external radiotherapy, somatostatin analogues, CVD chemotherapy, therapeutic doses of high-specific activity [131][I]meta-iodobenzylguanidine, peptide receptor radiotherapy, and molecular targeted drug therapy) based on clinical findings, such as assessment of the rate of tumour progression, biochemical phenotypes, nuclear imaging findings, and germline genetic testing-based molecular clusters.[6,15] The establishment of multidisciplinary teams in specialised centres for determining individualised treatment strategies and the development of more effective novel molecular targeted drugs according to the methods meticulously established by the FIRSTMAPPP trial are eagerly awaited.

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Accelerating the progress of low birthweight reduction

Low birthweight (LBW) is associated with multiple adverse effects including neonatal mortality, growth and development retardation, and higher risk of chronic diseases in adulthood, such as hypertension, cardiovascular diseases, and type 2 diabetes.[1] A 30% reduction in LBW between 2012 and 2030 is one of the Global Nutrition Targets, and achieving this target could also aid progress towards other Sustainable Development Goals (SDGs), including those relating to neonatal mortality and SDG2 to eliminate malnutrition.

In this issue of *The Lancet*, Yemisrach B Okwaraji and colleagues[2] urge the acceleration of progress in LBW reduction to achieve this global target. They report that global LBW estimates for 2020 are about 19·8 million (95% credible interval 18·4–21·7 million), equivalent to 14·7% (13·7–16·1) of liveborn newborns at that time.[2] Almost three-quarters of these LBW newborns were born in southern Asia (44·5%) and sub-Saharan Africa (27·1%). Around two-thirds of LBW newborns were in the 2000 g to less than 2500 g subcategory within northern America, Australia and New Zealand, central Asia, and Europe. The estimated average annual rate of reduction (AARR) was 0·3% per year between 2012 and 2020 worldwide, which is much lower than required to achieve the 2030 target.[2]

The key strength of the study by Okwaraji and colleagues[2] is that 2042 administrative and survey datapoints for LBW prevalence were systematically collected from 158 (81%) of 195 countries and areas worldwide, covering 75% of global livebirths with LBW

data. A Bayesian method is applied to model the LBW trend from 2000 to 2020, which maximises the use of the available data and accounts for regional variation and data quality bias. Additionally, for the first time to our knowledge, LBW is reported by subcategory within northern America, Australia and New Zealand, central Asia, and Europe.

The study also has some limitations.[2] The availability of LBW data could affect the trend estimates. Administrative source data were available for 113 countries and areas, household survey data were identified for 95 countries and areas, and no data on LBW were available for 37 countries and areas. Data source and quality could also introduce bias into the LBW estimates.

Improving the quality of LBW estimates in the future will require strengthening routine data collection systems, increasing the facility birth rate, supplying and using standardised electronic scales, and training health-care workers to measure and record birthweight correctly.[1,3] Improving health information systems is also important to minimise recall bias and to increase the quantity of individual-level data available for estimating the LBW prevalence. Either low-quality birthweight records or recalled birthweight could show data heaping, especially for birthweights of 2500 g, which could have a direct effect on the estimation of LBW prevalence. Adjusting for data heaping would be more appropriate for estimating LBW in such a situation.[4] Improving

data availability and quality is crucial to monitor the reduction of LBW globally.

To accelerate the progress of LBW reduction, LBW could be specified as preterm, small for gestational age (SGA), or both on the basis of cause, as proposed by the *Lancet* Small Vulnerable Newborn Series team.[3] The number of preterm births was estimated at 13·4 million with a prevalence of 9·9% in 2020, with no downward trend from 9·8% in 2010.[5] Preterm births could contribute about two-thirds of LBW newborns,[6] with the other third possibly related to SGA births.[6] Additionally, older age at childbearing and medically assisted reproduction could increase the risk of LBW and preterm delivery.[7,8]

Maternal nutrition, infection, and environmental exposures contribute about half of preterm births and 39% of SGA births in low-income and middle-income countries (LMICs).[1] Maternal nutritional status has the greatest population-attributable fraction for SGA births in LMICs.[9] Adequate nutrition over the life course is crucial for a healthy pregnancy and delivery of a newborn with normal weight. However, maternal undernutrition remains a concern in low-income countries and among the poorest households in middle-income countries.[10] Supplementation with multiple micronutrients and balanced energy and protein supplements, and supplementation or fortification of foods with folic acid, could be fully implemented for undernourished pregnant women to decrease the risk of SGA and preterm births.[11,12] Maternal nutrition counselling during antenatal care is important for women to improve the quality of their diet. More studies into the effects of a healthy diet on SGA and preterm birth reduction are warranted to implement healthy diet interventions during pregnancy. Gestational weight gain is a valuable indicator for monitoring the health of a pregnancy; however, data on gestational weight gain are missing for many LMICs.[10] Identifying an ideal range for gestational weight gain will be necessary to minimise SGA and large-for-gestational-age births globally.

LBW reduction to achieve the 2030 target remains a great challenge for the global community. Strengthening the monitoring of LBW and implementing comprehensive interventions before and during pregnancy are crucial to accelerate LBW reduction.

We declare no competing interests.

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Making COP28 rhetoric a reality

The outcomes of the 28th Conference of the Parties UN Climate Change Conference (COP28) held in Dubai, United Arab Emirates, in December, 2023, have been welcomed by some commentators, notably for the launch of the Loss and Damage Fund, the first Health Day, the Declaration on Sustainable Agriculture, Resilient Food Systems and Climate Action, and the first inclusion of fossil fuels in the official negotiations.[1] Other commentators have argued that these steps, while important, are insufficient to tackle the climate crisis taking us beyond the 1·5°C global temperature commitment of the Paris Agreement.[1,2] Such critiques are instructive, but it is now crucial to focus on pathways forward to ensure that the promises made at COP28 become reality. We propose that to operationalise such promises, and in ways that advance planetary health equity, there is an urgent need for national regulations and international treaties centred on mitigation.

In the first COP Declaration on Climate and Health, signed by more than 120 countries at COP28, nation states committed to develop and implement policies to "maximize the health gains" and "prevent worsening health impacts", while also integrate health in climate policies.[3] Climate change mitigation is arguably the biggest preventive health action possible in this area.[4–6] Therefore, if countries included in their next nationally determined contributions

(NDCs), which set out the country targets to meet the objectives of the Paris Agreement and are due by the end of 2024, the development and implementation of mitigation policies focused on "transitioning away from fossil fuels" and "shifting […] to more sustainable (agricultural) production and consumption approaches", human health would vastly improve.[5,7,8]

In the Global Stocktake at COP28 (the negotiations outcome document that assessed the state of the commitments made with the Paris Agreement), countries committed to "transitioning away from fossil fuels in energy systems, in a just, orderly and equitable manner".[7] Equity, both within and between countries, must be at the centre of the development of these policies. However, prioritisation of profit in the current economic system has downgraded equity considerations, while creating power dynamics that increase inequities, with big corporations such as the fossil fuel industry having power over governments.[9] However, governments' actions, such as the removal of fossil fuel subsidies, can shift financial support from the polluters to the people, especially those most affected by pollution and climate change.[5] This additional public money could be invested in environmentally sustainable housing, jobs, and transport to help people transition to a life less dependent on fossil fuels. Internationally, a Fossil Fuel Non-Proliferation Treaty, currently supported by 12 nation states,[10] with Colombia,