World Health Organization

SEXUAL, REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH POLICY SURVEY 2018–2019: REPORT

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Sexual, reproductive, maternal, newborn, child and adolescent health policy survey, 2018–2019: report

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Foreword

Reducing maternal, newborn, child and adolescent morbidity and mortality, and improving health and well-being, remain key health priorities globally. Under the Sustainable Development Goals (SDGs) and the United Nations Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health (2016–2030), all countries have committed to improving health for all, especially for women, children and adolescents, via transformative multisectoral action to accelerate coverage of interventions, reduce gender inequalities and equity gaps, and improve the quality of services. Achieving these goals requires the adoption and implementation of strong rights-based, evidence-informed and equity-focused policies spanning the continuum of care for sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH), reaching beyond traditional health system boundaries. Such a life-course approach is essential for ensuring that all people can live healthily throughout their lives into old age.

Within the World Health Organization, the Department of Maternal, Newborn, Child and Adolescent Health and Ageing and the Department of Sexual and Reproductive Health and Research have been tracking policies in SRMNCAH for more than 10 years. This global survey harnesses these efforts and creates a single report on the status of national policies, guidelines and laws on SRMNCAH across the continuum. With responses from more than 150 countries, this survey represents the most comprehensive database on SRMNCAH policies and guidelines currently available. The policy documents collected through the survey, which provide a valuable repository for the health community, are available at: https://www.who.int/data/maternal-newborn-child-adolescent/national-policies?selectedTabName=Documents.

Having the appropriate laws, policies and guidelines in place is a critical first step for countries to achieve universal health coverage for healthier populations through the provision of primary health care. However, only through effective implementation of these laws, policies and guidelines can improvements in the health of women, children and adolescents occur globally. We hope the information generated through this survey will provide an opportunity for countries to initiate the necessary policy dialogues and strategic reviews to achieve the SDGs.

Dr Ian Askew

Director
Department of Sexual and Reproductive Health and Research

Dr Anshu Banerjee

Director
Department of Maternal, Newborn, Child and Adolescent Health and Ageing

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Finally, we thank all Member States (Annex 7) that took part in the survey, allowing the assessment and completion of this report.

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List of abbreviations

AFR	African Region
AIDS	acquired immune deficiency syndrome
AMR	Region of the Americas
ANC	antenatal care
BCG	Bacillus Calmette-Guerin
CHW	community health worker
CPR	contraceptive prevalence rate
CSE	comprehensive sexuality education
DHS	Demographic and Health Survey
ECD	early childhood development
EMOC	emergency obstetric care
EMR	Eastern Mediterranean Region
EUR	European Region
EWEC	Every Woman Every Child
HIS	health information system
HIV	human immunodeficiency virus
HPV	human papilloma virus
iCCM	integrated community case management
ICM	International Confederation of Midwives
IMCI	integrated management of childhood illness
IPTp	intermittent preventive treatment in pregnancy
IUD	intrauterine device
IVF	in-vitro fertilization
KMC	Kangaroo Mother Care
LBW	low birth weight
MCA	WHO Department of Maternal, Newborn, Child and Adolescent Health and Ageing
MICS	Multiple Indicator Cluster Survey
MNCAH	maternal, newborn, child and adolescent health
MoH	Ministry of Health
NICU	newborn intensive care unit
ORS	oral rehydration solution
PEP	postexposure prophylaxis
PID	pelvic inflammatory disease
PPH	postpartum haemorrhage
PRG	Policy Reference Group
PSBI	possible serious bacterial infection
RDT	rapid diagnostic test
RMNCAH	reproductive, maternal, newborn, child and adolescent health
SARA	Service Availability and Readiness Assessment
SDG	Sustainable Development Goal
SDI	service delivery indicators
SEAR	South-East Asia Region
SNCU	special newborn care unit
SPA	Service Provision Assessment
SRH	WHO Department of Sexual and Reproductive Health and Research
SRMNCAH	sexual, reproductive, maternal, newborn, child and adolescent health
STI	sexually transmitted infection
TB	tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VLBW	very low birth weight
WHA	World Health Assembly
WHO	World Health Organization
WPR	Western Pacific Region

Executive summary

To track country progress in adopting World Health Organization (WHO) recommendations in national health legislation, policies, strategies and guidelines related to sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH), WHO conducted the 2018 global Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health Policy Survey (global SRMNCAH policy survey).

