Delivering the Promise: Equity, Rights and Resilience in RMNCAH-N

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CanWaCH
Canadian Partnership for Women and Children's Health

ABOUT

The Canadian Partnership for Women and Children's Health (CanWaCH) is a proud membership of more than 100 non-governmental organizations, academic institutions, health professional associations and individuals partnering to improve health outcomes for women and children in more than 1,000 communities worldwide. Learn more at CanWaCH.ca.

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ACRONYMS

10YC	10-year commitment
CAR	Central African Republic
COVID-19	Coronavirus Disease 2019
CSE	Comprehensive sexuality education
DRC	Democratic Republic of Congo
FIAP	Feminist International Assistance Policy
FP2030	Family Planning 2030
GDP	Gross domestic product
GFF	Global Financing Facility
HiAP	Health in All Policies
HPF	Health Pooled Fund
KNNAP	Kenyan Nutrition Action Plan
2SLGBTQI+	Two-Spirit, lesbian, gay, bisexual, transgender, queer, intersex and additional
LMIC	Low- and middle-income countries
MMR	Maternal Mortality Rate
NFNSP	National Food and Nutrition Security Policy
ODA	Official Development Assistance
RMNCAH-N	Reproductive, Maternal, Newborn, Child, and Adolescent Health and Nutrition
SDG	Sustainable Development Goal
SRHR	Sexual and reproductive health rights
SSA	sub-Saharan Africa
UHC	Universal Health Coverage
UN	United Nations
WHO	World Health Organization

EXECUTIVE SUMMARY

Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition (RMNCAH-N) is not only a cornerstone of global health, but it is fundamental to human rights, gender equality, economic growth and social resilience. Yet nearly a decade since the adoption of the Sustainable Development Goals (SDGs), progress in RMNCAH-N has stalled in many countries and, in several cases, regressed. Millions of women, adolescents and children, particularly in fragile, conflict-affected and under-resourced settings, are being left behind, with preventable deaths, chronic inequities and unmet health needs deepening across generations.

This position paper presents a comprehensive and evidence-driven analysis of the current global landscape of RMNCAH-N, highlighting critical trends, systemic gaps and regional disparities that threaten the achievement of SDG targets by 2030 and the sustainability of the hard-earned impact. It underscores how overlapping crises such as COVID-19, conflict, climate change and financing gaps have exposed and exacerbated structural weaknesses in health systems. These challenges are most acute in Sub-Saharan Africa, where countries face the highest maternal mortality and adolescent fertility rates, sanitation deficits, and the lowest access to family planning and universal health coverage.

Despite these challenges, the paper demonstrates that transformative progress is possible. Global examples from countries such as Bangladesh, South Sudan, Kenya, Ethiopia and Morocco offer valuable lessons on how rights-based, equity-centred and locally driven strategies, supported by gender-responsive health policies and political will, can deliver measurable impact even in resource-constrained settings. Key enabling factors include health system strengthening, multi-sectoral collaboration, and alignment between donor priorities and national-level leadership.

Framed around Canada's values and global commitments, particularly the Feminist International Assistance Policy (FIAP) and 10-Year Commitment to Global Health and Rights, this paper calls on Canadian policymakers, donors, and development actors to seize this pivotal moment and continue to provide unwavering support and long-standing commitment towards improving global health. The recommendations provide a clear path forward:

1. Bridge the global funding gap by catalyzing multi-sectoral collaboration to accelerate investments in RMNCAH-N.
2. Prioritize women, adolescents, and children in fragile contexts through long-term, targeted investments and strengthened data systems.
3. Invest in policy and local partnerships to support inclusive governance and locally led health system reform.
4. Earmark funding for neglected SRHR areas, including safe abortion and comprehensive sexuality education.
5. Reinforce gender equality as a cross-cutting priority across all sectors of development assistance.

The path to 2030 and beyond requires urgent, coordinated and courageous action. Canada is uniquely positioned to continue our long-standing role in promoting global health through catalytic investment, political will and partnerships that elevate the voices and rights of the most marginalized. By embracing an integrated, feminist and systems-focused approach, Canada can help shift the trajectory of global RMNCAH-N progress, ensuring that every woman, every child and every adolescent not only survives but thrives.

1. Background: A Defining Moment for RMNCAH-N and Global Development

Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition (RMNCAH-N) sits at the core of the Sustainable Development Goals (SDGs), serving not only as a pillar of global health but also as a critical driver of equity, economic growth and social progress. Central to SDG 3 on health and well-being, RMNCAH-N interventions act as a lifeline for the most vulnerable populations, providing lifesaving care while fostering broader advancements in education, gender equality and poverty reduction. Since the adoption of the SDGs in 2015, some progress has been made, but it is alarmingly evident that we remain far off track. For millions of women, adolescents and children, the promise of 2030 continues to be elusive.[1]

Each year, an estimated 260,000 women succumb to preventable complications related to pregnancy and childbirth.[2] Nearly 2.3 million newborns die within the first month of life, primarily from causes that could be mitigated with timely, quality care.[3] These statistics represent more than just a failure in service delivery; they reflect a profound failure to uphold rights, redistribute power and challenge the systemic inequities that jeopardize lives across generations. Strengthening RMNCAH-N contributes not only to the health of individuals but also to the overall well-being and resilience of communities. It plays a transformative role in empowering women, promoting gender equality and reducing socio-economic disparities, particularly in access to health services, education and employment opportunities.[4] Prioritizing RMNCAH-N in global health is essential for advancing human rights, achieving the SDGs and addressing broader economic, social and developmental challenges at both micro and macro levels.[5]

The slowdown in RMNCAH-N progress is not attributable to a lack of evidence or effort but rather the result of a convergence of crises and structural failures. The COVID-19 pandemic diverted critical resources, disrupted supply chains, and reversed years of hard-fought gains in maternal and child survival. Health systems, especially in fragile and under-resourced settings, buckled under pressure.[6] As attention and funding shifted toward emergency response, core services such as antenatal care, skilled birth attendance and adolescent health programming were sidelined. These disruptions were further compounded by fragmented and siloed responses among global health actors, revealing a persistent lack of coordination in implementing integrated RMNCAH-N strategies.[7] The cumulative effect has led to missed interim targets and deepened existing vulnerabilities for many countries. According to the UN's 2023 SDG progress report, the countries falling furthest behind are overwhelmingly those grappling with overlapping crises, including humanitarian emergencies, political instability and weakened governance structures.

The compound effects of the pandemic have been intensified by rising global fragility, displacement and conflict.[8] In countries experiencing protracted emergencies or governance breakdowns, health systems have become victims of instability, and essential services have crumbled under the burden of crisis. Gender-based violence, child marriage and unmet needs for family planning have surged, disproportionately impacting women and girls who are not merely underserved but are structurally excluded from care.[9] At the same time, the global development landscape is being reshaped by accelerating climate change, economic shocks and geopolitical upheaval. Droughts, floods, food insecurity and inflation are exacerbating existing vulnerabilities, particularly in fragile and low-resource settings.[10] The intersection of environmental degradation and political instability threatens to push entire populations, particularly women and girls, further away from essential services. For RMNCAH-N, this manifests as escalating risks, diminishing safety nets, and a widening gap between needs and responses.

