



CELEBRATING
10 YEARS

PROTECT THE PROGRESS:

Rise, Refocus, Recover

2020 Progress Report on the Every Woman Every Child Global Strategy
for Women's, Children's and Adolescents' Health (2016–2030)



EVERY WOMAN
EVERY CHILD

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Protect the progress: rise, refocus and recover. 2020 progress report on the Every Woman Every Child Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)

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10 YEARS

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“The **achievements** of the Every Woman Every Child movement in the past 10 years have been outstanding in terms of **mobilizing action** to generate greater investment in and to deliver services for the health and rights of more and more women, children and adolescents. Through **active promotion** of the EWEC framework – survive, thrive and transform – EWEC plays a central role in **maintaining momentum** towards the achievement of the Sustainable Development Goals, and ultimately towards securing gender equality and human rights. As the world faces multiple crises that threaten this important progress, now more than ever, partners need to **recommit** to the EWEC agenda and prioritize attention to ensuring the **health, lives** and **rights** of all women, children and adolescents.”

MICHELLE BACHELET

United Nations High Commissioner for Human Rights

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“The work of the Every Woman Every Child movement to realize **gender equality** through improving the health of women, girls and adolescents everywhere has been **groundbreaking**. Women, girls and adolescents have the human right to health, and improving their health is key to achieving sustainable development by 2030. Improved health and gender equality can also contribute to **more peaceful and stable societies**. Every Woman Every Child has been **making a difference** for 10 years and I have been honoured to support this work.”

H.E. TARJA HALONEN

Former President of Finland and Alternate Co-Chair of the High-level Steering Group for Every Woman Every Child

Foreword



2020 started with some promise and hope for the Every Woman Every Child initiative. One decade since it was launched by my predecessor, former United Nations Secretary-General Ban Ki-moon, maternal mortality and child marriages were declining and more children lived to see their first birthday than at any time in history.

COVID-19 is now compounding global challenges, including humanitarian and climate crises, and putting the progress that has been achieved at grave risk. Measures to control the virus have disproportionately affected women and children, through lower rates of immunization, school closures, higher reported rates of violence against girls and women, and increased poverty, hunger and food insecurity. The pandemic has made achieving the SDGs – and realizing their promise for women, children and adolescents everywhere – seem less likely than at any time since the 2030 Agenda was launched five years ago.

This report on the *United Nations Every Woman Every Child Global Strategy for Women's, Children's and Adolescents' Health* comes at a critical time for the strategy itself – and for the Every Woman Every Child movement driving it. After focusing on women, child and adolescent health for a decade, we know what works. We must protect the progress that has been made, through continued support for the global partnerships that have advanced the SDGs for some of the world's most vulnerable people.

It is our collective responsibility to ensure that progress for women, children and young people is not reversed by conflict, the climate crisis or COVID-19. The will to fight the pandemic must be matched by the will to honour the commitments and investments that have been made. Failure to do so could result in close to 23 million 5- to 24-year-olds and 48 million children under five dying before 2030 – an unconscionable prospect. I call on all to refocus our efforts so that maternal, child and adolescent health is not neglected as we respond to the COVID-19 crisis.

Together, we can and must steer the recovery from the pandemic towards a more inclusive and sustainable path, leaving no woman, child or adolescent behind.

A handwritten signature in black ink, which appears to be "António Guterres". The signature is fluid and cursive, written on a white background.

António Guterres

A child drinks water from a well point in Gwembe Valley, Zambia, that was rehabilitated with UNICEF support.



“Ten years ago, the founders of Every Woman Every Child showed remarkable foresight in calling for a **global movement** that would build on the **collective strength** of international organizations, governments, the private sector and civil society to end all preventable deaths of women, children and adolescents. Recent months have proven them right and shown that there can only be an **effective response** to global health challenges if we all pull in the same direction and if we **give a voice to everyone**, including women, children and the most vulnerable communities. Recent months have also highlighted how women, who make up the bulk of the health workforce, have often been left out of decision-making processes, and how children suffer the consequences of our lack of preparedness. COVID-19 is but one in a series of health crises we need to tackle but it is a wake-up call for us to recommit to **inclusive governance** and **genuine collaboration** for the well-being of all.”

ELHADJ AS SY
Chair, Kofi Annan Foundation



Message from the Co-Chair of the High-Level Steering Group for Every Woman Every Child



Dear friends,

This year marks the 10th anniversary of Every Woman Every Child, a global health movement driving ambitious action for women's, children's and adolescents' health and well-being. It has been a tremendous decade. Many thanks to everyone who has contributed towards the achievement of our important goals.

And indeed, there's much to celebrate. We have witnessed significant declines in child and maternal mortality – over 25 million child marriages have been prevented, and more girls are going to school and staying in school than ever before. These and other important advances would not have been as great – or perhaps would not have been attained at all – without Every Woman Every Child's dedicated and focused efforts to implement its landmark Global Strategy for Women's, Children's and Adolescents' Health.

However, this progress has not reached every woman, nor every child. Many deep-rooted inequities continue to deprive women, children and adolescents of their rights. To cite just a few examples:

Conflict – in-country or in the home – climate and contagion are enormous threats to the health and well-being of women, children and adolescents around the globe.

Humanitarian crises are a major source of injustice. Maternal and child mortality rates are substantially higher in countries chronically affected by conflict, and 40% of under-5 deaths globally occur in fragile contexts.

Discrimination, abuse and violence against women, children and adolescents – which are among the most widespread of human rights violations – continue to erode physical and mental health. The unrelenting and dire threats to their safety and security are illustrated to shocking effect in statistics that reveal persistently high rates of intimate partner violence and the disproportionate impact of HIV on adolescent girls in some of the countries hardest hit by AIDS.

The climate crisis, now an existential threat, continues to have a disproportionate impact on women and children. The evidence is clear: exposure to polluted air prenatally and during the newborn period is associated with many negative consequences, including increased risk of acute respiratory diseases in childhood, considerable morbidity and mortality, reduced lung function, slowing brain maturation, and impaired growth in cognitive function in schoolchildren.

Disease has long been a barrier to progress – and the world is now confronting its newest contagion in the novel coronavirus. The COVID-19 pandemic has exposed

the lack of fairness in societies around the globe. It is an unprecedented threat that has already disrupted routine childhood vaccinations, kept children out of school, reduced access to sexual and reproductive services, increased rates of gender-based violence, and more.

The current situation may be challenging, but it is time to go from crisis to comeback. Protecting the progress requires putting women and children front and centre of all responses to the pandemic. However, this should only be the first step. Vulnerabilities, challenges and needs should also guide a wide range of health, social and economic policies and decisions that can advance overall well-being.

We need national policies and budgets to target inequality and protect human rights, including protecting national budgets and services for women's, children's and adolescents' health. We need global solidarity and cooperation. We need multilateralism and multi-stakeholder partnerships that Every Woman Every Child supports, and that have been so vital over the past decade and are now needed on an unprecedented scale. Because doing things on our own simply doesn't work.

We should learn from the COVID-19 pandemic that showed to all of us – from Europe to Africa to small island states – the importance of technologies. I firmly believe that digitalization is an equalizer of opportunity. And we should also use digital means to strengthen the EWEC movement and its goals. By using new technologies, we can reach out to a wider audience of supporters to raise awareness and help those in need more successfully.

EWEC is heading into its second decade with an even stronger mandate to achieve its goal of a world in which every woman, child and adolescent not only survives, but thrives and transforms. That can only be achieved when everyone, in every setting, realizes their rights to physical and mental health and well-being, has social and economic opportunities, and is able to participate fully in shaping sustainable and prosperous societies.

The urgent need to overcome obstacles to this vision is as critical today as it was at the movement's launch in 2010.

2020 can still go down in history as the year that the world and its leaders came together to halt and reverse a potential long-lasting decline and catastrophe. It is up to us, all of us – world leaders, and world citizens – to ensure this is the crisis when we finally got it right. In doing so we need to work together, with a strategic view and focused plan, and use every means to deliver our message, mobilize new supporters and advocates, and help the most vulnerable among us.

Thank you.

**President of the Republic of Estonia
Co-Chair of the High Level Steering Group
for Every Woman Every Child**

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ABBREVIATIONS

CoC	continuum of care
CSO	civil society organization
DTP3	diphtheria–tetanus–pertussis
EWEC	Every Woman Every Child
FP2020	Family Planning 2020
GDP	gross domestic product
GFF	Global Financing Facility
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
ICPD	International Conference on Population and Development
MAYE	Global Consensus Statement on Meaningful Adolescent and Youth Engagement
MCV1	measles-containing-vaccine first-dose
NGO	nongovernmental organization
ORS	oral rehydration salts
PMNCH	Partnership for Maternal, Newborn and Child Health
RMNCAH	reproductive, maternal, newborn, child and adolescent health
SDG	Sustainable Development Goal
SUN	Scaling Up Nutrition
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
WASH	water, sanitation and hygiene
WHO	World Health Organization

Executive summary

THE PAST 10 YEARS HAVE BEEN
A **TIME OF PROGRESS** FOR
MANY OF THE WORLD'S WOMEN,
CHILDREN AND ADOLESCENTS



Zahra, 18, holds her 6-month-old daughter, Zaineab, at an emergency shelter in Vienna. They, and Zaineab's father, Abbas, are from Ghazni, Afghanistan, and are among refugees who are living in the shelter.

“

The COVID pandemic may have shifted the focus of interventions, but the needs of adolescents, women and children will continue during and long after this pandemic. Slowing the progress will have a long-term impact on social and economic development for many generations to come.”

**NATASHA SALIFYANJI
KAOMA**

CEO, Copper Rose Zambia
and member of the
High-Level Steering Group
for Every Woman Every Child

Trends in women’s, children’s and adolescents’ health in the past 10 years: progress for many but not for all

The past 10 years have been a time of progress for many of the world’s women, children and adolescents, and the Every Woman Every Child (EWEC) movement, launched in September 2010, has been one of the key multilateral drivers of progress in this regard. The movement’s mobilizing efforts have contributed to dramatic success throughout the decade in many indicators relevant to women’s, children’s and adolescents’ health, such as in reducing maternal and child mortality and in improving child nutrition and education. Yet, inequities have persisted across regions and countries, and within countries.

- The number of maternal deaths worldwide dropped from an estimated 451 000 in 2000 to 295 000 in 2017, a reduction of about 35%, with the most significant declines occurring since 2010. These deaths, however, are not evenly distributed and are increasingly concentrated in sub-Saharan Africa and South Asia, where 86% of all maternal deaths occurred in 2017.
- The mortality rate for children aged under 5 years declined by almost 50% between 2000 and 2019, from 76 deaths per 1000 live births to 38. The neonatal mortality rate declined at a slower pace during this same period, from 30 deaths per 1000 live births to 17, a 42% decrease. An increasing proportion of child deaths are now occurring during the neonatal period in sub-Saharan Africa, the only subregion where the child population is expected to grow in the coming decades, and among the most disadvantaged population groups in all countries.
- Coverage levels of key interventions vary across the continuum of care for women’s, children’s and adolescents’ health in low- and middle-income countries. Coverage of some interventions, such as immunizations, skilled attendant at birth and access to safe water, currently exceeds 80%, but falls below 50% for others, including exclusive breastfeeding and treatment of diarrhoea with oral rehydration salts (ORS). These differences indicate areas of success that need to be sustained with continued resources, and gaps that need to be filled.
- Assessing trends in intervention coverage sheds light on whether progress has been accelerating, stagnating or even reversing since EWEC was first launched. The findings, pre-pandemic, are more positive than negative. Five out of 16 interventions tracked showed 10 percentage points or greater changes in coverage throughout the past 10 years; among those were treatment of pregnant women with HIV, which has improved as a result of substantial global investment; rotavirus vaccine, which is a relatively new intervention being rapidly adopted and scaled up by countries; and postnatal care for babies, the success of which can be attributed in part to considerable global advocacy and emphasis in recent years. Concerning trends are declines in diphtheria–tetanus–pertussis and measles vaccinations, and very

modest gains in the treatment of pneumonia and diarrhoea. These declines and slow gains are a reminder that even interventions that had achieved high coverage levels can suffer reversals if women’s, children’s and adolescents’ health does not remain high on the political agenda.

- Equity analyses are core to accountability. The variations in progress underscore that strategies to achieve success must be adapted to the widely divergent realities at both regional and country levels. This adaptation process must involve a focus on subnational patterns to determine which population groups are missing out and where they are located. Sensitivity to local context and history is essential for developing effective and relevant policies and programmes in all countries.
- Achieving the Sustainable Development Goals and the vision of EWEC requires a focus on the most disadvantaged. Women and children living in wealthier households in every region have much higher coverage levels on average for a core set of reproductive, maternal, newborn and child health interventions than their poorer counterparts. Household wealth in all countries and regions plays a key role in whether women and children receive the services they need. These unacceptable inequities need to be addressed through strategies that target disadvantaged population groups and aim for universal health coverage.

The power of commitments in driving success: EWEC’s role and contributions

A building block for progress in women’s, children’s and adolescents’ health and well-being is political commitment and financial investments. EWEC’s convening power – and the strong support for its mandate and multi-stakeholder approach – is reflected in the commitments galvanized across sectors and issue areas that have played an important role in driving progress throughout the past decade.

- **Since 2010, the movement has mobilized 776 commitments, including financial commitments worth a cumulative total of nearly US\$ 186 billion** by governments and other partners. The 348 commitments, including financial commitments made since the launch of the updated Global Strategy and the 2030 Agenda for Sustainable Development in September 2015 were worth a total of about US\$ 44 billion. That amount is in addition to an unprecedented estimated US\$ 97 billion commitment for women’s, children’s and adolescents’ health from the Government of India. Financial commitments have increased over time from low-income and low- and middle-income countries, and pledges from civil society increased by US\$ 7 billion between 2018 and 2019, from US\$ 4.9 billion to US\$ 11.9 billion.
- The commitments covered all six of the EWEC focus areas, and results from a survey of nongovernmental commitment makers give an idea of scope:

A BUILDING BLOCK
FOR PROGRESS
IN WOMEN’S,
CHILDREN’S AND
ADOLESCENTS’
HEALTH AND
WELL-BEING
IS POLITICAL
COMMITMENT
AND FINANCIAL
INVESTMENTS

EWEC TOP PRIORITY AND FOCUS AREAS

EWEC is focused on delivering on the updated Global Strategy for Women's, Children's and Adolescents' Health (2016–2030). This strategy is closely aligned with the movement's main overall objectives and was developed to translate the 2030 Agenda for Sustainable Development, which articulated the Sustainable Development Goals, into concrete guidance on how to hasten progress for women, children and adolescents through a multisectoral approach. The Strategy 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). EWEC includes six focus areas, all examined in this report: early childhood development; adolescent health and well-being; quality, equity and dignity in services; sexual and reproductive health and rights; empowerment of women, girls and communities; and humanitarian and fragile settings.

An estimated 599 million women, children, adolescents and newborns were reached through service delivery activities in 2019, which was 157 million more than were reached in the previous year. Yet, due to the COVID-19 pandemic, almost half of the nongovernmental commitment makers that responded to the EWEC Commitments Progress Questionnaire anticipate a decrease in their financial commitments in the coming years and uncertainty as to their ability to deliver on previous commitments made. It is imperative that pledges continue to be made and honoured during and after the pandemic so that women, children and adolescents are not left behind and so that their futures remain full of possibilities for themselves and the societies where they live.

Health and beyond: challenges ahead in creating an enabling environment for women, children and adolescents to thrive

Achievements in women's, children's and adolescents' health and well-being are accomplished through two main mechanisms: the health sector, and through multisectoral actions that improve social determinants and environmental conditions. Yet, there has been uneven progress in creating a nurturing environment for children and adolescents to reach their full potential and for women to have access to greater life opportunities, including more economic options and political participation. Climate change and its environmental impacts is also a looming threat to the lives of children today and to future generations.

- There is considerable room for progress on key early childhood development indicators, including addressing the low percentage of children receiving early childhood education, the large numbers of children in low- and middle-income countries, particularly those living in Africa, who do not have official proof of their identity in the form of a birth certificate, and the large numbers of children exposed to violent discipline, both physical and psychological, by caregivers. Many countries are struggling with multiple forms of malnutrition, putting children and adolescents at high risk of poor short- and long-term health and development. Globally in 2019, 144 million children aged under 5 years were stunted, 47 million were wasted, and 38 million were overweight.
- Armed conflict affects tens of millions of women, children and adolescents around the world. It increases their mortality due to violence and injuries or, more commonly, through indirect consequences of conflict – especially infectious diseases. Existing evidence also links conflict to other health outcomes such as poorer mental health, with both immediate and long-term (including intergenerational) effects,^{1,2} and poorer reproductive health.^{3,4}

The solution to these complex issues is the same as for COVID-19: simultaneous action across all three pillars of the primary health-care model. This includes

investing into health systems so that they are resilient to shocks; coordination across sectors so that the health, education, WASH (water, sanitation and hygiene), agricultural and social protection sectors work together to prevent any child or adolescent from being left behind; and greater empowerment of people and communities so that they can play a definitive role in shaping programmes and policies according to their needs, and in holding governments accountable for progress on their terms.

COVID-19 threats and consequences

The COVID-19 pandemic has resulted in millions of infections and hospitalizations and thousands of deaths, and has intensified pre-existing challenges and created new ones with potentially long-lasting detrimental consequences. Evidence is accumulating that the pandemic and responses by governments to control it are slowing down and even beginning to reverse some of the progress made since EWEC began 10 years ago. Countries' mitigation strategies have frequently resulted in disruptions to the delivery of essential reproductive, maternal, newborn, child and adolescent health (RMNCAH) services, putting women, children and adolescents at higher risk of death, disease, and disability from preventable and treatable causes. Key informants from local health ministries and country networks of the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) report major disruptions in basic health-care services for women and children. Some of the most severely impacted services have been routine immunization services, malaria bednet distribution campaigns, family planning and antenatal care services. Models of the potential outcomes of various levels of essential RMNCAH service disruptions show potentially catastrophic consequences depending on how long disruptions continue.

