



2015

*Every Woman,
Every Child,
Every Adolescent:*
Achievements and
Prospects

The Final Report of the
independent Expert Review
Group on Information and
Accountability for Women's
and Children's Health

IERG

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PREFACE

This fourth and final report from the independent Expert Review Group on Information and Accountability for Women’s and Children’s Health (iERG) signals the conclusion of an unusual experiment in global health. The 2011 Commission on Information and Accountability (CoIA) was a landmark moment for women and children. Born from the UN Secretary-General’s signature *Every Woman, Every Child* initiative, the Commission sought to mark a new era in the way progress was measured for two critically important Millennium Development Goals. The Commission redefined the meaning of “monitoring and evaluation” and “mutual accountability,” transforming a purely technical process of tracking indicators into a political process of evaluating those indicators transparently and democratically, judging the performance of institutions responsible for making promises and commitments to women and children, and acting on the results of those evaluations and judgements.

The model of accountability adopted sought to recognise:

1. the continuum of care and service delivery, by requiring the engagement of communities; primary, secondary, and tertiary care; and rehabilitation, in the provision of services throughout the life course;
2. at every level, the need for adequate and consistent monitoring; timely and comprehensive review; and appropriate remedial and concerted action by all stakeholders;
3. the need to engage all stakeholders, and for each participant to be held accountable for their contribution;

within a social, financial, and political accountability framework that operated at both national and international levels.

Given the difficulties in transparency, as well as the non-comprehensiveness of information available, the iERG adopted a phased approach to accountability, not envisaged by the Commission. It is not surprising that this experiment has generated considerable discussion and debate. It was seen by some observers as a much-needed opportunity to strengthen accountability globally and in countries. Those who have followed the annual recommendations of the iERG have seen a marked improvement in performance and results. For those who have not, the annual iERG reports and recommendations may have appeared to be a distraction. The product of CoIA, the iERG has, with the tools available to it, sought to translate the hopes of *Every Woman, Every Child* into an opportunity to regularly review what has worked to advance the health of women and children, what has failed, and what needs to be prioritised in the future.

Our successors will judge whether this experiment has helped to advance the growing movement to protect and strengthen the health of women, children, and adolescents. Our tentative view is that while the imperfections of this first foray into independent accountability have been all too visible—most obviously of all, the profound difficulty of triggering sustainable accountability mechanisms in countries—-independent accountability can be said to have passed the “proof of concept” stage. If independent accountability was a new medicine, it has passed its phase 1 trial.

Indeed, this final report has for the first time benefitted from the availability of data from some of the development partners that support women’s, children’s, and adolescents’ health in countries.

As we complete this final iERG report, it is becoming clearer that post-2015, the idea of an independent group to monitor, review, and stimulate action to accelerate advances in the health of women, children, and adolescents will continue. All stakeholders seem to agree that independent accountability has value for improving the oversight of results and resources globally and in countries. Again, not surprisingly, there is vigorous debate about the details. Where should this group be hosted? What should be its exact terms of reference? Who will fund it? Who should it report to? How should its recommendations be acted upon? These details matter. But, much more importantly to us, the idea of independent accountability seems secure, at least in this one sphere of global health and in the short term. The success of independent accountability depends less on the logistical details of its operation than on the commitment of stakeholders to take the notion of accountability seriously. It is up to all of us who care about delivering better health for women and children to make sure that accountability means what it says—counting and being accountable to women, children, and adolescents.

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ABBREVIATIONS

AFRO	WHO African Region	IPU	Inter-Parliamentary Union
AIDS	Acquired immune deficiency syndrome	ITU	International Telecommunication Union
ANC	Antenatal care	LAC	Latin America and Caribbean
AUH	Asignación Universal por Hijo	Lao PDR	Lao People's Democratic Republic
CAREP	Care seeking for suspected pneumonia	MDGs	Millennium Development Goals
CCT	Conditional cash transfer	MDSR	Maternal death surveillance and response
CEE	Central and Eastern Europe	MICS	Multiple Indicator Cluster Surveys
CIS	Commonwealth of Independent States	MMR	Maternal mortality ratio
CoIA	Commission on Information and Accountability for Women's and Children's Health	NMR	Neonatal mortality rate
CoLSC	UN Commission on Life-Saving Commodities	ODA	Official Development Assistance
CRS	Creditor Reporting System	OECD	Organisation for Economic Co-operation and Development
CRVS	Civil registration and vital statistics	OECD-DAC	OECD – Development Assistance Committee
DG	Director-General	OHCHR	Office of the High Commissioner for Human Rights
DHS	Demographic and Health Surveys	PAHO	Pan American Health Organization
DPR Korea	Democratic People's Republic of Korea	PEPFAR	President's Emergency Plan for AIDS Relief
DRC	Democratic Republic of the Congo	PMNCH	Partnership for Maternal, Newborn, and Child Health
DTP3	Diphtheria-tetanus-pertussis	PNC	Postnatal care
EBF	Exclusive breastfeeding	RMNCAH	Reproductive, maternal, newborn, child, and adolescent health
EMoC	Emergency obstetric care	SAGE	Strategic Advisory Group of Experts on Immunization
EMRO	WHO Eastern Mediterranean Region	SBA	Skilled birth attendant
EPMM	Ending Preventable Maternal Mortality	SDGs	Sustainable Development Goals
EURO	WHO European Region	SEARO	WHO South-East Asia Region
EWEC	Every Woman Every Child	STI	Sexually transmitted infection
FARDC	Forces Armées de la République Démocratique du Congo	TB	Tuberculosis
FFD3	Third International Conference on Financing for Development	TFR	Total fertility rate
FP2020	Family Planning 2020	U5MR	Under-five mortality rate
FPS	Family planning needs satisfied	UNAIDS	Joint United Nations Programme on HIV/AIDS
G7	Group of Seven	UNECA	UN Economic Commission for Africa
Gavi	The Global Alliance for Vaccines and Immunisation	UNFPA	United Nations Population Fund
GBD	Global Burden of Disease	UNGA	United Nations General Assembly
GDP	Gross domestic product	UNICEF	United Nations Children's Fund
GFF	Global Financing Facility	UNSG	United Nations Secretary-General
HIV	Human immunodeficiency virus	USAID	United States Agency for International Development
IAP	Independent Advisory Panel	WHO	World Health Organization
ICPD	International Conference on Population and Development	WPRO	WHO Western Pacific Region
ICT	Information and communication technology		
iERG	Independent Expert Review Group		
IPPF	International Planned Parenthood Federation		

