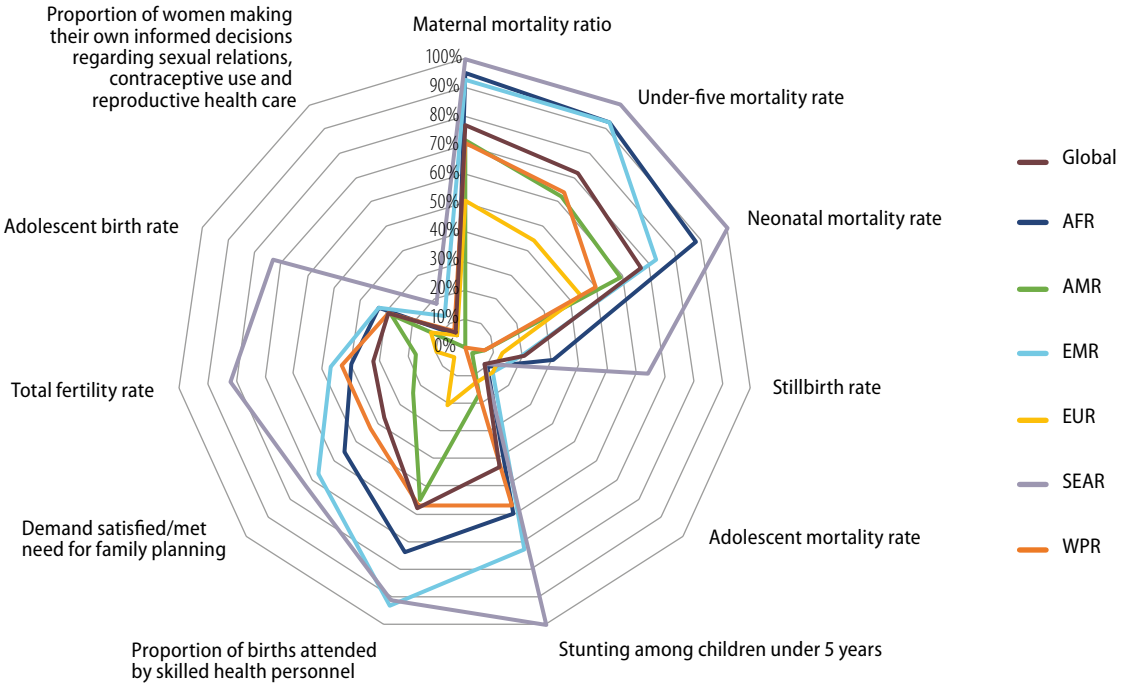
11. Cross-cutting

11.1. Availability of national targets for monitoring key SRMNCAH indicators

Generally, the monitoring of key SRMNCAH interventions globally includes the setting of national targets for achieving reductions in mortality and increases in coverage of key health interventions. Globally, countries most commonly have national targets for reducing mortality rates, with 77% of countries having a national target for maternal mortality, 72% for under-five mortality and 67% for neonatal mortality. Less common are national targets for adolescent mortality (9%), stillbirth (21%), adolescent birth (29%), total fertility (32%), demand satisfied for family planning (37%), stunting among children under 5 years (43%) or proportion of births attended by skilled health personnel (58%) (Table A.2.66, Fig. 83).

Regionally, the pattern is similar, with national targets for maternal mortality, child mortality and neonatal mortality being the most commonly available across regions. All countries (100%) in the South-East Asia Region have national targets for maternal mortality, child mortality, neonatal mortality and stunting among children under 5 years. Countries in the African Region and Eastern Mediterranean Region also have high availability of national targets for maternal mortality (95% and 93% of countries, respectively), child mortality (93% of countries in both regions) and neonatal mortality (African Region: 88%, Eastern Mediterranean Region: 73%). The European Region has the smallest proportion of countries with national targets for these key indicators, with only 51% of countries having a national target for maternal mortality and 44% having a national target for both child and neonatal mortality. Other regions with lower availability of national targets for key indicators are the Region of the Americas (maternal mortality: 72%, child mortality: 62%, neonatal mortality: 59%) and Western Pacific Region (maternal mortality: 71%, child mortality: 64%, neonatal mortality: 50%) (Table A.2.66, Fig. 83).

