In the health care sector, women represent around 70% of the global workforce, but experience an average gender pay gap of around 28% (122-124). According to a study by Global Health 50/50, women from LMICs make up 42% of the global population but hold only 9% of board seats where global health decisions are being made (125). These figures call for further shifting of power and influence in global health away from historically dominating wealthier countries as well as increasing women's leadership in global health decision-making.

During the COVID-19 pandemic, as examined more closely in Section 2, women have experienced disproportionate job and income losses while also representing a larger percentage of workers on the front lines of response efforts. In September 2021, for example, women were more likely than men to report loss of employment (26% compared with 20.4%) (126).

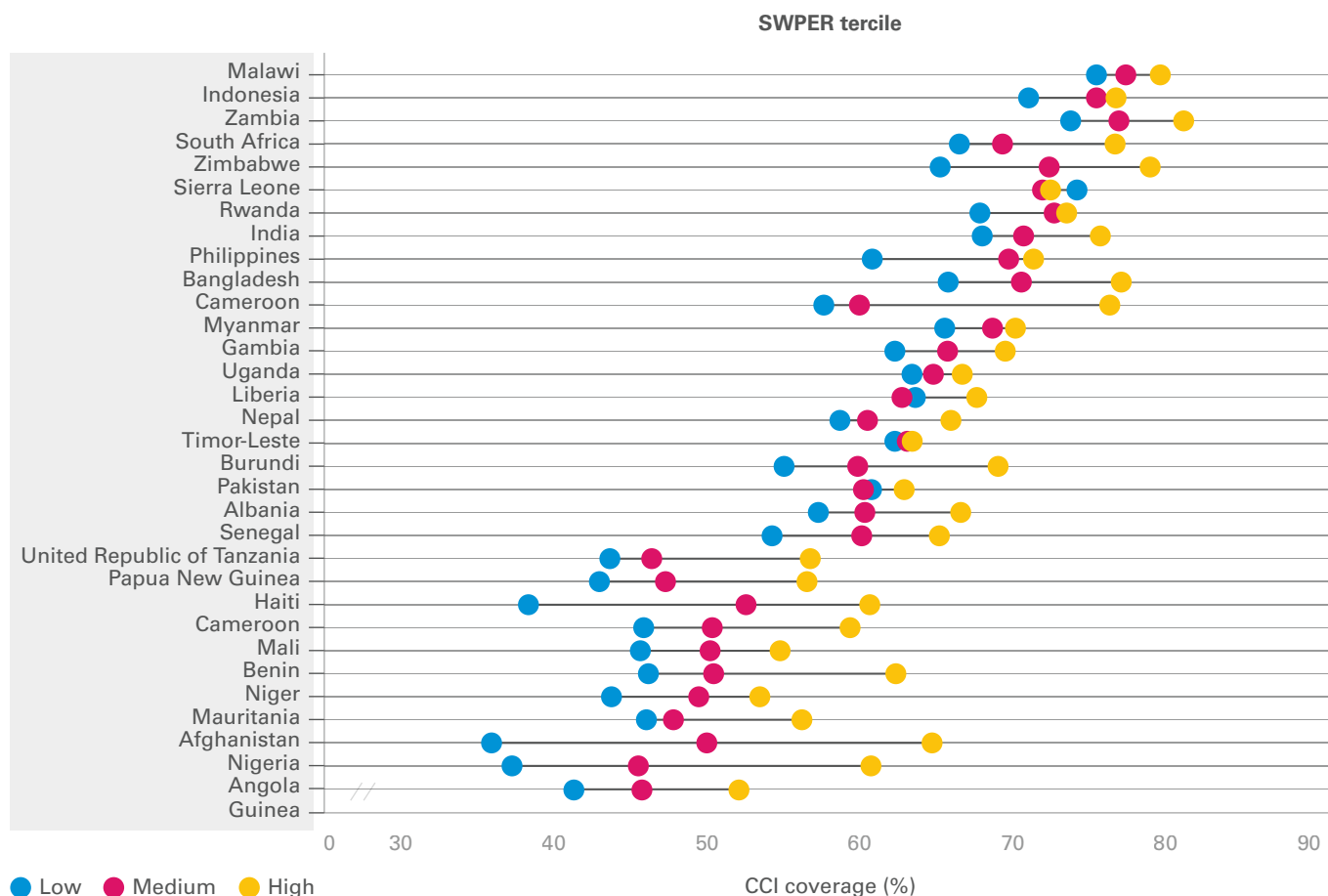
Another issue central to the achievement of gender equality is the realization of women's sexual and reproductive health and rights. Even as top national courts in countries including Mexico and Nepal have issued rulings in favour of women's reproductive rights in the past couple years (127,128), policies protecting these rights are under threat in many other places. For example, the Supreme Court in the United States of America recently overturned its 1973

5 This figure represents UN Women calculations based on information provided by permanent missions to the United Nations. Some leaders hold positions of both head of government and head of state; only elected heads of state have been taken into account.

ruling in *Roe vs. Wade* that legalized abortion, thereby removing the federal right to abortion access and returning the issue of abortion regulation to the state level, and in Poland, a 2021 high court ruling eliminated exemptions to the country’s abortion ban for any reason (129-131). Such developments have potentially dire consequences for this and future generations.

Fig. 1.7. Correlation between women’s empowerment and access to key health services for them and their children

Average levels of the CCI by terciles of the social independence domain of the SWPER, 32 countries, 2015–2022



Source: International Center for Equity in Health (132).

The proportion of unsafe abortions, for example, has been found to be significantly higher in countries with highly restrictive abortion laws compared with those with less restrictive laws (104).

Women’s empowerment levels vary widely across and within countries and can fluctuate depending on political and institutional level commitment to upholding women’s rights and principles of inclusivity and diversity. **Figure 1.7** shows the distribution of the composite coverage index (CCI) by the social independence component of the survey-based women’s empowerment index (SWPER) (90), the one of the three SWPER domains most closely associated

with health outcomes, in 32 countries with available data⁶. The CCI is a weighted average of eight essential interventions for women's and children's health (133)⁷. As shown in the figure, coverage levels of the CCI are highest among women scoring in the top tercile of the social independence component of the SWPER in all but one country.

Panel 3. **The case for adolescent and youth participation**

Achieving the SDGs cannot be done without improving the health and well-being of adolescents and young people (the adolescent period is defined by WHO and UNICEF as ages 10–19 years, with young people aged 20–24 years). The numbers alone make this evident: according to the latest UN estimates, 41% of the global population is younger than 24 and around 16% is aged 15–24 years (134). Most of the world's more than 1.2 billion young people aged 15–24 years live in LMICs (31, 134). It is these countries where health, education and social services are lagging the furthest behind and where adolescents and young people face the greatest challenges to their ability to survive and thrive. Increases in rates of child marriage, adolescent depression and anxiety, and violence against women and girls in the past two years are just a few of the trends that have heightened their vulnerability.

Another challenge facing adolescents is the growing digitalization of their worlds, which exposes them at early ages to bullying, sexual predators and age-inappropriate ideas, images and concepts. This is a difficult problem to address because social media, the internet and other digital outlets also present opportunities for adolescents to connect positively with others and to gain new skills and knowledge. In general, there are huge educational, social and economic disadvantages to adolescents without access to digital technologies. Finding ways to increase access to such technologies while curbing their harmful effects is an issue that all countries must tackle.

There is growing recognition that greater adolescent participation is vital to improving their lives and tackling the existential threats they face. Studies have shown, for example, that adolescent participation in the design of research improves the quality and applicability of research findings. Other studies have found that adolescent involvement in the development of health services results in greater adherence of adolescents to treatment and to better health outcomes (135–137).

-
- 6 The survey-based women's empowerment index (SWPER) is based on Demographic and Health Survey data (not available from Multiple Indicator Cluster Surveys) and includes three domains, with the social independence domain the one that is most closely associated with health outcomes: (1) social independence: conditions that enable women to achieve their goals (school attainment, access to information, age at pivotal life events, spousal asset differentials and access to information); (2) decision making: the extent of the women's participation in household decisions, which may also be considered a measure of instrumental agency; (3) attitude towards violence: closely related to the concept of intrinsic agency, as a proxy for the woman's incorporation of gender norms-related acceptability of violence.
- 7 The eight interventions are: (1) family planning coverage with modern methods; (2) skilled birth attendant; (3) at least four antenatal care visits by a skilled provider; (4) BCG vaccination; (5) three DTP vaccinations; (6) measles vaccination; (7) oral rehydration salts (ORS) therapy for diarrhoea; and (8) care-seeking for childhood pneumonia.

A key principle of the Convention on the Rights of the Child (CRC) is that every child has a right to be heard and to participate in decisions that affect her or his life (138). Not allowing or enabling adolescents to exercise these rights therefore violates commitments under the CRC in addition to being a missed opportunity to support their improved health, safety and security, and future prospects. More recently, the Global Consensus Statement on Meaningful Adolescent and Youth Engagement affirms that young people have a fundamental right to actively and meaningfully engage in all matters that affect their lives (139).

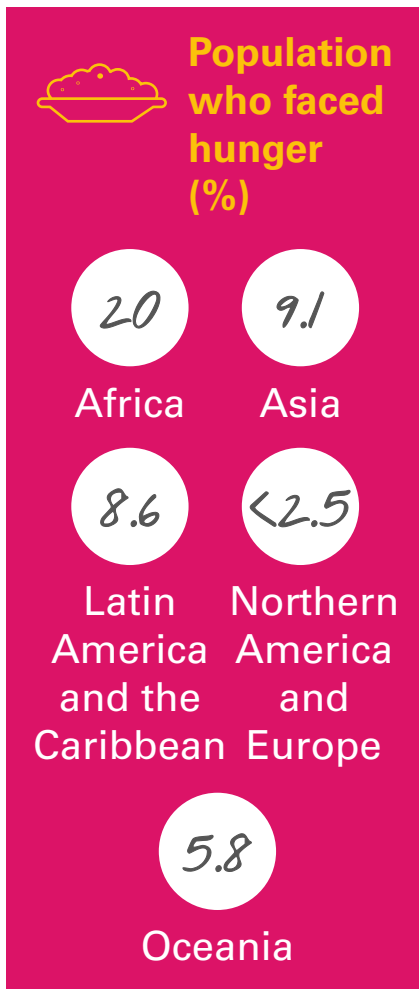
UNICEF defines adolescent participation as “about being informed, engaged and having a voice and influence in decisions and matters that affect one’s life – in private and public spheres, in the home, in alternative care settings, at school, in the workplace, in the community, in social media, in peace processes and in broader governance processes” (140). Participation is also a central theme of My Body, My Life, My World, the UNFPA global strategy for adolescents and youth launched in November 2019. The My World pillar is a call to “promote the leadership of adolescents and youth and their fundamental right to participate in sustainable development, humanitarian action and in sustaining peace” (141). This approach is based on the recognition that policies and services are more likely to meet the needs of adolescents when they have a say in their development and implementation.

Youth participation in practice

WHO and UNICEF have published guidance materials on adolescent participation and engagement in health and other sectors that can be adapted for different settings (140,142). UNFPA’s adolescent and youth strategy includes the following call to action: “Services fully geared to realizing the rights and choices of adolescents and youth must be integrated in comprehensive sexual and reproductive health and rights interventions, policies and programmes. All health care providers should have accurate and adequate skills to serve adolescents and youth, and all health facilities should offer necessary commodities, services and information” (141). As part of its efforts to put this strategic priority into practice, UNFPA partnered with UNICEF to introduce in 2021 the Gender-Transformative Accelerator Tool of the Global Programme to End Child Marriage. One of the tool’s top objectives is to build and support adolescent girls’ skills, agency and empowerment by promoting their increased engagement in developing and leading efforts to reduce early marriage. In less than a year, the tool had been rolled out in several countries including Ethiopia, India and Niger.