Amid this complexity, a new approach is urgently needed, one that transcends fragmented interventions and short-term aid. To achieve the 2030 targets and to sustain its generational impact, we must reimagine how RMNCAH-N is delivered, funded and governed. This involves investing in resilient systems, centering equity and rights, and addressing the upstream determinants of poor health. It emphasizes the recognition that sustainable progress is not merely about services; it encompasses social transformation.

Canada, alongside global partners, stands at a strategic inflection point. With its Feminist International Assistance Policy (FIAP), longstanding commitments to global health, and strong partnerships across the Global South, Canada is uniquely positioned to support and invest in global health for the future of our world. Our existing role must now be complemented by catalytic investment, strong partnerships, and a willingness to take risks in areas where needs and opportunities are most critical.

This paper responds to this moment. It provides an evidence-based assessment of our current status, identifies why progress is stalling, and outlines what urgent and strategic actions must be taken to regain momentum. It offers a roadmap for action informed by lived realities, grounded in rights, and designed for impact.

We are not starting from scratch. We begin from a foundation of knowledge, resilience and potential. What is needed now is political will, smart investment, and coordinated action to transform that potential, as well as the hard-earned results so far, into tangible and sustainable progress.

1.1 Aim and purpose

This paper aims to provide a critical analysis of the current global landscape of RMNCAH-N within the framework of the 2030 SDGs. It seeks to assess progress, identify systemic challenges and gaps in financing and equity, and highlight evidence-based practices and strategies.

Targeted toward Canadian policymakers, health advocates, donors and development leaders, the paper is designed to inform strategic decision-making and influence future investments. It positions Canada and its global partners to take informed, transformative action through rights-based, gender-responsive and systems-strengthening approaches, particularly in fragile and under-resourced settings. Ultimately, it offers a roadmap to recalibrate global commitments and catalyze meaningful progress in RMNCAH-N outcomes.

1.2 Guiding questions

- What is the global status of RMNCAH-N progress toward the 2030 SDG targets, and which indicators and regions are most off track?
- Which systemic and structural factors are driving stalled or uneven progress, and what proven strategies and innovations from global exemplars can inform context-specific solutions?
- What role can Canada play in catalyzing global RMNCAH-N progress through its FIAP, 10YC, and leadership in fragile and under-resourced settings?

2. The State of RMNCAH-N: Recalibrating Global Commitments and Action

2.1 Context: Complex realities and systemic intersections

This paper offers a comprehensive synthesis of the global landscape of RMNCAH-N, highlighting both the entrenched and emerging challenges that shape health outcomes for women and children. It identifies where Canadian and global investments can be most catalytic in accelerating progress toward the 2030 SDGs and underscores the need for a recalibration of global priorities to ensure that progress is not only made but sustained in the most vulnerable contexts.

Global progress on RMNCAH-N has been profoundly uneven. While gains have been made in some countries and regions, many others, particularly those facing fragility, conflict and weak governance, have seen stagnation or regression. The challenges to improving RMNCAH-N outcomes are complex and systemic. Gender inequality, poverty, inadequate health infrastructure, climate vulnerability, youth bulges and fragile governance systems intersect in ways that compound risk and deepen exclusion. These systemic weaknesses are particularly acute in countries with high fertility rates, slow economic growth, high debt burdens and heavy reliance on Official Development Assistance (ODA). These structural vulnerabilities leave countries especially exposed to external shocks, such as pandemics (e.g., COVID-19), global inflation, abrupt shifts in aid priorities and climate-induced disasters.

INSIGHT

RMNCAH-N as a barometer of systems

RMNCAH-N indicators are more than health statistics. They are proxies for state capacity, gender equality, institutional strength and social equity.

RMNCAH-N indicators serve as a litmus test for the resilience, inclusiveness and responsiveness of a country's health system. They also reflect the broader status of gender equality and social inclusion. Countries with better RMNCAH-N outcomes typically have stronger institutions, inclusive policies and more equitable access to care. Regions that typically have greater capacity in these areas, such as Europe and the Americas, are in the 80th percentile or above when it comes to access to universal health coverage, access to sexual and reproductive health services and gender equality.[11] Conversely, weak or failing systems are often mirrored by high maternal and child mortality, low access to family planning, and stark gaps in adolescent and youth health services, as is evidenced in regions such as sub-Saharan Africa, where access to health coverage is on average below 50 per cent, and countries lag in achieving SDGs.[12]

DATA SNAPSHOT

Maternal Mortality Rate

Global average MMR: 197 per 100,000

South Sudan: 1,223 per 100,000

Sub-Saharan Africa: 454 per 100,000

Global SDG target: <70 per 100,000

To accelerate progress, the global health community must not only assess where gains have been made but also identify where they have stalled and why. This demands an approach that goes beyond technical solutions, placing equity, systemic resilience and intersectional analysis at the heart of all interventions. The future of RMNCAH-N hinges on the ability to address upstream drivers of poor health, align financing with need, and tailor solutions to the political and social realities of each context.

2.2 Priorities: Urgent indicators requiring immediate action

Across key RMNCAH-N indicators, evidence points to significant and persistent gaps that demand urgent, coordinated action. These indicators not only reflect the status of health system capacity but also serve as proxies for broader development, social justice and human rights.

Maternal mortality remains one of the most alarming and persistent challenges. This indicator represents not only maternal death during childbirth, but also the general health status of pregnant people, their access to health services during pregnancy and birth, and the impact of inequities in health outcomes.[13] As of 2023, the global average maternal mortality rate (MMR) stood at 197 deaths per 100,000 live births. However, in Sub-Saharan Africa (SSA), the rate was more than double that, at 454.[14] Countries, such as South Sudan (MMR 1,223[15]), Chad, Nigeria, the Central African Republic (CAR) and Guinea-Bissau, report maternal mortality rates that are not only far above the SDG global target of 70 but also above the national-level target of 140 per 100,000.[16]

These figures reflect a deadly combination of inadequate access to emergency obstetric care, lack of skilled birth attendance, and systemic gender inequities that limit women's autonomy and mobility. Over 70 per cent of these deaths are preventable, underscoring the urgent need for targeted investments in maternal health services, including gender-responsive health policy, skilled personnel, transportation, facility readiness, and gender-responsive, adolescent-friendly and climate-resilient care.