Figure 83. Availability of national targets for monitoring key SRMNCAH indicators, by WHO region



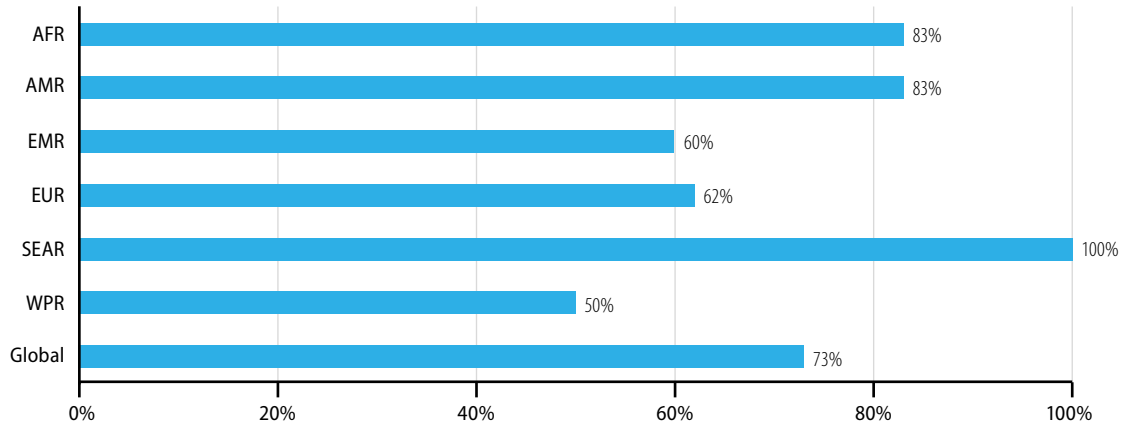
11.2. Availability of national coordinating body for SRMNCAH

A national coordinating body that looks at SRMNCAH and its components is available in 79% of countries globally. Regionally, availability of a national coordinating body for SRMNCAH is highest in the South-East Asia Region (100% of countries), followed by the Region of the Americas (83%) and African Region (83%), and lowest in the Eastern Mediterranean Region (60%), Western Pacific Region (50%) and European Region (62%). By World Bank income group, low-income and upper-middle-income countries have higher availability of a national coordinating body that looks at SRMNCAH (84% and 85%, respectively) compared to lower-middle-income and high-income countries (79% and 45%, respectively) (Table A.2.67, Fig. 84).

11.3. Availability of national policy ensuring engagement of civil society organization representatives in national-level planning and periodic reviews of SRMNCAH programmes

A national policy to ensure engagement of civil society organization representatives in national-level planning of SRMNCAH programmes is available in 55% of countries globally. Regionally, availability of such a national policy is highest in countries in the South-East Asia Region (64%), followed by the Region of the Americas (62%) and African Region (62%), and is lowest in the Western Pacific Region (36%), European Region (46%) and Eastern Mediterranean Region (53%). By World Bank income group, there is lower availability of national policies to ensure the engagement of civil society organization representatives in national-level planning of SRMNCAH programmes among high-income countries (34%) compared to upper-middle-income countries (59%), lower-middle-income countries (62%) and low-income countries (66%) (Table A.2.68, Fig. 85).

