ACTING ON THE CALL

ENDING PREVENTABLE CHILD AND MATERNAL DEATHS: A FOCUS ON EQUITY

JUNE 2016

USAID
FROM THE AMERICAN PEOPLE

Cover Photo: Amy Fowler/USAID

FOREWORD

By Ariel Pablos-Méndez
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Today, we stand at a turning point in history.

For the first time, we see within our reach a world in which no child dies from preventable causes, no matter where he or she is born. A world in which no woman dies from childbirth complications that we know how to prevent, no matter the country in which she lives. A grand convergence in health, in which women and children in the poorest communities have the same access to quality health services as those in the wealthiest. All of this is within our grasp.

Although our goal to end preventable child and maternal deaths within a generation may sound ambitious, global progress over the course of the previous generation has demonstrated that it is attainable.

Over the past two and a half decades, the world has reduced child mortality by more than half, and maternal mortality by nearly as much. Each day this year, 18,000 fewer children will die than on each day in 1990, and 630 fewer women will die during childbirth. And since 2008 alone, U.S. Agency for International Development (USAID) efforts have contributed to saving the lives of 4.6 million children and 200,000 women.

Behind each of these numbers is a child who will live to celebrate a fifth birthday, and a mother who will live to see her child grow.

In 2012, global leaders convened in Washington, D.C. for the Child Survival: *Call to Action* and committed to ending preventable child deaths within a generation. Two years later, USAID released the first *Acting on the Call* report, which laid out a roadmap to save 15 million children and 600,000 women by 2020.

Then with the 2014 *Acting on the Call* report, we formulated country-specific plans for expanding interventions that would have the greatest impact on child and maternal mortality rates in 24 priority countries, that together account for more than two-thirds of child and maternal deaths worldwide. We followed up in 2015 with country-by-country updates, examining the progress made over the past year and providing new recommendations for reaching 38 million women with increased access to high-quality health services around the time of delivery.

This year, in the 2016 *Acting on the Call* report, we again detail our progress over the past 12 months, and further outline how, with a new emphasis on equitable access to health care which focuses on the poorest 40 percent of the population, we can save 8 million lives, or nearly three-quarters of the remaining gap to achieve our goal by 2020.

Our findings speak to the lifesaving impact that these focused efforts are having. In India, we saw a 13 percent reduction in neonatal mortality in USAID-supported facilities targeted with a quality improvement methodology. For the first time ever, every health zone in the Democratic Republic of Congo received malaria program coverage. In Ghana, nearly 15,000 community health volunteers have been trained in infant and young child feeding to prevent and cure under-nutrition in children. In Liberia, as we work to strengthen health systems, there are now 200 more health facilities that can provide 24-hour emergency obstetric care.

Now is not the time for complacency. In those countries that have made the greatest progress, we must build on our success. In those countries that have provided more challenges, we must revisit our approach to identify and implement the most successful courses of action. Although globally the number of under-5 deaths is decreasing each year, the number of births remains steady thus requiring health systems to remain responsive.

We are now better positioned than ever to accelerate global progress, working in partnership with target countries to invest their increasing domestic resources for health. This past year marked a global transition that will galvanize our collective efforts with renewed energy. The Sustainable Development Goals (SDGs) set 17 new ambitious targets. The child mortality SDG goal reflects global embrace of the analytical work done for USAID's 2012 *Call to Action* summit.

We have the tools and the knowledge to achieve our goals. We have the expertise and the resources. And, we are grateful to have bipartisan support for these efforts as well as the support and contribution of many partners in the US and around the world. Now it is time that we demonstrate the devotion, and the determination to end preventable child and maternal deaths within a generation.

Photo: Amy Fowler/USAID

ACTING ON THE CALL

Ending Preventable Child and Maternal Deaths: A Focus on Equity
June 2016

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Photo: David Rochkind/USAID

ACRONYMS

ANC Antenatal Care

AOTC *Acting on the Call*

ARR Annual Rate of Reduction

(B/C)EmONC (Basic/Comprehensive) Emergency Obstetric and Newborn Care

BMGF Bill & Melinda Gates Foundation

CBHI Community-Based Health Insurance

CHW/FCHV Community Health Worker, Female Community Health Volunteer

DfID Department for International Development (UK)

DHS Demographic and Health Survey

DTP Diphtheria, Tetanus, Pertussis vaccine

EPCMD End(ing) Preventable Child and Maternal Deaths

EPI Expanded Program on Immunizations

FP Family Planning

FP2020 Family Planning 2020

GAIN Global Alliance for Improved Nutrition

GFF Global Financing Facility

GO$ Government of [country name]

GVAP Global Vaccine Action Plan

HIV Human Immunodeficiency Virus

HMIS Health Managment Information System

HQI Harmonized Quality Improvement

HSS Health Systems Strengthening

iCCM Integrated Community Case Management

IDB International Database

IGME Interagency Group for Child Mortality Estimation

IMCI Integrated Management of Childhood Illness

LiST Lives Saved Tool

MCH/MNCH/RMNCAH Maternal and Child Health, Maternal, Newborn and Child Health, Reproductive, Maternal, Newborn and Child & Adolescent Health

MCPR Modern Contraceptive Prevalence Rate

MDGs Millennium Development Goals

MICS Multiple Indicator Cluster Surveys

NGO Non-Governmental Organization

ORS Oral Rehydration Solution

OOP Out-of-Pocket expenditure

PMNCH Partnership for Maternal, Newborn, and Child Health

PPH Post Partum Hemorrhage

RED/C-QI Reaching Every District/ Community-Quality Improvement

SBCC Social and Behavior Change Communication

SDGs Sustainable Development Goals

U5MR Under-5 Mortality Rate

UNFPA United Nations Population Fund

UNICEF United Nations Children's Fund

USAID U.S. Agency for International Development

USG United States Government

WASH Water, Sanitation and Hygiene

WHO World Health Organization

WQ Wealth Quintile

INTRODUCTION
ACTING ON THE CALL: YEAR TWO REPORT

For USAID, *Acting on the Call* (AOTC) is a continuous improvement process in the Agency's drive to end preventable child and maternal deaths (EPCMD). Starting in 2012 with the *Call to Action*, USAID embraced strategic programming shifts and a bold endgame to help USAID priority countries reach parity with more developed countries in child mortality. In 2012 we estimated that to reach this goal, EPCMD countries would need to achieve an average annual rate of reduction (ARR) of under-5 deaths of 4.1 percent. Between 2012 and 2015, we have achieved an ARR in our countries of 3.6 percent, indicating a need for further progress. Despite the need for additional work, some countries are on track to meet these expectations. Based on country specific target ARRs, Bangladesh, India, Indonesia, Malawi, Nepal, Rwanda, Senegal, Tanzania, and Uganda are on track to achieve the SDGs under-5 mortality target of 25 child deaths per 1,000 live births by 2030.

In 2014, with the *Acting on the Call* report, USAID together with partner countries, demonstrated, how a focus on high impact solutions such as access to quality and respectful care during delivery, clean cord treatment for newborns, and strengthening routine immunization in our 24 priority countries could put them on a path to achieve an end to preventable child and maternal deaths. In 2015, while reporting on progress to date, we also elaborated on high-impact interventions for maternal health that could provide increased access to delivery care for 38 million women in priority countries.

This 2016 *Acting on the Call* report specifically addresses equity, the notion that everyone should have a fair opportunity to reach their full health potential. In addition to an overall progress report, it looks at how we can further accelerate impact through an equity-based approach. The report presents data from the 24 priority countries, describing what could be achieved if the bottom two wealth quintiles (the bottom two-fifths or 40 percent of the population when sorted by level of wealth) had the same opportunities and access to health interventions as the rest of the population. It looks more closely country by country at those interventions where inequities in coverage and access occur. The accompanying technical briefs examine the various ways programs can address equity issues, in some cases suggesting novel solutions or new ways to look at data to understand and address inequity.

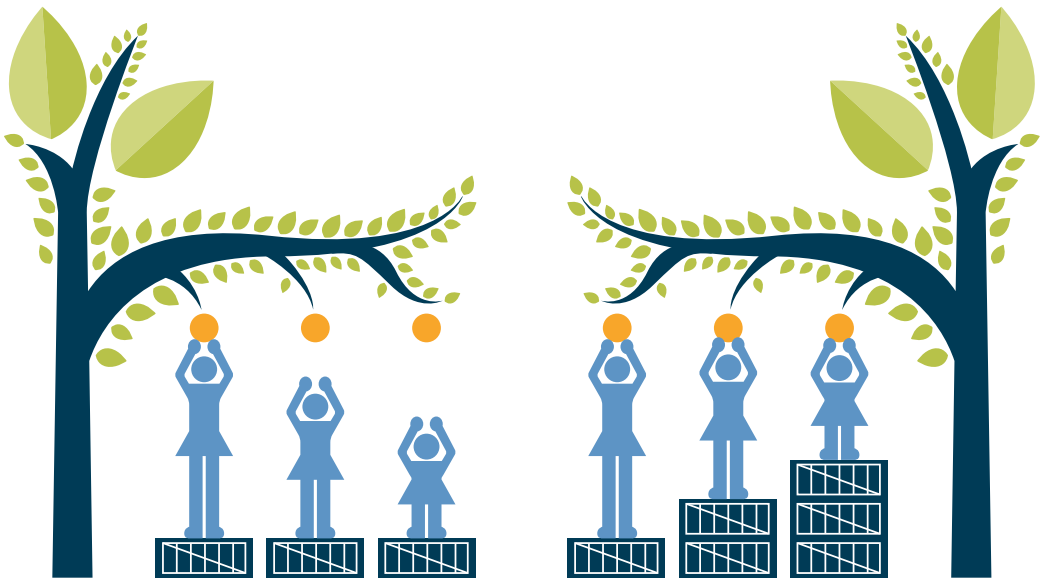


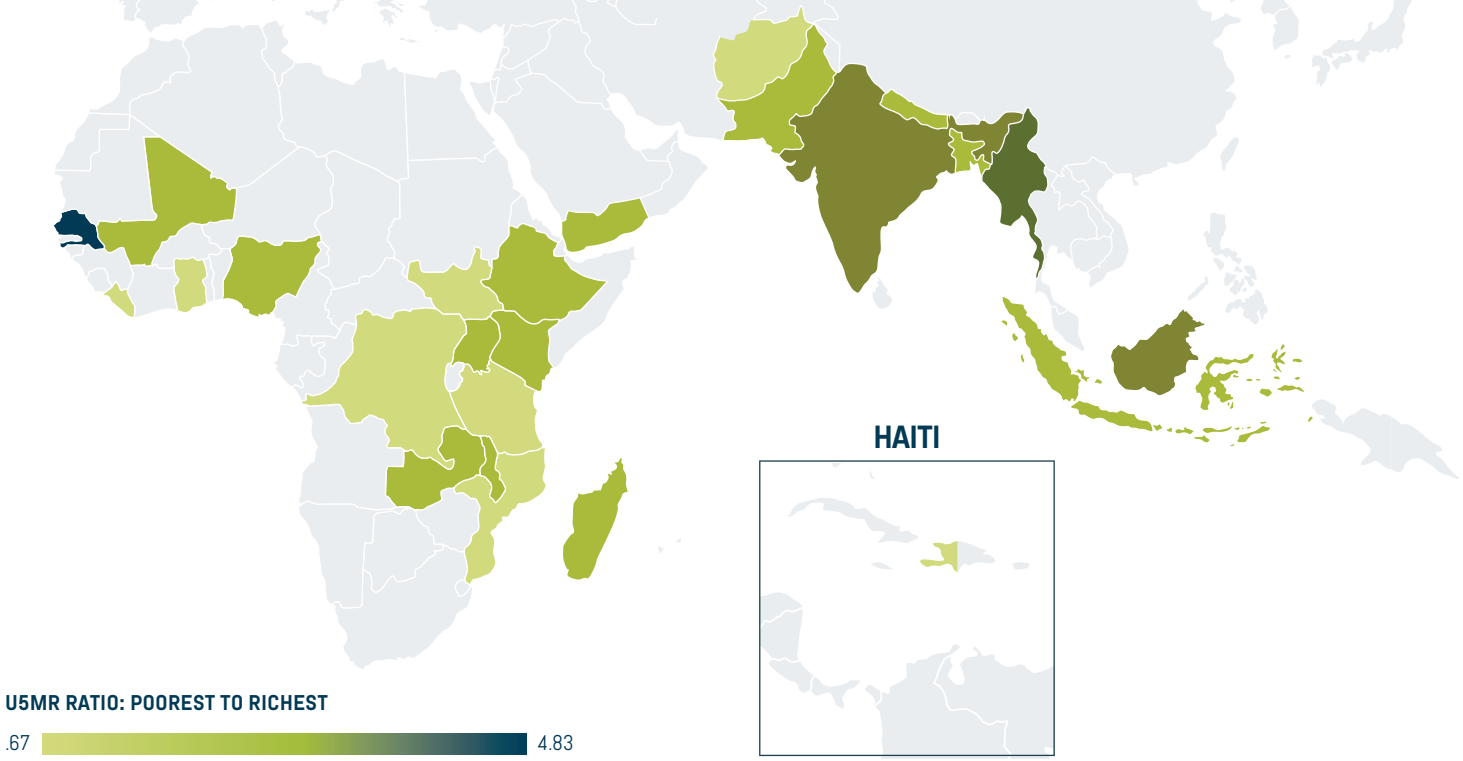
Photo: USAID

Fatima delivered her baby at the Smiling Sun Clinic in Tongi, just north of Dhaka, Bangladesh. Her first pregnancy and home delivery ended in a stillbirth. Back then she chose to give birth at home because she could not afford a skilled provider. Upon hearing she could go to Smiling Sun Clinic for free, Fatima went to the clinic for care during her second pregnancy. The 17-year-old Tongi facility is one of 300 Smiling Sun Clinics in the country, and serves 94,000 people through its main and satellite facilities. USAID provides financial support to Smiling Sun Clinics around the country. The clinics serve the poorest of the poor for free, and charge a partial payment to those with modest incomes. Other clients pay for 100 percent of their services, which helps ensure sustainability of the clinic is high if donor funding ceases. The clinic is open six days per week, but emergency obstetric care is available 24 hours every day. Fatima can stay in the facility until she is healthy enough to go home. While at the clinic she is being counseled on healthy behaviors such as breastfeeding and vaccinations for her baby.

Fatima's story exemplifies the need for an equity-based approach to health improvement in poor countries. Equality in programs and services is based on the principle that everyone has an equal right to access those programs and services. Equity supports and enhances equality by recognizing that some groups within society have less access to programs and services than others, and that steps should be taken to rectify this. In Fatima's case, she was not aware that she could access the Smiling Sun Clinic during her first pregnancy, even though it was available. Achieving equity means successfully reaching those people who are otherwise marginalized and less able than others to access those services. Often these are the poorest members of society. This is because they cannot afford services and also because they are more likely to be marginalized in other ways. Therefore, they may not have access to the information required to address their health care needs, even if the system exists. This additional exclusion may be due to cultural differences, educational differences, or other societal aspects leading to a lack of political and economic power for certain groups. What constitutes equity is dependent on the local situation, and programming to address equity requires an analysis of many factors contributing to unjustifiable differences in health outcomes.

UNDER-5 MORTALITY RATE

RATIO OF POOREST 20% TO RICHEST 20% IN MOST RECENT HOUSEHOLD SURVEY (2006-2014)



"WHO IS BEING EXCLUDED?"

NIGERIA

In **Nigeria** (2013) **18.8%** of all children failed to receive a single intervention

of these		*compared to*	of all children
62%	belong to the poorest quintile		23%
93%	from the rural areas		64%
50%	are girls		50%
89%	have mothers with no education		49%
26%	live in the Northeast region		18%
57%	live in the Northwest region		36%
6%	have adolescent mothers		4%

MADAGASCAR

In **Madagascar** (2008) **4%** of all children failed to receive a single intervention

of these		*compared to*	of all children
60%	belong to the poorest quintile		25%
99%	from the rural areas		89%
45%	are girls		49%
66%	have mothers with no education		25%
12%	live in Androy region		3%
13%	live in the Atsimo Andrefana		7%
11%	have adolescent mothers		8%

HAITI

In **Haiti** (2012) **1.3%** of all children failed to receive a single intervention

of these		*compared to*	of all children
59%	belong to the poorest quintile		22%
86%	from the rural areas		64%
58%	are girls		49%
54%	have mothers with no education		22%
10%	live in Grand'anse region		4%
13%	live in the South region		8%
2%	have adolescent mothers		4%

Interventions included: Improved source of drinking water, tetanus toxoid in pregnancy, at least one antenatal care visit with a skilled provider, skilled birth attendance, immunizations (BCG, DTP and measles) and vitamin A supplementation (Demographic Health Surveys (DHS), 2011). Analyses performed by the International Center for Equity in Health, Federal University of Pelotas, Brazil.

PAKISTAN

In **Pakistan** (2012) **1.8%** of all children failed to receive a single intervention

of these		*compared to*	of all children
81%	belong to the poorest quintile		24%
96%	from the rural areas		70%
23%	are girls		49%
93%	have mothers with no education		58%
36%	live in Baluchistan region		5%
32%	live in Sindh region		23%
3%	have adolescent mothers		1%

ETHIOPIA

In **Ethiopia** (2011) **10.5%** of all children failed to receive a single intervention

of these		*compared to*	of all children
36%	belong to the poorest quintile		22%
98%	from the rural areas		87%
47%	are girls		48%
84%	have mothers with no education		70%
7%	live in the Somali region		3%
5%	have adolescent mothers		3%

MOZAMBIQUE

In **Mozambique** (2011) **2.9%** of all children failed to receive a single intervention

of these		*compared to*	of all children
57%	belong to the poorest quintile		23%
99%	from the rural areas		72%
50%	are girls		50%
65%	have mothers with no education		37%
73%	live in Zambésia region		21%
8%	live in Niassa region		6%
3%	have adolescent mothers		6%

SOUTH SUDAN

In **South Sudan** (2010) **12.7%** of all children failed to receive a single intervention

of these		*compared to*	of all children
29%	belong to the poorest quintile		21%
89%	from the rural areas		76%
45%	are girls		49%
98%	have mothers with no education		84%
26%	live in Warrap region		14%
17%	live in Upper Nile region		12%

MALI

In **Mali** (2012) **4.8%** of all children failed to receive a single intervention

of these		*compared to*	of all children
51%	belong to the poorest quintile		21%
99%	from the rural areas		81%
53%	are girls		49%
99%	have mothers with no education		84%
35%	live in Mopti region		13%
22%	live in Segou region		19%

AFGHANISTAN

In **Afghanistan** (2010) **11.7%** of all children failed to receive a single intervention

of these		*compared to*	of all children
50%	belong to the poorest quintile		21%
97%	from the rural areas		84%
46%	are girls		49%
98%	have mothers with no education		91%
17%	live in the South region		12%
20%	live in the West region		12%

DEMOCRATIC REPUBLIC OF CONGO

In **Democratic Republic of Congo** (2013) **2.5%** of all children failed to receive a single intervention

of these		*compared to*	of all children
53%	belong to the poorest quintile		22%
98%	from the rural areas		69%
47%	are girls		50%
42%	have mothers with no education		19%
27%	live in Katanga Oriental region		11%
23%	live in Equateur region		14%
5%	have adolescent mothers		6%

INDIA

In **India** (2005) **1.8%** of all children failed to receive a single intervention

of these		*compared to*	of all children
70%	belong to the poorest quintile		25%
97%	from the rural areas		74%
47%	are girls		47%
85%	have mothers with no education		50%
16%	live in the Rajasthan region		6%
20%	live in the Uttar Pradesh region		16%
4%	have adolescent mothers		4%

YEMEN

In **Yemen** (2013) 1.8% of children failed to receive a single intervention

of these		*compared to*	of all children
27%	belong to the poorest quintile		23%
73%	from the rural areas		73%
47%	are girls		48%
74%	have mothers with no education		56%
10%	live in the Sanaa City		8%
10%	live in the Ibb region		11%
1%	have adolescent mothers		2%

Photo: Amy Fowler/USAID

Reducing inequities helps improve global development

The global community has recognized the importance of addressing equity within the framework of the SDGs, and equity is a critical component of several of the SDGs.[1]

This focus on equity helps strengthen the linkages between health and other development sectors by concentrating attention on the most vulnerable populations. If certain population subgroups are continually underserved by the health system, therefore suffering a disproportionate burden of morbidity, this endangers the well-being of societies at large and can even hold back health progress for the most advantaged.

Ensuring that vulnerable populations can reach their full health potential means that children will be both developmentally and economically able to go to school. This will occur because of improved nutrition in the first 1,000 days, effective utilization of quality health care services, and fewer illnesses. Better educated children are more likely to delay marriage and pregnancy, subsequently care for their own children, and are more likely to be economically productive members of society. Increased labor force participation reduces instability and violence in societies. Attention to health equity can lead to a virtuous cycle of improvement, enabling countries to reach the SDGs. Equity-focused programs concentrate resources where they have the most potential to do the most good, and such equity-based approaches can be more cost effective in saving lives.[2]

USAID's effort to end preventable child and maternal deaths sets ambitious targets based on the notion that all of our priority countries can be assisted to sharpen programs and accelerate progress at a pace previously achieved by "best performers." Achieving this vision requires that programs be implemented to the highest standards of effectiveness, relying on new research into the best approaches, and utilizing implementation approaches that stretch every dollar. These include looking for new partnerships and new financing tools, and continuing to identify ways to improve the cost effectiveness of our efforts, such as through an equity-based approach focusing on the bottom 40 percent of the population.

2030 AGENDA FOR SUSTAINABLE DEVELOPMENT

Source: The Sustainable Development Goals are a UN Initiative.

Monitoring Programs for Equity

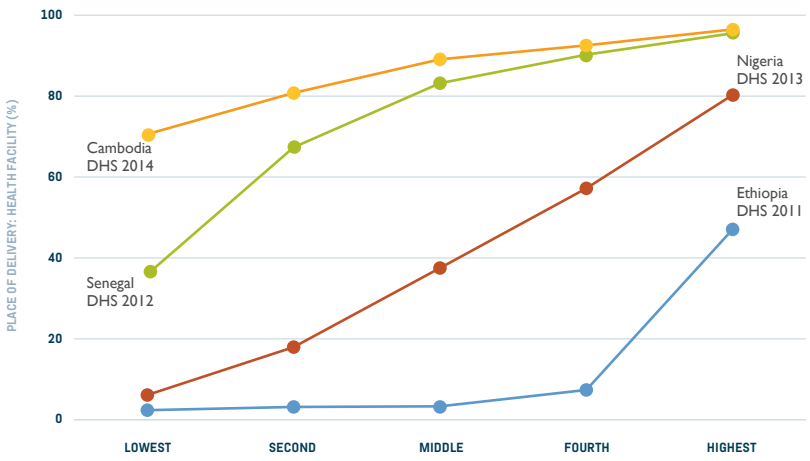
The SDGs emphasize the importance of looking at program data through an equity lens. This means disaggregating data by wealth quintile or other equity stratifiers: education, social class, sex, province or district, place of residence (rural or urban), race or ethnic background, and any other characteristic that can distinguish minority subgroups (e.g., language or immigrant status). It also means examining trends in equity that are masked when only national trends are examined.

Overall, improvements may disproportionately affect better off segments of the population, masking those left behind. Inequity can increase even as national indicators are showing progress. Attention to equity issues can lead to greater success in achieving national goals such as ending preventable child and maternal deaths.[3]

When we look at inequity on a population level, it is important to recognize that different countries require different approaches to improve overall population health in an equitable way. Describing individual country patterns of inequity is an effective way to communicate the problem, and may help to indicate appropriate responses. The patterns will vary across countries and across interventions.

Figure 1 highlights coverage of facility delivery by wealth quintile in four selected countries where USAID implements maternal and child health programs, including three EPCMD priority countries.

FIGURE 1: **FACILITY DELIVERY (%) BY COUNTRY AND WEALTH QUINTILE, 2011-2014**



Source: ICF INTERNATIONAL, DHS, 2011-2014

- In Cambodia, the majority of births are delivered in a health facility, even among the poorest quintile of the population, indicating relatively high achievement, despite the need for some further attention to the poorest population group.
- In Senegal, fewer than 50 percent of pregnant women in the poorest quintile deliver in a health facility. In contrast, the majority of women in the upper four quintiles deliver in a health facility, indicating a marked exclusion within the bottom quintile which must be understood and addressed.
- Nigeria shows the most extreme differences in coverage of facility delivery between the poorest and the wealthiest, and a linear increase in coverage from quintile to quintile, indicating that issues associated with equity and exclusion must be addressed within each group.
- Ethiopia shows a pattern of need across the population. Fewer than 10 percent of pregnant women in the bottom four quintiles deliver in a health facility, whereas almost 50 percent of women in the highest quintile do. Equity-based programmatic approaches may be less specifically targeted to the poorest population groups compared to countries such as Senegal and Cambodia, as the need cuts across most of the population.

Photo: Amy Fowler/USAID

Equity-based programmatic approaches

Beyond a close examination of the data to identify inequities, addressing health equity requires looking deeply into programs to understand why specific disadvantages occur, and then working to address them.

In some countries, these disadvantages may be geographically-based. For example, this year in Ghana, USAID successfully pivoted the health portfolio to some of the most underserved areas of the country to address lagging health indicators in the Northern region.

Disadvantages may also stem from access to equipment or services. According to Dr. Patrick Ubi, the former chief at General Hospital Akampa in Cross River State, Nigeria, the facility lacks appropriate equipment, including an ultrasound machine, incubator, and functional delivery beds, as well as training and skills for personnel. There is also no water, unreliable power, and women in labor must cross a 30-year-old rickety bridge to reach the facility. Though delivery is free in public facilities, women needing an ultrasound are referred to private facilities, where they must pay for the service. The hospital carries out 20 deliveries a week, including three cesarean sections. Because of the lack of equipment and personnel, Dr. Ubi who is still on staff at the hospital, has difficulty completing all necessary obstetric services. He is hopeful that a public-private partnership led by USAID and known as "Saving Mothers, Giving Life" can help alleviate some of these problems so that he can provide every woman that comes to his facility the care they deserve.

Inequitable distribution of resources is frustrating for both users and providers. Like Dr. Ubi, providers want to help their patients and are frustrated by lack of resources, or they refer patients for needed services, only to discover patients can't access those services due to transportation or financial barriers, or lack of knowledge about availability.

Financial barriers are another significant cause of inequity when accessing health care. Families may not be able to afford care, or they may not be aware of resources available to provide affordable care. In Indonesia, USAID is working to ensure the poorest and most vulnerable women are aware of their insurance status and know how to use it to access the health system, particularly for maternal and neonatal health services.

Even when all the needed resources to deliver health services (trained providers, commodities, facilities, etc.) are available, and users are able to access care, users may still feel they are unfairly treated by health care providers. They may experience care differently due to language barriers, crowding in facilities or other forms of discrimination, leading to avoidable inequities in health outcomes.

Often, more than one reason accounts for inequities, and our programs must work to address multiple issues simultaneously.

Key questions a USAID program manager must ask to understand and address the root causes of inequities:

- Are programs more accessible to certain population groups? If so, why, and what can be done to address that?
- Are programs designed to address the health needs of the most vulnerable and marginalized?
- How are new interventions or programs introduced? Do they spread out from the capital, or is an effort made to introduce them to more vulnerable populations first?
- Is the most appropriate delivery channel being used to get services to the most vulnerable? For example, are community-based approaches used if facilities are not accessible to everyone?
- Are there unseen financial barriers to accessing care—including out-of-pocket payments for services, but also potential transportation costs, etc.?
- Is the program being monitored or evaluated from an equity perspective?

The 2016 *Acting on the Call* Report

This 2016 *Acting on the Call* report examines equity from various perspectives.

The report begins by examining inequities in health financing. Health financing impacts equity when the poor pay more for health services. USAID focuses on increasing public and private domestic resource mobilization as well as developing novel financing partnerships like the Global Financing Facility (GFF) for Every Woman, Every Child.

The report next looks at looks at equity on a country by country basis and in the context of our best performer modeling to understand where we are in terms of progress toward our goals, and how they can better be achieved through an equity-based approach. On the country pages we depict current inequities in under-5 mortality by showing the distance each quintile must go to reach the "best performer" targets for 2020 established by our *Acting on the Call* report in 2014. We also show that significant progress toward our 2020 lives saved goals can be achieved by focusing our efforts on the poorest women and children. On average nearly three quarters of our target can be met through a focus on 40 percent of the population. We use example indicators to show how such an effort would eliminate major inequities.

Following the country pages, each of our technical areas provides a unique lens on equity issues that serve to demonstrate the complexity of this issue. This section begins with a look at how service delivery choices within the health system impact equity related to child health. Using the example of immunization, we show how continuity of care is important to equity especially for an intervention requiring repeated contacts with the health system. In examples from treatment of child illness, we demonstrate how equity may be achieved by using a case-management approach, and by incorporating private sector delivery channels into an equity-based approach.

Child health also provides a contrast with family planning when looking at equity trends over time. Whereas we see widening equity gaps with respect to child mortality, examples from family planning demonstrate how overall progress can be achieved while also reducing equity gaps between wealthy and poorer populations.

The report then begins to examine equity issues beyond wealth. Mistreatment of pregnant women, especially those in vulnerable groups, is an important equity issue that affects both maternal and newborn outcomes and is also a human rights issue. Social and behavior change communication (SBCC) is important across our health programs. Achieving impact through SBCC requires careful segmentation of populations and targeting messages to them. Our water, sanitation and hygiene (WASH) and nutrition programs demonstrate how broader contextual factors can lead to inequities in outcomes which must be understood and addressed.

DEPARTMENT OF STATE AND USAID	**2009** Fiscal Year	**2010** Fiscal Year	**2011** Fiscal Year	**2012** Fiscal Year	**2013** Fiscal Year	**2014** Fiscal Year	**2015** Fiscal Year	**2016** Fiscal Year	**Total**
($ MILLIONS)	**7,741**	**8,477**	**8,279**	**8,599**	**8,420**	**8,826**	**9,277**	**8,841**	**68,461**
ENDING PREVENTABLE CHILD AND MATERNAL DEATHS	1,736	2,206	2,183	2,285	2,262	2,398	2,534	2,417	18,021
CREATING AN AIDS FREE GENERATION	5,609	5,713	5,684	5,893	5,773	6,000	6,000	6,000	46,672
PROTECTING COMMUNITIES FROM INFECTIOUS DISEASES	396	558	413	421	385	428	743	424	3,768

HEALTH FINANCING

How health systems are financed represents a nation's values and priorities related to ensuring access to quality health care for poor, vulnerable, and marginalized populations. Country health financing also impacts the ability of countries to deliver care to those in need. Effective and robust health financing to address maternal and child health requires a combination of domestic (both public and private) and donor resources sufficient to reach vulnerable populations with key interventions.

The last 50 years have seen a historic five-fold increase in GDP per capita in the world, driven by demographic dividends, global trade, and better governance, with half of low-income countries graduating to higher status since the year 2000. As a result, public and private domestic resources now dwarf official development assistance, putting domestic resource mobilization for health at the heart of the Post-2015 agenda (Figure 2).

FIGURE 2:

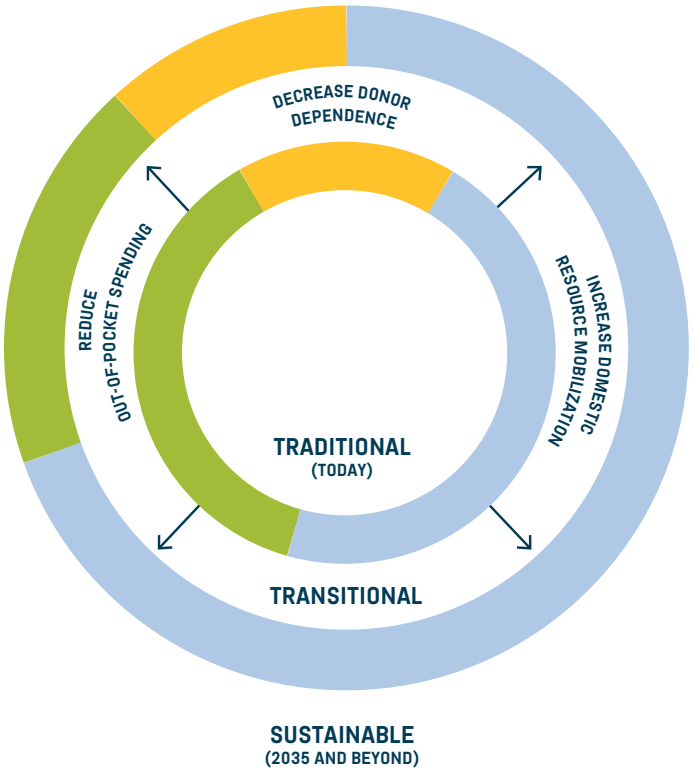
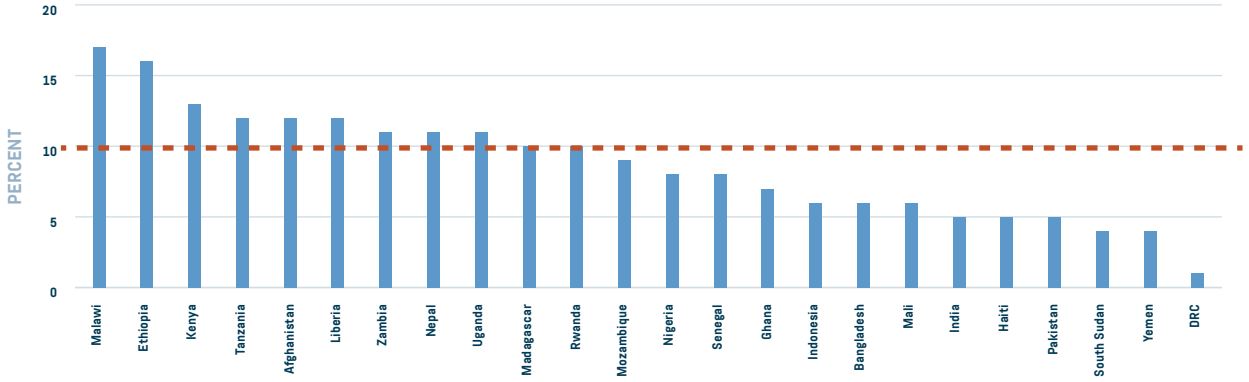


Figure 3 represents the percentage of the government budget spent on health, providing an indication of how EPCMD countries prioritize health. Of the EPCMD countries in 2014, Malawi dedicated the largest share of its budget, 17 percent, to health. The Democratic Republic of Congo devoted just 1 percent.

Donor assistance for maternal, newborn, and child health (MNCH) services totaled $9.6 billion in 2014. Nearly two-thirds, or $6.6 billion, was dedicated to child health, and the remaining $3 billion to maternal health. Donor financing for MNCH services varies across the EPCMD countries, ranging from $238 million to Nigeria, to $2 million to South Sudan. However, these differences change when the dollars are mitigated by the population of children under-5. From a per-child perspective, Ghana receives the most funding related to maternal and child health and India the least (Figure 4).

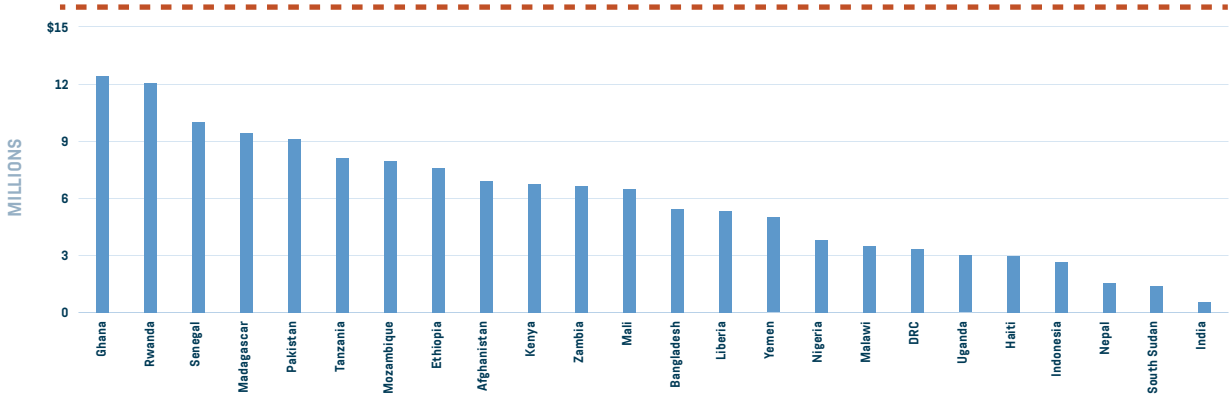
In some countries, other private sources of financing, such as through non-governmental organizations, also factor strongly into the makeup of health funding. Figure 5 demonstrates that for countries such as Haiti, Liberia and Mozambique these sources of financing can be a large proportion of total health funding.

FIGURE 3: **PERCENT OF GOVERNMENT BUDGET SPENT ON HEALTH, 2014 IN EPCMD COUNTRIES AS COMPARED TO MEDIAN VALUE FOR LOW AND LOWER MIDDLE INCOME COUNTRIES**



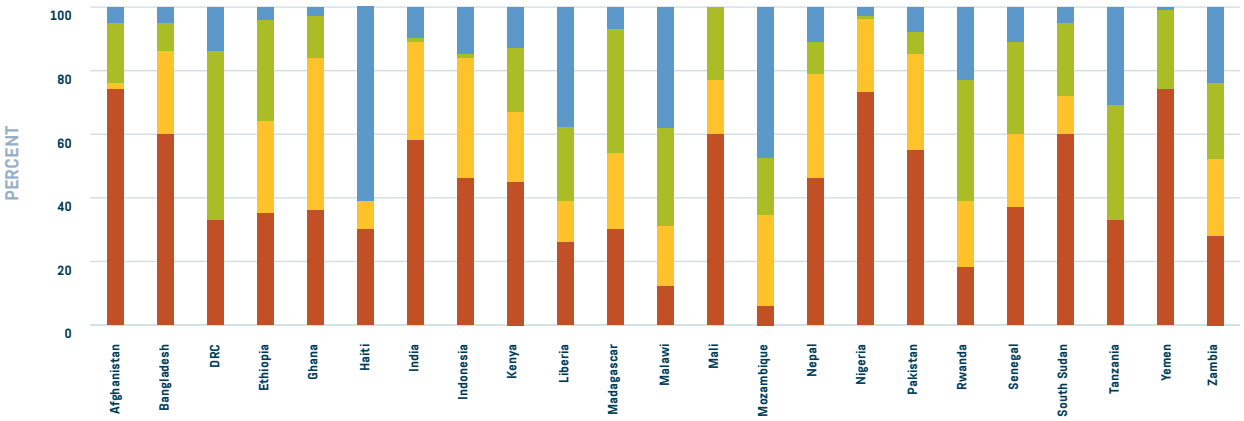
Source: WHO Global Health Expenditure Database, General Government Health Expenditure Series, 2014

FIGURE 4: **DEVELOPMENT ASSISTANCE FOR CHILD HEALTH PER UNDER-5 POPULATION, 2014 IN EPCMD COUNTRIES AS COMPARED TO MEDIAN VALUE FOR LOW AND LOWER MIDDLE INCOME COUNTRIES**



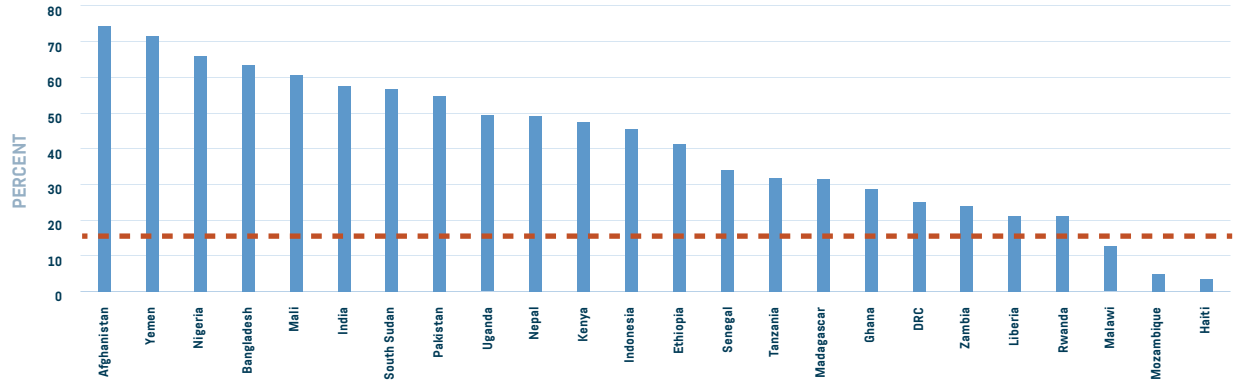
Sources: IHME, Development Assistance for Health (DAH) Database, 1990-2014; U.S. Census Bureau 2015 Estimates

FIGURE 5: **TOTAL HEALTH EXPENDITURE IN 23* EPCMD COUNTRIES, 2014**



Source: WHO Global Health Expenditure Database, 2014 *Data unavailable for Uganda.

FIGURE 6: **OUT-OF-POCKET EXPENDITURES AS A PERCENTAGE OF TOTAL HEALTH EXPENDITURE AGAINST INTERNATIONAL STANDARD OF 15% OOP BY EPCMD COUNTRIES**



Source: WHO Global Health Expenditure Database, General Government Health Expenditure Series, 2014

USAID uses information related to health financing to advocate for better use of available resources. For example, the prime minister of the Democratic Republic of Congo recently agreed to increase domestic resources for health to 7 5 percent of the budget and for the first time, allocated $3.5 million for contraceptives. In Tanzania, USAID helped to double the allocations to health from concessional loans from $100 million to $200 million.

Improving the health financing system

Given the differences in the financing landscape in each of the 24 priority countries, USAID works with countries to optimize the use of resources devoted to maternal and child health, prioritizing the poor, vulnerable, and underserved populations.

High out-of-pocket spending (OOP), a regressive form of financing, is one of the leading causes of impoverishment in low and middle income countries. It is an indicator of the high financial barrier to accessing health care, and of the scarcity of financial risk protection schemes to shield people from impoverishing health expenditures.