COVID-19 and responses to the pandemic have also negatively impacted the food system through trade restrictions and disruptions in transportation, increasing the risk of food insecurity for millions of families.⁵ A recent estimate using the International Food Policy Research Institute poverty model indicates an increase in extreme poverty in 2020 of between 80 million and 120 million people, and an estimated increase of approximately 40 million to 60 million additional children living in monetary poor households.⁶ Widespread school closures are a serious detriment to learning and human capital development, with some children and adolescents likely to never return to school and others potentially exposed to increasing levels of domestic violence and higher risks of early pregnancy.⁷ Projections from 2020 to 2030 suggest that the economic consequences of the COVID-19 pandemic could cause a one-third reduction in progress towards ending gender-based violence and could result in an additional 13 million child marriages taking place that otherwise would not have occurred.⁸



Nurses wear masks and gloves to protect against the coronavirus in a health centre in the south of Côte d'Ivoire.

“

“Even before the COVID-19 pandemic, a child under the age of 5 died every six seconds somewhere around the world. Millions of children living in conflict zones and fragile settings face even greater hardship with the onset of the pandemic. We need to work collectively to meet immediate needs caused by the pandemic while also strengthening health systems. Only then can we protect and save lives.”

HENRIETTA H. FORE
UNICEF Executive Director

EWEC's short- and longer-term future: safeguarding gains

These and other COVID-related impacts represent a severe shock to the EWEC movement, its multi-stakeholder partners, and all other organizations, institutions and people seeking to realize the full promise of the Global Strategy on behalf of women, children and adolescents everywhere. For the sake of their current and future health and well-being, there is an urgent need to safeguard the tremendous investments and gains since the launch of EWEC 10 years ago to prevent a reversal of progress and put the world back on track to realize the SDGs. COVID-19 has made the road ahead for EWEC more difficult, but there is reason for optimism. The United Nations, with roots in the League of Nations, had its beginnings in the devastation of World War II and played a significant role in the rapid recovery of countries in its aftermath. The same principles that were in action then are needed now, and they are already embedded in the EWEC movement. Through multilateral action, multisectoral approaches and strong partnerships much can be accomplished to realize EWEC's vision of an equitable and just future for all women, children and adolescents.

Safeguarding gains requires investments in health systems to be prioritized in the decade ahead, and it is especially important that this include significant investments in health and other sector information systems. Resources are needed to enhance country capacity to collect, analyse and use their own data for decision-making and to improve the ability of civil society to use data for advocacy and greater accountability. Data are needed for countries to be able to understand what is happening with the pandemic on the ground, and to generate evidence-based response plans specific to the health sector and across sectors for coordinated action. Data are core to understanding any persisting inequities and identifying the women, children and adolescents being left behind so that programmes and policies can be designed to reach them. Data are also a powerful tool for civil society to demand quality of care, access to services, and for their right to be heard – all vital components of the sector's critical advocacy role.



Health workers demonstrate proper handwashing to a child at the Bayat Community Health Centre in Klaten, Central Java, Indonesia.

Introduction

THE EVERY WOMAN EVERY CHILD MOVEMENT HAS BEEN ONE OF THE KEY MULTILATERAL DRIVERS OF PROGRESS THROUGHOUT THE PAST DECADE

Lola, 15, reads in a hammock after finishing her schoolwork, at home in her backyard in Gamboa, Colón Province, Panama, during the COVID-19 pandemic.

“

“The creation of Every Woman Every Child 10 years ago helped galvanize a global movement for women’s and children’s health at a critical time, when progress on the Millennium Development Goals (MDGs) had stalled. By mobilizing partners from all sectors who were determined to make progress for the most vulnerable, Every Woman Every Child not only drove progress on the MDGs, it also demonstrated the power of collective action to tackle some of the most stubborn challenges of our time.”

ELIZABETH COUSENS
President and CEO, United Nations Foundation

The past 10 years have been a time of progress for many of the world’s women, children and adolescents. This positive trend in their overall health and well-being – which enriched individuals, families and communities around the world – is due in large part to strong, innovative partnerships based on collaboration and commitments among governments, multinational institutions, civil society groups, academia and the private sector.

The Every Woman Every Child (EWEC) movement, launched in September 2010, has been one of the key multilateral drivers of progress throughout the past decade, along with other institutions, movements and agendas such as the Sustainable Development Goals (SDGs); universal health coverage agenda; Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund); Global Financing Facility (GFF); Gavi, the Vaccine Alliance; Partnership for Maternal, Newborn & Child Health; Countdown to 2030; and others. The movement is now poised to protect the progress that was made prior to the COVID-19 pandemic, and to strengthen its role in helping countries recover over the next 10 years in support of the United Nations Secretary-General’s call in 2019 for a Decade of Action to accelerate efforts to meet the SDGs. But the success of EWEC’s future can only be ensured through close and careful learning from the past. Moving forward effectively requires understanding what has worked and why over the past decade, where gaps and challenges remain, and what solutions and strategies have the potential to further accelerate progress. Taking stock now of the lives of the women, children and adolescents the EWEC movement aims to support, as this document does, is not only useful but necessary.

One critical consideration is that the progress has been uneven. Far too many women, children and adolescents remain left behind and unreached by information, services, and legal, social and policy changes that have benefited millions of others. The most vulnerable and marginalized include, among others, individuals and families of disadvantaged ethnic groups, those living in remote areas, and those affected by conflict or other humanitarian disasters, many of whom are forced to leave their homes and sometimes become refugees, migrants or internally displaced persons – often with limited access or rights to health and other services.

Another concern is that the hard-won gains could easily be reversed. Until recently, this might have been considered an unlikely possibility, given the remarkable trends of the past decade. But the COVID-19 pandemic has utterly changed the global health and development landscape as it continues to precipitate and expose social and economic inequities that leave many women, children and adolescents disproportionately disadvantaged. The pandemic and governments’ efforts to control it are causing immense disruption across a full range of issues and areas of particular importance to them, including education,

health services, and protection from abuse and violence. Many women, children and adolescents are uniquely vulnerable to extreme poverty, malnutrition and other severe consequences of steep and sudden economic shocks associated with COVID-19. As the global crisis continues, reliable evidence is starting to emerge confirming predictions about dire economic downturns and reductions in access to critical services. Some of the progress related to the health and well-being of women, children and adolescents appears to be unravelling, as seen in certain key indicators.

And yet, EWEC must operate in this new world. COVID-19 and its impacts are already guiding and shaping EWEC’s strategic priorities and approaches, and the lessons learned from the pandemic and responses to it – both good and bad – will influence how the movement leads on behalf of the most vulnerable for years to come. One valuable message from this stocktaking exercise is that well-designed and targeted investments in health can have huge dividends for women, children and adolescents. As the pandemic has reinforced, however, gains can be fragile if they are not safeguarded and sustained, which can only be done through strengthened and expanded multilateralism and multisectoral action to build on the successes this approach has delivered since 2010.

History and focus of the movement

EWEC was launched during the United Nations Summit on the Millennium Development Goals in September 2010 as a special initiative of the United Nations Secretary-General to mobilize action for improving women’s, children’s and adolescents’ health. Underpinning the movement are three overarching objectives of promoting the ability of all women, children and adolescents to survive, thrive and achieve their potential so that they can transform themselves and the world for the better. Cutting across these objectives are the principle of equity and the belief that peace and prosperity can only be achieved by placing women, children and adolescents at the centre of development efforts.

Five years later, world leaders adopted the ambitious 2030 Agenda for Sustainable Development, through which the SDGs were drafted and approved, and a new Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030) was developed to translate the SDG agenda into concrete guidance on how to accelerate progress in women’s, children’s and adolescents’ health through a multisectoral approach. EWEC has focused since then on delivering the Global Strategy, which is closely aligned with the movement’s main overall objectives. The Strategy 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).⁹

VISION OF THE EWEC MOVEMENT

By 2030, a world in which every woman, child and adolescent in every setting realizes their rights to physical and mental health and well-being, has social and economic opportunities, and is able to fully participate in shaping prosperous and sustainable societies.

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“While we have made great progress in our shared work to advance the rights and well-being of women and children, we also know there is so much more to be done. Ending sexual violence is key to this work, and I am convinced that we now have the momentum to create real and lasting change. Together, we can create a world where every woman, child and adolescent is safe, protected and thriving.”

DR DANIELA LIGIERO
CEO and Executive Director,
Together for Girls

Previous assessments of these indicators have shown mixed progress and persistent equity gaps across and within countries.¹⁰ For example, although dramatic success has been achieved in reducing maternal and child mortality and in improving child nutrition and education, many countries are still plagued by uneven access to some essential RMNCAH services, such as treatment for childhood illnesses like pneumonia and diarrhoea and a poor track record in removing barriers to coverage, such as fees and other out-of-pocket expenses.¹¹ In numerous countries, mass migrations, rapid urbanization and humanitarian situations including armed conflict are among the many development challenges that have weakened their ability to reach every woman, child and adolescent with the services they need and to create an enabling environment. Even before the onset of the COVID-19 pandemic, children and adolescents in much of the world were facing the direct effects of – or were increasingly likely to soon be confronted with – the potentially catastrophic consequences of climate change and ecological degradation. Commercial practices that encourage unhealthy behaviours, such as eating sugary foods and beverages, pose a threat to child and adolescent health and well-being, and technological advancements such as the internet present both opportunities such as virtual learning and greater connectivity to the world and risks including harmful exposure to exploitation.¹²

Even though many of these and other challenges have been exacerbated by COVID-19, most were serious before the pandemic and will remain so after it ends. Therefore, although the pandemic’s impact on relevant indicators must be at the forefront of planning efforts, strategic decision-making and priorities should also be informed by past trends and other developments in women’s, children’s and adolescents’ health to which EWEC contributed in the pre-COVID era of the past decade.

This report is organized into three sections. The first takes stock of global progress towards the survive, thrive and transform dimensions of the Global Strategy. Essentially, it presents the baseline before COVID-19. The second section provides a concise summary of the latest tracking of the EWEC commitments and endorsements of the Global Consensus Statement on Meaningful Adolescent and Youth Engagement (MAYE), both of which can be used in part to assess the global community’s accountability in investing in women’s, children’s and adolescents’ health. The final section synthesizes up-to-date information on the impact of COVID-19 on turning back the clock on women’s, children’s and adolescents’ health, and some strategies countries have introduced to reduce this erosion. This section also discusses how the pandemic has made irrevocably clear the urgency of strengthening health information systems so that countries have the data they need to swiftly and effectively respond to emergencies such as COVID-19 and to regularly monitor their health systems under “normal” circumstances to ensure they

are allocating adequate human and financial resources to women’s, children’s and adolescents’ health.

This structure allows for reflection at this opportune time on several issues: 1) How well was the world doing towards achieving the SDGs and Global Strategy targets, including strengthening primary health care as a main strategy for achieving universal health coverage, at the cusp of the pandemic?; 2) What do we know now about the scale of the impact of COVID-19 on the health and well-being of women, children and adolescents? How has the pandemic exacerbated health inequalities and brought underlying social injustices boiling to the surface?; and 3) What can the global community do to support countries to “build back better” and stay on track for achieving the SDGs so that the lofty vision of the Global Strategy can be realized when the Decade of Action concludes?



Ava, 4, shares a moment of intimacy with her mother, Chloe, pregnant with her second child, at their home in Johannesburg, South Africa, during the COVID-19 pandemic.

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“Research shows that educated women are more likely to use contraception, marry later, have fewer children, and be better informed about nutrition. In other words, educated women are free to make a choice. However, there is still a long way to go with 258 million children still not entering the classroom. Poverty, early marriage or pregnancy and violence are all factors that keep girls from completing their education. UNESCO is committed to working with countries, and collaborating with partners such as EWEC. It’s time for eliminating barriers to access education and supporting girls to flourish and be free to make their own choice. For themselves and next generations. Her Education means Our Future.”

STEFANIA GIANNINI
UNESCO Assistant Director-
General for Education

Section 1

SURVIVE, THRIVE AND TRANSFORM: THE INGREDIENTS FOR SUCCESS AND DEVELOPMENT

This section reviews data and developments associated with the targets and objectives within the three main EWEC priority areas: survive, thrive and transform (Box 1.1). Structurally, the section is organized into survive and thrive focus areas, with elements of transform integrated throughout. These three concepts are intricately interrelated, with the broad contextual factors that are highlighted within the enabling environments of the transform domain all relevant to the progress and challenges observed in mortality and inequalities in women's, children's and adolescents' access to quality health services.

Survive

Leading up to the pandemic, major gains had been made in improving maternal, newborn and child survival. The mortality rate for children aged under 5 years declined by nearly 50% between 2000 and 2019, from 76 deaths per 1000 live births to 38. The neonatal mortality rate declined at a slower pace during this same period, from 30 deaths per 1000 live births to 17, a 42% decrease (Figure 1.1). Despite substantial progress in child survival, however, these improvements have not been evenly distributed across the world or in all age groups. There is a growing concentration of child mortality in Africa, an increasing percentage of child deaths occurring during the neonatal period, and a higher disproportion among the most vulnerable population groups in all countries.¹³ A recent analysis of 36 low- and middle-income countries found significant disparities in under-5 mortality rates by ethnic groups in more than two thirds of them, highlighting the importance of equity-oriented subnational research for identifying and targeting programmes for groups of children being left behind.¹⁴ Among adolescents aged 15–19, leading causes of death vary between boys and girls, with maternal conditions ranking higher for girls and interpersonal violence ranking higher for boys, which suggests the need for gender-specific programming. Top causes of death affecting both boys and girls include road injury and self-harm.¹⁵

Demographic trends indicate that children will increasingly be living in urban centres, growing numbers will be living in humanitarian settings, and Africa – already the most youthful continent in terms of average age – is experiencing a “youth bulge” that will soon make it the continent where most children live.¹⁶ Because of laudable gains in child survival throughout the past two decades, global and national programmatic emphasis was pivoting to responding to the growing number of children living with chronic disabilities and noncommunicable diseases and understanding how this burden varies across settings.¹⁷ Country health systems will need to be strengthened considerably so that they can continue to provide basic packages of essential, life-saving preventive and curative services to all children, while also expand to reliably deliver high-quality services to those suffering from chronic conditions and mental health disorders. In the short term at a minimum, this additional burden may prove taxing or prohibitive for many low- and middle-income countries that are already overstretched trying to respond to the COVID-19 pandemic.

LEADING UP TO THE PANDEMIC, MAJOR GAINS HAD BEEN MADE IN IMPROVING MATERNAL, NEWBORN AND CHILD SURVIVAL

BOX 1.1

Every Woman Every Child Global Strategy objectives and related SDG targets

SURVIVE

END PREVENTABLE DEATHS



Reduce global maternal mortality to less than 70 per 100 000 live births;

Reduce under-5 mortality to at least as low as 25 per 1000 live births in every country;

Reduce newborn mortality to at least as low as 12 per 1000 live births in every country;

End epidemics of HIV, tuberculosis, malaria, neglected tropical diseases and other communicable diseases; and

Reduce by one third premature mortality from noncommunicable diseases and promote mental health and well-being.

THRIVE

ENSURE HEALTH AND WELL-BEING



End all forms of malnutrition and address the nutritional needs of children, adolescent girls, and pregnant and lactating women;

Ensure universal access to reproductive health-care services (including for family planning) and rights;

Ensure that all girls and boys have access to good-quality early childhood development;

Substantially reduce pollution-related deaths and illnesses; and

Achieve universal health coverage, including financial risk protection and access to quality essential services, medicines and vaccines.

TRANSFORM

EXPAND ENABLING ENVIRONMENTS



Eradicate extreme poverty;

Ensure that all girls and boys complete free, equitable and good-quality primary and secondary education;

Eliminate all harmful practices and all discrimination and violence against women and girls;

Achieve universal and equitable access to safe and affordable drinking water and to adequate and equitable sanitation and hygiene;

Enhance scientific research, upgrade technological capabilities and encourage innovation;

Provide legal identity for all, including birth registration; and

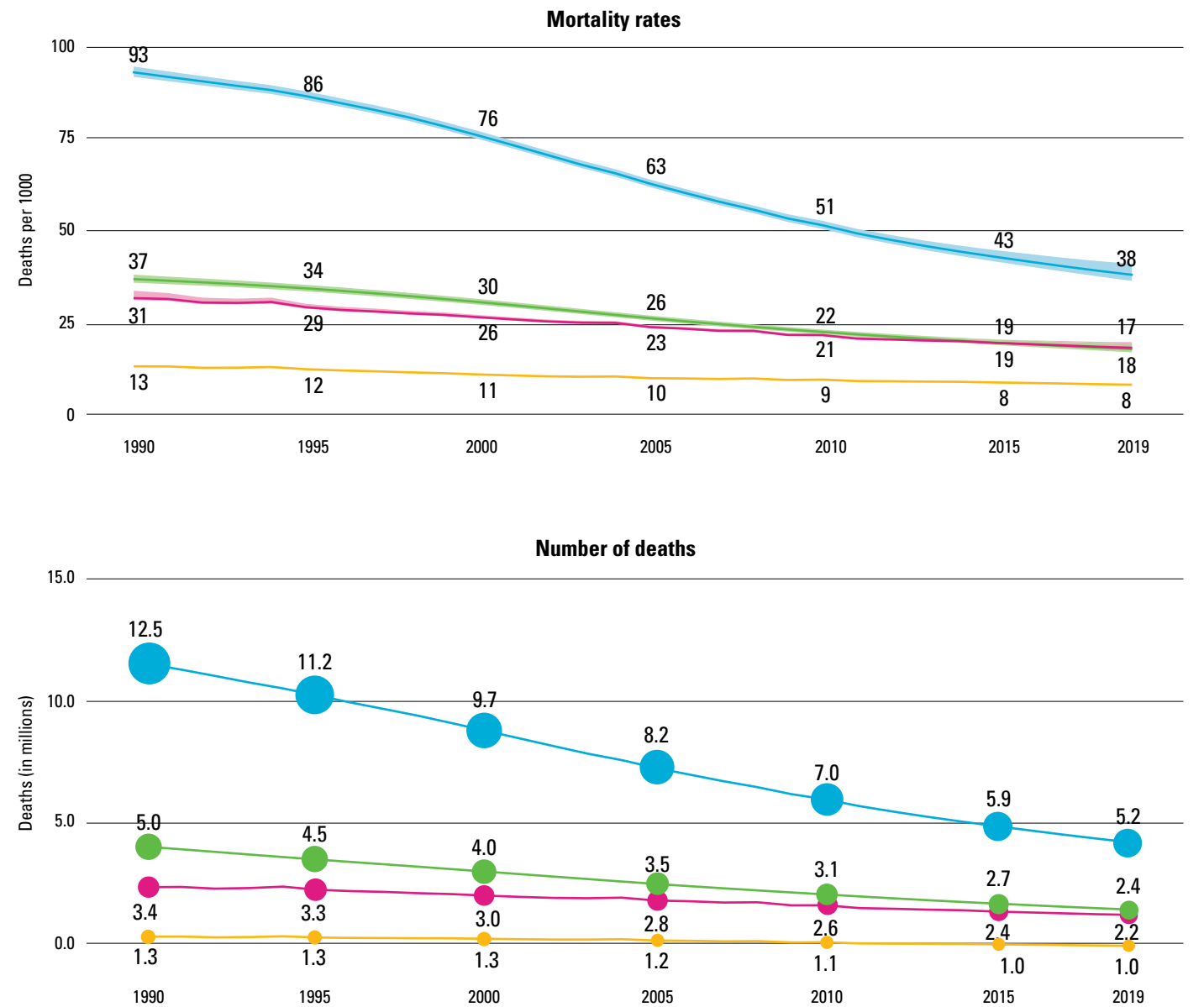
Enhance the global partnership for sustainable development.