Increased opportunities for youth participation in community activities and in civic life are also needed to improve inclusivity, innovation, and to help build the next generation of leaders. United Nations agencies, the Partnership for Maternal, Newborn & Child Health (PMNCH), and other organizations have supported several initiatives in this area, including leadership skills-building opportunities for adolescents and young people (141,143,144).

The fact that many agencies and organizations are promoting youth participation underscores its importance as a vital strategy for improving their lives and tackling the existential threats they face. Expansion of efforts to increase adolescent participation in research, in programme design and implementation across sectors, and in civic engagement could result in immediate improvements in adolescent health and well-being plus longer-term benefits of building the next crop of effective leaders.



1.5 Conflict and climate impacts on food security are putting millions of women and children at risk

Even before COVID-19 and the Ukraine crisis increased the risk of food insecurity and famine, around 618 million people in 2019 globally were facing hunger (145) and the world was off track to achieve SDG 2 (“End hunger, achieve food security and improved nutrition and promote sustainable agriculture”) (146,147). World hunger has risen since the pandemic started, with around 150 million more people experiencing hunger in 2021 compared with 2019 levels. Around 2.3 billion people were moderately or severely food insecure in 2021, and 11.7% of the global population faced food insecurity at severe levels (145).

Regional disparities in people experiencing hunger were exacerbated by the pandemic, with Africa, Asia and Latin America and the Caribbean bearing the heaviest burdens. Approximately 20% of the population in Africa (278 million people), 9.1% in Asia (425 million people) and 8.6% in Latin America and the Caribbean (56.5 million people) faced hunger in 2021, compared with 5.8% of the population in Oceania and less than 2.5% in Northern America and Europe. The gender gap in food insecurity also widened globally and in every region during the pandemic. In 2021, 31.9% of women worldwide were moderately or severely food insecure, compared with 27.6% of men (145).

Current food crises and the rise in global hunger are attributed to an often mutually reinforcing set of drivers, including pandemic-induced economic contractions and supply chain disruptions, extreme climate events such as the drought conditions affecting the Horn of Africa, and conflict situations. When underlying drivers such as these are left unresolved, food crises can become protracted with cumulative negative impacts on women and children. According to WFP’s latest global report on food crises, conflict and insecurity was the primary driver in 7 of the top 10 food crisis countries (Afghanistan, the Democratic Republic of the Congo, Ethiopia, Haiti, Nigeria, Pakistan, South Sudan, Sudan, the Syrian Arab Republic and Yemen) (148). Families displaced from their homes due to conflict are among the most vulnerable to acute food insecurity and malnutrition, as noted in Panel 2. In 2021, the six countries with the highest numbers of internally displaced persons – Afghanistan, the Democratic Republic of the Congo, Ethiopia, Sudan, the Syrian Arab Republic and Yemen – were among the top 10 food crisis countries (148).

Since early in 2022, the war in Ukraine has exposed some perils of the interconnectedness of global food chains and the fragility of food systems in many LMICs. Countries from Egypt to Sri Lanka to Kenya are coming under strain from weather extremes,

rising food and fuel prices, and disruptions to the distribution of fertilizer and to global trade. As prices for goods have increased around the world so have the costs of providing emergency food assistance. Since the onset of the conflict in Ukraine, for example, WFP estimates it is paying US\$ 73.6 million more a month for its operations than in 2019 (a 44% increase) (149). At the same time, many donor countries are recovering from economic downturns, facing inflationary pressures and prioritizing COVID-19 response efforts, Europe's refugee crisis and financial and material support for Ukraine. This combination of factors has led to predictions that the numbers of people in poverty and experiencing hunger and food insecurity will continue to grow unless the global community collectively responds.

On the opposite end of the spectrum, overweight and obesity levels are worsening in almost all parts of the world. Around 39% of the adult global population was overweight in 2016 and 13.1% were obese (150). The prevalence of overweight and obesity among children and adolescents ages 5 to 19 increased from 4% in 1975 to about 18% in 2016 (150), with similar rates for girls and boys (18% and 19%, respectively). Latest estimates show that about 5.7% of children under the age of 5 are overweight or obese (36), placing them at higher risk of premature death and disability in adulthood (151).

All forms of malnutrition – undernutrition, overweight and obesity, and micronutrient deficiencies – negatively affect individuals, communities and societies with potential intergenerational effects. Poor nutrition during early life impedes both physical and cognitive development, reduces school performance and adult productivity, and increases the risk of overweight and diet-related chronic diseases in adulthood (152).

Achieving healthy growth and development in children starts with ensuring women have access to adequate nutritious foods (153). Women who have experienced chronic malnutrition are at higher risk of obstructed labour due to cephalopelvic disproportion, and those with poor diets before and during pregnancy have an elevated risk of anaemia, pre-eclampsia, haemorrhage and death. Latest global estimates indicate that around 15% of all women are obese (150, 154) and women with obesity are at increased risk of almost all pregnancy complications. Poor maternal nutrition can also result in stillbirth, low birth weight, neural tube defects and developmental delays in babies. Before the pandemic hit in 2019, an estimated 9% of women aged 20 years and older worldwide were underweight (body mass index below 18.5) (155) and around 571 million women aged 15-49 years (29.9%) were anaemic (156). These numbers have likely increased in the past two years.



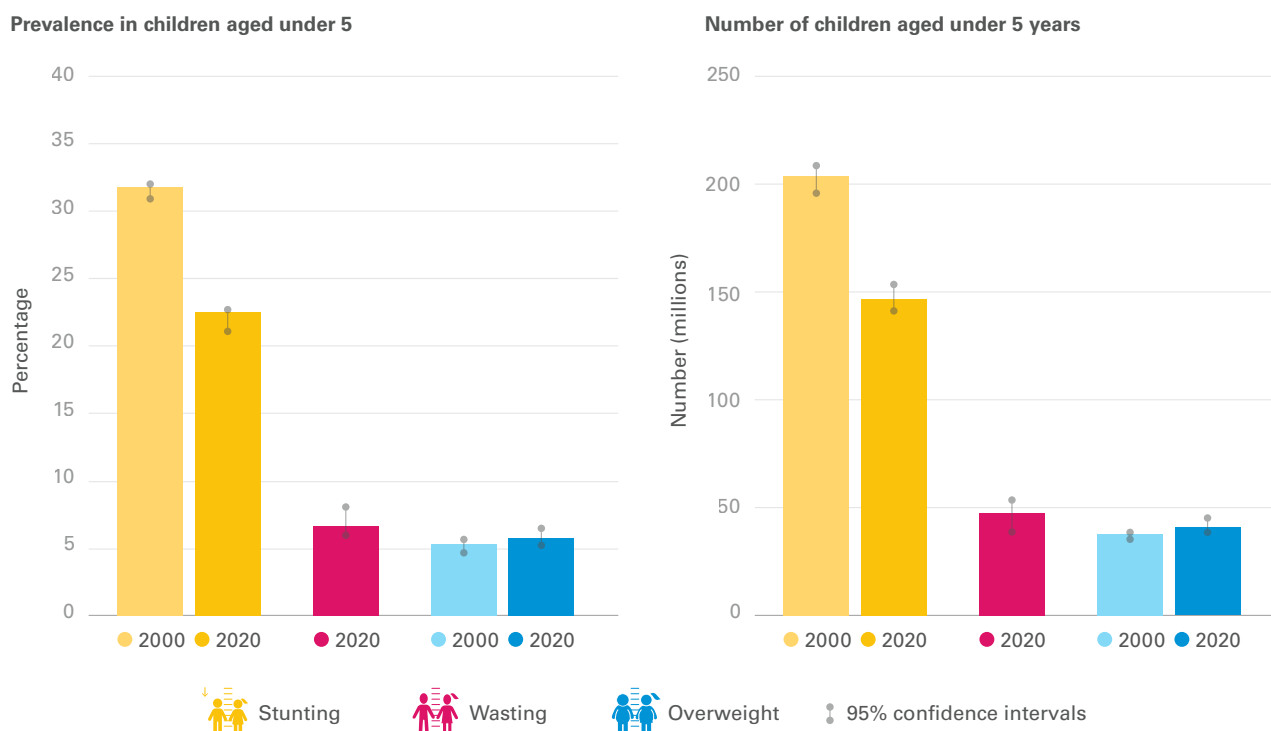
>45 million
children (6.7%)
under the age of
5 were wasted in
2020

13.6 million
of these children
were affected by
severe wasting

In 2021, the six
countries with the
highest numbers
of internally
displaced persons
– Afghanistan,
the Democratic
Republic of the
Congo, Ethiopia,
Sudan, the Syrian
Arab Republic and
Yemen – were
among the **top**
10 food crisis
countries



Fig. 1.8 Percentage of children aged under 5 years affected by stunting, wasting and overweight, global, 2000 and 2020*



*Household survey data on child height and weight were not collected in 2020 due to physical distancing policies, with the exception of four surveys. These estimates are therefore based almost entirely on data collected before 2020 and do not take into account the impact of the COVID-19 pandemic. However, one of the covariates used in the country stunting and overweight models takes the impact of COVID-19 partially into account.

Source: WHO (36).

Almost half of all deaths in children under the age of 5 are attributable to undernutrition (43,157). **Figure 1.8** shows the latest data on prevalence of malnutrition among children under the age of 5. Children who are stunted are more susceptible to dying from infections and are predisposed to becoming overweight and to developing diet-related noncommunicable diseases later in life.

Stunting is associated with poor cognitive development and, therefore, can impact a child's future life prospects. Although global prevalence of stunting declined from 33.1% in 2000 to 22% in 2020, some 149 million children under the age of 5 were stunted in 2020 (158). Wasting is a life-threatening condition caused by a combination of a lack of intake of nutritious food, poor nutrient absorption and repeated bouts of diseases such as diarrhoea, measles and malaria. Over 45 million children (6.7%) under the age of 5 were wasted in 2020, and 13.6 million of these children were affected by severe wasting (158). Children living in rural settings, poorer households, who belong to indigenous population groups or ethnic minorities, and whose mothers received no formal education were more vulnerable to stunting and wasting (159).

Nutrition throughout childhood and early adolescence affects the timing of puberty with consequences on linear growth, body composition, and development of other physiological systems. The adolescent period is also a time of social transition from primary dependence upon caregivers to the development of greater autonomy and represents a unique opportunity to foster healthy habits around eating and physical exercise (160).

However, adolescents have been largely neglected to date in global nutrition policy frameworks and in the design of programmes aimed at improving their access to healthy foods, food choices and participation in exercise including sports. Equipping adolescents with knowledge about healthy eating and skills on how to prepare nutritious foods as well as engaging them in the development of nutrition programmes tailored to their needs and circumstances could have positive long-lasting impacts on their health and well-being. Comprehensive programmes for improving adolescent nutrition should also address other risk factors for poor short- and long-term health such as tobacco and alcohol use.



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Section 2

COVID-19 pandemic threats to the health and well-being of women, children and adolescents

As Section 1 of this report made clear, the threats to improved women’s, children’s and adolescents’ health and well-being come from a wide range of different causes and sources. Although some challenges over the past year or so are not directly related to the COVID-19 pandemic, it is interlinked with most of them and remains a huge factor in all efforts to rejuvenate progress toward the SDGs. The pandemic has not gone away, and its current and potential future impacts – combined with those related to conflict, climate change and food and economic pressures – will continue to influence what countries and other stakeholders are able and willing to do to support women’s, children’s and adolescents’ health. Section 2 examines these impacts and also highlights some of the lessons learned in responding to COVID-19 that offer promise for better progress in the run up to 2030.

More than halfway through the third year of the pandemic, much has been learned about transmission and the direct health effects of SARS-Cov-2 infection in pregnant women and their newborns, and in children and adolescents. A growing body of evidence also exists on the economic and indirect impacts of the pandemic, including negative effects of country response measures on women’s and children’s health and well-being. Among these adverse consequences are disruptions to health and social services, educational loss, increased poverty, worsening mental health, and reduced safety and security from all forms of violence.