Viewing OOPs against an international standard (Figure 6) demonstrates that financial barriers exist for accessing health services in most EPCMD countries and indicates a need to promote and implement financial risk protection schemes.

USAID works to reduce the burden of high OOPs by creating sustainable financing mechanisms. These include progressive revenue collection and risk pooling mechanisms that cross-subsidize the poor and near-poor to reduce financial barriers to accessing the health system, without causing undue financial hardship from catastrophic health expenditures.

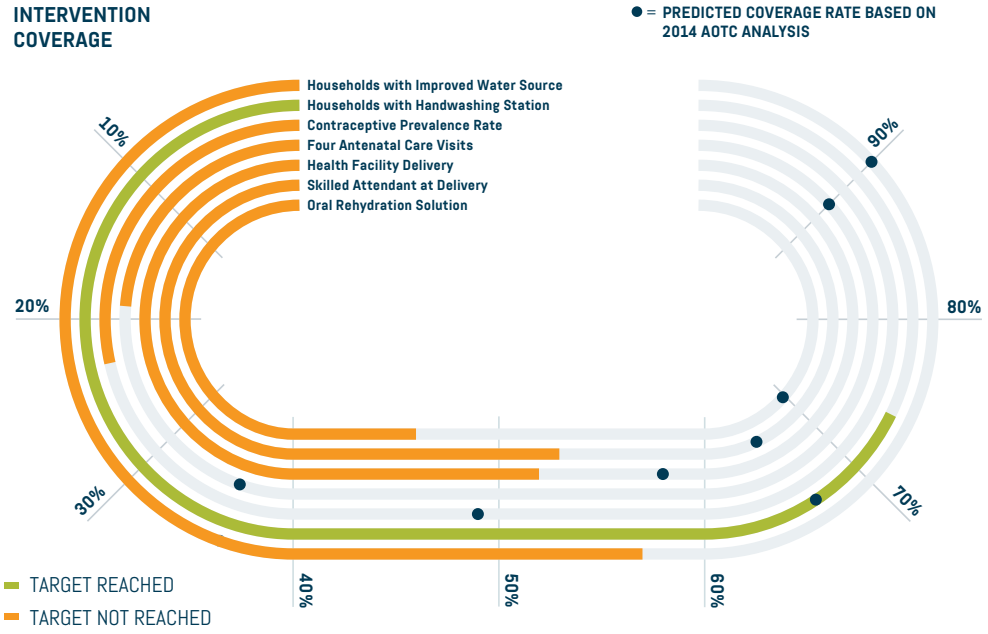
An example of effective risk pooling to achieve equity came from USAID's support to expand Ethiopia's community-based health insurance (CBHI), a district solidarity fund that provides subsidies for the poor. Ethiopia successfully piloted a CBHI scheme, and in the past year has expanded it 700 percent, using financing from a combination of central government and household contributions to reach 6.5 million people. Close to 15 percent of pilot district populations were poor. In addition to reducing the potential for catastrophic costs, this scheme addressed another factor contributing to inequity: financial marginalization of women and children within households. Early evidence shows that women and children have been empowered to seek care by direct control of their CBHI card without having to seek money from the male head of household.[4]

Photo: Thomas Cristofoletti/USAID

AFGHANISTAN

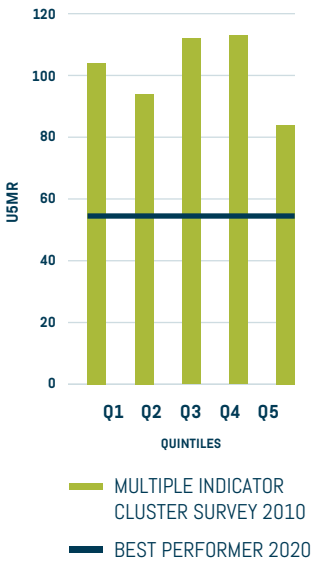
	2015	1990
Total Population	32.5M ↑	13.5M
Population Under 5 Years	5.2M ↑	2.6M
Under-5 Deaths / Year	94.3K ↓	96K
Under-5 Mortality Rate Per 1,000 Live Births	91 ↓	176
Births	1.3M ↑	739K
Maternal Mortality Ratio Per 100,000 Live Births	396 ↓	1,300

INTERVENTION COVERAGE



Estimates are based on trends from most recently available surveys and therefore may not reflect acceleration due to *Acting on the Call* efforts

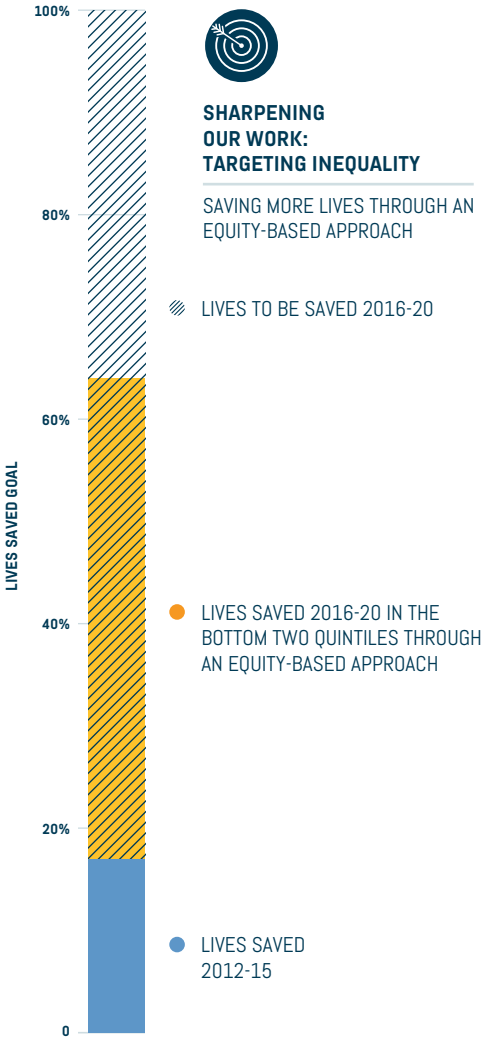
UNDER-5 MORTALITY RATE BY WEALTH QUINTILE V. BEST PERFORMER 2020



PROGRESS IN THE LAST YEAR:

- A health facility-level HMIS Harmonized Quality Improvement (HQI) activity was launched in five regions. This will enable frequent implementation monitoring of high-impact interventions.
- The Ministry of Public Health and other stakeholders are working to ensure immunization services are appropriately integrated in the HQI Program. The Ministry of Public Health is now working to develop standards for integrated management of childhood illness (IMCI) services in the HQI package. These standards will enforce effective implementation of case management for child illness at the health facility level.
- The Ministry of Public Health started the scale up of community-based distribution of misoprostol for the prevention of post-partum hemorrhage in four provinces, and is promoting the prevention and management of pre-eclampsia/eclampsia through initiation of a pilot test on calcium supplementation.
- The Ministry of Public Health introduced antenatal corticosteroids for the effective management of preterm labor.
- The Ministry of Public Health included 7.1 percent chlorhexidine in the Essential Medicine List and in all the relevant in-service training curricula for a mass scale-up of this important newborn care intervention.
- The Reproductive, Maternal, Newborn and Child Health (RMNCH) Balanced Scorecard was introduced. Using existing HMIS data it provides a snapshot of progress on RMNCH key indicators across districts and provinces.
- The Afghan Midwives Association and the Afghan Nurses Association, with the support of USAID and other donor partners, have requested that the president establish a Midwifery and Nursing Council. to enhance quality throughout the midwifery and nursing professions.

2016-2020: AN EQUITY-BASED APPROACH
309,000 LIVES SAVED IN THE BOTTOM TWO QUINTILES
OF WHICH 96,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

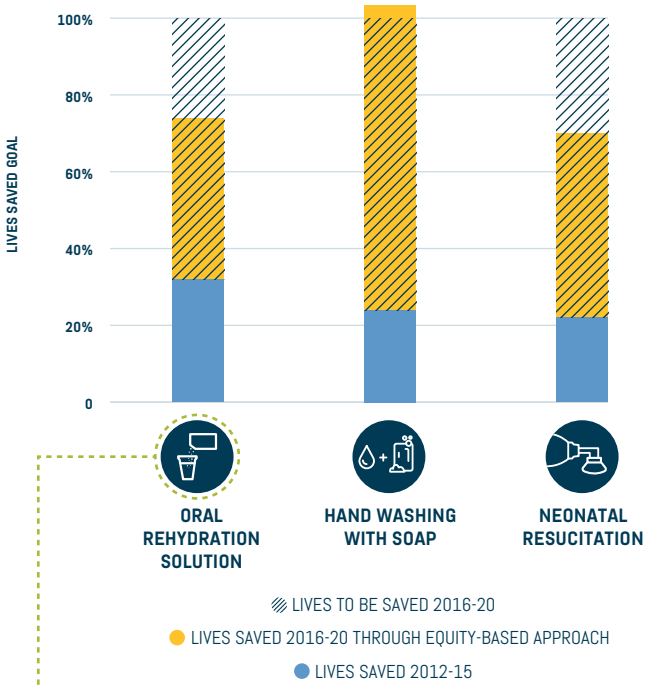


SHARPENING OUR WORK: TARGETING INEQUALITY

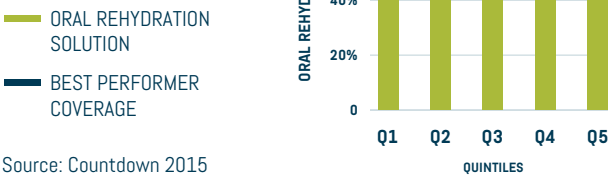
SAVING MORE LIVES THROUGH AN EQUITY-BASED APPROACH

An equity-based approach focuses on the bottom two quintiles but impacts all five quintiles

INTERVENTIONS BENEFITTING MOST WITHIN A COMPREHENSIVE EQUITY-BASED APPROACH



REACHING EQUITY IN ORAL REHYDRATION SOLUTION



Source: Countdown 2015

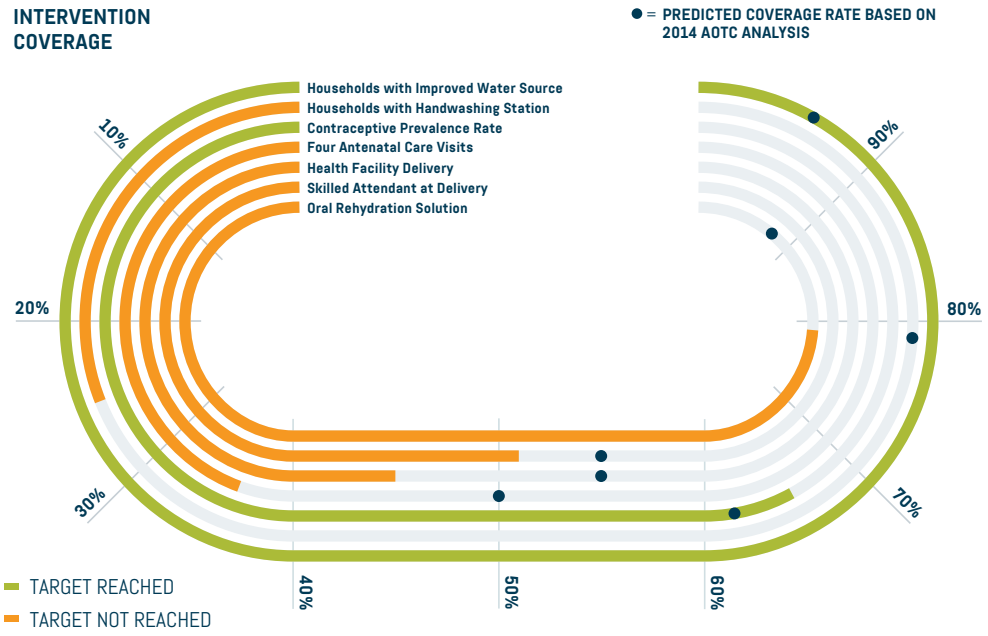
ENDING PREVENTABLE CHILD AND MATERNAL DEATHS REQUIRES A COMPREHENSIVE EQUITY-BASED APPROACH. USAID'S COMPREHENSIVE EQUITY-BASED APPROACH INCLUDES:

- Promoting, along with the Ministry of Public Health, respectful maternity care approaches within existing Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) services.
- Increasing gender sensitivity: the Ministry of Public Health has revised their Family Planning (FP)/RMNCH learning resource packages to ensure that gender sensitive services are incorporated. They have also finalized a gender action plan for use by the Basic Package of Health Services implementing NGOs and completed a gender capacity assessment for selected Ministry of Public Health departments.
- Developing and disseminating a patient's charter of rights, along with accompanying training materials, to obtain community feedback regarding respectful health services for use by Community Health Workers (CHW).
- Rolling out the National Implementation Plan for Comprehensive Newborn Care 2016-2020.
- Addressing youth: the Ministry of Public Health Child and Adolescent Department has developed national guidelines for youth friendly health services including Health Quality Improvement Plan standards and selected youth and adolescent health indicators that will be included in the national health management information system (HMIS).

BANGLADESH

	169M ↑ Total Population	17.1M ↓ Population Under 5 Years	119K ↓ Under-5 Deaths / Year	38 ↓ Under-5 Mortality Rate Per 1,000 Live Births	3.6M ↓ Births	176 ↓ Maternal Mortality Ratio Per 100,000 Live Births
2015						
1990	112M	17.8M	531K	143	4M	800

INTERVENTION COVERAGE



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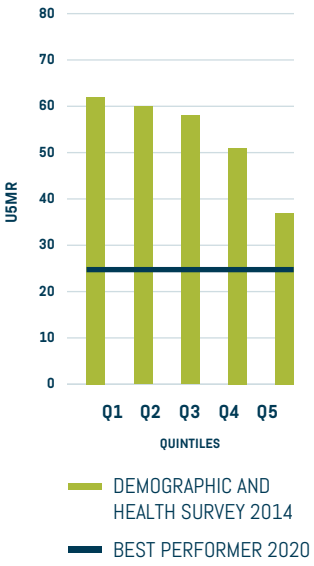
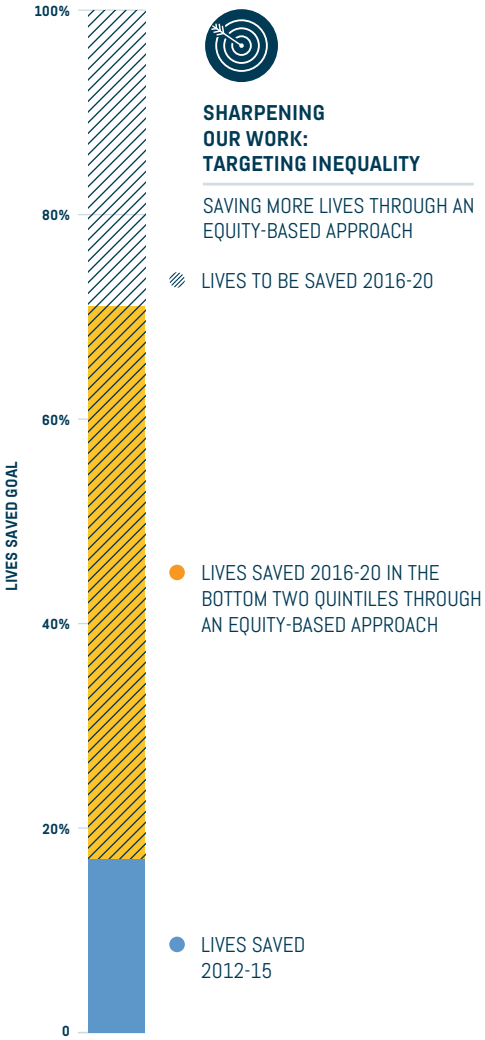
UNDER-5 MORTALITY RATE BY WEALTH QUINTILE V. BEST PERFORMER 2020



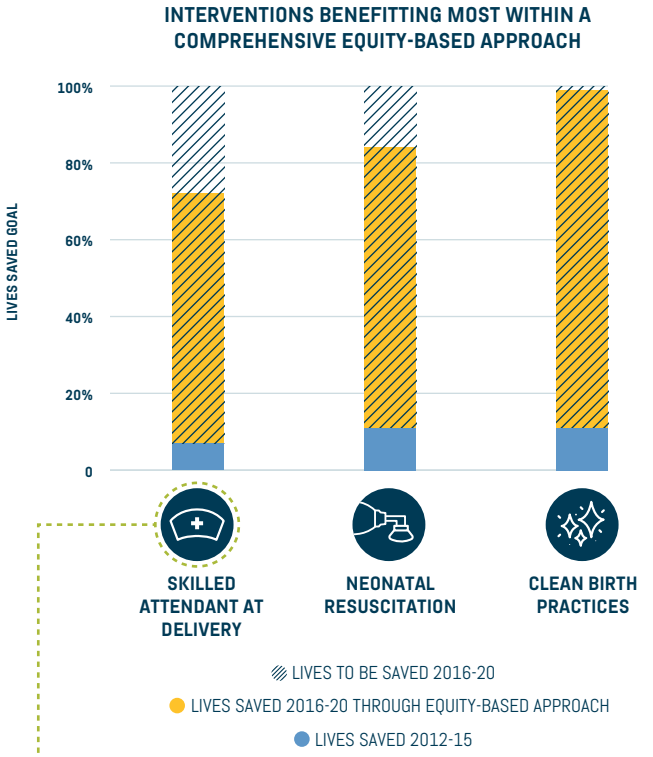
PROGRESS IN THE LAST YEAR:

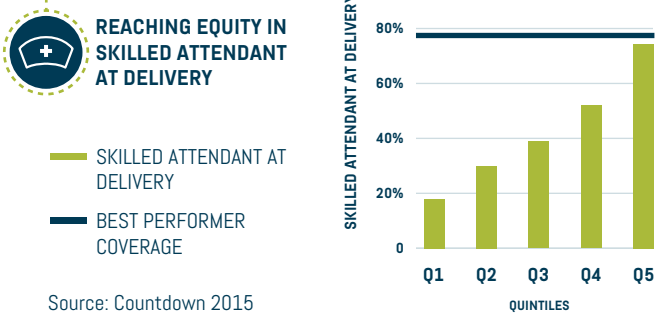
- The 2015 National Nutrition Policy was approved, calling for strengthened multisectoral nutrition programming for women, children, and adolescents. The National Plan of Action for Nutrition is currently under development to make the policy operational.
- The Breast Milk Substitute Code, which makes the promotion or marketing of breast milk substitutes illegal, was passed, and a National Advocacy and Communication Strategy on Nutrition was finalized and is awaiting endorsement.
- Two hundred dedicated Severe Acute Malnutrition units were established in public health facilities throughout the country to treat children identified for malnutrition.
- The National Fistula Strategy was approved to reduce the burden among those living with fistula and those at highest risk, including the poorest, least educated, and those with least amount of reproductive choice.
- Implementation of evidence-based high-impact practices in hard to reach areas continued to impact child health:
  - Sepsis management for newborns at union facilities was rolled out to five districts.
  - 1.73 million children were treated for diarrhea , 775,000 from the lowest wealth quintiles.
  - 115, 000 children were treated for pneumonia, nearly half from the lowest wealth quintile.
- A Memorandum of Understanding between Ministry of Health & Family Welfare, and Bangladesh Garment Manufacturing Exporters Association, was signed to expand FP services to reach garment factory workers (primarily women of reproductive age) in over 40 garment factories.
- The National Family Planning Policy to expand immediate post-partum family planning methods now includes implants and progestin-only pills, as well as technical assistance to strengthen and support compliance with both United States Government (USG) and Government of Bangladesh FP regulations and laws.

2016-2020: AN EQUITY-BASED APPROACH
189,000 LIVES SAVED IN THE BOTTOM TWO QUINTILES
OF WHICH 3,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS



An equity-based approach focuses on the bottom two quintiles but impacts all five quintiles





Source: Countdown 2015

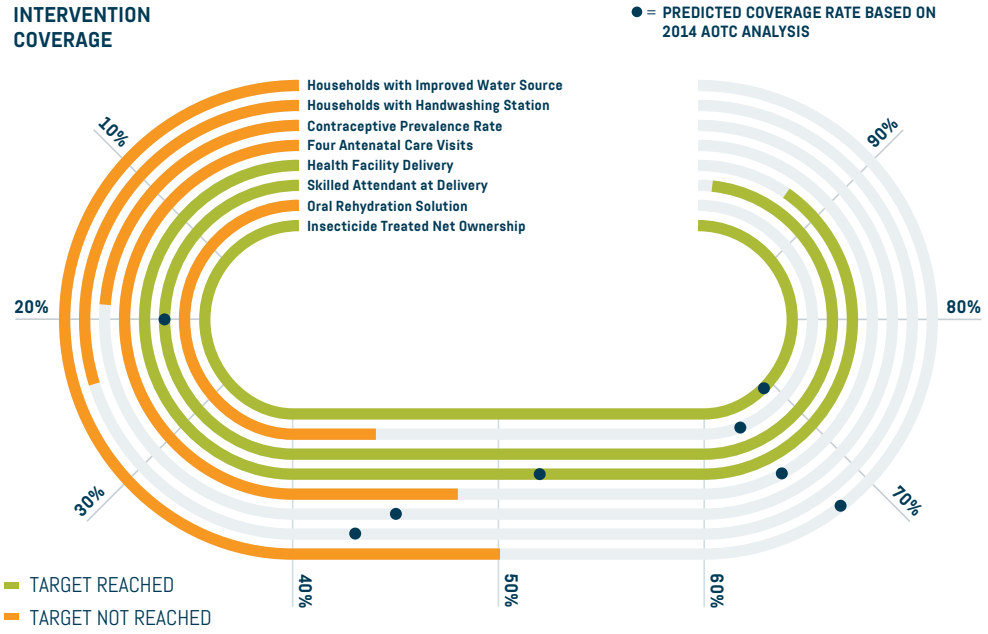
ENDING PREVENTABLE CHILD AND MATERNAL DEATHS REQUIRES A COMPREHENSIVE EQUITY-BASED APPROACH. USAID'S COMPREHENSIVE EQUITY-BASED APPROACH INCLUDES:

- Supporting increased antenatal care (ANC) for women through CHW outreach, particularly to the poorest women.
- Reducing gender-based violence among the most vulnerable populations by strengthening referral networks with organizations that can provide legal, protective and other support to victims of gender-based violence.

DEMOCRATIC REPUBLIC OF CONGO

	Total Population	Population Under 5 Years	Under-5 Deaths / Year	Under-5 Mortality Rate Per 1,000 Live Births	Births	Maternal Mortality Ratio Per 100,000 Live Births
2015	79.4M ↑	12.4M ↑	305K ↑	98 ↓	2.8M ↑	693 ↓
1990	39M	7.4M	266K	171	1.8M	930

INTERVENTION COVERAGE



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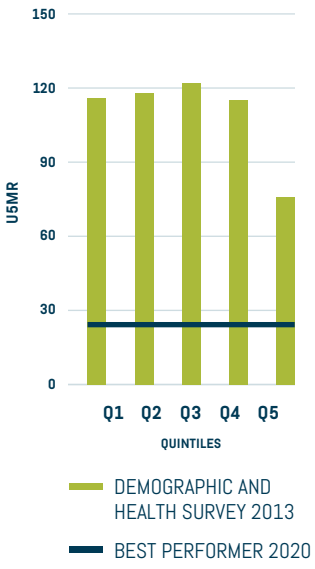
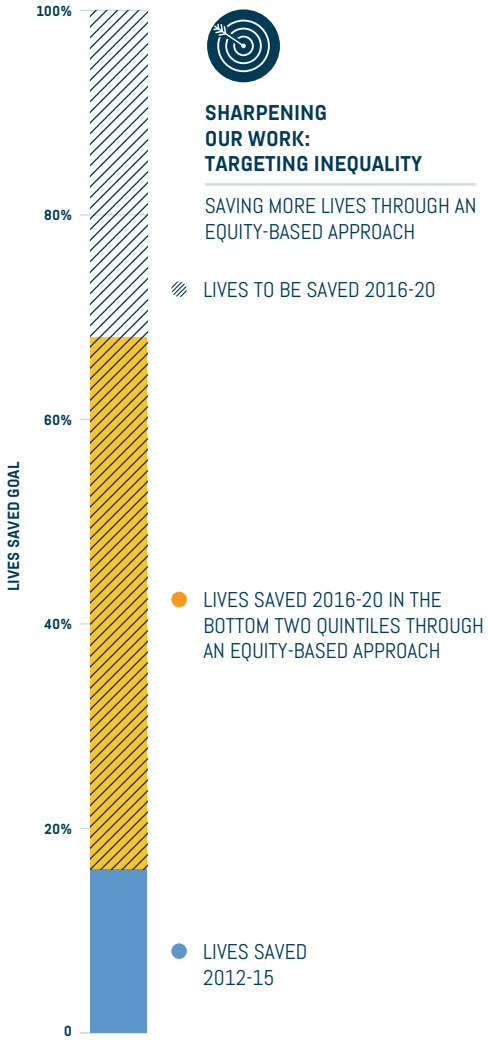
UNDER-5 MORTALITY RATE BY WEALTH QUINTILE V. BEST PERFORMER 2020



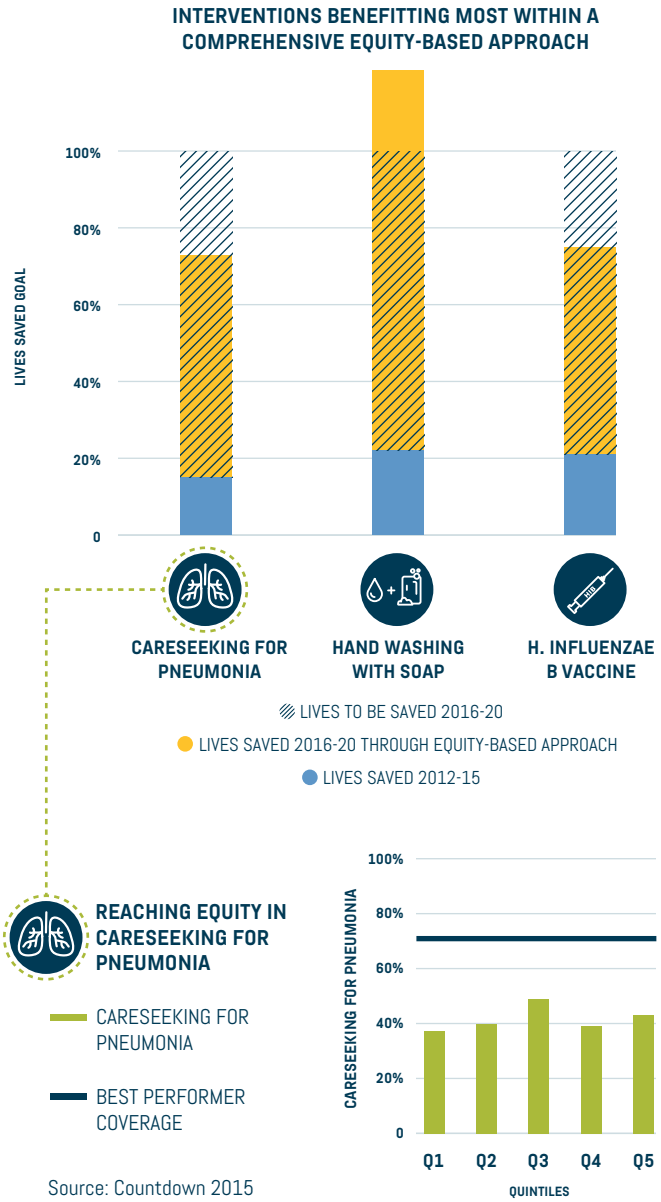
PROGRESS IN THE LAST YEAR:

- For the first time, all 516 of the nation's health zones received malaria program coverage due to USAID's and other partners' increased footprint.
- The Governmnet of the Democratic Republic of Congo (GoDRC) has added a line item into the national budget for contraceptive commodities, and the government has begun advocating for increased availability of family planning commodities across the country.
- Sayana Press, an injectable contraceptive, was introduced at the community level by training and educating community health workers.
- Chlorhexidine for newborn cord care has been scaled up to reach most vulnerable populations.
- Revised maternal, newborn, and child health guidelines were released to improve quality of service country wide.
- Pneumonia management with antibiotics has been scaled up to provide better case management for children under-5 with acute respiratory infections.

2016-2020: AN EQUITY-BASED APPROACH
438,000 LIVES SAVED IN THE BOTTOM TWO QUINTILES
OF WHICH 91,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS



An equity-based approach focuses on the bottom two quintiles but impacts all five quintiles



Source: Countdown 2015

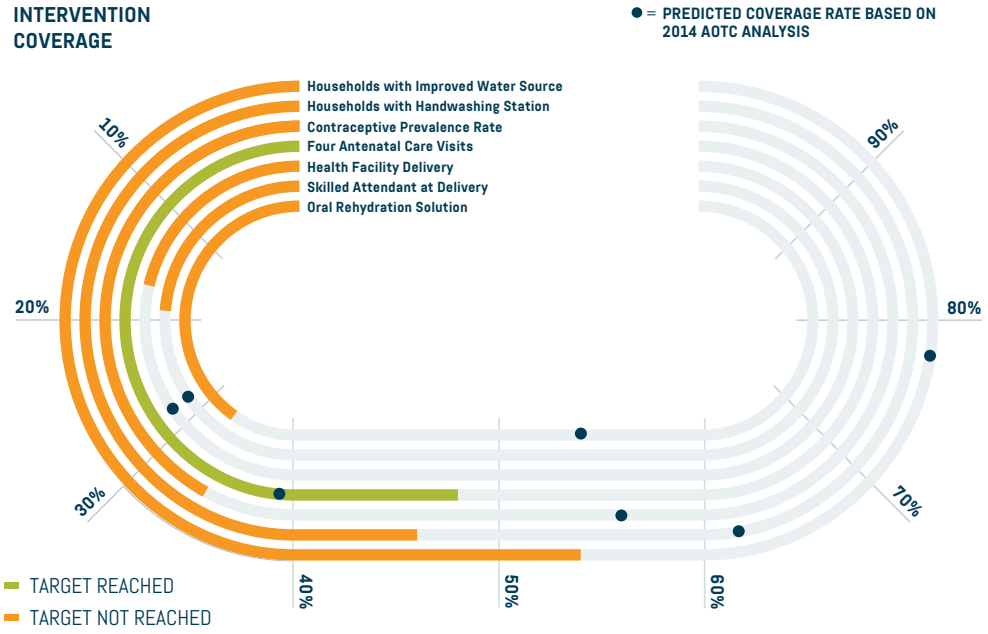
ENDING PREVENTABLE CHILD AND MATERNAL DEATHS REQUIRES A COMPREHENSIVE EQUITY-BASED APPROACH. USAID'S COMPREHENSIVE EQUITY-BASED APPROACH INCLUDES:

- Working with the government and other health donors on a five-year health development plan, which includes a minimum package of activities to be implemented countrywide and targeted toward the most vulnerable populations.
- Strengthening the distribution system of medicines and family planning commodities to ensure they reach remote and isolated rural areas.
- Building the capacity of Congolese health professional organizations by providing in-service training and pre-service education on key maternal, newborn, and child health interventions.

ETHIOPIA

	2015	1990
Total Population	99.4M ↑	47.5M
Population Under 5 Years	16.5M ↑	8.5M
Under-5 Deaths / Year	184K ↓	444K
Under-5 Mortality Rate Per 1,000 Live Births	59 ↓	204
Births	3.6M ↑	2.2M
Maternal Mortality Ratio Per 100,000 Live Births	352 ↓	950

INTERVENTION COVERAGE



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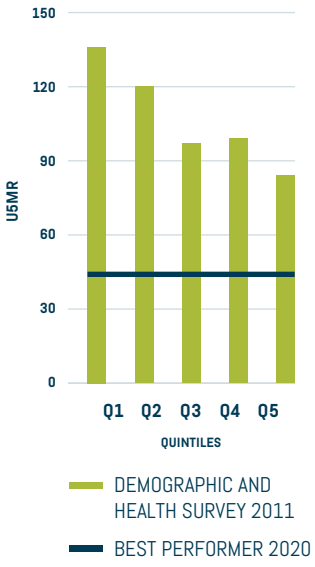
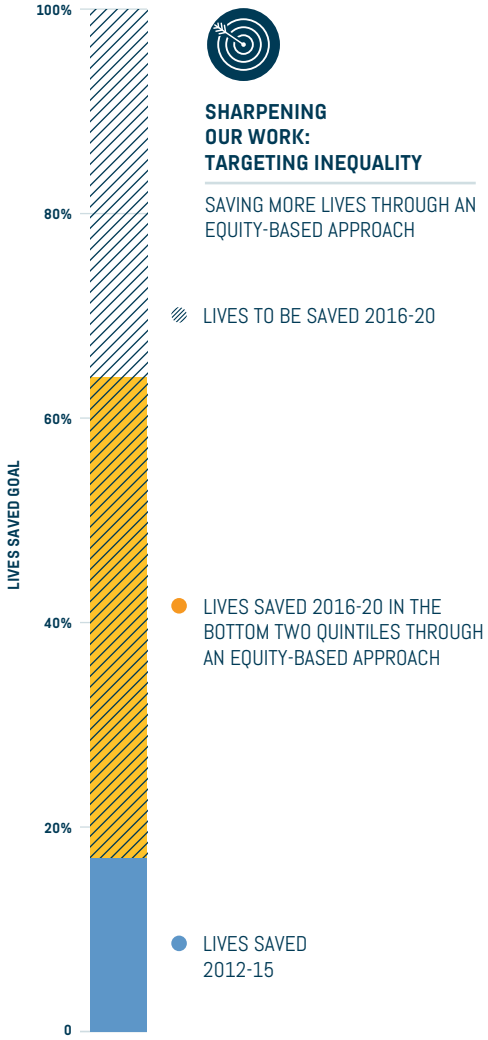
UNDER-5 MORTALITY RATE BY WEALTH QUINTILE V. BEST PERFORMER 2020



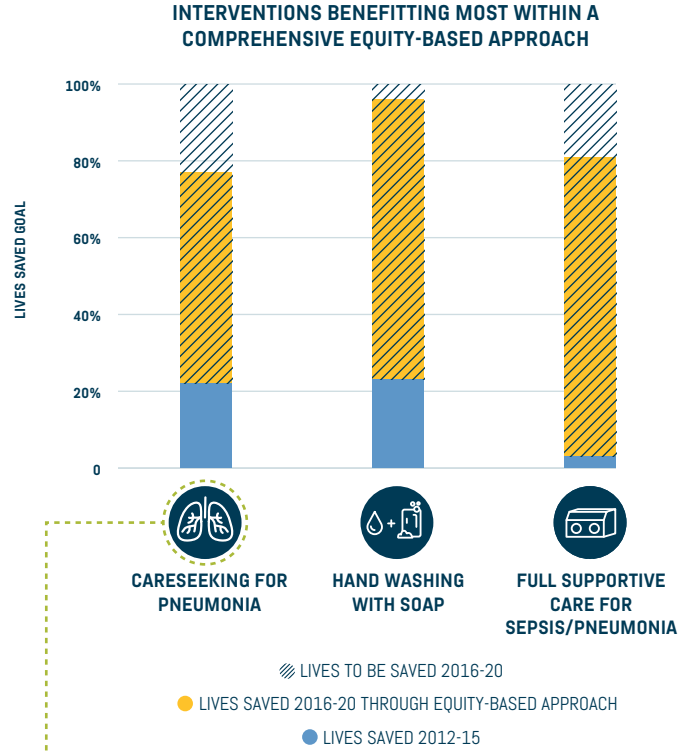
PROGRESS IN THE LAST YEAR:

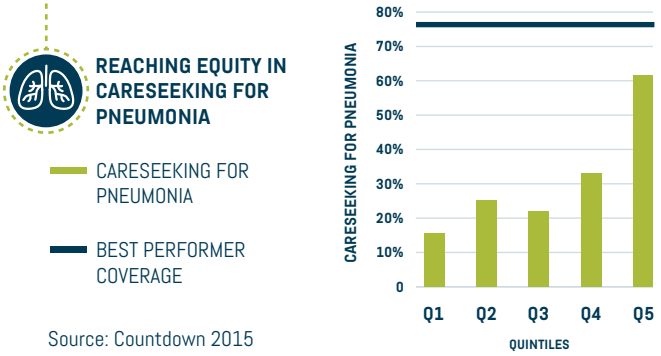
- USAID provided expertise and assistance to the Government of Ethiopia (GoE) to develop, revise, and implement key strategies and guidelines, including the National Child Survival Strategy, Comprehensive Multi-Year Plan for the Expanded Program on Immunization, and Community-Based Neonatal Care Guidelines.
- USAID helped the GoE to revise and pilot the Integrated Management of Newborn and Child Illness guidelines, incorporating life saving interventions for newborn survival, including the introduction of chlorhexidine for cord care to reduce deadly infections.
- The recent National Child Survival Strategy contains explicit child survival targets and expands the Health Extension Workforce role to provide children with both preventive and curative services, including pneumonia, diarrhea, malaria, uncomplicated severe malnutrition, and community-based treatment for newborn sepsis.
- USAID contributed to the roll-out of community-based newborn care in 18 zones/196 districts in rural areas, and partnered with the GoE and the Ethiopian Pediatric Society to develop a comprehensive proposal to implement the 'Helping Babies Survive' program in 180 hospitals.
- USAID supported a supplementary immunization campaign and routine immunization in polio-supported areas, increasing vaccination coverage for the Penta 3 vaccine by 24 percent, measles vaccine by 30 percent, and Oral Polio Vaccine 3 by 25 percent.
- USAID trained 1,300 providers in long-acting reversible contraceptives including Implanon and the intrauterine contraceptive device as part of an effort to build capacity of health care workers, including health extension workers, to provide comprehensive family planning information and services.

2016-2020: AN EQUITY-BASED APPROACH
400,000 LIVES SAVED IN THE BOTTOM TWO QUINTILES
OF WHICH 139,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS



An equity-based approach focuses on the bottom two quintiles but impacts all five quintiles





Source: Countdown 2015

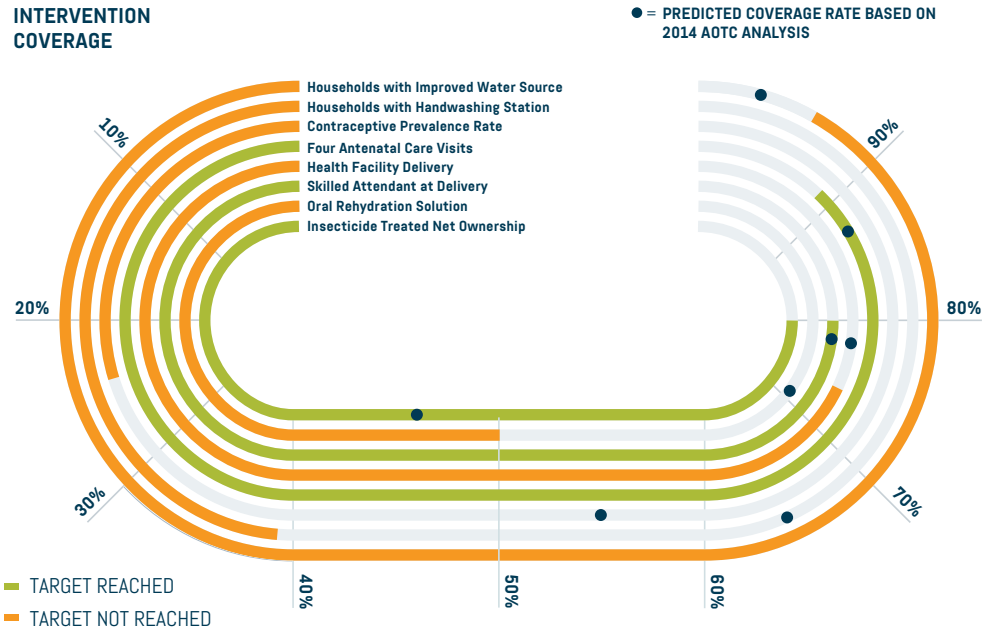
ENDING PREVENTABLE CHILD AND MATERNAL DEATHS REQUIRES A COMPREHENSIVE EQUITY-BASED APPROACH. USAID'S COMPREHENSIVE EQUITY-BASED APPROACH INCLUDES:

- Collaborating with the GoE to improve the health of Ethiopians focused on the most vulnerable women, girls, newborns, and children under the age of five.
- Targeting resources to women and children in the greatest need of services. USAID recently performed an analysis to identify geographic locations with the poorest maternal, newborn and child health indicators.
- Supporting expansion of community-based health insurance schemes that reached 6.5 million people this year.
- Assisting the GoE in targeting nomadic/semi-nomadic populations and the hard to reach in agrarian areas for intensive and focused development efforts in maternal and child health, as well as family planning.
- Supporting the GoE to strengthen services in areas with high under-5 mortality and low vaccine coverage to integrate immunization into delivery models for mobile populations in hard-to-reach areas.