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EXECUTIVE SUMMARY

The iERG's 2015 Recommendations: a Post-2015 Vision

- **Global accountability:** By 2016, establish and implement a global independent accountability mechanism to monitor, review, and act on results and resources for women's, children's, and adolescents' health, working across all 17 SDGs, reporting annually to the UN Secretary-General.
- **National accountability:** By 2016, in all countries establish and implement transparent, participatory, democratic, and independent national accountability mechanisms to monitor, review, and act on results and resources for women's, children's, and adolescents' health, with special attention to the translation of recommendations into action and reporting to Heads of State.
- **Accountability for sustainability:** In 2017, convene a global ministerial summit to report on progress towards the goals both of the new Global Strategy for Women's, Children's, and Adolescents' Health and the SDGs relevant to women, children, and adolescents; and to report on how national accountability informs and strengthens global accountability.

INTRODUCTION

The independent Expert Review Group on Information and Accountability (iERG) was created in 2011 as a mechanism to strengthen accountability for women's and children's health (see Annex 1). It was a body invented by the Commission on Information and Accountability (CoIA), chaired by President Kikwete of Tanzania and Prime Minister Harper of Canada (see Annex 2) (1). The idea of accountability is rooted in human rights. But sometimes the concept of accountability can seem far removed from the lived experiences of women, children, and adolescents. Measurement of progress, tracking of resources, and the construction of structures to deliver accountability in countries and globally can feel dry and abstract. In this, the iERG's fourth and final report, we wish to put the lived experiences of women and children at the heart of our concerns. The failure to deliver accountability is not merely a failure to meet the norms and standards of a political process. It is a fundamental violation of the dignity of the most vulnerable citizens living in our communities. For hundreds of millions of women and children worldwide, the promises and commitments of national political leaders, as well as global heads of health agencies and development organisations, have fallen short of expectations. Our final report will

certainly document successes. But as the true stories we begin with in the Introduction show, the egregious betrayals of the poor by the powerful continue to distort the history of women's and children's health. These deceptions are unacceptable. Accountability must make the realities of life for women and children worldwide its central concern. We hope this report goes at least some way to doing so.

2015 has been a year of reflection. The UN Secretary-General's signature health initiative, *Every Woman, Every Child*, was launched in 2010 (2). It has become one of the fastest growing movements in global health, attracting over 400 commitments by 300 partners, together with US\$60 billion of financing (3). Ban Ki-moon was right to say this year that, "The world is currently reducing under-5 and maternal deaths faster than at any time in history." In 49 priority countries targeted by *Every Woman, Every Child*, achievements have been historic. 870 000 new health workers. A 49% increase in oral rehydration therapy for treating diarrhoeal disease. A 25% increase in skilled birth attendance. Progress has accelerated, and the Secretary-General's Global Strategy for Women's and Children's Health has made a crucial contribution to this acceleration.

But there is always a reckoning. As much as the global community should admire the achievements of the Global Strategy, it left substantial room for improvement. In 2010, a commitment was made, one that should not be forgotten (2):

“In the 49 countries of the world with the lowest income, progress would be incredible. Between 2011 and 2015, we could prevent the deaths of more than 15 million children under 5, including more than 3 million newborns. We could prevent...about 570 000 women from dying from complications relating to pregnancy and childbirth.”

This headline promise was turned into an advocacy campaign for the Global Strategy: “Saving 16 million lives by 2015.” But in the Progress Report on the Global Strategy, published earlier this year, the true figure was revealed—2.4 million deaths averted since 2010. This substantial difference between what was promised and what was delivered is hard to comprehend. There are at least two possible explanations. First, that the Global Strategy failed. Second, that the calculation of 16 million deaths was

exaggerated or an error. If the former explanation is true, the global community needs to conduct a careful autopsy on what went wrong and why. If the latter explanation is correct, how did the full technical capacity of WHO and partner agencies make such a mistake? It is not good enough, as the Progress Report does, to gloss over this discrepancy in numbers by saying that the Global Strategy has delivered “substantial gains.”

2015 has also been a year of transition. Ban Ki-moon has called the process leading to the post-2015 Sustainable Development Goals (SDGs), “The Road to Dignity” (4). 17 SDGs have been agreed upon, and health is one of those Goals (SDG-3) (Panels 1 and 2; see main report). Women’s and children’s health is embedded within that Goal. In parallel, a new Global Strategy has been drafted to meet the challenge of a more inclusive and complex era (5). Agreement about the SDGs and the elements of a new Global Strategy does not mean that the approach to women and children is “business as usual.” There are already several critical differences in the approach and attitudes to women and children.

PROGRESS IN WOMEN’S AND CHILDREN’S HEALTH

According to the latest figures available to the iERG, 6.3 million children under 5 died in 2013 (11, 12). Figures for the 75 iERG countries, taken from the Global Burden of Disease (GBD), are shown in Table 1 (see main report) (11). An alternative presentation, using data from the UN Interagency Group for Child Mortality Estimation, is shown in Figure 1. The headline message from these numbers is that although the 2013 estimate represents a 64% reduction in child mortality since 1970 (when 17.6 million deaths took place), most countries will not achieve the MDG-4 target—which requires a 4.4% rate of mortality decline annually. The GBD collaboration singles out five countries that have made especially strong progress—in Southeast Asia, Cambodia, Lao PDR, and Viet Nam; and in eastern sub-Saharan Africa, Ethiopia and Rwanda. With annualised rates of decline in child mortality above 4%, these countries show that political commitment and judicious investments in health and (especially) maternal education can deliver results above expectation. The global causes of child death are shown in Figure 2 (see main report) (12). An alternative presentation of selected causes of child deaths is shown in Table 2 (see main report) (13). A particular concern is the growing importance of newborn mortality. In 2013, 2.8 million neonatal deaths occurred globally (14). Most of these deaths were preventable. Newborn mortality is falling, but more slowly than for under-5 deaths. The result is that newborn deaths now account for 44% of total under-5 deaths. Deaths in newborns can be divided into