FIGURE 1.1

Child deaths declined dramatically, with slower progress among newborns and adolescents

Global mortality rates and number of deaths by age, 1990–2019

Under-5 mortality rate Mortality rate among adolescents aged 10–19 Under-5 deaths Deaths among adolescents aged 10–19
 Neonatal mortality rate Mortality rate among children and youth aged 5–24 Neonatal deaths Deaths among children and youth aged 5–24



Note: All figures are based on unrounded numbers. The solid line in the first chart represents the median estimate and the shaded area represents the 90% uncertainty bound 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.

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“Women and girls are on the front line in this pandemic, and no more so than in the most fragile and conflict-riven places. They face greater risk of sexual violence, exploitation and abuse, trafficking, and early and forced marriage. They’re at greater risk of exposure and infection because they have the majority of caregiving roles in homes and in communities. Women and girls must be front and centre of humanitarian decision-making and response. Now more than ever, their efforts, capacities and leadership should be promoted.”

MARK LOWCOCK

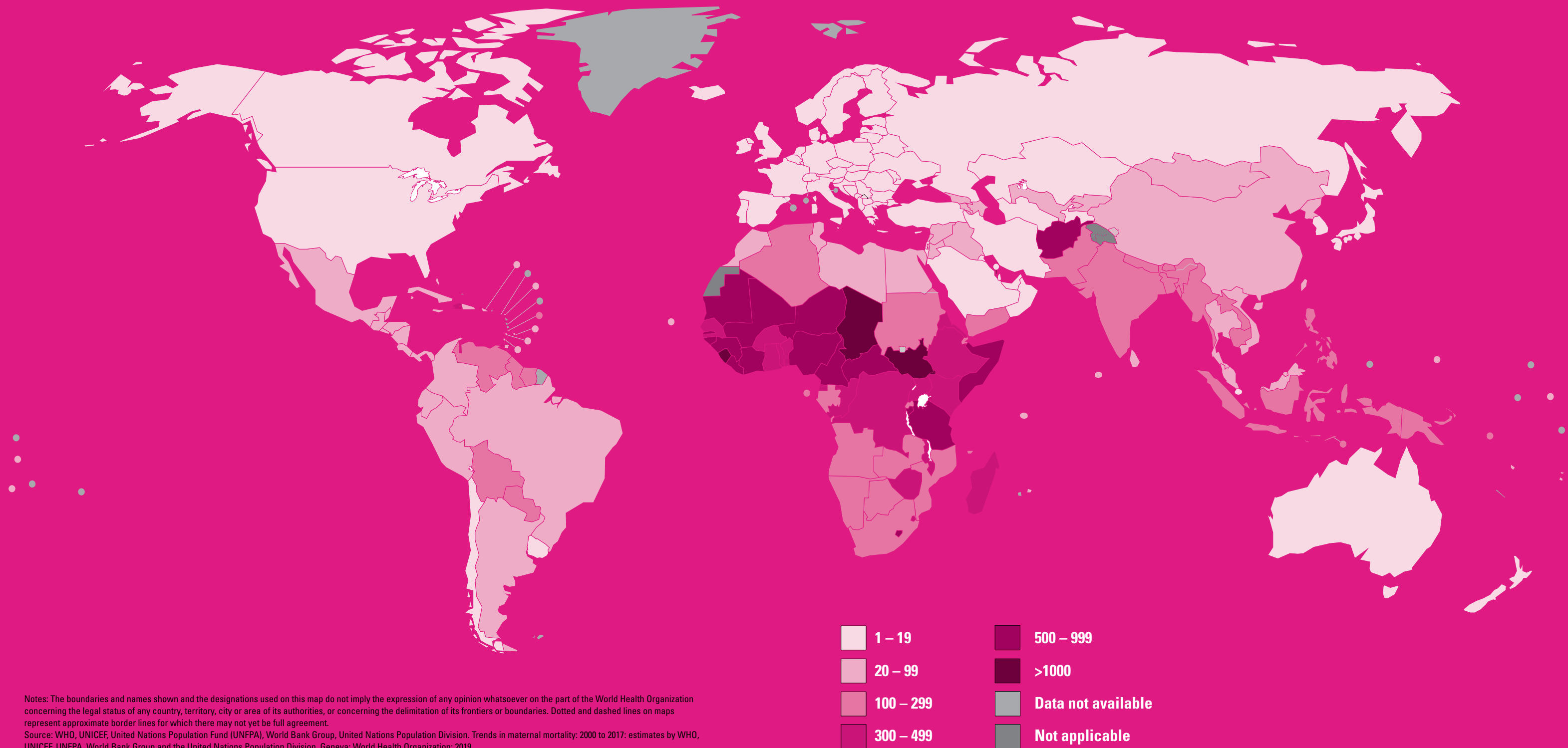
United Nations Under-Secretary-General for Humanitarian Affairs

The number of maternal deaths dropped from an estimated 451 000 in 2000 to 295 000 in 2017, a reduction of about 35%, with the most significant declines occurring since 2010.¹⁸ These reductions have been attributed to a combination of improvements in access to key maternal health services such as antenatal and skilled delivery care and social determinants including improvements in gender inequality in some contexts.¹⁹ Such achievements are precarious, however, and underlying them are pervasive inequities that must be addressed for the global goals to be reached. In 2019, for example, 64% of pregnant women were estimated to receive antenatal care in the first trimester of pregnancy, as recommended. However, only 35% of women living in low-income countries compared with 83% of women in high-income countries received early antenatal care.²⁰ The global pandemic poses threats to progress in women’s and adolescent girls’ life conditions and opportunities given disruptions in maternal health services, increases in reported levels of domestic violence in many countries during periods of lockdowns, and ongoing closures in childcare services and schools, which make it disproportionately harder for women to participate in the workforce and in political matters.^{21,22}

Maternal deaths, similar to the child mortality picture, are increasingly concentrated in sub-Saharan Africa and South Asia. These two regions accounted for approximately 86% of all maternal deaths in 2017 (Figure 1.2). Maternal conditions are a leading cause of adolescent deaths (ages 15–19) in these two regions, which are also the two regions with the highest adolescent fertility levels.^{23,24} Wide variations have been found between West and Central Africa compared with Eastern and Southern Africa, and across countries within each of these two subregions, in factors linked with adolescent sexual behaviour and childbearing, such as normative marriage patterns, desired family size, access to family planning, and awareness of how to prevent HIV and other sexually transmitted infections.²⁵ Research on sub-Saharan Africa has also shown that adolescent girls who live in urban areas, are well educated and are in the higher wealth strata experience lower rates of early marriage, early pregnancy and rates of HIV infection compared with those living in rural areas, with less education and in poverty. Although these findings are not surprising, they point to the importance of deeper dives within regions and within countries to understand the cultural, structural and health systems factors at play so that programmes can be appropriately designed to reach all adolescent girls in need and therefore further drive down maternal deaths overall. Such analyses need to consider age patterns in general, as studies have shown that intervention coverage of reproductive and maternal health services varies by age across contexts, often with older women and adolescents experiencing lower coverage and higher risk of poor obstetrical outcomes.²⁶

Jaya, 18 months old, was given oral rehydration salts and zinc by an accredited social health activist in Gujarat, India, through a UNICEF partnership with the Narottam Lalbhai Rural Development Fund that focuses on complementary feeding and hygiene practices.

FIGURE 1.2

Maternal mortality levels were highest in sub-Saharan Africa and South Asia**Maternal mortality ratio per 100 000 live births by country, 2017**

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 maps represent approximate border lines for which there may not yet be full agreement.

Source: WHO, UNICEF, United Nations Population Fund (UNFPA), World Bank Group, United Nations Population Division. 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.

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The world has seen impressive progress in reducing preventable child and maternal deaths over the past decades. But too many women, children and adolescents are still missing out on essential health and nutrition services, with the most deprived and marginalized left furthest behind. Increased political commitment, investment and accountability will be critical in driving continued progress, especially as we aim to build back better from the COVID-19 pandemic and ensure every woman's, child's and adolescent's right to survive and thrive.”

INGER ASHING

CEO, Save the Children International and member of the High-Level Steering Group for Every Woman Every Child

IMPROVING MATERNAL, NEWBORN, CHILD AND ADOLESCENT SURVIVAL: A SPOTLIGHT ON HEALTH INTERVENTION COVERAGE

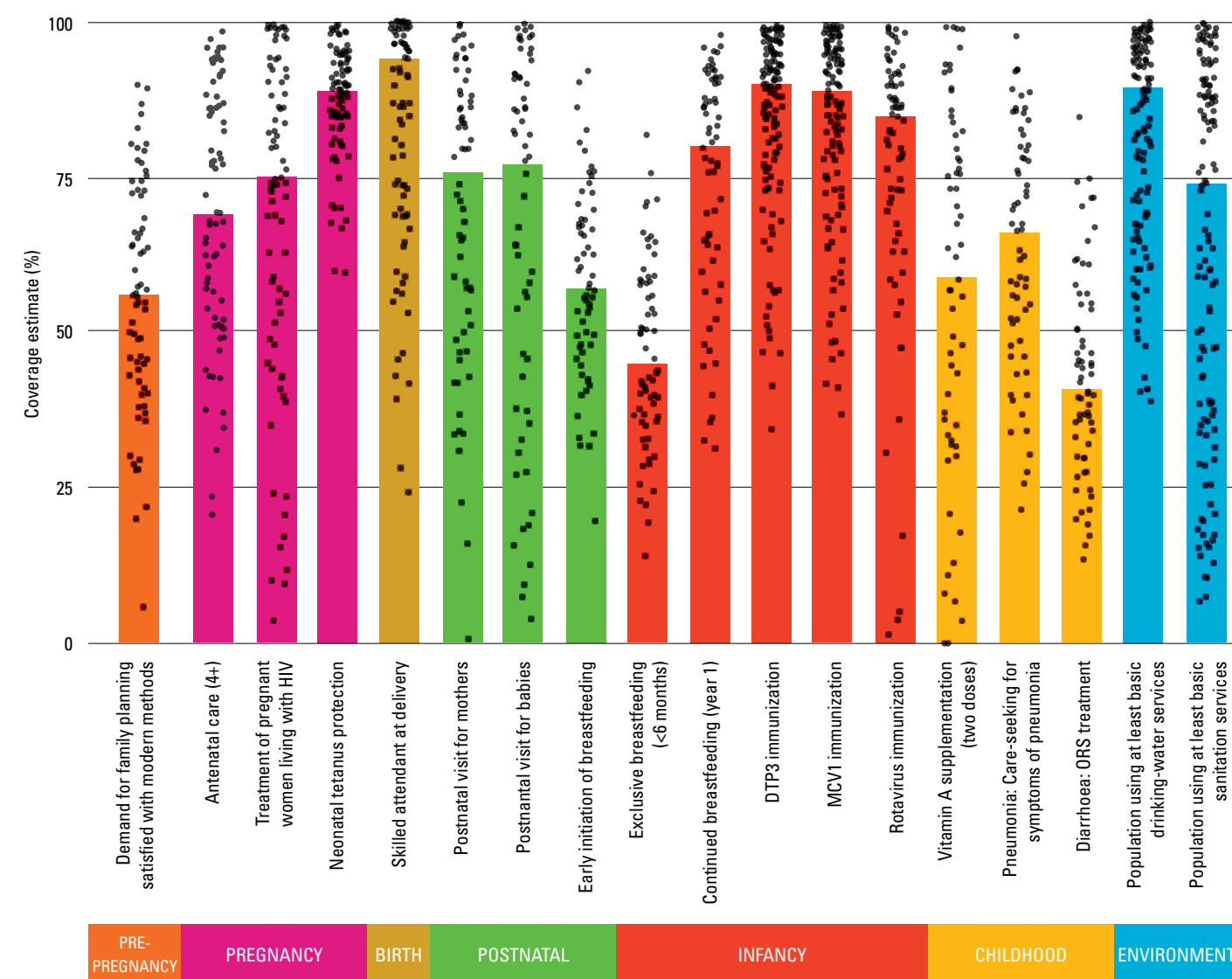
A snapshot of the current status of coverage with a core set of health interventions helps to illustrate how the world is doing in reaching all women, children and adolescents with interventions across the continuum of care. Countdown to 2030's signature continuum of care chart includes indicators across the dimensions of family planning, pregnancy, childbirth, postnatal care and childhood, and the cross-cutting area of water and sanitation. Figure 1.3 shows progress on this chart prior to the COVID-19 pandemic in all low- and middle-income countries with available data. Summary data (Table 1.1) show that these countries were far from achieving universal coverage for many interventions even before the pandemic, with larger gaps for family planning, early initiation and exclusive breastfeeding, and treatment of childhood illnesses. The good news is that more than 80% coverage had been achieved for immunization interventions, skilled attendant at birth, and access to at least basic safe drinking water. As will be described later in this report, however, both immunization services and institutional deliveries have plummeted in many parts of the world in the wake of COVID-19, putting millions of women and children at risk of poor health outcomes.

Conclusions about whether progress before COVID-19 was accelerating, stagnating or even reversing since EWEC was first launched can be drawn by assessing trends in intervention coverage. This was done by evaluating change in coverage over the past 10 years, comparing the time periods of 2010–2014 and 2015–2019 (Figure 1.4 and Table 1.2; only countries with at least one estimate for each time interval were included). Five out of the 16 interventions showed 10 percentage points or greater changes in coverage, while average coverage levels dropped in the more recent time interval for two of the interventions (diphtheria–tetanus–pertussis (DTP3) vaccination and measles-containing-vaccine first-dose (MCV1)). Interventions with marked improvement include treatment of pregnant women with HIV, which has benefited from substantial global investment; rotavirus vaccine, which is a relatively new intervention being rapidly adopted and scaled up by countries; and postnatal care for babies, the success of which can be attributed in part to considerable global advocacy and emphasis in recent years. Concerning trends are declines in DTP3 and measles vaccinations, and very modest gains in the treatment of pneumonia and diarrhoea.

FIGURE 1.3

Important progress was achieved pre-pandemic in immunizations, skilled attendant at birth and access to safe drinking water, less so for breastfeeding and family planning

Median national coverage of select interventions along the continuum of care, most recent survey for each low- and middle-income country* with data available, 2015 and later (%); bars represent the global median and black dots represent country estimates



*According to World Bank income classifications, 2020.

Source: Data from WHO and UNICEF on immunization rates, July 2020, WHO and UNICEF Joint Monitoring Programme for Water Supply and Sanitation, June 2019, Joint United Nations Programme on HIV/AIDS, June 2020, Joint UNICEF and WHO database on skilled birth attendant, February 2020, and UNICEF (www.data.unicef.org) and WHO global databases (www.who.int/gho/databae/en/), August 2020 (based on Demographic and Health Surveys, Multiple Indicator Cluster Surveys, and other national surveys).