GHANA

	Total Population	Population Under 5 Years	Under-5 Deaths / Year	Under-5 Mortality Rate Per 1,000 Live Births	Births	Maternal Mortality Ratio Per 100,000 Live Births
2015	26.3M ↑	3.8M ↑	54K ↓	62 ↓	819K ↑	319 ↓
1990	15.5M	2.7M	70K	128	603K	580

INTERVENTION COVERAGE



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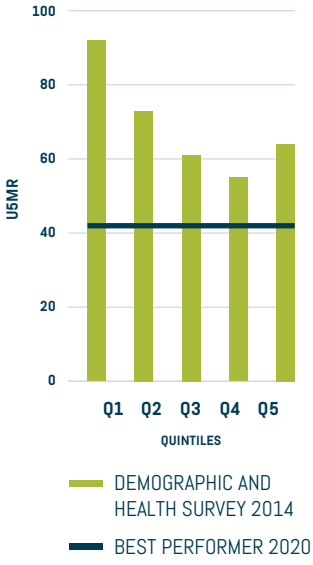
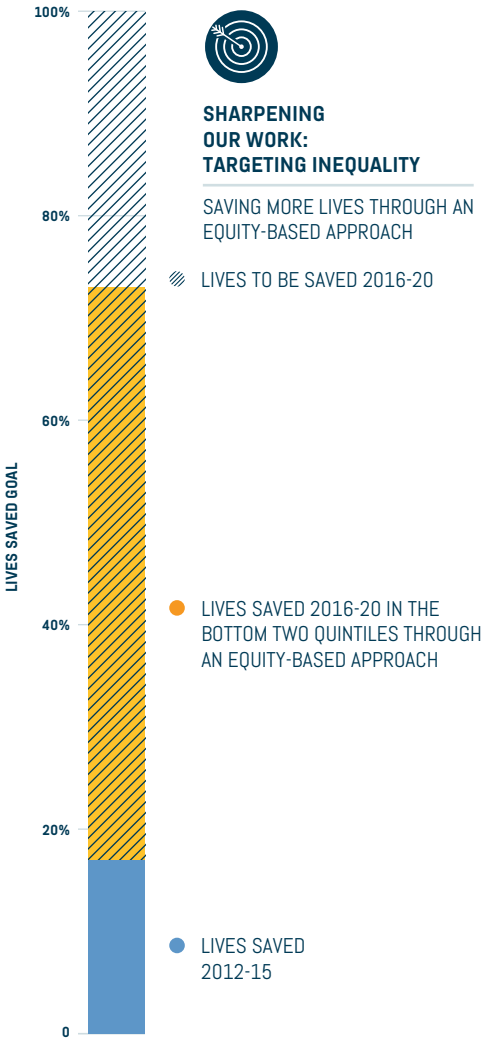
UNDER-5 MORTALITY RATE BY WEALTH QUINTILE V. BEST PERFORMER 2020



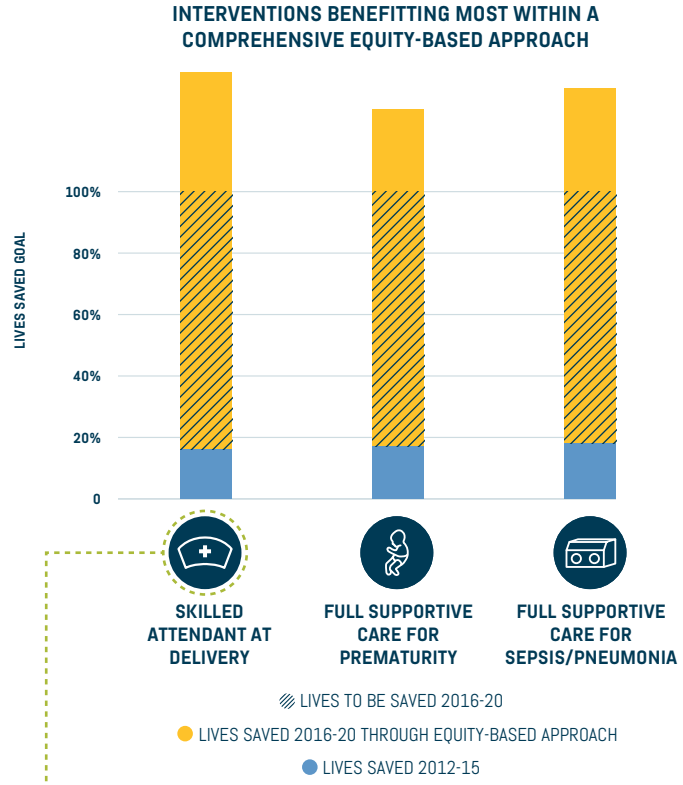
PROGRESS IN THE LAST YEAR:

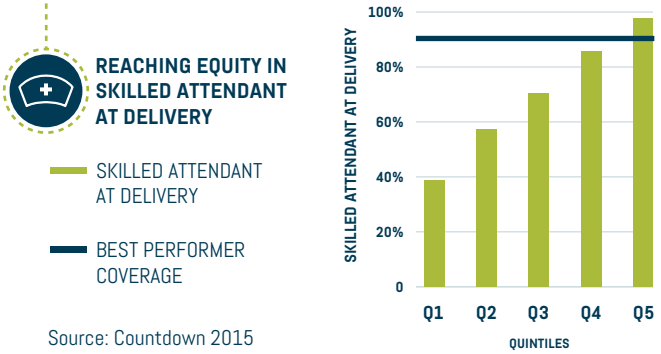
- Trained over 1,000 providers from 12 regional and municipal hospitals in emergency triage assessment and treatment, while providing on-site technical assistance to institutionalize guidelines and improve maternal and child care.
- Supported multidisciplinary teams of regional and district Ghana Health Service staff in 25 underserved districts to conduct integrated coaching visits to 586 facilities to promote linkages between data and service delivery by increasing staff understanding of key reporting forms and registers.
- Incorporated chlorhexidine and antenatal corticosteroids into the Essential Medicines List of Ministry of Health.
- Scaled up training of Community Health Nurses in Ghana and trained additional health volunteers to support Community Infant and Young Child Feeding using a new curriculum that incorporates best practices.
- Scaled-up training of health and family planning providers in long-acting reversible contraceptive methods for implementation at the community level, including IUD implant insertion and removal.
- Engaged over 6,000 women in village savings and loan programs and saved approximately a quarter million Ghana Cedis (USD $70,000) through the formation of these groups. It is expected that these women will use their increased access to resources to better provide care for their families.
- Developed costed implementation plan for increasing quality family planning services.

2016-2020: AN EQUITY-BASED APPROACH
94,000 LIVES SAVED IN THE BOTTOM TWO QUINTILES
OF WHICH 23,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS



An equity-based approach focuses on the bottom two quintiles but impacts all five quintiles





Source: Countdown 2015

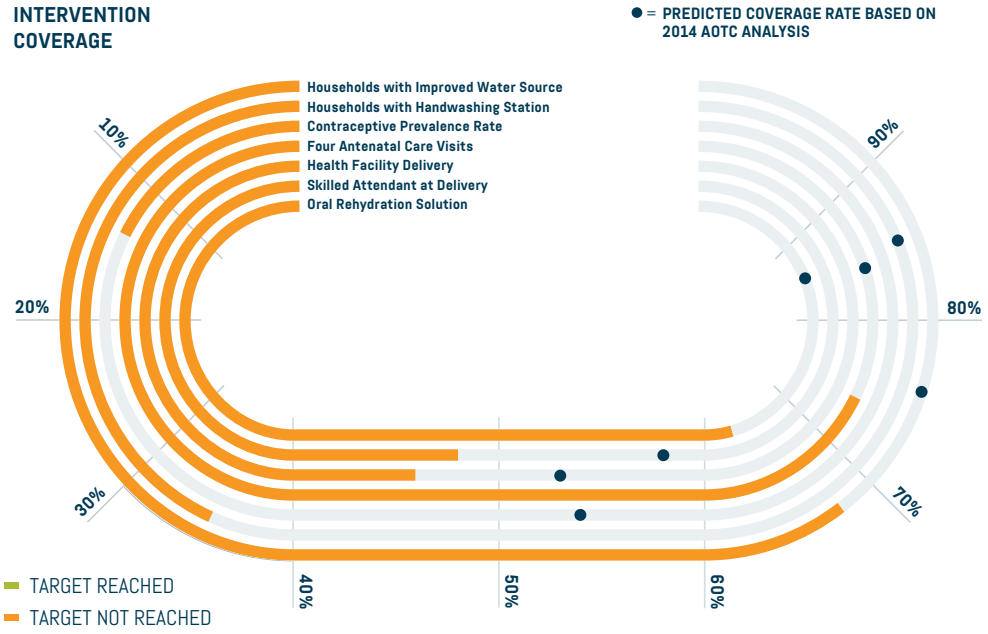
ENDING PREVENTABLE CHILD AND MATERNAL DEATHS REQUIRES A COMPREHENSIVE EQUITY-BASED APPROACH. USAID'S COMPREHENSIVE EQUITY-BASED APPROACH INCLUDES:

- Ensuring services in some of the most underserved areas of the country–specifically the Northern region–to address lagging health indicators.
- Rolling out the national policy for Community-based Health Planning Services zones, which serve as the first point of care in many communities.
- Supporting the National Health Insurance Agency (NHIA) to strengthen its management, roll out a new capitated payment system, monitor quality through a series of clinical audits, engage with providers, and incorporate preventative services and products into the coverage package in order to enable the NHIA to increase access to, and use of, health services.
- Supporting the Ghana Health Service to update and implement several key national policies, guidelines, and training strategies and materials in the areas of RMNCH and nutrition. These standardization efforts will help improve the quality of care and services, including in traditionally underserved areas.

HAITI

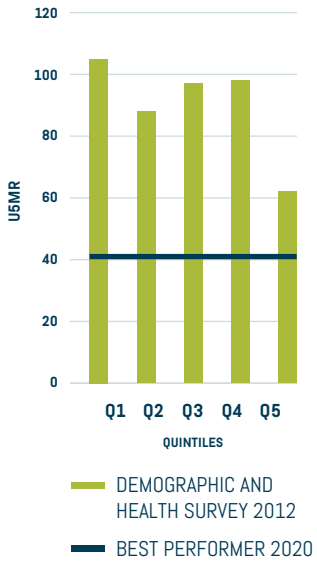
	Total Population	Population Under 5 Years	Under-5 Deaths / Year	Under-5 Mortality Rate Per 1,000 Live Births	Births	Maternal Mortality Ratio Per 100,000 Live Births
2015	10.1M ↑	1.1M ↑	18K ↓	69 ↓	226K ↓	359 ↓
1990	6.8M	1M	36K	144	260K	620

INTERVENTION COVERAGE



Estimates are based on trends from most recently available surveys and therefore may not reflect acceleration due to *Acting on the Call* efforts

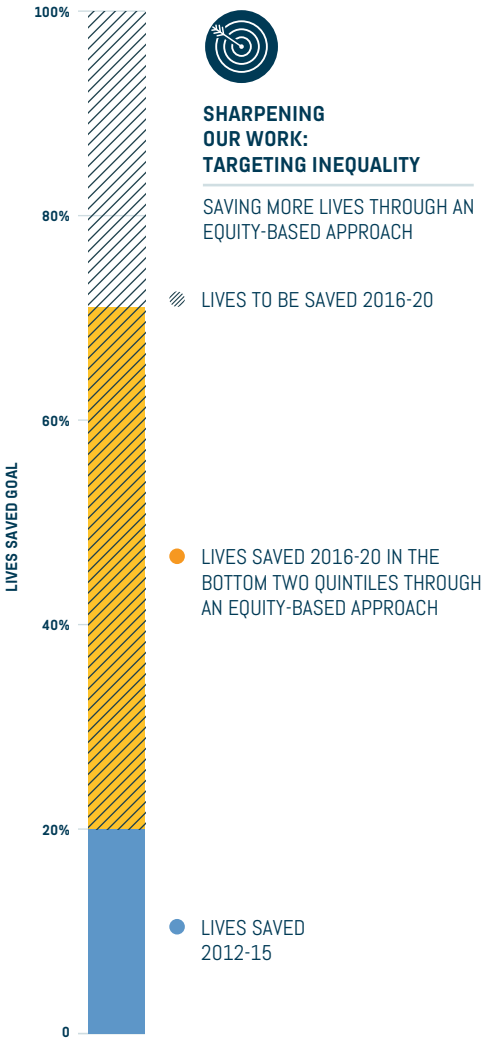
UNDER-5 MORTALITY RATE BY WEALTH QUINTILE V. BEST PERFORMER 2020



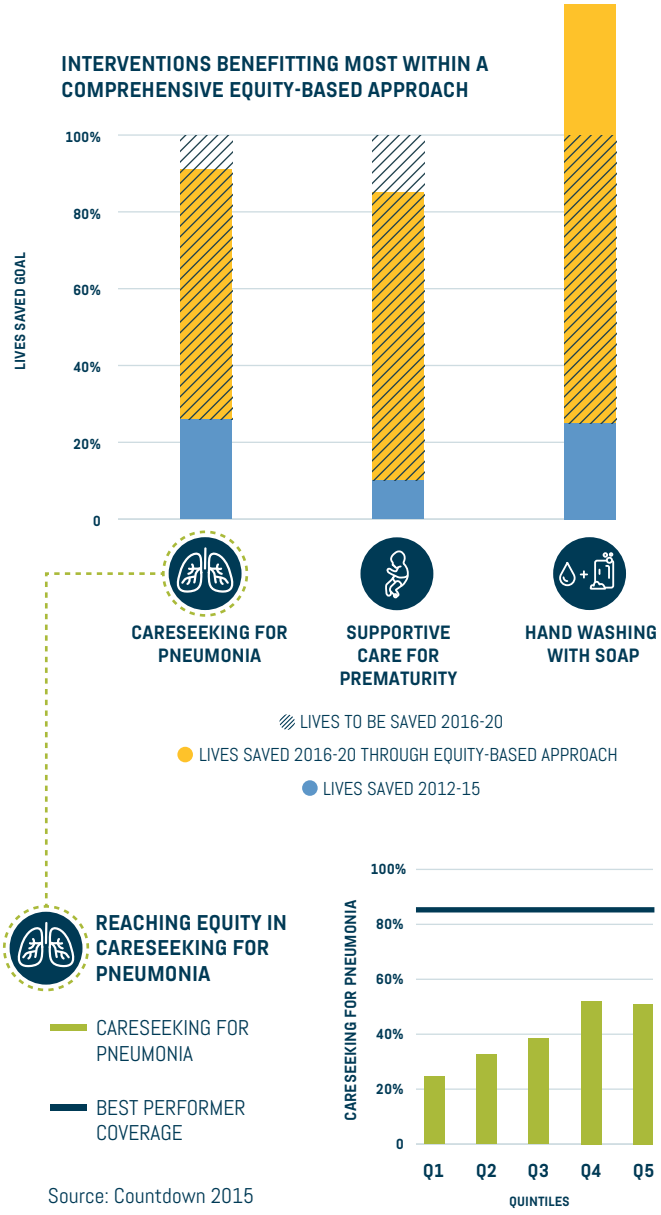
PROGRESS IN THE LAST YEAR:

- Supported specialized training of family planning service providers, increasing the total number of providers trained in long-acting modern contraceptive methods in USAID-supported regions.
- Introduced a standardized community-based maternal death audit system in two pilot communities in the Northern Area and initiated preparations to scale-up the system to communities in selected USAID-supported sites.
- Introduced the inactivated polio vaccine, and started preparations for introducing pneumococcal vaccine by the end of 2016.
- Provided 2,000 households with access to a home garden with nutritious vegetables.
- Launched a water, sanitation, and hygiene infrastructure rehabilitation initiative in six of the 23 priority sites identified as being at high risk for cholera outbreak, including heavily populated urban areas as well as remote, hard-to-reach rural areas.

2016-2020: AN EQUITY-BASED APPROACH
43,000 LIVES SAVED IN THE BOTTOM TWO QUINTILES
OF WHICH 10,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS



An equity-based approach focuses on the bottom two quintiles but impacts all five quintiles



Source: Countdown 2015

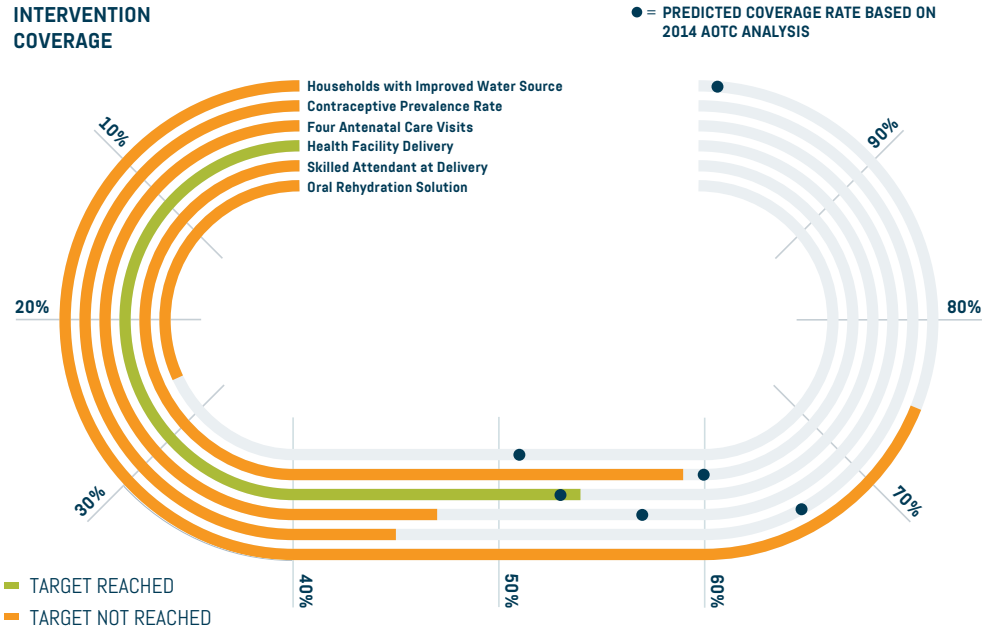
ENDING PREVENTABLE CHILD AND MATERNAL DEATHS REQUIRES A COMPREHENSIVE EQUITY-BASED APPROACH. USAID'S COMPREHENSIVE EQUITY-BASED APPROACH INCLUDES:

- Deploying mobile teams to ensure hard-to-reach communities have health services, including information on healthy behaviors, referrals as appropriate, and knowledge of services at supported facilities.
- Through an agreement with the Ministry of Health, ensuring that supported sites have access to ancillary commodities, so that voluntary surgical contraceptive services are available totally free of charge, thereby increasing their accessibility to the poor.

INDIA

	1.25B ↑ Total Population	117M ↓ Population Under 5 Years	1.2M ↓ Under-5 Deaths / Year	48 ↓ Under-5 Mortality Rate Per 1,000 Live Births	24.5M ↓ Births	174 ↓ Maternal Mortality Ratio Per 100,000 Live Births
2015						
1990	869M	119M	3.3M	126	26.5M	600

INTERVENTION COVERAGE



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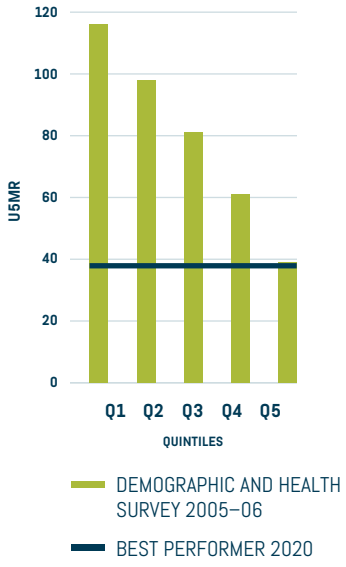
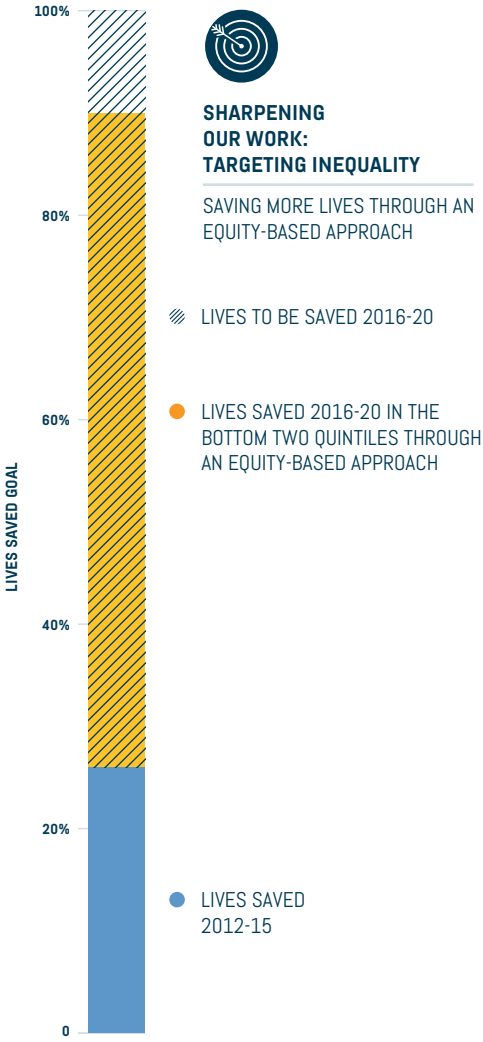
UNDER-5 MORTALITY RATE BY WEALTH QUINTILE V. BEST PERFORMER 2020



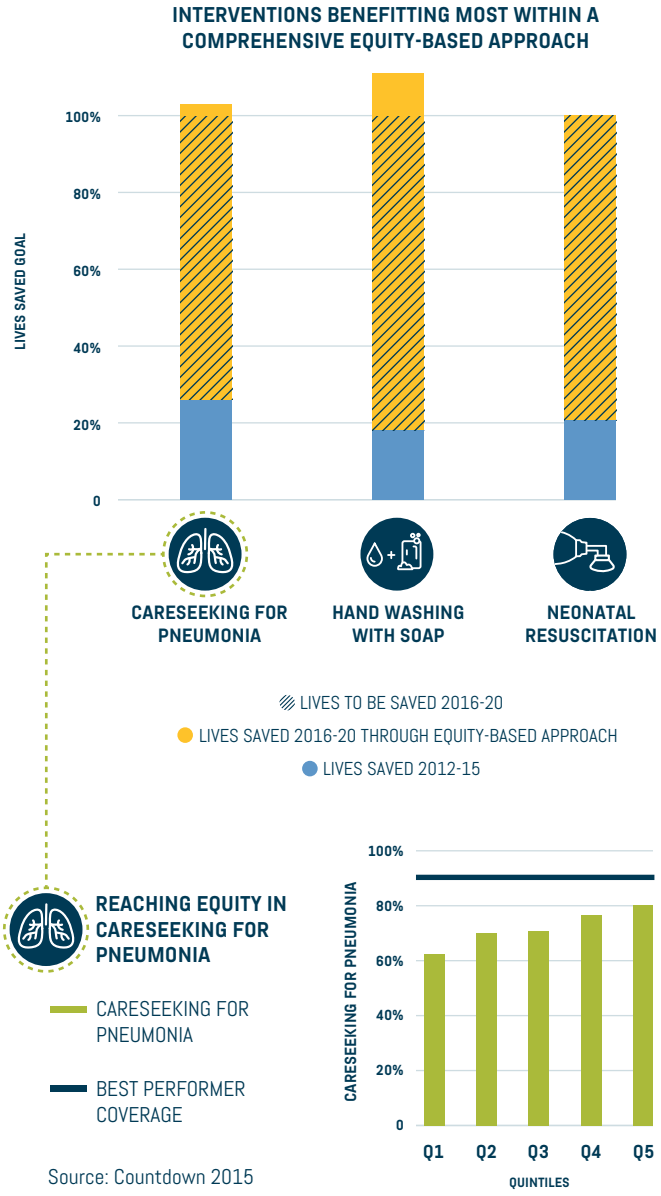
PROGRESS IN THE LAST YEAR:

- Established quality improvement teams in health facilities across High Priority Districts, resulting in a 13 percent decline in neonatal mortality at USAID supported facilities.
- Supported the Government of India (GoI) in hosting the third global *Call to Action* Summit, where the 2015 *Acting on the Call* report was launched by Prime Minister Narendra Modi.
- Supported data systems for assessing facility level readiness and providers' competency assessments, which have been scaled up nationally across 184 high priority districts to cover a population of 339 million.
- Influenced national policy to introduce injectable contraceptives and expand choice of contraceptives to clients.
- Partnered with the Bill & Melinda Gates Foundation (BMGF) and UNICEF to introduce rotavirus vaccine in the GoI immunization program.
- Enhanced facility readiness to address reproductive, maternal, newborn, child and adolescent health services in over 4,000 facilities across India by using supportive supervision data and addressing noted weaknesses in provider skills and competencies.
- Supported the training of service providers on placement of post-partum intrauterine contraceptive device, increasing access to long-acting contraception across project states.
- Support the state of Jharkhand to develop the "Jharkhand Drug Availability Tracking Tool 2015-16" to help monitor availability of 90 essential medicines across 229 facilities, thereby helping reach 33 million people.
- National Family Health Survey round four rolled-out in 15 states using real time data collection and monitoring and, for the first time, district level estimations of key health indicators.

2016-2020: AN EQUITY-BASED APPROACH
2,722,000 LIVES SAVED IN THE BOTTOM TWO QUINTILES
OF WHICH 619,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS



An equity-based approach focuses on the bottom two quintiles but impacts all five quintiles



Source: Countdown 2015

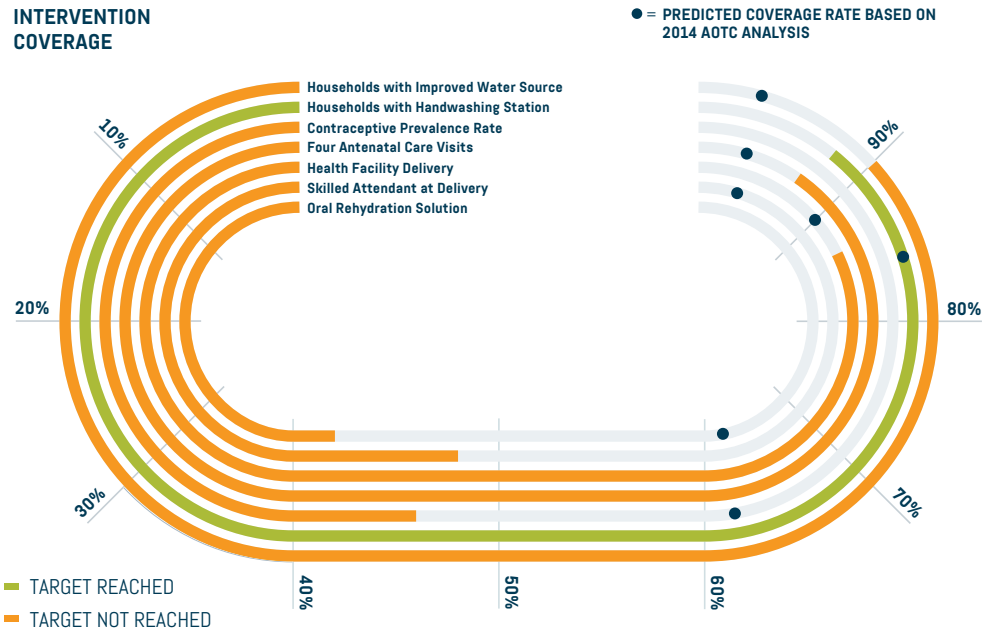
ENDING PREVENTABLE CHILD AND MATERNAL DEATHS REQUIRES A COMPREHENSIVE EQUITY-BASED APPROACH. USAID'S COMPREHENSIVE EQUITY-BASED APPROACH INCLUDES:

- Supporting the National Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) Unit that monitors the progress in improving key health outcomes in 184 High-Priority Districts across the country.
- Collaborating with the private sector to help it comply with, and take advantage of, a recent law mandating certain companies to invest in Corporate Social Responsibility activities.
- Paying special attention to urban poor settings to reduce out-of-pocket expenditures and scale up improved quality in private clinics. This is because health indicators among urban poor are even worse than in rural areas, even as out-of-pocket expenditures are high.
- Strengthening the health delivery system in select urban geographies to promote innovative ideas, in order to accelerate substantial and sustainable progress toward creating healthy cities.

INDONESIA

	Total Population	Population Under 5 Years	Under-5 Deaths / Year	Under-5 Mortality Rate Per 1,000 Live Births	Births	Maternal Mortality Ratio Per 100,000 Live Births
2015	256M ↑	21.3M ↓	147K ↓	27 ↓	4.3M ↓	126 ↓
1990	182M	21.5M	385K	83	4.6M	600

INTERVENTION COVERAGE



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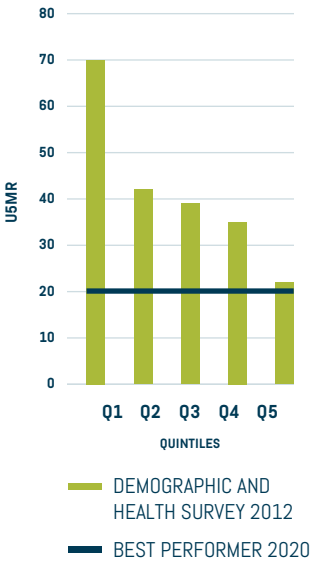
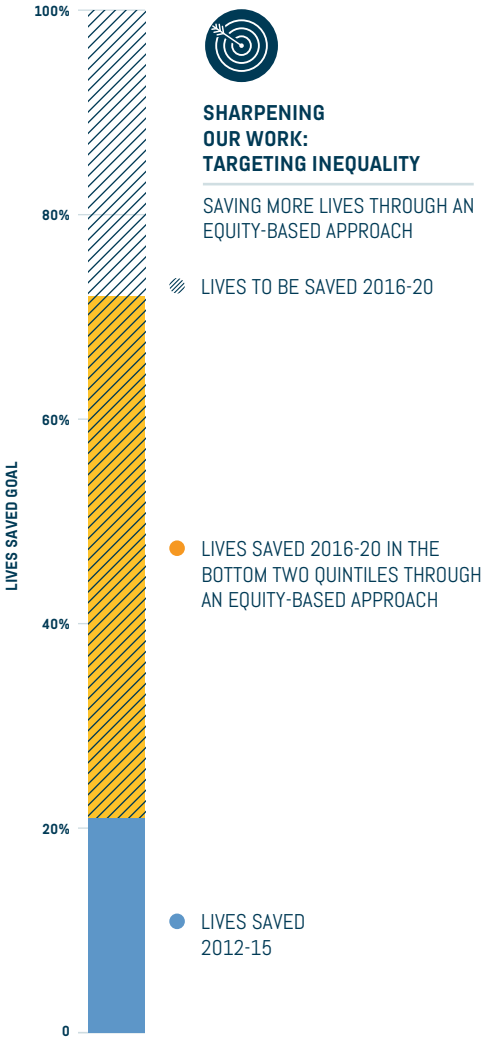
UNDER-5 MORTALITY RATE BY WEALTH QUINTILE V. BEST PERFORMER 2020



PROGRESS IN THE LAST YEAR:

- Finalized a national costed implementation plan for the Newborn Action Plan.
- Helped Government of Indonesia (GoI) develop and disseminate "Guidelines for Clinical Mentoring for Neonatal Health" to all 34 provinces across Indonesia.
- The GoI finalized the "2015 Collaborative Improvement Guidelines," which identify the USAID-supported mentoring model as a key approach through which quality of care and collaboration across facilities can be improved.
- Assisted the GoI in publishing national budget guidelines advocating and allowing provincial and district governments to use centrally allocated special allocation funds to implement and scale up approaches to provide lifesaving clinical and referral interventions.

2016-2020: AN EQUITY-BASED APPROACH
140,000 LIVES SAVED IN THE BOTTOM TWO QUINTILES
OF WHICH 12,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS



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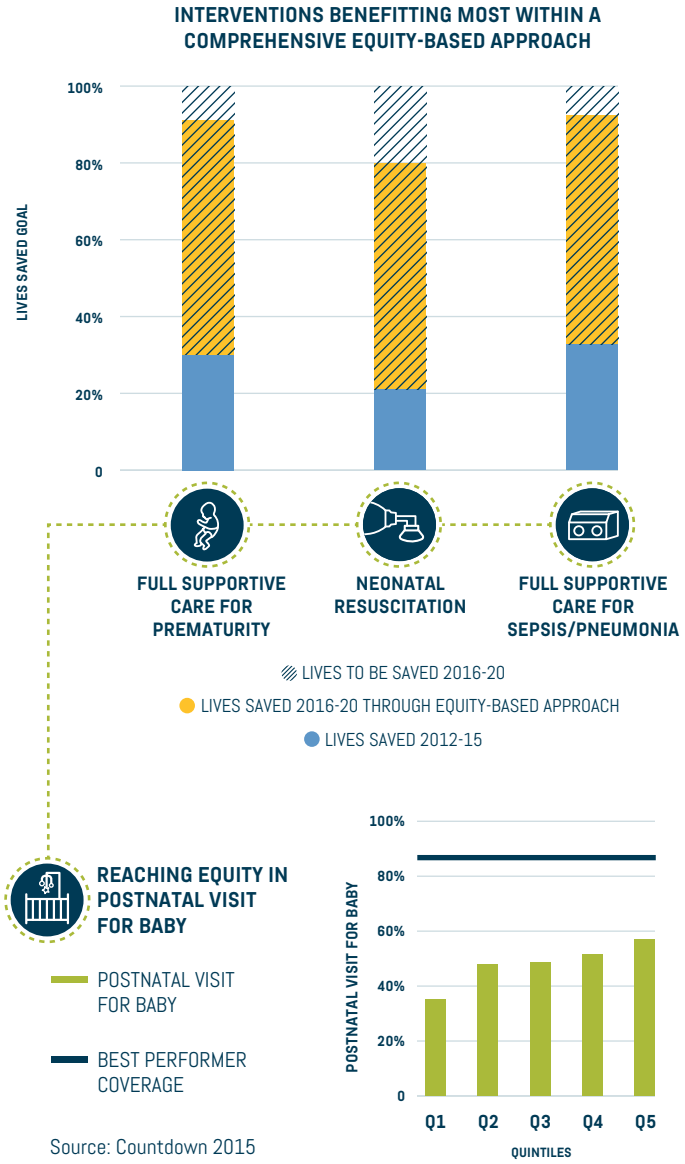


Source: Countdown 2015

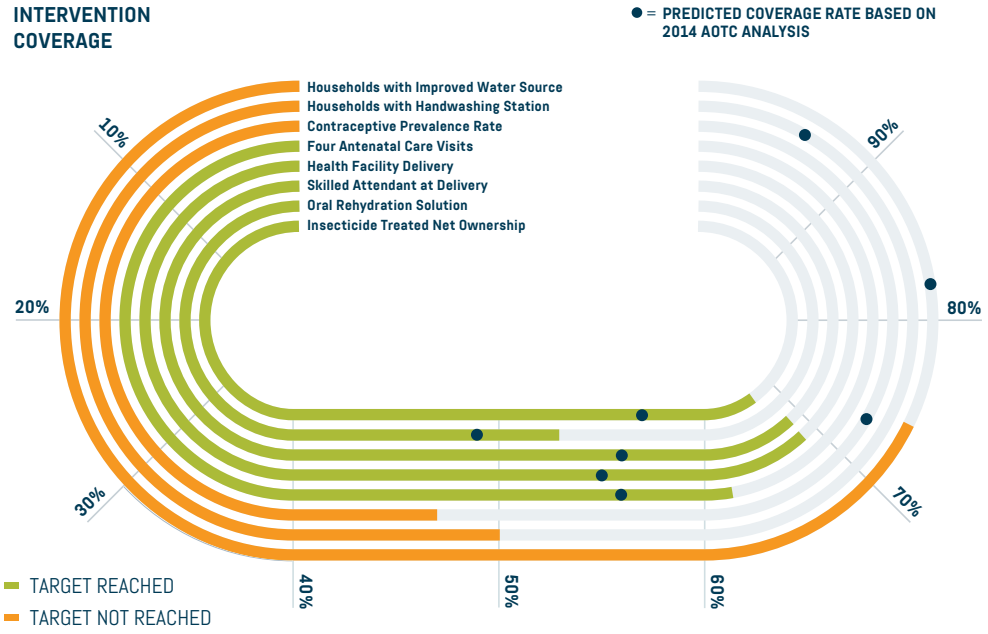
ENDING PREVENTABLE CHILD AND MATERNAL DEATHS REQUIRES A COMPREHENSIVE EQUITY-BASED APPROACH. USAID'S COMPREHENSIVE EQUITY-BASED APPROACH INCLUDES:

- Ensuring the poorest and most vulnerable women are aware of their insurance status, and that they understand how to access and use the health system, especially for maternal and neonatal health services.
- Working with the faith-based network known as Muhammadiyah to identify barriers for women and children and help them to register with the national social health insurance provider. This is accomplished by leveraging its health care networks across the country to help improve use of services by the poorest and most vulnerable.
- Linking community health care providers with primary health care networks through the SijariEMAS information system, improving the referral system from primary to secondary care.
- Working together with UNICEF, to assist provincial and district governments in Eastern Indonesia in supporting the integration of the evidence-based and minimum service standards into health program planning and budgeting.

KENYA

	2015	1990
Total Population	45.9M ↑	23M
Population Under 5 Years	6.4M ↑	4.2M
Under-5 Deaths / Year	74.4K ↓	95K
Under-5 Mortality Rate Per 1,000 Live Births	49 ↓	98
Births	1.2M ↑	927K
Maternal Mortality Ratio Per 100,000 Live Births	510 ↑	400

INTERVENTION COVERAGE



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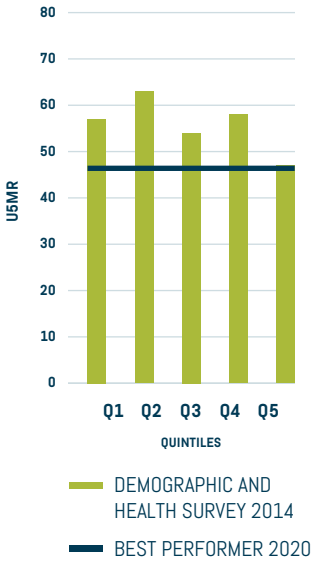
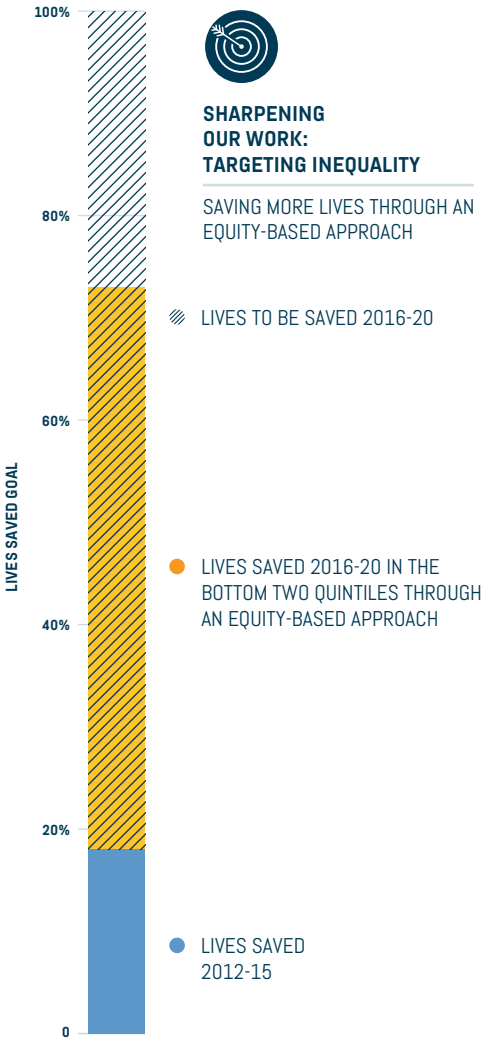
UNDER-5 MORTALITY RATE BY WEALTH QUINTILE V. BEST PERFORMER 2020



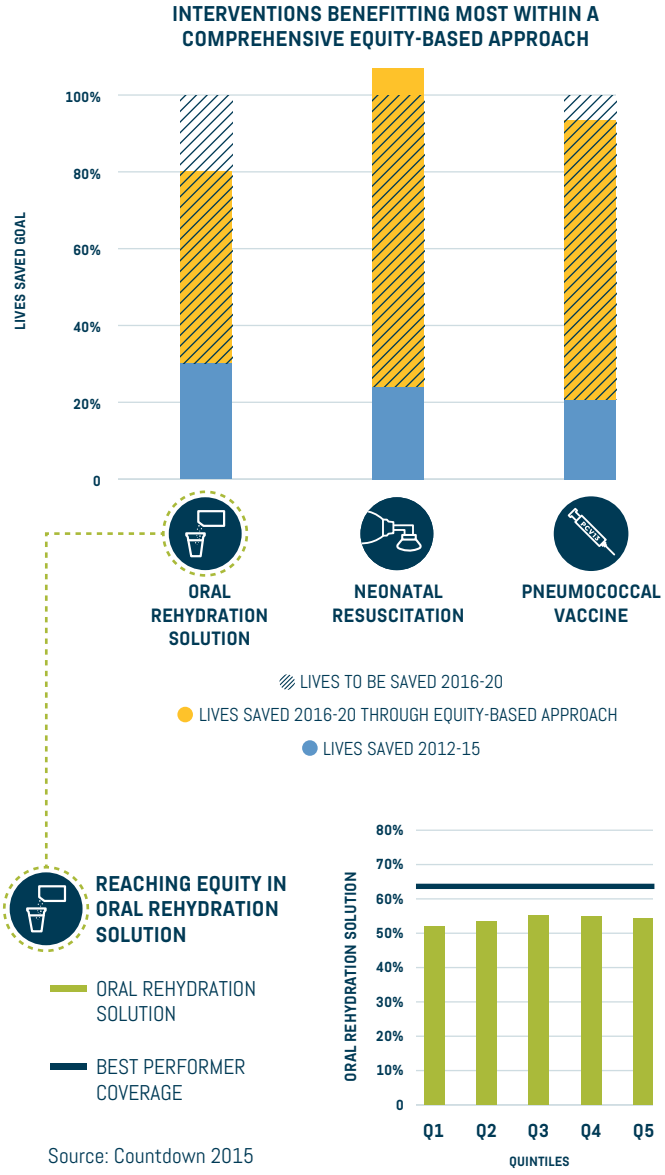
PROGRESS IN THE LAST YEAR:

- Procured 4,766 delivery kits, 1,903 fetoscopes (to monitor fetal heart rates), 1,231 vacuum extractors, 2,264 newborn Ambu Bags (manual resuscitators), 2,548 pediatric Ambu Bags, and 1,251 room heaters so that facilities could provide quality care to newborns.
- Supported sites enabling 624,180 women to receive skilled care during labor and delivery. Continued efforts to scale up emergency obstetric and newborn care (EmONC) in 17 counties, increasing the number of facilities offering the entire set of EmONC signal functions.
- Provided technical expertise at the national and county levels for the development and rollout of the RMNCH Scorecard, as well as for review and use of the Maternal and Perinatal Death Surveillance and Review guidelines, and the maternal and perinatal mortality reporting system.
- Refurbished maternity wards and newborn units in more than 100 facilities in 11 counties, increasing services for pregnant women and improving working conditions for health care providers.
- Provided support for supply chain strengthening for nutrition commodities, including redistribution of Vitamin A capsules between various health facilities to prevent stock outs.
- In partnership with the Ministry of Health's Unit of Vaccines and Immunization Services, financed a mass media immunization campaign targeting caregivers of children under 2 years old in the 10 counties with the lowest immunization coverage. In addition, 200 community health volunteers received training in interpersonal communication to promote immunization.

