



**Rise, Respond,**

**Recover**



*Renewing progress on  
women's, children's  
and adolescents'  
health in the era of  
COVID-19*



## Abbreviations

<b>Global Strategy</b>	Global Strategy for Women's, Children's and Adolescents' Health
<b>LMIC</b>	Low- and middle-income country
<b>PMNCH</b>	Partnership for Maternal, Newborn & Child Health
<b>SDG</b>	Sustainable Development Goal
<b>SRHR</b>	Sexual and reproductive health and rights
<b>UHC</b>	Universal health coverage
<b>UNICEF</b>	United Nations Children's Fund
<b>WHO</b>	World Health Organization

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## Rise, Respond, Recover

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**T**his action brief summarizes the latest status and trends of key areas related to women's, children's and adolescents' health and well-being from a global perspective. It aims to promote coordinated action among global and national partners to recognize and overcome the disproportionate impact of the COVID-19 pandemic on women, children and adolescents and to accelerate progress to meet the Sustainable Development Goals (SDGs).

*Rise, Respond, Recover is an update to Protect the Progress: 2020 progress report on Every Woman Every Child Global Strategy for Women's, Children's and Adolescents' Health (September 2020), capturing key evidence points presented in May 2021 to the World Health Assembly as well as top priorities and activities among partners.*

# The equity agenda for women, children and adolescents



## The problem

The world is growing even more inequitable for many women, children and adolescents around the world. The COVID-19 pandemic has exposed and expanded the threats to their health and well-being that they face on a daily basis. These threats are violating the principle of leaving no one behind that is at the centre of our collective commitment to deliver the Global Strategy for Women's, Children's and Adolescents' Health and achieve the SDGs by 2030.



## The response

Getting back on track even in the midst of the ongoing COVID-19 crisis should be an imperative, not just an option. And we must do it now to avoid even more lives being lost and people's prospects being diminished. In every country, we must work together to sustain and improve the critical services that give women, children, and adolescents the opportunity to be healthier and safer – and to have the opportunity to lead happier and more productive lives.



## The actions

All stakeholders should take immediate coordinated action to target critical gaps. The PMNCH Call to Action on COVID-19 identifies seven action areas where coordinated action is needed urgently to protect the delivery of sexual, reproductive, maternal, newborn, child, and adolescent health services, as well as to address the underlying causes of disparity, including gender inequality. To deliver on the **COVID-19 Call to Action** and the **Decade of Action** to achieve the SDGs, specific attention is required to ensure:



**Real-time, quality data** in every country across all areas of relevance to women's, children's and adolescents' health – so we can know where the specific gaps are and can act quickly and decisively to close them up and expand essential services including social protection;



**Digital health innovations** to improve national COVID-19 response efforts and strengthen health systems;



**Sharing of lessons learned and experiences** among partners and among countries about sustaining critical services for children and adolescents during this pandemic – so we can build resilience and strengthen our collective emergency preparedness and response agenda for future crises; and



**Unwavering focus on equity in every aspect of the global COVID-19 response**, including access to COVID-19 vaccines, therapies and tests and protective equipment for frontline health workers, including nurses and midwives – so we can end the global pandemic more quickly while saving lives and restoring economic and social stability for everyone.



## Foreword

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**A**s we all know, the COVID-19 pandemic has devastated the lives of women, children, and adolescents in multiple, interconnected ways. Their stories tell us what we need to know. A young woman in Colombia with polycystic ovarian syndrome who has stopped getting her period cannot get a medical appointment. A 40-year-old single woman in South Africa who is depressed because she does not have an income, and who says, “I almost committed suicide because I didn’t know who to turn to or what to do to put food on the table for my children.” A teenager in Panama who struggles with virtual learning yet also sees how much worse it is for her classmates who do not have Internet at home.

Their lives should not have been upended, even in the midst of a pandemic. They show that we have lost our momentum and our way.

For 20 years or more before 2020, progress, though imperfect and uneven, had been made globally in many key areas that affect their health and well-being. Much of the recent progress is due in part to coordinated, multisectoral efforts including the Global Strategy for Women’s, Children’s, and Adolescents’ Health, for which I am proud to be a new Global Advocate.