two categories—early (0-6 days of age) and late (7-28 days of age). Most early neonatal deaths are caused by preterm birth (41%) or intrapartum (27%) complications. For late neonatal deaths, infections are the largest cause (almost half of newborn deaths). Equity analyses reveal severe disparities, despite often impressive average reductions in child deaths. Figure 3 (see main report) displays the proportion of under-5 deaths in the poorest and richest quintiles for a selection of iERG countries, together with several other nations included as comparators. The countries are ranked according to the percentage of all under-5 deaths that occur in the poorest quintile. Almost half of Brazil’s under-5 deaths take place in this poorest quintile.

For maternal mortality (MDG-5a), the GBD study has reported estimates for 2013: 292 982 deaths, compared with 376 034 deaths in 1990 (15). Table 3 (see main report) shows their maternal mortality data for the 75 iERG countries of concern. Figure 4 shows data from the Maternal Mortality Estimate Interagency Group, with trends in maternal mortality in the 75 iERG countries. These data are divided by average annual rate of reduction for two periods: 1990-2000 and 2000-2013. Although not universally consistent, one can see many examples of acceleration in reductions in maternal mortality (in 56 countries, although with 19 nations showing decadal decelerations in progress). Figure 5 shows countries ranked by reduction trends in under-5 and maternal mortality, from best to worst.

Countries that rank highly on both measures fall into the lower left of the diagram. If rankings on under-5 and maternal mortality were highly correlated, the points in the figure would cluster along the 45 degree line, which they quite evidently do not. The fact that they are as scattered as they are suggests that very different policies and influences may be affecting success in these two domains.

Achieving universal access to reproductive health services (MDG-5b) is the most off-track MDG of all. A report from the Guttmacher Institute in 2014 provides a comprehensive recent assessment of access to basic sexual and reproductive health services (16a). Currently, 225 million women in developing countries wish to avoid pregnancy, but are not using modern contraceptives. If all women who sought to avoid pregnancy used modern contraception, the number of unintended pregnancies would fall by 70% and unsafe abortions would drop by 74%. If contraceptive needs were met and all pregnant women and their newborns received basic standards of care, maternal deaths would fall from 290 000 to 96 000, newborn deaths would decline to 660 000, and HIV transmission from mother-to-child would be nearly eliminated. For women aged 15-49, a package of essential sexual and reproductive health services, costing no more than \$25 per woman aged 15-49 years, would include: contraceptive services, pregnancy and newborn care, services for pregnant women living with HIV, and treatment of four other STIs. In its submission to the iERG, Family Planning 2020 (FP2020) provided its latest judgement on progress made and gaps remaining in improving access to modern contraceptives (Figure 6). The Guttmacher Institute also drew the iERG's attention to the neglected importance of unsafe abortion rates. Although estimates for safe and unsafe abortion have not been made since 2008, it is clear that unsafe abortion remains common in many low-income settings, especially among adolescents.

The iERG commissioned Professor Cesar Victora (University of Pelotas, Brazil) to examine socioeconomic, gender, and urban/rural inequalities for women's and children's health. His full findings are reported in Annex 3. The key findings from this equity analysis are:

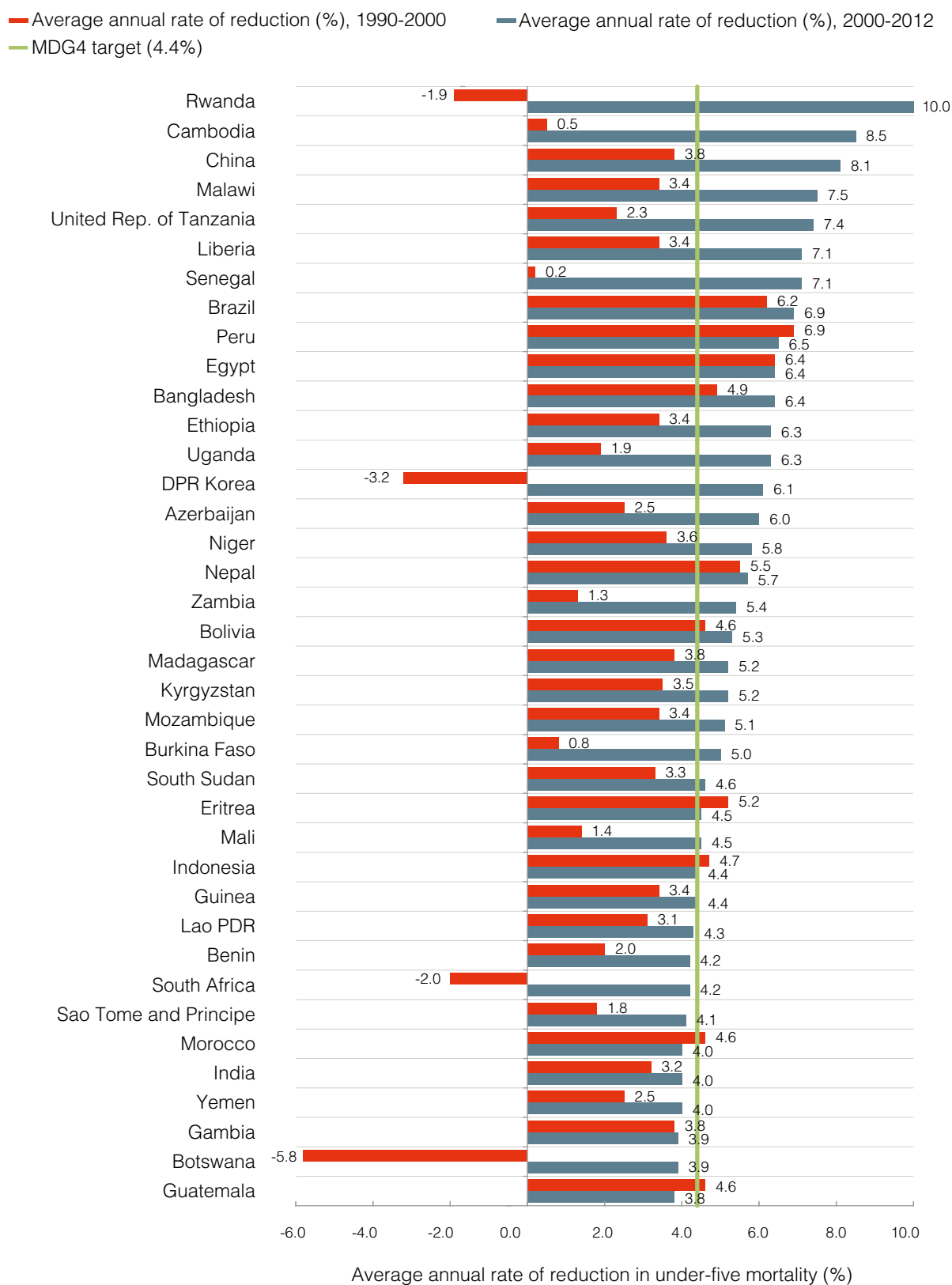
- Pro-rich inequalities are observed for all indicators, except for breastfeeding.
- The widest gaps are seen for skilled birth attendance.
- Postnatal care coverage is especially low across all quintiles.
- Pro-urban inequalities are seen for all indicators, except for exclusive breastfeeding.
- Boys and girls show similar coverage levels for post-natal care, exclusive breastfeeding, DPT3 vaccine, and pneumonia care seeking.
- For family planning, there are consistent pro-rich coverage patterns.
- Inequalities are largest in Africa.
- Adolescents have a much greater unmet need for contraception.
- For antenatal care, in every region there are pro-rich coverage patterns.
- At the global level, there are important inequalities in total fertility: ranging from 2.8 children/woman in the richest quintile to 5.4 in the poorest quintile.
- At the global level, the average number of children per urban woman is 3.1, compared with 4.6 among rural women.
- In all regions, fertility and stunting are inversely related to wealth.

