National, regional, and worldwide estimates of low birthweight in 2015, with trends from 2000: a systematic analysis

Hannah Blencowe, Julia Krasevec, Mercedes de Onis, Robert E Black, Xiaoyi An, Gretchen A Stevens, Elaine Borghi, Chika Hayashi, Diana Estevez, Luca Cegolon, Suhail Shiekh, Victoria Ponce Hardy, Joy E Lawn*, Simon Cousens*

Summary

Background Low birthweight (LBW) of less than 2500 g is an important marker of maternal and fetal health, predicting mortality, stunting, and adult-onset chronic conditions. Global nutrition targets set at the World Health Assembly in 2012 include an ambitious 30% reduction in LBW prevalence between 2012 and 2025. Estimates to track progress towards this target are lacking; with this analysis, we aim to assist in setting a baseline against which to assess progress towards the achievement of the World Health Assembly targets.

Methods We sought to identify all available LBW input data for livebirths for the years 2000–16. We considered population-based national or nationally representative datasets for inclusion if they contained information on birthweight or LBW prevalence for livebirths. A new method for survey adjustment was developed and used. For 57 countries with higher quality time-series data, we smoothed country-reported trends in birthweight data by use of B-spline regression. For all other countries, we estimated LBW prevalence and trends by use of a restricted maximum likelihood approach with country-level random effects. Uncertainty ranges were obtained through bootstrapping. Results were summed at the regional and worldwide level.

Findings We collated 1447 country-years of birthweight data (281 million births) for 148 countries of 195 UN member states (47 countries had no data meeting inclusion criteria). The estimated worldwide LBW prevalence in 2015 was 14.6% (uncertainty range [UR] 12.4–17.1) compared with 17.5% (14.1–21.3) in 2000 (average annual reduction rate [AARR] 1.23%). In 2015, an estimated 20.5 million (UR 17.4–24.0 million) livebirths were LBW, 91% from low-and-middle income countries, mainly southern Asia (48%) and sub-Saharan Africa (24%).

Interpretation Although these estimates suggest some progress in reducing LBW between 2000 and 2015, achieving the 2.74% AARR required between 2012 and 2025 to meet the global nutrition target will require more than doubling progress, involving both improved measurement and programme investments to address the causes of LBW throughout the lifecycle.

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Introduction Low birthweight (LBW) is defined as a birthweight below 2500 g regardless of gestational age and is usually applied to livebirths only. LBW includes both appropriately grown preterm neonates (<37 completed weeks of gestation) and term and preterm growth-restricted neonates (<10th centile of weight for gestational age and sex) but remains an important public health indicator, especially in settings where accurate gestational age assessment is not possible. LBW is a substantial public health problem in every country, associated with a range of both short-term and long-term consequences affecting human capital. More than 80% of neonatal deaths are in LBW newborns, of which two thirds are preterm and one third are term small-for-gestational-age. LBW newborns also have a higher risk of morbidity, stunting in childhood, and long-term developmental and physical ill health including adult-onset chronic conditions such as cardiovascular disease.

Factors influencing LBW include extremes of maternal age (especially younger than 16 years of age or older than 40 years), multiple pregnancies, obstetric complications, chronic maternal conditions (eg, hypertensive disorders of pregnancy), infections (eg, malaria), and nutritional status. Other contributors include exposure to environmental factors, such as indoor air pollution, and tobacco and drug use.

In 2012, the World Health Assembly (WHA) endorsed a Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition, which specified six global nutrition targets, including a 30% reduction in the number of LBW livebirths between 2012 and 2025. LBW is thus a key indicator of progress towards the achievement of the targets specified by the WHA.
of the global nutrition targets and monitoring LBW trends is an essential component of the Global Nutrition Monitoring Framework approved by member states at the WHA in May, 2015. These targets are reiterated in the Sustainable Development Goals (SDGs).

Previously, it was estimated that there were 20–6 million LBW livebirths in the year 2000; however, there are no contemporary standardised worldwide, regional, and national estimates or systematic trend estimates for LBW, which are essential for tracking progress towards the global nutrition target. The LBW prevalence and trends presented here aim to fill this gap and assist in setting the baseline against which to assess progress towards the achievement of the WHA targets.

Methods
Overview
Our study was a systematic analysis of livebirth LBW input data from national administrative sources and nationally representative surveys. We sought to identify all available LBW input data for livebirths. We accessed data that met preset inclusion criteria, and implemented data preprocessing steps, including adjustments to raw data where applicable, to calculate an LBW prevalence from each datapoint—ie, the number of livebirths (regardless of the gestational age) with a birthweight of less than 2500 g divided by the total number of liveborn babies who are weighed or for whom a birthweight could be imputed. Finally, we estimated the LBW prevalence for 195 countries for the years 2000–15 and summed the results to obtain regional and global estimates. We report national-level estimates for 148 countries with data meeting our inclusion criteria. We present our methods in a manner that follows the Guidelines for Accurate and Transparent Health Estimates Reporting (GATHER) checklist, which promotes transparency, including the sharing of input data and modelling code (appendix).