But COVID-19 has stopped us in our tracks and put the Sustainable Development Goals (SDGs) even further out of reach. It has also forced us to reconsider how successful we really had been before the pandemic.

As much data presented in this report highlights, huge equity gaps have persisted for decades across all major indicators that tell us about the health and well-being of women, children and adolescents. For example, globally, the number of maternal deaths dropped 35% between 2000 and 2017. However, sub-Saharan Africa and South Asia accounted for 86% of all maternal deaths, a share that has risen as disparities widen. Poor nutrition continues to harm the health and futures of hundreds of millions of children, as seen by data showing that more than 1 in 5 of all children under age 5 were stunted in 2018. The rate is higher in 2020, at least 1 in 4 children, in one third of countries with reported data.

Those who have always borne the brunt of inequities are also those who are disproportionately affected by the direct and indirect impacts of COVID-19. They include women, children and adolescents living in poverty, conflict zones, culturally and socially rigid contexts where they are disadvantaged

and discriminated against, and unsafe and exploitative environments.

By further exposing these gaps and their consequences, the COVID-19 pandemic is giving us an opportunity to rewrite the script. We should do this by acknowledging the reality that inequity is itself a form of a pandemic, and that truly sustainable development cannot be achieved without it being at the centre of all our global health and well-being actions. We can only put COVID-19 behind us and be more resilient for future health and socio-economic crises and shocks if we forcefully address inequities through global, regional and national partnerships across the overall development agenda.

An obvious immediate step should be global commitment to ending the COVID-19 pandemic everywhere more quickly through equitable access to COVID-19 vaccinations, which would enable countries to rebuild more quickly and save the lives of many of the most vulnerable women and children.

At the same time, we can start working together to identify other key solutions to generating equity-centred progress and making sure they are available everywhere. This has already been happening at all levels. In response to the shocks, partners have come together to rapidly develop and put in place new and innovative approaches and systems to deliver services to women, children and adolescents and protect the gains. Digital solutions have been shown to be particularly effective and efficient, and can serve as an 'equalizer of opportunity'.



Let's share these examples and get them adapted wherever possible, with particular attention to where the gaps in access and quality have been the most persistent and destructive. As this brief makes clear, improved access to real-time, quality data and digital solutions, with adequate and effectively used financial and technical support to maximize their use and value, is a critical approach to overcoming the current shortcomings and accelerating the progress called for in the Global Strategy.

It is our collective responsibility – and moral obligation – to increase our investments while also ensuring that resources are channelled toward the hardest to reach. Regaining momentum toward the Global Strategy will help to put these monstrous inequities further behind us, hopefully forever. This is a journey we can and must go on together to keep the promise to every woman, every child, and every adolescent.

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# Women, children and adolescents

## at the centre of the SDGs

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**W**omen, children and adolescents have long faced entrenched health, social, and economic challenges in most parts of the world. Changing this reality for good will benefit all of us. Societies cannot reach their fullest potential unless women, children, and adolescents are better supported, and that can only happen by ensuring that they are healthy and safe, and have equal access to opportunities. Progress also depends upon women's empowerment and ensuring that women and girls can make their own decisions about their lives. The Sustainable Development Goals (SDGs) are the framework to make this a reality.

The centrality of the health of women, children, and adolescents to achieving the SDGs was reinforced by the launch in 2016 of the Global Strategy for Women's, Children's and Adolescents' Health (Global Strategy), which provided a road map for ending all preventable deaths among women, children and adolescents within a generation<sup>1</sup>. Substantial progress has been made over the past several years in many critical areas related to their health and well-being. But this progress has often been uneven and inconsistent. Even before COVID-19, trends were variable, with progress on track or accelerating towards some targets,

while far behind or slowing on others. The uneven progress across regions, countries, populations and other factors is a particular concern that has been exacerbated by the pandemic.