TABLE 1.1

Summary of national coverage of select interventions along the continuum of care, most recent survey for each low- and middle-income country* with data available, 2015 and later

Order	CoC phase	Indicator	Countries with data	Median coverage (%)	Minimum (%)	Maximum (%)	Countries with lowest value	Countries with highest value
1	Pre-pregnancy	Demand for family planning satisfied with modern methods	69	56	6	90	Albania	Democratic People's Republic of Korea
2	Pregnancy	Antenatal care (4+)	75	69	21	98	Afghanistan	Turkmenistan
3	Pregnancy	Treatment of pregnant women living with HIV	85	75	4	99	Sudan	Belarus, Benin, Botswana, Costa Rica, Cuba, Eswatini, Guinea, Guyana, Mozambique, Malawi, Malaysia, Namibia, Rwanda, Uganda
4	Pregnancy	Neonatal tetanus protection	99	89	60	99	Central African Republic, Nigeria	Dominican Republic, Eritrea, Guyana, Honduras, Maldives, Sao Tome and Principe, Sri Lanka
5	Birth	Skilled attendant at delivery	96	94	24	100	Chad	Albania, Armenia, Bosnia and Herzegovina, Botswana, Bulgaria, China, Cuba, Democratic People's Republic of Korea, Dominica, Dominican Republic, El Salvador, Fiji, Grenada, Jamaica, Jordan, Kazakhstan, Kyrgyzstan, Malaysia, Maldives, Republic of Moldova, North Macedonia, Saint Lucia, Sri Lanka, Turkmenistan, Tunisia, Uzbekistan
6	Postnatal	Postnatal visit for mothers	60	76	11	100	Somalia	Turkmenistan
7	Postnatal	Postnatal visit for babies	54	77	4	100	Chad	Turkmenistan
8	Postnatal	Early initiation of breastfeeding	65	57	20	92	Pakistan	Burundi
9	Infancy	Exclusive breastfeeding (<6 months)	64	46	14	82	Tunisia	Sri Lanka
10	Infancy	Continued breastfeeding (year 1)	65	80	28	98	Botswana	Nepal
11	Infancy	DTP3 immunization	133	90	35	99	Papua New Guinea	Albania, China, Cuba, Dominica, Fiji, Guyana, Iran (Islamic Republic of), Maldives, Morocco, Sri Lanka, Tonga, Turkmenistan, Turkey
12	Infancy	MCV1 immunization	133	89	37	99	Papua New Guinea	China, Cuba, Eritrea, Georgia, Iran, Kazakhstan, Maldives, Morocco, Nicaragua, Tonga, Turkmenistan, Saint Vincent and the Grenadines, Sri Lanka
13	Infancy	Rotavirus immunization	73	85	2	99	Philippines	Fiji, Guyana, Kiribati
14	Childhood	Vitamin A supplementation (two doses)	63	59	0	99	Bangladesh, Benin, Gabon, Guinea-Bissau, Papua New Guinea	Burkina Faso, Democratic People's Republic of Korea, United Republic of Tanzania, Zambia
15	Childhood	Pneumonia: Care-seeking for symptoms of pneumonia	58	62	26	98	Somalia	Tunisia
16	Childhood	Diarrhoea: ORS treatment	62	40	14	85	Togo	Sierra Leone
17	Environment	Population using basic drinking water services	130	90	39	100	Chad	Armenia, Costa Rica, Paraguay, Thailand, Tonga
18	Environment	Population using basic sanitation services	130	74	7	100	Ethiopia	Libya, Malaysia, Uzbekistan

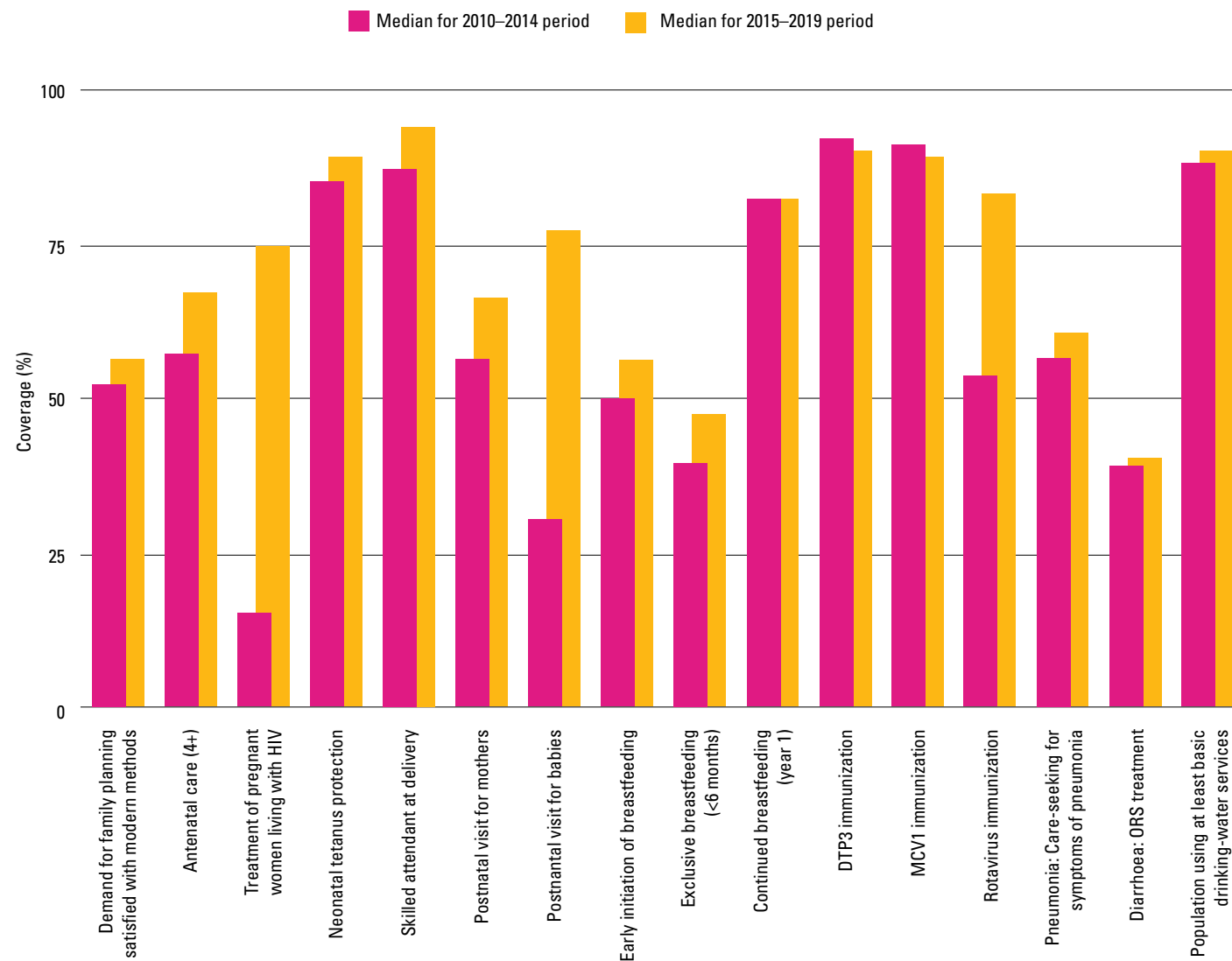
*According to World Bank income classifications, 2020.

Source: Data from WHO and UNICEF on immunization rates, July 2020, WHO and UNICEF Joint Monitoring Programme for Water Supply and Sanitation, June 2019, Joint United Nations Programme on HIV/AIDS, June 2020, Joint UNICEF and WHO database on skilled birth attendant, February 2020, and UNICEF (www.data.unicef.org) and WHO global databases (www.who.int/gho/databae/en/), August 2020 (based on Demographic and Health Surveys, Multiple Indicator Cluster Surveys, and other national surveys).

FIGURE 1.4

Gains in treatment of pregnant women with HIV and rotavirus vaccine were significant pre-pandemic, while declines in measles vaccinations and DTP3 were a cause of concern

Median national coverage of select interventions along the continuum of care, 2010–2014 and 2015–2019, among low- and middle-income countries that have data for both time periods



Source: Data from WHO and UNICEF on immunization rates, July 2020, WHO and UNICEF Joint Monitoring Programme for Water Supply and Sanitation, June 2019, Joint United Nations Programme on HIV/AIDS, June 2020, Joint UNICEF and WHO database on skilled birth attendant, February 2020, and UNICEF (www.data.unicef.org) and WHO global databases (www.who.int/gho/databae/en/), August 2020 (based on Demographic and Health Surveys, Multiple Indicator Cluster Surveys, and other national surveys).

TABLE 1.2

Median national coverage of select interventions along the continuum of care, 2010–2014 and 2015–2019, among countries that have data for both time periods, ordered by the proportion of the gap closed between the two intervals

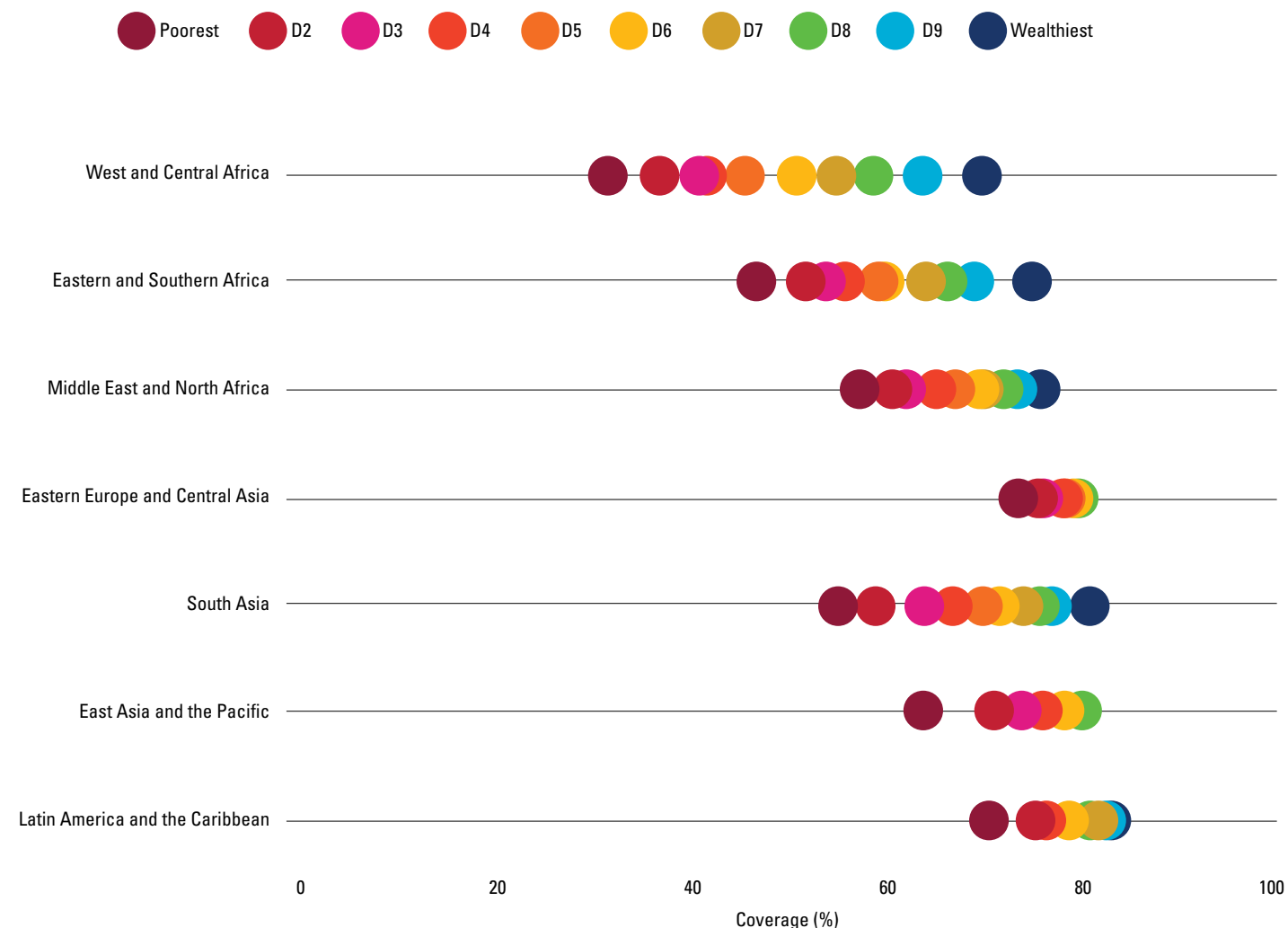
Order	Indicator	n	2010–2014 median	2015–2019 median	Percentage point change	Proportion of the gap closed
1	Treatment of pregnant women living with HIV	85	15	75	60	71
2	Postnatal visit for babies	34	30	78	48	69
3	Rotavirus immunization	51	53	83	30	64
4	Skilled attendant at delivery	87	87	94	7	54
5	Neonatal tetanus protection	99	85	89	4	27
6	Antenatal care (4+)	61	58	68	10	24
7	Postnatal visit for mothers	44	56	66	10	23
8	Population using at least basic drinking-water services	130	88	90	2	17
9	Pneumonia: Care-seeking for symptoms of pneumonia	50	56	62	6	14
10	Early initiation of breastfeeding	48	50	56	6	12
11	Exclusive breastfeeding (<6 months)	45	39	46	7	11
12	Demand for family planning satisfied with modern methods	54	52	56	4	8
13	Diarrhoea: ORS treatment	52	39	40	1	2
14	Continued breastfeeding (year 1)	46	82	82	0	0
15	MCV1 immunization	133	91	89	-2	-22
16	DTP3 immunization	133	92	90	-2	-25

Source: Data from WHO and UNICEF on immunization rates, July 2020, WHO and UNICEF Joint Monitoring Programme for Water Supply and Sanitation, June 2019, Joint United Nations Programme on HIV/AIDS, June 2020, Joint UNICEF and WHO database on skilled birth attendant, February 2020, and UNICEF (www.data.unicef.org) and WHO global databases (www.who.int/gho/databae/en/), August 2020 (based on Demographic and Health Surveys, Multiple Indicator Cluster Surveys, and other national surveys).

FIGURE 1.5

Household income everywhere is a key factor in access to health for women and children

Composite coverage index by region and wealth decile, countries with available data, 2010–2020



Source: Re-analysis of Demographic and Health Survey and Multiple Indicator Cluster Survey data sets at the International Center for Equity in Health at the Federal University of Pelotas in Brazil.

Other critical approaches to understanding gaps and successes in reaching the goals and targets of the Global Strategy and SDGs include ranking countries according to performance on delivering a core package of essential services, exploring improvements in the quality of care provided, including women's experiences of care, and highlighting subnational inequalities in intervention coverage. The composite coverage index was used in a recent analysis to rank low- and middle-income countries with available data. The index is an established summary measure for intervention coverage that correlates with key indicators of health status, such as child mortality and stunting. It has four components (reproductive health, maternal health, child immunization and treatment of childhood illnesses), and is limited to interventions delivered through the health system. The best performers were found to be spread across different world regions, indicating some universality in the ingredients of success. The lowest performers were all found to be in Africa, with the exception of Yemen. They have made less progress in improving maternal and child survival, and most were experiencing or had experienced a recent conflict.²⁷ These findings indicate the need for coordinated attention on Africa and on helping countries develop resilient health systems, including health information systems to avoid massive disruptions when a crisis strikes.

The composite coverage index is also frequently used to document inequities in intervention coverage. Figure 1.5 shows vast differences in the index's average coverage levels by wealth deciles across regions. In all regions, the index was highest among the wealthier deciles, and was below 80% for the lowest decile. These figures make clear that household income level everywhere plays a key role in whether women and children receive the services they need.

Greater emphasis in the global community is being placed on monitoring the quality of care to ensure that services delivered will have the expected health impact, and considerable measurement advancements by technical working groups involving experts from United Nations agencies and academic and research institutes are under way on quality of care, including respectful maternity care, and effective coverage. The aim is to eventually replace or supplement the service contact interventions described above and included in global monitoring frameworks such as the SDGs and the Global Strategy with standardized measures of quality of care once greater consensus is achieved on them and comparable data are available for most countries. Efforts are also under way to revise health facility assessment tools so that service readiness and quality can be more consistently measured and monitored.²⁸

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“The work of Every Woman Every Child in bringing stakeholders together to enable transformative change is vital as we seek to achieve the Sustainable Development Goals in health. We have been delighted to work with EWEC as we deliver innovation in a range of areas, including detecting and treating cervical cancer, developing child-friendly formulations of TB and HIV medication, as well as malaria treatments for pregnant women and children. Together we are concretely improving maternal and infant health and will continue to do so.”

DR PHILIPPE DUNETON
Acting Executive
Director, Unitaid

“

“The COVID-19 pandemic threatens to turn back the clock on years of progress in reproductive, maternal, child and adolescent health. This is unacceptable. The GFF partnership will double down on its efforts to engage with partners and countries and honour the global commitment to ensure that all women, adolescents and children can access the quality, affordable health care they need to survive and thrive.”

DR MUHAMMAD ALI PATE
Global Director for Health, Nutrition and Population at the World Bank Group, Director, Global Financing Facility and member of the High-Level Steering Group for Every Woman Every Child

Extensive research has documented the association between progress on coverage of essential interventions for women, children and adolescents and key equity stratifiers, such as household wealth, urban-rural location, women’s education and ethnicity, among others.^{29,30,31} Takeaways from recent in-depth equity analyses convey a message of good news, yet a clear indication also that much more needs to be done, such as:

- Although large disparities remain in intervention coverage between women and children in advantaged versus disadvantaged population groups, the pace of progress in increasing coverage has been faster among women and children in less well-off groups. This suggests that pro-poor strategies are working and should continue to be implemented during COVID-19 to avoid losing ground on equity.
- Slower progress and even some reversals in the coverage of child health interventions occurring even before COVID-19 are alarming and, unless addressed, will put the world at jeopardy of not reaching the SDG and Global Strategy targets for child survival. The latest joint WHO–UNICEF estimates show that approximately 20 million children did not receive all doses of DTP3 in 2019, and 18 countries experienced a 10-percentage point or greater drop in DTP3 coverage in the past 10 years.³² The world must remain vigilant in providing these basic services for all children.
- Comparing regional trends and national-level data is a first step to understanding global progress. Yet, such analyses often mask severe subnational disparities. Comprehensive assessments even for global monitoring purposes should, therefore, include breakdowns at the subnational level.
 - Variations in progress are evident across regions and across countries within regions. Strategies to achieve success, including global goals and targets, should be adapted to the widely divergent realities at both the regional and country levels.
 - The process for adapting strategies for implementation in different countries must involve a focus on subnational patterns to determine which population groups are missing out and where they are located. Sensitivity to local context and history is essential for developing effective and relevant policies and programmes in all countries.
 - Equity analyses are core to accountability. Global, regional and country monitoring efforts must include a focus on the poorest and most vulnerable population groups, as progress within these groups will be a determining factor in achieving development goals.

Achievements in maternal, newborn, child and adolescent survival and reductions in stillbirths are accomplished through two main mechanisms: through health systems, and through a combination of factors outside the health sector that result in improvements in social determinants and living conditions. The ability of health-care systems to deliver high-quality services to all women, children and adolescents depends on supportive policies and regulations, and sufficient resources, including financial, health-care workers and supplies and equipment. The coverage analyses above show that even pre-pandemic, many countries were falling short of reaching universal health coverage. Section 3 describes the strains on health systems caused by the pandemic, including diversion of health-care workers to the COVID-19 response, and the need for governments to allocate more resources to the health sector and introduce innovative solutions so that essential primary health-care services are not neglected. Multisectoral strategies such as coordination among agriculture, education and social protection sectors are also needed to break intergenerational cycles of poverty and to ensure that women’s rights are upheld and that children and adolescents are safe and have shelter, enough food, and access to education so that they can reach their full potential.

Thrive

Many drivers underlie the likelihood that children and adolescents will be able to thrive and become productive members of their respective societies. This section examines three of them: early childhood development, nutrition, and the havoc that conflict causes on maternal, newborn, child and adolescent survival, well-being and life chances (Panel 1).