Input data
Figure 1 summarises the administrative and survey data inputs and estimation methods. We considered population-based national or nationally representative datasets for inclusion if they contained information on birthweight or LBW prevalence for livebirths (appendix). Nationally representative estimates of LBW prevalence can be derived from a range of sources, broadly defined as administrative data or representative household surveys. National administrative data are defined as data from national systems including Civil Registration and Vital Statistics (CRVS) systems, national Health Management Information Systems (HMISs), and birth registries. Nationally representative household surveys include Demographic and Health Surveys (DHSs), Multiple Indicator Cluster Surveys (MICSs), and other national surveys.

The optimal data source is a CRVS system that records details on all births, including their birthweight, on a continuous basis. Where all newborns are weighed accurately at birth, birthweight is recorded, registration is complete, and the system functions efficiently, the
resulting LBW prevalence will be accurate and timely. However, existing administrative data systems might not cover all births, or might not collect birthweight data at all. In these settings, household surveys, such as the UNICEF-supported MICS and the USAID-supported DHS are important data sources for estimates of child health, including LBW, but are recognised to have biases. These data systems rely on accurate birthweight measurement, but despite increasing prevalence of facility births, many newborns are not weighed, and when weighed, so-called heaping at specific birthweights (eg, multiples of 100 g or 500 g) is common. We excluded subnational or other non-population-based data such as those from demographic surveillance sites and individual hospital data from the LBW data searches as they are rarely nationally representative.

To identify national administrative data, we searched the websites of the national statistical offices (NSOs) and ministries of health of all countries. Data from years 2000–16 were included. For countries with more than one source of national administrative data available for a given year, we gave preference to NSO website data where available. Where NSO data were unavailable, we used data obtained from the Ministry of Health website. We used WHO regional databases and a UNICEF database (TRANSOMNEE)\(^{20}\) to identify countries with national administrative data not retrieved through initial searches. These data were only included if they contained a reference to their source or could be verified as national administrative data from the NSO or Ministry of Health. Where necessary we contacted WHO and UNICEF regional and country offices to request further details of data sources.

We obtained datasets for all DHSs and MICSs with a midpoint of data collection of 1998 or later, and for which raw datasets were publicly available and contained birthweight data.\(^{21-23}\) A national team from the China Health Information and Statistics Center of the National Health Commission reanalysed data from the Chinese National Health Services Surveys. If data were available from both national administrative or nationally representative surveys for a given country, all data meeting the inclusion criteria were included in the database and subsequent modelling process.

Where no national administrative or nationally representative survey data were readily available through web-based searches, we contacted UNICEF and WHO regional and country offices in September–December, 2014, and again in autumn 2015 and invited them to provide details of any available national LBW data.

From October, 2017, to January, 2018, we did a joint WHO–UNICEF country consultation process to enable each country to provide feedback on the LBW input data used, modelling methods, and preliminary estimates for their country. We received further data from 55 countries through the consultation process, resulting in 341 new or updated country-year observations.

**Exclusions based on population representativeness at a national level**

We excluded national administrative data covering less than 80% of the population, or from countries with less than 80% facility births in the data source year or less than 80% of the UN estimated livebirths in a given year. We also excluded survey data that were not nationally representative, as well as those with less than 30% weighed at birth. We applied a lower threshold for coverage of livebirths weighed to surveys (≥30%) compared with administrative data sources (≥80%) because raw data are available for surveys, allowing multiple imputation of missing birthweights by use of other covariates from the survey. This was not possible for data from administrative sources.

**Data quality assessment**

We identified several potential sources of bias in LBW data sources (table 1). These include errors in birthweight measurement and recording (including heaping of recorded birthweights on 2500 g), misclassification between livebirths and stillbirths, missing birthweight data, and, for administrative data, non-representativeness at national level of births captured in the data system. Overall, these biases are likely to result in an

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**Table 1:** Administrative and survey data inputs and estimation methods