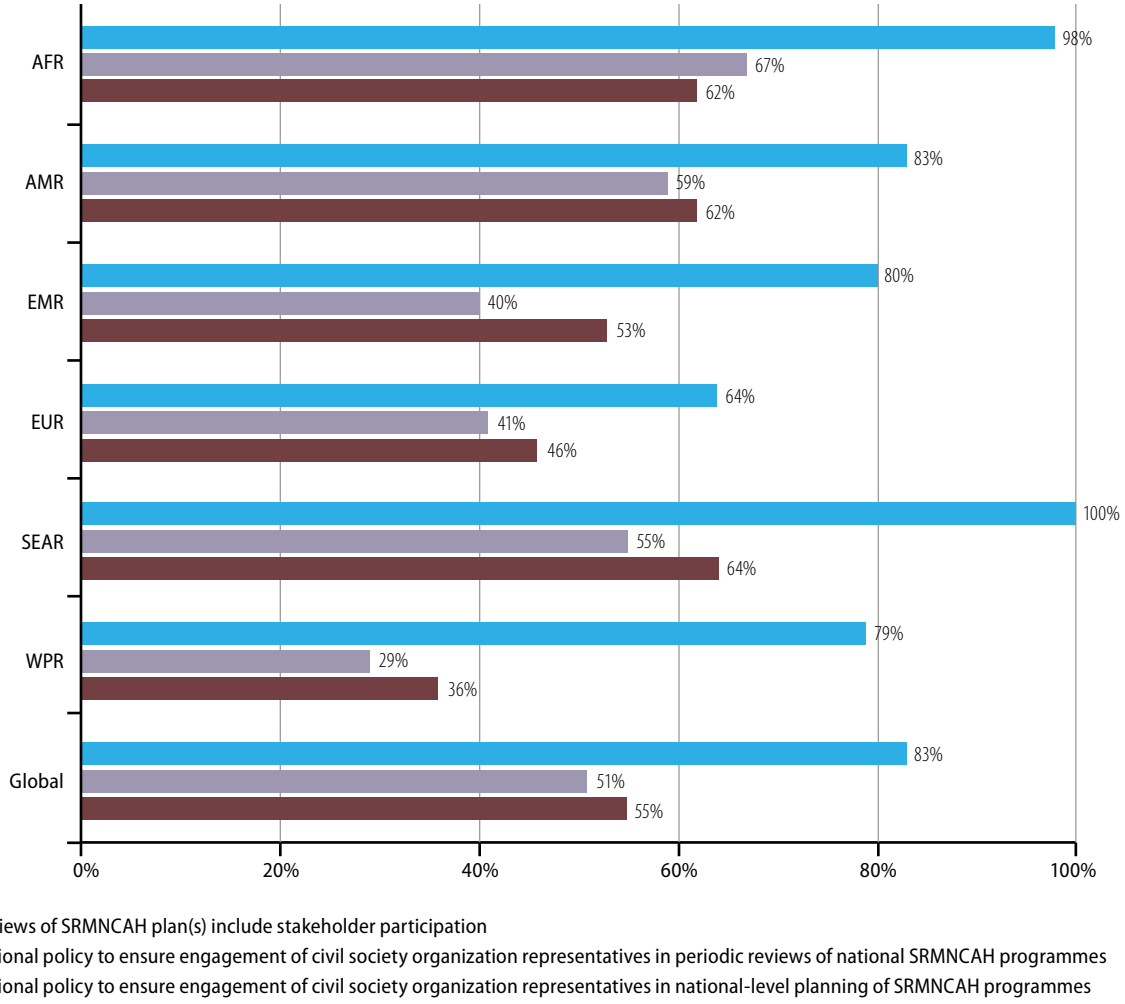
Figure 84. Availability of national coordinating body overseeing all components of SRMNCAH, by WHO region



National policies to ensure the engagement of civil society organization representatives in periodic reviews of national SRMNCAH programmes are available in 51% of countries globally. Regionally, availability of such national policies is highest in the African Region (67% of countries), Region of the Americas (59%) and South-East Asia Region (55%), and lowest in the Western Pacific Region (29%), Eastern Mediterranean Region (40%) and European Region (41%). By World Bank income group, low-income and lower-middle-income countries more frequently have national policies to ensure the engagement of civil society organization representatives in periodic reviews of national SRMNCAH programmes (67% and 62%, respectively), compared to upper-middle-income and high-income countries (46% and 32%, respectively) (Table A.2.68, Fig. 85).