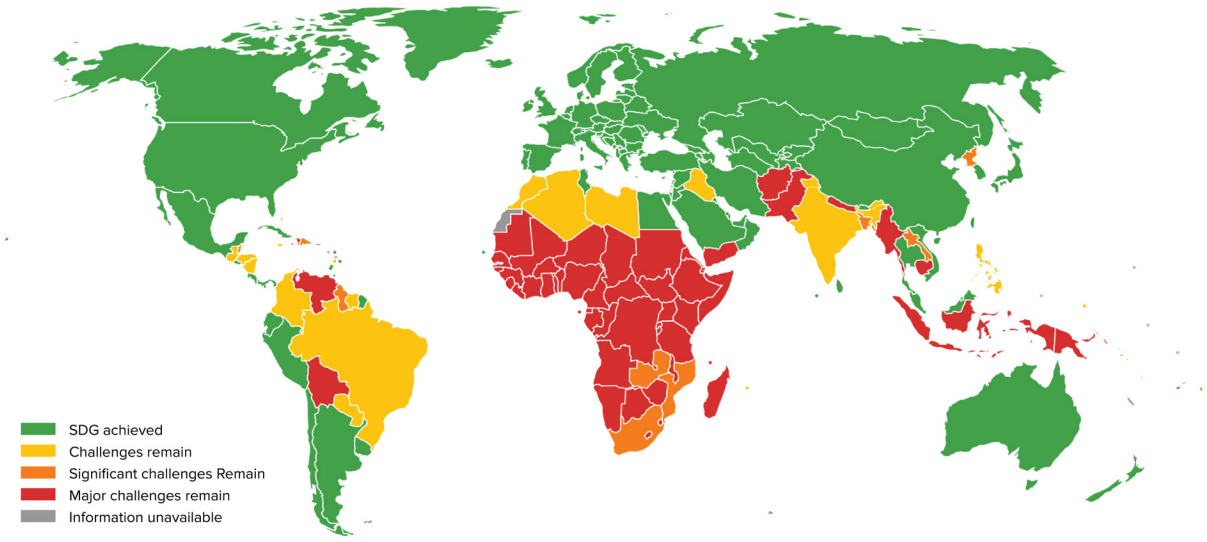

Figure 1: Geographic location of countries in peril, MMR. Source: UN SDG Stats

Adolescent fertility and mortality continue to expose deep gaps in service coverage and policy implementation. In 2021, some of the highest adolescent birth rates (exceeding 100 births per 1,000 girls aged 15 to 19) were found in countries such as CAR, Mozambique, Niger, Liberia and Chad.[17] Early childbearing not only poses serious health risks to adolescents, such as obstructed labour, maternal mortality and neonatal complications, but also reflects broader issues of early marriage, lack of comprehensive sexuality education (CSE), and poor access to adolescent and youth-friendly sexual and reproductive health rights (SRHR) services.[18] At the same time, adolescent mortality is unacceptably high in countries like Somalia, Sierra Leone, Chad and the Democratic Republic of Congo (DRC), often driven by preventable causes including pregnancy-related complications, unsafe abortion, gender-based violence and malnutrition.

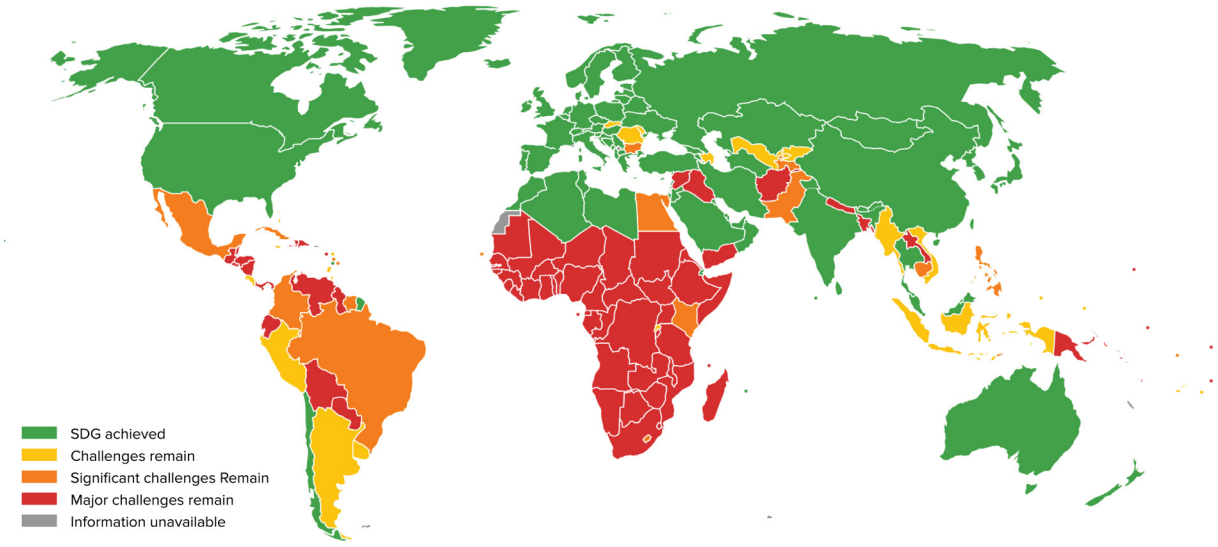

Figure 2: Geographic location of countries in peril, adolescent fertility. Source: UN SDG Stats

Access to basic sanitation services remains a critical but often overlooked determinant of RMNCAH-N outcomes. In many countries, including Ethiopia, Chad, Madagascar, South Sudan and Benin, less than 30 per cent of the population has access to basic sanitation.[19] These gaps disproportionately affect women and girls, increasing the risk of infectious diseases, menstrual health complications and neonatal infections. Sanitation access is closely tied to infrastructure, urban-rural disparities and socioeconomic status, and must be addressed as a cross-cutting priority.[20]

Universal Health Coverage (UHC) remains elusive in many parts of the world. UHC aims to provide essential health services to all people, without creating financial hardship, rather than individual out-of-pocket health care spending. The World Health Organization's (WHO) UHC Service Coverage Index shows that countries such as Somalia, South Sudan, Nigeria and Angola continue to provide essential health services to less than half of their populations. Between 2019 and 2021, more than 10 countries experienced declines of over five percentage points in UHC coverage, reflecting the fragility of gains made in previous decades.[21] Out-of-pocket expenditures account for almost half of total health spending in SSA, creating significant barriers to care for the poorest and most marginalized.[22]

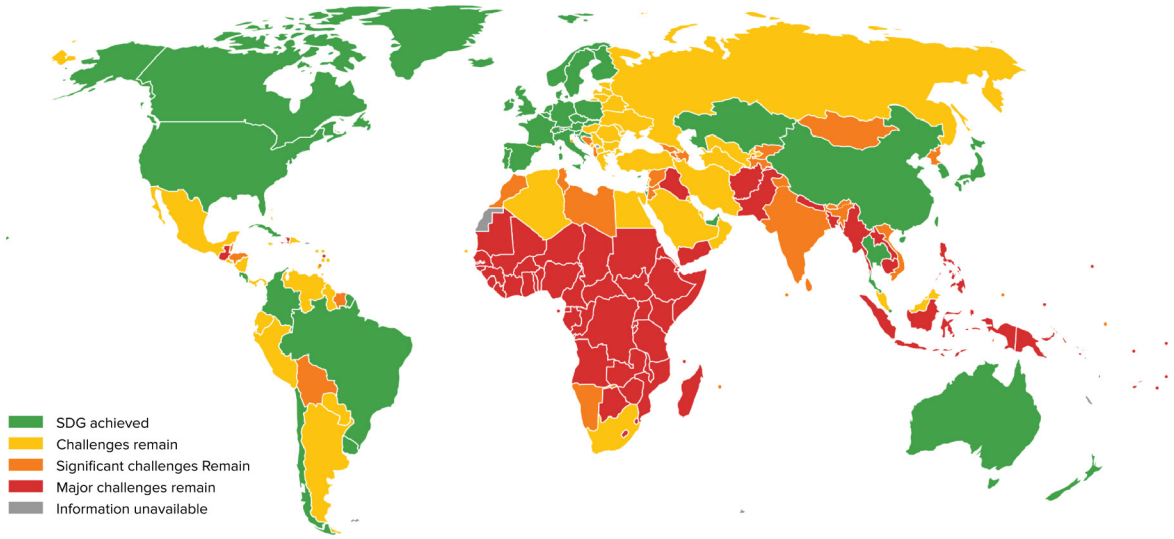

Figure 3: Geographic location of countries in peril, UHC. Source: UN SDG Stats

Meeting the demand for family planning through modern methods is one of the slowest-moving RMNCAH-N indicators. As of 2024, countries such as Somalia, Chad, South Sudan and Mauritania still report that fewer than 30 per cent of women of reproductive age have their family planning needs met with modern methods. Adolescents face additional barriers, including stigma, provider resistance, lack of confidentiality and legal restrictions.[24] These access gaps perpetuate cycles of early pregnancy, unsafe abortion and maternal mortality, particularly in humanitarian and low-resource settings.