2016-2020: AN EQUITY-BASED APPROACH
169,000 LIVES SAVED IN THE BOTTOM TWO QUINTILES
OF WHICH 74,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS



An equity-based approach focuses on the bottom two quintiles but impacts all five quintiles



Source: Countdown 2015

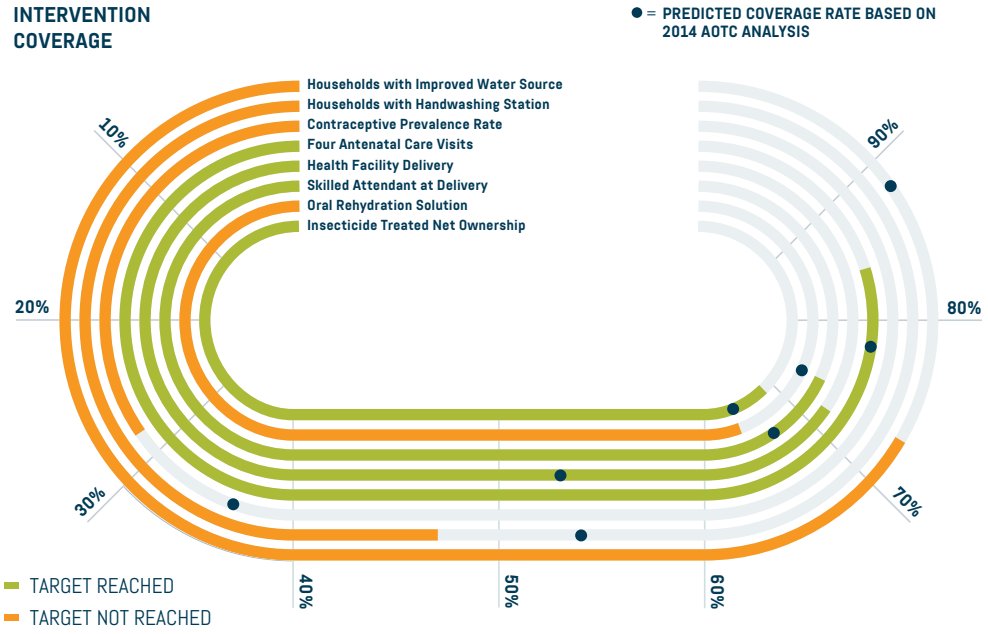
ENDING PREVENTABLE CHILD AND MATERNAL DEATHS REQUIRES A COMPREHENSIVE EQUITY-BASED APPROACH. USAID'S COMPREHENSIVE EQUITY-BASED APPROACH INCLUDES:

- Focusing health resources in fewer geographic areas guided by epidemiology, equity, and the goal of reaching vulnerable populations, while also ensuring alignment of resources with Government of Kenya, other development partners, the private sector, and faith-based partners.
- Improving access to and quality of RMNCAH services for residents of Nairobi's informal settlements where health outcomes are poorer than in the rest of the county.

LIBERIA

	Total Population	Population Under 5 Years	Under-5 Deaths / Year	Under-5 Mortality Rate Per 1,000 Live Births	Births	Maternal Mortality Ratio Per 100,000 Live Births
2015	4.2M ↑	651K ↑	10.5K ↓	70 ↓	144K ↑	725 ↓
1990	2.1M	386K	22.5K	247	102K	1,200

INTERVENTION COVERAGE



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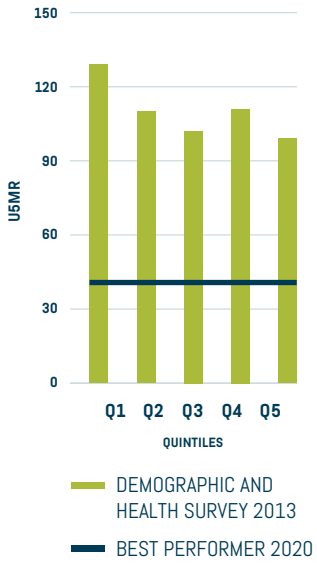
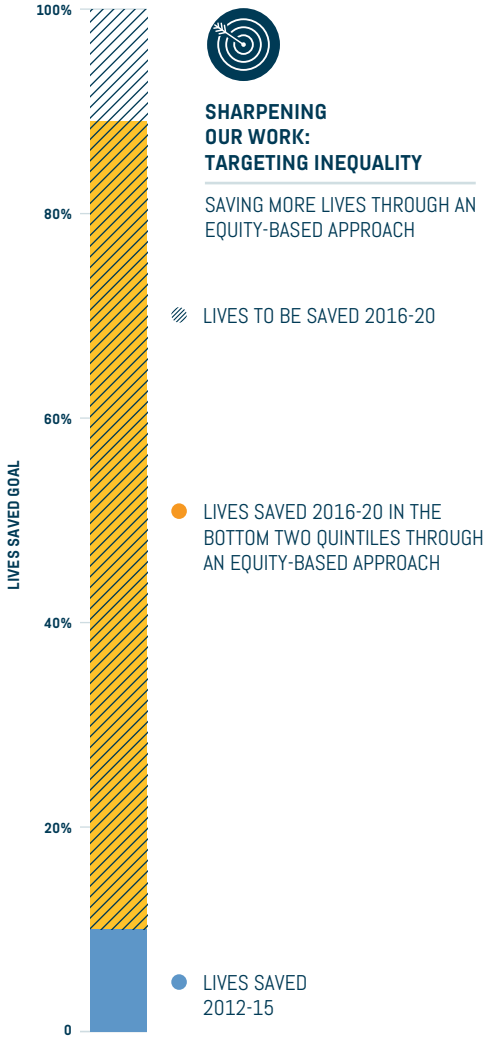
UNDER-5 MORTALITY RATE BY WEALTH QUINTILE V. BEST PERFORMER 2020



PROGRESS IN THE LAST YEAR:

- Supported pilot studies for chlorhexidine for newborn cord care and kangaroo mother care interventions and development of a related national policy.
- Trained and equipped community health volunteers to deliver integrated community case management (iCCM) to children under age 5 in over 230 communities.
- Provided mentoring and on-the-job training in quality maternal, newborn and child health care to nearly 700 frontline health providers.
- Successfully expanded access to safe water, sanitation, and hygiene through community-level interventions, including Community-Led Total Sanitation and WASH entrepreneurs who sold WASH commodities and services, and by rehabilitating nearly 400 water points to reduce water-and sanitation-related diseases.
- More than 7,000 health providers, community members and NGO workers were trained on infection prevention and control between July and November 2014, at the height of the Ebola crisis.
- As part of the post-Ebola strategy, conducted Periodic Intensified Routine Immunization activities as a response to measles outbreaks, and aimed at improving vaccination coverage in all counties.
- Strengthened over 3,000 community volunteers, through training and supervision. These trained health volunteers reached more than 75,000 women with key maternal and child health messages.

2016-2020: AN EQUITY-BASED APPROACH
34,000 LIVES SAVED IN THE BOTTOM TWO QUINTILES
OF WHICH 12,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS



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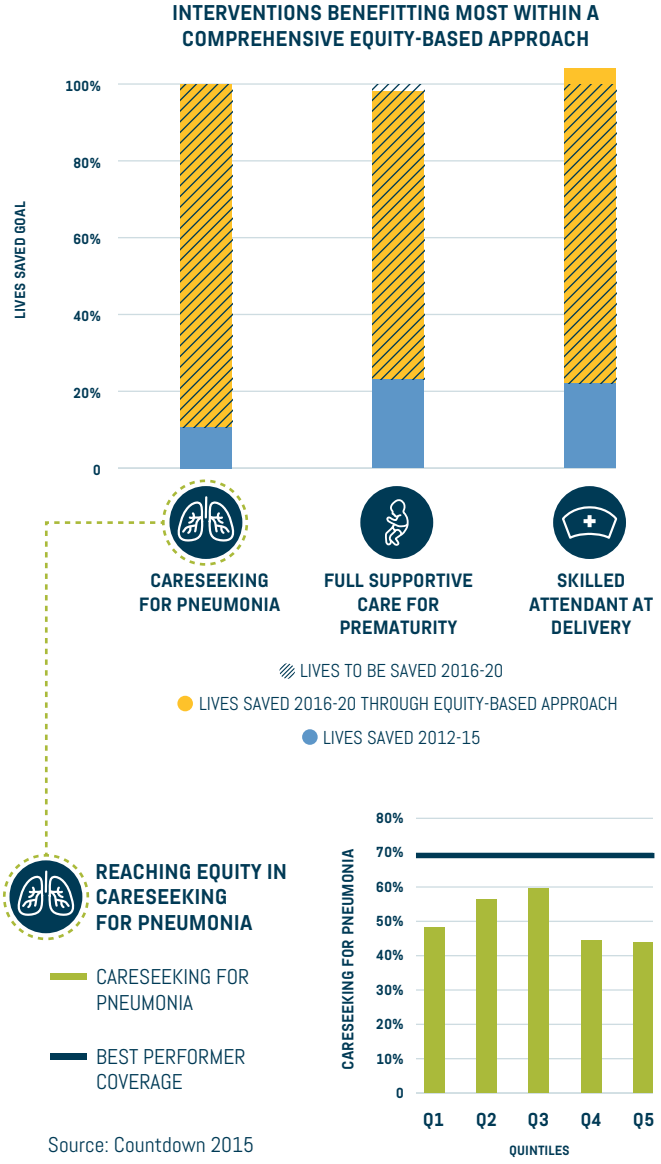


Source: Countdown 2015

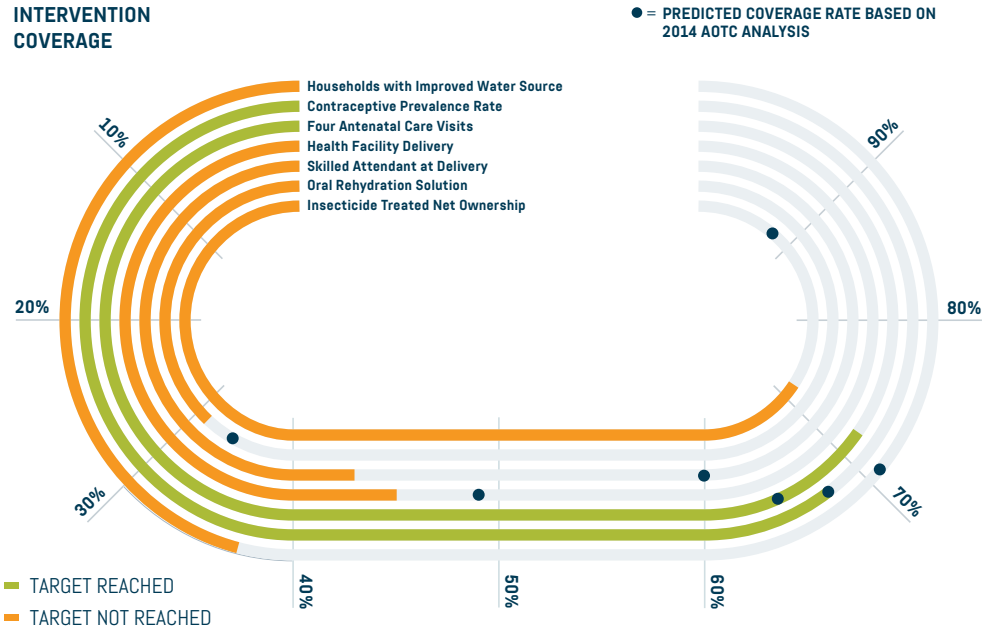
ENDING PREVENTABLE CHILD AND MATERNAL DEATHS REQUIRES A COMPREHENSIVE EQUITY-BASED APPROACH. USAID'S COMPREHENSIVE EQUITY-BASED APPROACH INCLUDES:

- Supporting the Ministry of Health to design and advance reforms, such as the proposed Liberia Health Equity Fund, to improve sustainability of health financing.
- Generating evidence and building consensus around the objectives and scope of reforms.
- Development of a National Quality Strategy and support to the Ministry of Health to roll out a comprehensive package of interventions to improve adherence to clinical standards at all levels for safe, quality care, in order to reduce facility-based morbidity and mortality. Approaches include roll-out of Improvement Collaboratives and other team-based and peer mentorship models, complemented by enhanced supportive supervision, and generation of evidence around quality improvement.

MADAGASCAR

	23.8M ↑ Total Population	3.6M ↑ Population Under 5 Years	40K ↓ Under-5 Deaths / Year	50 ↓ Under-5 Mortality Rate Per 1,000 Live Births	777K ↑ Births	353 ↓ Maternal Mortality Ratio Per 100,000 Live Births
2015	23.8M	3.6M	40K	50	777K	353
1990	11.6M	2.1M	80K	158	530K	640

INTERVENTION COVERAGE



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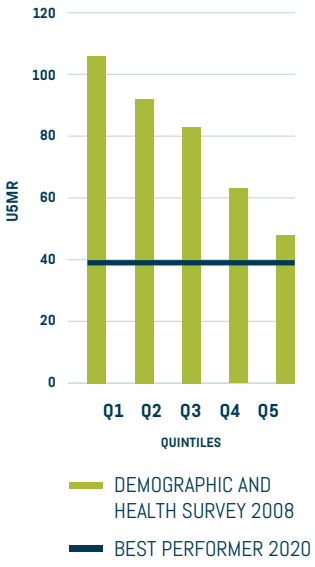
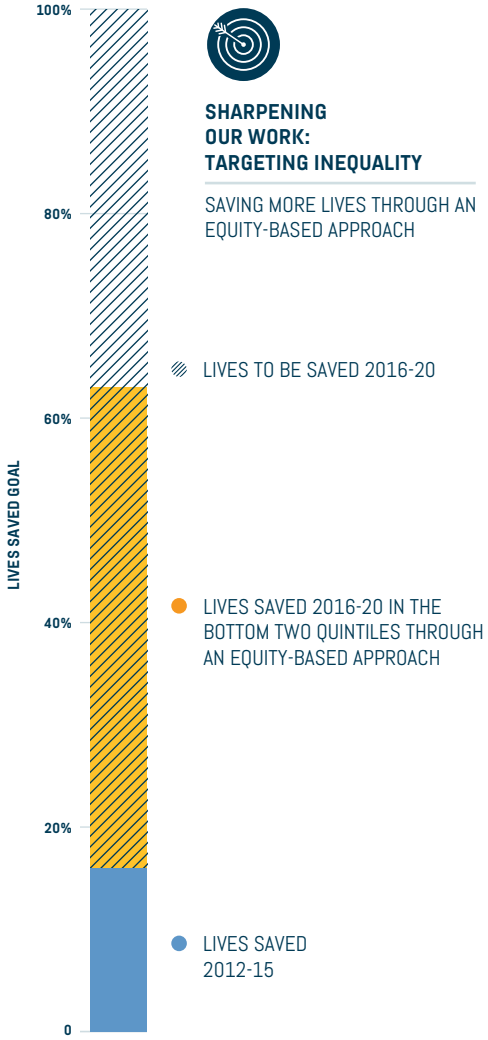
UNDER-5 MORTALITY RATE BY WEALTH QUINTILE V. BEST PERFORMER 2020



PROGRESS IN THE LAST YEAR:

- Community-based use of chlorhexidine approved to treat umbilical cord infections. Scale-up for community distribution in 15 of the country's 22 regions is now underway.
- Partners have come together to provide coordinated support to the country's polio campaigns. In addition, more resources have been devoted to immunization support to prevent future outbreaks.
- Community-based use of misoprostol was approved to treat postpartum hemorrhage (PPH).
- Integrated community health activities and integrated social marketing activity contributed to the treatment of over 1.8 billion liters of water serving over 1 million people.
- Developed a public-private partnership with Coca-Cola to develop WASH infrastructure and behavior change communication to target the urban poor and underserved rural areas.
- Conducted two studies to assess the sociocultural determinants of malnutrition, as well as the relationship between malnutrition and parasites. Findings will inform future activities to target malnutrition.

2016-2020: AN EQUITY-BASED APPROACH
89,000 LIVES SAVED IN THE BOTTOM TWO QUINTILES
OF WHICH 43,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS



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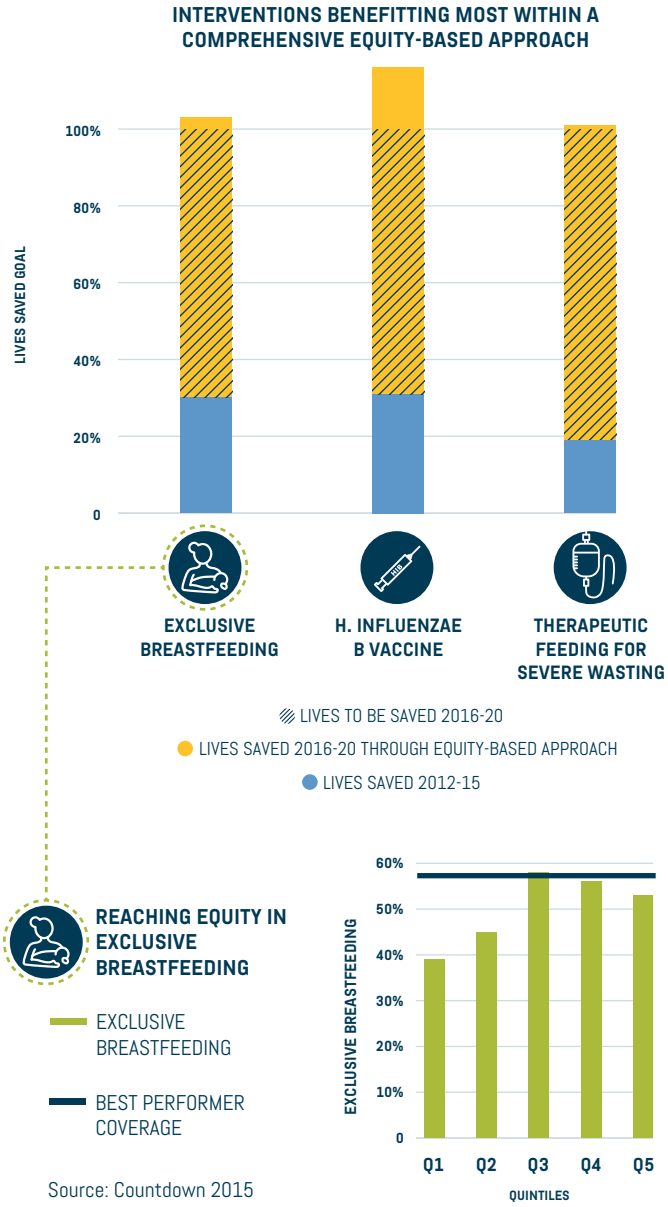


Source: Countdown 2015

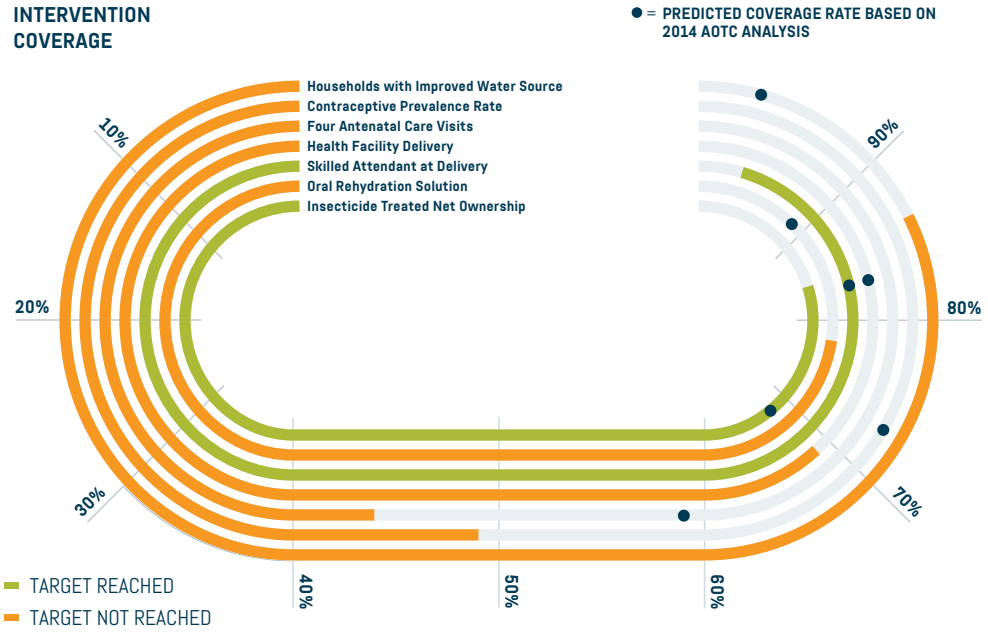
ENDING PREVENTABLE CHILD AND MATERNAL DEATHS REQUIRES A COMPREHENSIVE EQUITY-BASED APPROACH. USAID'S COMPREHENSIVE EQUITY-BASED APPROACH INCLUDES:

- Implementing community health programs in rural and underserved areas to provide training and support to community health volunteers so they can provide accessible and culturally appropriate health care to their communities.
- Initiating a new activity to expand community-based activities in seven remote districts in the northwest and east coasts.
- Supporting a private clinic franchise which offers Maternal and Child Health (MCH) and FP services targeting clients from the lowest two wealth quintiles through integrated social marketing.
- Implementing a Development Credit Authority 50% loan guarantee to increase access to credit for health service providers. This parallels support for the development of loan products targeted at health providers in poor and underserved regions.
- Providing support for the implementation of a youth voucher program to reach teens 15-19. Young people are receiving a free voucher redeemable at a Blue Star social franchise clinic for a package of voluntary FP and sexually transmitted infection information and services. E-vouchers are available for those with mobile phones.

MALAWI

	18M ↑ Total Population	3.3M ↑ Population Under 5 Years	40K ↓ Under-5 Deaths / Year	64 ↓ Under-5 Mortality Rate Per 1,000 Live Births	747K ↑ Births	634 ↓ Maternal Mortality Ratio Per 100,000 Live Births
2015						
1990	9.5M	1.8M	102.5K	244	459K	1,100

INTERVENTION COVERAGE



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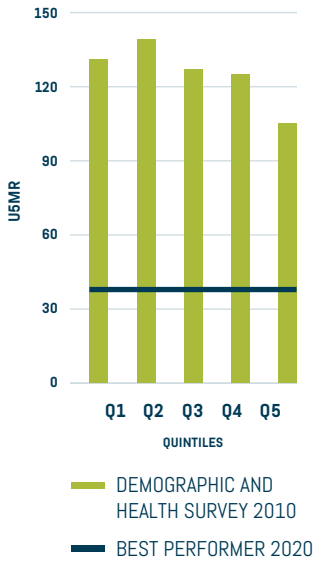
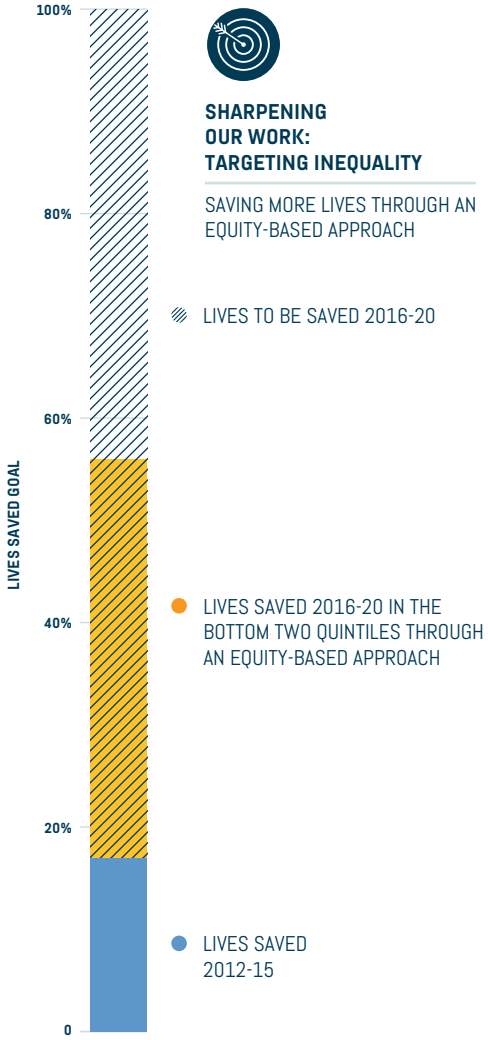
UNDER-5 MORTALITY RATE BY WEALTH QUINTILE V. BEST PERFORMER 2020



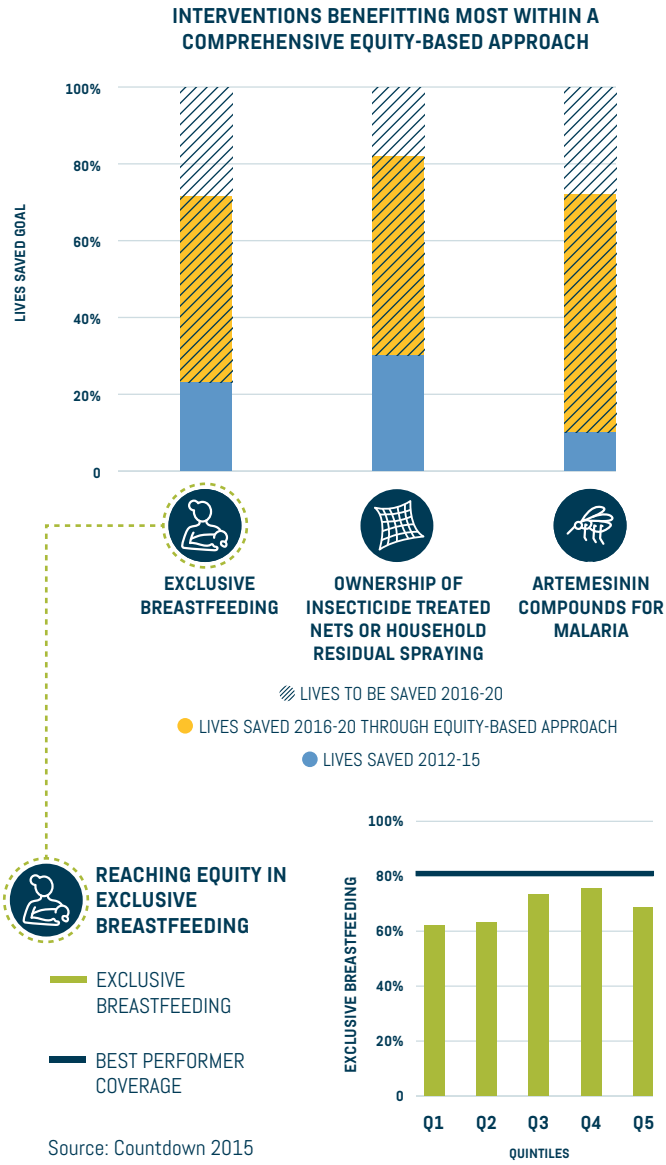
PROGRESS IN THE LAST YEAR:

- Conducted training of trainers on postnatal care. Postnatal care registers were printed and distributed to all facilities in the country to enable better monitoring of quality service provision for newborns.
- Trained health workers on the use of antenatal corticosteroids in Obstetric and Pediatric Associations in all district hospitals.
- Integrated family planning and immunization services, (a recognized high-impact practice) were rolled out in two districts.
- Conducted a facility assessment and finalized plans to enable facilities to provide high quality care for pre-term infants.
- Community-based maternal and newborn health guidelines were rolled out in 16 districts.

2016-2020: AN EQUITY-BASED APPROACH
76,000 LIVES SAVED IN THE BOTTOM TWO QUINTILES
OF WHICH 31,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS



An equity-based approach focuses on the bottom two quintiles but impacts all five quintiles



Source: Countdown 2015

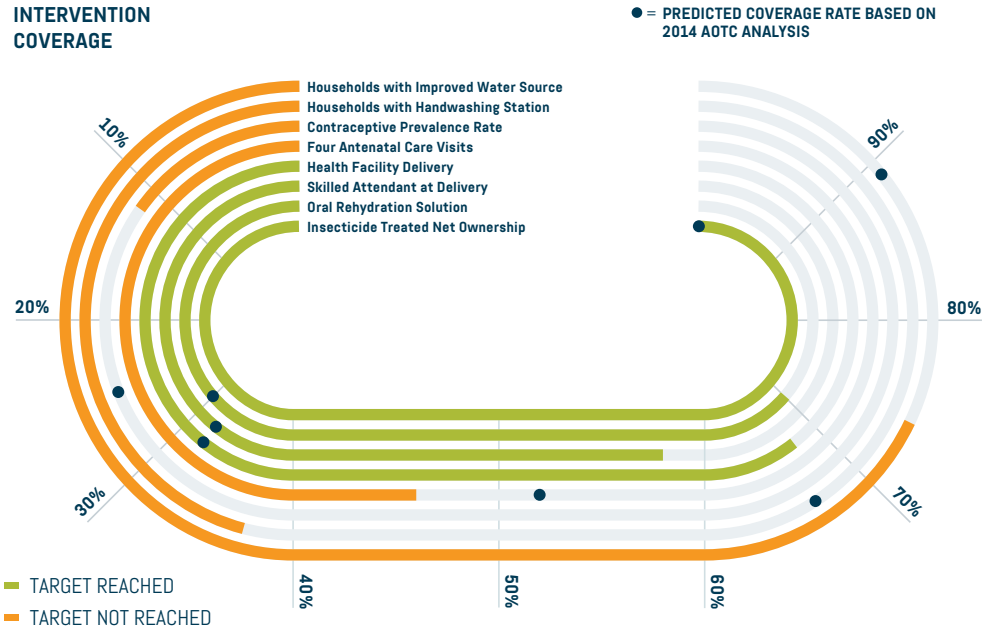
ENDING PREVENTABLE CHILD AND MATERNAL DEATHS REQUIRES A COMPREHENSIVE EQUITY-BASED APPROACH. USAID'S COMPREHENSIVE EQUITY-BASED APPROACH INCLUDES:

- Consideration of gender and geographic locations to target hard-to-reach and vulnerable groups, such as adolescents seeking sexual and reproductive health care, orphans and vulnerable children, rural and traditional communities, and border and migrant populations.
- Improving equity and efficiency in the delivery of quality Essential Health Package services through a human rights-based approach.
- Outreach, including mobile clinics, to overcome barriers to serving hard-to-reach populations.
- Shifting of essential services to Health Surveillance Assistants to reach more communities and village clinics with immunization, family planning, and child health services.
- Conducting sensitization meetings to raise awareness about available services and the need for special groups to access them.

MALI

	2015	1990
Total Population	17M ↑	8.5M
Population Under 5 Years	3.2M ↑	1.6M
Under-5 Deaths / Year	82K ↓	90.7K
Under-5 Mortality Rate Per 1,000 Live Births	115 ↓	253
Births	763K ↑	440K
Maternal Mortality Ratio Per 100,000 Live Births	587 ↓	1.1K

INTERVENTION COVERAGE



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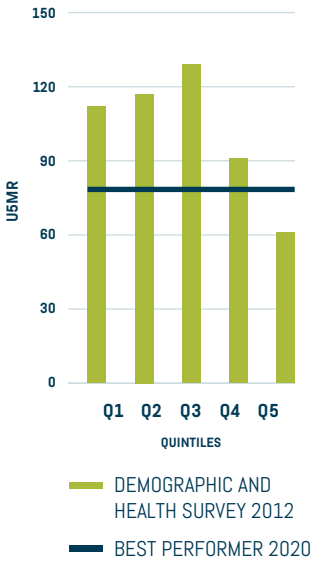
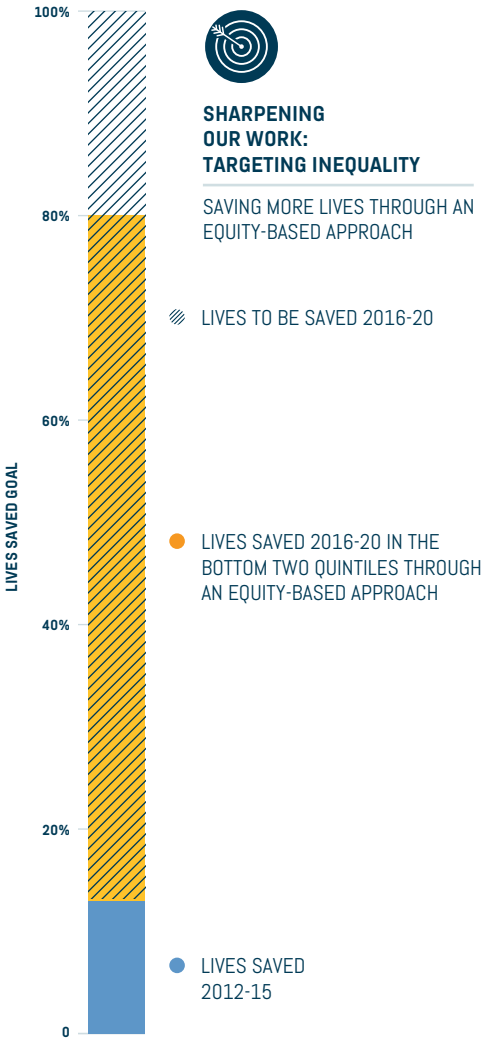
UNDER-5 MORTALITY RATE BY WEALTH QUINTILE V. BEST PERFORMER 2020



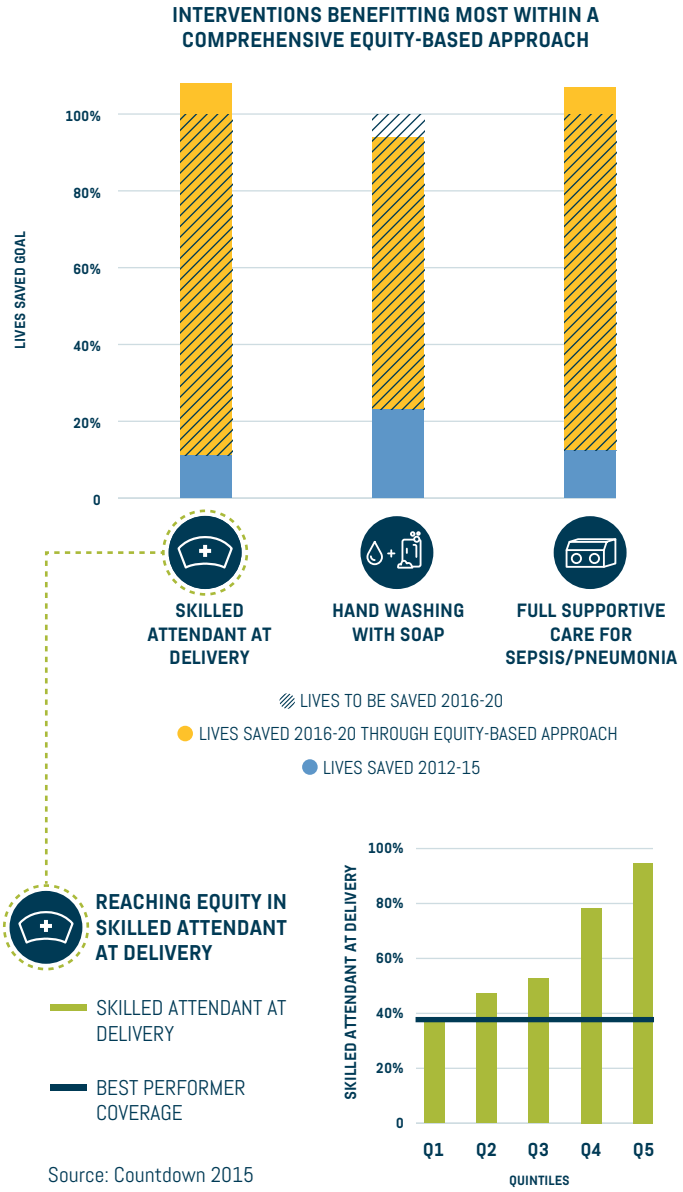
PROGRESS IN THE LAST YEAR:

- Supported the Ministry of Health to determine an essential integrated package of care for the community, and developed tools for management and supervision of community health workers to provide the care package.
- Supported the development of a chlorhexidine roll-out plan to health facilities in four districts, to include training and social and behavior change components.
- Supported the Ministry of Health to update its malaria in pregnancy strategy and develop data collection and reporting tools to reflect the new World Health Organization (WHO) recommendations.

2016-2020: AN EQUITY-BASED APPROACH
173,000 LIVES SAVED IN THE BOTTOM TWO QUINTILES
OF WHICH 52,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS



An equity-based approach focuses on the bottom two quintiles but impacts all five quintiles



Source: Countdown 2015

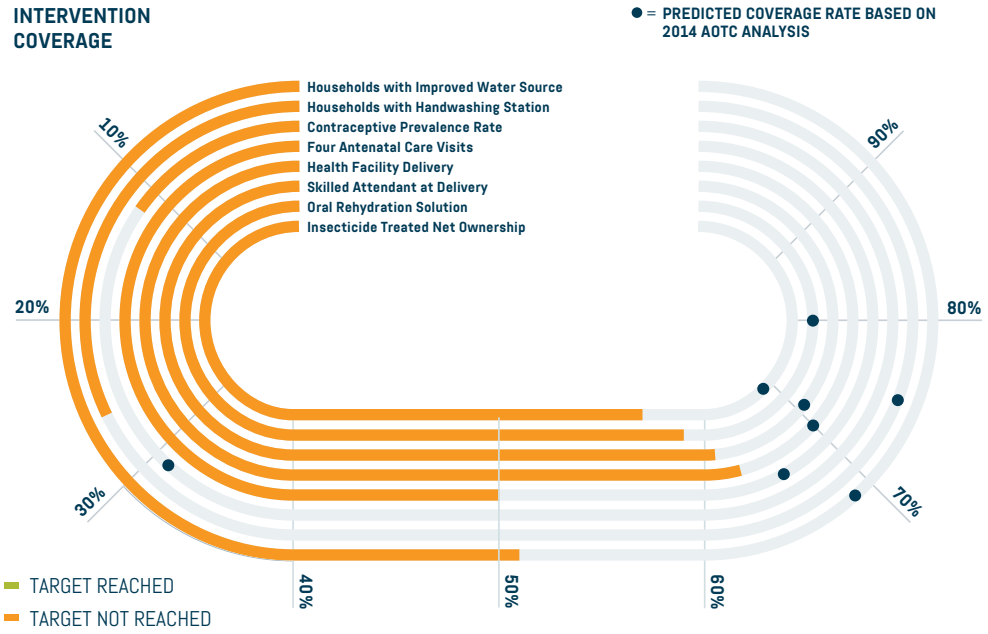
ENDING PREVENTABLE CHILD AND MATERNAL DEATHS REQUIRES A COMPREHENSIVE EQUITY-BASED APPROACH. USAID'S COMPREHENSIVE EQUITY-BASED APPROACH INCLUDES:

- Supporting nearly 1,500 community health agents to provide an essential package of simple, preventive , and curative health care services for underserved communities and households located more than five kilometers from a clinic, to achieve 100 percent population coverage in three large regions of Mali.
- Leveraging existing commercial distribution channels to support the marketing of products and provision of services, to expand community-based health care delivery using social network approaches, and strategically expanding public and private franchises and NGO clinics.
- Four mobile outreach teams, composed of a doctor and a midwife, traveling to rural and peri-urban locations in four priority program regions to deliver a comprehensive range of FP methods. Each mobile team serves approximately 30 sites in each region and builds capacity of clinic staff over a period of two years.
- Working with local legislators to promote inclusion of salaries for Community Health Agents in the national budget, and advocate with parliamentarians and religious leaders for greater support for family planning and women's health issues.