<table>
<thead>
<tr>
<th>National administrative data</th>
<th>National representative surveys</th>
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<tbody>
<tr>
<td>3540 datapoints</td>
<td>310 datapoints</td>
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<tr>
<td>113 countries</td>
<td>113 countries</td>
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<table>
<thead>
<tr>
<th>Estimation dataset</th>
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<tbody>
<tr>
<td>1447 datapoints, 148 countries</td>
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<table>
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<tr>
<th>National estimate</th>
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<tbody>
<tr>
<td>81 excluded</td>
</tr>
<tr>
<td>53 with &lt;30% weighed</td>
</tr>
<tr>
<td>28 owing to data quality</td>
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<tr>
<th>B-spline regression</th>
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<tr>
<td>57 countries with at least 8 years of high-coverage administrative data</td>
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<tr>
<th>Hierarchical regression</th>
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<tbody>
<tr>
<td>91 countries with included data but not meeting B-spline criteria</td>
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<table>
<thead>
<tr>
<th>No estimate</th>
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<tbody>
<tr>
<td>47 countries without any LBW estimate meeting inclusion criteria</td>
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</table>

**Figure 1:** Administrative and survey data inputs and estimation methods

LBW=low birthweight. LBW survey datasets were excluded on quality criteria: seven datasets were excluded because of extreme heaping around three values, nine because more than 10% of births weighed at least 4500 g, one because of excessive heaping on the tail end of the birthweight distribution, seven because of an inability to obtain results from adjustment procedures, and four because very low numbers of livebirths were weighed. 18 years of data between 2000 and 2015, with at least one datapoint before 2005 and one after 2010. The estimate for India was based on partial data for the most recent survey; therefore, modelled estimates are not shown for individual country.
Likely effect on LBW prevalence estimates

<table>
<thead>
<tr>
<th>Coverage of weighing: bias in newborns weighed at birth</th>
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<tbody>
<tr>
<td>Many newborns in LMICs are not weighed at birth, especially if born at home. These are more likely to be socioeconomically disadvantaged and at higher risk of LBW.</td>
</tr>
<tr>
<td>Extremely preterm or sick babies, those stillborn or dying soon after birth and those born around threshold of viability are the most likely to not be weighed.</td>
</tr>
<tr>
<td>These babies are at high risk of being LBW.</td>
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<tr>
<th>Coverage of data system: bias in newborns included in data source</th>
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<tbody>
<tr>
<td>Low coverage of administrative data systems in many LMICs (eg, lower coverage of birth registration for those who die shortly after birth, missing home births, and births in private facilities even if weighed). Births in private facilities are more likely to be socioeconomically disadvantaged and at lower biological risk of LBW; however, high prevalence of medical interventions (eg, caesarean sections) both indicated and elective before 37 weeks, may increase risk of LBW.</td>
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<tr>
<th>Loss of birthweight data: biases in missing birthweight data</th>
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<tbody>
<tr>
<td>In surveys, biases in card retention (eg, birthweight not available for babies who died who are more likely to have been LBW).</td>
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<tr>
<td>Missing administrative birthweight data on sickest babies (frequently LBW) who are transferred immediately to (and weighed in) a newborn ward.</td>
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<tr>
<th>Measurement units error</th>
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<tr>
<td>Heaping of recording of birthweight on 2500 g. As definition excludes babies with birthweight exactly 2500 g, those LBW newborns with birthweight near the threshold frequently heaped at 2500 g.</td>
</tr>
<tr>
<td>Errors in birthweight measurement (eg, poorly calibrated scales, inappropriate devices), suboptimal weighing practices (eg, clothed or delayed weighing until days after birth).</td>
</tr>
<tr>
<td>Extremely preterm or sick babies and those born around threshold of viability who die soon after birth are more likely to be misclassified as stillbirth. These babies are at high risk of being LBW.</td>
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<th>LBW-low birthweight</th>
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<tr>
<td>↓: the potential bias is likely to lead to a decreased LBW prevalence. ↑: the potential bias is likely to lead to an increased LBW prevalence.</td>
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For newborns who are both included in the data source and weighed at birth.

Table 1: Potential sources of bias in low birthweight data

underestimate of LBW prevalence. We took a two-step approach to seek to adjust for possible biases. First, we did a quality assessment of all the available data. Second, where possible, we adjusted included data.

Raw individual-level data were available from household surveys as the datasets are in the public domain, allowing analysis of data quality and recording errors. We excluded surveys with inadequate data quality in three areas as follows. First, implausible birthweight distribution defined as extreme heaping whereby more than 55% of all birthweights in the dataset fall on only three values (eg, >55% of birthweights in the dataset were 2500 g, 3000 g, or 3500 g); more than 10% of births weighed at least 4500 g; or excessive heaping on the tail end of the birthweight distribution with more than 5% of birthweights at 250–500 g and 550 g. Second, inability to obtain from adjustment procedures of multiple imputation or fitting of a mixture of two normal curves, or both. Third, data from surveys with very low numbers of livebirths weighed (<200) and hence high stochastic variation.