These concerns are not new, but the urgency to address them continues to grow. ***The principle of leaving no one behind is at increased risk of being left behind itself***, which will weaken the achievement of the SDG agenda in much of the world. Halting this spiral away from equity should be one of the main priorities of all partners involved in promoting women's, children's and adolescents' health globally, regionally, nationally, and sub-nationally. This brief discusses why we need to act now and recommends some steps we should take together to ensure the Global Strategy will be realized for everyone.





# 2

## Where we are now, and why we need to recommit to women, children, and adolescents wherever they live

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**E**vidence shows that strong, dedicated action by countries and their partners has driven dramatic gains over the past 20 years in particular, improving and saving the lives of millions of women, children and adolescents. Yet as noted in a 2020 report by the Independent Accountability Panel for Every Woman, Every Child (EWEC), ‘Caught in the COVID-19 storm: women’s, children’s, and adolescents’ health in the context of universal health coverage (UHC) and the SDGs’, progress towards the targets of the SDGs to save the lives of women and children was lagging by 20% even before COVID-19 struck<sup>2</sup>.

How and to what extent COVID-19 has affected the health and well-being of women, children and adolescents is likely not to be known for years, especially since many countries are still in the throes of the pandemic and many of the impacts will be felt long after the crisis subsides. Even now, more than a year after the pandemic exploded in much of the world, our ability to understand the effects at country level and globally is constrained by longstanding gaps in data quality and availability. For many of the key indicators, the most reliable data allowing for extensive cross-country comparisons and global consolidation date from 2019 or earlier, before the COVID-19 era.

As these shortcomings indicate, the pandemic, has brought into stark relief the weaknesses of country health information systems. One of the main recommendations in this brief includes strategic actions to improve data collection and reporting procedures, including policies around data sharing and data standards.

Yet as suggested by the existing data summarized below – nearly all of it referring to the situation before the pandemic – there is reason to be concerned about many of the trends in women’s, children’s, and adolescents’ health, even without factoring in the effects of COVID-19. The September 2020 report on the Global Strategy, ‘Protect the Progress’, highlighted many of the same figures and trends, and nearly a year later the urgent need to get back on track is even stronger<sup>3</sup>.

In addition to the summary below, the annex of this brief provides a snapshot overview of how we are faring in some of the key issues and indicators of direct relevance to women’s, children’s and adolescents’ health. The selected examples below and in the annex give a clear picture of the progress that has been made, where it has been lacking, and how and where the COVID-19 pandemic is making the need for more urgent, coordinated action stronger than ever.

## 2.1

### Selected mortality markers

**A**lthough the risks of poor health outcomes associated with pregnancy have lessened in the past couple decades, we still have a long way to go. Of the 130 low- and middle-income countries (LMICs) assessed in a recent analysis, only about one-third (43) had already reached key targets regarding maternal mortality, neonatal mortality, and stillbirths before 2020. Nearly half, or 62, of all countries with available data need to experience major declines in mortality, often at a much faster rate, to reach the targets by 2030<sup>4</sup>.

Globally, the number of **maternal deaths** dropped from an estimated 451,000 in 2000 to 295,000 in 2017, a reduction of about 35%<sup>5</sup>. However, sub-Saharan Africa accounted for two-thirds (66%) of all maternal deaths in 2017, with another 20% in Southern Asia. Lack of access to quality antenatal and delivery care is one reason for these disproportionate results. In 2020, 59% of pregnant women globally were estimated to receive four or more **antenatal care** visits. However, only 38% of pregnant women in the poorest quintile received four or more antenatal care visits compared to 78% of women in the richest quintile.

Progress in reducing **stillbirths**, another major indicator that is also related to access to high-quality antenatal and skilled delivery care, has matched reductions in maternal deaths. In 2019, an estimated 2.0 million babies were stillborn at 28 weeks of pregnancy or later, with a global rate of 13.9 stillbirths per 1,000 total births<sup>7,8</sup>. This represents a 35% reduction from 21.4 stillbirths per 1,000 total births in 2000. The pace of improvement is however not sufficient to avoid leaving tens of millions of

women and their families bereft<sup>7</sup>. According to projections in 'A neglected tragedy: the global burden of stillbirths', a report released in October 2020, an additional 20 million stillbirths will take place before 2030 if the trends observed between 2000 and 2019 continue<sup>8</sup>.