2.1 Direct effects: SARS-Cov-2 infection in pregnant women and children

Current evidence points to an increase in maternal mortality during the COVID-19 pandemic, although this increase is not uniform across countries and it is not clear to what extent the increase is due to direct or indirect effects (161-163). Risk of severe disease and death among pregnant and postpartum women with SARS-CoV-2 infection appears to be higher in women who are older, from minority groups, and who have co-morbidities, including obesity, diabetes and hypertension (163). Research has also shown increases in preterm birth, admission to neonatal intensive care units and stillbirth among infants born to women with SARS-CoV-2 infection during pregnancy or childbirth compared with those who have never been infected. Also, studies have shown that pregnant women have a higher risk of severe COVID-19 disease, intensive care unit admission, invasive ventilation and need for extracorporeal membrane oxygenation compared with non-pregnant women (163).

In terms of infection risks and vulnerability, mother-to-child transmission of SARS-CoV-2 is possible but rare, with no clear evidence of transmission through breastmilk (164,165). Children and adolescents are susceptible to SARS-CoV-2 infection and may transmit the virus to others. The risk of transmission to and from children depends on the level of community

transmission, the measures implemented to control the virus and on biological factors related to the virus itself (for example, the type of variant circulating in the population) (166). An unprecedented number of children have tested positive since the emergence of variants of concern (VOCs), including alpha, beta, gamma, delta and omicron, all of which have proven to be more infectious than the first variant. SARS-CoV-2 infections among children and adolescents typically cause less severe illness and fewer deaths as compared with adults (166).

In general, children infected with SARS-CoV-2 present with milder symptoms of COVID-19 disease even when infected with a VOC. There is no conclusive evidence that VOCs cause more severe disease in children (166).

An additional direct toll on children from the pandemic is experience of orphanhood. 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 disease (167). Orphanhood increases the likelihood that a child will experience poverty, abuse, delayed development, reduced access to education and institutionalization (168). Adolescents who are orphaned also face an increased risk of sexual violence, exploitation, HIV infection, suicide and pregnancy (169,170).



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2.2 Excess mortality due to the COVID-19 pandemic

Multiple scenario-based models warned that the COVID-19 pandemic could result in substantially increased mortality around the world if services were disrupted for extended periods of time. These models predicted that increased deaths in women, children and adolescents would mostly result from indirect impacts such as lockdowns that restricted access to care, overwhelmed health care systems, transportation disruptions and fear of using health services (171).

WHO estimates that the full death toll associated directly or indirectly with the COVID-19 pandemic between 1 January 2020 and 31 December 2021 was approximately 14.9 million (ranging from 13.3 million to 16.6 million) (172). Most of these deaths were in the adult population. It is unclear if the pandemic has increased mortality among children and young people in part because of limited data on COVID-19 deaths disaggregated by age and sex.

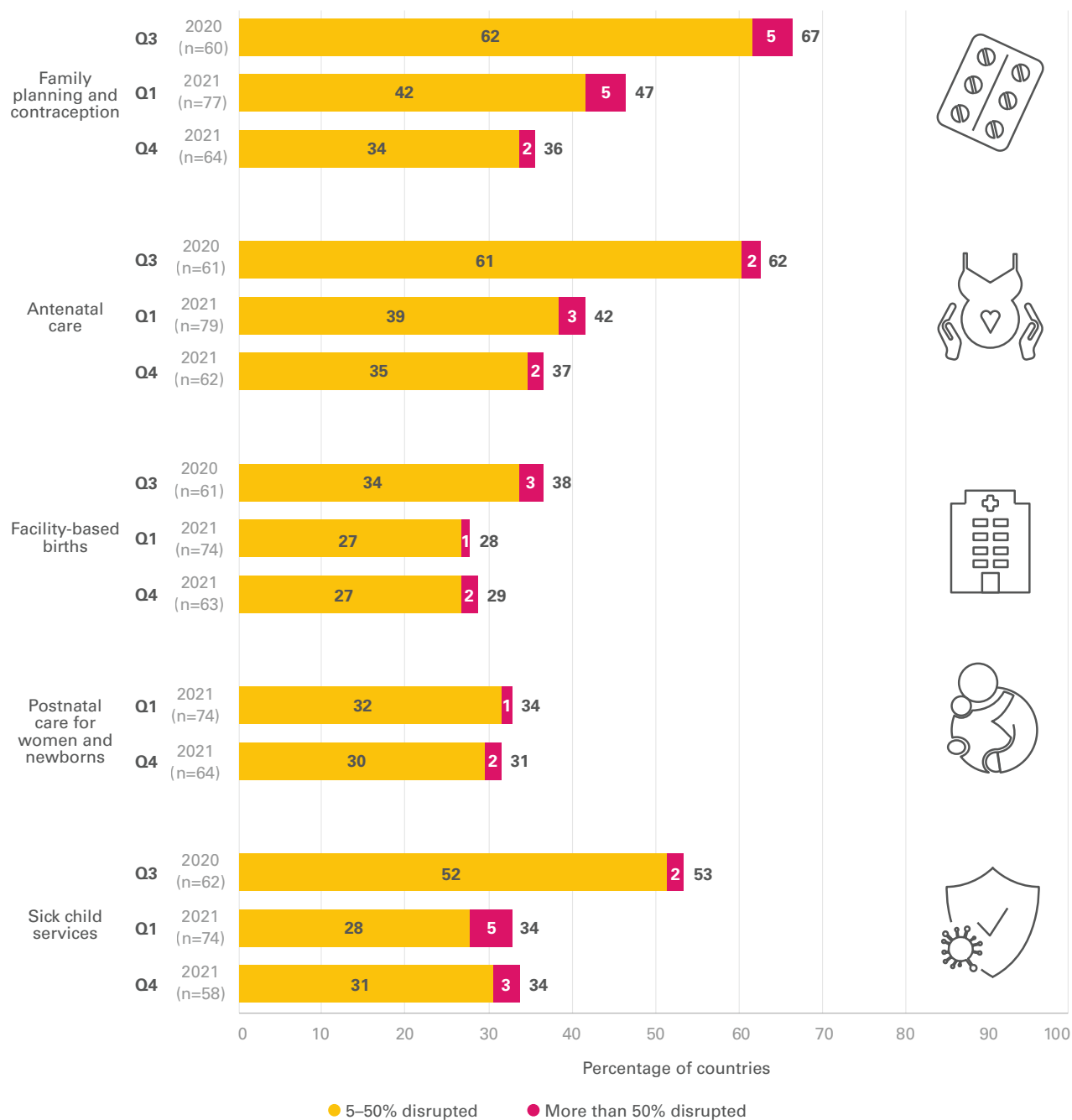
2.3 Disruption and re-establishment of essential health and social services

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 2021 (7,10). **Figure 2.1** summarizes results from the third round of the WHO global pulse survey on continuity of essential health services during the COVID-19 pandemic, which reflected the period November–December 2021. According to that round of survey responses, about two thirds of countries reported either no disruptions or fewer disruptions in selected SRMNCAH health delivery channels than in the previous two rounds (7).

Figure 2.2 provides additional information from the third global pulse survey round, showing recovery levels of a key set of SRMNCAH services organized by degree to which the respondents perceived the service to have returned to pre-pandemic coverage levels (7).

Fig. 2.1. Restoring access to key services for women and children in the COVID-19 era: slow but steady progress since early 2021

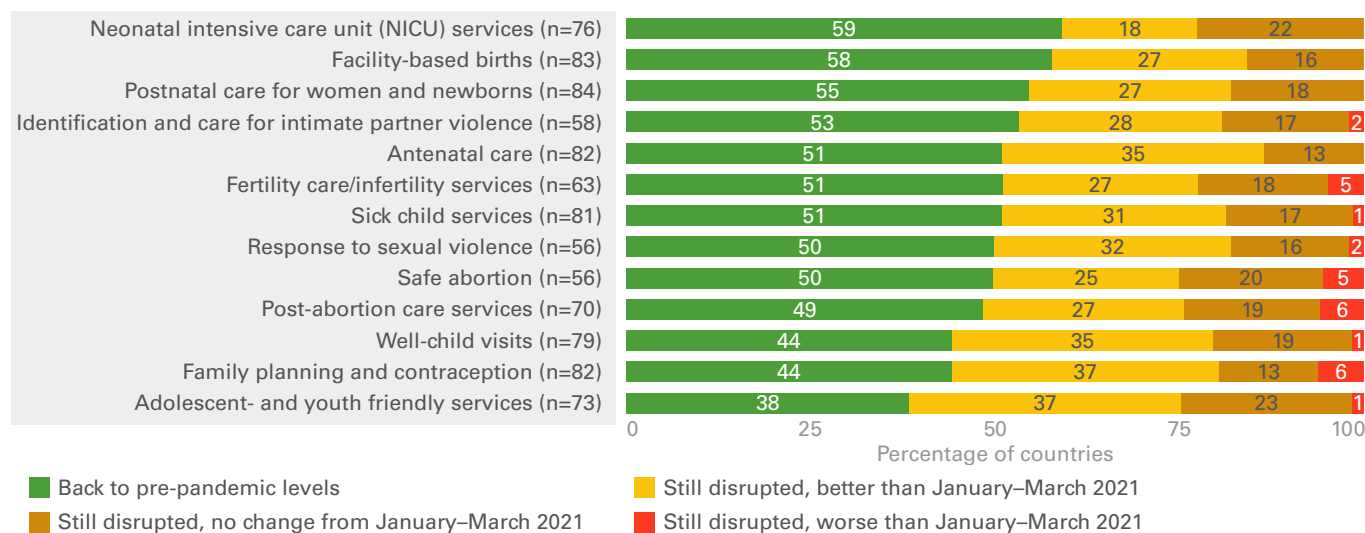
Comparison of disruptions for SRMNCAH services in countries that responded to all three rounds of the WHO global pulse survey on continuity of essential health services during the COVID-19 pandemic: Q3 2020 (round 1), Q1 2021 (round 2) and Q4 2021 (round 3)



Source: WHO (7).

Fig. 2.2. SRMNCAH interventions: country-level impressions of the return to pre-pandemic service levels

Perceptions of levels of disruption and recovery in SRMNCAH services in countries that responded to all three rounds of the WHO global pulse survey on continuity of essential health services during the COVID-19 pandemic in Q4 2021, as compared with Q1 2021



Source: WHO (7).

The findings of the WHO surveys – that health service disruptions are lessening and that there are differences in the magnitude of disruption based on type of service – are similar to the health sector findings of UNICEF’s COVID-19 socioeconomic impact surveys as well as other studies that have examined the changes in health services using routine health information (173-176).

The UNICEF surveys have been more broad-based because they assessed service disruptions in health and other sectors relevant to the overall well-being of children and adolescents, such as child protection, nutrition, and water, sanitation and hygiene (WASH). As illustrated in **Figure 2.3**, these surveys found that while service disruptions lessened across all sectors in the second year of the pandemic, the number of countries reporting severe disruptions in at least one service across nutrition, health and WASH increased between the first and third quarters of 2021. Child protection was the only sector with sustained improvements over time (9).