The SDG framework includes several targets related to early childhood development. The topic gained more political traction following the launches of a 2016 series in *The Lancet* on advancing early childhood development from science to scale and the 2018 World Bank, WHO and UNICEF Nurturing Care Framework.³³ These two publications stress the critical window of the first 1000 days of life for human capital development and lay out five components of nurturing care: health, nutrition, early learning, responsive caregiving, security and safety, which are facilitated by a supportive policy environment and services. Figure 1.6 shows 13 key facts on how children were faring before the pandemic started based on an analysis of available data on the indicators included on the Early Childhood Development Countdown to 2030 country profiles from 197 countries. These stark facts show how much more effort is needed to provide children with a good head start in life, beginning with all mothers receiving high-quality antenatal care and a safe delivery, and all children receiving postnatal care and a birth certificate. Early childhood development should not be shortchanged due to the pandemic given that nurturing care provides the foundation for every child’s future.

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“Women and children bear the brunt of the health and socioeconomic impacts of the COVID-19 pandemic because of their pre-existing vulnerabilities, especially in disasters and crisis situations. The ‘Protect the Progress’ report is a clear accounting of what has been achieved and what we must all do to protect women, children and adolescents everywhere in this time of crisis.”

H.E. JAGAN CHAPAGAIN
Secretary General of the International Federation of Red Cross and Red Crescent Societies (IFRC), and member of the High-Level Steering Group for Every Woman Every Child

PANEL 1

COUNTRIES IN CRISIS: HOW CONFLICT IMPACTS WOMEN'S, CHILDREN'S AND ADOLESCENTS' HEALTH FOR GENERATIONS

The adverse effects of the COVID-19 pandemic on women's, children's and adolescents' health in armed conflict settings is a major source of concern. Disruptions in already fragile essential health and nutrition services are likely to further disadvantage the health and well-being of millions of women, children and adolescents living in dire circumstances due to conflict.

Even before the pandemic, increasing numbers of women, children and adolescents were affected by armed conflict either because they are refugees, are internally displaced or are living close to armed conflict. The number of refugees almost doubled during the past decade, from 10.5 million in 2008 to 20.4 million by the end of 2018.³⁴ The majority are women (24% of all refugees) and children (53%). Based on data from the Internal Displacement Monitoring Centre, the number of internally displaced persons due to conflict and violence increased from about 25 million in 2009–2010 to 45.7 million in 2019, of whom almost 21 million were women and girls.^{35,36} Moreover, many more women and children, especially those who are poorer and more vulnerable, may be affected by conflict even without being displaced from their homes if they are unable to move away from nearby conflict. A recent estimate indicates that approximately 420 million children aged under 18 years were living in areas affected by conflict in 2017.³⁷

Armed conflict increases the mortality of women, children and adolescents due to violence and injuries or, more commonly, indirect consequences of the conflict – especially infectious diseases. An analysis

of data from 35 countries in Africa showed that, from 1995 to 2015, infants exposed to armed conflict in their first year of life had a 7.7% higher chance of dying before reaching age 1 year than expected in that region without armed conflict. This corresponded to 3.1–3.5 million infants (and 4.9–5.5 million children aged under 5 years) in Africa whose deaths were attributable to armed conflict during this period.³⁸ The effect of armed conflict on mortality among women of childbearing age was also large, with a 21% increase in the risk of death among women of childbearing age in Africa.³⁹

National surveys provide ample evidence of the negative impact of conflict, especially during active phases, on child mortality, coverage of health interventions, and childhood stunting and wasting.⁴⁰ Inequalities in coverage of reproductive/maternal health and child vaccination are significantly worse in conflict-affected countries.⁴¹ Existing evidence also links conflict to other health outcomes, such as poorer mental health, with both immediate and long-term (including intergenerational) effects,^{42,43} and poorer sexual and reproductive health.^{44,45}

Obtaining reliable data and evidence from conflict-affected populations remains a major challenge. Armed conflicts tend to occur more frequently in countries that are data poor in the first place. This problem is aggravated by the political nature of conflict data and the inability to collect objective data because of security concerns and population displacement. Data on adolescents are sparse to non-existent.

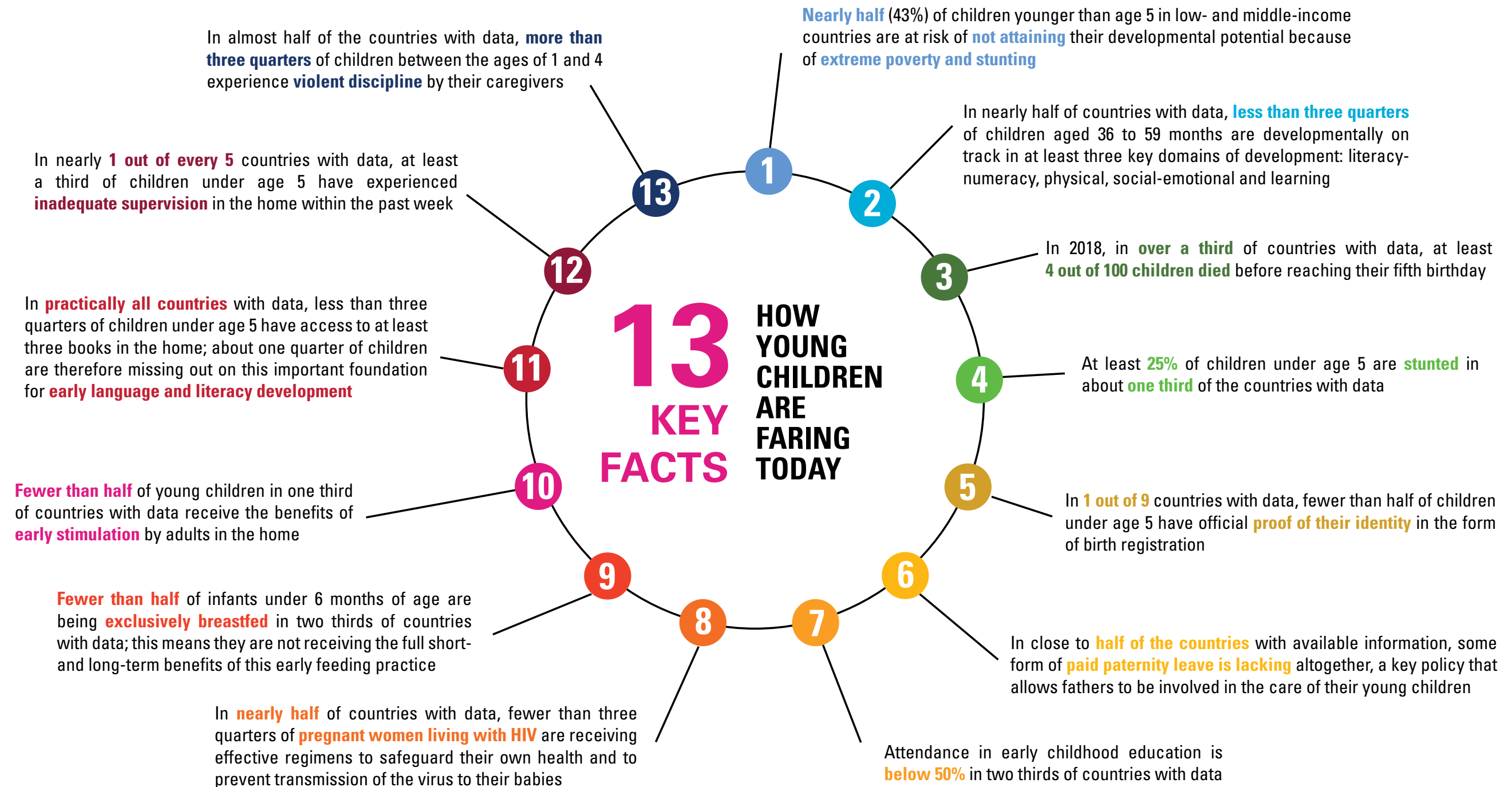


Ashwaq, 14, carries a water container at a settlement for internally displaced persons in Khamir, Yemen. Ashwaq, who has eight brothers and sisters, was displaced with her family from Saada in Amran Governorate.

FIGURE 1.6

Early childhood development programmes are not reaching most children, depriving them of a solid foundation

Thirteen key facts: keeping the world accountable for early childhood development



Source: Early Childhood Development Countdown to 2030 Technical Working Group, country profile database, 2020; [Nurturing-care.org/resources/country-profiles](https://nurturing-care.org/resources/country-profiles).

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“I cannot imagine more urgency than during and beyond COVID-19 to deliver on all commitments for every woman, every child and every adolescent; to ensure that they are healthy, well nourished and thriving. EWEC will do everything to support countries and communities to get back on track, scale up investments and find solutions that address the needs, and uphold the rights, of women, children and adolescents, everywhere.”

GERDA VERBURG
United Nations Assistant Secretary-General and SUN Movement Coordinator

The nutrition transition is happening at varying paces around the world, with some countries saddled with high levels of undernutrition and micro-nutrient deficiencies while also struggling with rising rates of childhood overweight and obesity. Globally, 144 million children aged under 5 years (21.3% of all children) were stunted in 2019, 47 million children (6.9%) were wasted, and 38 million children (5.6%) were overweight.⁴⁶ Although stunting rates have fallen over the past 20 years (from 32.4% of all children aged under 5 years in 2000 to 21.3% in 2019), the global prevalence of wasting and rates of overweight have remained about the same.

Despite making progress on reducing child stunting, Africa and Asia continue to account for the greatest share of all forms of malnutrition. More than half of all stunted children, two thirds of all wasted children, and almost half of all overweight children aged under 5 years live in Asia. About 40% of all stunted children, 25% of all wasted children and 25% of all overweight children live in Africa.⁴⁷ Although child stunting levels have fallen in Latin America in the past decade, a recent study found that indigenous population groups living in 13 Latin American countries were more likely to be stunted than other ethnic groups. This finding, which echoes evidence regarding indigenous and other marginalized groups in other regions, highlights the need for equity-based research that can identify which groups of children are experiencing the highest levels of malnutrition and should be targeted for programmes.⁴⁸

Although rising trends in children’s and adolescents’ body mass index have plateaued in many high-income countries, the levels are accelerating in parts of Asia and are as high as 20% or more in several countries in Polynesia and Micronesia, the Middle East and North Africa, the Caribbean and the United States of America.⁴⁹ A contributing factor to these concerning trends in child and adolescent overweight is lack of physical activity. New WHO estimates show that more than 80% of 11–17-year-old school-going adolescents worldwide are not meeting current physical activity recommendations.⁵⁰

Early childhood development, nutrition and poor health outcomes resulting from humanitarian situations such as conflict situations, natural disasters and disease outbreaks (e.g., Ebola, cholera and other epidemics including COVID-19) are all complex issues that cannot be addressed through the health sector alone. Instead, actions need to take place simultaneously across all three pillars of the primary health-care model and at the policy level for women, children and adolescents to thrive.

- Investment is needed into health systems so that they are resilient to massive shocks like conflicts or pandemics and can consistently provide high-quality, integrated services for women, children and adolescents, even during adverse moments.

- Coordination is imperative across sectors so that the agricultural sector and food system, for example, deliver adequate nutritious food to women, children and adolescents, and so that the health, education and social protection sectors work together to prevent any child or adolescent from going unnoticed.
- People and communities need to be empowered through greater engagement in the planning of health and nutrition services, and in monitoring their delivery. At all levels of political leadership, it is imperative that governments and stakeholders listen to, and act on, the expressed needs and priorities of people.⁵¹

The ability of women, children and adolescents to survive, thrive, and transform themselves and their community hinges in part on political commitments and their implementation. Section 2 provides an update on the EWEC commitments.



Kokilaben and her 7-month-old son, Mityasi, received take-home rations during the lockdown in Gujarat, India, due to the COVID-19 pandemic.

“

“Accountability is democratization. It is about ensuring that every development cent, every tax dollar collected, is spent equitably, effectively, economically and efficiently on the needs of all. Listening to and acting on the voices of communities.”

JOY PHUMAPHI
Co-Chair of the Independent Accountability Panel for Every Woman Every Child

Section 2

EVERY WOMAN EVERY CHILD COMMITMENTS: MAKING GOOD ON PROMISES

SECTION 2

EWEC's convening power – and the strong support for its mandate and multi-stakeholder approach – is reflected in the commitments galvanized across sectors and issue areas. Since 2010, the movement has mobilized 776 commitments, including financial commitments worth a cumulative total of nearly US \$186 billion by governments and other partners to improve women's, children's and adolescents' health and well-being.

This section provides an overview of those commitments, focusing primarily on the most recent – the 348 total commitments made through EWEC and Family Planning 2020 (FP2020) from September 2015 to December 2019 to advance the updated Global Strategy for Women's, Children's and Adolescents' Health.⁵² (Panel 2 lists key moments that resulted in more commitments to the EWEC Global Strategy.) It includes an analysis of: 1) the commitments made by governments and nongovernmental commitment makers; 2) information reported from nongovernmental commitment makers who responded to the 2019 EWEC Commitments Progress Questionnaire on progress achieved towards advancing their EWEC commitments; and 3) published reports including previous analyses of EWEC commitments.⁵³ The data and the analyses presented in this section therefore serve as a benchmark for commitments made and progress attained by EWEC commitment makers before the COVID-19 pandemic (Box 2.1 describes the methods). A summary of the Global Consensus Statement on Meaningful Adolescent and Youth Engagement is described in Box 2.2.⁵⁴ Commitments made by partners to implement these efforts will be included as part of EWEC commitments starting in 2020. In addition, Box 2.3 describes the commitments mobilized at the Global Vaccine Summit in 2020.

The 348 commitments made since the launch of the Updated Global Strategy (2016–2030) and the Agenda 2030 for Sustainable Development in September 2015 were worth about US \$44 billion. That amount is in addition to an unprecedented estimated US \$97 billion financial commitment for women's, children's and adolescents' health from the Government of India announced at the Partnership for Maternal, Newborn and Child Health (PMNCH) Partners' Forum in 2018.⁵⁵ India's commitment represents the largest financial commitment pledged in support of the EWEC movement.⁵⁶ As illustrated in Figure 2.1, new commitments were made every year between 2015 and 2019. In 2019, 37 new commitments were made in support of EWEC, a 12% increase from 2018. It is worth noting that the US \$44 billion pledged during the time frame September 2015 to December 2019 (not factoring in India's contribution) approximates the US\$ 45 billion pledged in the preceding five years, September 2010 to August 2015.

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“At Merck for Mothers, we are optimistic about the future of private sector engagement and the powerful positive impact we can have on the lived experiences of women and girls, when we work together across sectors. Private sector collaborators are catalysing new innovations to leapfrog progress; they are applying their expertise in scaling sustainable solutions; and they are augmenting the provision of critical health-care services – all capabilities and resources that will be needed to achieve the Sustainable Development Goals by 2030.”

DR MARY-ANN ETIEBET
Lead and Executive Director,
Merck for Mothers

PIVOTAL MOMENTS IN GARNERING POLITICAL MOMENTUM AND CONCRETE COMMITMENTS FOR THE EWEC GLOBAL STRATEGY

2019 ICPD+25 Conference, Nairobi

2019 marked the 25th anniversary of the landmark International Conference on Population and Development (ICPD) held in Cairo in 1994. During the summit, EWEC and the United Nations Population Fund (UNFPA) jointly mobilized 20 new financial and programmatic commitments⁵⁷ by nongovernmental actors to accelerate progress towards the achievement of the Global Strategy and the ICPD Programme of Action.

2019 Global Fund replenishment

Donors at the Global Fund's Sixth Replenishment Conference in October 2019 pledged US\$ 14.02 billion for the next three years – the largest amount ever raised for a multilateral health organization. The funds will be essential to efforts to prevent and treat all living with HIV, tuberculosis and malaria – three infectious diseases that disproportionately affect women, children and adolescents in many contexts.⁵⁸

2018 PMNCH Partners' Forum

The Partners' Forum, co-hosted by PMNCH and the Government of India in December 2018, galvanized high-level commitments contributing to a 12% increase in the number of EWEC commitments from 2018 to 2019.⁵⁹ A notable event during the gathering

was the Government's announcement of an increase in national health-care spending to reach 2.5% of gross domestic product (GDP) by 2025.⁶⁰ It is estimated that about US\$ 97 billion of this investment will be devoted to women's, children's and adolescents' health to advance the EWEC Global Strategy. This commitment represents the largest financial commitment pledged by a single commitment maker in support of the EWEC movement.⁶¹

2018 GFF replenishment

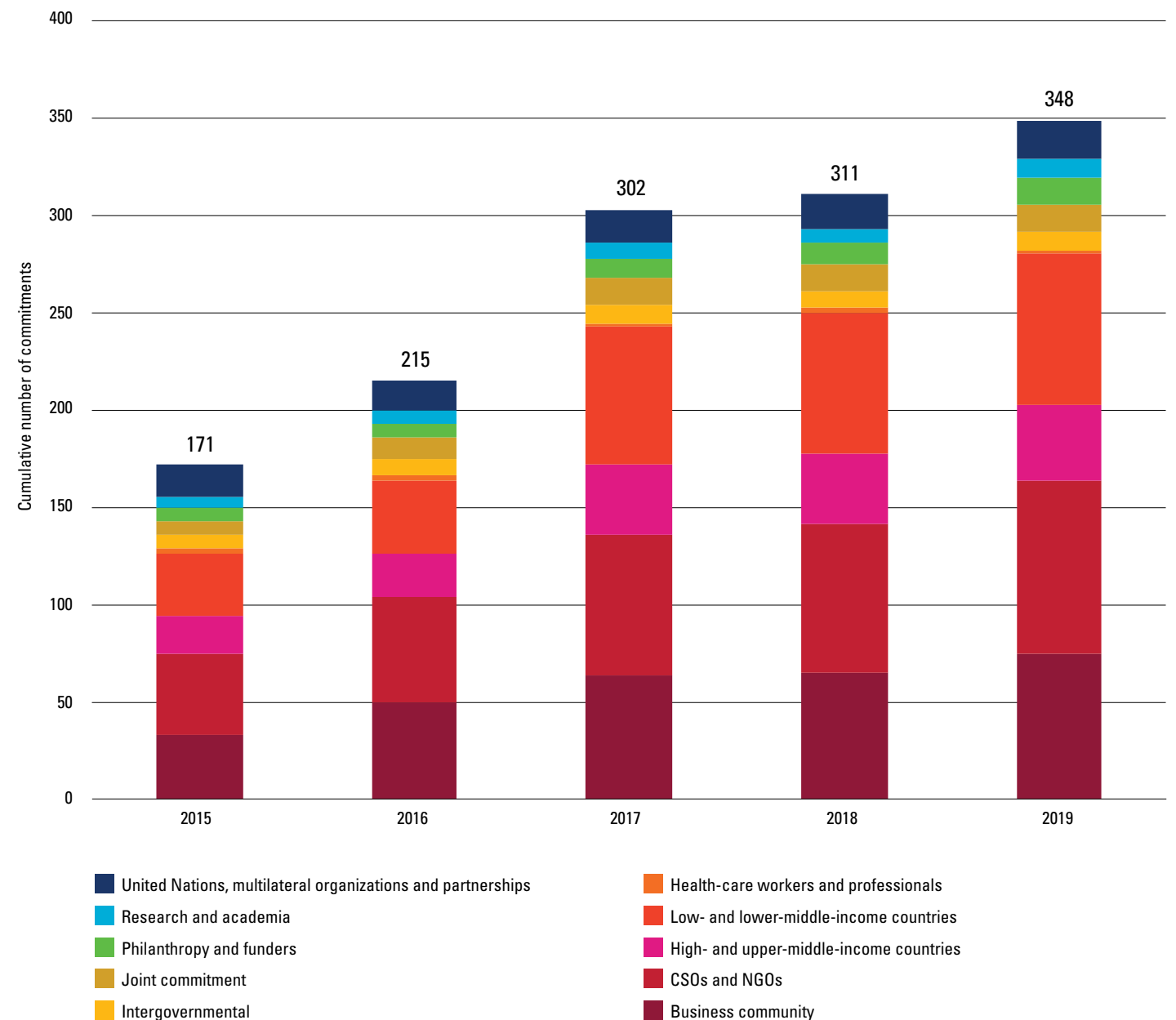
The Global Financing Facility (GFF) mobilized more than US\$ 1 billion from 13 multi-stakeholder partners in a successful replenishment in support of EWEC. This marked an important milestone towards the goal of raising an additional US \$2 billion to expand to 50 countries with the greatest health and nutrition needs and contribute to saving and improving millions of women's, children's and adolescents' lives by 2030. Since the GFF launch in 2015 and as of 30 June 2020, total contributions to the GFF Trust Fund from 16 donors have amounted to US\$ 1.53 billion⁶² (Box 2.4).