The global SRMNCAH policy survey began with consultations with a Policy Reference Group (PRG) in order to identify priority policy areas to include in the survey. Next, a draft questionnaire was created based on PRG-identified priorities, available data and past rounds of maternal, newborn, child and adolescent health (MNCAH) policy surveys. This questionnaire, consisting of six modules (cross-cutting, maternal and newborn health, child health, adolescent health, reproductive health and gender-based violence), was programmed into an online platform, and all WHO Member States were invited to complete the survey. In each country, the WHO country office or other assigned country focal point was responsible for coordinating with the Ministry of Health and/or other United Nations agencies to complete the survey. Of the 194 WHO Member States, a total of 150 completed the survey for an overall response rate of 77%. The findings of this report are reflective of the 150 Member States that responded to this survey. Five additional countries that are not WHO Member States completed the survey; their responses are not reflected in this report but will be included in corresponding regional reports.

Countries were asked about the national availability of key policies, guidelines and laws related to SRMNCAH as well as specific contents of their policies. Across the continuum of care, availability of 16 key policies was assessed: family planning/contraception; diagnosis, treatment and counselling for sexually transmitted infections (STIs); comprehensive national cervical cancer prevention; antenatal care (ANC); childbirth; postnatal care for mothers and newborns; management of low-birth-weight and preterm newborns; child health and development of children; early childhood development; integrated management of childhood illness; management of childhood pneumonia; management of childhood diarrhoea; management of malaria with appropriate recommendations for children (in malaria-endemic countries); management of acute malnutrition in children; adolescent (10–19 years) health issues; and availability of a multisectoral plan of action for gender-based violence (Fig. 1 and 2).

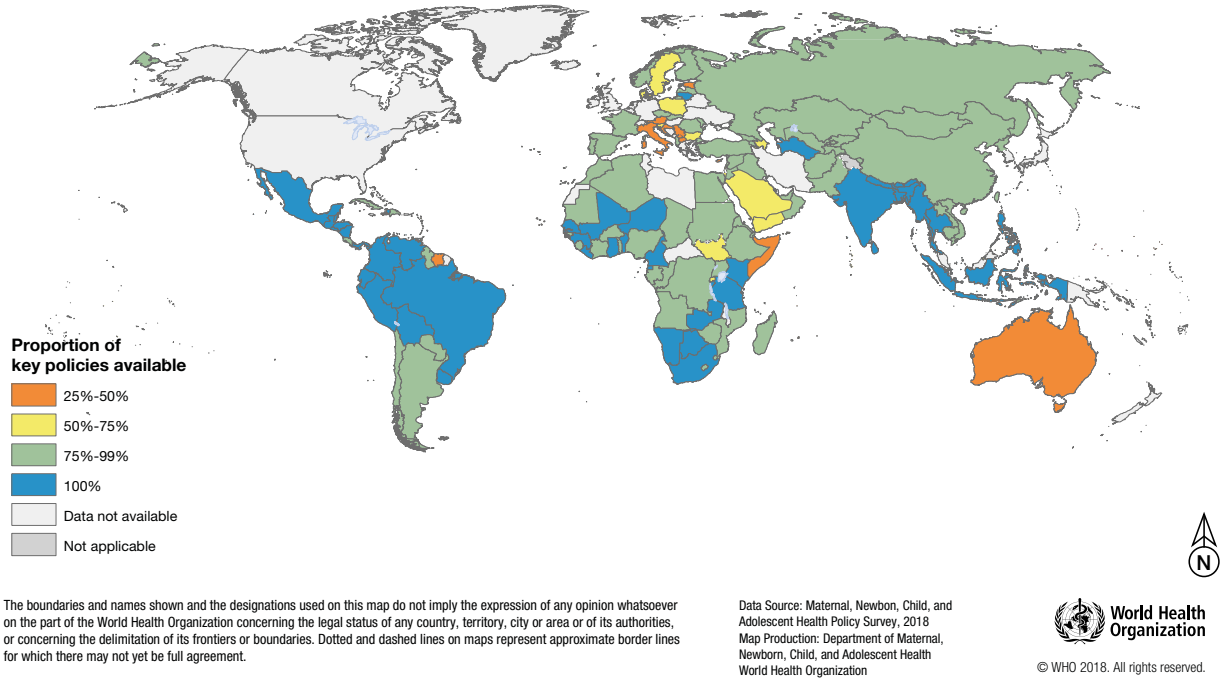
The results of the survey show that, globally, countries have on average 13 of the 16 (83%) key policies. Availability of the 16 key policies varies by region: 95% of countries in the South-East Asia Region have all 16 policies, compared to 69% of countries in the Western Pacific Region. While most countries have at least 75% of the key policies, 16 of the 150 countries fall below the 50% mark.