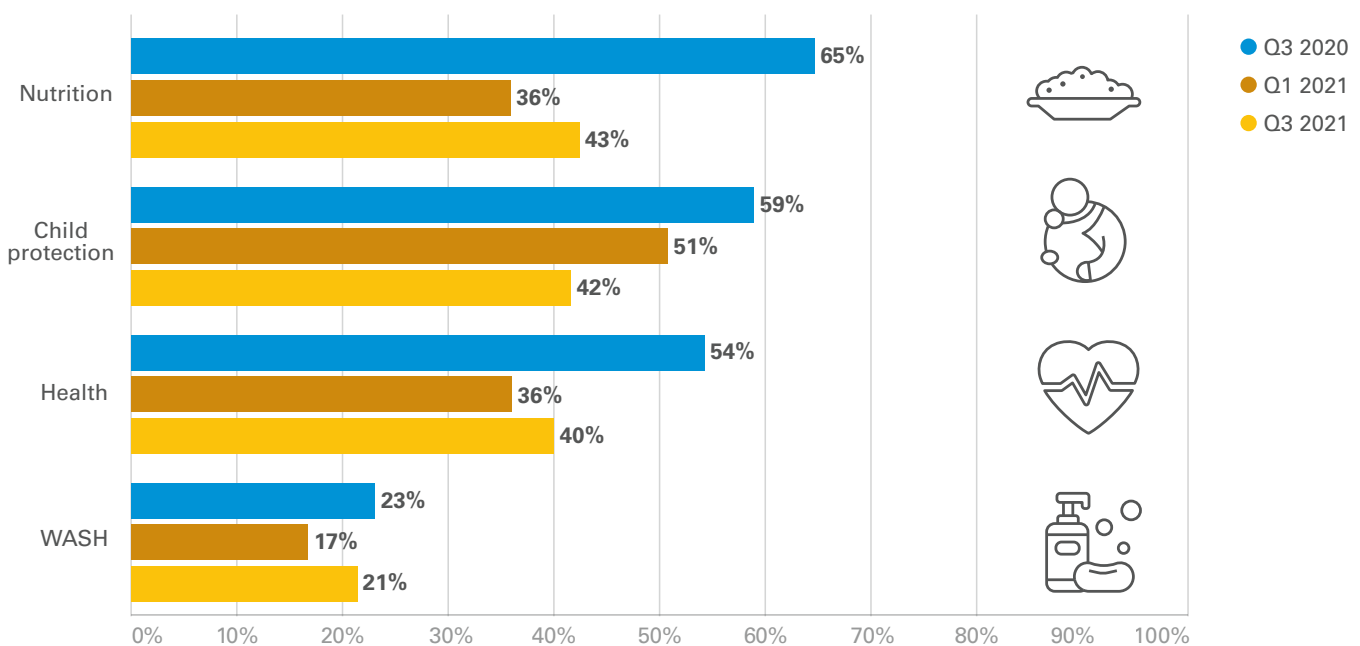
One notable issue related to disruptions in service is that health care workers have been heavily affected by this pandemic. Based on surveillance data reported to WHO between January 2020 and May 2021, there were 6643 deaths among health care workers due to COVID-19 (177), but this figure significantly underreports the burden of mortality worldwide because of incompleteness in the surveillance data and the fact that the pandemic is still ongoing more than a year later. Beyond the direct, personal

health impacts, health care workers continue to face challenges, including interruptions in training, social discrimination and physical and verbal attacks, with many also having caretaking responsibilities for friends and family members (82,178). A survey of midwifery associations conducted in 2020 by the International Confederation of Midwives found high levels of stress and burnout among midwives. The survey also found widespread closures of midwifery education courses, available courses being switched to an online format or small group learning and drops in student completion of midwifery curriculums (82). These trends may result in a decrease in the availability of midwifery services critical to the prevention of maternal and newborn deaths and stillbirths.

These WHO and UNICEF COVID-19 survey findings on service disruptions and recovery suggest that while much of the world began returning to the pre-pandemic so-called normal for essential SRMNCAH services by the end of 2021, some countries continued to struggle and rates of recovery differed across specific services and sectors. Many countries have worked diligently to address service disruptions despite encountering obstacles. Panel 4 presents a case study highlighting some actions countries introduced to mitigate COVID-19 impacts and maintain equitable service delivery for women, children and adolescents.

Fig. 2.3 Overall health and well-being of children and adolescents two years into the pandemic: uneven progress in ending service disruptions

Proportion (%) of countries reporting severe disruptions in at least one service type, by sector and round of UNICEF COVID-19 socioeconomic impact survey



Source: UNICEF (9).

Panel 4. Examples of actions taken by countries to mitigate the impact of COVID-19 on sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH)

Through its headquarters, regional and country office teams, WHO has supported 20 countries in five WHO regions during the COVID-19 pandemic to ensure that during their response to the crisis, actions would be taken to mitigate indirect effects on maternal, newborn, child and adolescent health due to disruptions to service provision and use. The most common actions reported by 17* of the 20** countries are listed in the table below (179).

Most common actions to maintain the provision and use of essential maternal, newborn, child and adolescent health services (N=17)*

Area of mitigation action	Number of countries reporting action
Teleconsultation, hotlines/social media platform for counselling, advice and support	15
Infection prevention and control, personal protective equipment (PPE) for health workers	15
Recruitment and training (including virtual) of health workers	14
Multimedia and community outreach information	14
Mobile teams and community provision/door-to-door	13

*Bangladesh, the Plurinational State of Bolivia, Cameroon, the Democratic Republic of the Congo, Ethiopia, India, Myanmar, Nepal, Nigeria, Pakistan, Romania, South Africa, Sudan, Tajikistan, Timor-Leste, Uganda, Yemen.

**Three additional countries participating in this initiative (Brazil, Cambodia and Kazakhstan) are not represented in this table.

Key lessons learned across all 20 countries included the following:

- **Governance.** Countries reported that it was difficult to ensure that health programmes were integrated into COVID-19 response committees and coordination mechanisms. A coordinated emergency approach across all government agencies and sectors is critical to ensure efforts to sustain SRMNCAH and other services are prioritized in emergency responses.
- **Data.** Real-time high-quality data was often lacking. This kind of data is needed to make the most informed and effective decisions.
- **Maintaining essential health services.** Balancing direct response to COVID-19 with efforts to maintain essential SRMNCAH services was a challenge. A plan for maintaining essential SRMNCAH services should be specified as part of larger country preparedness and response plans. Although such maintenance plans were not always present at the start of the pandemic, they were developed in all countries over time.

2.4 Impacts of COVID-19 on mental health and exposure to violence among women, children and adolescents

In many countries, especially during lockdowns, records from helplines, police forces and other service providers showed a rise in reported cases of **violence against women**, in particular intimate partner violence.



Estimates for 2020 show a global increase among the general population in major depressive disorders of 27.6% and of anxiety disorders of 25.6% after the pandemic began, compared with rates prior to its start (180,181). Although data are mixed, younger age and female gender were often reported as risk factors for these disorders. Overall suicide rates in most countries did not rise early in the pandemic, but available evidence indicates a higher risk of suicidal behaviours among young people. Several pandemic-related factors are likely responsible for these negative mental health trends among women and young people, including economic hardship and limits on social engagement and mobility, all of which have affected them to a considerable extent in most societies.

According to results from the third round of WHO's pulse survey on continuity of essential health services during the COVID-19 pandemic, over 33% of responding WHO Member States reported ongoing disruptions to mental, neurological and substance use services between November and December 2021 (7). Many mental health care providers made efforts to mitigate these disruptions by offering telehealth services, including through the telephone and digital platforms, such as video-conferencing and web applications (180). However, inadequate digital infrastructure, pre-existing inequalities in access to digital platforms and low levels of technological literacy were reported as barriers to delivering e-health services, including to women, children and adolescents (180).

In many countries, especially during lockdowns, records from helplines, police forces and other service providers showed a rise in reported cases of violence against women, in particular intimate partner violence (182). The possible causes for this uptick in cases could include that lockdown measures increase the time women are in physical proximity to abusive partners, elevations in stress levels due to economic downturns could trigger violent reactions, and decreased access to social support services because of restricted mobility (183). Early on in the pandemic, WHO called for considering intimate partner violence and sexual violence services as essential services to be continued during the COVID-19 crisis (184). However, about a third of countries that responded to the third round of the WHO global pulse survey on continuity of essential health services during the COVID-19 pandemic reported disruptions to these vital services (7).

Lack of comparable data on rates of violence against women before and during the pandemic makes it difficult to confirm if there was a true increase in incidence. However, there is considerable anecdotal evidence suggesting that rates of

violence against women have increased. WHO estimates do show, however, that rates of violence against women were unacceptably high even before the pandemic, with nearly 1 in 3 women reporting having ever been subjected to physical and/or sexual violence by an intimate partner or sexual violence by someone other than an intimate partner (185).

Recent reviews have also found an increase in violence against children associated with periods of lockdowns and restricted mobility. Family violence – which typically refers to violence against women and children – was reported to have increased based on the findings of a review of 22 surveys from eight countries and one multi-country study including 37 countries. Administrative records from three high-income countries from 1 March to 31 December 2020 similarly showed an increase compared with three years earlier in child abuse-related injuries treated in hospitals (186). Studies over that same time period in 2020 also found, however, a decrease in police reports and referrals to child protective services compared with the previous few years. This decrease could reflect a reduction in child abuse or children’s more limited access to protective support networks – for example, because lockdown measures and school closures inhibited their access to relatives, friends, neighbours, school teachers and health care providers who could have identified and reported any abuse, and restricted access to shelters and other social support services (187-189). Children and adolescents may have also faced a heightened risk of online abuse due to increased time on the internet and social media, a concern that is discussed in Panel 3 (190).

2.5 Implications of education service disruptions on children and adolescents

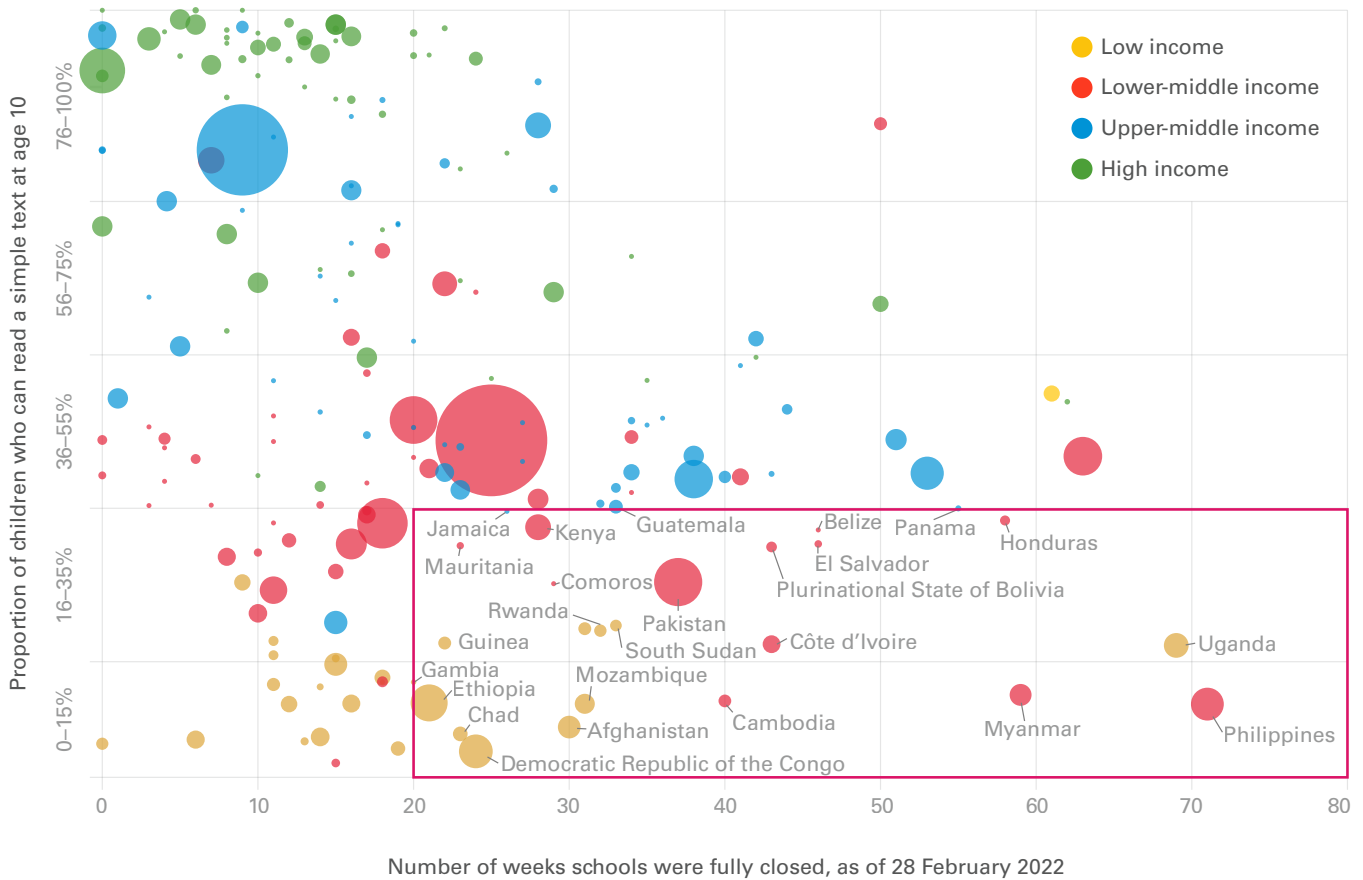
Disruptions in education systems have been a major concern in most countries. School closures have ranged from none or a couple of months in a handful of countries to more than a full school year in others. Provision of educational services has also been intermittent during the pandemic, with schools opening and closing depending on surges in cases of COVID-19. Virtual or hybrid options have left many students behind or prompted them to drop out of school. Worldwide, lack of internet connectivity and access to devices such as laptops or smartphones prevented at least one third of students from the possibility of pursuing learning remotely (191). In the second year of the COVID-19 pandemic, education disruptions continued: from February to May 2021, schools in around 30 countries remained fully closed and schools in 60 countries remained partially closed (192).