WARNING

The Cost of Unmet Need

Family planning needs remain unmet for over 70% of women in Somalia, Chad and Mauritania. Among adolescents, access to contraceptives is even more limited, contributing to high rates of unintended pregnancies and unsafe abortions.

2.3 Positioning: Strategic focus, regional imperatives informed by global success

To meaningfully advance RMNCAH-N outcomes, global strategies must prioritize regions where progress is most at risk and where the barriers to health equity are most entrenched. Sub-Saharan Africa (SSA) remains the global epicentre of underperformance across nearly every RMNCAH-N indicator. Of the 10 countries furthest behind in achieving the 2030 RMNCAH-N goals, nine are in SSA, namely South Sudan, Somalia, Liberia, Chad, the CAR, Nigeria, Mozambique, Niger and the DRC.[23] The only non-African country in this high-risk group is Afghanistan. These countries exhibit the steepest gaps across maternal and neonatal mortality, adolescent fertility, family planning access, sanitation and universal health coverage.

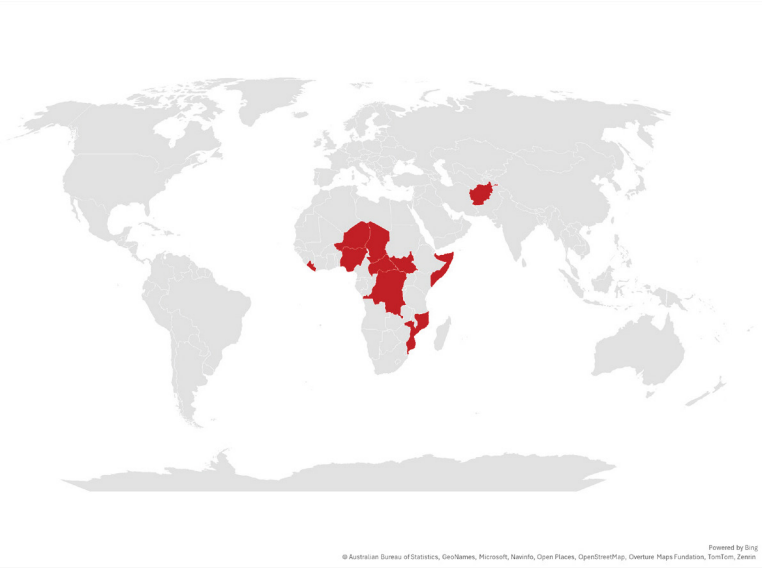

Figure 4: 10 countries most at risk of not achieving SDG RMNCAH-N goals by 2030

There are multiple reasons why progress has slowed so significantly in these countries. They face a combination of chronic poverty, slow or negative economic growth, growing inequality and systemic governance challenges.[25] High levels of internal conflict have not only disrupted health infrastructure but also fueled widespread internal displacement, food insecurity and climate vulnerability. These countries are among the most climate-sensitive globally, regularly facing devastating droughts, floods and weather-related displacement that further weaken already fragile health systems.[26] Compounding this is the demographic reality, many of these countries have extremely high fertility rates and a predominantly adolescent population. This underscores the urgent need to scale up investments in adolescent and youth-focused health services, which are critically under-resourced.[27]

Figure 5: Regions experiencing high rates of climate crisis, conflict, and socio-economic vulnerability. Source: UniBW[28]

The SSA region has also been adversely affected by shifts in ODA priorities. Following the COVID-19 pandemic, aid flows originally dedicated to maternal, child and adolescent health have been redirected toward pandemic response, global conflict mitigation and migration management. Although SSA continues to receive the highest share of net ODA, much of this funding now supports short-term humanitarian needs rather than long-term system building.[29] The result is a cycle of reactive programming that does little to address the structural causes of poor RMNCAH-N outcomes.

While these fragile and high-need countries demand urgent focus, it is also essential to draw lessons from global success stories that illustrate what works and why. Several low- and middle-income countries (LMICs) have made substantial strides toward achieving RMNCAH-N targets, despite resource constraints and complex social contexts. Countries such as Ethiopia, Senegal, Nigeria, Morocco, Bangladesh, Nepal and India have made notable progress in improving maternal and neonatal mortality rates, expanding health infrastructure and increasing equity in service delivery.[30] In some cases, the rate of improvement has outpaced regional or global averages.

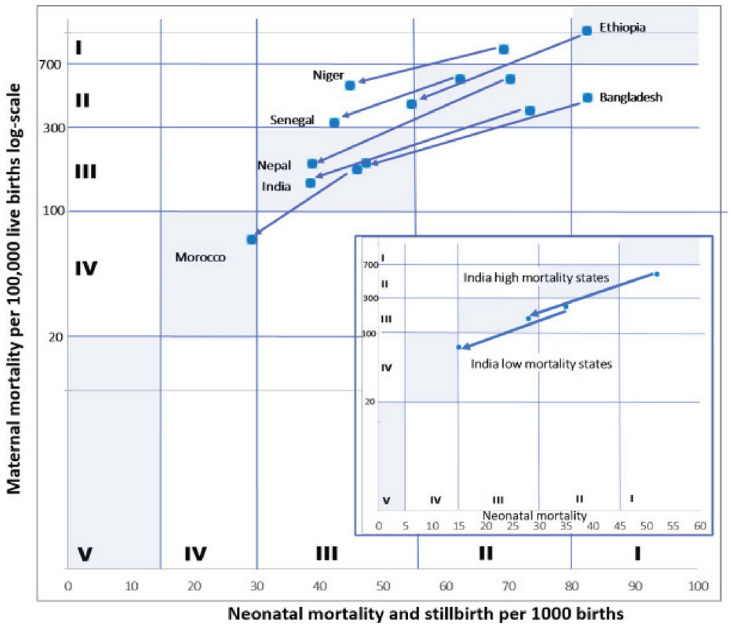

Figure 6: Mortality trajectories in the 7 positive outlier countries.
Source: Campbell et al.

CASE STUDY

Health Pooled Fund in South Sudan

The Health Pooled Fund (2012–2024), supported in part by Canada, demonstrated measurable improvements in maternal and neonatal health despite ongoing conflict, proving that long-term investments in system-building can work, even in fragile contexts.