Although mortality trends for newborns, children and adolescents have improved over the past few decades, the rate of progress has varied across these age groups. **While under-five mortality rate** halved between 2000 and 2019, the reduction in **neonatal mortality** has been slower (a 42% decrease). The reduction in **adolescent mortality** was even smaller during this time frame, from 11 deaths per 1,000 in 2000 to 8 deaths per 1,000 in 2019<sup>7</sup>. Almost 1 million adolescents died in 2019, primarily due to road traffic injuries, diarrhoeal diseases, tuberculosis, interpersonal violence and suicide.

## 2.2

### Selected risk factors and services

Other domains of relevance to women's, children's and adolescents' health include behavioural and other risk factors and coverage of interventions and services. Progress in many of these areas was slowing down in the years before the pandemic, with equity gaps by age, geography and national per capita income already recognized as major obstacles to the rate and pace of improvement needed for development commitments to be met.

In the critical area of sexual and reproductive health and rights (SRHR), the proportion of women of reproductive age (15–49 years) who have their need for family planning satisfied with **modern contraceptive methods** increased only very modestly from 74% in 2000 to 77% in 2020, an average annual increase of only 0.16% over the two decades<sup>10</sup>. Such a minimal proportion increase over two decades means that the absolute numbers actually rose over that period. In 2019, around 270 million women in this age group who wanted to stop or delay childbearing were not using any modern method of contraception, compared with 237 million in 2000<sup>11</sup>.

The percentage increase in having needs for family planning satisfied with modern contraceptive methods was much greater over that time period (from 39% to 60%) for adolescent girls aged 15–19 years, who often face different and unique challenges that make them especially vulnerable and hard to reach. The 2020 level however is much lower than the 76.8% among women of reproductive age overall. Huge inequalities also exist among

countries and regions. Fewer than one in two adolescent girls in South Asia, sub-Saharan Africa and the Middle East and North Africa had their demand satisfied in 2020, compared with three in four or larger percentages in every other region. Such gaps help to explain why the annual number of **births per 1,000 adolescent girls aged 15–19 years** globally fell only from 45 in 2015 to 41 in 2020<sup>11a</sup>.

The weaker-than-desired reduction in births among adolescent girls has been accompanied by relatively poor progress toward other key SRHR indicators for the age group. For example, girls and young women are far more vulnerable than their male peers to contracting HIV in the regions with the highest burdens of that virus. Globally in 2020, around 5000 young women aged 15–24 years became infected with HIV every week. In sub-Saharan Africa, **6 in 7 new HIV infections among adolescents aged 15–19 years were among girls**, and young women aged 15–24 years in that region were twice as likely to be living with HIV than young men of the same age<sup>12</sup>.

As these figures suggest, SRHR inequities are extensive across multiple indicators, including **unintended pregnancies and unsafe abortions**. According to the most recent figures, three-quarters of abortions in Africa and Latin America were unsafe, and the risk of death from an unsafe abortion was highest in Africa<sup>6</sup>.

Key nutrition indicators convey a lot about the health and well-being of children, adolescents, and women. **Breastfeeding** has long been a top priority because it helps ensure adequate nutrition to infants, reduces

infections, and promotes a strong maternal-infant bond. Globally, only 44% of babies were exclusively breastfed in 2019. This means that over half of all infants did not receive this life saving intervention<sup>13</sup>.

Other markers of paediatric nutrition show huge risks to many children's short- and longer-term health and development. Globally in 2020, 149.2 million children aged under 5 years were stunted, 45.4 million were wasted, and 38.9 million were overweight<sup>14</sup>. The global rate of stunting among children younger than 5 years fell from 33.1% in 2000 to 22% in 2020<sup>14</sup>. But, like so many others, that trend is also unevenly distributed. In almost a third of the 155 countries with data in 2020, at least 25% of children younger than 5 years were **stunted**<sup>13</sup>. The majority of stunted children live in sub-Saharan Africa and South Asia. Meanwhile, lack of exercise and poor access to high quality and diverse have contributed to more than 340 million children and adolescents aged 5–19 years worldwide being **overweight or obese** in 2016<sup>15</sup>. That corresponded to an 18% share of all young people in that age group, a steep increase from just 4% in 1975<sup>15</sup>.