The longer the duration of school closure, the greater the time needed to make up for lost learning and the greater the risk that some students will never return. **Figure 2.4** shows a direct relationship between the length of time a school is

Increases in rates of child marriage, adolescent depression and anxiety, and **violence against women and girls** in the past two years are just a few of the trends that have heightened their vulnerability.



Fig. 2.4. Proportion of children who can read simple text and duration of school closures, as of 28 February 2022



Source: UNICEF (193).

closed and children's reading capabilities (193). Learning is not the only casualty 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 (194).

Findings from a literature review by the United Nations Educational, Scientific and Cultural Organization (UNESCO), UNICEF and World Bank of 104 countries and territories covered by existing literature indicated that about 80% of the children had learning losses related to pandemic-induced closures as of 22 February 2022 (193). Separately, according to UNESCO, while a majority of countries had fully opened schools at the end of February 2022, 42 countries had only opened schools partially and six countries still had their schools fully closed (191). Many education systems also have developed new policies and protocols aimed at limiting the need to close again due to COVID-19 or similar crises. However, the long-term impact of the COVID-19-related educational disruptions could be crippling if investments are not made to make up for the months of lost learning in primary and secondary schools and to halt and reverse increased school drop-out rates (195).

2.6 Indirect effects of COVID-19 on women’s, children’s and adolescents’ experience of food insecurity and poverty

Childhood, adolescence and pregnancy are life phases that require additional calories and healthy diets to ensure proper growth; however, the COVID-19 pandemic has contributed to higher hunger rates and lower availability of healthy diets, especially for persons living in LMICs. After remaining relatively unchanged since 2015, the prevalence of undernourishment (SDG Indicator 2.1.1) jumped from 8% in 2019 to around 9.3% in 2020 and continued to rise in 2021 – though at a slower pace – to around 9.8% (145). Almost 3.1 billion people could not afford a healthy diet in 2020. This is 112 million more than in 2019, reflecting the inflation in consumer food prices stemming from the economic impacts of the COVID-19 pandemic. Food inflation and scarcity prompted by the invasion of Ukraine in early 2022 has made the situation more precarious for millions around the world (145).

The ongoing impact of COVID-19 in terms of the multiple material deprivations (for example, education, health, housing, nutrition, sanitation and water) (196) experienced by individual children will continue to be a serious challenge and concern in most societies. Timely data are difficult to obtain, but 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 situation (197). There is some evidence that this situation may be improving, but the pace and extent of economic recovery are weaker in low-income countries (198). And although there has been an increase in social protection measures in many contexts, there is also evidence that these measures have primarily benefitted those already more advantaged (198). This suggests that the temporary social protection measures are failing to prevent women and children from falling into poverty.



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3.1 Key points from this progress report and lessons learned to help guide future efforts

The 2022 Global Strategy progress report provides an assessment of the situation of women's, children's and adolescent's health in this third year of the COVID-19 pandemic. Its analysis and discussion are guided by recent convergence in the global community around designing policies and programmes based on the nurturing care framework, adapted to encompass the preconception period through the first two decades of life. The nurturing care framework and the SDGs recognize the ripple effects of early life events throughout an individual's life course as well as the interconnectedness of women's, children's and adolescents' health with broader social, political and environmental events.

Section 1 presents abundant evidence showing that inequities persist despite great progress in reducing maternal and child mortality in the two decades leading up to the pandemic. A child's life trajectory and rights to health, education, opportunities and safety are still largely determined by where that child is born. Data showing stagnation or drops in coverage of lifesaving interventions similarly serve as a reminder of the need to be more vigilant about bridging gaps and placing women, children and adolescents at the centre of development efforts. Section 1 also showcases key drivers of women's, children's and adolescents' health and well-being. It emphasizes that women's empowerment and adolescent participation are pivotal to achieving the 2030 Agenda yet notes that there is a long way to go in reducing gender inequality and increasing young people's meaningful opportunities to actively engage in community and civic life. Also stressed is the importance of addressing the complex factors underpinning today's unacceptable levels of malnutrition and developing effective strategies to reach women, children and adolescents affected by conflict, forced migration, poverty and climate change impacts.

Section 2 takes stock of the direct and indirect effects of COVID-19 on women, children and adolescents. Although children and adolescents are less likely to experience severe health consequences from SARS-COV-2 infection compared with adults, multiple years of education, health, nutrition and social service disruptions have impacted and will continue to impact their lives (7,10,181,193). Even as much of the world has begun to focus on other threats, it is essential to reflect on lessons learned from the pandemic and its implications for the health and well-being of this and following generations.

The challenges ahead are daunting and there is a lot of ground to make up. However, it is possible to overcome many of these challenges if all stakeholders involved in delivering the 2030 Agenda recognize the urgency and play their part in accelerating progress.

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The swift formation of the Access to COVID-19 Tools Accelerator (ACT-A), a partnership launched by WHO and partners in April 2020, was a rapid and innovative response to the COVID-19 crisis (199). ACT-A brought together a consortium of stakeholders including governments, civil society, private sector actors and global health organizations to develop and equitably deliver COVID-19 tests, treatments and vaccines. It is an example of what can be done when the global community works jointly to combat major health threats. New efforts to improve the global architecture for addressing potential future pandemics and outbreaks such as the proposed development of a legally binding pandemic instrument to protect all families and communities (200,201), the establishment of the WHO hub for pandemic and epidemic intelligence (202), and the World Bank's Financial Intermediary Fund for Pandemic Prevention, Preparedness and Response (14) reflect the global community's commitment to continue working together on future disease outbreaks. Advocacy will be needed to ensure that women, children and adolescents are not forgotten in these and other evolving development-related initiatives, and that country priorities and perspectives are placed at the centre.

A major lesson from the pandemic is how much more can be accomplished through partnership compared with acting alone. This lesson serves as a call that renewed commitment across all stakeholders is needed to meet the holistic goals in the Global Strategy.

Another highlight from the past two years is the advancements made in data collection methods, guidelines and innovative strategies for delivering services across the continuum of care even under lockdown conditions. Examples include but are not limited to new guidelines on community engagement in quality of care initiatives for maternal, newborn and child health (203); materials developed through the Every Newborn Action Plan to improve measurement and monitoring of services for small and sick newborns (204); a new comprehensive agenda for promoting the health and well-being of children and adolescents (27); guidance on conducting telehealth consultations with children and adolescents (205); and policy briefs to protect children from the harmful impact of food marketing (206) and from tobacco and second-hand smoke (207). These accomplishments should be followed by efforts to increase their uptake and additional research on new approaches for reaching those left even further behind in the pandemic's wake.

The COVID-19 pandemic has made clear that health, well-being, economic development and political stability are interconnected. It has also underscored that country boundaries are porous and that strengthening primary health care and surveillance systems around the world will benefit all countries and people. There will be numerous entry points in the coming years to raise these issues and to place women, children and adolescents at the centre of discussions on them.

3.2 Recommendations to accelerate progress to benefit all women, children and adolescents

Listed below are recommendations, grouped around six main areas, for putting the world on track to achieve Agenda 2030 and that will enable women, children and adolescents to survive and thrive. All stakeholders involved in their health and well-being – governments, multilateral agencies, donors and foundations, civil society organizations, health care professional associations, private sector actors and academic and research institutions – have a responsibility for acting on them.

Strengthen primary health care systems to deliver essential interventions to all women, children and adolescents

All individuals, families and communities have a right to person-centred primary health care that offers equitable, high-quality and respectful care throughout the life course. Comprehensive primary health care systems provide services that are inclusive and accessible to every woman, child and adolescent, including those who are poor, from marginalized groups, living in remote locations and with disabilities.

Priority actions to build comprehensive primary health care systems include:

- Making primary health care systems ready to deliver the full spectrum of essential health services, including mental health and nutrition services, from preconception through the first two decades of life. This will require governments and their partners to invest in health care infrastructure and supply chains so that health care workers are able to provide services according to international and national standards. Investments in the health care workforce are also essential to ensure an adequate number of workers are trained and supervised, equitably distributed and sufficiently remunerated.
- Building strong community health components to increase service availability and acceptability. This would include implementing health literacy and other approaches to improving care-seeking behaviours and uptake of prevention and promotion services. It would also involve strengthening local accountability mechanisms to ensure health systems are responsive to community needs.
- Conducting implementation research that can generate evidence for tailoring interventions to specific contexts and improving service uptake and use. Research on service innovations is also needed to expand service availability, accessibility and acceptability. Telehealth and e-service options that were started during COVID-19 should be evaluated and continued or expanded as appropriate.

- Strengthening health information systems to enable countries to regularly collect, analyse and use high-quality data. Many countries experience substantial data gaps, thereby limiting their ability to use evidence to plan, implement and monitor health policies and programmes. (See Panel 5 on such gaps in relation to the 16 core Global Strategy Indicators.)

Improve multisectoral collaborations so that services are better integrated and reach every woman, child and adolescent

Improving women's, children's and adolescents' health and well-being cannot be achieved solely by strengthening health care services. Addressing social determinants of health is equally important. This means that all women, children and adolescents need access to social protection services and education and training opportunities. Good health also depends on availability of clean water and sanitation services as well as access to a diverse, nutritious diet.

Priority actions to improve service integration across sectors include:

- Increasing coverage of basic water and sanitation services and scaling up programmes on hygiene practices to interrupt the malnutrition-infection cycle.
- Increasing uptake of WHO's Essential Nutrition Action Framework (208) and improving the delivery of nutrition services through the health sector. Key services include ready-to-use products or therapeutic food for acute malnutrition, counselling to support and protect breastfeeding, and micronutrient supplements for pregnant women, children and adolescents. Building the nutrition competence of health care workers should also be prioritized.
- Increasing the availability of health and nutrition services delivered through school platforms including but not limited to mental health support, school meals and health education programmes on healthy eating, exercise habits and hand washing. Adolescents should be involved in the development of school programmes on nutrition, exercise and sexual and reproductive health to improve their uptake and positive effects.
- Making access to education equal so that all children and adolescents can learn and receive other services delivered through school platforms. Every child has the right to an education that offers that child access to skills and opportunities to build a productive life.
- Improving linkages between social protection and health services so that women, children and adolescents in need of services can be better identified and reached. Cash transfer and food voucher programmes should be implemented in areas experiencing financial hardship or food insecurity.