Issues of equity received insufficient attention during the era of the MDGs, as these findings starkly and shockingly indicate. Although equity is frequently discussed, it is seldom prioritised in policies and programmes. Post-2015, whatever mechanism for accountability is chosen for women, children, and adolescents, equity must be made a supreme priority. UNICEF has put equity-focused programming at the heart of its recent work on reducing child mortality, to its enormous credit and largely thanks to the personal leadership of its Executive Director, Anthony Lake. As Lake wrote in UNICEF's analysis of equity in the MDGs, "If development is to be truly sustainable, it must be truly equitable—and seek to reach every child. For children who have equal opportunities will in turn create greater opportunities for their own children and the generations that follow" (16b).

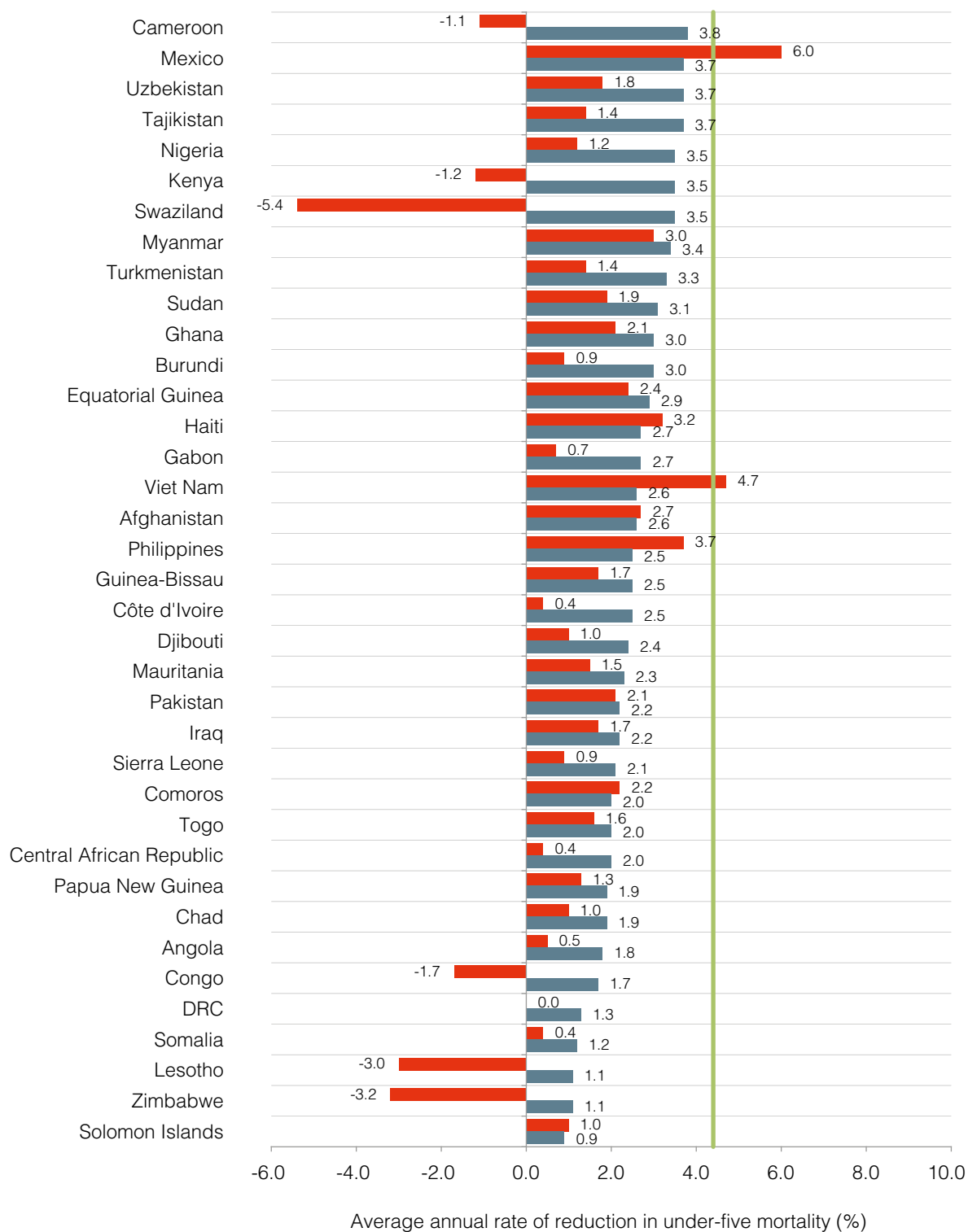
The architecture of accountability for *Every Woman, Every Child* has led to a strong collaboration between the Partnership for Maternal, Newborn, and Child Health (PMNCH) and the iERG. In three past PMNCH reports, commitments to the Global Strategy have been documented and issues investigated in ways that have been synergistic and complementary to the work of the iERG. In 2015, PMNCH is not producing an annual report. However, we are fortunate that the Partnership has continued tracking financial flows to RMNCH. Here, we present a summary of their latest findings:

- The number of stakeholders committing to women's and children's health has increased from 111 in 2010 to 334 in 2015 (Figure 7).
- Since May, 2014, an additional 34 commitment makers made pledges to the Global Strategy—17 of them in support of the Every Newborn Action Plan.

Figure 1. Trends in child mortality in the 75 iERG countries, by average annual rate of reduction, 2000-2012



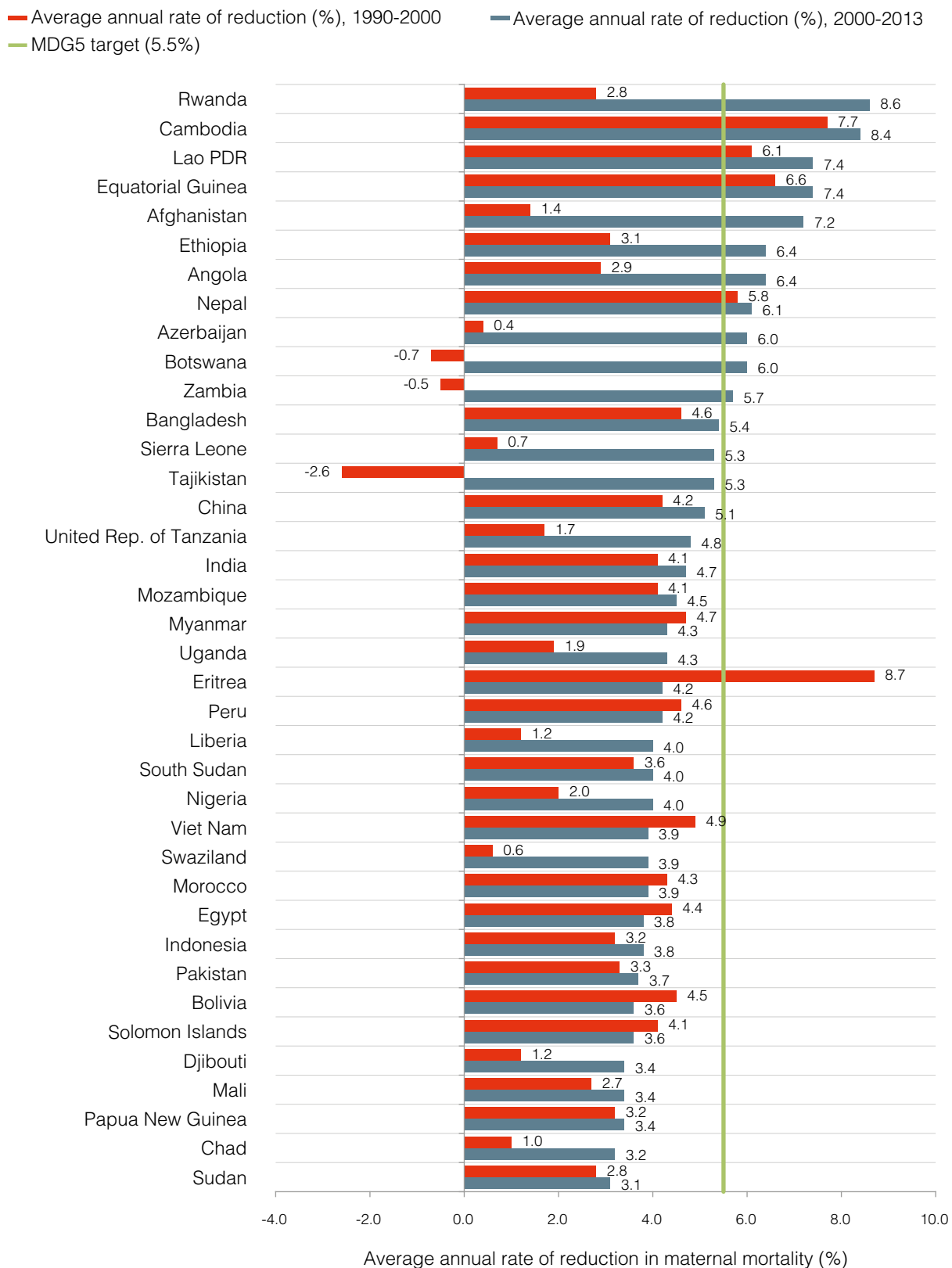
■ Average annual rate of reduction (%), 1990-2000 ■ Average annual rate of reduction (%), 2000-2012
| MDG4 target (4.4%)