We made no further categorisation of data quality among included surveys. We made adjustments to the data from nationally representative household surveys by use of a revised methodology to seek to overcome the limitations of the previously used approach to address missing birthweights and heaping. We implemented a modelling approach that comprised multiple imputation with individually linked variables for all surveys (appendix). We replicated multiple imputations five times per survey and used several variables related to birthweight available in the survey datasets, including maternal factors (height, body-mass index [BMI], and parity), and newborn factors (sex, singleton–multiple status, and perceived size at birth).

To address heaping, we fitted a mixture of two normal distributions to each survey dataset. Whereas previous studies have found that, under ideal conditions such as low-risk full-term singleton livebirths included in the WHO child growth standards, birthweight is approximately normally distributed, this assumption might not apply to all national populations. We tested this assumption in an analysis of high-quality administrative data from the USA. Fitting a single normal distribution to this data from which the proportion of LBW could be estimated resulted in an overestimate of the proportion of livebirths with LBW compared with the raw data. This might indicate that the population of all births comprises two or more subpopulations with different distributions. Fitting a mixture of two normal distributions resulted in an estimated proportion of LBW very close to that seen in the raw data. We also investigated fitting a mixture of three normal distributions. However, this did not substantially improve the estimate of the proportion of LBW.

In summary, we estimated the proportion of LBW livebirths from each survey by the use of five steps. First, we developed five datasets that had a birthweight for each livebirth (reported where available or imputed). Second, we fitted two normal distributions to the datasets. Third, we calculated the LBW Z score for each of the two normal distributions:

\[ Z_{2500} = \frac{2500 - \text{mean birthweight}}{\text{SD birthweight}} \]

Fourth, we estimated the percentage of LBW (LBW%) for each of the two distribution curves:

\[ \text{LBW}(\%) = P(x < Z_{2500}) \]

(i.e., the percentage of the area under the curve \( <Z_{2500} \)). Finally, we estimated the overall LBW prevalence by calculating the LBW(%) of the full dataset, which was a weighted average of the LBW(%) from both curves. The weights used were based on the proportion of the population estimated to belong to each subpopulation.
Since data from administrative data sources in the public domain usually only provide an aggregate number of LBW livebirths—ie, total livebirths or the reported LBW prevalence without individual-level data, or both—it was not possible to adjust LBW estimates to account for missing data and heaping in these data. To our knowledge, there are no previously used markers of data quality specifically for reported aggregated LBW prevalence. To assess and categorise the quality of available national level routine data, we reviewed previously used data quality criteria from other related maternal and perinatal global estimation exercises. Of these, only population representativeness, assessed by completeness of birthweight data, was feasible to apply (appendix). Datapoints from countries with less than 80% facility births or reporting a birthweight for less than 80% of the UN estimated livebirths in a given year were excluded. We further categorised included data into higher quality administrative data (data from countries with a facility birth prevalence ≥90% and with the data source covering ≥90% of UN estimated livebirths in the given year) and moderate quality administrative data (data from countries with a facility birth prevalence of at least 80% and with the data source covering at least 80% of UN estimated livebirths in the given year, not fulfilling higher quality criteria).

Exclusions based on implausibility

We used conservative cutoffs to identify implausible LBW data. We excluded datapoints with an LBW prevalence of less than 2·1%, on the basis of the lowest population-based LBW prevalence in any country from the INTERGROWTH study. Since the INTERGROWTH study only included healthy women at low risk of pregnancy complications, including preterm birth and fetal growth restriction, the national LBW prevalence for all countries would be expected to be substantially higher than this cutoff. For example, the lowest national LBW prevalences from countries with strong national reporting systems are around 4%. The highest population-based LBW prevalence from any data source was 37%. We therefore decided to exclude datapoints with LBW prevalence greater than 40%; however, no datapoints were excluded on the basis of LBW prevalence of more than 40% (figure 1).

Estimation of LBW prevalence by year and country

We defined higher quality time series administrative data for LBW prevalence as data from countries with the earliest year of data available before 2005, the latest year after 2010 with data available for at least half of all years, and no evidence of large year-on-year variability in LBW prevalence (coefficient of variation <15%). We estimated LBW prevalence for all other countries by means of a regression model. We modelled the logarithm of LBW prevalence as the outcome variable by use of restricted maximum likelihood estimation and including a country-level random effect.

We investigated multiple predictor variables associated with LBW, including distal determinants such as geographical and socioeconomic factors, more proximal demographic and biomedical factors, and markers of perinatal outcome (appendix). We included dummy variables in the model to account for systematic bias in different data types (higher quality national administrative data, moderate quality national administrative data, and nationally representative survey). We included all potential predictors with time series data or estimates available by country for 2000–15 in the model selection process (appendix).