- Strengthening food fortification programmes through better links with the agricultural sector and improved communication through media and other channels. Food systems should be re-oriented to address food deserts and social media and advertising about food should be regulated, with particular attention to media targeted at children and adolescents.

Improve women's empowerment and bolster women's and adolescent girls' leadership opportunities

Women and adolescent girls have the same right to participate in civic life and engage in the labour force as men and adolescent boys. Improving women's empowerment can result in benefits to individual women, families and to societies. Securing women's and adolescents' sexual and reproductive rights, including reducing their exposure to violence, is also vital to their health and well-being.

Priority actions to improve gender equality and sexual and reproductive rights include:

- Proactive endorsement by governments and parliamentarians to boost women's representation in executive and legislative bodies, and to ensure they have real power as well as numbers.
- Introducing workplace policies across all sectors that are gender responsive. Strategies to eliminate gender bias in the workforce and to promote diversity and inclusivity, such as parental leave benefits, should also be implemented so that women are better able to advance in their careers.
- Championing sexual and reproductive rights at all levels, from grassroots to global, to ensure these rights are upheld.
- Investing in youth-led accountability processes and creating opportunities for adolescent girls and young women to become leaders and to participate in the design of programmes and policies that impact their lives.

Advance and leverage private-public partnerships to improve funding and services for women, children and adolescents

Better harnessing of private-public partnerships can increase the funding envelope for women's, children's and adolescents' health. Such partnerships are also crucial for increasing service availability, particularly in countries where a large portion of health care services are delivered through the private sector, and innovations in services and service delivery to improve their uptake and reach.

Secure increased financial investments by governments and their partners in women’s, children’s and adolescents’ health

As countries respond to emerging health threats, funding allocations to the health sector should be increased and diversions of funds from core services for women, children and adolescents should be avoided. Priority actions are described in Panel 6.

Secure the food supply and prioritize humanitarian food assistance while also building more resilient food systems

Humanitarian food assistance is a lifeline to women, children and adolescents living in severely food insecure or famine contexts and food assistance programmes need to be properly resourced. Food systems that are more resilient to the impacts of climate change and conflict situations also should be developed.

Priority actions to secure the food supply and reduce the risk of famine include:

- Preventing countries from hoarding food to protect domestic supplies and ending trade restrictions that affect access to fertilizer and hamper the global food trade. The multilateral architecture under the UN Decade of Action on Nutrition (2016–2025) (209) should work with the World Trade Organization on these tasks.
- Delivering humanitarian food assistance where there is a risk of famine such as countries experiencing severe drought.
- Developing longer-term strategies to build resilient food systems.



Panel 5. Addressing data gaps to achieve Agenda 2030

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 4 in 10 of the world's deaths remain unregistered (210). As noted in Section 2 of this report, the lack of age-disaggregated data and poor inclusion of women, children and adolescents in early COVID-19 research, testing and surveillance activities hampered definitive understanding of the direct effects of infection on them (211).

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 Cluster Surveys, resulting in far fewer surveys being conducted in 2020 and 2021 in comparison with previous years (212). Assessment of the 16 core Global Strategy indicators (213) further substantiates large data gaps and decreases in data collection efforts during the pandemic. **Table 3.1** shows that about half of the 11 indicators that are estimates are based on data from 2019 or earlier, data are available for less than half of WHO Member States for three of the four survey- or surveillance-based indicators.

Table 3.1. Availability of data for the Global Strategy's 16 core indicators

Indicators based on estimates for all or some countries	Number of WHO Member States with data or estimates (year)*
Maternal mortality ratio (per 100 000 live births) (SDG 3.1.1)	183 (2017)
Stillbirth rate (per 1000 total births)	194 (2019)
Neonatal mortality rate (per 1000 live births) (SDG 3.2.2)	194 (2020)
Under-5 mortality rate (per 1000 live births) (SDG 3.2.1)	194 (2020)
Adolescent mortality rate, by age and sex (per 100 000 population)	183 (2019)
Coverage of essential health services (index based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, noncommunicable diseases and service capacity and access) (SDG 3.8.1)	194 (2019)
Percentage of population using (a) safely managed sanitation services and (b) a hand-washing facility with soap and water (SDG 6.2.1)	78 (2020)
Prevalence of stunting (height for age <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age (SDG 2.2.1)	154 (2020)
Proportion of population with primary reliance on clean fuels and technology (SDG 7.1.2)	191 (2020)

Indicators based on estimates for all or some countries	Number of WHO Member States with data or estimates (year)*
Domestic general government health expenditure (including reproductive, maternal, newborn, child and adolescent health)	188 (2019)
Out of-pocket health expenses as percentage of total health expenditure	188 (2019)
Indicators based on surveys, civil registration and vital statistics or surveillance	Number of countries with data since 2019
Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1000 women in that age group (SDG 3.7.2)	183
Extent to which countries have laws and regulations that guarantee women aged 15–49 years access to sexual and reproductive health care, information and education (SDG 5.6.2)	74
Proportion of children under 5 years of age whose births have been registered with a civil authority, by age (SDG 16.9.1)	66
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 (SDG 4.1.1)	85
Indicator without data	
Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months (SDG 5.2.1) and proportion of young women and men aged 18–29 years who experienced sexual violence by age 18 (SDG 16.2.3)	There is no agreed upon methodology on how to combine these indicators. SDG 5.2.1 is tier I, for which data are regularly produced by countries for at least 50% of countries and of the population in every region where the indicator is relevant. Meanwhile, SDG16.23 is a tier II indicator, which is conceptually clear, has an internationally established methodology and standards are available, but data are not regularly produced by countries.

More than ever, routine health data systems are seen as extremely important to ensure continued and real-time monitoring during emergencies such as the COVID-19 pandemic. Due to the difficulties of conducting in-person surveys during the pandemic, WHO and partners developed guidance on the analysis and use of routine data to monitor the effects of COVID-19 on essential health services, with a section dedicated to reproductive, maternal, newborn, child and adolescent health (RMNCAH) (214). Several countries used these routine data to assess the indirect impact of the COVID-19 pandemic on health services (173-176). Given what was learned during the pandemic, the analysis and use of health facility data

guidance for RMNCAH programme managers document (215) is being updated. It will be critical in the future to invest more in country routine health information systems (216).

In addition to intervention coverage, it is important to measure and monitor the quality of care, which is essential for health services to result in expected improvements in health outcomes. However, measurement of quality of care remains fragmented and non-standardized (217). Recently there have been efforts to improve the standardization of measures to assess quality of care for women and children (218,219). However, just as with routine health information systems, more investments are needed to improve this area of measurement and monitoring.

Panel 6. Financing for women's, children's and adolescents' health

Pre-COVID stagnation in funding for women's, children's and adolescents' health

Despite the launch in 2015 of the Global Financing Facility for Women, Children and Adolescents (GFF), financing trends for women's, children's and adolescents' health prior to the COVID-19 pandemic indicated an urgent need for substantial investment to bridge worsening equity gaps that threaten the achievement of the Global Strategy goals. While investments in many health areas saw positive annual increases in the period 2015–2019, in many cases these increases were smaller than those seen during the Millennium Development Goals era (2000–2015) (220).

Meagre increases in official development assistance

Evidence from 2019 suggested that the previous positive trend in development assistance for health, which had already begun to weaken, was at risk of slowing down even further (221). Since then, COVID-19 and conflict situations such as the Ukraine crisis have negatively impacted national economies. Both official development assistance (ODA) from donor countries and domestic funding have been directed to response and recovery efforts, leaving less funding available for other priorities. The need to address the climate crisis may further limit prospects for increasing funds allocated to women's, children's and adolescents' health.

Preliminary evidence from the Organisation for Economic Co-operation and Development (OECD) suggests there was a 4.4% increase in ODA from 2020 to 2021 (222). However, this figure is largely inflated by donations for COVID-19 vaccines. If COVID-19 vaccine purchases are excluded, the ODA increase falls to a meagre 0.6%. ODA to low-income countries (LICs) in 2021 only grew by 1%, and by 2.5% to the least-developed countries. Cuts and reallocation of ODA enacted by some OECD countries in 2022 (223) will have a significant detrimental impact on the most vulnerable women, children and adolescents with potential long-term effects.

Domestic health spending also set to fall in many countries

Shortfalls in ODA come against a backdrop of a reduced fiscal space that prevents several countries, especially LICs, from securing the necessary domestic investments to improve women's, children's and adolescents' health. According to the latest macro-fiscal projections from the International Monetary Fund, 126 countries will increase their per capita general government expenditure (GGE) above pre-COVID levels in the next five years (224,225). Yet in 52 countries (non-GGE-growth countries), per capita GGE is

projected to remain below pre-pandemic levels. These countries will face harsh choices and may opt to fund other priorities at the expense of essential health services.

Two years into the pandemic, the Independent Panel on Pandemic Preparedness and Response notes that, despite repeated calls for targeted action, there is still a lack of domestic investment in strengthened national public health institutions, health systems and social protection systems on the scale needed to build resilience to cope with future crises (226). For most LICs to get on track in meeting Global Strategy targets, unprecedented increases in health spending – reaching historical highs comparable to the extraordinary spending commitments of high-income countries – will be required. This financing crisis for global health needs to be widely recognised and addressed as a highest priority.

Leadership required to increase the impact of investments

The World Bank Group, International Monetary Fund, WHO and World Trade Organization Multilateral Leaders Task Force has called for urgent international support for countries facing weak government spending growth in the years ahead (225). In addition to increased investment, it is more important than ever to improve the efficiency and impact of domestic health financing and development assistance for health. Greater political will and leadership is required to align and direct resources in support of national goals for women, children's and adolescents' health, and to bolster transparent financial management and accountability mechanisms.

Development partners, governments and other stakeholders should work together to extend and scale up innovative and equity-enhancing financing strategies, such as blended financing mechanisms, to improve service coverage among women, children and adolescents. All partners should also support multisectoral action to acknowledge and address the differentiated impacts of health financing decisions on them, including in relation to gender, race, income and sexual orientation.

More evidence is required to understand how resources can be most effectively distributed and expended at subnational levels to improve health outcomes for the most vulnerable women, children and adolescents. Monitoring financial trends will help to build a stronger evidence base to support financing for equity in relation to their health and well-being wherever they live.

Greater investment in women's, children's and adolescents' health will have positive effects that extend far beyond national borders. Such investment is one of the most powerful levers for a global pandemic recovery and will build a healthier, more productive and resilient future for all.



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Photo captions

Cover photo: Zenaba Oumar, 35, is cuddling her 7 months old baby Hadja outside the health center at the Amma internally displaced persons camp near Liwa, Chad.

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Introduction: Young girl from Santa Rita, Bolivia.

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Page 3: Mudassar, 11 months old, tastes ready-to-use therapeutic food to treat severe acute malnutrition at the nutrition camp set up by UNICEF for flood-affected children in Sukkur, Pakistan. Mudassar and his family were displaced when torrential monsoon rains and subsequent floods washed away their village in another district.

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Page 4: Semah, 8, poses for a portrait outside her school in Surkhrod district, Nangarhar province, Afghanistan, in 2019. She and her family came from Kunar province to Surkhrod district so that she could attend school.

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Page 16: Sanaicar, 5, and her friend Neldaisha, 4, draw pictures at “La casita”, a shelter for unaccompanied children in Metetí, Darién province, Panama, where children are cared for and protected until reunification with their families. The two girls are children of Haitian migrants and arrived in Panama unaccompanied, but both were reunited with their families the day after his picture was taken.

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Page 19: Waleed Al-Ahdal, who lives with his children in Al Jufaina internally displaced persons camp in Marib Governorate, Yemen, prepares the Iftar, the evening meal during Ramadan, for the children and himself.