Sexual and reproductive health

Globally, national policies/guidelines on reproductive health care are almost universal; 94% of countries report that they have a national policy or guideline for reproductive health.

Somewhat fewer countries (88%) have a national policy/guideline on family planning/contraception. All countries in the African Region and the South-East Asia Region have such a policy/guideline, as do most countries in the Eastern Mediterranean Region (93%) and the Region of the Americas (86%). Fewer countries in the European Region and the Western Pacific Region have a national policy/guideline on family planning/contraception (74% and 79%, respectively).

Figure 1. Availability of key SRMNCAH policies, globally



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 or 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.

Data Source: Maternal, Newborn, Child, and Adolescent Health Policy Survey, 2018
Map Production: Department of Maternal, Newborn, Child, and Adolescent Health
World Health Organization

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Globally, 87% of all countries have a national policy/guideline on STI diagnosis, treatment and counselling. Regionally, there are high proportions of countries with such a policy in the African Region (93%), Region of the Americas (93%), South-East Asia Region (91%) and Western Pacific Region (100%). A moderate proportion of countries in the Eastern Mediterranean Region (80%) and the European Region (72%) also have a national policy on STIs.

Globally, most countries have a national policy/guideline on comprehensive national cervical cancer prevention (80%). All countries in the South-East Asia Region, 87% of those in the European Region, 86% in the Western Pacific Region and 79% in both the African Region and the Region of the Americas have a comprehensive national cervical cancer prevention policy. In contrast, only 47% of countries in the Eastern Mediterranean Region have such a policy.

Antenatal care

Globally, almost all countries have a national policy/guideline on ANC (96%). All countries in the Region of the Americas and the South-East Asia Region, and 93–97% of those in the African Region, Eastern Mediterranean Region and European Region have a national policy/guideline on ANC. In the Western Pacific Region, 86% of countries have such a policy/guideline.