Several of the intervention coverage indicators referred to above are among those included in the Countdown to 2030 continuum of care chart, which presents information on 16 indicators capturing information on essential services for women's and children's health in LMICs. Many results were positive, most notably those showing improvements in coverage of at least 10 percentage points over 10 years through 2019 in 5 of the 16 interventions

tracked, including treatment of pregnant women with HIV, immunization with rotavirus vaccine, antenatal care visits and postnatal care for babies. But, concerning trends include declines in diphtheria–tetanus–pertussis (DPT3) and measles vaccinations, and very modest gains in the treatment of pneumonia and diarrhoea.

## 2.3

### Selected impacts of COVID-19

The direct and indirect effects of the COVID-19 pandemic, and in particular the responses by governments to contain the spread of the virus, threaten much of the progress made in women's, children's and adolescents' health. Many LMICs, where the needs are greatest and health systems the most fragile, have experienced challenges to maintaining essential health services during COVID-19.

Listed below are several examples of impacts and projections reported over the last year that are highly relevant to the health, well-being and future prospects of women, children, and adolescents. They provide only a snapshot of overall impact, highlighting the disproportionate effects of the pandemic on these three population groups and their health and safety risks.

### Reported and observed impacts



In March and April 2021, more than a year after the COVID-19 pandemic first prompted lockdowns worldwide, 39% of 124 countries surveyed reported a drop compared with the same time the previous year in the coverage of **family planning services**, with 23 of them (19%) reporting a decline in coverage of more than 10%. Of those 124, nearly the same share (38%) reported drops over the same period in the coverage level of **maternal health services** (antenatal and post-natal)<sup>16</sup>.



More than one third of countries recently reported disruptions to both routine facility-based and outreach **immunization** services<sup>16</sup>. Of 89 countries responding to survey questions on routine outreach immunization services, 39% reported declines of at least 5%, with 18% reporting declines of more than 25%. For routine facility-based immunization services, 34% of 103 countries reported disruptions of at least 5%, with 10% reporting a decline greater than 25%<sup>16</sup>.



41% of 92 countries responding to recent survey questions on management of moderate and severe **malnutrition** reported disruptions of at least 5%, with 17% reporting disruptions greater than 25%<sup>17</sup>.



Drops in access to child protection services by **children with disabilities** compared with the same period last year were reported recently by 21% of 124 countries responding to a UNICEF survey<sup>16</sup>.



Of 61 countries responding to UNICEF survey questions in the 2021 first quarter, 24% reported disruptions of at least 5% in services for intimate partner and sexual **violence prevention and response**<sup>17</sup>.



As of 30 June 2021, **schools** in 19 countries were closed country-wide, and schools were only partially open – either just in some locations or only for certain grade levels – in a further 56 countries<sup>18</sup>. One year into the COVID-19 pandemic, close to half the world’s students were still affected by partial or full school closures, and it was estimated that 100 million additional children will fall below the minimum proficiency level in reading as a result of the health crisis<sup>19</sup>. The inequities are especially stark in regions such as Latin America, where schools have stayed shut longer than in any other region since March 2020. The poor there are highly disadvantaged by virtual learning, as just 45% of the poorest fifth of students in the region are estimated to have access to the internet at home, compared with 98% of the richest fifth<sup>20</sup>.

## Projections from modelling (direct and indirect impact of COVID-19)



It has been estimated that reductions of about 15% in coverage of key **high-impact maternal and child health interventions** for six months in 118 LMIC could result in 253,500 additional child deaths and 12,200 additional maternal deaths<sup>21</sup>. Reductions approaching 45% for six months would result in 1,157,000 additional child deaths and 56,700 additional maternal deaths<sup>20</sup>.



As many as 47 million women in 114 LMICs may be unable to use modern **contraceptives** if the average lockdown, or COVID-19-related disruption, continues for six months with major disruptions to services. Such an impact could result in an additional 7 million **unintended pregnancies**<sup>13</sup>.



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<sup>13</sup>.