MOZAMBIQUE

	25M ↑ Total Population	4M ↑ Population Under 5 Years	82K ↓ Under-5 Deaths / Year	79 ↓ Under-5 Mortality Rate Per 1,000 Live Births	976K ↑ Births	489 ↓ Maternal Mortality Ratio Per 100,000 Live Births
2015						
1990	13M	2M	132K	233	611K	910

INTERVENTION COVERAGE



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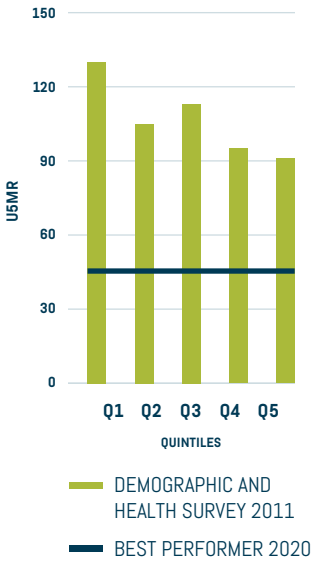
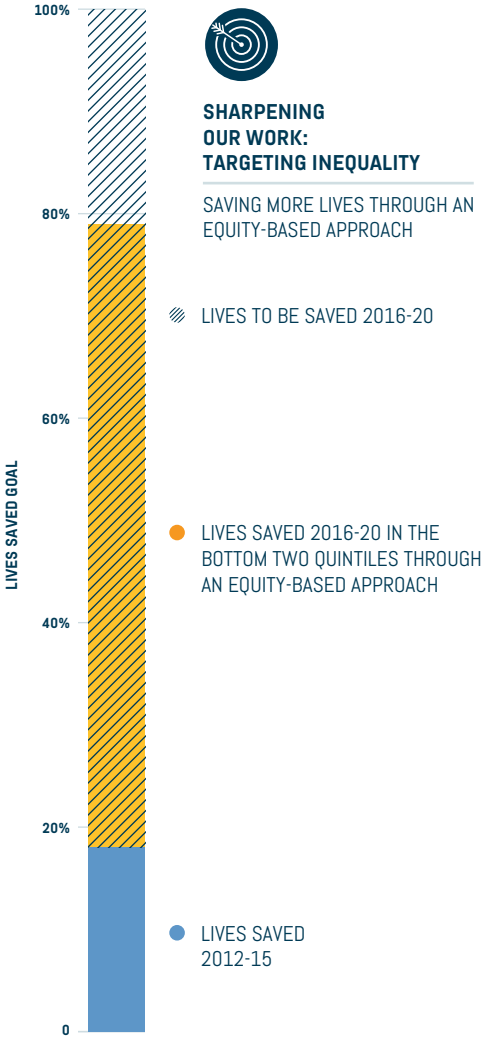
UNDER-5 MORTALITY RATE BY WEALTH QUINTILE V. BEST PERFORMER 2020



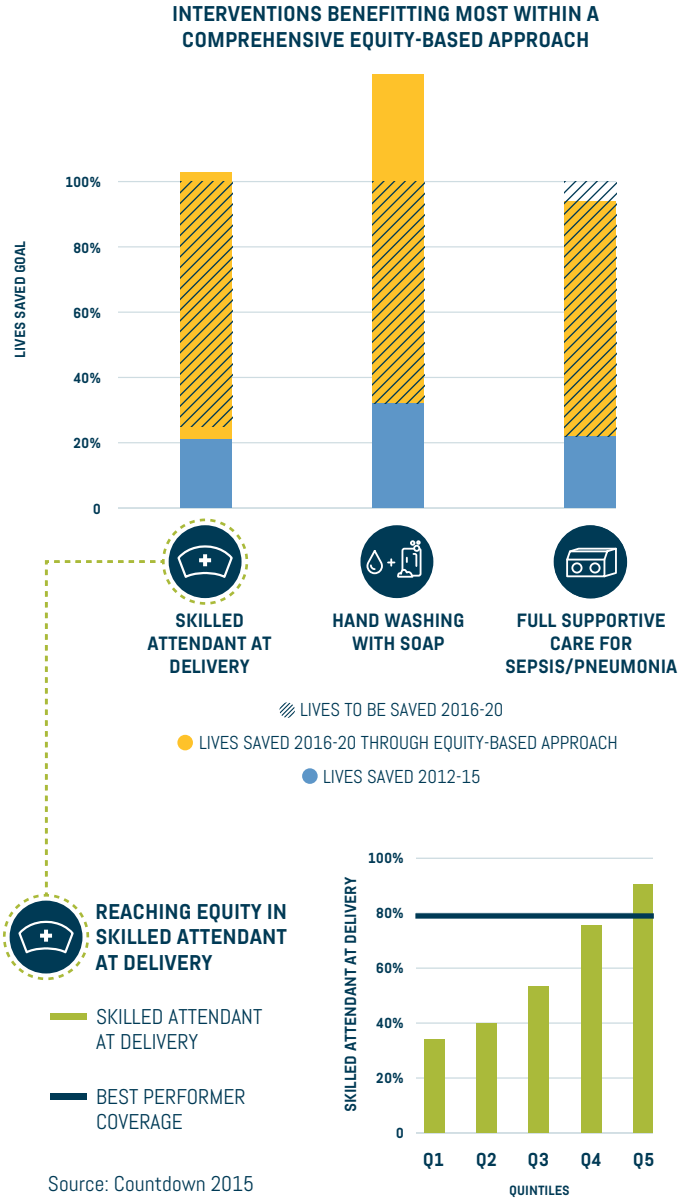
PROGRESS IN THE LAST YEAR:

- The Government of Mozambique (GoM) approved a national policy for family planning integration, and operationalized integrated activities to support MNCH/RH/FP/Malaria/Nutrition areas in Nampula and Sofala, covering 27 percent of the country's population.
- In collaboration with the GoM, gradually introduced chlorhexidine for cord care at health facilities, Sayana Press injectable contraceptive, and three new vaccines (Rotavirus, IPV and measles second dose).
- Revitalized IMCI activities nationwide through training, technical assistance, and supportive supervision. Trained MCH nurses in IMCI at the national scale while implementing facility based-IMCI to address the major diseases responsible for under-5 death.
- The Ministry of Health adopted a National Behavioral Change Strategy for Nutrition.
- The National Fortification Policy has been adopted and includes mandatory fortification of five key staple foods, and the phased roll out of a national micronutrient powder program.

2016-2020: AN EQUITY-BASED APPROACH
160,000 LIVES SAVED IN THE BOTTOM TWO QUINTILES
OF WHICH 37,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS



An equity-based approach focuses on the bottom two quintiles but impacts all five quintiles



Source: Countdown 2015

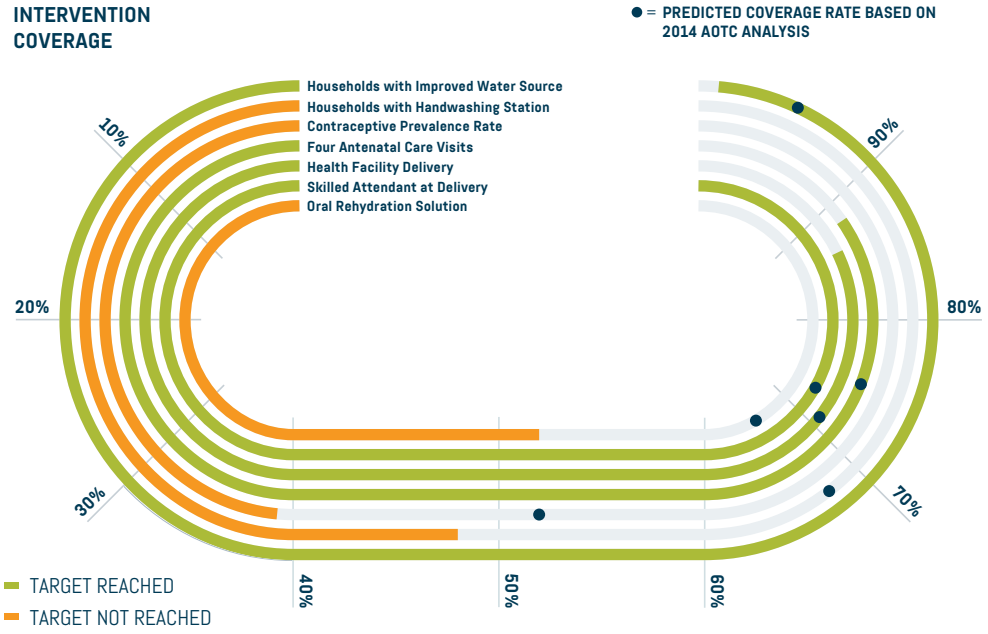
ENDING PREVENTABLE CHILD AND MATERNAL DEATHS REQUIRES A COMPREHENSIVE EQUITY-BASED APPROACH. USAID'S COMPREHENSIVE EQUITY-BASED APPROACH INCLUDES:

- Expansion of high-impact, evidence-based interventions, including: iCCM to address the major diseases responsible for under-5 deaths, including recognition of danger signs; misoprostol for the prevention of postpartum hemorrhage; and chlorhexidine during newborn cord care.
- Targeting family planning services to populations with unmet needs, including postpartum women, adolescents, high parity women, and post-abortion women. Services will be delivered at facility and community levels through mobile brigades and Community Health Workers, and will address gender barriers by building an enabling environment that increases male engagement and community awareness in support of FP.
- Focusing maternal health service on adolescents, with programs aiming to increase both the capacity of communities and the responsiveness of the Ministry of Health to be to meet the growing needs of this sizable population of young mothers.

NEPAL

	31.6M ↑ Total Population	3.1M ↓ Population Under 5 Years	20K ↓ Under-5 Deaths / Year	36 ↓ Under-5 Mortality Rate Per 1,000 Live Births	651K ↓ Births	258 ↓ Maternal Mortality Ratio Per 100,000 Live Births
2015						
1990	19M	3.2M	95K	142	768K	770

INTERVENTION COVERAGE



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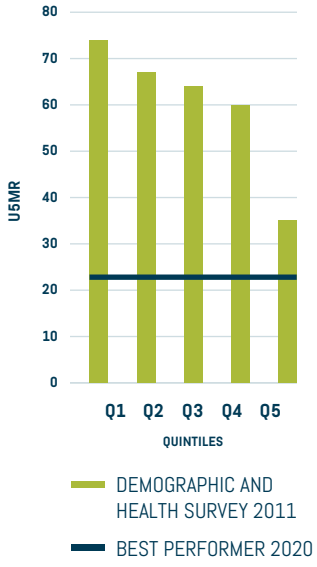
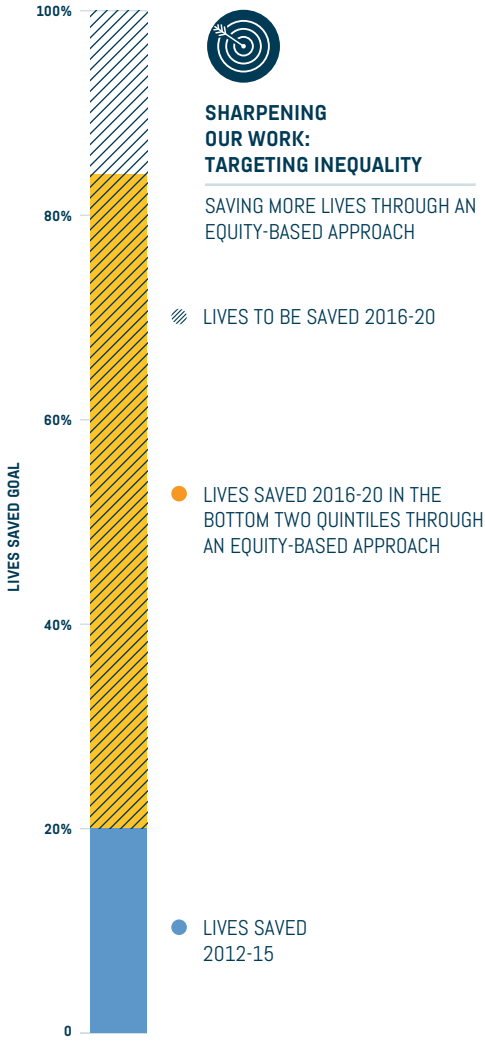
UNDER-5 MORTALITY RATE BY WEALTH QUINTILE V. BEST PERFORMER 2020



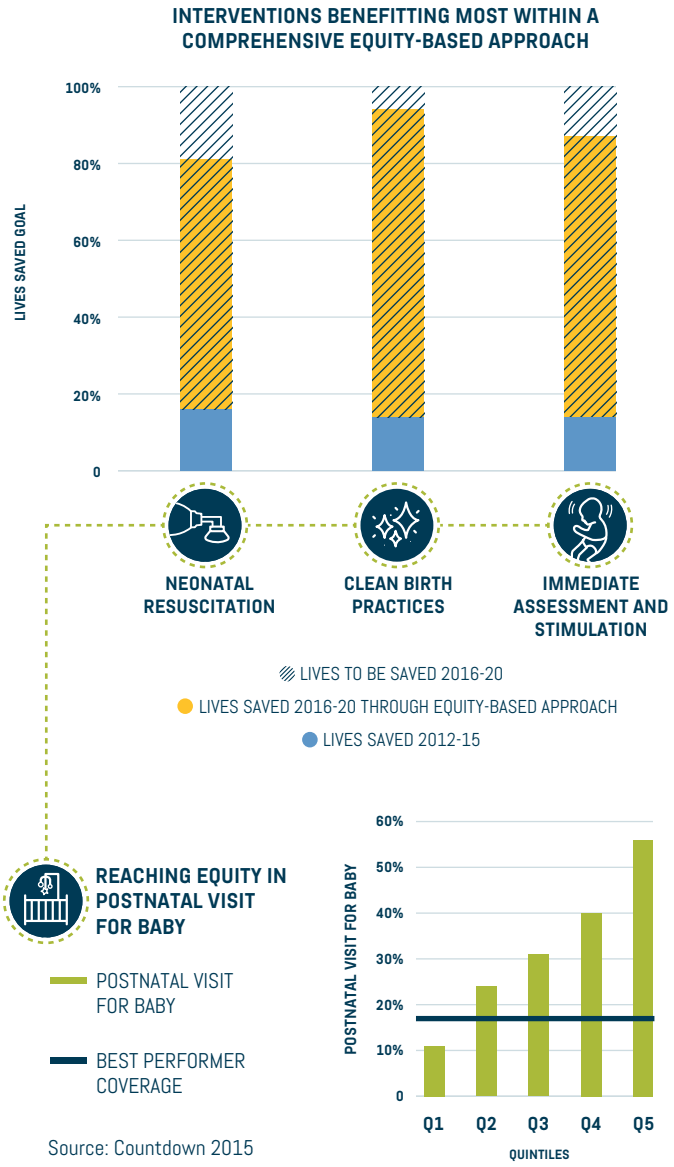
PROGRESS IN THE LAST YEAR:

- Advocated for nutrition at both policy and implementation levels, prioritizing nutrition in national programming while also leading efforts to harmonize program planning among donors in coordination with the Government of Nepal (GoN). As a result, the GoN has scaled up implementation of the multisectoral nutrition plan in an additional 10 districts. USAID will continue to support implementation of integrated maternal, newborn and child health, family planning, WASH and nutrition activities in 40 out of 75 districts in Nepal.
- Actively supported the Ministry of Health in preparing a harmonized annual work plan and participated as a key member of the National Nutrition and Food Security Coordination Committee and Nutrition Technical Committee. Also actively engaged in several GoN coordination platforms under the Ministry of Health and National Planning Commission while also providing support to the Ministry of Health in finalizing the maternal and infant young child nutrition action plan. The plan incorporates both outcome and goal level nutrition indicators, as reflected in the Nepal Health Sector Strategy 2015-2020.
- Played a major role in conducting the post-earthquake needs assessment, which helped the GoN prioritize nutrition and food security activities in highly-affected districts.
- Advocated for the local mobilization of nearly $1 million for health interventions from GoN block grants provided at the village level. Key strategies included raising awareness of availability of block grants, using local data for decision making, and building community capacity to participate in local planning and monitoring processes.
- Chlorhexidine for newborn cord care was endorsed as a key newborn intervention in Nepal's Every Newborn Action Plan and is being scaled up nationally.
- Rolled out a quality improvement system in three districts and select Village Development Committees in 11 other districts. under the Health for Life Project, with the plan to scale-up fully in a total of 14 districts.

2016-2020: AN EQUITY-BASED APPROACH
45,000 LIVES SAVED IN THE BOTTOM TWO QUINTILES
OF WHICH 7,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS



An equity-based approach focuses on the bottom two quintiles but impacts all five quintiles



Source: Countdown 2015

ENDING PREVENTABLE CHILD AND MATERNAL DEATHS REQUIRES A COMPREHENSIVE EQUITY-BASED APPROACH. USAID'S COMPREHENSIVE EQUITY-BASED APPROACH INCLUDES:

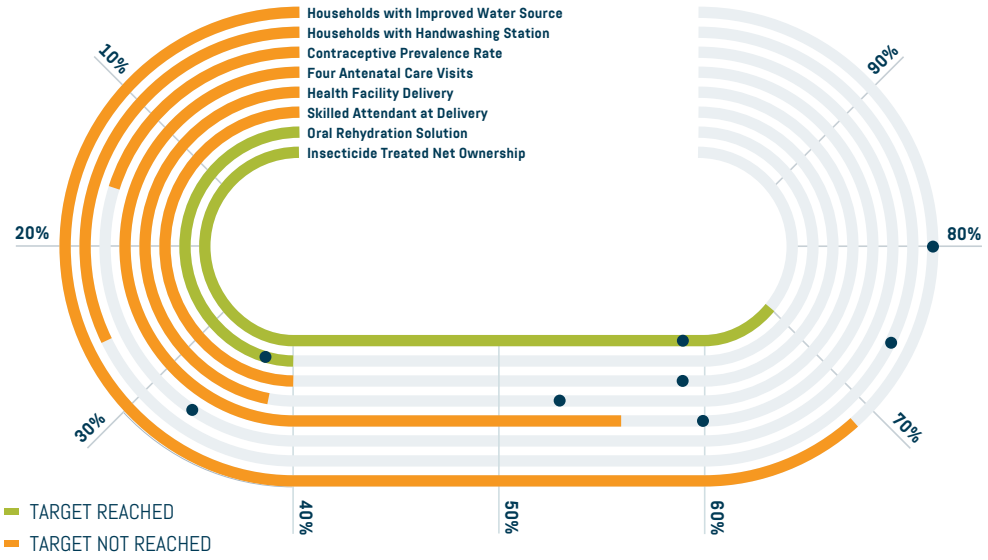
- Reaching all 1,000-day households (those with pregnant women and/or children under 2) within 41 districts in Nepal, with special attention paid to reaching disadvantaged groups. These groups are often the poorest of the poor, and have historically suffered discrimination through the caste system or are cut off from access to basic services due to their remote geographic location.
- Targeting service delivery and demand generation activities among the most disadvantaged and remote populations in 22 districts. These activities will include strengthening public and private clinics through provider training, provision of underutilized FP methods including intrauterine contraceptive devices and implants, mobile outreach camps to reach remote populations, and promotion of healthy behaviors.

NIGERIA

	2015	1990
Total Population	182M ↑	97M
Population Under 5 Years	30M ↑	17M
Under-5 Deaths / Year	750K ↓	848K
Under-5 Mortality Rate Per 1,000 Live Births	109 ↓	213
Births	6.8M ↑	4.3M
Maternal Mortality Ratio Per 100,000 Live Births	814 ↓	1110

INTERVENTION COVERAGE

● = PREDICTED COVERAGE RATE BASED ON 2014 AOTC ANALYSIS



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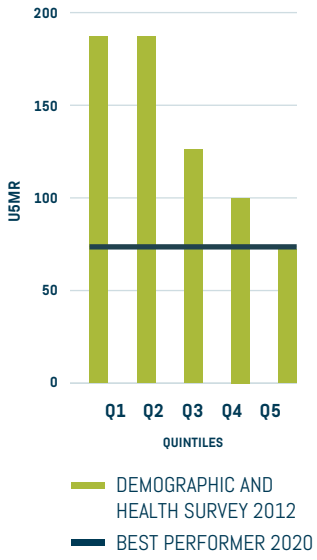
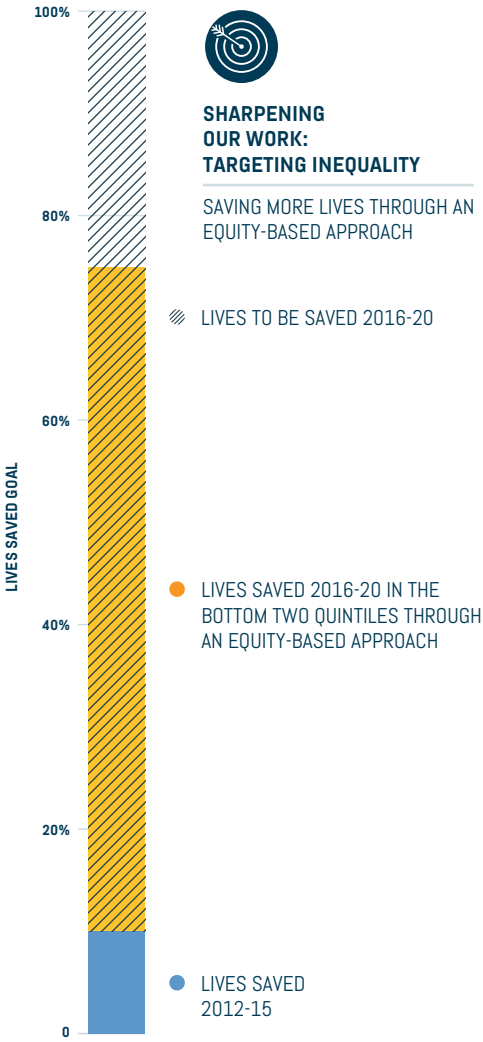
UNDER-5 MORTALITY RATE BY WEALTH QUINTILE V. BEST PERFORMER 2020



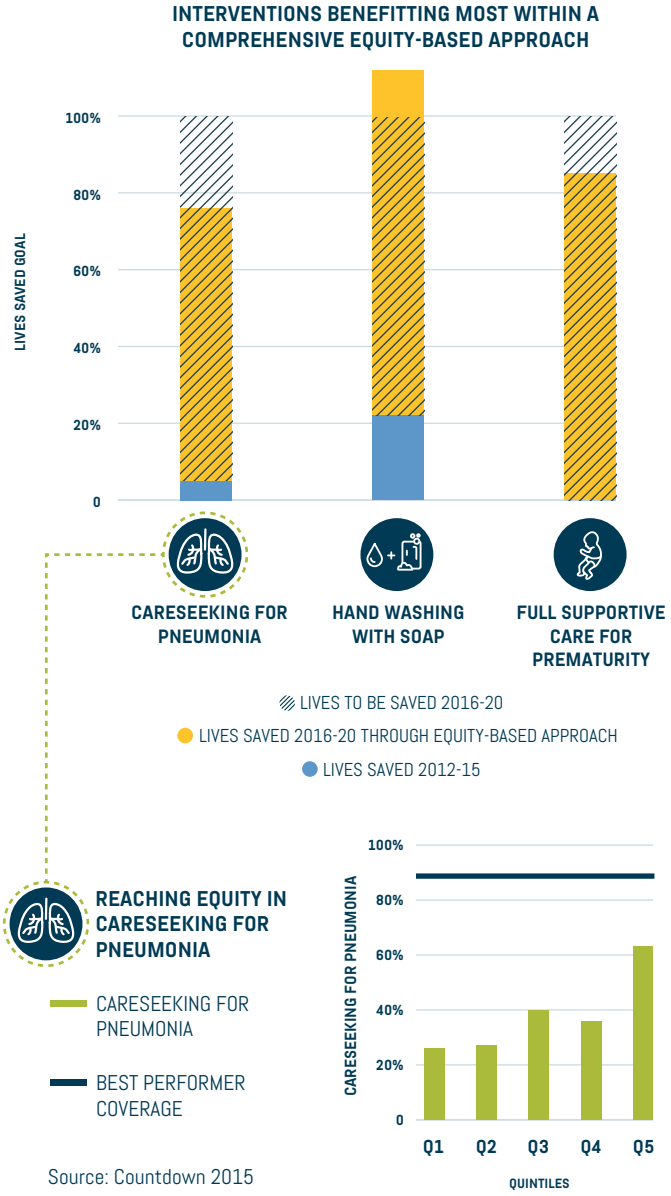
PROGRESS IN THE LAST YEAR:

- In 2015, the Federal Ministry of Health agreed to institutionalize Maternal Death Reviews nationally. The National Council on Health, the highest policymaking body in the Nigerian health sector, subsequently approved inclusion of perinatal deaths into the process and changed the name to Maternal, Perinatal and Deaths Surveillance and Response.
- A national training of trainers for Essential Newborn Care Course was conducted, where 48 national trainers were successfully trained.
- Supported the dissemination of results of National RMNCH activities, including the Verbal and Social Autopsy Survey on causes of under-5 mortality, the first such population-based study ever conducted in Nigeria.
- Supported a landscape analysis on pre-eclampsia and eclampsia, and the implementation of national and state level follow-up actions identified in the report.
- Began supporting local production of quality oxytocin and magnesium sulfate.
- Developed the National Chlorhexidine Scale-up Strategy to improve cord care for both facility and non-facility deliveries.
- Pneumoccocal vaccine has been introduced in three pilot states, and a proposal for introduction of meningitis A and rota virus vaccines has been approved at the national level for submission to Gavi.

2016-2020: AN EQUITY-BASED APPROACH
1,392,000 LIVES SAVED IN THE BOTTOM TWO QUINTILES
OF WHICH 488,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS



An equity-based approach focuses on the bottom two quintiles but impacts all five quintiles



Source: Countdown 2015

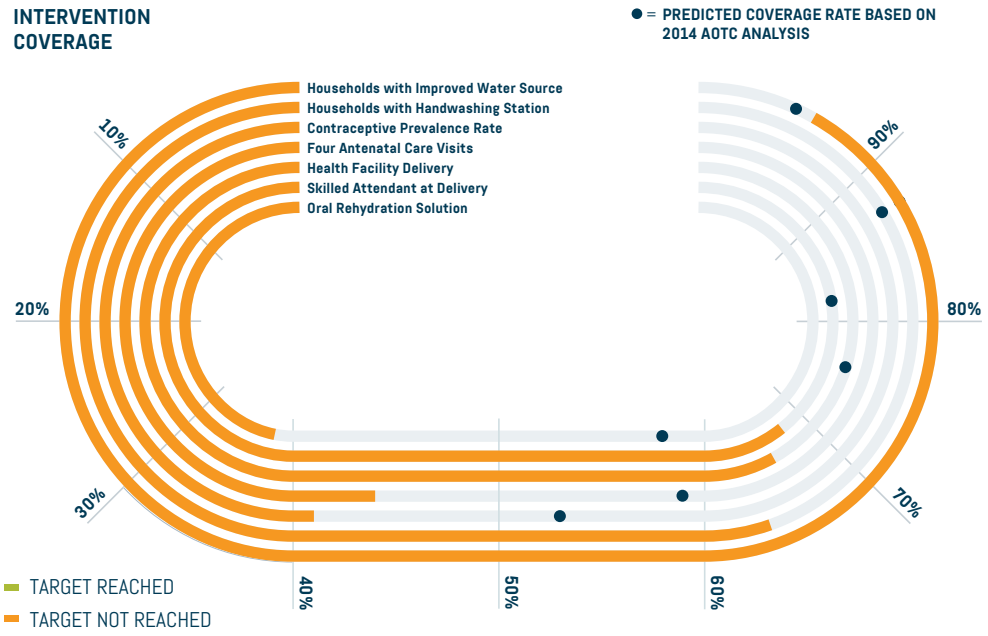
ENDING PREVENTABLE CHILD AND MATERNAL DEATHS REQUIRES A COMPREHENSIVE EQUITY-BASED APPROACH. USAID'S COMPREHENSIVE EQUITY-BASED APPROACH INCLUDES:

- Facilitating the establishment of birth centers and mothers waiting homes, by communities and government counterparts, for those mothers who are high risk, live far away and/or have other difficulties accessing a health center for delivery on time.
- Implementing Essential Newborn Care Course step-down training in three focus states to reach the lowest quintiles in Nigeria which generally depend on public health facilities to access care. This training will support an improved standard of newborn care in all public secondary and tertiary health facilities, and in selected private secondary health facilities.
- Establishing technical assistance and guidance to federal and state agencies to develop appropriate health care financing policies and implementation of health care financing schemes to increase primary health care service delivery for, and utilization by, vulnerable populations.

PAKISTAN

	2015	1990
Total Population	199M ↑	119M
Population Under 5 Years	21.4M ↑	20.9M
Under-5 Deaths / Year	432K ↓	619K
Under-5 Mortality Rate Per 1,000 Live Births	81 ↓	138
Births	4.5M ↓	5M
Maternal Mortality Ratio Per 100,000 Live Births	178 ↓	490

INTERVENTION COVERAGE



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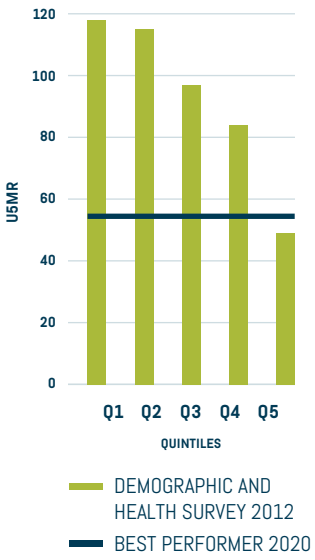
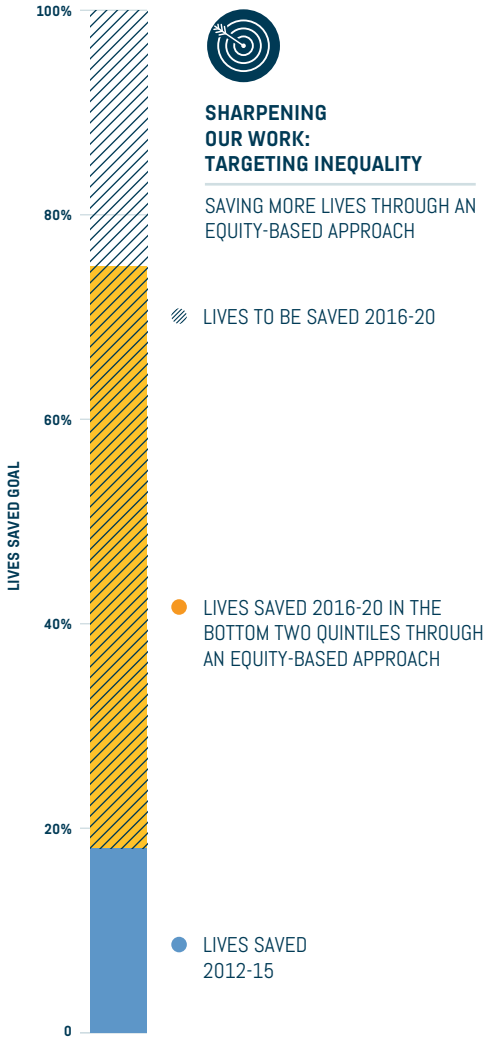
UNDER-5 MORTALITY RATE BY WEALTH QUINTILE V. BEST PERFORMER 2020



PROGRESS IN THE LAST YEAR:

- Completed planning for the GAIN fortification activity and kicked off implementation. Consultations are underway with the Government of Pakistan (GoP) and flour millers in Pakistan to begin trading fortified wheat flour and edible oil with Afghanistan.
- Began implementing the World Food Program and UNICEF stunting prevention program, with an anticipated reach of 1.2 million people across five districts in Sindh.
- Made great strides in WASH. After a baseline assessment a three-tiered social mobilization structure was established in Jacobabad city. WASH clubs have been established in 25 schools and 300,000 people have been reached through radio messages and behavior change communication materials.
- The vaccine logistics management information system (vLMIS) was scaled-up to an additional 13 districts increasing the total to 83. USAID advocated with donors (Gavi, BMGF, DFID) and GoP to scale-up vLMIS to an additional 10 districts with full coverage (166 districts) expected by end of 2016. GoP approved a five-year expanded program on immunizations (EPI) program valued at $553 million, which includes vLMIS.
- Supported Federal EPI vaccine and dry stores efforts to achieve ISO certification 2001-2008 signaling success in adhering to international standards of vaccine storage and distribution. Additionally, gross capacity of vaccine storage at Federal EPI increased by 35 percent through donation of four cold/freezer rooms.
- Funded National Chlorhexidine Working Group, which meets on a quarterly basis to inform scale-up efforts across the country. Provinces are in the process of drafting Action Plans. Chlorhexidine and Helping Babies Breathe initiatives have already been scaled-up to 15 districts in Sindh and local production of chlorhexidine is expected in 2016.

2016-2020: AN EQUITY-BASED APPROACH
840,000 LIVES SAVED IN THE BOTTOM TWO QUINTILES
OF WHICH 259,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS



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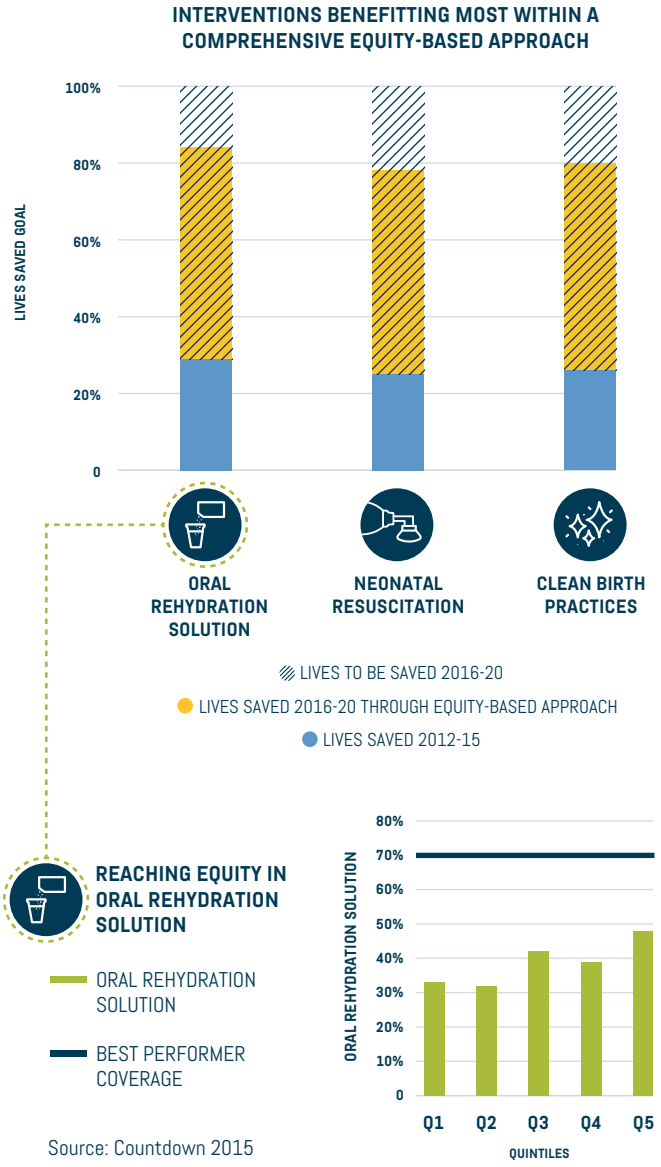


Source: Countdown 2015

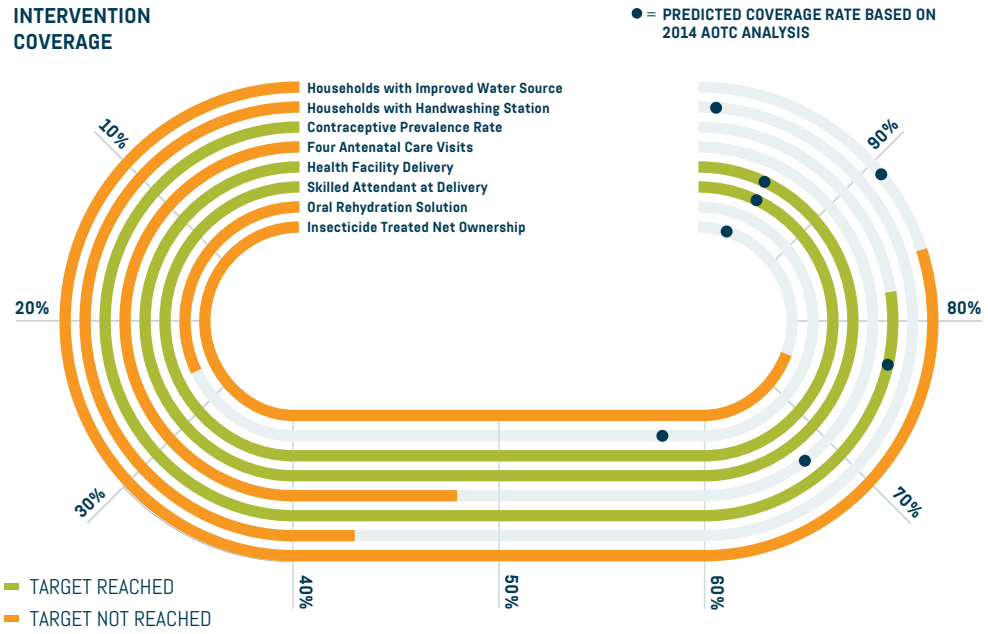
ENDING PREVENTABLE CHILD AND MATERNAL DEATHS REQUIRES A COMPREHENSIVE EQUITY-BASED APPROACH. USAID'S COMPREHENSIVE EQUITY-BASED APPROACH INCLUDES:

- Prioritizing access to services in hard-to reach-populations. The current MCH Program specifically targets rural communities across 15 districts.
- Implementing vouchers within the MNCH program to increase facility level births and postpartum family planning, and increased access to skilled birth attendants.
- Ensuring the family planning and reproductive health service delivery activity uses vouchers and the poverty index tool to increase access to quality FP services for women living on less than $2 per day. This activity also uses two mobile outreach units to serve women in areas far from any public or private facility.
- Both service delivery and social and behavior change communication activities implementing community outreach actions through Community Support Group meetings, reaching segments of the population that might not always go to facilities for care.

RWANDA

	12.7M ↑ Total Population	2M ↑ Population Under 5 Years	14.2K ↓ Under-5 Deaths / Year	42 ↓ Under-5 Mortality Rate Per 1,000 Live Births	427K ↑ Births	290 ↓ Maternal Mortality Ratio Per 100,000 Live Births
2015						
1990	7M	1.3M	49.3K	151	304K	910

INTERVENTION COVERAGE



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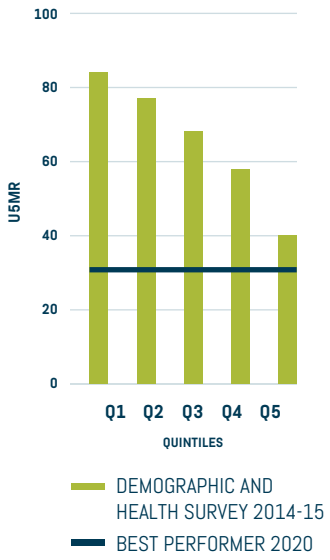
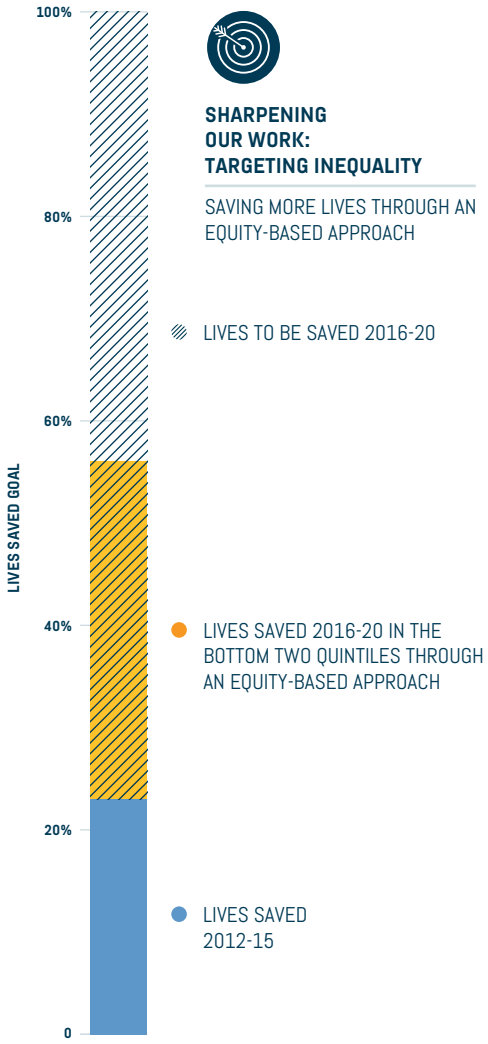
UNDER-5 MORTALITY RATE BY WEALTH QUINTILE V. BEST PERFORMER 2020



PROGRESS IN THE LAST YEAR:

- USAID provided support that resulted in nearly 175,000 women receiving quality antenatal care services that otherwise would not have had access to them. Support was provided for the training of facility and community based health care providers to conduct outreach and share information with community members on the importance of getting antenatal care.
- In concert with the Ministry of Health, support was furnished for the integration of PPH management into the maternal and neonatal health package, including management of PPH at the community level. Community Health Workers were trained to detect warning signs of PPH, administer misoprostol, and support the referral of mothers to the nearest health center using mobile phone text messaging.
- Nearly a hundred health care providers came together to identify the most common gaps in labor and delivery management in Rwanda that lead to birth asphyxia. These gaps guided the development of a comprehensive tool to help providers identify birth asphyxia risk factors which was rolled out to all health facilities.