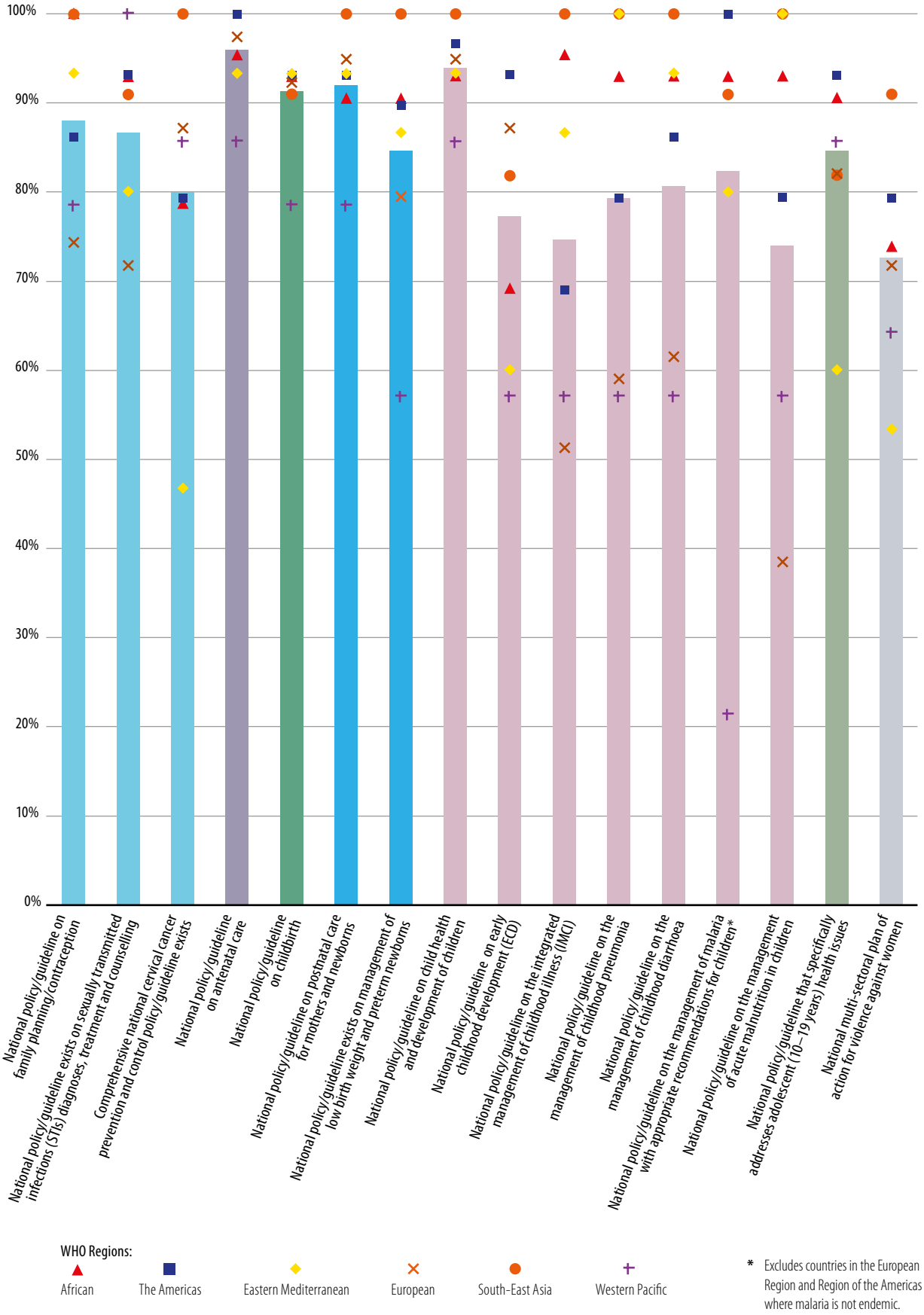
In their national policies/guidelines on ANC, 93% of countries globally specify the minimum number of ANC contacts during a normal pregnancy, with 52% recommending at least four contacts and 39% recommending at least eight contacts. In addition, 94% of countries specify when the first ANC contact should occur, 94% include a statement on counselling and interventions to be delivered during ANC services, and 79% recommend the use of an ultrasound prior to 24 weeks of gestation.

Childbirth

Globally, almost all countries (91%) have a national policy/guideline on childbirth. There is little variation by region, with more than 90% of countries in the African Region, Eastern Mediterranean Region, European Region, Region of the Americas and South-East Asia Region having a national policy on childbirth.

In addition, 87% of countries globally have a national policy/guideline on the right of every woman to

Figure 2. Availability of 16 key SRMNCAH policies, by WHO region



* Excludes countries in the European Region and the Region of the Americas where malaria is not endemic.

have access to skilled care at childbirth. The most common components included in this policy/guideline are: a recommendation for the prevention and treatment of postpartum haemorrhage (87%); a recommendation on the use of magnesium sulfate for the prevention and treatment of eclampsia (86%); and a recommendation on the place of childbirth (83%). Fewer national policies/guidelines on the right of every woman to have access to skilled care at childbirth include a recommendation on the presence of a companion of choice during labour and birth (59%) or a recommendation for the woman to choose the birthing position (46%).

Postnatal care for mothers and newborns

Globally, 92% of countries have a national policy/guideline on postnatal care for mothers and newborns. All of these countries recommend a health assessment for both mother and newborn, with the exception of 3% of countries in the Region of the Americas where the recommendation is for mothers only.

Eighty-five per cent of countries globally have a national policy/guideline on the management of low-birth-weight and preterm newborns. Most of these national policies/guidelines: recommend feeding breastmilk (81%); specify the presence of skilled personnel to assist mothers who have difficulties breastfeeding (80%); and recommend Kangaroo Mother Care (or skin-to-skin contact) for clinically stable newborns weighing 2000 g or less at birth (71%). Some national policies/guidelines indicate the level of the health facility where Kangaroo Mother Care should be provided (55%).

Child health

Globally, 93% of countries have a national policy/guideline on child health and development of children. In 55% of countries, this national policy/guideline is for ages 0–9 years. In 37% of countries, the national policy on child health and development of children is for ages 0–5 years only.

Globally, 80% of all countries have a national policy/guideline on the management of childhood pneumonia: 41% of countries have a policy for children aged 0–5 years, and 38% for ages 0–9 years.