In 83% of all countries, periodic reviews of national SRMNCAH programmes include stakeholder participation. Regionally, 100% of countries in the South-East Asia Region and 98% in the African Region include stakeholder participation in periodic reviews of national SRMNCAH programmes, compared to 64% of countries in the European Region and 79% in the Western Pacific Region (Table A.2.68, Fig. 85).

Figure 85. Availability of national policies to ensure engagement of civil society organization representatives in national-level planning and periodic reviews of SRMNCAH programmes, by WHO region



11.4. Participation of stakeholders in reviews of national SRMNCAH programmes

Key stakeholders eligible to participate in periodic reviews of national SRMNCAH programmes include:

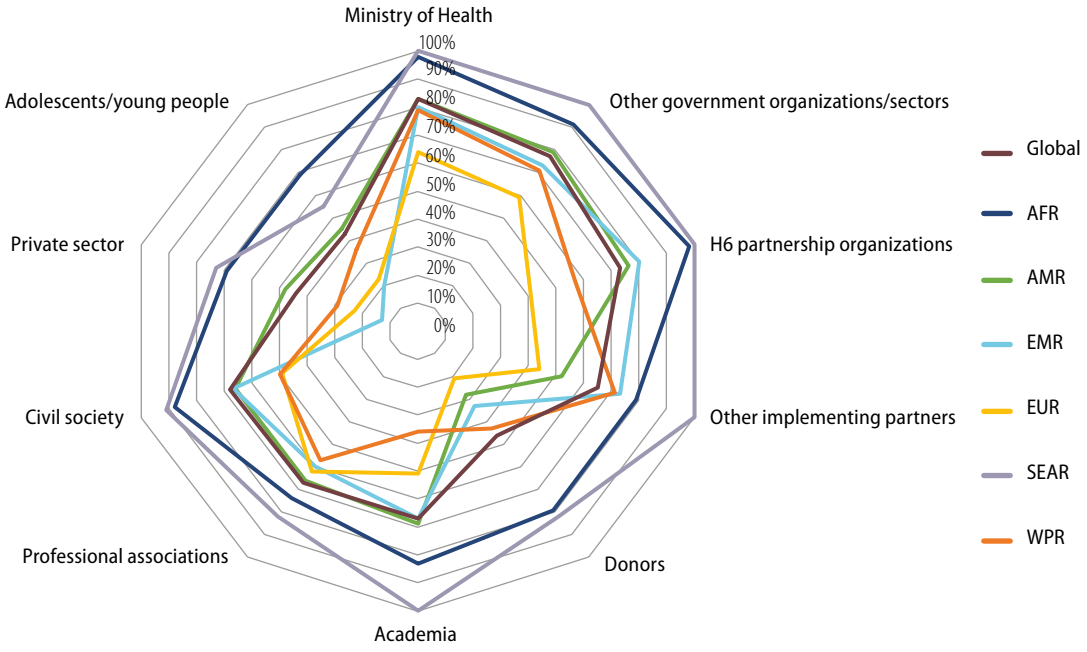
- Ministry of Health
- other government bodies/sectors
- H6[6] partnership organizations (UNAIDS, UNFPA, UNICEF, WHO, UN Women, World Bank)
- other implementing partners
- donors
- academia
- professional associations
- civil society
- private sector
- adolescents/young people.

Globally, the most common stakeholders who participate in reviews of national SRMNCAH programmes are the Ministry of Health (83%), other government bodies (77%) and H6 partnership organizations (73%). Stakeholders who less frequently participate in reviews of national SRMNCAH programmes globally are adolescents/young people (43%), the private sector (44%) and donors (46%). Civil society, academia, professional associations and other implementing partners participate in reviews of SRMNCAH programmes in approximately two thirds of countries globally (Table A.2.69, Fig. 86).