We assessed correlations between predictors by use of the variance inflation factor. We dropped predictors with a variance inflation factor of greater than 10 as this is likely to indicate high correlation with other predictors. We retained predictors when the direction of the coefficient was biologically plausible. We sought to maximise the predictive power of the model, while avoiding overfitting. We removed one predictor at a time from the model, commencing with the predictor with the largest value of the Bayesian information criterion (BIC) on univariate analysis, and refitted the model. If removing this predictor improved the model (lower BIC compared with the model containing the predictor), we dropped the predictor from the model. If the BIC was higher, we retained the predictor. We cycled through all the predictors once.

The final model included the logarithm of neonatal mortality rate, the proportion of children underweight (below −2SDs from median weight for age of reference population), data type (higher quality administrative data, lower quality administrative data, household survey), UN region (southern Asia, sub-Saharan Africa or other region), and a country-specific random effect (table 2). We assessed model performance by use of diagnostic plots. The model seemed to fit the data reasonably well overall ($R^2 = 0.48$), and both the estimates of the country-specific random effects (SD 0.31) and the residuals for the individual datapoints included (SD 0.11) appeared to be approximately normally distributed (appendix).

Table 2: Model coefficients for included predictor variables of low birthweight prevalence

<table>
<thead>
<tr>
<th>Predictor variable</th>
<th>Coefficient (95% CI)</th>
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<tbody>
<tr>
<td>Neonatal mortality prevalence</td>
<td>0.009 (0.005 to 0.012)</td>
</tr>
<tr>
<td>Child underweight</td>
<td>-0.615 (-0.31 to 1.260)</td>
</tr>
<tr>
<td>Region</td>
<td></td>
</tr>
<tr>
<td>Other regions</td>
<td>-</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>0.300 (0.169 to 0.4)</td>
</tr>
<tr>
<td>Southern Asia</td>
<td>0.6 (0.355 to 0.915)</td>
</tr>
<tr>
<td>Data type</td>
<td></td>
</tr>
<tr>
<td>High-quality administration data</td>
<td>-</td>
</tr>
<tr>
<td>Moderate-quality administration data</td>
<td>-0.008 (-0.0 to 0.002)</td>
</tr>
<tr>
<td>Nationally representative survey</td>
<td>0.165 (0.132 to 0.198)</td>
</tr>
</tbody>
</table>
For the 91 countries with data in the input dataset, we included the best linear unbiased prediction of the country-specific effect in the LBW prediction. For countries with no data, contributing only to the regional and global levels, we assumed the country random effect to be zero. We used high-quality national administrative data as the reference standard for prediction purposes for all countries in the higher-income regions (North America, Europe, and Australia and New Zealand). We used nationally representative household surveys as the reference for prediction purposes for countries from all other regions. We generated uncertainty ranges (URs) for modelled estimates by use of a bootstrap approach. When presenting by region we used an aggregate grouping of the United Nations regional subgroups (appendix). To obtain worldwide and regional estimates of uncertainty we summed the country LBW estimate at worldwide or regional level for each of the 1000 samples obtained from the bootstrap or B-spline approach and used the 2·5th and 97·5th centiles of the resulting distributions (appendix). Analyses were done with Stata 14.

We used livebirth estimates from the World Population Prospects: the 2017 revision 30 to estimate the absolute number of LBW livebirths (livebirths × low birthweight rate) in a given year. LBW estimates generated from all 195 countries contributed to the regional and global estimates. National-level estimates are presented for the 57 countries with higher quality time series data and 91 other countries with at least one LBW prevalence datapoint since 2000 meeting the inclusion criteria (total 148 countries; figure 2; appendix). The modelled national-level estimate generated is not shown for 47 countries without any input data.

### Role of the funding source

The funders of the study had no role in the study design, data collection, data analysis, data interpretation, or writing of the report. HB had full access to all the data in the study and all authors had final responsibility for the decision to submit for publication.

### Results

Our final dataset was 1447 country-years of birthweight data (281 million births), comprised of 1026 high-coverage and 192 moderate-coverage datapoints from administrative data sources and data from 229 surveys (figure 1; table 3; appendix). Although data were available for 148 countries, most datapoints were categorised as national administrative data, predominantly from high (65%) or upper middle-income (28%) settings. The majority (34%) of LBW datapoints meeting inclusion
criteria from low-income and lower middle-income settings were from household surveys. Countries from high-income regions had an average of 13 datapoints included compared with eight for upper-middle-income, four for lower-middle-income, and two for low-income regions (appendix). For 47 countries, no data fulfilling the inclusion criteria were located.