Globally, 81% of countries have a national policy/guideline on the management of diarrhoea in children: 37% of countries specify this policy for ages 0–9 years, while 43% specify ages 0–5 years only.

Eighty-two per cent of countries globally have a national policy/guideline on the management of malaria with appropriate recommendations for children: 53% of countries include recommendations for children aged 0–9 years, 26% for ages 0–5 years only, and 3% for ages 5–9 years only.

Globally, 75% of all countries have a national policy/guideline on the management of acute malnutrition in children: in 37% of countries this national policy/guideline is for children aged 0–9 years, in a further 37% of countries it is for ages 0–5 years only, and in 1% of countries (all in the Western Pacific Region) it is for ages 5–9 years only.

Fifty-nine per cent of all countries have a national policy/guideline for routine assessment of overweight or obesity in health facilities for children: in 37% of countries the national policy/guideline is for children aged 0–9 years, in 21% it is for ages 0–5 years only, and in 1% of countries (all in the European Region) it is for ages 5–9 years only.

Globally, more than three quarters of countries (77%) have a national policy/guideline on early childhood development. These countries are most common in the Region for the Americas (83%), Europe (87%) and South-East Asia (82%).

Some 70% of countries have a national policy or guideline on integrated management of childhood illness (IMCI), including all countries in the South-East Asia Region and 95% of countries in the African Region. Nearly all low-income countries (97%) and lower-middle-income countries (92%) have policies/guidelines on IMCI.

Adolescent health

Globally, 85% of countries have a national policy/guideline that specifically addresses adolescent health issues. In most regions, over 80% of countries have an adolescent health policy (Region of the Americas: 93%, African Region: 91%, Western Pacific Region: 86%, European Region: 82%, South-East Asia Region: 81%). However, only 60% of

countries in the Eastern Mediterranean Region have such a policy. Globally, 62% of countries have a national standard for delivery of health services to adolescents. However, only 44% of countries have a national standard for delivery of health services to adolescents that includes a clearly defined comprehensive package of health services, and in which activities are being carried out to monitor the implementation of these standards. In addition, 64% of countries have a national adolescent health programme: 52% of countries have at least one designated full-time employee for this programme, and 34% have regular government budget allocation.

Violence against women

Globally, 73% of countries have a national multisectoral plan of action for responding to violence against women. Regionally, availability of a national multisectoral plan of action for violence against women varies. The highest availability is in the South-East Asia Region (91% of countries), followed by the Region of the Americas (79%), African Region (74%) and European Region (72%). The lowest availability is in the Eastern Mediterranean Region, where 53% of countries have such a plan, followed by the Western Pacific Region (64%). In addition, 79% of countries have a national guideline/protocol specifically for the health sector to address violence against women/gender-based violence. The most widely included topics, each reported by 71% of countries, are HIV postexposure prophylaxis for survivors of sexual assault, STI prophylaxis for survivors of sexual assault and psychosocial support including psychological first aid/first-line support. The least frequently included topic is access to safe abortion in cases of rape or incest (45%).

Key conclusions of the 2018–2019 SRMNCAH policy survey

The 2018–2019 global policy survey revealed progress in the adoption of WHO recommendations in national health policies and guidelines related to SRMNCAH across the world and highlighted several ongoing challenges. In general, the survey revealed disparities between regions in policy adoption and highlighted areas for increased focus across the continuum of care for mothers and children and gender-based violence. Countries in the South-East Asia Region are more likely to have the 16 key SRMNCAH policies in place, while countries in the Western Pacific Region and the European Region are less likely to have these key policies. Policies related to child health are less available across regions than policies relating to sexual and reproductive health, pregnancy, childbirth and postnatal care.

The results of this global survey should serve as a benchmark for countries and help focus national efforts to implement strong, evidence-informed, equity-focused policies at the country level that span the continuum of care in SRMNCAH.