Regionally, the pattern is similar, with the Ministry of Health and other government bodies being among the most common stakeholders who participate in reviews of SRMNCAH programmes across regions. However, there are notable differences in the levels of participation of other stakeholders. For example, in countries in the South-East Asia Region stakeholders from almost all groups (73–100% of all stakeholders except adolescents/

6 The H6 partnership harnesses the collective strengths of UNFPA, UNICEF, UN Women, WHO, UNAIDS and the World Bank Group to deliver technical support and advance the Every Woman Every Child Global Strategy in support of country leadership and action for women's, children's and adolescents' health.

Figure 86. Participation by stakeholders in reviews of national SRMNCAH programmes, by WHO region



young people) participate in reviews of SRMNCAH programmes, while in countries in the European Region participation by stakeholders other than the Ministry of Health and other government bodies is low (20–65%) (Table A.2.69, Fig. 86).

11.5. Areas addressed by national policies/guidelines to improve quality of care in SRMNCAH services

Access to high-quality health services is important for ensuring population health. Efforts to better the care delivered are often framed by national policies/guidelines on improving the quality of care. Globally, national policies/guidelines to improve the quality of care in the area of SRMNCAH most often include maternal health services (77%), newborn health services (77%) and child health services (75%). Sexual and reproductive health services and adolescent health services are less frequently included (69% and 65%, respectively). On average, countries include three or four of these five key service areas in national policies/guidelines to improve the quality of care; only 57% of countries have policies that include all five service areas (Table A.2.70, Fig. 87).

Regionally, the pattern is similar, with maternal, newborn and child health being the service areas most commonly included in national policies/guidelines to improve the quality of care. In the South-East Asia Region, maternal, newborn and child health services are included in almost all national policies/guidelines to improve the quality of care (maternal health: 91%, newborn health: 100%, child health: 100%), while these service areas are included less frequently by countries in the Western Pacific Region (57%, 50% and 57%, respectively). The average proportion of service areas included in national policies/guidelines to improve the quality of care is highest in the Eastern Mediterranean Region, Region of the Americas and South-East Asia Region, (85%, 81% and 91%, respectively), compared with the African Region, European Region and Western Pacific Region (65%, 72% and 53%, respectively). The proportion of countries that include all five service areas in their national policies/guidelines to improve the quality of care in SRMNCAH is highest in the Region of the Americas (76%), followed by the South-East Asia Region (73%), Eastern Mediterranean Region (60%), African Region (52%), European Region (51%) and Western Pacific Region (36%) (Table A.2.70, Fig. 88).

Figure 87. Service areas addressed by national policies/guidelines to improve quality of care in SRMNCAH, globally