South Sudan's case study shows that despite being one of the world's most fragile states and heavily dependent on humanitarian assistance, there is demonstrated potential for long-term, coordinated health system investment. Despite the ongoing crisis, the Health Pooled Fund (HPF) contributed to notable improvements in maternal health outcomes.[31] Health systems strengthening resulted in the expansion of basic health and nutritional services at primary health facilities, developed in partnership with the government, and the support and training of local service providers, such as community health workers. The increase in available health services at facilities, such as the availability of skilled birth attendants, resulted in significant advancements in maternal health, including a 10 per cent increase to 53 per cent, if births delivered in a health facility, surpassing program goals.[32]

These expanded health services also resulted in increased access to modern contraception. Access to family planning services, training and community sensitization once again allowed HPF to exceed its goals, with 11 per cent of all women in South Sudan using modern contraceptives. Further, the program aimed to reduce wasting in children under five to 7, which was surpassed by almost two percentage points.[33] The HPF exceeded its goals in childhood vaccination rates and the treatment of diarrheal diseases in children under five. This experience underscores that even in conflict-affected settings, it is possible to achieve measurable progress when aid is structured around long-term systems strengthening rather than fragmented, emergency relief, and there is a focus on partnership and primary care.[34]

What unites these success stories is a shared emphasis on health systems strengthening, multi-sectoral collaboration and the expansion of universal health coverage,[35] especially through the incorporation of traditional birth attendants and community health workers.[36] Ethiopia's experience is illustrative: by prioritizing rural health infrastructure, deploying health extension workers and scaling up government-led health insurance schemes, the country achieved one of the most significant reductions in maternal mortality in the region — from 72 per cent to 44 per cent. It also saw reductions in neonatal mortality (a 3.4 per cent decrease), stillbirths (3 per cent), and adolescent fertility (2.2 per cent).

These expansions in infrastructure and health workforces, particularly in rural areas, ensured that Ethiopia was one of the top five performing countries in SSA.[37] Similarly, Bangladesh focused on training and integrating community health workers and traditional birth attendants into the broader health system, as well as increased investment in the decentralized health system and policy, while achieving high levels of contraceptive coverage[38] and gender-responsive health coverage. The result was a maternal mortality reduction of 79 per cent, nearly twice that of the global average of 40 per cent. Their ability to sustain reductions in maternal mortality year to year is a direct result of their efforts to build and enhance more accessible health systems.[39] In both countries, government commitment and alignment with donor resources were crucial.

These countries also recognized the value of incorporating progressive SRHR policies, including access to family planning and safe abortion services, supported by legal frameworks and service delivery models designed for inclusion.[40] Bangladesh's dual strategy of high family planning coverage and economic empowerment of women played a pivotal role in transforming RMNCAH-N outcomes at scale.

Gold Standard: Kenya's Multi-Sectoral Approach

Kenya's multi-sectoral approach to nutrition brings together ministries, communities, civil societies and international organizations, and has resulted in reduced childhood stunting, wasting and low birth weights.

Multi-level and multi-sectoral collaboration has also proven effective in addressing the social determinants of health.[41] Kenya's approach to multi-sectoral collaboration, and adaptation of a Health in All Policies (HiAP) approach is a leading example of how integrating health with education, agriculture and civil society partnerships can enhance capacity to address key health needs. Priority RMNCAH-N needs are being addressed through policies such as the Kenyan Nutrition Action Plan (KNNAP) and the National Food and Nutrition Security Policy (NFNSP). Both agendas bring together various ministries (health, agriculture, education, WASH) at different levels, civil society and other organizations, to address malnutrition.[42]

Kenya has made significant progress towards achieving its targets.[43] Stunting rates amongst children under five have dropped from 26 per cent to 18 per cent, and wasting, or acute malnutrition rates, remain low at 5 per cent.[44] There has been progress on other SDGs, with 90 per cent of women giving birth with the presence of skilled birth attendants, and 66 per cent attending four or more antenatal care visits.[45] Maintaining this progress will require continued commitment through institutionalized political support, development of strong infrastructure, health systems and governance, reliable resourcing support and ongoing improvements. This type of integrated, locally driven approach enables communities to take ownership of their health outcomes and ensures that gains are both scalable and sustainable.

Another enabling factor in these success stories has been effective alignment between donor strategies and national priorities.[46] In Morocco, strong political leadership and a supportive policy environment were instrumental in reducing maternal mortality by 68 per cent to achieve the SDG of 70 per 100,000 live births and halving neonatal mortality rates.[47] This progress was achieved not only through health-specific reforms but also through broader equity-focused investments in women's empowerment, equitable service delivery and increased domestic resource mobilization.[48]

These examples provide powerful evidence that progress is possible, even under difficult circumstances. They also reaffirm that while financial resources are essential, so too are political will, strong institutions, inclusive governance and community engagement. As such, the global RMNCAH-N strategy must strike a deliberate balance between responding to immediate crises in fragile states and investing in the long-term transformation of health systems, informed by proven success models and localized innovation.

2.4 Equity and Fragility: Deepening vulnerabilities and barriers to progress

Equity is not just a principle — it is a necessity for achieving RMNCAH-N goals. The persistent disparities in health outcomes within and between countries are underpinned by systemic inequities across gender, income, geography, education and identity. Women and adolescent girls, particularly those living in poverty, conflict-affected areas or displacement settings, face multiple layers of marginalization that hinder access to care and opportunities for empowerment.[49]

Gender inequality remains one of the most significant structural barriers to improved health outcomes. In countries with low Global Gender Gap Index scores — such as Afghanistan, Chad, Algeria, Pakistan, Mali and the DRC — women are denied autonomy over their reproductive choices, face heightened risks of gender-based violence and have limited access to economic or educational opportunities.[50] These gender-based disparities have direct and devastating impacts on RMNCAH-N indicators, from high adolescent fertility to low contraceptive use and maternal deaths from unsafe abortion.