2016-2020: AN EQUITY-BASED APPROACH
32,000 LIVES SAVED IN THE BOTTOM TWO QUINTILES
OF WHICH 16,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS



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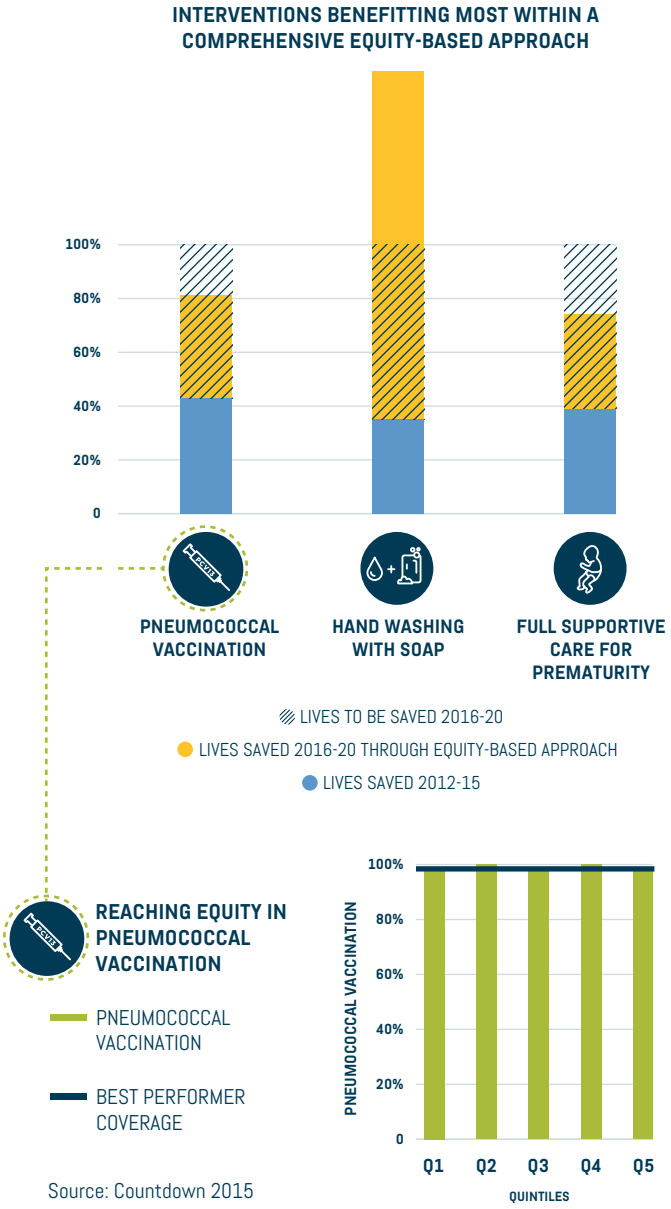


Source: Countdown 2015

ENDING PREVENTABLE CHILD AND MATERNAL DEATHS REQUIRES A COMPREHENSIVE EQUITY-BASED APPROACH. USAID'S COMPREHENSIVE EQUITY-BASED APPROACH INCLUDES:

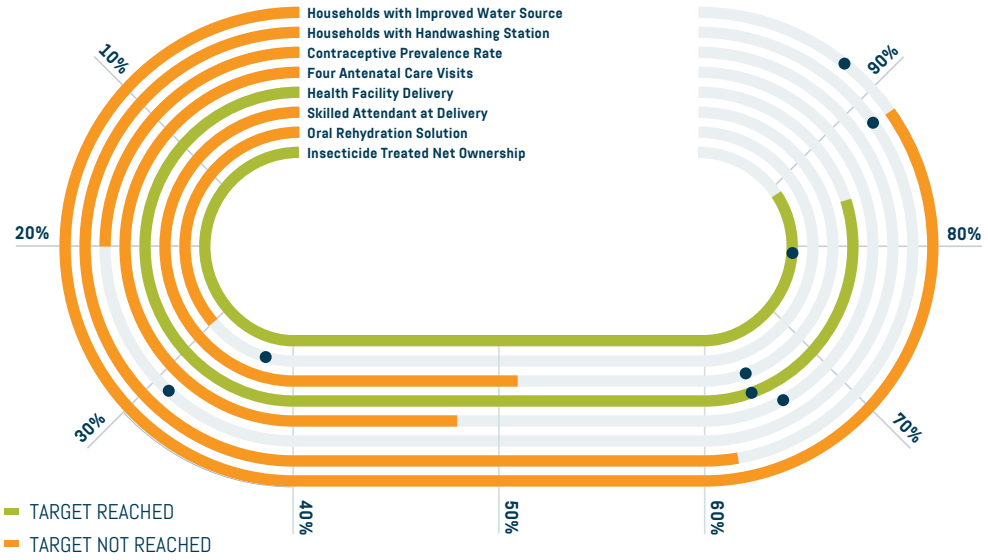
- Strengthening the community based health insurance (CBHI) implementation. CBHI enrollment falls between 70-80 percent and this enables Rwandans not enrolled in the formal sector to access quality RMNCH services. Through the referral system, CBHI members can access tertiary level health services available in the country, significantly contributing to equitable care. Additionally, the country has a fee waiver system for the poorest of the poor. The CBHI and waiver system contributes to financial protection for the poor, shielding households from catastrophic expenditures on health and consequent impoverishment.
- Strengthening the Government of Rwanda Performance-Based Financing and health financing in general. This has improved the ability of hospitals to innovatively use the resources they generate to improve quality of services and to incentivize staff. Technical assistance will also be provided toward the accreditation of district hospitals, and to ensure accredited facilities offer a similar minimum package of services across all district hospitals.

SENEGAL

	Total Population	Population Under 5 Years	Under-5 Deaths / Year	Under-5 Mortality Rate Per 1,000 Live Births	Births	Maternal Mortality Ratio Per 100,000 Live Births
2015	14M ↑	2.2M ↑	27K ↓	47 ↓	482K ↑	315 ↓
1990	7.3M	1.4M	44K	142	342K	670

INTERVENTION COVERAGE

● = PREDICTED COVERAGE RATE BASED ON 2014 AOTC ANALYSIS



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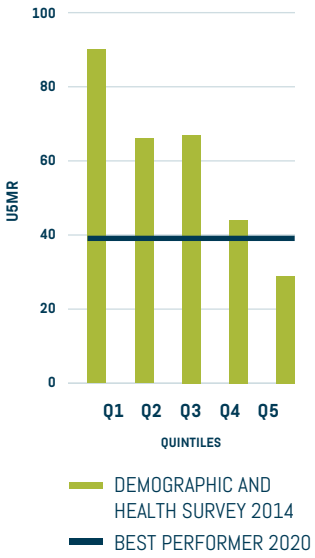
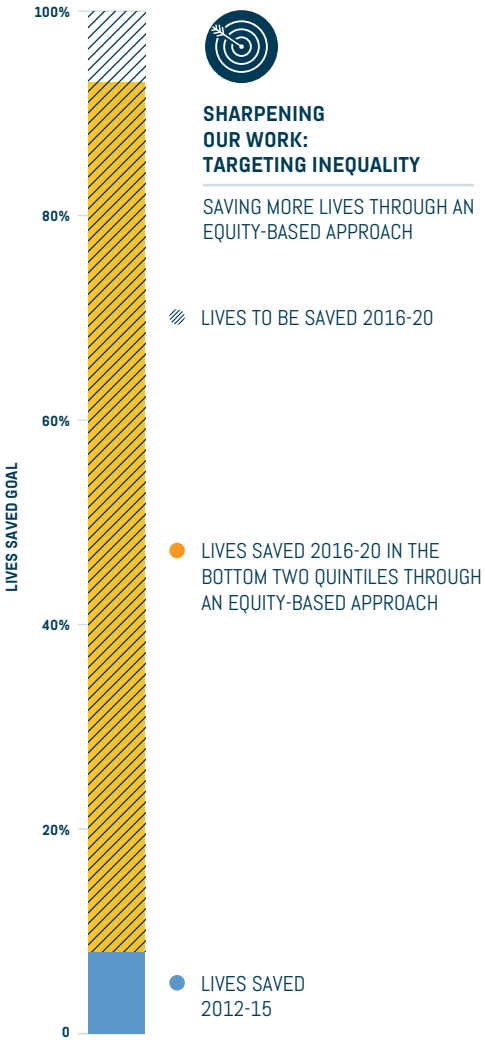
UNDER-5 MORTALITY RATE BY WEALTH QUINTILE V. BEST PERFORMER 2020



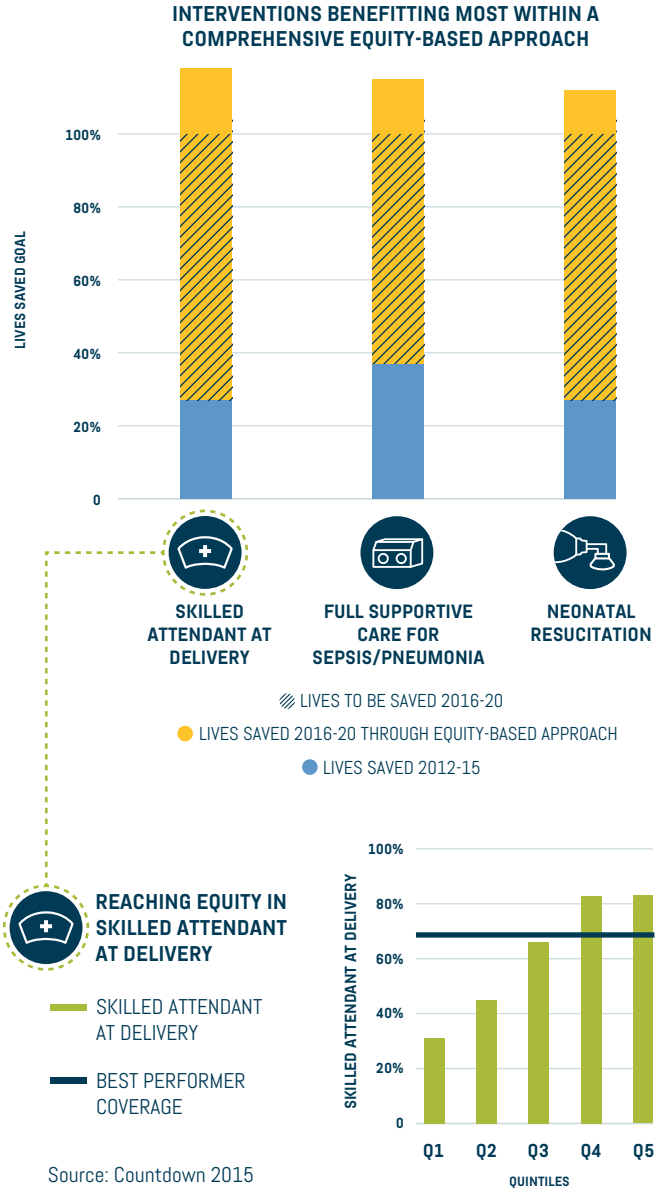
PROGRESS IN THE LAST YEAR:

- Provided technical assistance to the Ministry of Health to elaborate, validate, and disseminate a national nutrition strategic plan and national family planning framework strategy.
- USAID has increased the availability of equipment for newborn care in 80 percent of facilities in 10 regions, scaled up availability of misoprostol for post-partum hemorrhage to over 979 health huts, and scaled up use of chlorhexidine for newborn sepsis to to over 1,200 health huts.
- In collaboration with the Government of Senegal (GoS) and other partners, USAID focused on proven high-impact interventions, training service providers in Kangaroo Mother Care and Helping Babies Breathe, and supported immunization and WASH programming.

2016-2020: AN EQUITY-BASED APPROACH
68,000 LIVES SAVED IN THE BOTTOM TWO QUINTILES
OF WHICH 25,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS



An equity-based approach focuses on the bottom two quintiles but impacts all five quintiles



Source: Countdown 2015

ENDING PREVENTABLE CHILD AND MATERNAL DEATHS REQUIRES A COMPREHENSIVE EQUITY-BASED APPROACH. USAID'S COMPREHENSIVE EQUITY-BASED APPROACH INCLUDES:

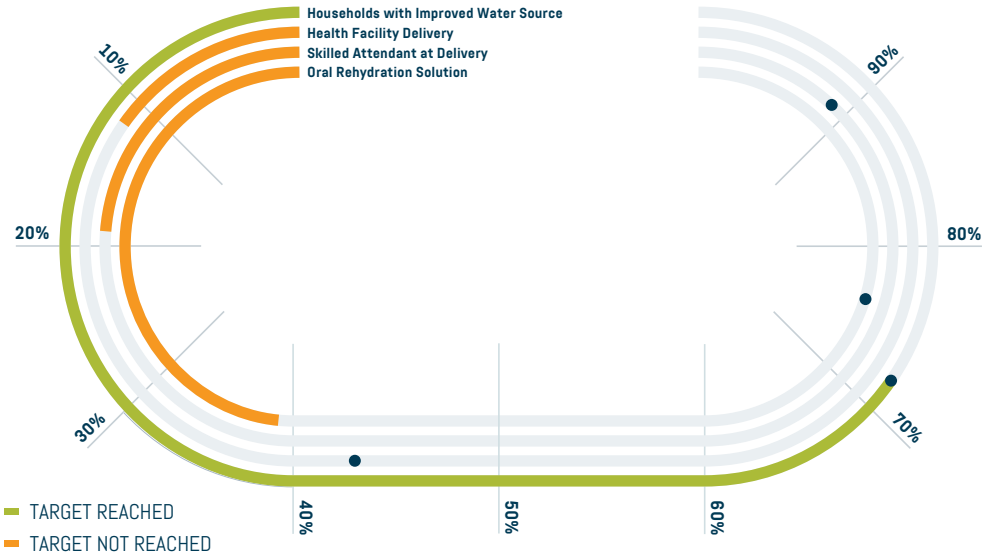
- Working to reduce inequities and reach the most vulnerable in line with the GoS vision in the Plan Senegal Emergent of "a Senegal where all individuals, all households and all communities enjoy universal access to promotional, preventive, curative health services of quality, without any form of exclusion."
- Concentrating investments on key drivers of mortality in areas with higher rates of child and maternal morbidity and mortality. Targeted investments will be made in areas already demonstrating lower rates of morbidity and mortality to leverage GoS resources and systems to ensure gains are sustained.
- Focusing on empowering women and girls, constructively engaging men and boys, and reducing gender-based violence.
- Integrating youth-friendly service delivery approaches, supporting and encouraging youth to engage in positive health behaviors, and engaging the broader community to foster an environment conducive for young people to thrive.
- Supporting the creation and expansion of mutueles, community-based health insurance, a cornerstone of the GoS effort to ensure access to essential health services throughout the country.

SOUTH SUDAN

	12M ↑ Total Population	2M ↑ Population Under 5 Years	39.5K ↓ Under-5 Deaths / Year	93 ↓ Under-5 Mortality Rate Per 1,000 Live Births	445K ↑ Births	789 ↓ Maternal Mortality Ratio Per 100,000 Live Births
2015						
1990	5.8M	1.1M	66.2K	252	263K	1,800

INTERVENTION COVERAGE

● = PREDICTED COVERAGE RATE BASED ON 2014 AOTC ANALYSIS



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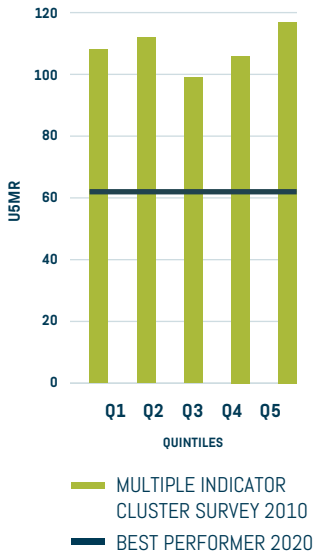
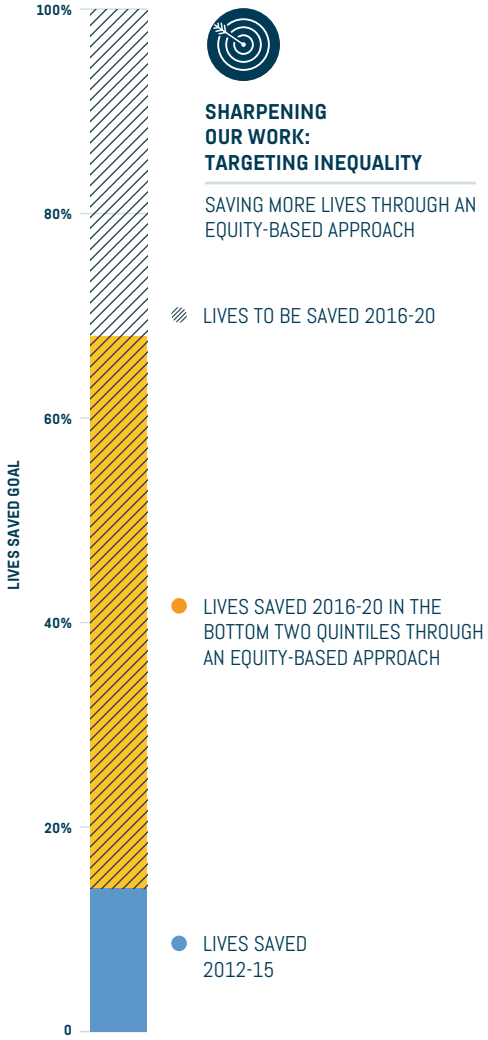
UNDER-5 MORTALITY RATE BY WEALTH QUINTILE V. BEST PERFORMER 2020



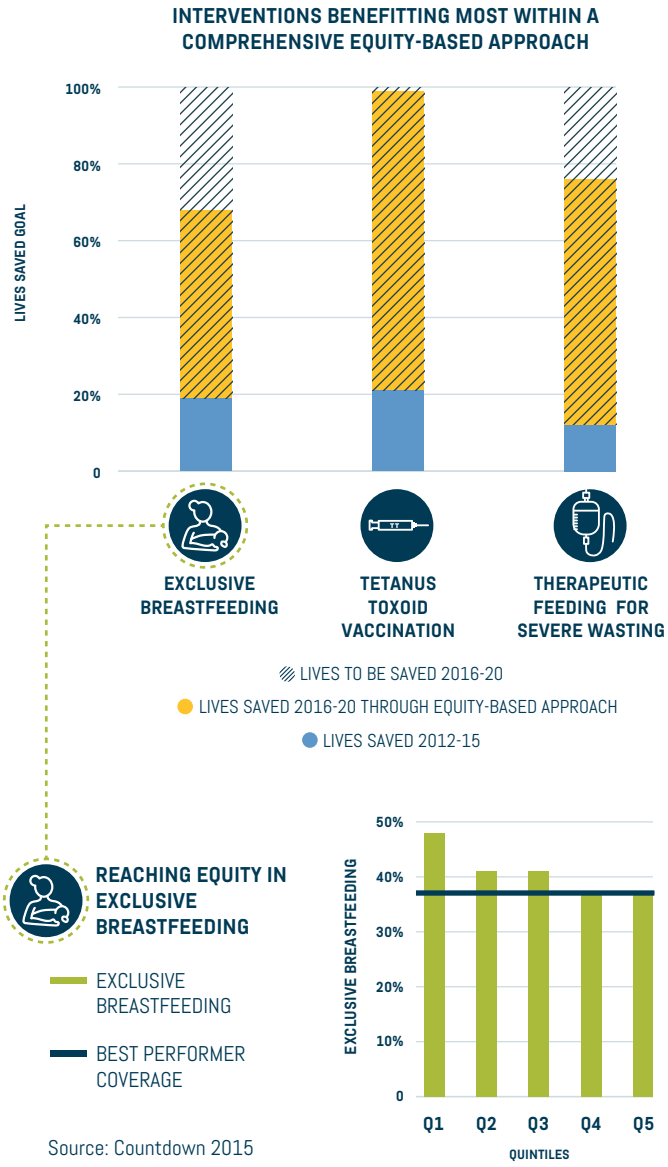
PROGRESS IN THE LAST YEAR:

- The Ministry of Health is in the process of adapting Focused Antenatal Care to raise it to one of their standards.
- Made strides to reduce child and maternal mortality by improving access to facility services for women and children, and by providing commodities such as uterotonics to women and mosquito nets to families in South Sudan.
- A learning phase for PPH prevention at the community level was conducted in two counties in one of the supported states. Its success led the Ministry of Health to recommend scale up of the activity to the whole country. Out of 16 counties in the two supported states, scale-up happened in eight, and in states supported by other partners, scale up was done in about three counties.
- USAID refocused its WASH portfolio to better complement its humanitarian assistance portfolio, supporting WASH activities in camps for internally displaced persons.
- Supported two national and two sub-national immunization days.

2016-2020: AN EQUITY-BASED APPROACH
38,000 LIVES SAVED IN THE BOTTOM TWO QUINTILES
OF WHICH 10,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS



An equity-based approach focuses on the bottom two quintiles but impacts all five quintiles



Source: Countdown 2015

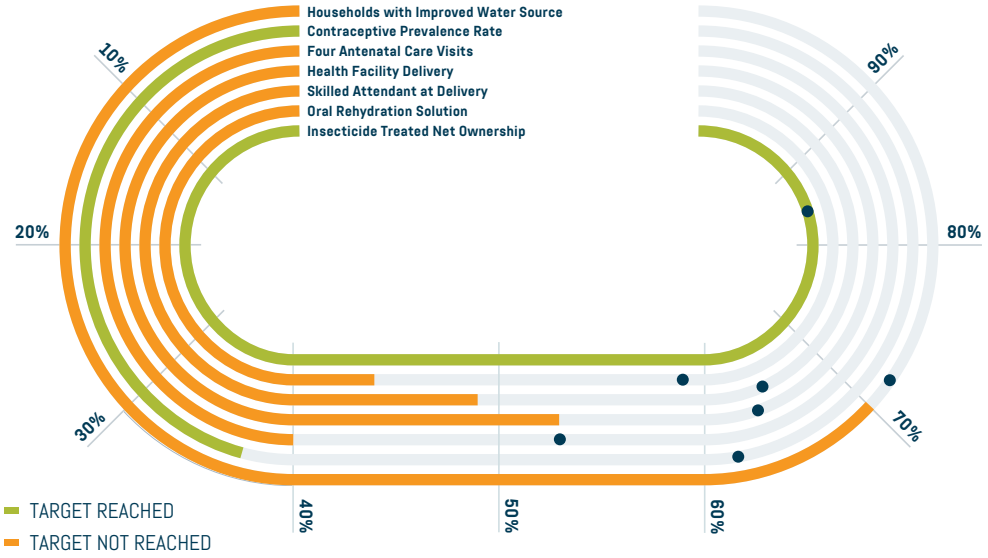
ENDING PREVENTABLE CHILD AND MATERNAL DEATHS REQUIRES A COMPREHENSIVE EQUITY-BASED APPROACH. USAID'S COMPREHENSIVE EQUITY-BASED APPROACH INCLUDES:

- Expanding quality care provision throughout the country by working in collaboration with four other donors through a pooled funding mechanism.
- Training midwives, the main cadre providing maternal health services in the two states, to enable them to perform the signal functions of basic emergency obstetric and newborn care and reach those women who might not otherwise receive emergency services.

TANZANIA

	2015	1990
Total Population	51M ↑	25M
Population Under 5 Years	8.4M ↑	4.4M
Under-5 Deaths / Year	98K ↓	179K
Under-5 Mortality Rate Per 1,000 Live Births	49 ↓	166
Births	1.9M ↑	1M
Maternal Mortality Ratio Per 100,000 Live Births	398 ↓	870

INTERVENTION COVERAGE



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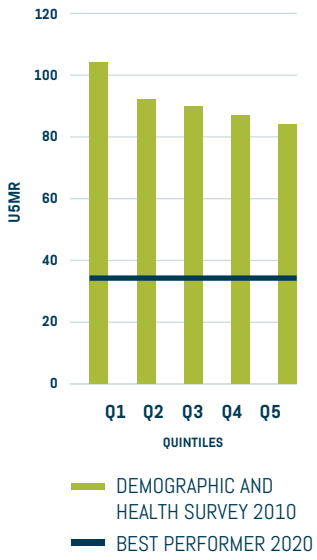
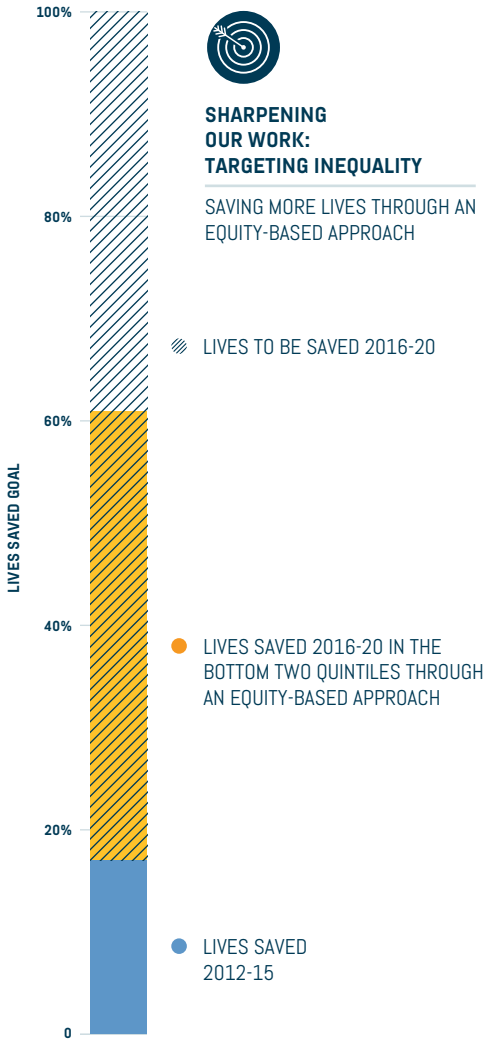
UNDER-5 MORTALITY RATE BY WEALTH QUINTILE V. BEST PERFORMER 2020



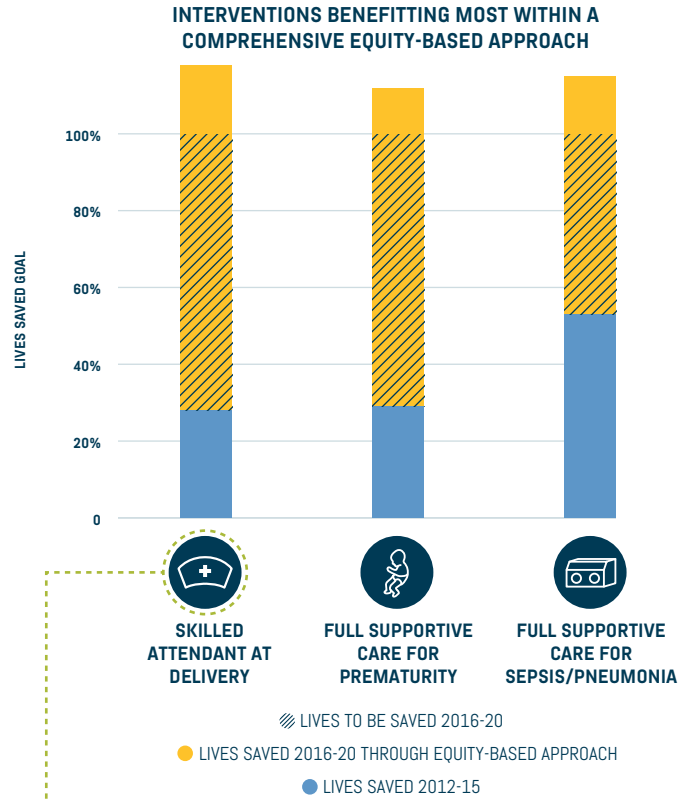
PROGRESS IN THE LAST YEAR:

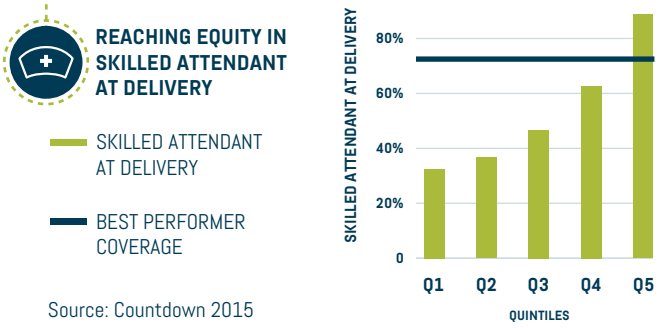
- Postpartum FP counseling was provided at all 225 supported RMNCH sites in Mara and Kagera regions, with 64 of 177 supported PP FP service delivery sites providing long-acting and reversible contraceptives to clients following labor and delivery.
- In support of Tanzania's Health Sector Strategic Plan IV, which incorporates the One Plan II, a results-based financing activity was piloted in one district of Shinyanga region. The results-based approach is intended to improve the accessibility, use, and quality of RMNCAH services at eligible facilities through increased accountability and responsiveness of the providers and managers.
- An antenatal corticosteroids policy was approved last year in Mainland for use at comprehensive obstetric and newborn care (CEmONC) sites. The training is complete and implementation is in progress at 33 USG-supported sites in two regions (Mara and Kagera).
- Maternal and perinatal death audit guidelines were approved last year, and national guidelines were used to train USG CEmONC supported facilities in Mara and Kagera regions. Data will be submitted at the district level and reviewed with partners and the regional health authority semi-annually.
- A national Respectful Maternal Care evidence-sharing and policy development meeting was held with key stakeholders. Data from the pilot districts in Tanga was validated with the districts and disseminated with the Regional Councilor in preparation for national dissemination. A national steering committee will have high level participation for dissemination and consultation regarding establishment of systems necessary to safeguard respectful care.
- Kangaroo Mother Care has been upgraded and/or initiated in 25 new supported facilities in Mara and Kagera regions, with over 700 newborns served.

2016-2020: AN EQUITY-BASED APPROACH
194,000 LIVES SAVED IN THE BOTTOM TWO QUINTILES
OF WHICH 84,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS



An equity-based approach focuses on the bottom two quintiles but impacts all five quintiles





Source: Countdown 2015

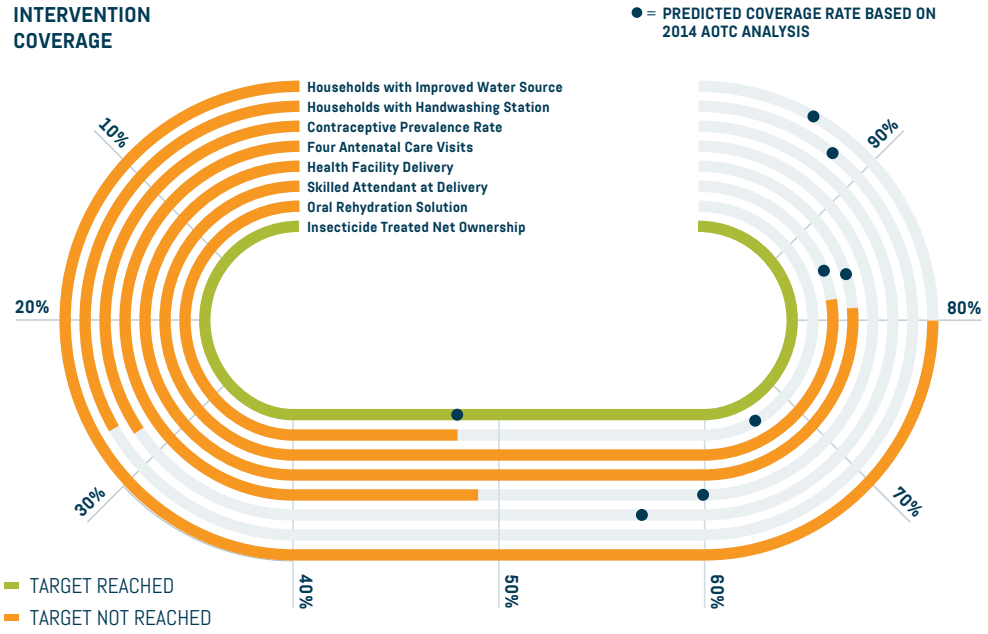
ENDING PREVENTABLE CHILD AND MATERNAL DEATHS REQUIRES A COMPREHENSIVE EQUITY-BASED APPROACH. USAID'S COMPREHENSIVE EQUITY-BASED APPROACH INCLUDES:

- Focusing RMNCAH program in the regions of the Lake Zone, which has been designated by the Government of Tanzania as the most underserved geographic area for maternal and child health services. An assessment found that this zone had the poorest outcomes of care, including highest child mortality, highest prevalence of malaria, and lowest uptake of both family planning and skilled birth attendance.
- Integration of respectful maternity care into supported health facilities. Lessons learned from a pilot in Tanga region are being compiled and shared in national forums. Many of the findings indicate a need to ensure more equitable distribution of human and financial resources to address the structural drivers of inequity and disrespectful care.
- District level capacity building to ensure facilities' competency with routine immunization tasks such as microplanning, cold chain management, service provision, community mobilization, and defaulter tracing in the 13 lowest performing districts identified by the National Vaccine Program to address the significant vaccination gaps in the country. The selected districts represented 40 percent of the under-vaccinated children in Tanzania.

UGANDA

	2015	1990
Total Population	37.1M ↑	16.5M
Population Under 5 Years	7M ↑	3.5M
Under-5 Deaths / Year	85.3K ↓	145K
Under-5 Mortality Rate Per 1,000 Live Births	55 ↓	178
Births	1.6M ↑	875K
Maternal Mortality Ratio Per 100,000 Live Births	343 ↓	600

INTERVENTION COVERAGE



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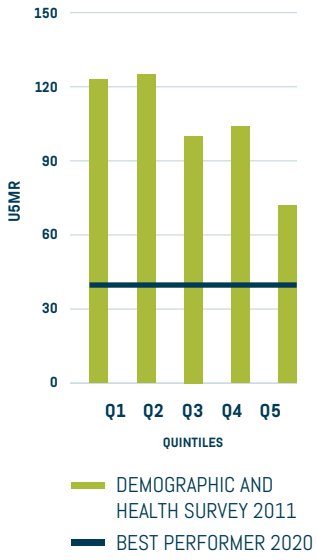
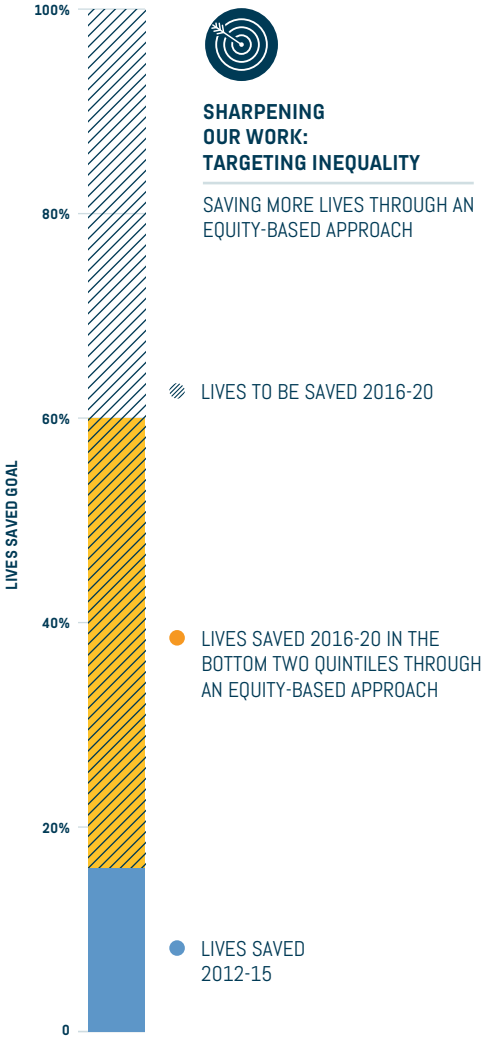
UNDER-5 MORTALITY RATE BY WEALTH QUINTILE V. BEST PERFORMER 2020



PROGRESS IN THE LAST YEAR:

- Enhanced services in the Southwest region through the regional integrated health program, which incorporated support for maternal and child health and family planning to improve overall health outcomes.
- Began a new activity designed to improve access to maternal and child health services for the poor, strengthen the quality of its programs, and provide leadership in the health financing community to improve financing options for health care in Uganda. This activity is coordinating and collaborating with the recently launched Ministry of Health's Reproductive Health Voucher Program, funded by the World Bank.
- USAID has been included in the GFF and is supporting completion of the costed RMNCAH plan, which will improve coordination of RMNCAH efforts.

2016-2020: AN EQUITY-BASED APPROACH
190,000 LIVES SAVED IN THE BOTTOM TWO QUINTILES
OF WHICH 80,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS



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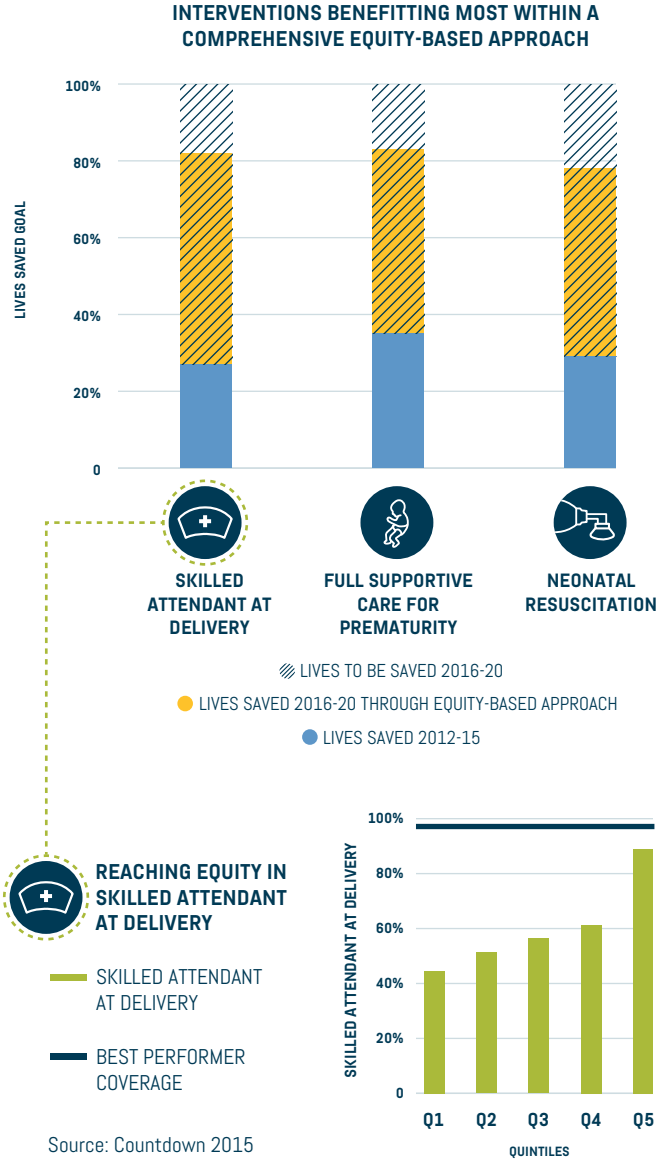


Source: Countdown 2015

ENDING PREVENTABLE CHILD AND MATERNAL DEATHS REQUIRES A COMPREHENSIVE EQUITY-BASED APPROACH. USAID'S COMPREHENSIVE EQUITY-BASED APPROACH INCLUDES:

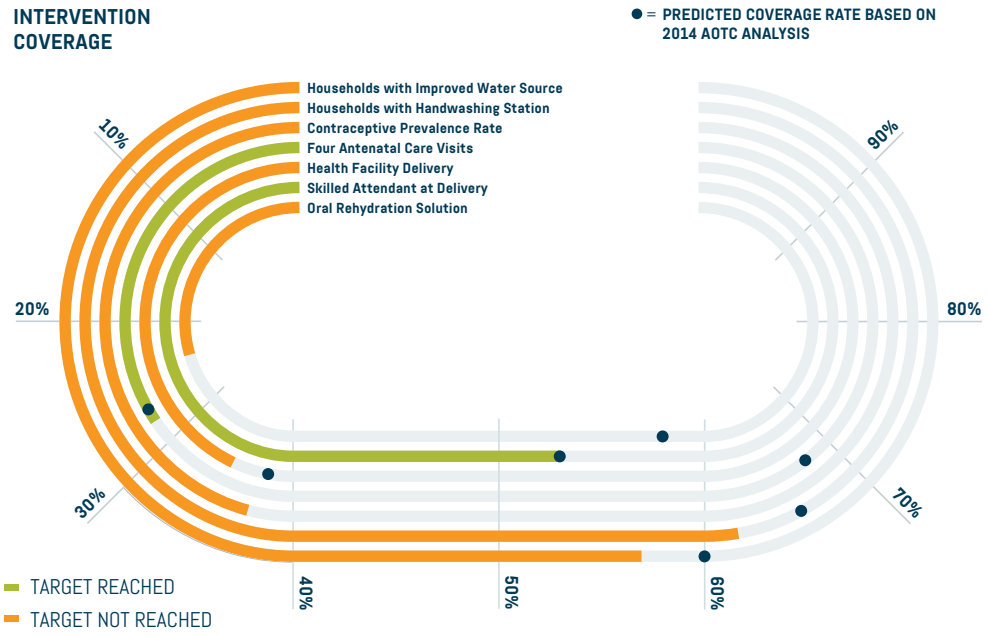
Improving access to care across programs through:

- Outreach service delivery (in addition to facility service support),
- Targeting populations with high burden of disease/death (e.g. youth, specifically girls),
- Developing integrated programming in regions with district-wide support to scale-up service delivery access points and thereby reduce health inequities,
- Ensuring integrated programs focus on high-impact interventions to reduce inequities,
- Supporting national level programs in family planning, nutrition and immunization and,
- Supporting service delivery in the poorest performing districts.