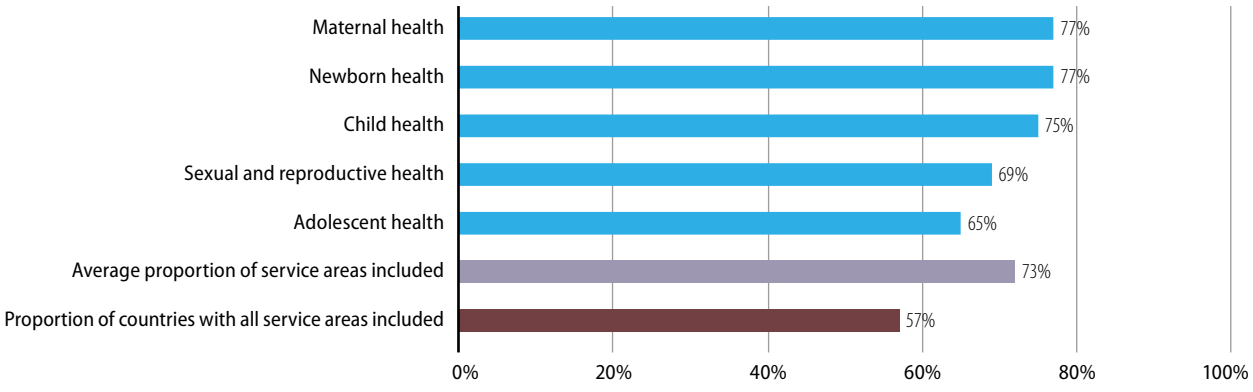
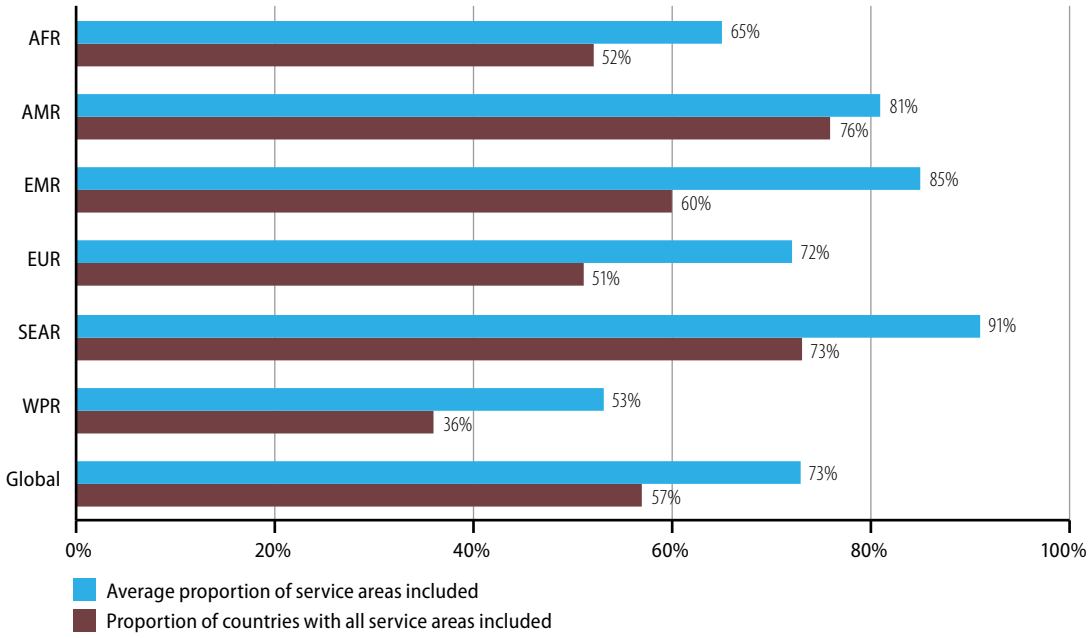


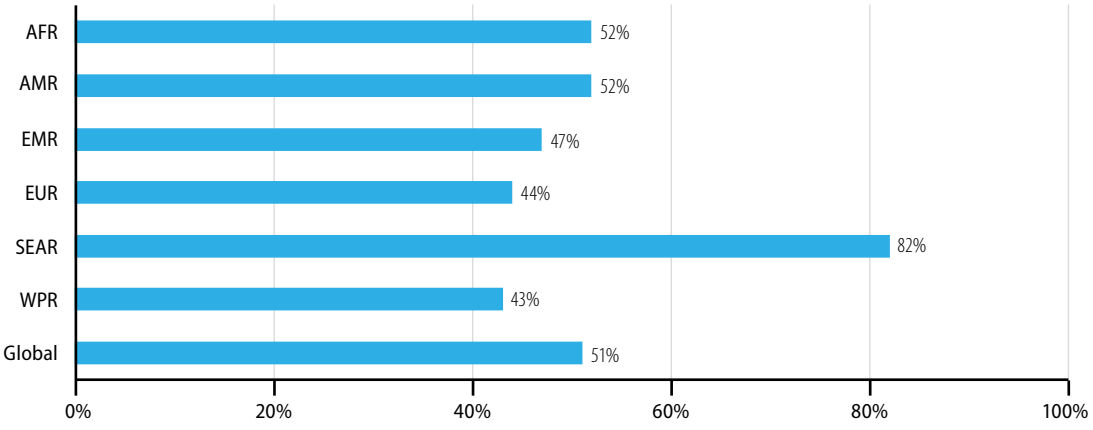
Figure 88. Average proportion of service areas and proportion of countries with all service areas included in national policy/guideline to improve quality of care in SRMNCAH, by WHO region