We estimate that the global LBW prevalence in 2015 was 14.6% (UR 12.4–17.1), compared with 17.5% (14.1–21.3) in 2000 (table 4). This represents an estimated 16.6% decline in the LBW prevalence over this period (average annual rate of reduction [AARR] 1.23%). Although the uncertainty around these estimates is sizeable, they suggest some reduction in LBW prevalence...
over this time period. The highest burden of LBW is in
the southern Asian, southeastern Asian, and sub-
Saharan African regions (table 4; figure 3). The estimated
rate of reduction in LBW prevalence is fastest in the
regions with the highest baseline LBW prevalence and
slowest in high-income regions and Latin America and
the Caribbean (table 4; figure 4). In 2015, 85 of the
148 countries with data had an estimated LBW prevalence
of less than 10%, whereas six countries were estimated to
have LBW prevalence of at least 20% (appendix).

The absolute number of livebirths with LBW globally is
estimated at 20.5 million (UR 17.4–24.0) in 2015
compared with 22.9 million (18.4–27.8) in 2000
(figure 4). This represents a 10–6% decline in the point
estimate against a 7.7% increase in the number of
livebirths overall during this period. However, in some
regions, despite reducing LBW prevalence, the overall
estimated number of LBW livebirths has increased
ingoing to demographic trends. In sub-Saharan Africa, the
number of LBW livebirths is estimated to have increased
from 4.4 million in 2000 to 5.0 million in 2015 (table 4).
Southern Asia remains the region with the largest
burden in terms of numbers, despite progress in
reducing LBW prevalence (AARR 1.37%). An estimated
9.8 million LBW livebirths were born in this region in
2015—nearly half (48%) of the worldwide total.

Discussion

We present global, regional, and national estimates for
LBW with trend estimates, which are essential for
tracking progress towards the Global Nutrition World
Health Assembly target regarding LBW. Our estimates
suggest that 20.5 million (UR 17.4–24.0) livebirths had a
birthweight of less than 2500 g in 2015. Estimated
progress in reducing LBW prevalence is slower than that required to meet the global nutrition target—\(^1\)—with an AARR of 1.23% between 2000 and 2015 compared with the required 2.74% between 2012 and 2025 to reach the target of a 30% reduction.

A strength of this work is that this LBW dataset is the largest compilation to date, including data from 148 countries and a more than 281 million births. In addition to the increased data quantity, we have applied new methods to adjust estimates on the basis of survey data that are more able to account for both data heaping and missing data. However, an important challenge is that almost half (48%) of all datapoints are from the high-income regions of North America, Europe, and Australia and New Zealand, which account for 4% of the world’s LBW livebirths. By contrast, only 13% of data are from sub-Saharan Africa and southern Asia, the regions with the highest LBW prevalence, accounting for nearly three quarters of all LBW livebirths in 2015. 47 countries—the majority (87%) low-income or middle-income—that account for 23% of all births worldwide had no data meeting inclusion criteria. This is a classic example of the inverse data law—the least data for the highest burden settings.\(^3\) In addition, when available, these data tend to be lower quality with more heaping and other challenges, which probably lead to underestimates of LBW (table 1).

Regarding trends, no high-quality LBW trend data were available for 138 countries (91 with some LBW data meeting inclusion criteria and 47 without such data), and we therefore predicted LBW prevalence by use of a statistical model. The regions with the highest estimated change in LBW prevalence (and numbers) are sub-Saharan Africa and southern Asia, where the data are most uncertain and the estimated trends are driven by changes in predictors, which might not accurately reflect true changes in LBW prevalence over the same time period. Hence, it is plausible that the true change in prevalence for LBW worldwide is lower than our estimation of 1.23%, and the gap to reach the target is even greater.

The LBW data available from the highest burden settings are predominantly from household surveys and are susceptible to bias owing to missing birthweights and heaping. From 2004 to 2017, UNICEF used a simple cross tabulation to adjust for missing birthweight by use of data from a single variable (perceived size at birth), and a crude standard adjustment for heaping that assumed that 25% of birthweights reported as 2500 g were actually below 2500 g in every survey.\(^4,5\) This previously used method had a number of important limitations.\(^6\)

Hence, we used multiple imputation to impute missing birthweights. We used several variables including perceived size. We sought to address heaping throughout the birthweight distribution by fitting a mixture of two normal distributions to the observed data to obtain an estimate of the proportion of livebirths with a birthweight of less than 2500 g. Although we believe our approach represents an advance on the previous method, it does require assumptions—namely, that missing birthweights are missing at random and that the true distribution of birthweights in a population can be well approximated by a mixture of two normal distributions.

Although we were able to adjust for heaping in the survey data for which we had individual birthweight data, we were unable to do so for national administrative data sources for which such data were unavailable. This might lead to an underestimate of the LBW prevalence from these sources when LBW livebirths with birthweights of less than 2500 g are recorded as (heaped on) 2500 g and categorised as normal birthweight.