Interruption of antiretroviral therapy for six months would increase **mother-to-child transmission of HIV** by approximately 1.6 (60%) times in a one-year period<sup>22</sup>.



More than 200,000 additional **stillbirths** could occur over the next 12 months in 117 LMICs due to severe COVID-related disruptions in health care services<sup>8</sup>.



In 2020, there were an estimated 119 women living in **extreme poverty** for every 100 men aged 25 to 34. The pandemic seems likely to prevent efforts to reduce this major inequity. Due in part to the effects of COVID-19, the gap is expected to increase to 121 women for every 100 men by 2030, with women from South Asia particularly affected<sup>23</sup>. UNICEF has estimated there could be an additional 118 million children in households defined as poor by national standards by the end of 2021 compared with 2019<sup>24</sup>.

The full extent of these losses may never be known without robust national data systems. One hopeful sign however from the most recent surveys by the World Health Organization (WHO) and UNICEF is that there has been a decrease in reported service disruptions compared with previous rounds in the 2020 third quarter. Yet, even if the disruptions were briefer and the setbacks smaller than expected, COVID-19 has caused reversals or stagnation in progress toward the SDGs, thereby putting more vulnerable people at higher risks of death, disease and disability from preventable and treatable causes.

Recent data analyses have revealed significant gender bias inherent in the response to COVID-19. For example, according to the 2021 Gender 50/50 Report, analysis covering more than 201 of the most influential organizations active in global health found that fewer than 2 in 10 COVID-19 health-related activities considered gender in an explicit way. Activities ranged from access to health services, protecting health care workers and supporting national and global surveillance<sup>25</sup>.



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# 3

## Where we need to go: renewed focus on equity

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**A**s countries adapt and respond to the pandemic, many are taking stronger action toward safeguarding critical health services for women, children and adolescents. Nearly 9 of 10 (87%) of the 112 countries responding to a WHO survey undertaken during the first quarter of 2021<sup>17</sup> reported having identified essential health services to be maintained during the pandemic in a national policy or plan, an increase from 70% in survey results covering the third quarter of 2020<sup>26</sup>.

As countries continue to invest in programmes and strategies to protect access to health services during the pandemic, it is important to apply a gender lens when doing so. The COVID-19 pandemic has further threatened and in many cases reversed progress toward all the SDGs, as it has proved to be not only a health crisis but a socio-economic one that affects all aspects of human behaviour and experience. The global economy contracted by 3.3% in 2020<sup>27</sup>, with variations across regions and countries. Latin America and the Caribbean was the most affected region, with a 7% decline in gross domestic product (GDP), with declines of 1.5% in Asia and 1.9% in sub-Saharan Africa, two other regions with many highly vulnerable women, children and adolescents.

These economic shocks are behind a recent World Bank estimation that the pandemic led to 97 million more people being in poverty in 2020<sup>28</sup>.

The overall consequences can be seen in humanitarian and fragile settings, where COVID-19 is not only intensifying pre-existing inequities but also creating new ones. Recent evidence tells us that between 1995 and 2015, conflict contributed to the deaths of more than 10 million children under the age of five<sup>29</sup>. Compared with non-conflict zones, maternal mortality is estimated to increase by 11% on average in conflict zones and by 28% in the worst-hit areas<sup>30</sup>. The global disruptions to essential health and social services caused by COVID-19 appear to worsen these conditions. For instance, data from November 2020 indicate that refugees and asylum seekers were unable to access COVID-19-related social protection measures in 59 countries<sup>31</sup>. Further, if left unaddressed, the large economic shocks induced by the COVID-19 pandemic may exacerbate drivers of conflict in the medium term and generate even larger welfare losses as a result.

Moving forward, it is vital to expand and strengthen legislation and regulations, set clear targets, and communicate better to bring people together. In



particular, finding ways to better ensure the full and inclusive participation of those most commonly left behind, such as women, children and adolescents in most contexts, is essential for strengthened accountability.

This ambition requires robust financing for women's, children's and adolescents' health, through increased and sustained official development assistance (ODA) and domestic funding, including a strong focus on essential health and social services for women, children and adolescents, as well as pro-equity funding schemes prioritizing the most vulnerable communities.