11.6. Availability of national quality of care steering committee/technical working group for SRMNCAH

A national quality of care steering committee/technical working group for SRMNCAH is available in only 51% of countries globally. Regionally, availability of a national quality of care steering committee/technical working group is highest in the South-East Asia Region (82% of countries), followed by the Region of the Americas (52%) and African Region (52%), and is lowest in Western Pacific Region (43%), European Region (44%) and Eastern Mediterranean Region (47%). By World Bank income group, availability of a national quality of care steering committee/technical working group for SRMNCAH is higher in lower-middle-income and upper-middle-income countries (67% and 51%, respectively) compared to low-income and high-income countries (47% and 37%, respectively) (Table A.2.71, Fig. 89).

Figure 89. Availability of national quality of care steering committee/technical working group for SRMNCAH, by WHO region



11.7. Most commonly used data sources to compare national maternal, newborn, child and adolescent mortality rates to mortality rates in other countries

Globally, the most commonly used data sources to compare national maternal, newborn, child and adolescent mortality rates to mortality rates in other countries are the WHO website or reports (67%), national health statistics (59%) and population surveys (for example, Demographic and Health Surveys, Multiple Indicator Cluster Surveys) (37%). Very few countries report using the World Bank website or reports (8%), Institute for Health Metrics Global Burden of Disease (5%), Countdown to 2030 website or reports (5%), UN Population Division website or reports (3%) or UNFPA website or reports (3%) as a main data source for comparing national maternal, newborn, child and adolescent mortality rates to mortality rates in other countries.

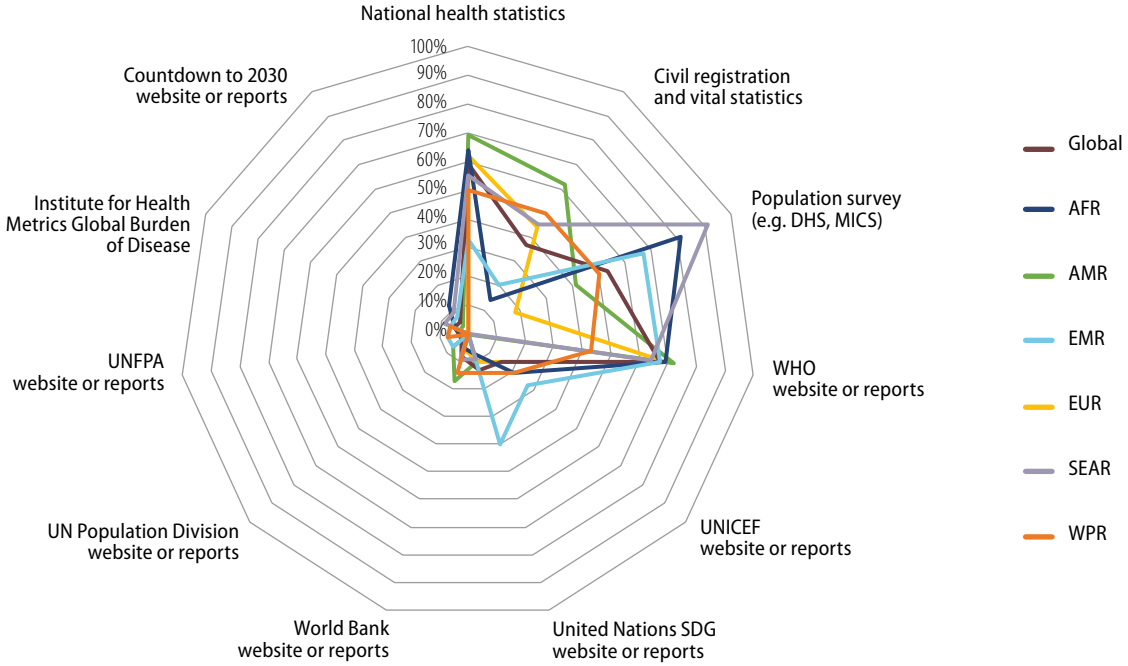
Regionally, the pattern is similar, with the WHO website or reports, national health statistics and population surveys (for example, Demographic and Health Surveys, Multiple Indicator Cluster Surveys) being the most commonly used data sources for comparing national maternal, newborn, child and adolescent mortality rates to mortality rates in other countries in all regions, with the exception of the European Region, where civil registration and vital events are used more frequently than population surveys (Table A.2.72, Fig. 90).