Global estimates have well recognised limitations,\(^7,8\) and investments in data systems are needed to improve multicountry tracking of progress towards global targets. Large countries, such as India, are taking steps to improve the data. However, ongoing efforts are required to support countries in strengthening their routine reporting systems to decrease missing and erroneous birthweight measurements as part of their commitment to report on the Global Nutrition Monitoring Framework and SDGs.\(^9\)

Improving measurement of birthweight must occur alongside improvements in recording and reporting of all birth outcomes for mothers and their newborns, whether live or stillborn.\(^10,11\) Challenges arising from the low quality of some data are compounded by absence of clear,

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**Table 5: Recommendations for improving birthweight data**
Internationally harmonised guidelines on how to assess LBW data quality.

More than 80% of all births worldwide are now in health facilities, yet despite this, most of the included datapoints from the highest burden regions are from household surveys, often with relatively low proportions having a reported birthweight. Improving the coverage and quality of birthweight data is crucial to drive actions to reduce LBW and will require action at many levels of the health system (table 5). Closing the gap between facility births and accurate birthweight recording should be feasible and would transform data availability. At the individual clinical level, appropriate equipment and trained staff are needed in both the public and private sectors. Weighing devices have been available since antiquity and routine birthweight measurement has been standard practice in Europe since the late 19th century; however, accurate information on birthweight is absent for most births worldwide. For example, heaping has been shown to be worse when analogue scales are used rather than digital ones and where scales with low precision are used. There is a pressing need to develop affordable, robust, portable, and accurate weighing devices for use in both facility and community settings.

Recording of birthweight data on health cards, which can be used as a data source at the time of the survey, could substantially improve the quality of survey birthweight data and reduce the need for adjustments (table 5).

The sickest and smallest newborns are often missing from the data systems, including those who die soon after birth, or are admitted to another ward. Data system improvements and linkages are required to capture information on these most vulnerable newborns.

Misclassification of early neonatal deaths as stillbirths remains an issue. Since these babies are more likely to be LBW, this can lead to an underestimate of LBW prevalence if stillbirths are excluded. Therefore, it is important that every newborn, whether live or stillborn, is weighed at birth and that core information including birthweight and gestational age is captured within the data system.

Societal and family demand for birthweight data is an understudied issue. Little is known about family and community perceptions and demand for birthweight measurement, including cultural barriers to birthweight measurement, especially in some community settings, and for stillbirths. Innovations that increase the value parents attach to birthweight data might help recall, and lead to improved recording on handheld health cards and birth certificates.

Birthweight reflects both intrauterine fetal growth and length of gestation. Assessing measures of weight for gestational age, for example small-for-gestational age, enables these two components to be distinguished. However, challenges in assessing gestational age accurately in many low-income and middle-income countries limit its use as a routine public health measure. Debate has focused on the appropriateness of a single birthweight-for-gestational age cutoff for defining fetal growth restriction, with ethnic-specific standards associated with more accurate prediction of neonatal mortality and morbidity. Clear guidance on appropriate standards will be required as more data on gestational age become available at a national level worldwide, enabling tracking of fetal growth.

Reducing LBW requires a multifaceted approach. Even in the absence of accurate gestational age data at a national level, an understanding of the underlying pathways to LBW in a given setting is required to reduce the burden. For example, in southern Asia around half of LBW newborns are phenotypically term but small-for-gestational age, which is driven by underlying maternal undernutrition including maternal stunting. Conversely preterm birth is the major contributor to LBW in settings with many adolescent pregnancies or with high prevalence of infection (eg, in east and southern Africa) or where pregnancy is highly medicalised with high levels of fertility treatment and intensive obstetric management including high prevalence of caesarean sections (eg, the USA and Brazil). Improved birthweight data, coupled with high-quality data on gestational age, will be needed to target interventions appropriately and to track progress. Ongoing initiatives to improve CRVS and HMISs should be designed to ensure that this information is captured for all births.

We estimate that there were 20·5 million LBW livebirths in 2015 worldwide, nearly three quarters of them in southern Asia and sub-Saharan Africa. Progress in reducing LBW prevalence (AARR 1-23%) is insufficient to reach the global nutrition targets, which will require an AARR of 2-74%. Accurate birthweight data are needed for all births to improve both individual clinical care and public health action. There are large data gaps for the countries with the highest burden. In addition to better birthweight data, better gestational age assessment would help to identify the most appropriate interventions in a given setting. Targeted action to address the underlying causes of LBW (preterm birth and fetal growth restriction) and improved care for those born with LBW is needed to ensure that all realise their full potential to survive and thrive. In the SDG era, these most vulnerable babies must not be left behind.