Partnerships at all levels – within and among countries – must be nurtured and re-energized to ensure women, children and adolescents are not left behind as countries continue to grapple with COVID-19 responses. To close the gaps in health equity, we must also promote a comprehensive, gender-responsive health systems approach that is truly inclusive not only of gender but also of age, race, sexual identity, socio-economic status and geography.

## 3.1

### Recommended action areas

#### to accelerate progress

All partners and stakeholders have a role to play to deliver on the **COVID-19 Call to Action** and the **Decade of Action** to achieve the SDGs, including by identifying where gaps and problems exist so that better-targeted, efficient and effective efforts

are designed and implemented. This important coordinated, collaborative work can be further advanced through the seven asks of the Call to Action, and the following concrete actions:



**National governments and global partners should work together to promote and support the gathering and use of real-time, quality data across all areas of relevance to women's, children's and adolescents' health.** One overarching lesson learned again and again over the course of the COVID-19 pandemic is that poor-quality and limited data hinders global and national efforts to respond quickly and effectively, a problem that continues to harm millions of women, children and adolescents as they struggle to survive and thrive. For example, data on morbidities and risk behaviours are frequently lacking, with the omissions particularly true for children aged 5–9 years and adolescents. The births of 1 in 4 children under 5 years of age worldwide are not registered, and neither are 4 of 10 world's deaths.

Priority action areas should include the following:

- ▶ Increased investments in **real-time data generation, analysis, and use in lower-income countries**. This is essential to properly balance current global investments in health data, which are currently heavily focused on modelling.

- ▶ Strengthened **civil registration and vital statistics (CRVS) systems** in all countries, with immediate attention to where the current gaps are greatest.
- ▶ Strengthened health information systems that can capture and integrate **disaggregated data**, including by sex, age and various indicators relevant to women's, children's and adolescents' health.
- ▶ More **standardization of data** across countries. The age groupings currently used to record and report health data vary greatly, for example, hindering the usefulness of such data both within and across countries. Variations in age and sex reporting during the pandemic have limited the ability to perform rapid and reliable cross-country analyses to guide public health and other policy responses such as school and workplace reopening.



**Global partners and national governments should lead the effort to expand access to and use of digital health innovations that can improve availability of essential services for women, children, and adolescents.** For example, since the start of the pandemic digital technology has been utilized successfully in many settings for telehealth consultations. These have enabled many women to practise self-care and thus avoid complete lack of access to information and resources for their essential health needs.

Even so, highly uneven access to digital technologies within and among countries means that not all benefit at the same pace. This was evident in responses to the pandemic, as the expansion and related policy change adaptations regarding telehealth opportunities were highly variable. Changes were much less likely to have occurred in lower-income countries – a situation that further widened inequities that harm millions of women, children and adolescents with multiple, often urgent service needs.

Better outcomes for children and adolescents in particular should also be pursued through globally negotiated policy and regulatory changes that seek to limit **negative health impacts of an increasingly digitalized world**. As highlighted in a 2020 WHO-UNICEF-Lancet commission, “Children around the world are exposed to advertising from business, whose marketing techniques exploit their developmental vulnerability and whose products can harm their health and well-being”, including by contributing to the growing crisis of childhood obesity<sup>32</sup>. The Commission's strong call was that children “need and deserve to be protected from marketing of tobacco, alcohol, formula milk, and sugar-sweetened beverages, gambling, and potentially damaging social media, and the inappropriate use of their personal data.”



**Global partners should promote and invest in identifying and sharing lessons learned on sustaining services critical for the health and well-being of women, children and adolescents, during times of crisis and in the context of UHC and SDGs.** This should include suggestions and information on how to adapt lessons learned to different contexts. For example, knowing how and where to invest to build more resilient health systems and structures is critical to progress, as highlighted by

the recent report of the Independent Panel for Pandemic Preparedness and Response<sup>33</sup>. The report noted that the “lack of planning and gaps in social protection have resulted in the pandemic widening inequalities with a disproportionate socio-economic impact on women and vulnerable and marginalized populations, including migrants and workers in the informal sector.”