2017 Family Planning Summit

The Family Planning Summit in July 2017⁶³ was a crucial moment in successfully mobilizing 77 new EWEC commitments to advance FP2020 goals regarding rights-based family planning programmes.

FIGURE 2.1

Continued support for the EWEC agenda resulted in increased commitment-making through 2019
Commitments to the updated EWEC Global Strategy, 2015–2019



Note: The number of commitments indicated per year are cumulative figures. The cumulative number of commitments made to the updated Global Strategy for Women's, Children's and Adolescents' Health was 348 at the end of 2019.
Source: 2019 Progress Reporting Questionnaire for EWEC Non-State Commitment Makers. PMNCH, in collaboration with EWEC and FP2020.



Aruzhan, 6, learns about earthquakes and how best to respond in the event that one should occur in the city of Almaty, Kazakhstan. Her school is one of the first in the country to implement a disaster risk reduction programme.

BOX 2.1 HOW EWEC **COMMITMENTS** ARE TRACKED

The tracking of commitments⁶⁴ to the Global Strategy includes the collection, analysis and triangulation of data from various sources, including: 1) original commitments made by all commitment makers, including government and nongovernmental commitment makers;⁶⁵ 2) reporting on the progress of commitments through an annual progress questionnaire (91 responses);⁶⁶ and 3) published reports and other relevant literature, including previous reports on EWEC commitments. The analysis of financial commitments involved calculations to estimate the total financial value of commitments, controlled for double counting and taking into account the estimated amount of additional financing that was pledged above baseline levels.⁶⁷

BOX 2.2 DRIVING **ACCOUNTABILITY** FOR MEANINGFUL ADOLESCENT AND YOUTH ENGAGEMENT

To help deliver on the EWEC Global Strategy's "transform" priority area, the Global Consensus Statement on Meaningful Adolescent and Youth Engagement (MAYE) was developed as a joint effort spearheaded by PMNCH, FP2020 and the International Youth Alliance for Family Planning.⁶⁸ The Consensus Statement outlines a definition and key principles of MAYE. It was finalized with guidance from 30 youth-led and youth-serving organizations from all over the world and launched during the International Conference on Family Planning in November 2018 and at the PMNCH's Partners Forum in December 2018. As of June 2020, more than 200 organizations – many of which are EWEC commitment makers – have pledged to advance MAYE by endorsing the Consensus Statement.⁶⁹

BOX 2.3 **COMMITMENTS MOBILIZED** AT THE GLOBAL VACCINE SUMMIT, 2020

While not part of the current EWEC reporting period, in 2020 the Global Vaccine Summit, hosted by the Government of the United Kingdom, marked a crucial milestone for reaffirming global commitments towards improving child health and immunization. Set against the backdrop of COVID-19, which has threatened the achievements made towards child immunization, the virtual summit convened leaders from countries, the private sector, civil society, foundations and organizations to pledge more than US\$ 8.8 billion to support Gavi, the Vaccine Alliance in its work to protect more than half of the world's children against deadly, debilitating vaccine-preventable diseases.⁷⁰

FUNDS ARE BEING PLEDGED FOR INVESTMENT CASES BUT GAPS REMAIN

For 21 of the GFF's partner countries⁷⁵ where data are available through GFF resource mapping and expenditure tracking, a total of US\$ 11 billion has been pledged for 2020 towards implementing investment cases – a country-led process that aligns priorities and donors in support of improving women's, children's and adolescents' health. The priorities in the 21 investment cases have been financed with US\$ 5.9 billion in contributions from the governments (53% of the resources), US\$ 4.6 billion in partner commitments (42%), and US\$ 490 million in financing from the International Development Association and the GFF Trust Fund (4%). The US\$ 11 billion represents more than two thirds of what is needed to fully finance these investment cases. A US\$ 4.5 billion gap remains.

Financial commitments from low- and lower-middle-income countries now account for 86% of the cumulative value of all government commitments. This also includes new financial commitments from Angola, Central African Republic and Gambia made between 2018 and 2019.⁷¹ Commitments from low- and lower-middle-income countries demonstrate their willingness to mobilize domestic resources to protect and improve RMNCAH. Continued prioritization of RMNCAH in these countries is especially important in the context of the COVID-19 pandemic.

While the financial commitments of low- and lower-middle-income countries have increased, cumulative financial commitments from high-income and upper-middle-income countries remained at the same level in 2019 as in 2018, at an estimated US\$ 17.8 billion. The same flat trend is true over the one-year period for the level of cumulative financial commitments from the private sector⁷² and foundations/philanthropies.⁷³ In comparison, cumulative financial commitments pledged by civil society increased by US\$ 7 billion between 2018 and 2019, from US\$ 4.9 billion to US\$ 11.9 billion.⁷⁴

While these figures show significant contribution by governments and nongovernmental commitment makers to achieving the targets of the Global Strategy (2016–2030) prior to the COVID-19 pandemic, they also show that the pace of increases in commitments varies by sector and needs to increase to ensure that women, children and adolescents are not left behind as the pandemic continues. The direct and indirect effects of COVID-19 on the most vulnerable women, children and adolescents will require urgent and increased financial commitments across all sectors to prevent jeopardizing hard-won gains. Going forward, efforts to mobilize additional resources from domestic and international sources for women's, children's and adolescents' health need to be continued, strengthened and protected.

Reach of commitments

Results from the 2019 EWEC Commitments Progress questionnaire for nongovernmental commitment makers offer a good indication of how vast the reach of the EWEC commitments has been. As illustrated in Figure 2.2, survey respondents responsible for about two thirds of nongovernmental commitments reported reaching an estimated 599 million women, children, adolescents and newborns through service delivery activities across all six EWEC focus areas in 2019, which was 157 million more people than the previous year. The focus areas are early childhood development; adolescent health and well-being; quality, equity and dignity in services; sexual and reproductive health and rights; empowerment of women, girls and communities; and humanitarian and fragile settings.

FIGURE 2.2

599 million women, children, adolescents and newborns were reached across all six EWEC focus areas in 2019

Number of people reached with service delivery activity by EWEC area



Note: Reports are from the 2020 online progress survey, reported by responding non-state commitment makers. Overall, information for 91 out of 147 commitments was provided for the survey – a response rate of 62%. Survey responders have the option to provide information on the relevant target populations reached and EWEC focus areas supported. Source: 2019 Progress Reporting Questionnaire for EWEC Non-State Commitment Makers. PMNCH, in collaboration with EWEC and FP2020.

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“Today, global child mortality rates are lower than ever. Since its inception, Gavi, the Vaccine Alliance support has played a central role in making this possible. But we haven’t done it alone. Purposeful collaboration with partners and initiatives like Every Woman Every Child has propelled our success. Now, as the COVID-19 pandemic looms, we have a chance to strengthen routine immunization to reach everyone, including the zero dose children – those missing out on basic vaccines. Two thirds of these children live below the poverty line and face multiple deprivations. By working together, we would multiply the chances of our success towards SDG 3 on healthy lives and well-being for all.”

ANURADHA GUPTA
Deputy CEO, Gavi, the Vaccine Alliance

Although commitment makers were active across all focus areas, activities and efforts in certain areas reached more people than others. In 2019, out of the total 599 million people reached, 204 million children were reached with activities related to early childhood development. Approximately 146 million women, newborns and children were reached with services relating to advancing quality, equity and dignity in health facilities. Furthermore, 50 million young people were reached through services for adolescent health and well-being, while 164 million people were reached with sexual and reproductive health and rights services. Notably, nongovernment commitment makers reported reaching only 1 million through efforts that improve gender norms and reduce discrimination. This suggests that efforts to advance gender equality need additional focus.

The survey results also indicate that more investments are needed for services in humanitarian and fragile settings, as that category accounted for only 6%, or 34 million people, reached (up from 1% in the 2015–2017 time period). Given that large numbers of preventable maternal, newborn and child deaths occur in humanitarian and fragile settings, it is critical that RMNCAH services in these contexts are prioritized as part of COVID-19 response strategies to avoid exacerbating existing sources of fragility and to help build resilience.

Impact of COVID-19 on EWEC commitments

An additional survey question was posed to nongovernmental commitment makers in 2020 regarding their assessment of the impact of the COVID-19 pandemic on their commitments to the Global Strategy. Of the 63 nongovernmental commitment makers that responded to this new question, almost half (27 respondents, or 43%) reported uncertainty, including a potential decrease in their financial commitments in the coming years, which could impact their ability to deliver on pledges to the Global Strategy.

These responses underscore the urgent need to safeguard the gains made throughout the past 10 years in women’s, children’s and adolescents’ health while also exploring ways to maintaining progress. The continuity of essential services and funding for RMNCAH – including those made possible by and supported through EWEC commitments – must not only be protected from cuts or reallocation as part of national COVID-19 response and recovery efforts, but also prioritized and increased to respond to the pandemic’s immediate and long-term repercussions. The leadership of low- and lower-middle-income countries in making commitments and the growth of civil society commitment-making in the past five years needs to be continued, and all other commitment makers, including high-income countries, need to follow their example.



Children play in the Balukhali refugee camp in Cox’s Bazar, Bangladesh.

Section 3

THE IMPACT OF COVID-19 ON WOMEN'S, CHILDREN'S AND ADOLESCENTS' HEALTH

There is little doubt that an economic, social and health crisis as severe and widespread as the COVID-19 pandemic will negatively affect the health and well-being of women, children and adolescents in nearly every setting – and as a result, slow down or reverse some of the progress made since EWEC began 10 years ago. In April the GFF Investors Group – which includes governments, civil society organizations, the private sector, United Nations agencies, the Gavi Alliance and the Global Fund – warned of these impacts and is deploying core GFF capacities to support its 36 partner countries to maintain essential health services for women, children and adolescents⁷⁶ through strengthening front-line service delivery, addressing demand-side constraints, and prioritization and planning exercises. The considerable uncertainty over how long the pandemic will last and how countries should effectively respond to it makes it difficult to predict the extent of the negative direct and secondary effects, where they will be the most significant, and who will be most adversely affected (and how).

This section reviews key findings from modelling efforts, research studies and country reports on the direct and indirect impacts of COVID-19 on women, children and adolescents. This information underscores the complexity of the global crisis while also serving as guidance for the EWEC movement as it builds investments and momentum in the decade ahead.

The potential pathways through which COVID-19 can influence women's, children's and adolescents' ability to survive, thrive and transform are highlighted in Figure 3.1. Although there may be some positive impacts, e.g., decreased pollution and car accidents, the general effect of the COVID-19 pandemic is overwhelmingly negative. In terms of direct health impacts, the proportion of reported cases of COVID-19 infection, hospitalizations and deaths from COVID-19 illness has been low in children compared with adults. It is estimated that those aged under 20 years may be roughly half as susceptible to infection as those aged over 20.⁷⁷ There is currently no evidence that pregnancy and childbirth increase the risk for becoming infected with COVID-19, but pregnancy may increase the need for intensive care treatment for COVID-19 compared with nonpregnant individuals of the same age.⁷⁸ Evidence is still accumulating on the impact of COVID-19 on pregnancy and perinatal outcomes and on the risks of transmission during pregnancy, childbirth and breastfeeding.

The indirect impacts of COVID-19 on women, children and adolescents, however, extend far beyond health and may have long-lasting detrimental consequences. Country mitigation strategies have frequently resulted in disruptions to the delivery of essential reproductive, maternal, newborn and child health services, putting women, children and adolescents at higher risk of death, disease and disability from preventable and treatable causes. These strategies have also negatively impacted the food system through



A student attends class at the primary school of San Pedro, in south-west Côte d'Ivoire, for the first time since the COVID-19 pandemic started.

“

“As we respond to COVID-19 and reimagine a better future, with sustained peace, including at home, we must repeat unequivocally that the rights of women and girls are not negotiable. Even in times of crisis – especially in times of crisis – their sexual and reproductive health and rights must be safeguarded at all costs.”

DR NATALIA KANEM
Executive Director of UNFPA
and Host of the Every Woman
Every Child Secretariat

trade restrictions and disruptions in transportation, increasing the risk of food insecurity for millions of families.⁷⁹ The global economic crisis following on the heels of the pandemic is impacting millions of households that may lose the ability to afford basic needs such as shelter, food and health care. A recent estimate using the International Food Policy Research Institute poverty model indicates an increase in extreme poverty⁸⁰ in 2020 of 80 million to 120 million people, and an estimated increase of approximately 40–60 million additional children living in monetary poor households.⁸¹ Widespread school closures are a serious detriment to learning and human capital development, with some children and adolescents likely to never return to school and others potentially exposed to increasing levels of domestic violence and higher risks of early pregnancy.⁸² Projections from 2020 to 2030 suggest that the economic consequences of the COVID-19 pandemic could cause a one-third reduction in progress towards ending gender-based violence and could result in an additional 13 million child marriages taking place that otherwise would not have occurred.⁸³

The impact of COVID-19 on health-care systems throughout the world is being documented through numerous surveys and reporting mechanisms. Shortages of health personnel, equipment and supplies; closures of routine health services; transportation disruptions; and fear of infection are common and are resulting in less use of health-care services. Harmful medical practices are being implemented in some countries as part of efforts to prevent COVID-19 transmission. These include, for example, more elective caesarean section deliveries, not allowing women to have companions present during childbirth, and separating infants from mothers with COVID-19 infection at birth, interfering with the initiation of breastfeeding.⁸⁴

WHO and UNICEF have mobilized their extensive country networks to gather qualitative information on disruptions in health services through “pulse” surveys. Key informants, including those agencies’ own staff and local health ministries, report major disruptions in basic health-care services for women and children. Some of the most severely impacted services have been routine immunization services, malaria bednet distribution campaigns, family planning and antenatal care services. For all these services, about half of country reports indicated partial or severe disruptions as early as March–June 2020 (Figure 3.2). The most common reasons provided for these disruptions are not seeking care due to fear of infection, closure of services, lockdowns limiting transport, supply shortages at facilities, and financial difficulties.



A 3-year-old girl receives a vaccination at a community health centre in Beijing, China. Provinces other than Hubei, the epicentre of the COVID-19 outbreak, have gradually resumed full vaccination services that had been halted due to the outbreak.