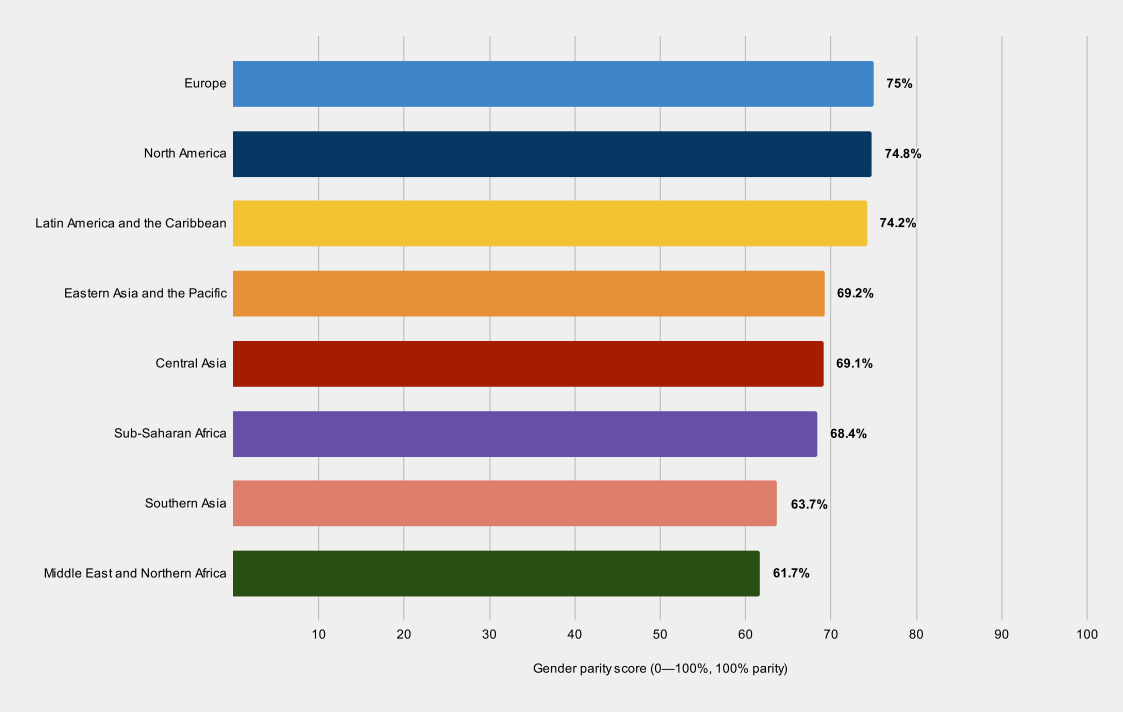

Figure 7: Gender gap closed to date, by region[51]

Socioeconomic inequality further compounds these barriers. Many SSA countries have seen an increase in out-of-pocket health expenditures while simultaneously decreasing public investment in health. In 2021, over half of the countries in the region spent more on external debt repayment than on health.[52] These imbalances not only constrain access to services but also deepen poverty, creating intergenerational cycles of poor health and limited opportunity.

Educational inequities represent another critical barrier to achieving RMNCAH-N goals. Limited access to quality education, including CSE, undermines individuals' ability to make informed health decisions, access economic opportunities and exercise agency over their lives. These disparities in education contribute to lower socioeconomic status, reduced decision-making power and diminished access to health care, perpetuating cycles of vulnerability and poor health outcomes across generations.[53] Other inequalities, such as barriers to access to health services and resources between rural and urban areas, discrimination in care for 2SLGBTQI+ populations, or those with disabilities, displacement status, culture, race or language, further hinder progress towards achieving the 2030 SDGs.

Fragility adds another dimension of risk.[54] Conflict-affected countries are also the most vulnerable to climate change impacts, including drought, food insecurity and population displacement.[55] These pressures strain health systems, disrupt service delivery, and increase the risk of maternal mortality and sexual violence.[56] Providing sexual and reproductive health services, family planning and safe birth facilities, as well as working to provide safe spaces and dignity in high conflict settings, are critical for building senses of empowerment and self-efficacy among women and girls.[57] In refugee settings, up to 50 per cent of maternal deaths are due to unsafe abortion, a tragic outcome of unmet SRHR needs in crisis contexts.[58] SSA is once again one of the most affected regions, containing seven countries with severe conflicts, and 45 per cent of all internally displaced people globally.[59]

FACT

Fragility and Displacement

In 2024, more than 83 million people were internally displaced, 80% of them women and children. Conflict zones report the highest maternal mortality rates and lowest access to SRHR services globally.

2.5 Financing gaps: A critical barrier to RMNCAH-N progress

Achieving RMNCAH-N goals is impossible without adequate and sustained financing. Yet both global and national investments in health are falling short. Development assistance for health fell by 23 per cent between 2021 and 2024, marking the most significant decline in over a decade.[60] ODA from major donors has increasingly been redirected to domestic refugee response or pandemic recovery, leaving fewer resources for long-term health system strengthening in LMICs.

These maps are based on forecasts of total health spending. Bins were established by assigning all countries to evenly distributed quartiles. Currency is reported in 2022 inflation-adjusted US dollars. Source: Financing Global Health 2023 Database

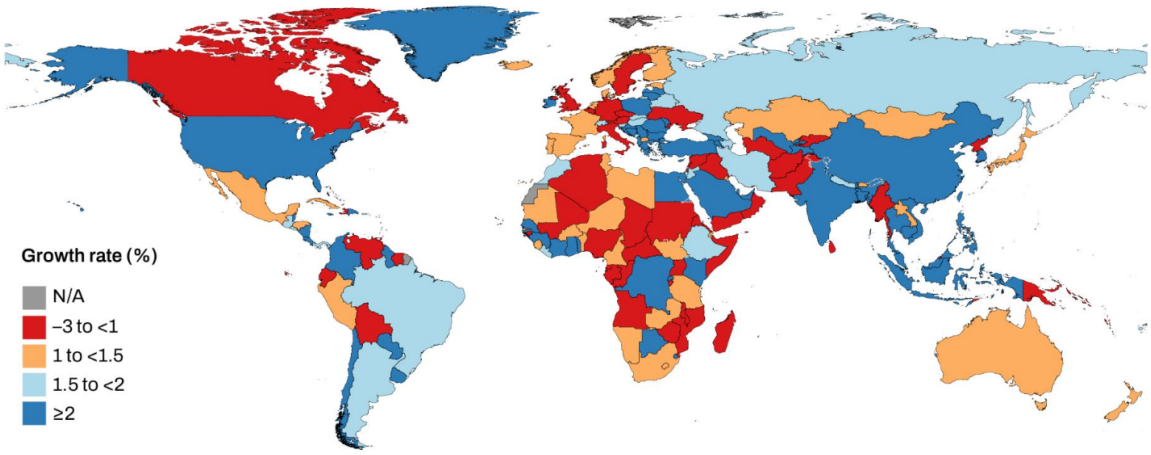

Figure 8: Total health spending per person, annual rate of change, 2019-2030[61]

National budgets are similarly constrained. Few LMICs meet the WHO-recommended 5 per cent of GDP allocation to health, and many SSA countries have reduced health spending since 2016.[62] In countries where government financing is insufficient, households are forced to bear the burden of care, leading to care avoidance, deepening poverty and deteriorating outcomes. Policy shifts in donor countries have further exacerbated these trends.[63] The abrupt reduction in USAID funding and the reimplementation of the Mexico City Policy (MCP) have had a devastating effect on SRHR funding, particularly in SSA.[64]

The dramatic shift in RMNCAH-N funding will result in 16 LMICs losing more than one-fifth of their development assistance, severely widening existing financing gaps.[65] Countries already lagging behind in achieving their RMNCAH-N goals, such as South Sudan, Somalia, the DRC, Liberia, Afghanistan, Sudan and Uganda will face disproportionate setbacks, compounding already fragile health systems and threatening the lives and well-being of women, children and adolescents.[66]

The expansion of the MCP has intensified these challenges. By barring U.S. global health funding from supporting organizations that provide or even discuss abortion services, this policy restricts access to comprehensive sexual and reproductive health care, with major repercussions on reproductive health outcomes.[67] The previous reinstatement of the MCP between 2017 and 2021 resulted in significant loss of life, decreased access to abortion and contraceptive care, negatively impacted the trust and relationships between care providers and patients, reduced the availability and reach of local care providers, and increased the burden on public health systems.[68] The expansion of MCP also influences national policies and funding decisions, through loss of leadership in global health policy, and the advancement of approaches and policies globally that stall progress towards RMNCAH-N goals, ultimately undermining progress toward gender equality and health equity.[69] The reinstatement of the MCP between 2017 and 2021 caused an estimated 108,000 maternal and child deaths, and 360,000 new HIV infections. With the current and ongoing expansions of this policy, the harmful effects threaten to be even more far-reaching.