YEMEN

	Total Population	Population Under 5 Years	Under-5 Deaths / Year	Under-5 Mortality Rate Per 1,000 Live Births	Births	Maternal Mortality Ratio Per 100,000 Live Births
2015	26.7M ↑	3.8M ↑	34.4K ↓	42 ↓	802K ↑	385 ↓
1990	11.8M	2.5M	71K	125	570K	610

INTERVENTION COVERAGE



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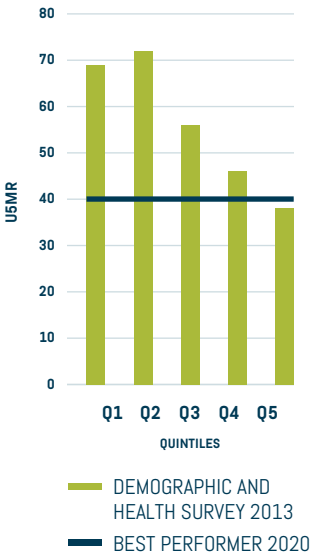
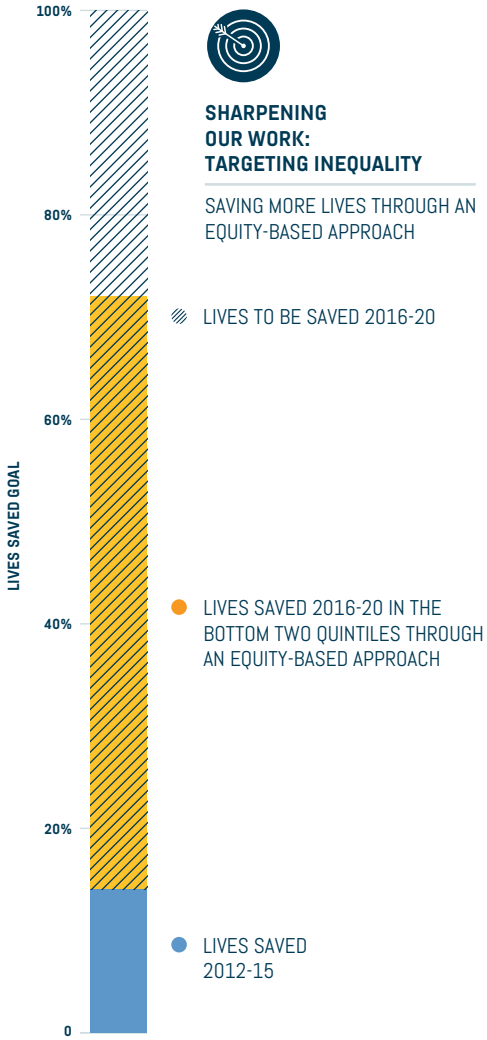
UNDER-5 MORTALITY RATE BY WEALTH QUINTILE V. BEST PERFORMER 2020



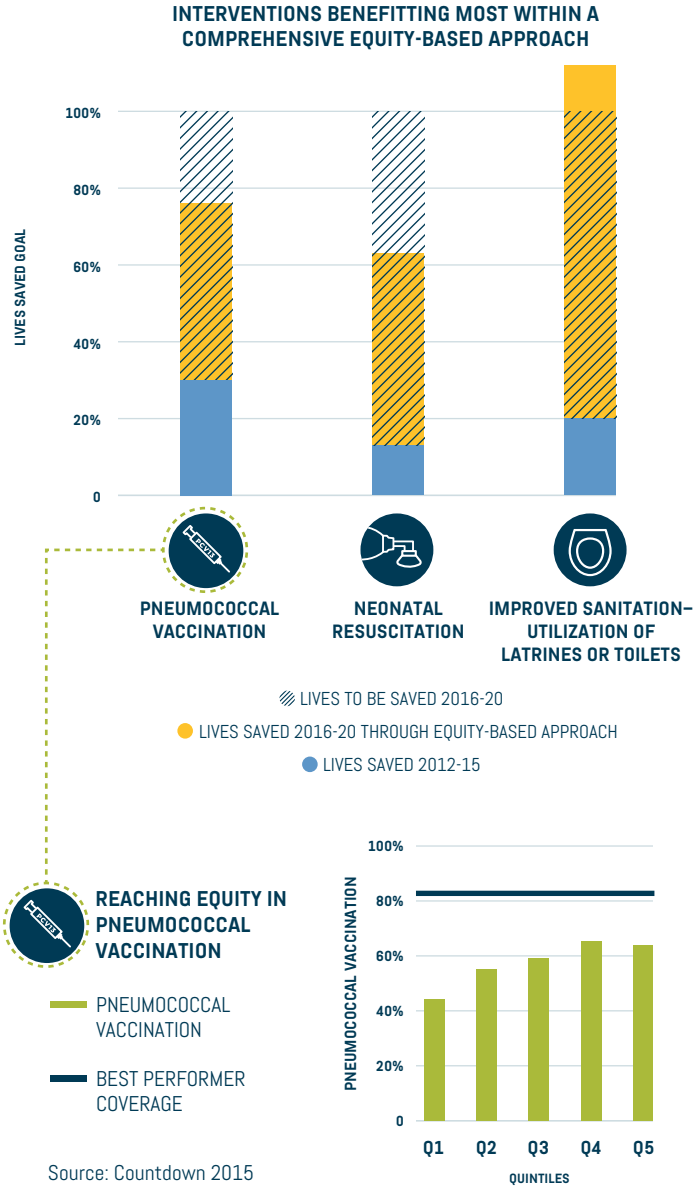
PROGRESS IN THE LAST YEAR:

By March 2015, the US Embassy had closed down operations due to the conflict. USAID/Yemen had fully evacuated staff and suspended all development partners. At present, USAID's suspension remains in effect.

2016-2020: AN EQUITY-BASED APPROACH
61,000 LIVES SAVED IN THE BOTTOM TWO QUINTILES
OF WHICH 18,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS



An equity-based approach focuses on the bottom two quintiles but impacts all five quintiles



Source: Countdown 2015

ENDING PREVENTABLE CHILD AND MATERNAL DEATHS REQUIRES A COMPREHENSIVE EQUITY-BASED APPROACH. USAID'S EQUITY-BASED APPROACH:

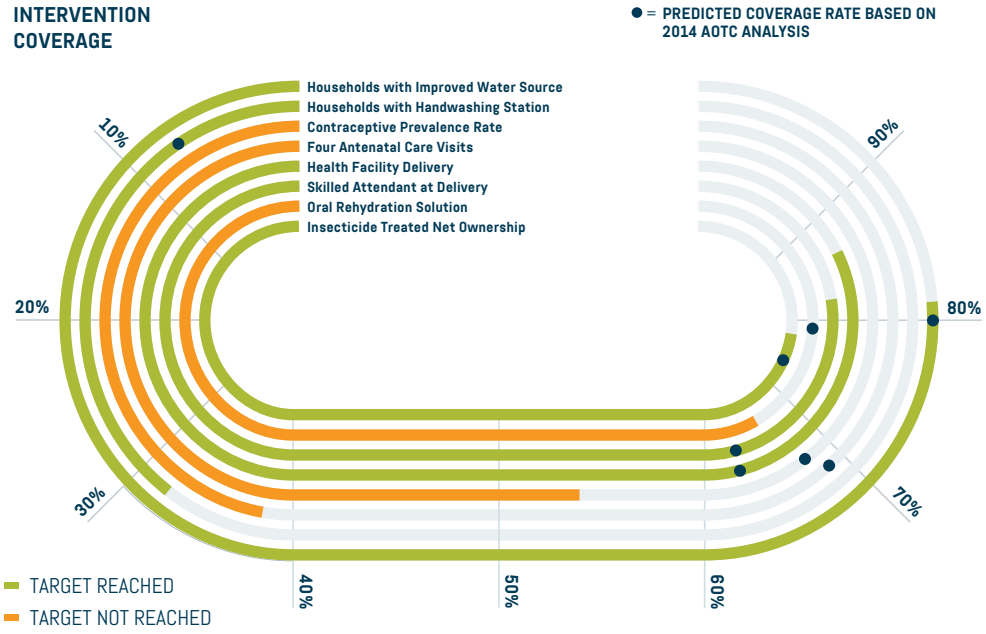
Once the security environment in Yemen improves, USAID plans to continue investing in MCH and FP/RH, informed in part by Humanitarian Assistance partners working on the ground for the past year.

Following post-conflict assessments, the mission expects to identify rapid improvements in access to and quality of basic healthcare services targeting Yemen's vulnerable women and children. This approach will slowly transition to a normalized development strategy once the country's basic health infrastructures, systems and workforce are stabilized.

ZAMBIA

	15.1M ↑ Total Population	2.7M ↑ Population Under 5 Years	40K ↓ Under-5 Deaths / Year	64 ↓ Under-5 Mortality Rate Per 1,000 Live Births	635K ↑ Births	224 ↓ Maternal Mortality Ratio Per 100,000 Live Births
2015						
1990	7.6M	1.4M	63K	192	339K	470

INTERVENTION COVERAGE



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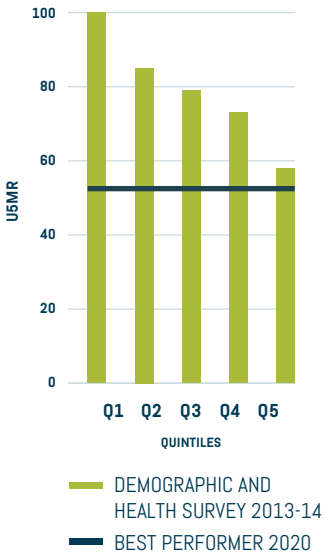
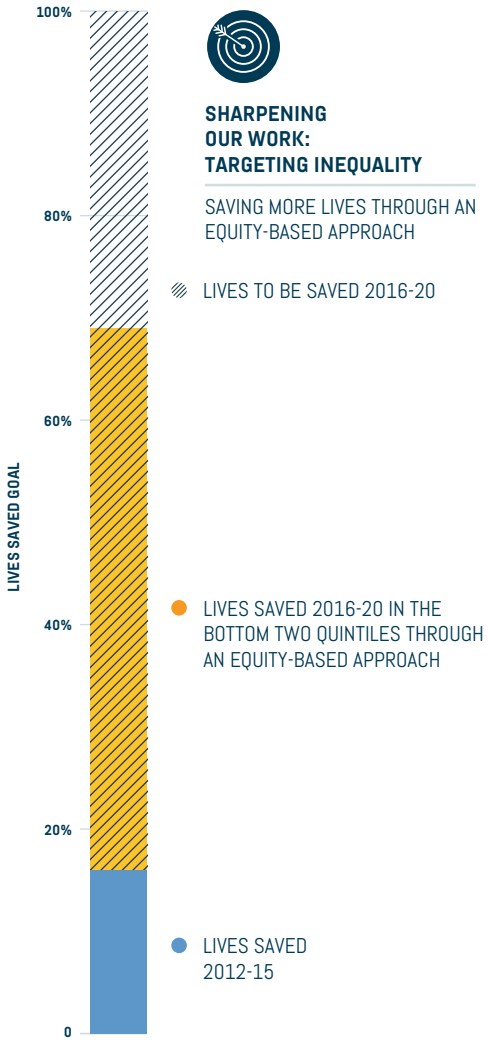
UNDER-5 MORTALITY RATE BY WEALTH QUINTILE V. BEST PERFORMER 2020



PROGRESS IN THE LAST YEAR:

- Developed the country RMNCH continuum of care work plan to better integrate service delivery.
- The Ministry of Health endorsed the provision of Injectable Depo Provera by Community-Based Distributors which will help increase access to this method of family planning and enable more women to space or limit births.
- Introduced new vaccines, including inactivated polio vaccine and second dose of measles & rubella in accordance with global immunization guidelines.
- Built health system capacity by training providers and community health workers in key RMNCH interventions (including long-acting, reversible contraceptives and community-based distribution) and supported scale-up in targeted districts through strengthening of logistics management systems and procurement of necessary equipment and reproductive health commodities.
- Strengthened data collection systems to inform program implementation, particularly around the Saving Mothers Giving Life project, where progress in target districts has been published.

2016-2020: AN EQUITY-BASED APPROACH
93,000 LIVES SAVED IN THE BOTTOM TWO QUINTILES
OF WHICH 33,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS



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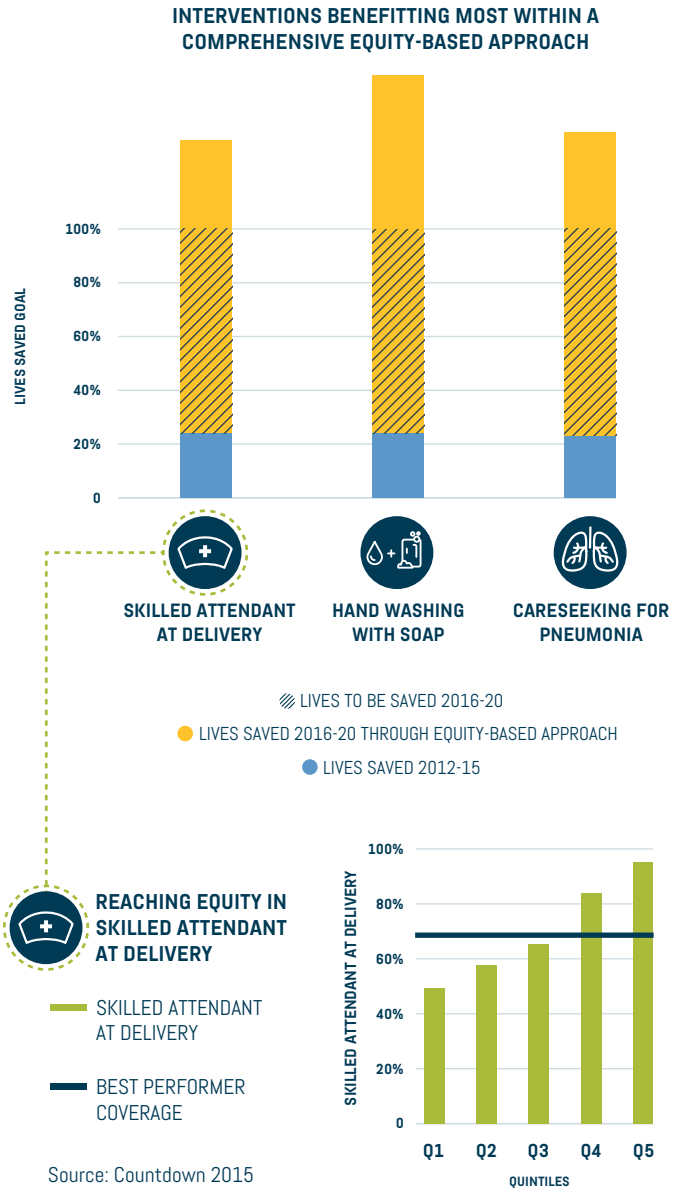


Source: Countdown 2015

ENDING PREVENTABLE CHILD AND MATERNAL DEATHS REQUIRES A COMPREHENSIVE EQUITY-BASED APPROACH. USAID'S COMPREHENSIVE EQUITY-BASED APPROACH INCLUDES:

- Scaling-up Respectful Mother Care to create an environment conducive to skilled delivery, including availability of skilled health care providers, quality infrastructure, availability of necessary equipment, and RMNCH commodities.
- Scaling-up maternal health services to reach those most at risk for adverse maternal and newborn outcomes is ongoing. Efforts will include employment of health care providers/midwives to work in remote areas, procurement of necessary equipment for provision of services, strengthening referral and communication systems, and building maternity homes and refurbishing facilities.
- Strengthening the provision of a continuum of care package at one point of service to integrate MNCH, family planning, and HIV services.

INTRODUCING BURMA AS USAID'S 25TH EPCMD PRIORITY COUNTRY

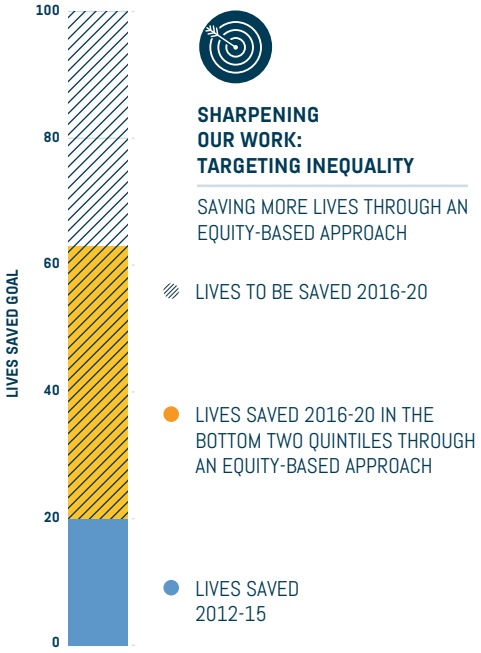
The 2015 election was an important step towards greater peace, prosperity, and democracy for the people of Burma and provides a unique opportunity to improve the health and well being of its citizens and to end preventable child and maternal deaths.

As an EPCMD priority country, USAID will work in partnership with the government and civil society on critical health and policy issues to accelerate the reduction in preventable child and maternal deaths by scaling up evidence-based, high-impact maternal, newborn and child health interventions. USAID will provide focused technical assistance to the Government of Burma's Ministry of Health, with a special focus on reaching poor and underserved populations, mobile populations, and other vulnerable groups.

Photo: Karen Fogg/USAID

BURMA

	56.3M ↑ Total Population	4.9M ↓ Population Under 5 Years	46.3K ↓ Under-5 Deaths / Year	50 ↓ Under-5 Mortality Rate Per 1,000 Live Births	1M ↓ Births	178 ↓ Maternal Mortality Ratio Per 100,000 Live Births
2015	56.3M	4.9M	46.3K	50	1M	178
1990	40.5M	5.5M	121K	110	1.2M	520



An equity based approach focuses on the bottom two quintiles but impacts all five quintiles

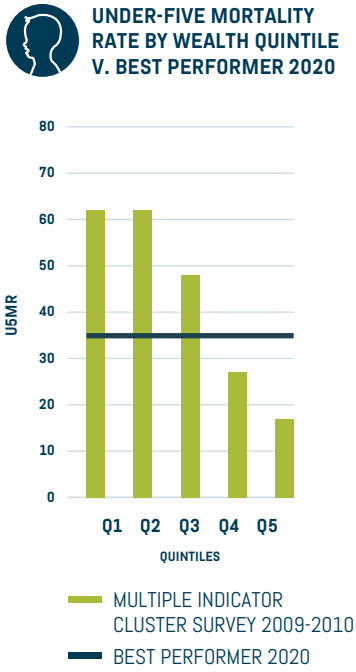
2016-2020: AN EQUITY-BASED APPROACH

48,000

LIVES SAVED IN THE BOTTOM TWO QUINTILES OF WHICH

5,000

ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS



Under the new democratically-elected government, Burma has a unique opportunity to improve the health and well-being of its citizens and to end preventable child and maternal deaths. While health system performance has improved in recent years, more focused work is needed to ensure women and children have access to quality health care.

Through a special focus on reaching poor, underserved, and mobile populations, as well as other vulnerable groups, the Government of Burma has demonstrated a commitment to working with partners and civil society to achieve accelerated reductions in maternal and under-5 mortality.

Health data is a challenge in Burma. To address data gaps, USAID is working with the Ministry of Health to conduct the first ever Demographic and Health Survey in Burma. This survey will provide critically needed information that will help the country identify the high impact programming necessary to target priority health interventions and support more effective allocation of health resources.

USAID is working in Burma to implement evidence based interventions that target poor, rural and marginalized populations including:

- Strengthening the capacity of midwives, who are the backbone of the health care service provision to provide high quality maternal and newborn care.
- Working to ensure access to critically needed medicines and supplies by strengthening the public health supply chain and regulatory systems.
- Employing mobile clinics to reach rural areas. These roving groups of doctors, nurses, midwives, and laboratory technicians bring a broad range of services to small villages: antenatal care, laboratory testing and immediate diagnosis, pharmacies that provide lifesaving antibiotics for infants and children with acute respiratory infections, and more.
- Increasing use of "May May," a maternal health smartphone application that provides crucial information on healthy pregnancy, safe delivery, malaria, and child illness.

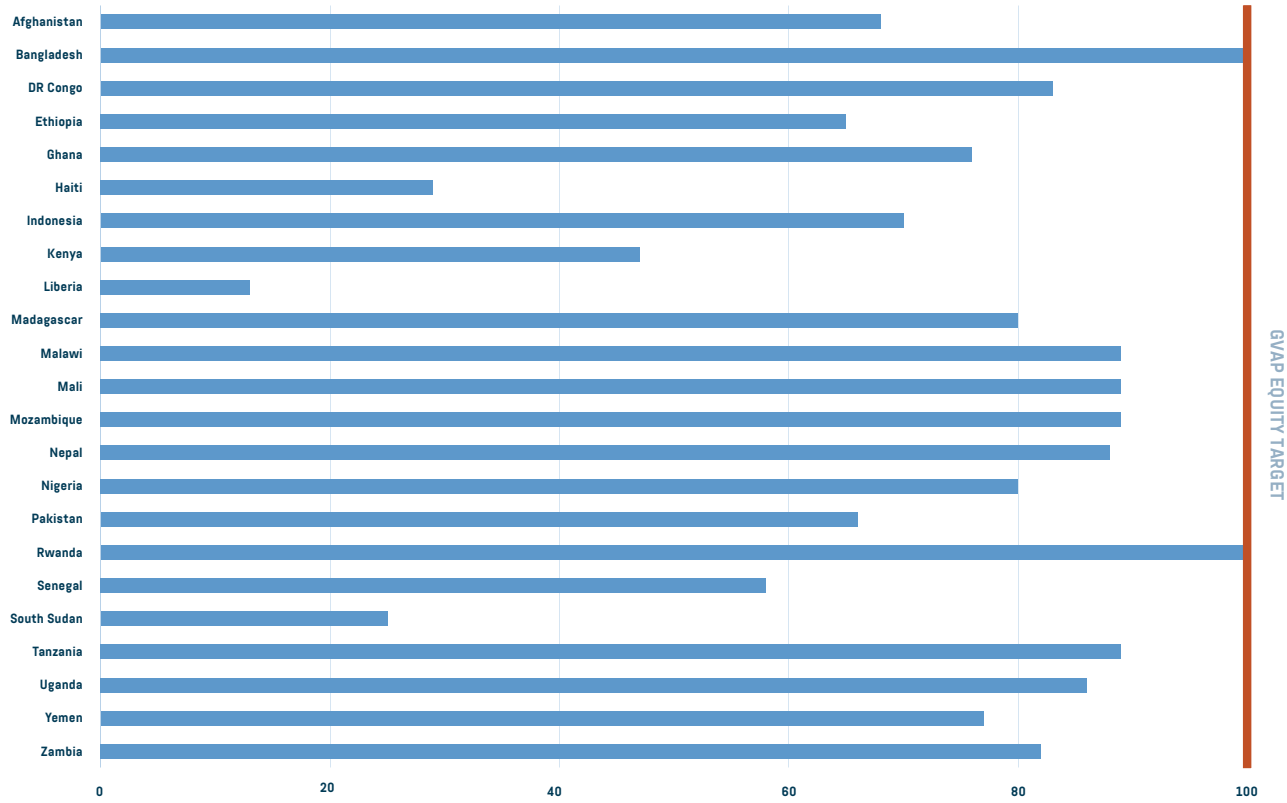
EQUITY IN ACCESSING ROUTINE IMMUNIZATION SERVICES

Vaccines prevent an estimated 2 to 3 million child deaths each year, helping young infants and children survive the most perilous period of life, when immune systems are not fully developed. Vaccines, however, do not always reach the children who need them, and millions die as a result. Addressing the systemic challenges affecting immunization programs is a key equity issue. Reaching unvaccinated and under-vaccinated children requires increasing the equity of vaccine delivery both for the first dose and to ensure repeat, on-time doses of the full vaccination schedule.[8]

Currently fewer than 5 percent of the world's children have received all 11 vaccines recommended by the World Health Organization, according to Gavi the Vaccine Alliance.[9]

Through its annual contribution ($235 million in FY16) to Gavi, USAID supports the accelerated introduction of new and underused vaccines into national routine immunization systems. Gavi's efforts also directly support the Global Vaccine Action Plan's (GVAP) overall goal of preventing millions of deaths by 2020 through more equitable access to existing vaccines for people in all communities. Almost all EPCMD priority countries, except Rwanda and Bangladesh, missed a previous target to achieve greater than 80 percent diphtheria, tetanus, and pertussis (DTP3) coverage in 100 percent of districts by 2015 (Figure 7). The GVAP now calls for countries to achieve the same coverage target for all the vaccines in the national schedule by 2020,[10] which is a more ambitious goal.

FIGURE 7: **PROPORTION OF DISTRICTS >= 80% DTP3 COVERAGE GVAP EQUITY INDICATOR**



Source: WHO: Immunization System Indicators database: Country Reported Data, 2014 There is no data available for India.

Photo: Amy Fowler/USAID

Immunization is generally accepted by families and communities. Despite their desire to immunize their children, many parents encounter obstacles, such as lack of information or misinformation, distance, and time constraints, as well as social, cultural, and political barriers. These are often due to perceived and actual deficiencies within the health services. The reasons why people never use immunization services, or stop using them after one or two encounters, differ from place to place. However, most strategies for increasing the use of routine immunization services focus on reaching the unreached, reducing dropouts, and limiting missed opportunities[11] (see sidebar).

Reaching the unreached, reducing dropouts, and limiting missed opportunities require an understanding of specific local factors leading to inequities in immunization. For example, Iganga, a rural district in Central Eastern Uganda, has a hard-to-reach population of more than half a million people. The district struggled with a weak routine immunization system, evidenced by a high dropout rate between those receiving one dose of Diptheria, Tetanus, Pertussis (DTP) vaccine and those receiving all three required doses, and poor overall access, resulting in a high number of unvaccinated and under-vaccinated children.

Iganga created a partnership with USAID to identify and address routine immunization system challenges by working from the district to the community level through community-driven solutions. Since 2012, USAID has worked with the district using the Reaching Every District/Community/Child-Quality Improvement (RED/C-QI) approach to achieve a stronger routine immunization system. The RED/C-QI approach is a process that addresses larger priority problems (e.g. persistently high drop-out rates) using small, rapid, doable changes that can be quickly tested and evaluated for adoption, adaptation, or abandonment at the local level. This approach has helped the district significantly reduce the DTP 1-3 dropout rate, from 18 percent in 2012 to under 10 percent in 2015.[12]

The Global Polio Eradication Initiative provides additional lessons on reaching the underserved. Eradicating the polio virus requires vaccinating every child in the developing world multiple times, and sustaining a disease surveillance system that identifies possible cases, even in the most remote areas. There is no other program in public health that reaches the doorstep of every child in the developing world. Many of the challenges to eradicating polio over the past decade have included reaching children in conflict, in geographically remote areas, and among underserved populations including mobile/migrant populations, pastoralists and nomads, and cross-border communities, as well as religious, ethnic, and tribal minorities. In Ethiopia, USAID support to routine immunization and polio contributes to reducing the number of unvaccinated children and increasing equity in vaccination coverage, particularly in hard-to-reach and mobile communities who are largely underserved by the country health systems.[13] USAID's support in the country enabled civil society organizations and local communities to engage in the effort to increase demand and access for vaccination services in some of the country's most unreached communities.

Reducing inequity in immunization services delivery requires consistency within the health system. Children must be reached multiple times on a specific schedule to achieve full immunizations. Improving equity requires an understanding of the community being served and the specific reasons families may be able access services on occasion, but not routinely.

Reaching the Unreached: Improve scheduling, raise awareness, expand outreach, and target services to meet urban and special population needs.

Reducing Drop-Outs: "Drop-outs" refers to caregivers who begin the vaccination schedule for their children but do not complete it. This indicates they have at least periodic access and motivation to use immunization services, but stop using them for one or more reasons.

Limiting Missed Opportunities: A missed opportunity occurs when a client, present in a situation in which vaccinations should be available, does not receive all the vaccines for which he or she is eligible. This can be due to breaks in the supply chain system, so that needed vaccines are not available when clients come for service, or for other reasons such as lack of referral within facilities if the child or his mother comes in for other services.

Photo: USAID

ENSURING EQUITY OF CARE FOR CHILD ILLNESSES

The scale-up of life-saving immunizations, such as pneumococcal and rotavirus vaccines, improvements in sanitation and hygiene, and the massive scale-up of malaria prevention and treatment interventions, are making it easier to treat child illness and save lives. At the same time, more children are not in traditionally "hard-to-reach" areas defined by geography, such as rural vs. urban districts. Increasingly, these marginalized children may be located in "hot spots" in peri-urban and urban slums, or in areas not defined by district borders but by displacement and migration due to conflict or natural disaster. Given a reduction in the burden of childhood illnesses and increase in prevention and treatment options, there is the risk that overall success can increase inequity, concentrating the remaining burden of childhood illnesses in marginalized populations.

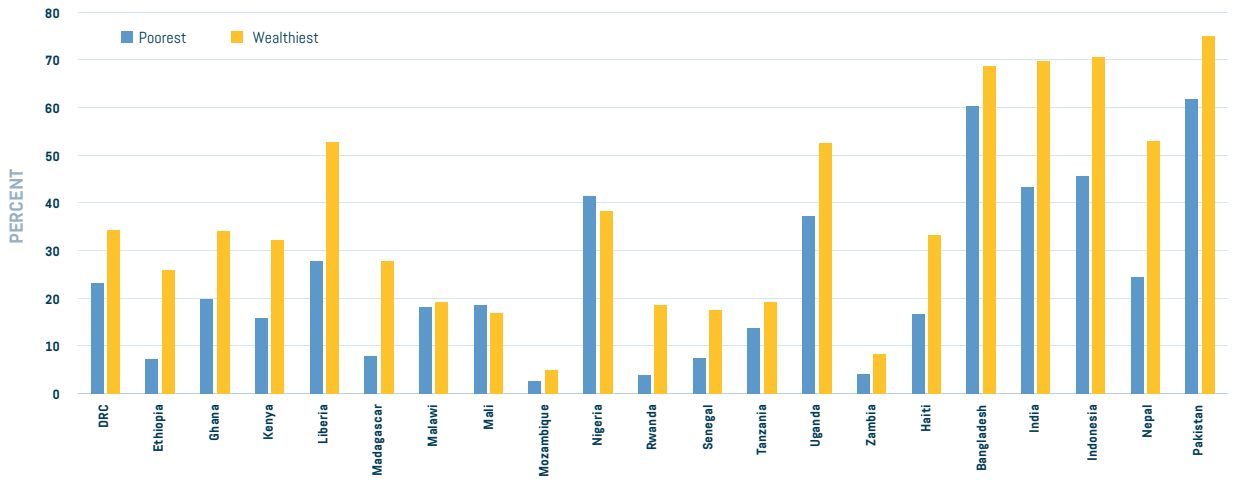
To address this, USAID uses diverse approaches to reach children most in need. Case management of malaria, pneumonia, and diarrhea is one key approach that can be implemented in both the public and private sector as well as in both facilities and communities. Effective case management of these three important illnesses is achievable, as they require minimal or no laboratory assessment (e.g. a rapid diagnostic test for malaria), and a set of proven treatment options exist (oral rehydration solution (ORS) and zinc for diarrhea, amoxicillin for pneumonia, and artemisinin-based combination therapies for malaria).

Case management at the community level also helps increase equity by ensuring that children are reached early with a correct diagnosis and are appropriately treated. This approach not only prevents severe disease and deaths among young children, it also unburdens families from incurring additional social and financial costs. Community-level health workers triage cases so children with severe illness or other diseases are referred to the higher levels of the health system for more appropriate care. For example, in Senegal, through the Dispensateurs de Soins a Domicile program, home care providers bring health services to rural communities where 42 percent of the population lives. They can diagnose simple illnesses, like malaria, pneumonia, or diarrhea, or they can refer to higher levels of care. This system has reduced malaria-related hospital visits, which burden the system and occupy valuable beds, by 62 percent since 2009.

The private sector may also play an important role in the care and treatment of childhood illness. Where the poor largely do not see private sector care, such as in Ethiopia (see Figures 8 and 9), USAID focuses its support on case management through the public sector, as this provides the most effective and efficient way to provide affordable, timely, and high quality care to children with the greatest need. Yet, in other countries such as Nigeria, where care-seeking occurs more frequently in the private sector among the poorest quintiles than in the wealthiest quintiles (see Figures 8 and 9), USAID is bringing community case management to vulnerable groups through private vendors selling treatments for child illnesses. Private sector utilization is also an important consideration in Asia where care-seeking in the private sector is consistently much higher across all wealth quintiles.

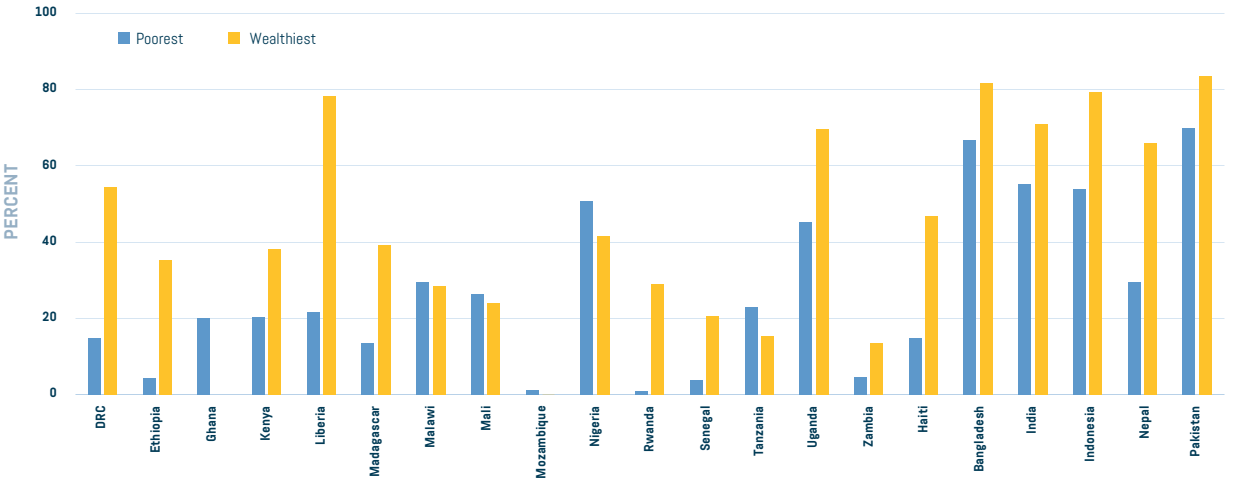
Improved information is critical to programming to improve equity and is foundational to ensuring an effective case management approach. While community-level care for childhood illnesses is vital to addressing child health equity, community-generated data is usually poorly incorporated into existing health information systems and thus limits a country's ability to understand if equity is being adequately addressed. USAID supports the scale-up of information systems at the district level to allow for more "real-time" monitoring and understanding of child health equity issues. For example, while nationally representative surveys have historically been the primary tool for measuring progress in malaria control, the dramatic reductions in malaria morbidity and mortality, coupled with intermittent frequency of these surveys and their lack of sub-national focus, make them less useful for targeting interventions and measuring progress. The President's Malaria Initiative (PMI) has therefore increased focused investments on improving the completeness and quality of routine health management information and disease surveillance systems to provide countries with real-time information on the malaria burden that can be disaggregated to the district and, eventually, village level.

FIGURE 8: **PROPORTION SEEKING CARE FOR DIARRHEA IN THE PRIVATE SECTOR, POOREST VS. WEALTHIEST QUINTILES**



Source: Winter, Rebecca; Wong,Wenjuan; Florey, Lia and Pullum, Thomas. 2015. Levels and Trends in Careseeking for Childhood Illness in USAID Priority Countries. DHS Comparative Reports No. 38. Rockville, MD; ICF International www.dhsprogram.com

FIGURE 9: **PROPORTION SEEKING CARE FOR ACUTE RESPIRATORY INFECTION IN THE PRIVATE SECTOR, POOREST VS. WEALTHIEST QUINTILES**



Source: Winter, Rebecca; Wong,Wenjuan; Florey, Lia and Pullum, Thomas. 2015. Levels and Trends in Careseeking for Childhood Illness in USAID Priority Countries. DHS Comparative Reports No. 38. Rockville, MD; ICF International www.dhsprogram.com

FAMILY PLANNING AND REPRODUCTIVE HEALTH

While work remains to be done to better monitor for equity during program implementation, the availability of wealth quintile information in the Demographic and Health Surveys allows examination of the extent to which health programs, including family planning programs, are reaching the poor and addressing inequalities, and the extent to which equity-based approaches accelerate progress. With respect to family planning, these data show that, on average and over time, there is a strong positive relationship between contraceptive use and equity.

As contraceptive use rises, the gap in use between richest and poorest narrows, particularly in the context of strong family planning programs.[14]

Access to family planning, and the ability to delay pregnancy or space pregnancies three years apart for optimal health and family well-being, also allows women greater options to join the work force, a greater ability to care for their family, and a greater ability to educate their children. It is no coincidence that, as the contraceptive prevalence among the poor increases, gender equity follows suit.

Previous *Acting on the Call* reports have documented the strong positive contribution of family planning to reducing mortality.[15,16] The analyses presented here look at trends over time in modern contraceptive use by wealth quintile and family planning program strategies for four EPCMD priority countries—Bangladesh and Rwanda, two top performer countries; Senegal, a country in the middle stages of the demographic transition from high to low fertility and mortality; and Nigeria, a country still in the early stages of transition.

Bangladesh

Bangladesh—poor, densely populated, primarily agrarian—is an unlikely success story, yet it has a mature and successful family planning program, with average modern contraceptive prevalence rate (MCPR) in 2014 above 50 percent for all quintiles. (Figure 10) Whereas in 1992, modern contraceptive use in the bottom four quintiles was very similar (and lower than use by the richest), by 2011 almost perfect equity was achieved and has remained as more recent 2014 data show. Beginning in the 1980s, Bangladesh implemented an integrated MCH/FP program, with the participation of both the public and private sector. Doorstep delivery by a large cadre of female outreach workers brought health and family planning information and services to women in their homes, both empowering women and significantly

Photo: Jane Silcock/USAID

expanding health access in an environment where women's mobility was severely constrained. Together with other social change factors, including increases in girls' education and employment opportunities for women, mass media and social marketing contributed to changes in norms with respect to gender, desired family size, and family planning.

Rwanda

In the aftermath of the genocide, with much of the health infrastructure destroyed, MCPR in Rwanda (Figure 11) plummeted. Disaggregating MCPR by quintile reveals that the lower four quintiles were particularly disadvantaged. Between 2000-2010, however, MCPR rose 10-fold, with an average increase of 7 percentage points per year between 2005-2010, a rate not seen before. Furthermore, the gap in use between the lower quintiles and the richest increasingly closed. How did Rwanda do this? Most analyses[17,18,19] credit: Strong political will; integration of family planning into the Economic Development and Poverty Reduction Strategy, which used results from a USAID-supported RAPID[20] model; investments in rebuilding the supply side infrastructure (USAID-supported), including launching community-based service delivery expanding the available method mix; and the introduction of results-based financing and community-based health insurance. By 2010, the distribution of MCPR across quintiles was more equitable than it had been in 1992, before the genocide.

FIGURE 10: **BANGLADESH 1993-2014: MCPR BY WEALTH QUINTILE**

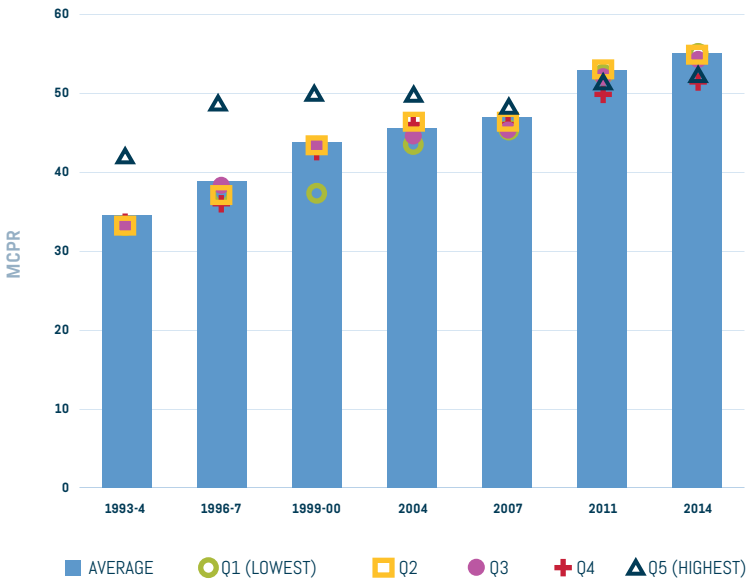
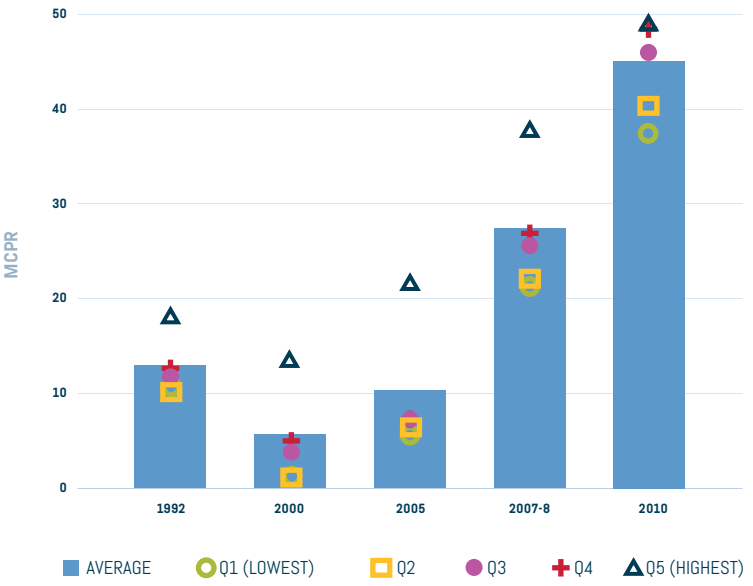


FIGURE 11: **RWANDA 1992-2010: MCPR BY WEALTH QUINTILE**



Senegal

Senegal (Figure 12) is a leader in Francophone West Africa in progress in health. Its equity profile, with higher modern contraceptive use among the wealthy, is not atypical of a country still in the early stages of the demographic transition. However, with faster increases in MCPR in the lower quintiles than among the richest, the gap is closing. Family planning in Senegal has benefited from the focused attention of the Ouagadougou Partnership, established in 2011 by USAID, the Government of France, the Bill & Melinda Gates Foundation, the Hewlett Foundation, and nine West African Francophone countries to focus attention on lagging family planning use in the region. Political commitment to family planning in Senegal is high: the Minister of Health routinely mentions family planning in her speeches, and other health leaders closely track progress against the defined goals. Other indicators of political support are that the 2005 Reproductive Health Law guarantees equitable access to reproductive health care; there are a range of policy documents that support family planning; and family planning is apart of the minimum essential services package. Additionally, mobile outreach is expanding access in hard-to-reach and rural areas. These and other efforts, many supported by USAID, have helped increase access for the non-rich, but more still needs to be done to reach the poor.