FIGURE 3.1

The COVID-19 pandemic will impede women's, children's and adolescents' ability to survive, thrive and transform

Logic model of impact of COVID-19 on non-COVID health outcomes of women, children and adolescents

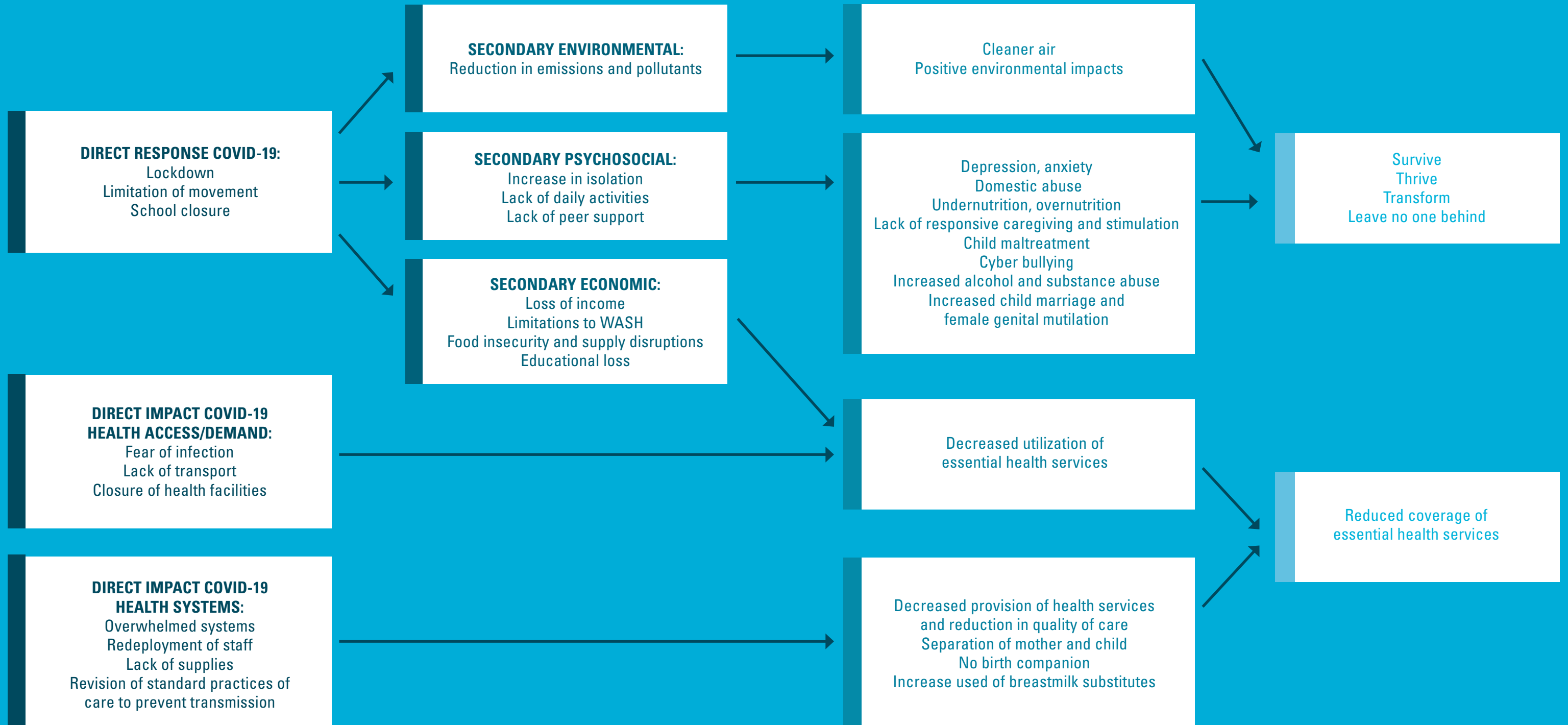
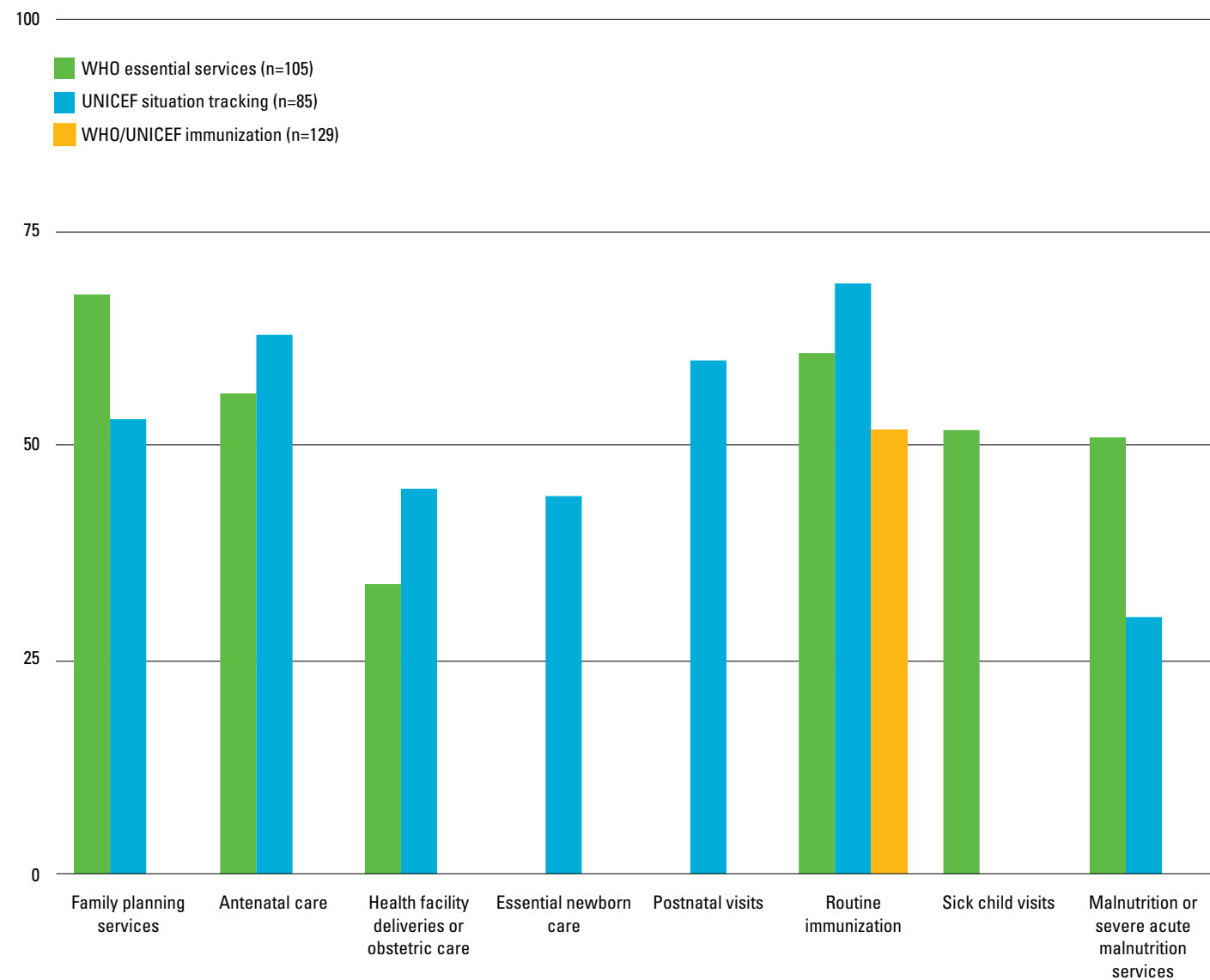


FIGURE 3.2

About half of country reports indicate partial or severe service disruptions related to the pandemic and responses to it

Percentage of countries that report any disruption in reproductive, maternal, newborn, child health and nutrition services due to COVID-19



Notes and sources: The number of countries from which data is available from each survey is indicated in the legend in parentheses (n=xx). WHO essential health services survey (https://www.who.int/publications/i/item/WHO-2019-nCoV-EHS_continuity-survey-2020.1). Disruption defined as “partial” (5% up to 50% of patients not treated as usual) or “full disruption” (more than 50% of patients not treated as usual). UNICEF situation tracking for COVID-19 socioeconomic impacts May–June 2020 (<https://data.unicef.org/resources/rapid-situation-tracking-covid-19-socioeconomic-impacts-data-viz>, accessed 3 July 2020). Percentage calculations include the number of individuals who report “not applicable / do not know”. WHO, UNICEF immunization pulse survey, April 2020. Reporting categories include “none”, “mild”, “moderate”, “severe”, “total suspension”. The percentage disrupted includes the moderate, severe and total suspension categories: (https://www.who.int/immunization/monitoring_surveillance/immunization-and-covid-19/en/).

Although the results in Figures 3.1 and 3.2 are qualitative, available quantitative data from routine health information systems substantiate these reductions in the use of health-care services. For example, as of July 2020, routine health information data from Lagos, the state in Nigeria with the largest number of reported COVID-19 cases at that time, showed large reductions in antenatal care visits. Although some recovery started in May, antenatal care attendance is considerably lower than attendance during the same months in the previous year (Figure 3.3). The first reported cases of COVID-19 in Lagos were in March and the number of cases has fluctuated since then, with peaks in May and June and some uptick in August.⁸⁵



Nurses in Kosovo* immunize a child. Vaccination programmes have resumed since the COVID-19 pandemic started.

*The above reference to Kosovo should be understood to be in the context of United Nations Security Council resolution 1244 (1999).

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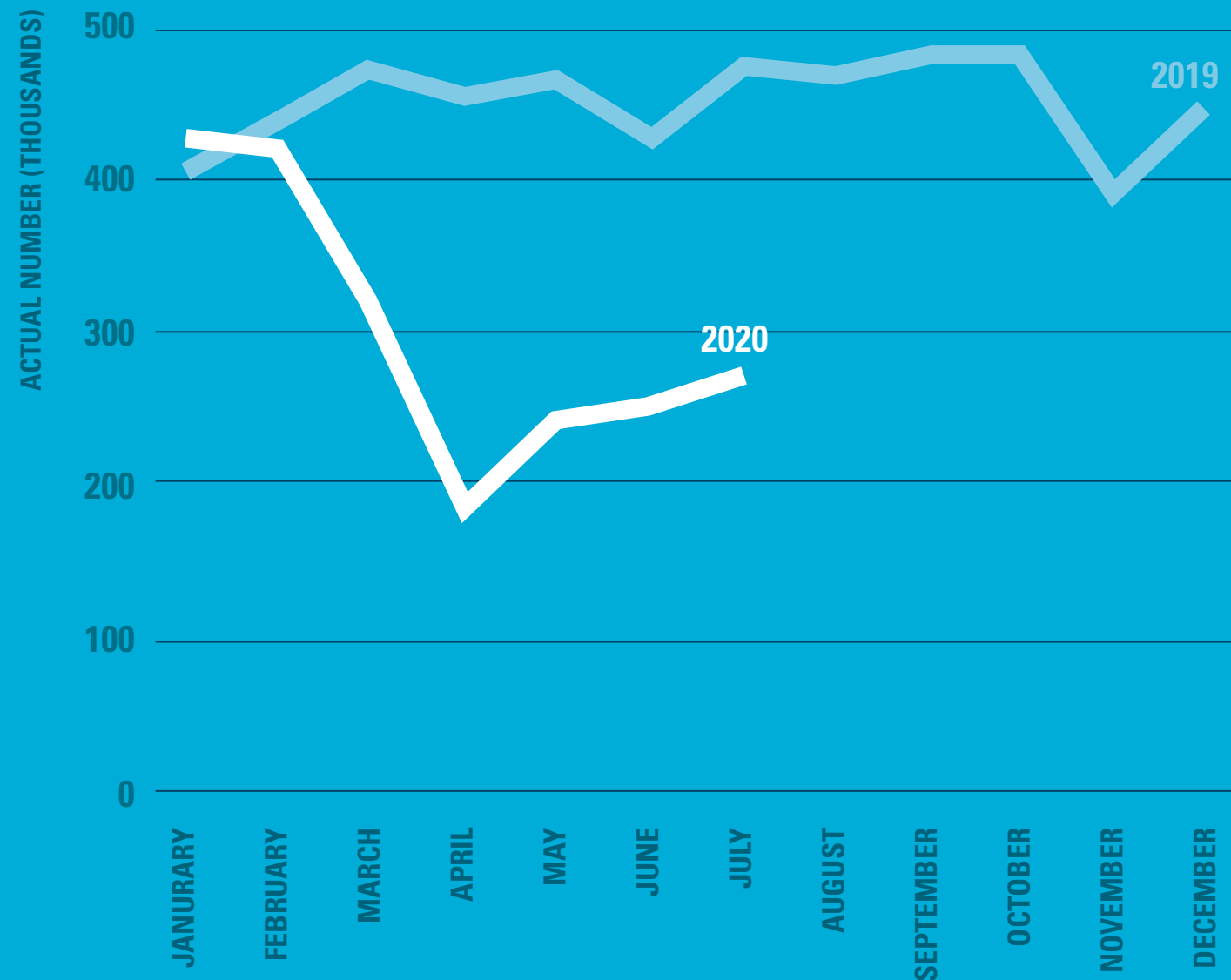
“The challenge of addressing the dual pandemics of HIV/AIDS and COVID-19 reminds us all that we must never take hard-fought progress for granted. The best way to ensure continued gains in the AIDS response is through focused global leadership and sustained investment in HIV prevention, diagnosis and treatment services for vulnerable and marginalized populations. We are determined to keep fighting to see a world where women have access to comprehensive family planning options, and no other mother, child, or family is devastated by HIV or AIDS.”

CHIP LYONS
PRESIDENT AND CEO,
ELIZABETH GLASER
PEDIATRIC AIDS FOUNDATION

FIGURE 3.3

Antenatal care attendance dropped in the wake of the pandemic

Antenatal total attendance comparison of first six months 2019 to first six months 2020 – Lagos State, Nigerian National Health Management Information System



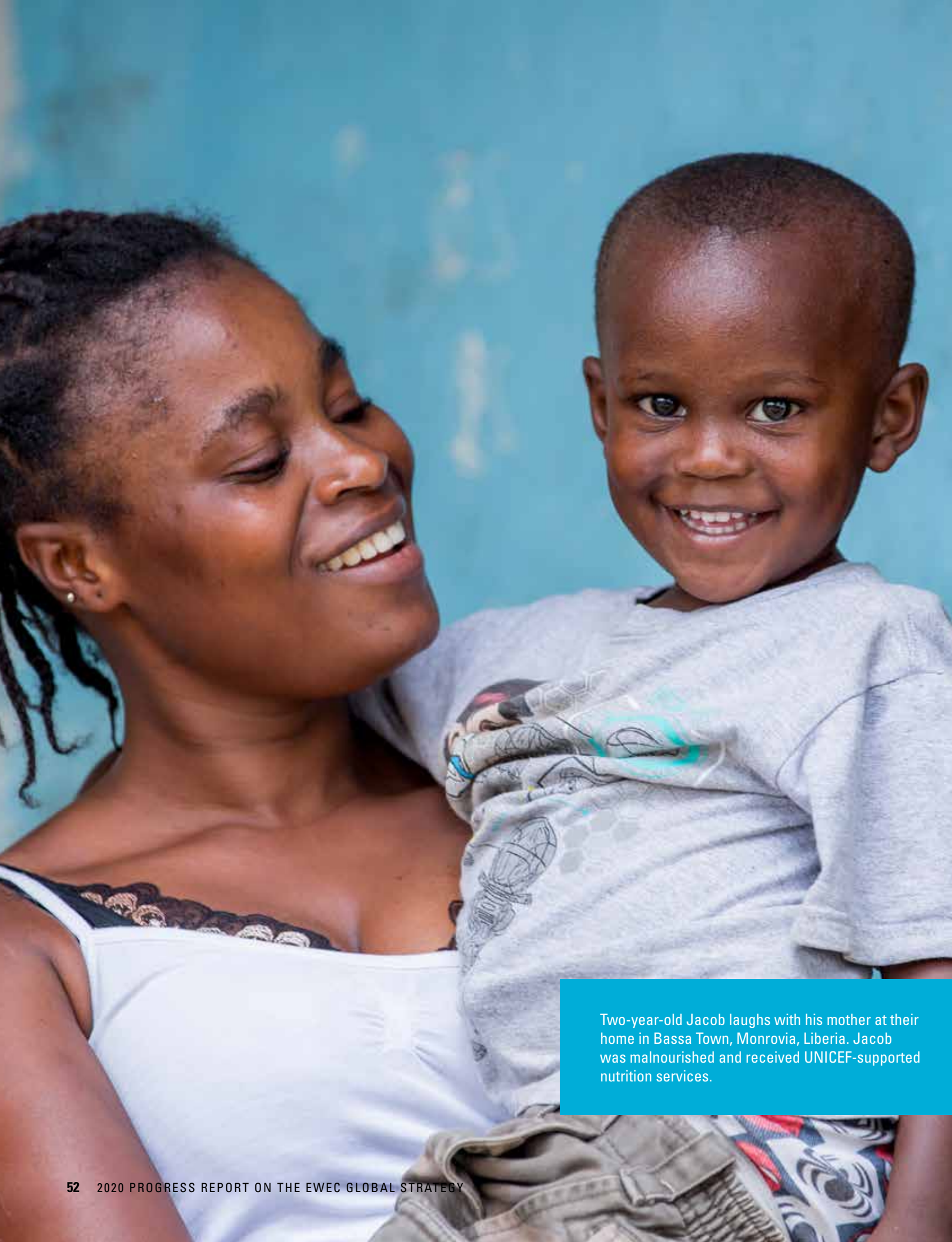
Source: Nigerian National Health Analytic Tool showing health service update during the COVID-19 pandemic; (<https://msdat.fmhconnect.gov.ng/covid/index.html>, accessed 22 July 2020).

Models of the potential outcomes of various levels of essential RMNCAH service disruptions show catastrophic consequences and can be useful for encouraging governments and partners to ensure such disruptions do not occur. Here are some select examples:

- One model suggests that reductions of about 15% in coverage of key high-impact maternal and child health interventions for six months in 118 lower-middle-income countries could result in 253 500 additional child deaths and 12 200 additional maternal deaths. Reductions approaching 45% for six months would result in 1 157 000 additional child deaths and 56 700 additional maternal deaths.⁸⁶
- Other models estimate that the COVID-19 pandemic may erode progress towards HIV and malaria goals. According to findings from a comprehensive review of several mathematical models,⁸⁷ interruption of antiretroviral therapy for six months would increase mother-to-child transmission of HIV (PMTCT) by approximately 1.6 times in a one-year period. Full suspension of PMTCT activities for three months could result in increases in new HIV infections in children by as much as 41% in Mozambique, 81% in Malawi, 53% in Zimbabwe and 70% in Uganda.⁸⁸
- Another model suggests that some 47 million women in 114 lower-middle-income countries may be unable to access modern contraceptives if the average lockdown measures continue across those countries for six months with major disruptions to services. An additional 7 million unintended pregnancies are expected to occur under this scenario.⁸⁹

Past experiences with service disruptions resulting from other outbreaks and disasters show a mixed picture on timelines for recovery, but offer hope that it will be possible to get back on track during and after COVID-19. Guinea, Liberia and Sierra Leone had severe Ebola epidemics in 2014–2015 that negatively impacted their health and other services, yet each had different starting points in terms of service coverage levels and different rates of recovery following the epidemic (Figure 3.4). Guinea had low intervention coverage levels and high inequalities before the Ebola outbreak began, and by 2018 national coverage levels showed some improvement, yet inequalities did not reduce. In contrast, surveys conducted in 2013 and 2019 in Liberia showed increases in coverage along with a reduction in the inequalities between the poorest and richest. In Sierra Leone, coverage levels increased and inequalities decreased, but this occurred due to declines among the richest rather than because of a more rapid increase among the poorest. These country Ebola experiences suggest that a strong recovery phase is possible from a crisis and that this can be accompanied by reductions in inequalities.