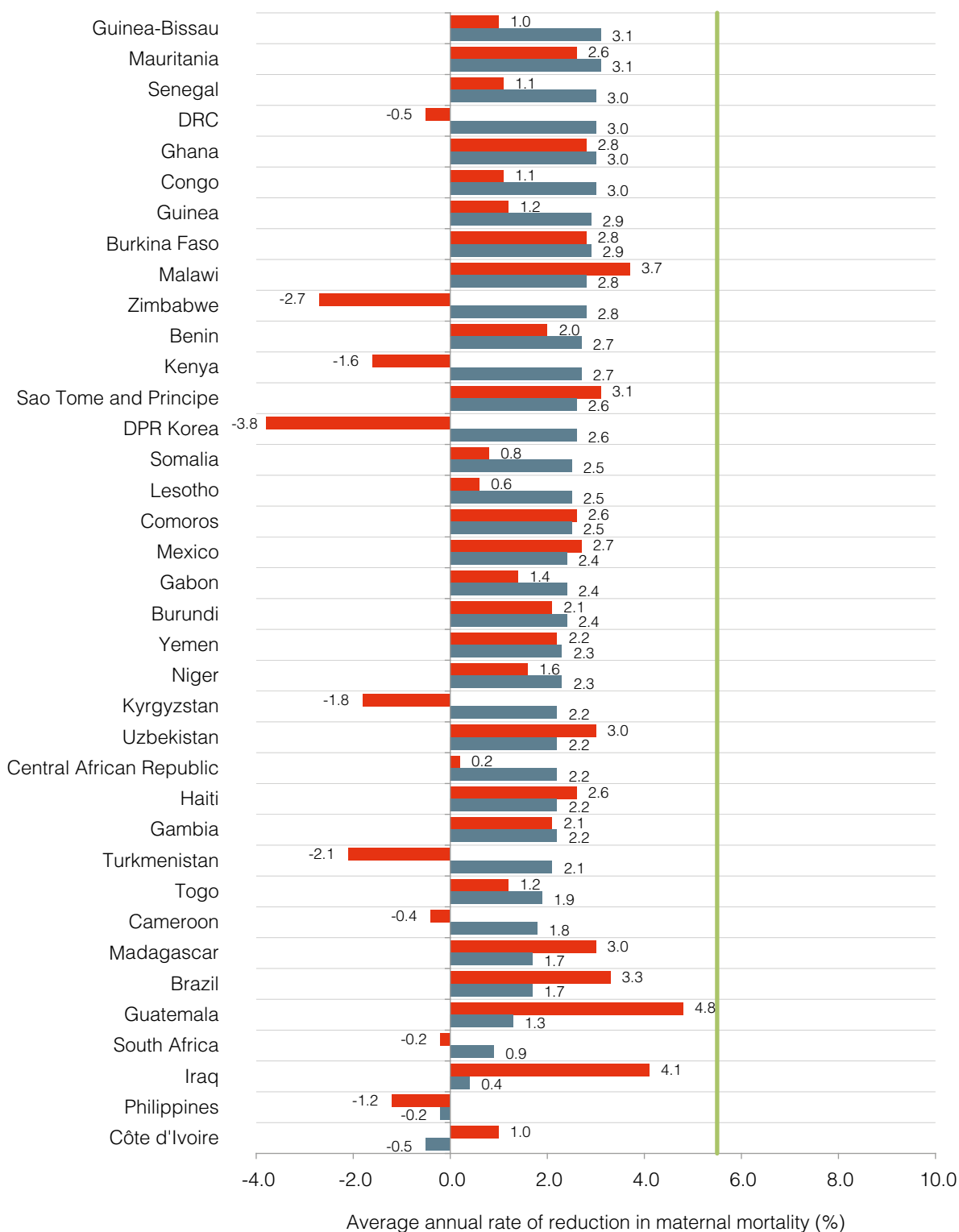
The goal for MDG4 was for countries to achieve a 4.4% average annual rate of reduction (AAR) in child mortality. In most iERG countries, the AAR for child mortality was faster in the years after 2000. However, in 10 countries, the AAR for child mortality was faster during the period from 1990-2000 compared to 2000-2012.

Source: UN Inter-agency Group for Child Mortality Estimation, 2013. Figure adapted from "Fulfilling the Health Agenda for Women and Children: The 2014 Report," Countdown to 2015.

Figure 4. Trends in maternal mortality in the 75 iERG countries, by average annual rate of reduction, 2000-2013



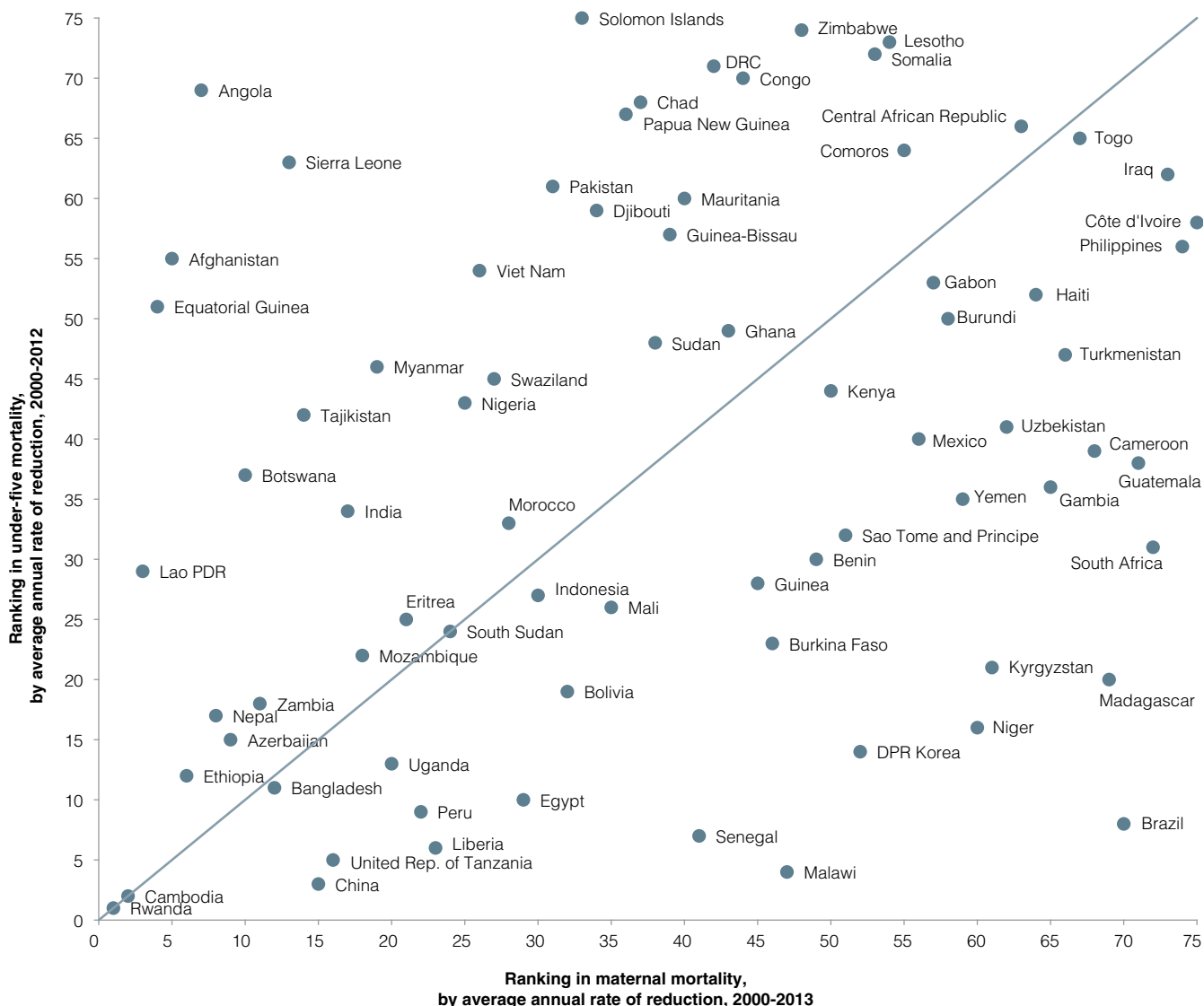
■ Average annual rate of reduction (%), 1990-2000 ■ Average annual rate of reduction (%), 2000-2013
— MDG5 target (5.5%)