Contributors
MdO, EB, CH, REB, and JEL contributed to overall co-ordination and overseeing of the process, and the idea was proposed by JEL. JK contributed to overall co-ordination and led the survey analysis work. HB contributed to overall coordination, collating of data sources, model fitting, and analysis. SC and GAS contributed overall statistical advice. LC contributed to administrative data collection and review, and initial data analysis. SS contributed to administrative data collection and review, model fitting, administrative data analysis, and preliminary survey analysis. XA contributed to survey analysis. VPH contributed to the data analysis and figures. MdO, DE, and CH contributed to co-ordination of the country consultation. The authors alone are responsible for the views expressed in this Article and they do not necessarily represent the views, decisions or policies of the institutions with which they are affiliated.
Declaration of interests
We declare no competing interests.

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Low birthweight: will new estimates accelerate progress?

Birthweight is an important gauge of maternal and fetal health as well as an important determinant of perinatal, neonatal, and postneonatal outcomes. Approximately 80% of newborns who die every year are low birthweight (LBW), under 2500 g, because they were either born preterm or small for gestational age or both. LBW newborns who survive have a greater risk of both short-term and long-term adverse health consequences.

In 2012, countries committed to a 30% reduction of LBW by 2025 as one of the Global Nutrition targets. Monitoring trends within and across countries is necessary to track progress and crucial to achieving the Sustainable Development Goal for health. UN agencies have previously tracked LBW estimates by means of non-comparable, national data sources, making it difficult to interpret and respond to patterns.

In *The Lancet Global Health*, Hannah Blencowe and colleagues present the first systematic estimates of global, regional, and national LBW trends that incorporate new data sources and analytical approaches to adjust survey data for heaping and missing data. The authors collated data from national administrative sources and nationally representative surveys for 148 of 195 UN member states. They estimated a worldwide LBW prevalence in 2015 of 14.6%, resulting in 20.5 million LBW livebirths, with 91% from low-and-middle income countries. The global trend estimate presented shows an average annual rate of reduction in LBW of only 1.23% between 2000 and 2015, well short of the estimated 2.74% required to meet the target.

Their work brings to light the enormous inequities in data availability. Nearly half of all datapoints (48%) were from high-income countries. Only 13% of input data came from sub-Saharan Africa and south Asia, the regions with the highest LBW prevalence. National administrative data came predominantly from high-income (65%) or upper-middle-income (28%) settings whereas for low-income and lower-middle-income settings, 54% of LBW datapoints were from household surveys. Furthermore, 47 countries had insufficient data to generate a national estimate, 62% of these being low-income and lower-middle-income countries.

Data on LBW prevalence is needed to assist countries in developing action plans and accountability measures and to monitor progress; yet many barriers prevent accurate LBW measurement. It is estimated that globally the birthweight of 48% of infants is not recorded, either because they are born outside of health facilities, or in ill-equipped health facilities, or because of weak health information systems. Routine administrative data sources, such as the District Health Information System 2 and civil registration and vital statistics systems, should be capturing data on birthweight. Investments in strengthening these routine data systems could provide disaggregated information to enable greater local and national use of data for action. In settings where routine information systems remain weak, surveys continue to be an important source for LBW data; and this paper has shown that analytical methods can be used to adjust for methodological biases.

The authors present an urgent and practical call to action to greatly improve the coverage of weighing at birth, including the need to count and weigh all babies (livebirths and stillbirths), strengthen existing data and health systems, and innovate better weighing devices. Yet achieving this practically, especially in emergency settings or weak health systems, remains a challenge. Although the paper calls for accurate gestational age measurement, which is a desperately needed component of high-quality antenatal care, birthweight remains a highly important and relevant indicator since accurate gestational age measurement is unlikely to be done systematically in the immediate future in many settings where the burden is greatest.

Alongside improving measurement, multidimensional, context-specific national action plans are needed to achieve the Global Nutrition targets with support from funders and implementation partners. These should include improving nutritional status of women and girls, before and during pregnancy; treating pregnancy-associated conditions such as pre-eclampsia; and providing quality antenatal care. Furthermore, feasible, cost-effective interventions exist to reduce adverse outcomes amongst LBW newborns, such as kangaroo mother care and household interventions such as early stimulation. Strong community-facility linkages are also required to identify and refer pregnant women at high risk of newborn or to address behavioural and social norms that negatively affect the care and survival of these babies. Digital health
Comment

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approaches, such as MomConnect in South Africa, also show promise.10

With continued momentum on child survival and health, including early childhood development,2,11,12 these new LBW estimates provide an opportunity to advance the agenda and call on all stakeholders to take concerted action in the effort to ensure that every newborn is weighed at birth, and that the information is collated and used for local action and accountability at the household, community, district, national, and global levels. At the same time, we must improve care for the 20·5 million LBW infants and their families each year.

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