We should begin taking steps now to limit the impact of a future pandemic and other such shocks. In particular, as we learned during COVID-19, it is important to support, protect and care for health workers, and to innovate to improve and maintain quality of care for women, children and adolescents during emergencies. Women, who make up 70% of the frontline health workforce, need to take a meaningful role in the design, implementation and monitoring of pandemic preparedness and response. Greater diversity in leadership roles– including by increasing representation of women of colour – can enhance crucial gender- and racially sensitive responses to disease outbreaks.



Global leaders should immediately and unreservedly commit to an equity-based approach to ending the COVID-19 pandemic, including by taking the necessary steps to dramatically **scale up access to vaccinations, therapeutic and testing options, and other vital tools and commodities, such as personal protective equipment (PPE) and medical oxygen**. When vaccine supplies are limited, one key component of an equity approach should be global coordination to ensure that people who are at highest risk of contracting the virus, and experiencing severe or life-threatening illness from it, are prioritized for vaccine access wherever they live. Vaccine equity across countries also must be accompanied by vaccine equity within countries. Both types of equity are essential for the health, well-being and safety of many women, children and adolescents. Women are often more at risk due to their disproportionate representation in the health care workforce and other jobs and activities requiring regular, direct engagement with others.

**Fully funding the Access to COVID-19 Tools Accelerator (ACT-A)** is essential to rapidly and equitably deploy COVID-19 diagnostics, therapeutics and vaccines globally and address obstacles in supply, demand, delivery, coordination and quality of care. At the national level, countries should invest to train and support health workers, raise awareness of vaccines and generate demand for them, and ensure that health systems can deliver on scaled up COVID-19 services while also maintaining and expanding other health services.



# 4

## The future is now

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**T**he significant progress made over the past two decades or more in women's, children's, and adolescents' health and well-being worldwide is a remarkable testament to the power of coordination, partnership, commitment and solidarity. It has shown that the health and rights of the most vulnerable not only can be improved, but must be improved – to save lives and to give them the opportunities to thrive that they deserve as well as to make their communities and societies stronger and more resilient overall.

Leaders around the world at all levels and in every sector should remember these lessons as they respond to the ongoing COVID-19 crisis and look to the future. Now is the time to leave no one's health behind and to invest in health systems for all<sup>34</sup>. We call on all leaders and other stakeholders across society to take urgent action for health systems that protect everyone. This includes building partnerships through genuine civil society engagement, giving UHC principles more weight in every crisis response, and empowering women, who are proving to be highly effective leaders themselves in health emergencies.

The final and most difficult work toward the SDGs and truly transforming the health and well-being of women, children and adolescents has always

been, and continues to be, delivering and maintaining the same quality and consistent services to the hardest to reach and reducing persistent equity gaps within and between countries. This however should not be an excuse<sup>32</sup> to accept a slower pace that will leave targets unmet and goals unachieved. Millions of women, children and adolescents who are left behind continue to be at huge and unnecessary risk of becoming sick, being abused, living in extreme poverty, and dying from preventable causes. Leaving them behind is unacceptable. We can – and must – do better.



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 ODA, for:

- 1 Sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) 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 frontline 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 hand washing facilities and quality potable drinking water, with a particular focus on healthcare centers, schools, and centers for refugees and internally displaced persons; and
- 7 Prevention of violence against women, children and adolescents through education and protection programs.

**The Call to Action on COVID-19** campaign orchestrated by the 1,200 member-organizations of PMNCH is one approach that aims to put these ideas and priorities into action. It supports governments to protect and advance the health of women, children and adolescents in the context of the response to COVID-19 through strengthened political commitment, policies and resource mobilization and financing. The campaign focuses on seven goals, including protecting access to sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) services; improving gender equality and access to SRHR; improving quality care; supporting and protecting frontline health workers, including nurses and midwives; ensuring stronger social safety nets, including through improved national data systems; clean water; sanitation; and prevention of violence. To date, 17 low-and-middle income countries and bilateral donors have committed more than \$20 billion, aligned with the PMNCH Call to Action on COVID-19.

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