1. Introduction

1.1. Background and rationale

Reducing maternal, newborn, child and adolescent morbidity and mortality remain key health priorities globally. Complications in pregnancy and childbirth are the leading cause of death for adolescent girls aged 15–19, globally *(1)*. Though the global under-five mortality rate has declined from 93 to 39 per 1000 live births over the past three decades, this is still markedly higher than the 9 per 1000 live birth rate in the European Region *(2)*. These figures suggest that intensified efforts to reduce mortalities and mitigate inequities are required. The Sustainable Development Goals (SDGs) set forth a number of ambitious targets to improve the health of women and children by 2030 *(3)*. These targets include:

- Reduce the global maternal mortality ratio from 216 per 100 000 live births in 2015 to less than 70 per 100 000 live births by 2030.
- Reduce global neonatal mortality to at least as low as 12 per 1000 live births and under-five mortality to at least as low as 25 per 1000 live births by 2030.
- Ensure universal access to sexual and reproductive health-care services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes.
- Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

Under the SDGs and the United Nations (UN) Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health (2016–2030), all countries have committed to improving the health of women, children and adolescents via transformative multisectoral action to accelerate coverage of interventions, reduce gender and equity gaps and improve the quality of services. Achieving these goals requires the adoption and implementation of strong, evidence-informed and equity-focused policies spanning the continuum of care for sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH), reaching beyond traditional health system boundaries. To track country progress in adopting World Health Organization (WHO) recommendations, the Department of Maternal, Newborn, Child and Adolescent Health and Ageing (MCA) and the Department of Sexual and Reproductive Health and Research (SRH) conducted the global SRMNCAH policy survey.

1.2. History of policy surveys in SRMNCAH

Since 2009, the MCA Department has regularly conducted a global policy survey among WHO Member States to track country progress in adopting WHO recommendations in national health policies related to maternal, newborn, child and adolescent health (MNCAH). To date four rounds of this survey have been held: 2009–2010, 2011–2012, 2013–2014 and 2016. In addition, as part of monitoring progress on the Global Reproductive Health Strategy approved by the World Health Assembly through resolution 57.12, the SRH Department has been tracking policies on sexual and reproductive health biennially since 2009. The 2018–2019 global SRMNCAH policy survey expands on these previous surveys by combining MNCAH and sexual and reproductive health into a single survey and by aligning with the SDGs and the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030).

1.3. Key objectives of the 2018–2019 global SRMNCAH policy survey

The key objective of the 2018–2019 global policy survey was to track country progress in adopting WHO recommendations in national health legislation, policies, strategies and guidelines related to SRMNCAH. WHO seeks to stimulate greater global and national policy dialogue, and to link this dialogue with the development of country-specific investment plans and accountability for accelerated progress towards the goals and targets of the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030). By undertaking these activities, WHO aims to provide a useful source of information for governments, partners and the community on the challenging path of implementing this Global Strategy.

2. Methods

2.1. SRMNCAH Policy Reference Group (PRG)

In order to optimize the approach used for SRMNCAH policy tracking, the MCA Department and the SRH Department established a global SRMNCAH PRG to obtain expert advice on the contents of the policy survey and the use of related outputs. The first meeting of the PRG was held in February 2017 to discuss which policy areas should be tracked. At this meeting, PRG members agreed to identify priority policy indicators to include in the survey and to exclude topics from the survey that are covered in other data sources.

The PRG was convened a second time in April 2019 to review preliminary findings from the completed policy survey. At this meeting, the PRG decided to create both a global report and customized regional reports to meet the needs of a global audience as well as individual Member States.

2.2. PRG survey to prioritize SRMNCAH policy survey questions

In July–August 2017, the MCA Department circulated a survey, via Survey Monkey, to PRG members as well as to a defined set of other SRMNCAH experts. This online survey included: questions about the respondent's identity, institutional affiliation and areas of expertise; a series of questions in which respondents provided recommendations about whether to drop, consider retaining or keep tracking specific SRMNCAH policy areas; and a final section in which respondents were asked to suggest policy areas they felt were missing from the list.

Survey responses were compiled in an Excel spreadsheet by MCA Department staff and analysed in collaboration with an independent analyst in September 2017. Responses were assessed according to the number and percentage of respondents who said that WHO "must keep" tracking certain SRMNCAH policy areas, categorized by respondent type. This decision was made as only small numbers of respondents recommended that specific policy areas could be dropped (0–2 policy areas for PRG members, 0–3 policy areas for other respondents). Slightly higher numbers of respondents selected "consider retaining" specific policy areas (0–5 policy areas for PRG members, 0–9 policy areas for other respondents). Qualitative responses to open-ended questions were grouped into categories by policy area, edited for concision and tallied. The results from the PRG survey, which are available in Annex 4, provided expert guidance on the prioritization of SRMNCAH policies to be tracked.