The goal for MDG5 was for countries to achieve a 5.5% average annual rate of reduction (AAR) in maternal mortality. In most iERG countries, the AAR for maternal mortality was faster in the years after 2000. However, in 19 countries, the AAR for maternal mortality was faster during the period from 1990-2000 compared to 2000-2012.

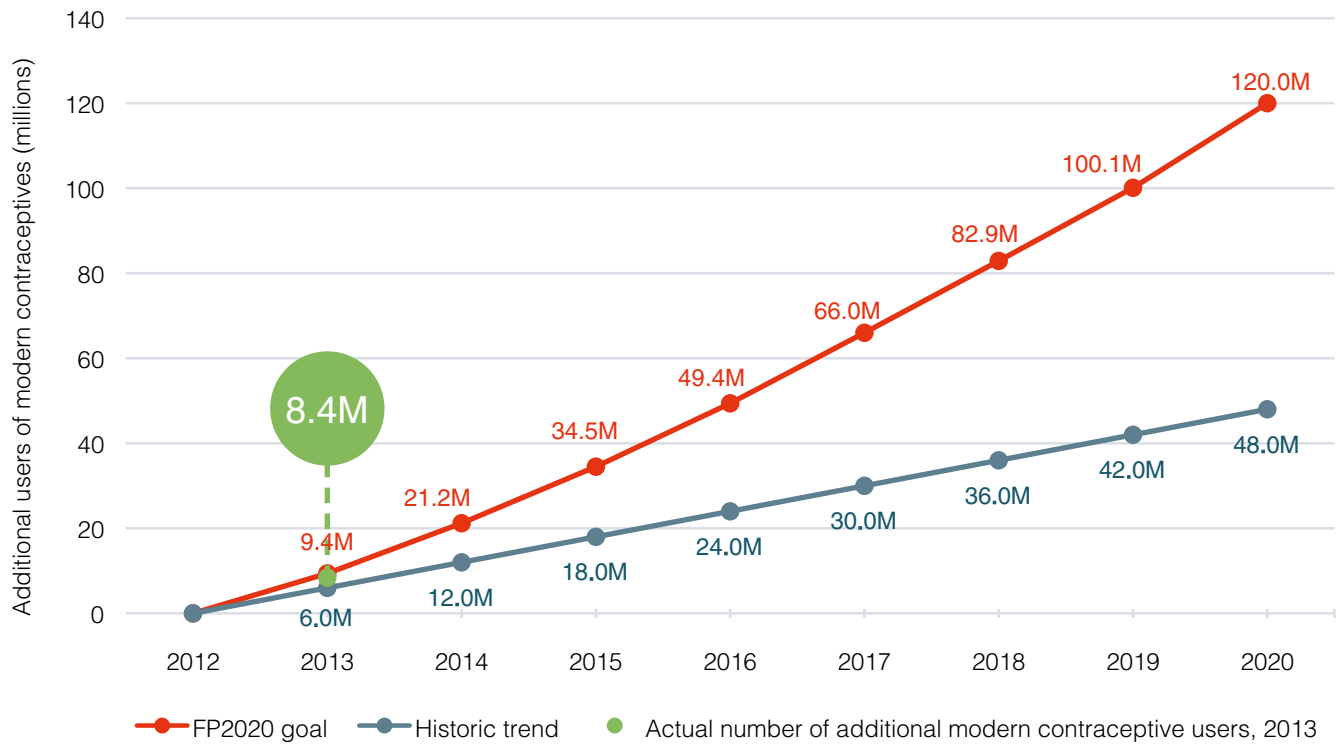
Source: Maternal Mortality Estimate Inter-agency Group, 2014. Figure adapted from "Fulfilling the Health Agenda for Women and Children: The 2014 Report," Countdown to 2015.