FIGURE 12: **SENEGAL 1997-2014: MCPR BY WEALTH QUINTILE**

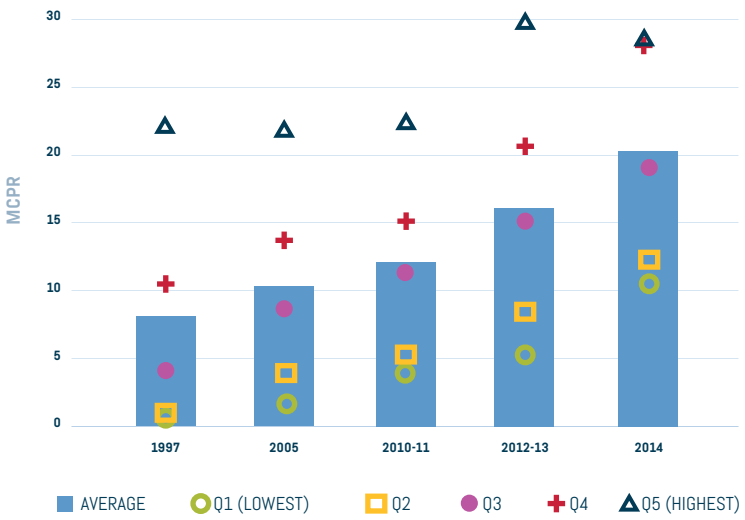
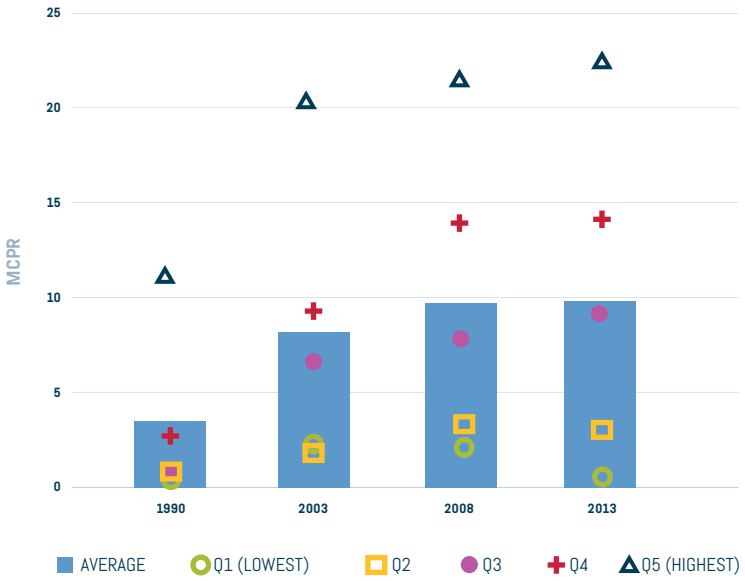


FIGURE 13: **NIGERIA 1990-2013: MCPR BY WEALTH QUINTILE**



Nigeria

Health indicators in Nigeria (Figure 13) remain stubbornly low despite decades of donor investment. Family planning is no exception. MCPR in 2013 averaged less than 10 percent and its distribution remains highly inequitable. Lack of political will, civil conflict in the North region, persistent stock outs, and large family size norms illustrate the difficulties in the enabling environment, the supply side constraints, and the demand side challenges. But the situation may be changing. At the London Summit on Family Planning in 2012, the Nigerian Government committed to improve voluntary family planning use as part of its effort to enhance maternal and child survival, to procure additional reproductive health commodities with government resources, and to improve equity and access to family planning for the poorest. Citing the wealth disparity in use of family planning, the Minister of State for Health committed to "increasing the awareness and demand for family planning regardless of socio-economic status and without coercion."[21]

Photo: Amy Fowler/USAID

MATERNAL AND NEWBORN CARE

Access to affordable, high quality, respectful maternal and newborn health care is fundamental to the survival of pregnant and childbearing women, girls, and newborns and can prevent most deaths that occur. However, even when women are able to get the care they need, they can suffer inequitable treatment. Mistreatment of women during pregnancy and labor and of newborn babies can negatively impact health outcomes, and is an important issue in addressing health equity.

The key drivers of inequity for mothers often involve multiple reinforcing factors which overall perpetuate inequity. For example, poverty or socio-cultural discrimination, coupled with factors predisposing a woman to be even more vulnerable (e.g., if she is disabled or a female head of household) can have deleterious effects on a woman's prospect for a healthy life for herself and her family.

Discrimination based on ethnic group, age, and HIV/AIDS status is common. For example, in a multi-country survey, adolescents were found to have poorer coverage of uterotonics to prevent postpartum hemorrhage and antibiotics to prevent infection after cesarean section.[22] Social stigma against women living with HIV may drive them away from using maternity services,[23] and from accessing family planning and safe pregnancy counseling. And when women with HIV do seek care, they may report that their status led to poor quality care, including delays, and avoidance of contact between patient and provider.[24]

Disparities in use of facilities for birth can also be seen in the context of social, ethnic, racial, religious, and age discrimination. While the proportion of women delivering with a skilled birth attendant and in facilities is rising, fear of discrimination and institutional disrespect and abuse can significantly deter women's use of facilities for normal and emergency birth care. Women desire dignified and respectful care during childbirth.[25] A Tanzania study found that respectful, attentive providers, and reliable access to drugs and equipment, have the largest influence on a woman's decision to give birth in a facility.[26] Yet, a "veil of silence" has obscured widespread humiliation and abuse of women in facilities during childbirth, a particularly vulnerable time.

While the above factors are identifiable, many of the inequities that women face are unfortunately not obvious and can remain hidden. Women and their birth attendants have normalized this disrespect and simply consider it to be expected. Women during childbirth and health care workers around the world have reported many violations of women's rights: Physical, sexual and verbal abuse; humiliation; non-consented and non-confidential care; stigma and discrimination; abandonment of care; and detention of the mother and newborn in facilities.[27]

Experience of mistreatment is not limited to the mother. Newborns deserve dignified care, but are often mistreated, too. Mothers who are already at heightened vulnerability due to limited education and awareness or inability to pay may find themselves

"IT IS THE TIME TO BE MAXIMALLY DISRUPTIVE OF THE PATTERNS THAT CURRENTLY ENTRENCH POOR HEALTH AND HEALTH INEQUITIES."

–PENELOPE HAWE

and their newborns subjected to increased disrespectful and abusive care, particularly during labor and delivery, and immediately postpartum. Physical abuse of the mother during pregnancy is one notable risk factor for preterm birth, which in turn contributes to neonatal mortality. Many neonatal deaths could be prevented if there were skilled and timely quality intrapartum and neonatal care. Yet fear of, or experience of, disrespect can be a powerful deterrent to receiving this care.

A potential contributing factor to disrespect and abusive care is that many skilled birth attendants, especially female providers, work in extremely difficult, stressful, isolated, and unsafe environments. At the provider level, they too experience inequities in their working conditions. These health care workers are often poorly paid, demoralized, and treated without respect. Such factors undermine the resilience of skilled birth providers and may have

Photo: Amy Fowler/USAID

a negative impact on their capacity to provide equitable quality care and to participate in policy and direction of health services.

USAID continues to play a leading role in synthesizing and creating evidence to understand and address mistreatment of women and newborns. For example, evidence from a USAID-supported multi-component intervention in Kenya shows that interventions in the facility (training in respectful care, quality improvement teams, site counselors for caregivers, monitoring of mistreatment, mentorship, and maternity open days) and in the community (community workshops, mediation/alternative dispute resolution, and counseling community members) can yield a decrease in abuse from 20 percent to 13 percent.[28]

USAID works at the community, health facility, district, regional, and national levels to support pro-equity and respectful care policies in plans and activities. USAID supports activities encouraging the mainstreaming of respectful maternity care in training, service provision, measurement and monitoring, and community and facility accountability to "own" the problem. USAID supports efforts to identify the problem and raise awareness about these issues through global advocacy groups, including WHO, the White Ribbon Alliance, the Maternal Health Task Force, and other partners. USAID also works to develop assessments and tools to measure these issues and provide data to inform program and policy decision-making.

Providing respectful maternity care and positive birth experiences for all women encourages women to deliver in a health facility and continue to seek timely, quality care for herself and her family. It is foundational to promoting health equity across the most vulnerable groups.

"BEING LOW STATUS LEADS TO DISCRIMINATORY BEHAVIOR BY HEALTH PROVIDER…SHE WILL ACCEPT IT AND SHE WON'T YELL BACK…"

–INTERVIEWEE, TRACTION PROJECT, 2010

SOCIAL AND BEHAVIOR CHANGE

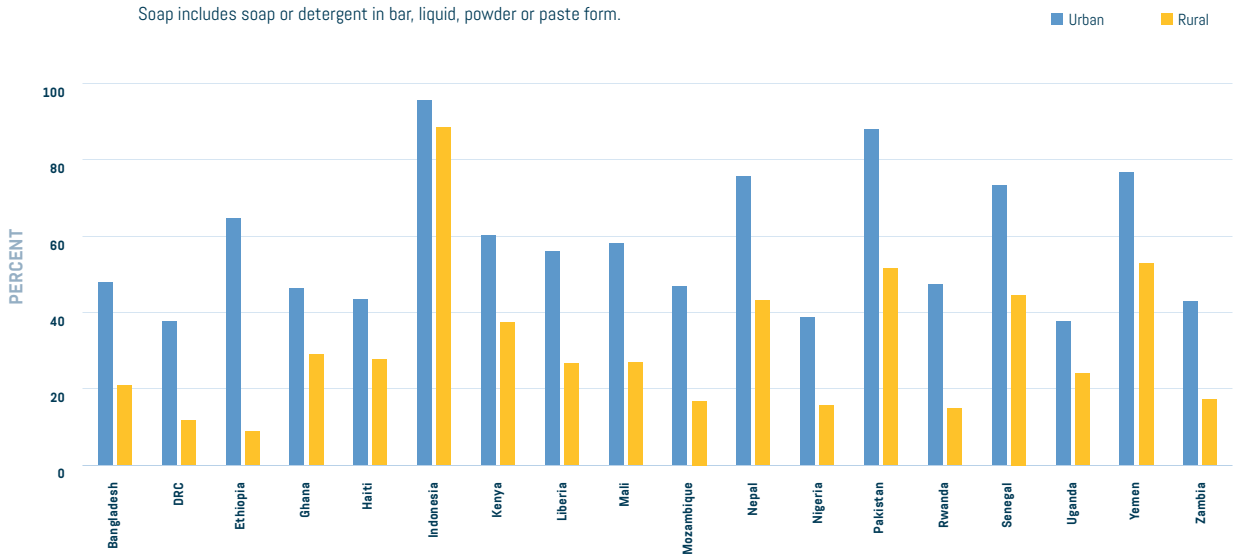
A cross-cutting concern for health equity is the adoption of healthy behaviors. For that reason, audience profiling and segmentation is standard practice in any social and behavior change program. A detailed understanding of the different groups, and the different motivations and barriers they face, is part of any effective program and provides more robust insights into the presence of inequities than an examination of differences based on income alone. This includes consideration of myriad dimensions of inequality, such as place of residence, race or ethnicity, occupation, gender, religion, education, socioeconomic status, and social capital or resources.

The practice of healthy behaviors sometimes follows the general expectation that those in higher wealth quintiles, with higher levels of education and residing in urban areas, are more likely to practice these behaviors than those in lower wealth quintiles, with lower levels of education and living in rural areas. This expectation holds true for handwashing. A large difference exists between urban and rural areas for presence of soap and water at household handwashing stations in Bangladesh, Ethiopia, Kenya, Liberia, Mali, Mozambique, Nepal, Nigeria, Pakistan, Rwanda, Senegal, Yemen, and Zambia (Figure 14).

At times, however, an unexpected pattern emerges. ORS use, for example, is highest in the fourth wealth quintile and among mothers with the second-highest level of education in Nepal; early initiation of breastfeeding is lowest in the fourth wealth quintile in Pakistan; and early initiation of breastfeeding actually decreases with increases in wealth and mother's education in Bangladesh (Figures 15 and 16).

FIGURE 14: **HOUSEHOLDS WITH SOAP AND WATER BY RESIDENCE**

Percentage among households where place for handwashing was observed.
Soap includes soap or detergent in bar, liquid, powder or paste form.



In some EPCMD priority countries, gender inequality appears to play a bigger role than wealth inequality. ORS use is higher for male children under-5 years of age than for female children under-5 years of age in Nepal, Indonesia, Pakistan, Bangladesh, and Yemen. In Nigeria and Uganda, however, a slightly higher level of female children receive ORS versus male children. Understanding how and why may be clearer with a look at sub-national, religious, and/or special population data.

In some instances, none of the "usual suspects" of inequitable/uneven practice of healthy behaviors emerge from the regularly available data—geography, gender, wealth quintile, or mother's education. The latest DHS data on ORS use in Kenya and early initiation of breastfeeding in Uganda, for example, show very equal levels of practice across gender, urban/rural location, socioeconomic status, and mother's education, but uptake is still quite low. In such cases, it is especially important to look at other dimensions of inequality that impact behavior, but are less regularly measured, such as religion, ethnicity, and occupation. It is also important to consider more distal factors that can influence behaviors, such as national registration policies for citizens that may affect access to health services for internal migrants.

A closer look at the data on the accelerator behaviors[29] through a multi-dimensional lens on equity can make programs more effective and contribute to the greatest declines in mortality.

FIGURE 15: **BREASTFEEDING WITHIN 1 HOUR OF BIRTH BY EDUCATION**

Percentage among last-born children born in the two years preceding the survey. Bangladesh 2014 DHS.

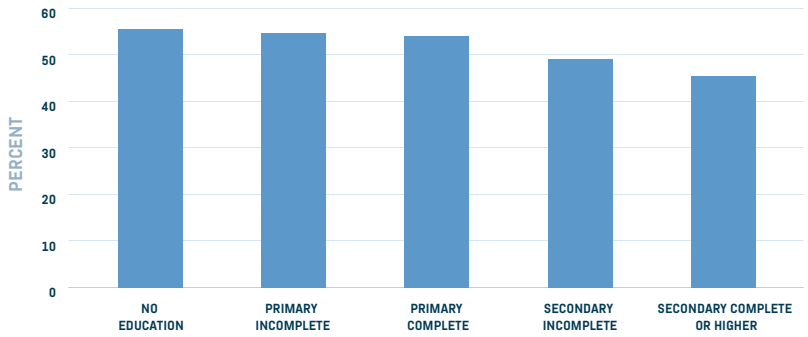
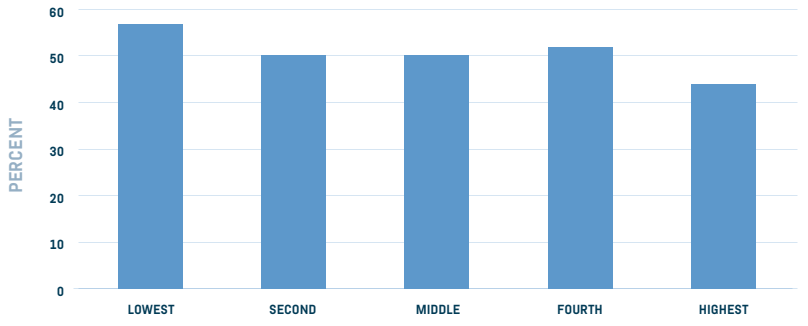


FIGURE 16: **BREASTFEEDING WITHIN 1 HOUR OF BIRTH BY WEALTH QUINTILE**

Percentage among last-born children born in the two years preceding the survey. Bangladesh 2014 DHS.



NUTRITION

In order to combat malnutrition and achieve equity, it is important to examine the inequalities that exist in the underlying structures and target the hardest to reach and most vulnerable populations. While the immediate determinants of adequate nutritional status are dietary intake and health status, many complex underlying determinants of undernutrition exist and influence the nutrition-enabling environment. These include gender inequality and women's disempowerment, early/child marriage, access to education, and other contributing environmental, sociocultural, economic, demographic, and political factors.

In many countries, the nutritional status of women and children is worst among those from the most marginalized groups. For example, in Nepal, where caste discrimination has been legally prohibited though the existence of castes still exists, high rates of anemia plague certain ethnic/geographic groups more than others. According to an analysis of the 2011 DHS data, women and children from the Dalit ("untouchable") caste in the Terai Plain region have the highest levels of anemia in the country (58 percent and 61 percent, respectively), well above the national average, 35 percent for women and 46 percent for children.[30]

Research has shown that a mother's education is closely linked to a child's health and growth. As seen in Figure 17, stunting in USAID nutrition priority countries is much higher among children whose mothers have no formal education, as compared to those whose mothers have secondary or higher education. For example, in Bangladesh 51 percent of children whose mothers have no education are stunted whereas only 22 percent of children whose mothers have a higher education are stunted. This figure also demonstrates the importance of viewing health inequities beyond bivariate measures (i.e. educated/not educated) to consider multiple

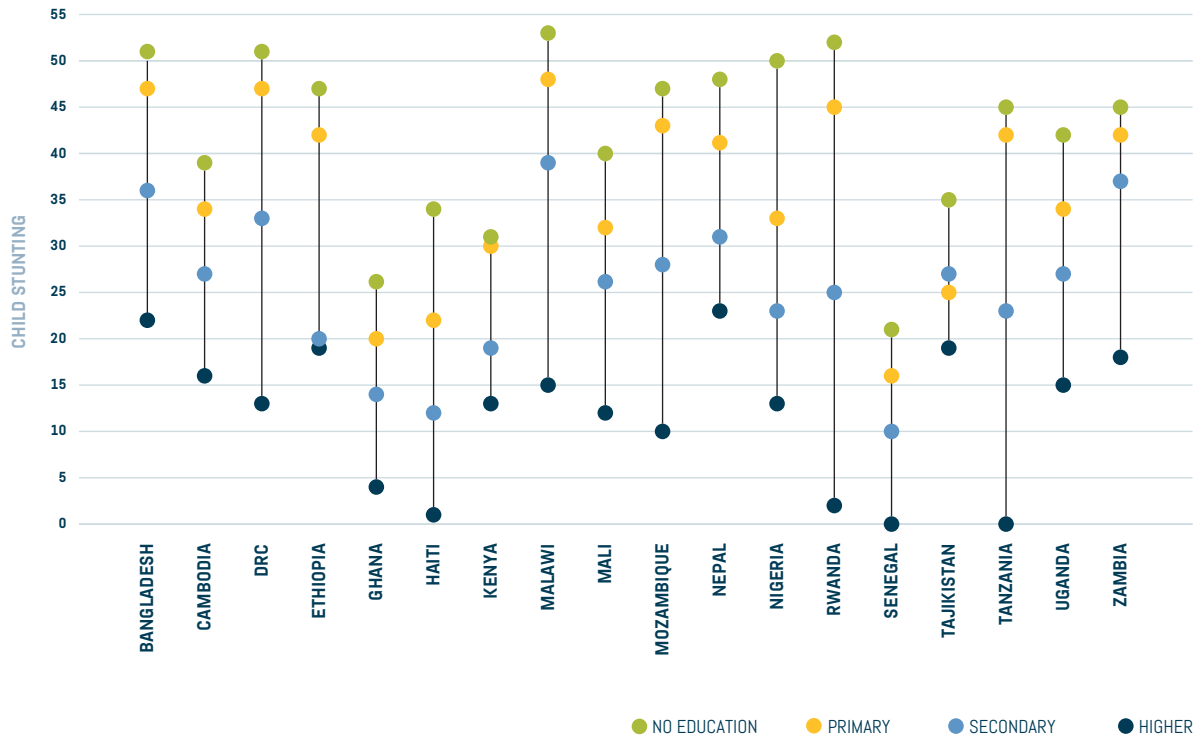
"Suaahara," which means Good Nutrition in Nepali, is a community-focused project in Nepal supported by USAID and dedicated to improving the health and nutritional status of pregnant and lactating women, and children under age 2. An integral part of Suaahara's work is integrating gender and social programs into nutrition-specific and nutrition-sensitive programs, particularly for disadvantaged groups. One focus of the project was to mainstream homestead food production to increase year-round access to diverse and nutritious foods in the home, which has contributed to female empowerment and gender equality by equipping mothers with skills and inputs to improve their household food security. Suaahara works in collaboration with the Government of Nepal, primarily through Female Community Health Volunteers (FCHVs), to reach the most disadvantaged groups, including those who have significantly lower levels of income, seek health services less frequently, and subsequently suffer poorer health and nutrition outcomes compared to other groups. The FCHVs have created positive impact not only on nutrition outcomes in their communities, but also in their own empowerment. Many women who have worked as FCHVs have been elevated in their communities as leaders in other organizations and government, and some have even enrolled in school. The trust and respect garnered by these women through their role as a FCHV has helped shape their empowerment in society and encouraged a gradual shift in gender dynamics in Nepal.[31]

dimensions within a variable. In many countries included in Figure 17, child stunting for mothers with a primary education is fairly close to the rates of child stunting for mothers with no education. However, while child stunting was generally lower among mothers with a secondary education, it was still considerably higher than in children born to mothers with a higher education in most countries, indicating that education of girls through at least secondary levels appears to be an important factor in addressing child stunting.

Disparities in nutrition practices and outcomes, including stunting, anemia, exclusive breastfeeding, and dietary diversity, exist in part because of a weak enabling environment and commitment, varying availability of quality nutrition services and support, and disparities in access to diverse and nutrient-rich foods within the household.

USAID's Multi-Sectoral Nutrition Strategy[32] aims to address the nutrition-related inequities that exist at the national, community, and household levels through effective coordination for nutrition-specific and nutrition-sensitive actions.

FIGURE 17: **CHILD STUNTING BY MOTHER'S EDUCATION: USAID NUTRITION PRIORITY COUNTRIES**

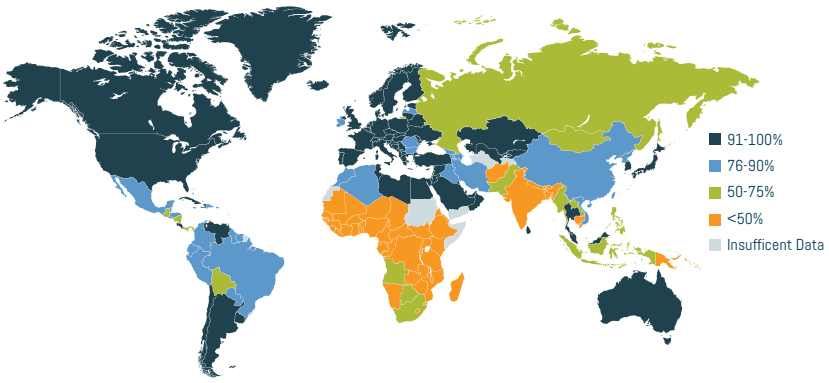


WATER, SANITATION AND HYGIENE

Goal 6 of the SDGs is to ensure availability and sustainable management of water and sanitation for all. Worldwide there is a tremendous disease burden associated with deficient hygiene, sanitation, and water supply—a burden that is largely preventable with proven, cost-effective interventions. Inequities in access to WASH services and thus increased risk of disease and child death result from a mix of contextual factors including social, economic, political, geographical and/or environmental factors, which must be understood and addressed to achieve equitable access.

Despite the progress toward reaching the original Millennium Development Goal (MDG) target of halving the proportion of people without access to improved sources of water, progress was not equal across or within EPCMD priority countries. For example, in Kenya, coverage of improved water supply in urban areas is 82 percent, but in rural areas this drops to 57 percent. In the Democratic Republic of Congo the inequity is even more dramatic, with coverage of improved water supply in urban areas at 81 percent, but in rural areas this drops to 31 percent. Poverty and other vulnerabilities create further inequities. Inequity is observed between the richest and poorest quintiles in all regions, across rural and urban areas (Figure 19). The poorest 20 percent of the population in sub-Saharan Africa are half as likely to use improved drinking water as those in the richest 20 percent.[33]

FIGURE 18: **IN 47 COUNTRIES, AREAS OR TERRITORIES, LESS THAN HALF THE POPULATION USES IMPROVED SANITATION IN 2015**



WHO/UNICEF Joint Monitoring Programme, Progress on sanitation and drinking water — 2015 update and MDG assessment

Proportion of population of Sub-Saharan Africa with access to improved drinking water, by urban, rural and wealth quintiles
WHO/UNICEF Joint Monitoring Programme, Drinking Water: Equity, safety, and sustainability, http://www.wssinfo.org/fileadmin/user_upload/resources/report_wash_low.pdf

And even in urban areas with high coverage of water services, those living in informal settlements are unable to access piped water through utilities because they lack land titles.

Progress towards universal access to sanitation has also been uneven. Among EPCMD priority countries, improved sanitation coverage in Indonesia and Pakistan is over 60 percent, while Madagascar, Tanzania, and Ghana have coverage of less than 15 percent (Figure 18). There are wide disparities between access to improved water supply and access to sanitation, particularly in rural areas. For example, in India 94 percent of the population has access to improved water, yet only 40 percent of the population has access to improved sanitation. In addition, there are specific challenges to sanitation access faced by persons with disabilities, a group not widely included in the design, implementation, and decision-making processes of WASH projects. Households affected by HIV and AIDS have a substantially greater need for WASH services to prevent diarrhea and opportunistic infections. However this population often has greater difficulty accessing water and sanitation. The poor sanitation practices of a single individual can affect the entire community, and lead to increased diarrheal disease and child mortality, so inclusiveness in design and implementation is an important principle of successful sanitation service provision, as well as a principle of equity.

Photo: Thomas Cristofoletti/Ruom for USAID

Photo: Morgana Wingard/USAID

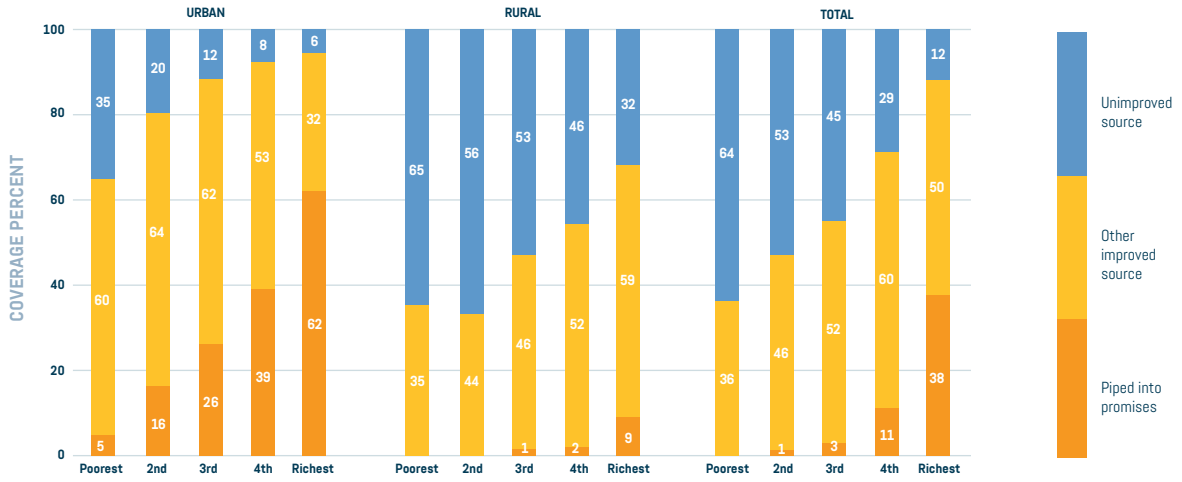
USAID's WASH programming aims to increase sustainable access to improved water and sanitation services for all by addressing inequities. Under its Water and Development Strategy,[34] USAID committed to placing strategic focus on WASH in priority countries with high levels of need. USAID WASH programs are also explicitly targeting the most vulnerable within countries through selection of target geographies based on rates of child mortality stunting, and access to WASH.

In Kenya, USAID worked to increase access to WASH for those affected by HIV and AIDS through the integration of improved WASH practices into HIV policies, programs, and training for community health workers.

Improved sanitation in dense urban environments, where the most vulnerable live, affects the health of everyone in the community through diarrheal disease, parasites, and enteropathy. Improving urban sanitation is critical to reducing undernutrition and child mortality. USAID has also recently revised its standard indicators for monitoring WASH programs to promote disaggregation by wealth quintile and gender where appropriate. Monitoring programming in this manner will help missions and implementing partners to quickly understand equity disparities and adaptively manage projects to reach the most vulnerable.

Using the sustainable development goals as a road map, USAID investments in WASH are aimed at providing sustainable and equitable access to WASH services and behaviors in order to reduce child mortality among the most vulnerable.

FIGURE 19: **THE RICHEST 20% IN SUB-SAHARAN AFRICAN COUNTRIES ARE OVER TWICE AS LIKELY TO USE AN IMPROVED DRINKING WATER SOURCE AS THE POOREST 20%.**



GLOBAL LEADERSHIP

An end to preventable child and maternal deaths is a global vision. It requires all development partners to work with country governments toward achieving the targets outlined in the SDGs and USAID's *Acting on the Call*. USAID continues to be a global leader in this space. Over the past year, USAID has developed strategic and technical documents, organized milestone events, and continued to rally a global consensus around a new and evolving set of high impact interventions or implementation approaches. USAID continues to create and build on established global partnerships with public, private, and multilateral entities so that all interested parties can play a meaningful role in achieving results.

June 2015

USAID, the World Bank, and WHO sponsored the **Measurement and Accountability for Results in Health Summit** in Washington, D.C. The summit resulted in the *Roadmap for Health Measurement and Accountability*,[35] outlining country-level investments to strengthen basic measurement systems and align partners and donors around common priorities.

The **Impact of Health Systems Strengthening (HSS) on Health Report**,[36] based on a study of systematic reviews of the effects on health of HSS, shows the value of investments in health systems strengthening on improving health for vulnerable people in low and middle income countries. Making decisions on who delivers health services, and where and how these services are organized, is important to achieving priority health goals in EPCMD.

USAID, in partnership with FP2020, the Bill & Melinda Gates Foundation, the World Health Organization, the United Nations Population Fund, and the David and Lucille Packard Foundation, sponsored the **First Global Postpartum Family Planning Meeting and Country Action Plans**. Each country team developed postpartum family planning action plans, and the steering committee will monitor progress and provide technical assistance.

July 2015

At the **Financing for Development** conference in Addis Ababa, Ethiopia, USAID committed $50 million to the GFF, an innovative financing approach among donors and host countries to accelerate efforts and narrow the financing gap to improve the health and the quality of life for women, adolescents, and children.

August 2015

USAID released its updated *Acting on the Call: Ending Preventable Child and Maternal Deaths* at the third **Call to Action Summit** in India. The report details further efforts to increase access to quality care around childbirth, as well as providing country specific updates from the 2014 ***Acting on the Call*** report.

September 2015

UNICEF released its ***Committing to Child Survival: A Promise Renewed***[37] 2015 Progress Report, with updated under-5 mortality estimates showing that in USAID's priority countries under-5 mortality has declined 48 percent since 1990. USAID has supported A Promise Renewed financially and technically since its inception in 2012.

Global leaders convened at the U.N. General Assembly to endorse the **Sustainable Development Goals**,[38] 17 targets and indicators that will guide international development efforts over the next 15 years. USAID analytic work done for the 2012 *Call to Action*, and the consensus built on a concrete target for under-5 mortality for every country, led directly to the adoption of the SDG target for under-5 and newborn mortality, as well as indirectly for maternal mortality.

The **Global Strategy for Women's, Children's, and Adolescents' Health** (2016-2030),[39] launched by Every Woman Every Child at the U.N. General Assembly, is a roadmap to achieve the SDGs for women and girls. More than 100 organizations and over 40 countries pledged non-financial and/or financial commitments to the Global Strategy, including a $3.3 billion contribution by the United States. USAID assisted in developing the strategy and is working to integrate the A Promise Renewed effort into it.

USAID launched its **Vision for Health Systems Strengthening** 2015-2019,[40] which aims to improve financial protection and access to high-quality services that reach underserved, marginalized, and high-priority groups. *The Vision for Health Systems Strengthening* will help guide USAID's work and investment focus to evidence-based HSS approaches that contribute to positive health outcomes and help create an environment for universal health coverage.[41]

DHS Analytical Studies 50 released a report ***Contraception Needed to Avoid High-Fertility-Risk- Births, and Maternal and Child Deaths that Would Be Averted***, which shows that family planning has large effects on reducing both maternal and child deaths. USAID will continue to review the evidence, to advance understanding of family planning's contribution to health outcomes.

In one of the first-ever studies of the impact of community-based, postpartum family planning in developing countries, published in *Studies in Family Planning*, USAID research has shown that **effective birth spacing, fertility counseling, and community education, can lead to healthy postpartum behaviors** including continued contraceptive use for 24 months after a birth, and reduction of short birth intervals.[42]

The launch of the **2015 Global Nutrition Report**[43] highlighted the critical relationship between climate change and nutrition, as well as the pivotal role business can play in advancing nutrition, and considers how countries can build food systems that are more nutrition friendly and sustainable. USAID provided technical and financial support to the development of the report.

October 2015

USAID provided technical and financial leadership for the **Global Maternal Newborn Health Conference**. The conference brought together researchers, policymakers, funders, and implementers to share new evidence, identify opportunities and gaps, and discuss the way forward to improve maternal and newborn health in support of the newly released SDGs.

The Partnership for Maternal, Newborn, and Child Health (PMNCH) launched its ***2016-2020 Strategic Framework***.[44] As PMNCH Board Member/ Board Co-Chair and Chair of its Donors & Foundations Constituency, USAID was actively engaged in shaping this new five-year Strategic Framework.

November 2015

The WHO released the ***Trends in Maternal Mortality: 1990 to 2015*** report,[45] citing a 44 percent reduction in maternal mortality worldwide over the past two and a half decades. In USAID's 24 priority countries, maternal mortality rates have been reduced by 46 percent since 1990.

In partnership with the WHO and UNICEF, USAID published ***Improving Nutrition Outcomes with Better Water, Sanitation and Hygiene: Practical Solutions and Policies for Programmes***,[46] summarizing the current evidence on the benefits of WASH for improving nutrition outcomes, and describing how WASH interventions can be integrated into nutrition programs.

December 2015

USAID announced **a partnership with the Peace Corps, the White House Social and Behavioral Sciences Team, and the General Services Administration** through which USAID will equip Peace Corps Volunteers to promote health behaviors for maternal and child health in 12 of the 24 focus countries and implement and rigorously evaluate behavior change interventions and activities for newborn, child and maternal health and nutrition that support EPCMD objectives.

January 2016

The Lancet journal published a five-paper series on **Ending Preventable Stillbirths**.[47] The series reported on the present state of stillbirths, highlighted missed opportunities, and identified actions for accelerated progress to end preventable stillbirths, and reach 2030 maternal, neonatal, and child survival targets. USAID authored one article and participated at the launch that occurred in New York.

A two-paper series in *The Lancet* journal on **breastfeeding**[48] described past and current global trends of breastfeeding, its short and long-term health consequences for mother and child, the impact of investment in breastfeeding, the determinants of breastfeeding, and the effectiveness of promotion interventions. USAID participated on a high level panel at the Global Series Launch event in Washington, D.C.

February 2016

USAID participated in, and provided technical input to, the first-ever **Ministerial Conference on Immunization in Africa** in Addis Ababa, Ethiopia, where ministers of health and finance from countries across Africa gathered. The outcome of the conference was a ministerial declaration, written and signed by ministers, in support of universal access to immunization as a cornerstone for health and development in Africa.

Photo: USAID

ANNEX

Data Sources:

The information presented on the country pages comes from common, publicly available sources as described below. Sources were chosen to maximize ability to compare across countries in a single year and based on common methodologies for estimation. Therefore, the numbers presented may vary from recently released data and/or from the official numbers used within countries. 1990 was selected as the reference year since that marked the start of the MDG era.

Total Population, Population Under-5, Number of Births:

http://www.census.gov/population/international/ The U.S. Census Bureau's International DataBase (IDB) estimates and projections (funded by USAID) are provided for each calendar year beyond an initial or base year, through 2050. The estimation and projection process is conducted by the statisticians and demographers of the U.S. Census Bureau's International Programs Center, and involves data collection, data evaluation, parameter estimation, making assumptions about future change, and final projection of the population for each country. The Census Bureau begins the process by collecting demographic data from censuses, surveys, vital registration, and administrative records from a variety of sources. Available data are externally evaluated, with particular attention to internal and temporal consistency. The resulting body of data in the IDB is unique because it exists for every country and is updated annually; these single year estimates reflect the demographic impact of sudden events, such as earthquakes, wars, and refugee movements. The U.N. maintains the only other similar source of estimates for all countries, but updates its data less frequently; its estimates do not yet reflect the precise timing of sudden events.

*The Census International Data Base did not have estimates for India, South Sudan or Yemen. For these countries data on total population and population under-5 from 2010 was taken from the U.N. Population Division **http://esa.un.org/unpd/wpp/unpp/panel_population.htm**. Data on Number of Births was calculated using the under-5 Mortality Rate and the number of under-5 Deaths (see sources below).

Under-5 Mortality Rate and Under-5 Deaths:

http://www.childmortality.org/ Estimates produced by the Interagency Group for Child Mortality Estimation (IGME). IGME, established by the UN, has a membership of leading academic scholars and independent experts in demography and biostatistics who review mortality data and publish annual country level estimates of under-5 mortality. To do so, IGME compiles all available national-level data on child mortality, including data from vital registration systems, population censuses, household surveys and sample registration systems, and weights these data based on quality measures. In order to reconcile differences caused by estimation technique, error rates and overlapping confidence intervals, the Technical Advisory Group of the IGME fits a smoothed trend curve to a set of observations and then uses that to predict a trend line that is extrapolated to a common reference year, in this case 2015.

Under-5 mortality rate (U5MR) estimates by wealth quintile were abstracted from the most recently available *Demographic and Health Survey* and *Multiple Indicator Cluster Survey* (MICS) with *Countdown to 2015 Maternal, Newborn & Child Survival*.

The year 2020 U5MR estimates presented on each country page were based on the 2014 AOTC "Best Performer" analysis described below. These data represent the U5MR to be achieved in 2020 with scale-up of interventions at the rate of change of the best performing country in a similar coverage category.

Maternal Mortality Ratio:

From the recently released report: Trends in Maternal Mortality: 1990 to 2015. Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division: **http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2015/en/.** The 2013 round of U.N. estimates (World Health Organization et al., 2013) provided an integrated evaluation of maternal mortality over the full interval from 1990 to 2013, utilizing all available data over this

period. A key goal of this analysis was to create comparable estimates of the Maternal Mortality Ratio and related indicators for one hundred eighty three countries (or territories), with reference to 5-year time intervals centered on 1990, 1995, 2000, 2005, and 2013. The 2015 report included two key methodological refinements to enhance the quality of the data. First, the 2015 model utilizes national data from civil registrations systems, population-based surveys, specialized studies and surveillance and censuses data to estimate trends for all countries. Second, the 2015 methodology is weights data from higher quality sources higher so these have a greater impact on the final estimates than data from lesser source.

Intervention Coverage Estimates

Intervention coverage rates were abstracted from the most recently available *Demographic and Health Survey* and *Multiple Indicator Cluster Survey* with special data from the Federal University of Pelotas, Brazil (*Countdown, 2015*).

2016 coverage estimates were based on an application of the annualized rate of change from the two most recently available survey data points. In cases for which there was only one historic data point available or for which the annualized rate of change between the two most recently available survey data points was negative, we used the last available data point as the 2016 coverage estimate.

"Predicted" coverage rates for 2016 presented on each country page were based on the 2014 AOTC "Best Performer" analysis described below. These data represent the coverage to be achieved in a given year (2016 or 2020) with scale-up of interventions at the rate of change of the best performing country in a similar coverage category.

Lives Saved Tool:

The Lives Saved Tool (LiST) was used to estimate the potential mortality reduction as a result of expanded coverage of selected maternal and newborn interventions. The LiST model projects intervention coverage rates by: 1.) analyzing trends in intervention coverage for the period 1990 to 2010 based upon data from household surveys conducted in low- and middle-income countries; 2.) developing country-specific models which project coverage changes for key maternal, newborn, and child health interventions;[49] and 3.) applying the rate of change pattern to create trends of coverage change for the period 2012 to 2020 according to data from the most recent measurement year.

Country-specific projections are based on mortality rates, causes of death, baseline health status, and coverage levels for effective interventions. The LiST analysis presented here does not include components related to the relative cost to scale interventions, the quality of service delivery, or sub-national differences in prioritization. These dimensions, therefore, must be considered along with other variables in determining programming priorities going forward.

As elsewhere in the report, estimates for under-5 mortality and deaths used in LiST were produced by the IGME, comprised of UNICEF, WHO, World Bank, and the U.N. Population Division[50] and cause of death profiles were based upon an estimation approach (*publication forthcoming*) that has been described.[51]

Similarly, baseline health status and coverage indicators were abstracted primarily from the most recent nationally-representative survey datasets which were available. Data sources include DHS and MICS with special data analysis by Federal University of Pelotas, Brazil. For national coverage estimates of immunization and WASH indicators, data were abstracted from global estimates maintained by World Health Organization/United Nations Children's Fund and WHO/UNICEF Joint Monitoring Programme, respectively.

Best Performer Methodology

The "predicted" and "best performer" coverage rates for 2016 and 2020 on the country pages estimate intervention coverage to be achieved under a specific scale-up scenario generated by LiST. Coverage trends were projected from the historical rates by analyzing the trends in coverage of interventions and contraceptive prevalence for the period 1990 to 2010, from the nationally-representative surveys that provide coverage data for these interventions.[52] Country-specific projections of coverage changes were then developed for key maternal newborn and child health MNCH interventions from the most recent measurement to 2020. There were two variants of these projections. First, the "historical trend" projects coverage of the interventions based on the country-specific historical information. The second projection was the "best performer"[53] scenario where coverage change for each intervention was not based on the country data but rather based on the best performing country (within categories).

The best rate of change achieved by any country with a similar level of coverage at baseline for each of the three grouped interventions was selected and applied to produce these "best performer" scenarios. Interventions with inadequate data to ascertain baseline coverage or track historic trends over time could not be stratified and scale-up was not included in the analyses. Coverage for some interventions lacking a reliable indicator was calculated using related proxy measures that were adequately reported in nationally-representative surveys. This projection yields much higher scale up of coverage than the "historical trend" scenario but is limited to rates of coverage change that have been achieved in the past by countries at similar levels of development.
In addition to estimated coverage change, for introduction and coverage of new vaccines we used the Gavi country-specific roll out plans. The 2020 coverage estimates presented on the country pages reflects the "best performer" scenario since it allows analysis of expected impact vis a vis current coverage rates under optimal conditions. However, comparisons between "best performer" projections and historical projections were also used to understand the net effect of our planned action plans over and above current progress and are reflected in top-line messaging.

Equity Methodology

To model the impact of an equity-based approach (i.e. scaling up coverage among the poorest), subnational models were created to reflect fertility and coverage of key interventions for the two lowest wealth quintiles (WQ) in each country. Total population was assumed to be one-fifth for each wealth quintile and baseline coverage by wealth quintile was abstracted from the most recent nationally representative household survey (e.g. DHS or MICS). Ratios (WQ 1 or 2 coverage rate divided by the national coverage rate) were applied for certain indicators to adjust national estimates when data disaggregated by WQ were not available. Baseline mortality rates and cause of death profiles for the subnational models were created by applying the most recent version of the Lives Saved Tool. Targets for 2020 for the subnational WQ models were set to match national targets from the *Acting on the Call* models (updated 2016) with a linear trend. Child death totals in this scenario were compared to a baseline where all coverage rates remain constant from 2012 to 2020 to estimate the number of child lives saved.

Photo: Syanne Luntungan, USAID EMAS

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