2.3. Review of existing data sources

In line with the PRG recommendation that global policy tracking be streamlined by examining existing sources from which relevant data could be extracted, the MCA Department developed a list of SRMNCAH policy data sources based on the Every Woman Every Child Global Strategy and WHO priorities in SRMNCAH. In addition, in February 2017 the PRG undertook a mapping of the policy tracking being done for the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030), which resulted in the identification of an additional 30 SRMNCAH policy data sources. A critical review of all these data sources was then undertaken by the MCA Department and indicators/sources selected and compiled in a single global SRMNCAH policy database. Results from this exercise can be found in Annex 5.

2.4. Mapping the MCA Department's MNCAH questionnaire and new SRMNCAH policy database to frame priority policy areas

A mapping exercise was conducted to compare the data in the newly created global SRMNCAH policy database and the MCA Department's questionnaire on MNCAH in order to decide which SRMNCAH policy areas to include in the 2018 global survey – taking into consideration the data already available through existing sources, which could therefore be excluded, thereby reducing the reporting burden on countries. Results from this exercise can be found in Annex 6.

2.5. Questionnaire development

On the basis of the information obtained from the prioritization mapping exercise, existing data sources and past rounds of MNCAH policy surveys, a

draft questionnaire was created. This questionnaire was shared with the PRG, United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA) and regional WHO SRMNCAH advisors for inputs, after which it was revised and a final version created. In the questionnaire, countries are asked about the availability/components of national policies in the following areas: family planning/contraception; diagnosis, treatment and counselling for sexually transmitted infections (STIs); comprehensive national cervical cancer prevention; antenatal care (ANC); childbirth; postnatal care for mothers and newborns; management of low-birth-weight and preterm newborns; child health and development of children; early childhood development; integrated management of childhood illness; management of childhood pneumonia; management of childhood diarrhoea; management of malaria with appropriate recommendations for children (in malaria-endemic countries); management of acute malnutrition in children; adolescent (10–19 years) health issues; and gender-based violence. The questionnaire and glossary of terms can be found in Annex 1.

2.6. Questionnaire administration

The global SRMNCAH policy survey questionnaire, consisting of six modules (cross-cutting, maternal and newborn health, child health, adolescent health, reproductive health and gender-based violence), was programmed into an online platform. This online survey platform was developed to be administered in a modular approach, to allow for specific respondents to complete the module(s) in their area(s) of expertise. The tool also enabled respondents to upload source documents used to complete the questionnaire. Before the launch of the online platform, staff members from the MCA and SRH Departments and regional offices tested it to identify any programming modifications needed.

Regional WHO staff were introduced to the online survey platform through webinars led by the MCA and SRH Departments. Additionally, a training manual and video on how to use the platform were provided to regional focal points. The latter cooperated with assigned focal points for the survey in each country to collect information on respondents, including to which module(s) each respondent was assigned. This information was relayed to MCA Department staff, who configured each country team on the survey platform, including mapping respondents to modules and generating unique login keys. The WHO country officer, or other assigned country focal point, was responsible for work with the Ministry of Health and/or other UN agencies to complete the survey. Country teams used various methods to complete the survey. In some countries, respondents completed assigned modules directly on the platform; in others, the survey was completed offline by respondents and then the data were entered by one individual onto the platform. Country teams reviewed the completed survey before submitting the final version. The survey and training materials were translated into all UN languages (Arabic, Chinese, English, French, Russian, Spanish) as well as Portuguese.

2.7. Data processing

Data were downloaded from the online platform into Excel. All data extraction and processing was conducted by the MCA Department. A cleaning code was written in STATA software to create and standardize value labels for response codes and to check for any validation errors that may have been missed in the survey platform programming. Data from the survey were split into two databases: the first containing direct responses to questions; and the second containing data stemming from information on source documents uploaded to the survey platform.

2.8. Data analysis

Statistical analyses were carried out using STATA 14 software *(4)*, and maps created using ArcGIS 10.5.1 *(5)*. Subanalyses were conducted by WHO region and World Bank income group (2015 groupings) (see Annex 7 and Annex 8, respectively). The denominator used in analyses was the total number of respondent countries, either overall or by the subgroup of interest. One exception was for questions related to malaria and community health workers, which were not asked in countries from the European Region and some countries from the Region of the Americas because they were not considered relevant. Tables have a footnote

to denote where the denominator is less than the 150 respondent countries. Non-positive responses (for example, "No", "Unknown" and items left unanswered) were treated equally. The results of the policy survey were compiled to align with the objectives and key recommendations made to WHO Member States in the Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health (2016–2030).