Global shifts in donor priorities and political agendas have weakened the foundation for coordinated, multilateral action.[70] These dynamics are particularly harmful for countries facing the largest health financing gaps.[71] Some governments and institutions, including Sweden,[72] Norway[73] and the Gates Foundation,[74] have stepped up funding for UHC and SRHR, and initiatives like the Global Financing Facility (GFF) continue to play an important role.[75] However, these efforts remain insufficient in the face of growing needs. A more coordinated, predictable, and gender-responsive financing approach is urgently required, with a clear focus on aligning resources to local priorities and ensuring that investments reach the most marginalized communities.

REALITY CHECK

U.S. Policy Shifts and Global Impact

Cuts in USAID funding and the reinstatement of the Mexico City Policy are projected to cause over 4 million unintended pregnancies and 8,000 maternal deaths in 2025 across 16 LMICs.

2.6 From challenge to change: The path ahead for RMNCAH-N

The current state of RMNCAH-N reflects a convergence of crises, but also a window of opportunity. The most urgent challenges lie in fragile, conflict-affected and under-resourced settings, where progress has been slowest, and the risks are greatest. Yet it is precisely in these contexts that the returns on strategic, coordinated investment can be most profound.

Moving forward, achieving the 2030 RMNCAH-N targets will require a rebalancing of global efforts toward long-term system-building, equity-centred design and meaningful engagement with communities. Canada and other global partners have a unique opportunity to create impactful and lasting change by investing where needs are greatest, aligning resources with rights-based approaches and supporting integrated solutions that empower women, children and adolescents to thrive.

3. The Call to Act: What Canada and Global Partners Must Do

Achieving RMNCAH-N goals by 2030 and sustaining progress beyond requires an urgent and strategic response that not only adapts to but also helps shape the rapidly evolving global landscape. To regain lost momentum and secure equitable health outcomes, a transformative shift is essential — one that centers rights-based, gender-responsive and resilient systems. The recommendations below outline a coordinated pathway to strengthen RMNCAH-N globally.

3.1 Building the momentum for 2030 and beyond

- **Multi- and cross-sectoral collaboration**: Strengthening collaborative approaches to ODA among donors, national governments, and regional institutions will enhance the effectiveness of funding and results.[76] This must be accompanied by robust monitoring and evaluation systems that track progress, surface challenges, and ensure that evidence informs course corrections and a context-appropriate package of interventions. Multi-sectoral approaches, recognizing the intersecting impacts of education, climate change, poverty and violence, are critical for delivering improved RMNCAH-N outcomes.[77]
- **Specified ODA streams**: National commitments to ODA must be not only protected but strategically redirected to address the rising need for targeted health funding, especially for RMNCAH-N. Protecting funding flows for the health of women, adolescents and children, while ensuring investments are used to strengthen domestic health systems, will be instrumental in achieving the 2030 targets.[78]
- **Health systems strengthening**: Developing comprehensive, resilient and gender-responsive health infrastructure and systems is essential for reaching the most vulnerable populations. Investments in health care, human resources, health information systems and capacity building along the continuum of care, particularly primary health care, are foundational to improving RMNCAH-N outcomes.[79] National government commitment to comprehensive SRHR care packages with an upstream focus on SRHR, such as access to contraceptives to avoid unwanted pregnancies, will also make a lasting preventative impact.[80]
- **Universal health coverage**: Reducing the burden of health spending by decreasing out-of-pocket spending for individuals is critical to reaching the 2030 goals.[81] Ensuring the incorporation of SRHR needs into this coverage creates a greater flow of resources to this vital health service.[82]

3.2 Canada's moment to make a significant impact

The global context provides Canada with a unique and timely opportunity to continue as a steadfast proponent of global health. Lessons from around the world align with Canada's values, commitments and feminist approach to global health and development. By seizing this moment, Canada can reinforce its long-standing commitments, strengthen diplomacy and play a catalytic role in advancing RMNCAH-N outcomes. Greater involvement will not only save lives but also increase global health stability by reducing disease burdens, addressing a key driver of fragility in global conflicts, unlocking economic potential and generating more health-related jobs domestically.

The following recommendations outline key opportunities where Canada's policy and funding commitments can deliver an outsized impact, advancing equity, increasing access to health care, creating resilient systems, and ensuring that women, adolescents and children everywhere are empowered.

Recommendation 1: Fill in the global investment gap

Catalyze global investment momentum in RMNCAH-N by mobilizing multi-sectoral collaboration to close critical funding gaps.

Amidst rising geopolitical uncertainty and retreating donor support, including cuts to USAID global health funding, Canada has a critical opportunity to respond to widening financing and leadership gaps in RMNCAH-N. Urgent investment is needed to prevent the reversal of hard-earned gains, particularly for women, adolescents and children in LMICs.

Canada should expand investments that are gender-responsive, equity-focused and directed to the most vulnerable populations, especially in fragile and conflict-affected settings. A multi-sectoral development approach linking health, education, gender equality and climate resilience will signal Canada's global leadership and commitment to feminist development and sustainable impact. Strengthening partnerships with civil society, multilateral institutions and local governments is key to ensuring that support addresses both immediate needs and long-term systems transformation. This collaborative approach to development is critical to tackling the structural drivers of poor health outcomes and ensuring long-term sustainability.

Recommendation 2: Prioritize women, adolescents and children in fragile contexts

Dedicate support to RMNCAH-N in fragile and humanitarian settings through funding commitments, long-term programming and data systems.

As global instability grows, and humanitarian crises become more complex and protracted, fragile and conflict affected settings are increasingly where the greatest health needs and inequalities are found. These environments disproportionately affect women, adolescents and children, who often face disrupted or inaccessible services. Achieving the 2030 goals requires targeted action in these high-risk contexts, particularly in SSA, where fragility intersects with climate, conflict and economic insecurity.

Canada has made strong policy commitments through the FIAP, which must be translated into impact in fragile settings with deliberate action. As of 2021, 30.8 per cent of Canada's ODA was given to fragile contexts, over a third of which was in the form of humanitarian assistance. However, much of this humanitarian assistance remains focused on short-term emergency response, with limited earmarking for RMNCAH-N or long-term service continuity.[83] To uphold its feminist and rights-based approach, Canada should scale up targeted support for RMNCAH-N in fragile settings that are at greatest risk of not achieving RMNCAH-N, through dedicated funding and embedded long-term health programming in humanitarian responses.

RMNCAH-N and SRHR interventions in humanitarian and fragile settings show that access to these critical services saves lives through expanded access to comprehensive care, such as post-abortion services, HIV prevention and treatment, and awareness of gender-based violence.[84] Despite these findings, there remain challenges in collecting and measuring data in fragile and humanitarian contexts, and a need for more effective evaluation of interventions to inform ongoing programming.[85]

Canada can help to shift this by investing in data systems that inform equitable health investments, support decision-making that prioritizes these needs, and measure the impact of investment in this area. By partnering with organizations such as the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises and other humanitarian experts, it can support the collection of important data from humanitarian settings and ensure that priorities are identified not only through these data, but with the input of appropriate actors from within the affected communities. Through data-driven priority setting, Canada can help shape a global response that is coordinated and evidence-driven, meeting not just humanitarian needs but also building long-term resilience in health systems in vulnerable communities.