© UNICEF/UN0624745/Al-hamdani

Page 22: Veronika, 10, and her mother Svetlana hug each other outside their temporary apartment in Krakow, Poland. The family fled the war in

Ukraine and plans to continue living in Poland until it is safe to go back to their homeland.

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Page 31: A child plays in the floodwaters in Gatumba, near Bujumbura, Burundi. Burundi, one of the poorest countries in the world, is extremely vulnerable to natural disasters brought on by the climate emergency.

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Page 32: A mother provides kangaroo care to her newborn infant in the special newborn care unit at Dantewada district hospital Chhattisgarh, India.

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Page 34: Birendra, 10, a student at the Mahendra Secondary School in Dadeldhura district, Nepal, receives the COVID-19 vaccine.

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Page 43: A mother and child in Puerto Cabezas, Nicaragua, standing in an area devastated by Hurricane Eta.

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Page 44: A father and child at a health center in Libreville, Gabon, that provides immunization services and medical check-ups for children.

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Page 50: Muih, 7, and his parents are attending a UNICEF-supported parenting club in Gia Lai, Viet Nam. Parenting clubs are part of a child care support system for mothers as well as fathers, whose role in childhood development is highlighted during club meetings.

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Page 55: Fatoumata Zara Alhader, 15, lives in Tahoua, Niger. She was only 12 years old when her father wanted to marry her off to a cousin, but her mother intervened. Fatoumata now lives with her mother and grandmother.

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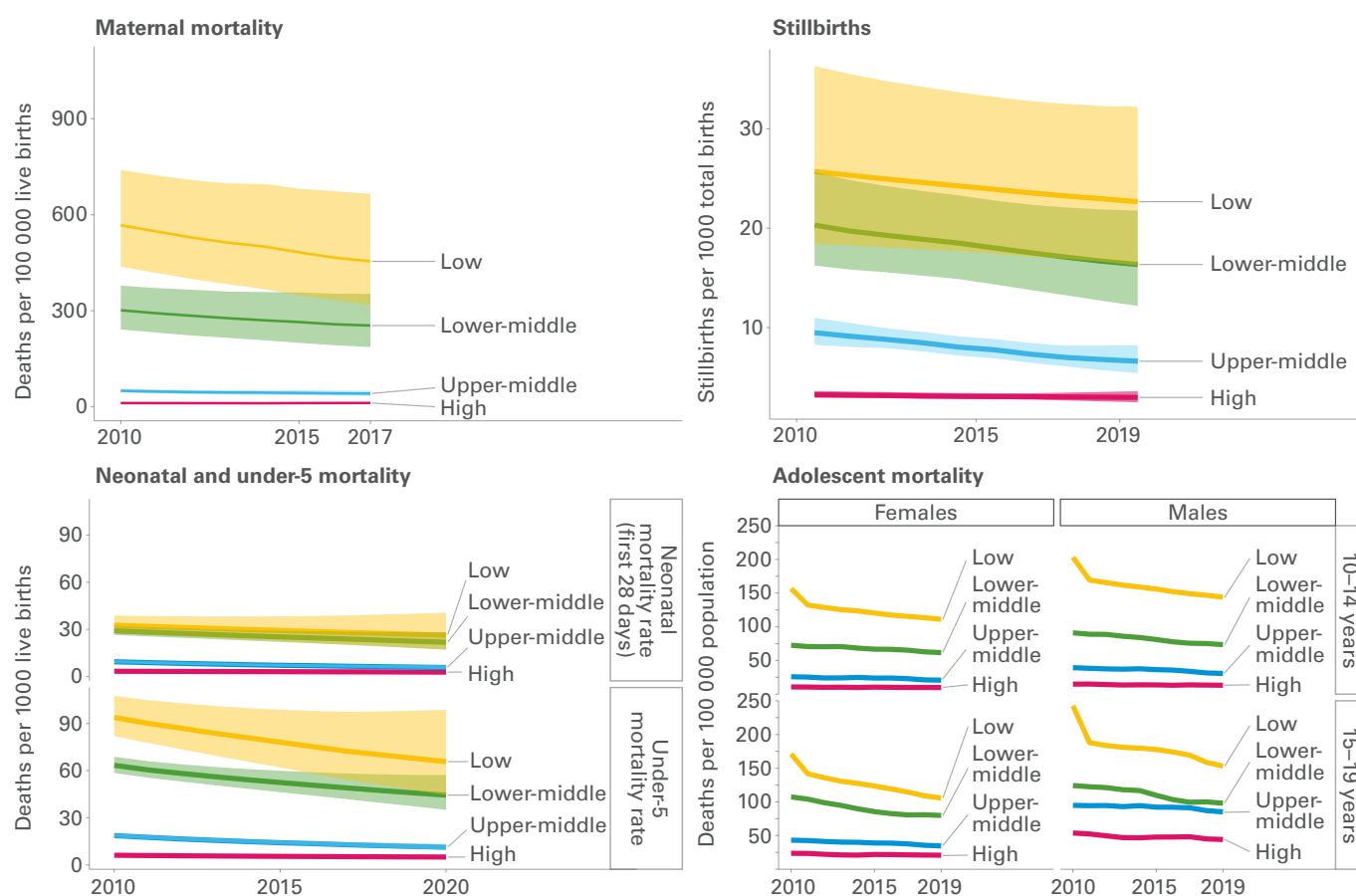
ANNEX: Global Strategy indicators

The annex presents the Global Strategy indicators, organized by the strategy's three components of survive, thrive and transform. Indicators displayed are those with available data on trends and able to be disaggregated by country income group (high, upper-middle, lower-middle and low).

- **Survive:** Income-group trends in mortality including maternal mortality, stillbirths, neonatal mortality, under-5 mortality, and adolescent mortality
- **Thrive:** Income-group trends in coverage of interventions, adolescent birth rate, health expenditure and clean fuels
- **Transform:** Income-group trends in birth registration, schooling and sanitation

Survive

Income-group trends in mortality: Maternal mortality, stillbirths, neonatal mortality, under-5 mortality and adolescent mortality



Notes and sources:

Maternal mortality: The maternal mortality ratio (MMR) is the number of maternal deaths during a given time period per 100 000 live births during the same time period. The solid line represents the maternal mortality rate and the shaded area represents the 80% uncertainty around the value. Source: Trends in maternal mortality, 2000 to 2017: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Geneva: World Health Organization; 2019 (https://www.unfpa.org/sites/default/files/pub-pdf/Maternal_mortality_report.pdf).

Stillbirths: Stillbirths per 1000 total births. The solid line represents the median and the shaded area represents the 90% uncertainty around the median value. Source: United Nations Inter-agency Group for Child Mortality Estimation (UN IGME). Levels and trends in child mortality: report 2020. Estimates developed by the United Nations Inter-agency Group for Child Mortality Estimation. New York: United Nations Children's Fund; 2020 (<https://www.unicef.org/media/79371/file/UN-IGME-child-mortality-report-2020.pdf>).

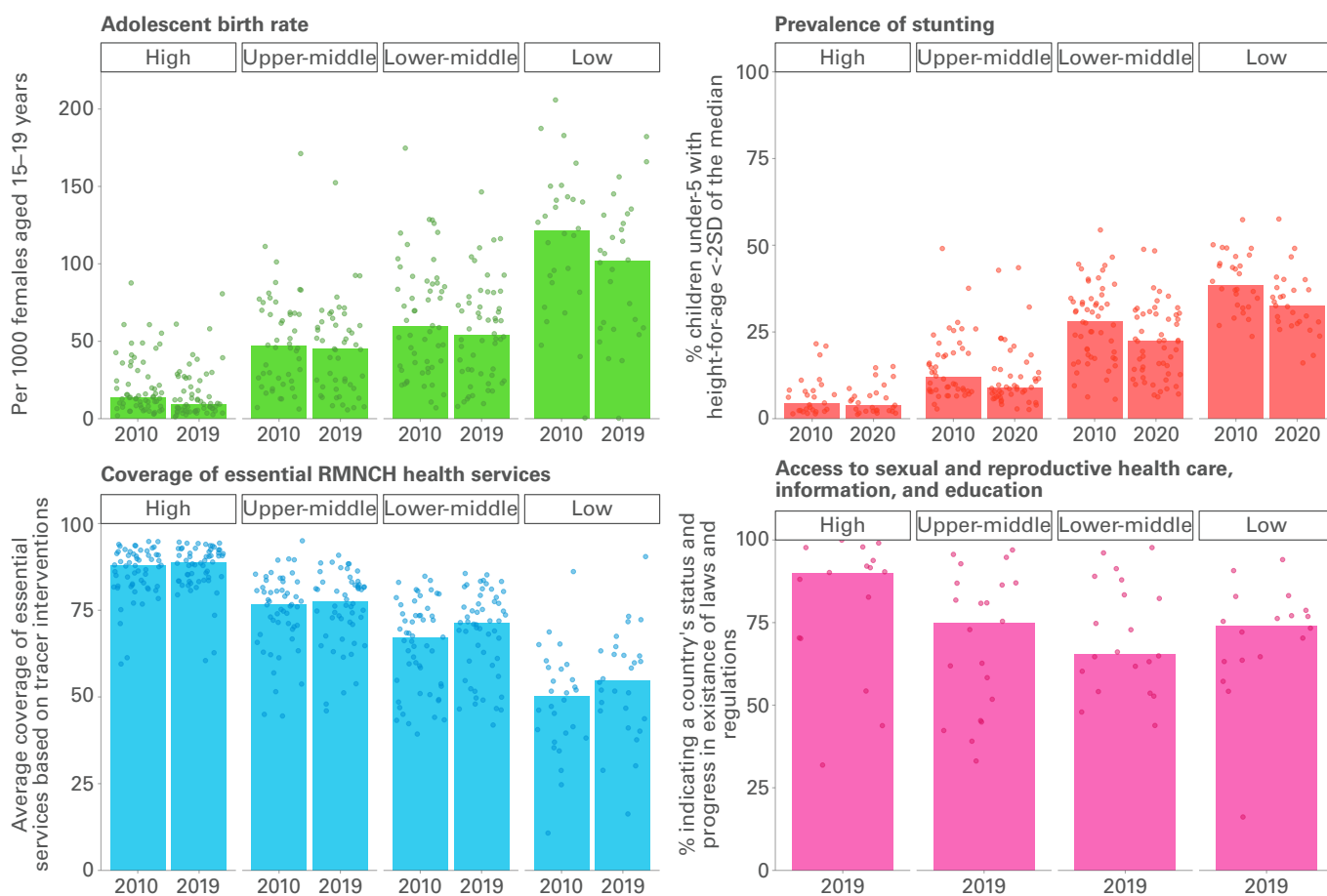
Neonatal mortality: Probability of dying in the first 28 days of life, expressed per 1000 live births. The solid line represents the median and the shaded area represents the 90% uncertainty around the median value. Source: United Nations Inter-agency Group for Child Mortality Estimation (UN IGME). Levels and trends in child mortality: report 2021. Estimates developed by the United Nations Inter-agency Group for Child Mortality Estimation. New York: United Nations Children's Fund; 2021 (<https://childmortality.org/wp-content/uploads/2021/12/UNICEF-2021-Child-Mortality-Report.pdf>).

Under-5 mortality: Probability of dying between birth and exactly 5 years of age, expressed per 1000 live births. The solid line represents the median and the shaded area represents the 90% uncertainty around the median value. Source: United Nations Inter-agency Group for Child Mortality Estimation (UN IGME). Levels and trends in child mortality: report 2021. Estimates developed by the United Nations Inter-agency Group for Child Mortality Estimation. New York: United Nations Children's Fund; 2021 (<https://childmortality.org/wp-content/uploads/2021/12/UNICEF-2021-Child-Mortality-Report.pdf>).