MODELS ESTIMATE THAT THE COVID-19 PANDEMIC MAY ERODE PROGRESS TOWARDS HIV AND MALARIA GOALS

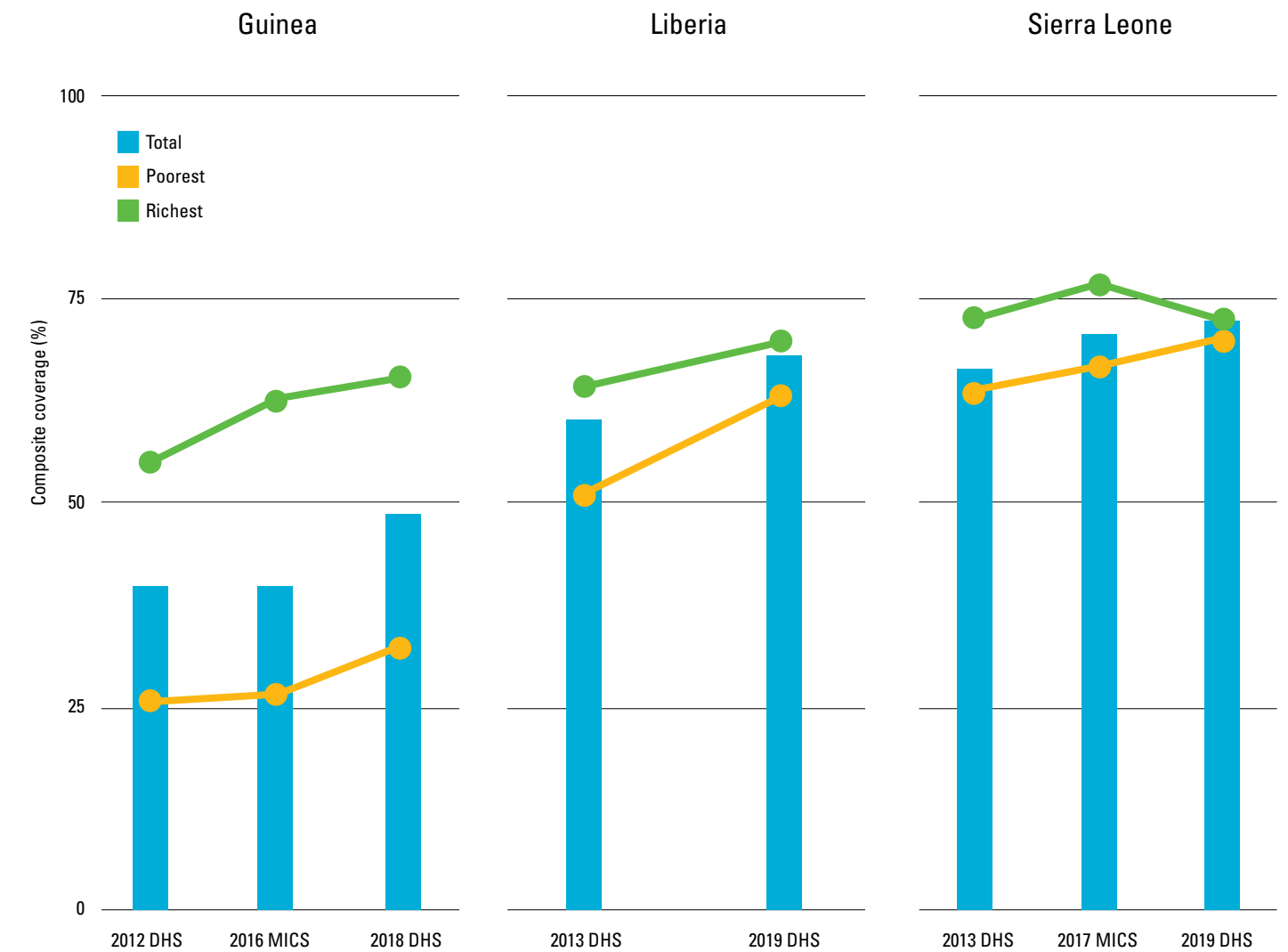


Two-year-old Jacob laughs with his mother at their home in Bassa Town, Monrovia, Liberia. Jacob was malnourished and received UNICEF-supported nutrition services.

FIGURE 3.4

Past pandemic experiences offer hope for getting back on track

Composite coverage index by national average and poorest and richest wealth quintile, national household surveys, Guinea, Liberia and Sierra Leone, 2012–2019



Source: Demographic and Health Surveys, Multiple Indicator Cluster Surveys.

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“Women-, children- and adolescent-centred approaches are critical. Our progress for them might be set back for now, but as both COVID-19 and HIV have shown us, acceleration and innovation are possible even during pandemics. We must and can step up our efforts for women, children and adolescents to survive, thrive and transform. There are no more excuses to leave them behind.”

WINNIE BYANYIMA
Executive Director, UNAIDS

There is also evidence from these three countries that community health workers can help mitigate disruptions to health services. While data show that the service utilization of community health workers dropped during the epidemics, communities reported seeking care more from community health workers after Ebola than from health facilities. This may be because close, long-established and trusting relationships between communities and these workers existed pre-Ebola.⁹⁰

Global guidance on best practices to deliver care to pregnant women with COVID-19 infection and to maintain RMNCAH essential services has been developed and widely disseminated.⁹¹ In addition, some countries have implemented innovative strategies to mitigate the indirect impact of COVID-19 on the non-COVID health and well-being of women and children. An example of such a strategy in Ghana is highlighted in Panel 3.



Margaret Gwada, the UNICEF Chief of Field Office in Tamale, Ghana, assists a mother who has just received a birth certificate for her child at the Birth and Deaths Registry.

PANEL 3

MITIGATING THE IMPACT OF COVID-19 ON WOMEN, CHILDREN AND ADOLESCENTS: THE GHANA STRATEGY

Ghana’s health system has been under strain from the COVID-19 pandemic since the country confirmed its first two cases on 12 March 2020. The pandemic has driven down demand for and utilization of many essential health services, including those associated with RMNCAH. For example, 591 617 children were registered for child welfare clinics from January to April 2020, compared with 728 017 for the same period in 2019.

Reasons for the decline are not entirely clear, but they may be linked to a reduction in the health workforce due to staff redeployment to support the COVID-19 response, and the perception of some clients that it may be risky to seek treatment at health facilities out of fear of becoming infected.

In response, leadership at the national and regional levels of the Ghana Health Service, in collaboration with health partners, took steps to ensure the continuity of RMNCAH services. These steps, which have helped to sustain demand for and utilization of these services, include:

- Guidelines for RMNCAH service reorganization and delivery during the COVID-19 outbreak were developed for both providers and clients.
- A series of virtual meetings were held, and the guidelines were disseminated to regional teams, districts and subdistricts to inform service delivery.
- Personal protective equipment and essential supplies were made available to health-care providers and clients to reduce the risk of

transmission of the virus to the barest minimum.

- Onsite coaching and supportive supervision are being conducted in health facilities to ensure implementation of the guidelines.
- Communities have been engaged through communication of the measures put in place to ensure their safety using various platforms – e.g., short message service and audio messages by telecom networks, voices of the Paediatric Society of Ghana, traditional leaders and other influential persons, community broadcast networks, billboards and mobile vans.

One specific example of work is in Fadama, a populous community in the north of Ghana’s capital, Accra. Community health nurses supplied with a backpack containing simple but essential medicines and supplies conducted health outreach to children to provide vaccinations. On average, the team visited 20 households in a day and attended to about five children per family. In addition, by holding smaller but frequent clinics, telephoning parents whose children missed vaccinations, and scheduling home visits where necessary, the team has ensured that children in their community are immunized.⁹²

As a result of these measures, utilization of services increased. An assessment of selected health facilities found that service providers felt more confident in providing RMNCAH, and patient trust in the capacity of the health system to provide safe services has improved.

PMNCH CALL TO ACTION ON COVID-19

“Protecting progress on reaching the SDGs for women, children, and adolescents requires the efforts of all partners. We must advocate for greater investment, and for evidence-based approaches to addressing gaps and inequities that obstruct progress, including those exacerbated by the COVID-19 crisis. The following Call to Action, launched by the Partnership for Maternal, Newborn & Child Health in July 2020, rallies partners behind seven common ‘asks’ of governments everywhere during the current pandemic and beyond.”

RT HON HELEN CLARK

Chair, The Partnership for Maternal, Newborn & Child Health and former Prime Minister of New Zealand

Our Call to Action:

Throughout the Covid-19 response and recovery, we urge governments to protect and promote the health and rights of women, children and adolescents through strengthened political commitment, policies and domestic resource mobilization and financing, supported by official development assistance, for:

- 1 Sexual, reproductive, maternal, newborn, child and adolescent health services, supplies, and information and demand generation including for contraception, safe abortion, immunization, safe delivery, stillbirth prevention, and mental health;
- 2 Advancing sexual and reproductive rights and gender equality;
- 3 Quality care, including respectful and dignified care, and effective community engagement and redress mechanisms;
- 4 Recruitment, training, equal and fair pay, and safe working conditions, including protective personal equipment, for front-line health workers, notably midwives and nurses;
- 5 Social protections, including food and nutrition security, for marginalized and vulnerable groups and enhanced data to better understand and address disparities experienced by adolescents, refugees, the internally displaced, migrants, indigenous communities, persons living with disabilities, among others;
- 6 Functional, safe, and clean toilet and handwashing facilities and quality potable drinking water, with a particular focus on health-care centers, schools, and centers for refugees and internally displaced persons; and
- 7 Prevention of violence against women, children and adolescents through education and protection programmes.

<https://www.who.int/pmnch/media/news/2020/call-to-action-on-COVID-19/en/#:~:text=To%20realize%20this%20Call%20to%20Action%2C%20PMNCH%20is%20working%20collectively%20to%3A&text=Support%20uptake%20of%20the%20call,viole%20education%2C%20and%20UHC>



Six-month-old Dhruvil in Gujarat, India, has been receiving take-home rations during the COVID-19 pandemic.

Section 4

WHAT'S NEXT FOR WOMEN'S, CHILDREN'S AND ADOLESCENTS' HEALTH?



Jesmin, a Rohingya refugee, stands in the flooded part of the Shamlapur camp in Cox's Bazar, Bangladesh, where she lives with her mother, father and siblings in a plastic shelter.

“

“There is no doubt that the pandemic has set back global efforts to improve the health and well-being of women and children, but that should only serve to strengthen our resolve. Our joint action under the Every Woman Every Child movement is more important than ever. We now must renew our commitment to a healthier, safer, fairer and more sustainable world for women, children and future generations.”

**DR TEDROS ADHANOM
GHEBREYESUS**

Director-General of the World Health Organization and Chair of the H6 Partnership

As EWEC steps into the next Decade of Action, while responding to the worst global health crisis of a generation, the movement is more critical than ever in championing multilateralism and in mobilizing action across all sectors to protect and improve the health and well-being of women, children and adolescents. There is an urgent need to safeguard the tremendous investments and gains realized by commitments since the launch of EWEC 10 years ago in order to prevent a reversal of progress. Immediate action is needed to mitigate the pandemic’s negative consequences in every country and to put the world back on track to realize the SDGs.

COVID-19 is exacerbating pre-existing inequalities, exposing failures in social, political and economic systems, and further marginalizing vulnerable groups.⁹³ The pandemic represents an extraordinary threat to the central focus of the EWEC movement: the health and well-being of women, children and adolescents worldwide. Hard-earned progress attained over the past decade in improving their ability to thrive and survive and in creating new opportunities for the world’s most vulnerable people is endangered on nearly all fronts.

This report presents trends in progress for women, children and adolescents in the first 10 years of the EWEC movement, taking stock of how well the world was doing before the pandemic began. Although significant reductions in maternal and child mortality were achieved and coverage of essential interventions improved in many countries, progress was uneven, with inequities still evident at regional, national and subnational levels. Progress in providing a foundation for children and adolescents to thrive and for women to have greater life opportunities has also not moved forward evenly around the world. This variation in success means that countries entered into the pandemic with different levels of health system capacity and different challenges rooted in history, culture, demography and society. The countries and population groups most at risk of severe reversals are those that were already falling behind. The report shows impressive and steady increases in commitments to EWEC in the past 10 years, with 348 new commitments made since the launch of the Agenda 2030 for Sustainable Development, including financial commitments worth a total of about US\$ 44 billion (not factoring in India’s financial contribution in 2019). All of these measures of success and remaining challenges were present when the COVID-19 pandemic began.

Section 3 of the report is a sobering picture of the impact to date of the pandemic on women, children and adolescents. Yet, there is reason for optimism. The United Nations, with roots in the League of Nations, had its beginnings in the devastation of World War II and played a significant role in the rapid recovery of countries in its aftermath. The same principles that were in action then are needed now and are already embedded in the EWEC movement. Through multilateral action, multisectoral approaches and strong partnerships, it is still possible to realize the EWEC vision of an equitable and just future for all women, children and adolescents.

BOX 4.1

DATA GAPS AND INNOVATIVE APPROACHES TO ADDRESS THEM

The EWEC Global Strategy monitoring framework is fully aligned with the SDGs and is organized across the areas outlined in this report (survive, thrive, transform and leave no one behind).⁹⁴ It consists of a set of 60 indicators, including a core set of 16 indicators. Since its establishment in 2010, updates have been possible for 54 of the 60 indicators; however, data have never been available for the remaining four. Seven of the core indicators are ideally collected through functional Civil and Vital Registration Systems, which many low- and middle-income countries are lacking. One in four children aged under 5 years does not have his or her birth registered;⁹⁵ and only 93 out of 193 countries are currently able to register more than 80% of deaths.⁹⁶

At the heart of the SDGs is the principle of equity. Identifying those who might be left behind and developing programmes to reach them requires collecting disaggregated data by key stratifiers including wealth, geography, gender, ethnicity, education and age, among others. Available COVID-19 data have highlighted the limits of many country information systems to capture disaggregated data and maintain its granularity, as the data are reported from communities to facilities and up to the national level. COVID-19 data are rarely gender- and age-disaggregated, for example, and when countries do report by age groupings, they are often inconsistent.⁹⁷ For example, the United States reports on age categories of 0 to 4, 5 to 17, 18 to 29, 30 to 39, 40 to 49, 50 to 64, 65 to 74, 75 to 84, 85+,⁹⁸ while South Africa reports 10-year age groups to age 99.⁹⁹ These differences in age groupings make

it challenging to generate a solid evidence base to inform decisions such as whether or how to re-open schools, or whether certain population groups are at higher risk, such as newborns compared with older children. Although appropriate age groupings may need to vary for certain conditions, some standard age breakdowns should be established to enable situation assessments that draw from multiple countries when a new disease or health condition arises.¹⁰⁰

In the past 10 years, there has been a surge in measurement innovations (for example, digitization, visual dashboards, league tables) and suggested methods to analyse data to assess service quality (for example, effective coverage measurement).¹⁰¹ Unfortunately, there has been little adoption and use of these tools and methods in low- and middle-income countries,¹⁰² and efforts to support the Global Strategy must include greater investments in Civil and Vital Registration Systems and routine health information systems in those settings. Support is also needed for equity data and analyses, including for the establishment of global standards for health groupings, and for helping countries introduce new data collection and visualization technologies. Finally, as the Global Strategy requires action across sectors to ensure improvements in the health and well-being of women, children and adolescents, it is also imperative that there be greater country ownership of the measurement and accountability agenda to ensure that more context-specific multisectoral actions are designed and implemented.



Schoolchildren in Cambodia's remote Ratanakiri District wash their hands using a facility procured and delivered by UNICEF Cambodia.

KEY MESSAGES

- 1 The COVID-19 pandemic has made clear how fundamental good data are across sectors to understanding the current situation for women, children and adolescents, for making policy and programmatic decisions, for assessing progress and for holding governments and partners to account. The pandemic has also shone a spotlight on glaring data gaps at global, regional, national and subnational levels that have plagued efforts to realize human rights and improvements in women's, children's and adolescents' health and well-being (Box 4.1). Investments in country information systems, including coordination across the information systems in different sectors and across different levels of the system (community, district, national, regional and global) is core to progress and accountability. These investments must support strengthening country ability to collect, analyse and use data for decision-making and civil society's ability to use data to demand high-quality services for all women, children and adolescents.
- 2 Achievement of the SDGs and the Global Strategy targets requires actions that support all three primary health-care pillars, including:
 - Greater investment is needed to build health systems that are resilient to shocks such as conflicts, natural disasters and disease outbreaks so that countries are able to consistently provide high-quality, integrated services for women, children and adolescents.
 - Multisectoral coordination is critical for addressing the social determinants of women's, children's and adolescents' health and making sure that no one is left behind. Links across the agricultural, health, education, water and sanitation, and social protection sectors are essential for ensuring that all women, children and adolescents receive adequate amounts of nutritious food, clean water and the other services they need to survive and thrive.
 - Greater participation of people and communities in decision-making around health and related services is a crucial step to ensuring that these services respond to their needs and are delivered respectfully and with a high level of quality. Civil society engagement in health-care planning and monitoring is also fundamental to holding governments and their partners accountable.
- 3 History can provide lessons needed to guide rapid recovery efforts. COVID-19 is neither the first global pandemic nor the first catastrophe to cause the world to tumult into recession. Recovery has often been achieved through multilateral action and continued investment in development. The EWEC platform can provide a mechanism to support these actions and sustained commitments so that women, children and adolescents are not forgotten and so that their futures remain full of possibilities.

“

“The 75th anniversary of the United Nations comes at a time of unprecedented global crises, with the COVID-19 pandemic threatening to undo decades of development progress. Women, adolescents and youth face interconnected challenges and they are often among the most vulnerable populations. As we kick off a Decade of Action to deliver on the Sustainable Development Goals – with a view towards recovering better together – there is an urgent need to realign and recommit to investing in the many known solutions that address the needs and uphold the rights of women, adolescents and youth, especially young women and girls, everywhere.”

JAYATHMA WICKRAMANAYAKE
the United Nations
Secretary-General's
Envoy on Youth

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 72. Cumulative financial commitments from the private sector remained the same at US\$ 1.3 billion from 2018 to 2019.
 73. Similarly, foundations and philanthropy's cumulative financial commitments remained the same from 2018 to 2019 at US\$ 1.5 billion.
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One-year-old Sugarmaa is held by her mother near their *ger* (nomadic tent) in Alag-Erdene District, Khövsgöl Province, Mongolia.





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