Recommendation 3: Invest in local policy and local partnership

Increase support for locally led policy reform and governance, in alignment with FIAP goals

Effective and inclusive policy environments are crucial for long-term improvements in RMNCAH-N, particularly in fragile and conflict-affected settings where health systems and social services face severe strain. Canada should deepen its engagement in national policy reform by building on Family Planning 2030's (FP2030) framework to renew and track family-planning commitments, while providing dedicated technical assistance for data collection, accountability mechanisms and community consultations. Simultaneously, it must support ministries of health to integrate SRHR, including antenatal and postnatal care, skilled birth attendance and adolescent services, into national emergency preparedness and response plans, restoring resilience after recent USAID funding cuts.

This engagement should tap both regional coalitions and humanitarian-development platforms. By partnering with the Ouagadougou Partnership, for instance, Canada can help embed emergency-preparedness strategies and contingency financing for SRHR service continuity into West Africa's regional workplans. Aligning with the Grand Bargain localization workstream will shift financing and decision-making power to local and national responders, emphasizing gender-responsive budgeting and procurement reforms. High-visibility policy moments such as the FP2030 Summit, Grand Bargain annual meetings, UNGA 80 humanitarian reform debates, and the next G7 Development Ministers' meeting offer invaluable opportunities to convene joint dialogues, amplify the voices of women, adolescents and local leaders, and secure commitments that reflect local priorities.

To translate global commitments into sustainable action, Canada must invest in multi-year capacity building and robust data systems through funding partnerships with national governments — partnerships that support the drafting and enactment of policy reforms on gender equity, early and forced marriage, and reproductive autonomy, and sustain investments in national health information systems disaggregated by age, sex, ethnicity, displacement status and disability.

Beyond government channels, Canada should champion and co-finance strategic platforms that elevate grassroots expertise and local innovation, such as strengthening women's rights organizations through the Association for Women's Rights in Development grants-management support; mapping NGO financing gaps via the Network from Empowered Aid Response's Resourcing Ecosystems for Local Action; and piloting pooled funding mechanisms under the Alliance for Empowering Partnerships. By supporting these multi-stakeholder networks and long-term government-CSO collaborations, Canada will not only fulfill its FIAP objectives but also catalyze resilient, equitable governance systems that truly reflect the priorities of women, adolescents and other marginalized groups.

Recommendation 4: Prioritize neglected SRHR areas

Earmark funding and establish a transparent implementation framework to address critical gaps in SRHR

Canada has established itself as a champion of SRHR in global development, particularly in fragile and conflict affected settings. Through its FIAP and the 10-year commitment (10YC) Canada has made important strides to integrate SRHR into its broader health and gender equity agenda.[86] Yet critical gaps remain globally, especially in the most neglected areas of SRHR, such as access to safe abortion services, long-acting reversible and emergency contraception, adolescent sexual health and comprehensive sexual health education. Ongoing identification of gaps in SRHR service delivery, particularly in fragile or high-conflict areas, will reveal further areas of priority need. Without clear identification of the most pressing SRH needs to inform funding priorities and intervention direction, progress on RMNCAH-N outcomes will continue to stall, and cycles of mortality, gender-based violence and inequality will persist.

Funding for neglected SRHR areas is frequently embedded within broader health budgets, limiting visibility, accountability or impact tracking. While Canada has advanced SRHR through its general ODA, humanitarian funding has been less consistent in prioritizing these critical areas.[87] The progress Canada has made in development programming to emphasize neglected SRHR issues should be further replicated in humanitarian investments.[88] Current funding options target primarily unwanted pregnancies and gender-based violence (GBV) but overlook

safe abortion and CSE.[89] By earmarking funds in both development and humanitarian streams, promoting a transparent framework for implementation, and strengthening reporting mechanisms, Canada can drive meaningful progress on many of the 2030 SDGs.

Leading by example in prioritizing, funding and monitoring neglected SRHR will enable Canada to help close critical gaps in RMNCAH-N outcomes. This commitment not only upholds the FIAP but also positions Canada as a forward-looking and consistent supporter of global health, capable of driving transformative global change.

Recommendation 5: Reinforce gender equality in development investment

Make gender equality and RMNCAH-N cross-cutting priorities across all sectors of Canadian development assistance

Canada's FIAP outlines a clear commitment to advancing gender equality and the empowerment of women and girls across all pillars of Canada's international development work. To bring this vision to life, especially in fragile and humanitarian contexts, Canada must deepen and sustain its investment in RMNCAH-N and sexual and reproductive health and rights. Canada's humanitarian and international assistance policies emphasize the importance of gender equality and RMNCAH-N, but critical services in this area globally remain underfunded, fragmented and are often siloed from core humanitarian responses.[90] This disconnect contributes to persistent gaps that hold back progress towards the 2030 SDG targets, particularly in maternal and adolescent mortality rates, sanitation and access to family planning. For women, adolescents and girls in the most vulnerable contexts, these gaps have profound and lasting impacts on their health, dignity and opportunities. When fully resourced and integrated across sectors, they catalyze progress and advance equity and inclusive development.

For meaningful change to occur, gender equality must be treated not as a standalone pillar, but as a cross-cutting priority embedded across global ODA. This includes key areas such as climate resilience, food security, governance and education. To sustain its role as a global supporter of equity and its commitment to FIAP, Canada must contin ue to model this approach in its own ODA, offering clear guidance and opportunities for partnership with other nations.

Canada can play a pivotal role in reshaping global norms. By prioritizing equity in resource distribution, Canada will not only advance the FIAP's mandate but also drive tangible progress toward the 2030 goals. Through scaled-up investments and close partnership and collaboration with local governments, multilateral agencies and civil society actors, Global Affairs Canada can ensure that SRHR and RMNCAH-N are not an afterthought but a cornerstone of both humanitarian and development assistance.

4. **Conclusion:** Reclaiming the Promise of 2030 and Beyond

The global state of RMNCAH-N stands at a pivotal juncture. The convergence of compounding crises, conflict, climate instability, economic fragility and shrinking development financing has not only stalled progress but has deepened existing inequities and widened the gap between commitments and outcomes. The burden remains heaviest for women, adolescents and children in fragile and under-resourced settings, where access to basic care is often precarious, and rights are routinely compromised.

This is not a story of failure, but of urgency and possibility. The evidence is clear. Countries that have prioritized systems-strengthening, equity and community-driven solutions, even amid resource constraints, have achieved transformational gains. These lessons must be scaled, contextualized, and supported by deliberate and sustained global action and investment.

What is needed now is not just more funding, but smarter, better-aligned investments. Not just policy, but political will. Not just a humanitarian response, but long-term system-building anchored in rights, resilience and respect for local leadership. Canada and its global partners have both the credibility and the responsibility to act decisively, to protect what has been gained, to respond to what is at risk, and to lead toward what is possible.

The challenges are complex and deeply interconnected, but not insurmountable. Achieving the 2030 goals and sustaining progress beyond will require urgent, equity-driven leadership and long-term smart investment, so that every woman, every child and adolescent not only survives but thrives for generations to come.

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