3. Response rate and scope of report

3.1. Response rate

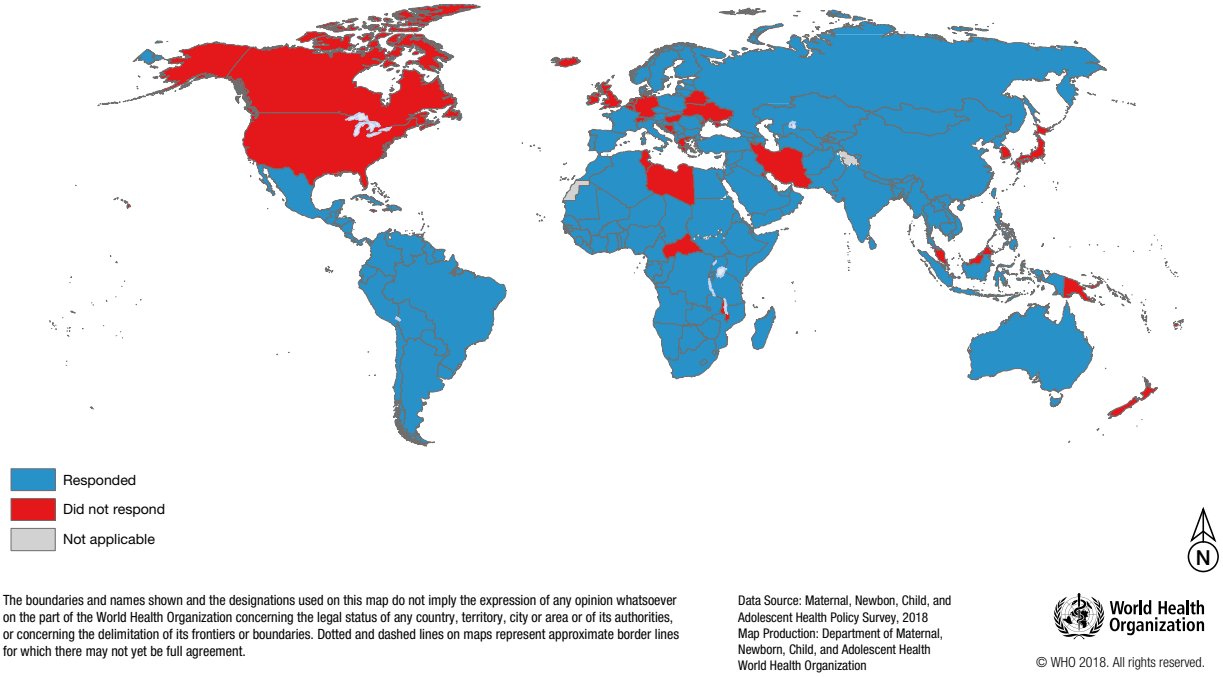
The global SRMNCAH policy survey was distributed to all 194 WHO Member States. A total of 150 Member States completed the survey for an overall response rate of 77%. Regionally, response rates ranged from 52% in the Western Pacific Region to 100% in the South-East Asia Region. By World Bank income group, response rates ranged from 66% for high-income countries to 89% for low-income countries (Table 1, Fig. 3).

Table 1. Response rate for the 2018 global SRMNCAH policy survey

		Total number of Member States	Number of Member States responding to the survey	Member State response rate
WHO region	AFR	47	42	89%
	AMR	35	29	83%
	EMR	21	15	71%
	EUR	53	39	74%
	SEAR	11	11	100%
	WPR	27	14	52%
World Bank income group	Low-income	36	32	89%
	Lower-middle-income	45	39	87%
	Upper-middle-income	55	41	75%
	High-income	58	38	66%
Global		**194**	**150**	**77%**

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

Figure 3. Map of WHO Member States that participated in the 2018 global SRMNCAH policy survey



3.2. Scope of report

The findings of this report are reflective of the 150 Member States that responded to the SRMNCAH policy survey. Additional publications will be prepared to cover in depth questions related to specific service areas. Region-specific reports will also be made available and may include data from non-Member States that responded to the survey. Further, all legislation-related questions will be reported on separately, as the relevant data are undergoing a critical validation process.