Adolescent mortality: 10–14 years mortality rate – probability of dying between age 10 years and age 15 years (expressed per 1000 children aged 10 years); 15–19 years mortality rate – probability of dying between age 15 years and age 20 years (expressed per 1000 children aged 15 years). Source: United Nations Inter-agency Group for Child Mortality Estimation (UN IGME). Levels and trends in child mortality: report 2021. Estimates developed by the United Nations Inter-agency Group for Child Mortality Estimation. New York: United Nations Children's Fund; 2021 (<https://childmortality.org/wp-content/uploads/2021/12/UNICEF-2021-Child-Mortality-Report.pdf>) and data from (<https://childmortality.org/>).

Thrive

Income-group trends in coverage of care and health outcomes trends



Notes and sources:

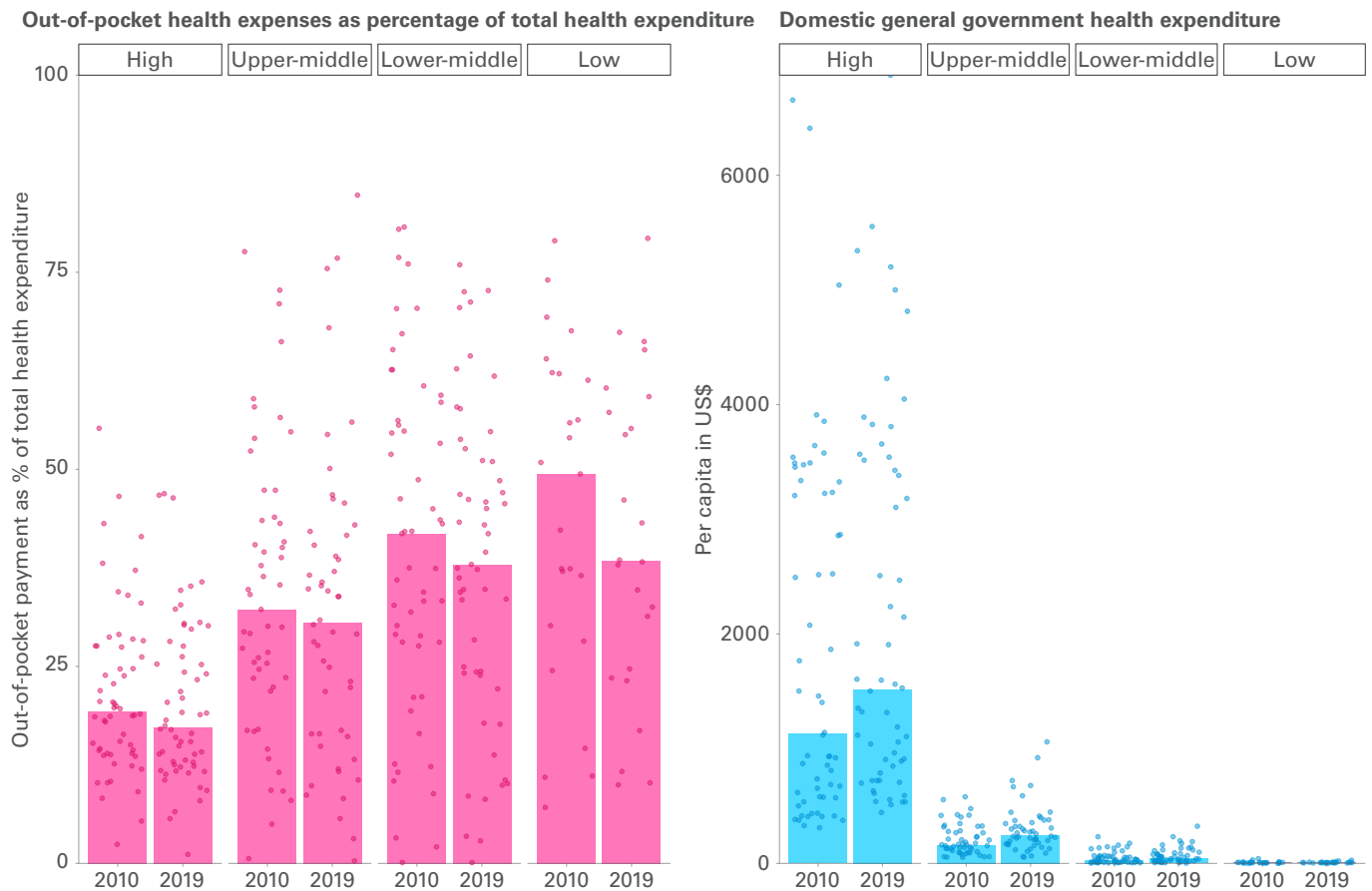
Adolescent birth rate: The annual number of births to women aged 15–19 years per 1000 women in that age group. Each point represents a country and the bar represents the median value of all countries. In order to maximize the number of countries with available data, estimates were used. Source: United Nations Population Division. World population prospects 2022.

Prevalence of stunting: Height-for-age <-2 standard deviation from the median of the World Health Organization child growth standards among children aged under 5 years. Each point represents a country and the bar represents the median value of all countries. Source: United Nations Children’s Fund, World Health Organization, International Bank for Reconstruction and Development/The World Bank. Levels and trends in child malnutrition: key findings of the 2021 edition of the joint child malnutrition estimates. Geneva: World Health Organization; 2021 (<https://www.who.int/publications/i/item/9789240025257>).

Coverage of essential RMNCH health services: Defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health. Each point represents a country and the bar represents the median value of all countries. Source: Primary health care on the road to universal health coverage:2019 monitoring report. Geneva: World Health Organization: 2019 (file:///C:/Users/user/Downloads/uhc_report_2019.pdf).

Access to sexual and reproductive health care, information, and education: Percentage (%) scale of 0 to 100 (national laws and regulations exist to guarantee full and equal access), indicating a country’s status and progress in the existence of such national laws and regulations. Each point represents a country and the bar represents the median value of all countries. Source: United Nations Population Fund global databases, 2020 (<https://www.unfpa.org/data>). Based on official responses to the United Nations 12th Inquiry among Governments on Population and Development.

Income-group trends in health expenditure

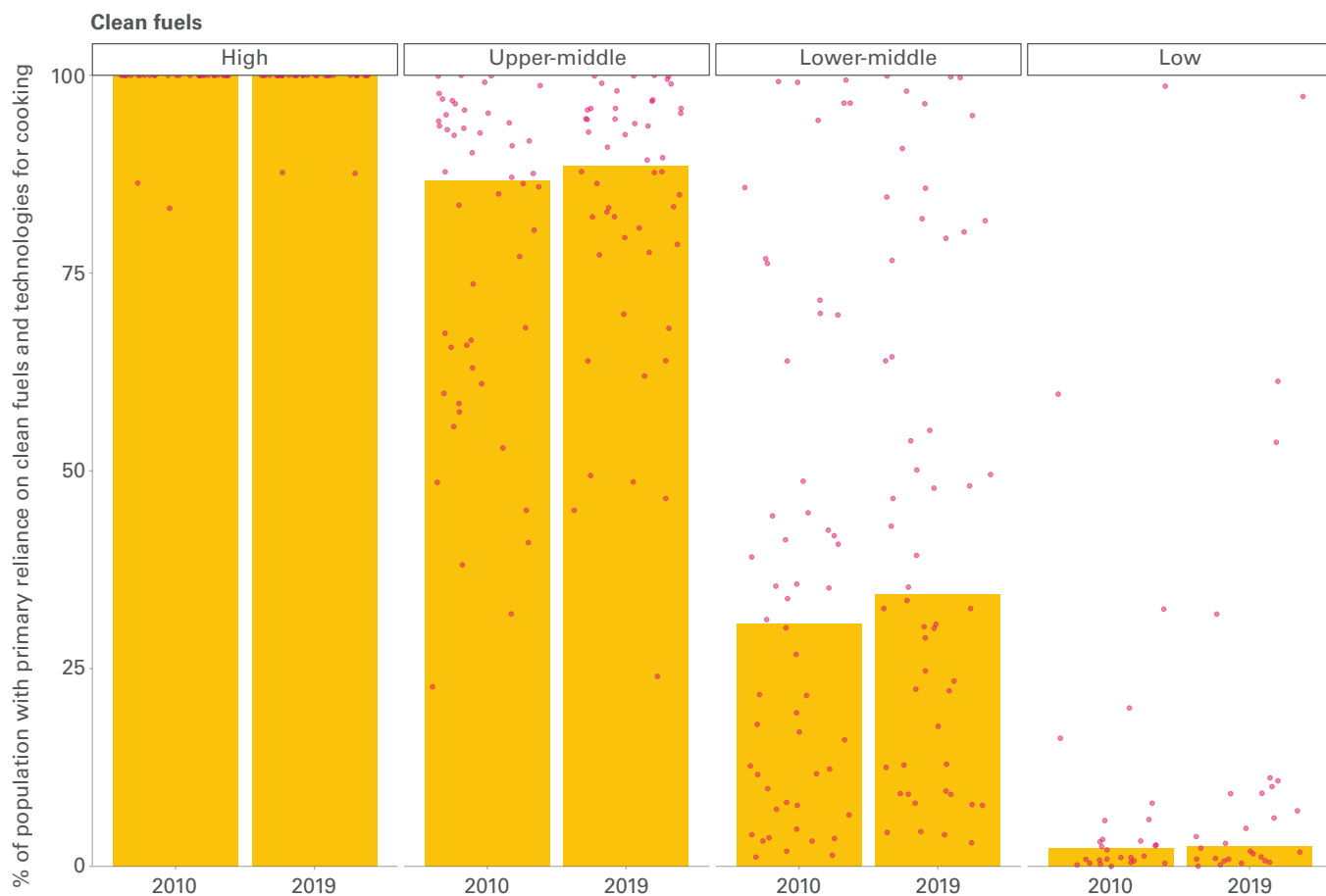


Notes and sources:

Out-of-pocket expenditure: Share of out-of-pocket payments of total current health expenditures. Each point represents a country and the bar represents the median value of all countries. Source: World Health Organization. Global health expenditure database [website] (<https://apps.who.int/nha/database>).

Domestic general government health expenditure: Average domestic general government health expenditures per person in US\$. Each point represents a country and the bar represents the median value of all countries. Source: World Health Organization. Global health expenditure database [website] (<https://apps.who.int/nha/database>).

Income-group trends in clean fuels



Notes and sources:

Clean fuels: Proportion of population with primary reliance on clean fuels and technology is calculated as the number of people using clean fuels and technologies for cooking, heating and lighting divided by total population reporting that any cooking, heating or lighting, expressed as percentage. Clean is defined by the emission rate targets and specific fuel recommendations (i.e., against unprocessed coal and kerosene) included in the normative guidance WHO guidelines for indoor air quality: household fuel combustion. Each point represents a country and the bar represents the median value of all countries. Source: Modelled based on nationally representative surveys and censuses compiled by WHO that provide estimates of primary cooking fuels and technologies.

Transform

Income-group trends in birth registration, schooling and sanitation



Notes and sources:

Birth registration: Estimated level of coverage of birth registration (%) since 2011. Each point represents a country and the bar represents the median value of all countries within each World Bank income group. Source: UNICEF global databases, 2021, based on DHS, MICS, other national surveys, censuses and vital registration systems.

Schooling: Percentage of children and young people in grade 2 or 3 of primary education, at the end of primary education and the end of lower secondary education achieving at least a minimum proficiency level in (a) reading and (b) mathematics. Each point represents a country and the bar represents the median value of all countries. Most recent estimate for a country used for each time period. Source: United Nations Educational, Scientific and Cultural Organization. Institute for Statistics.

Handwashing and sanitation: Handwashing – percentage of the population living in households that have a handwashing facility with soap and water at home. Sanitation – percentage of the population using at least basic sanitation services, that is, improved sanitation facilities that are not shared with other households. Each point represents a country and the bar represents the median value of all countries. Most recent estimate for a country used for each time period. Source: WHO/UNICEF Joint Monitoring Programme estimates.

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