11.8. Comparing policy availability and intervention coverage

Having comprehensive policies in place is key to improving population health. As such, in the 2018–2019 survey WHO assessed the relationship between SRMNCAH policy availability and coverage of key health interventions globally. The main challenge in this work centred around the availability of coverage data, which were available for only 75 out of the 150 SRMNCAH survey respondent countries. The analysis for the subset of countries that had coverage data did not reveal any clear relationship between the availability of SRMNCAH policies and levels of intervention coverage, which demonstrates that having a policy in place is perhaps necessary but not sufficient to improve coverage of health interventions.

Identifying gaps in policy availability is a first step in addressing improvements in health for women and children; however, this should be accompanied by further investigation into policy implementation, quality of care and coverage for specific interventions at the country level.

Figure 90. Most commonly used data sources to compare maternal, newborn, child and adolescent mortality rates, by WHO region



12. Limitations of the 2018–2019 SRMNCAH policy survey

The 2018 global SRMNCAH policy survey has a number of limitations, which should be taken into account when interpreting its findings.

First, the survey asked about national policies only. In countries with decentralized governments, while there may not be a national policy, there may be multiple subnational-level policies. The survey tool was not able to capture this information. Thus, not having a national policy does not mean that at the subnational level (such as at the state level) there is no policy.

Second, the survey represents countries' self-reported responses. While countries were asked to upload source documents, providing source document evidence was not required. In addition, where source documents were provided, the survey database was not validated against the contents of the source document. A source document validation exercise is being conducted, and the results of that work will be made available in a future report. Finally, country teams did not have the opportunity to validate the reported data after the survey was submitted. Moving forwards, the survey results will be presented at regional and country levels, which may result in some changes to the database. While these changes are not reflected in this global report, they will be reflected in the MCA Department's data portal, where the survey data set will also be made available for further analysis; see https://www.who.int/data/maternal-newborn-child-adolescent.

13. Conclusions

The 2018–2019 global policy survey represents the most comprehensive examination of SRMNCAH policies in the world, with data obtained and analysed for more than 150 countries. Overall, extensive availability of key SRMNCAH policies was identified, with more than 80% of respondent countries having most key policies in place, although there was some variation by region. The correlation between policy availability and changes in levels of intervention coverage was difficult to assess due to a lack of data on coverage trends in key areas. Moving forwards, it is important for each country to assess coverage of key SRMNCAH interventions in relation to national policies in order to identify gaps in implementation. Conducting country-level policy dialogues is an important next step with a view to identifying possible causes for the lack of implementation and developing solutions. Although having the appropriate laws, policies and guidelines in place is critical, only through implementation of these laws, policies and guidelines will improvements in the health of women and children occur globally.

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