Figure 5. 75 iERG countries ranked by reduction trends in under-five and maternal mortality



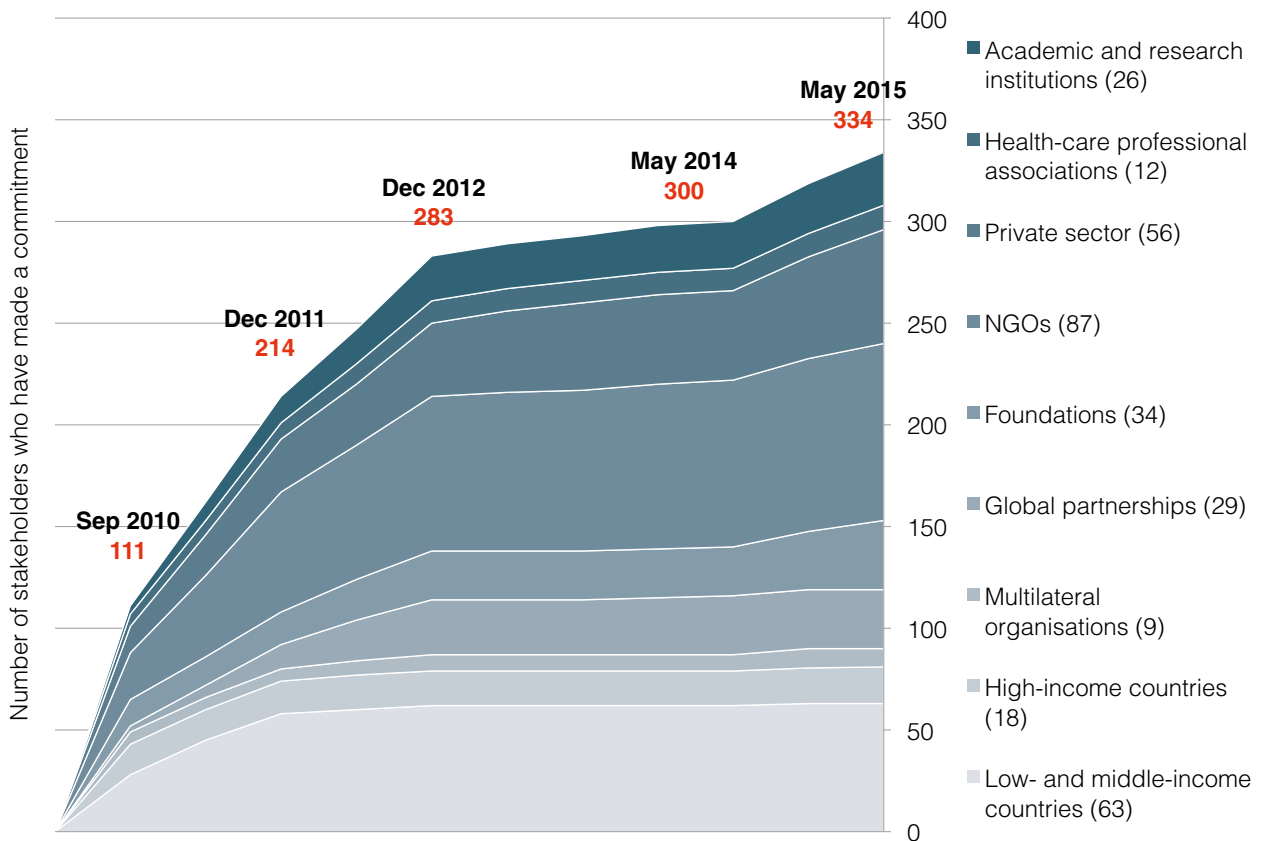
Source: UN Inter-agency Group for Child Mortality Estimation, 2013. Maternal Mortality Estimate Inter-agency Group, 2014. Figure adapted from "Fulfilling the Health Agenda for Women and Children: The 2014 Report," Countdown to 2015.

Figure 6. Global contraceptive users: FP2020 goal vs. historic trend



Source: Brown et al., 2014. Developing the '120 by 2020' Goal for the Global FP2020 initiative. *Stud Fam Plann*. Figure adapted from "2015 Report to the independent Expert Review Group," FP2020.

Figure 7. Stakeholders with commitments to the Global Strategy, by constituency, September 2010–May 2015



Source: *Every Woman Every Child* website. Figure adapted from "Global Strategy: Update on Implementation of Financial Commitments," PMNCH, 2015.

- Financial commitments to the Global Strategy have reached US\$45 billion (once double-counting has been removed); 9 financial commitments have been made since May, 2014.
- As of May, 2015, US\$31 billion of the US\$45 billion committed has been disbursed (Figures 8 and 9; see main report).
- Annual disbursements for women’s and children’s health have increased substantially since the launch of the Global Strategy: donors disbursed US\$11.9 billion for RMNCH in 75 priority countries in 2013, an increase of 25% since 2010; in 2013, RMNCH ODA to these 75 countries grew by 15%, a substantially higher figure than 2011 (0.5%) and 2012 (7.8%) (Figure 10; see main report).
- Previously underfunded areas, such as family planning, have seen steep increases in financial support—50.5% since the launch of the Global Strategy (from US\$452.9 in 2010 to US\$681.6 in 2013) (Figure 11; see main report).
- There are persistent geographic inequities in RMNCH funding—DRC and Guinea, for example, continue to receive relatively small amounts of ODA (Figure 12; see main report).
- However, there are signs that for some countries, advocacy around equity may be having an impact—eg, countries with high maternal mortality (such as Sierra Leone, Chad, and Côte d’Ivoire) saw rises in RMNCH support in 2013 after a phase of decline.
- Countries are increasingly demonstrating their commitment to women’s and children’s health—domestic public sector spending on RMNCH increased 115% from 2006 to 2013 for our 75 countries of concern (Figure 13; see main report).

THE COMMISSION ON INFORMATION AND ACCOUNTABILITY: A FINAL REPORT CARD

Figure 14. Summary of global progress on implementation of the recommendations from CoIA

Recommendation	Target year	2013	2014	2015
Vital events	2015	Red	Green	Diagonal lines
Health indicators	2012	Yellow	Yellow	Red
Innovation	2015	Red	Yellow	Yellow
Resource tracking	2015	Yellow	Yellow	Diagonal lines
Country compacts	2012	Red	Yellow	Yellow
Reaching women and children	2015	Red	Yellow	Grey
National oversight	2012	Yellow	Yellow	Diagonal lines
Transparency	2013	Red	Yellow	Grey
Reporting aid	2012	Yellow	Green	Yellow
Global oversight	2012	Green	Green	Green

- The target will be difficult to achieve
- Progress is being made, but continued and concerted effort is needed to achieve the target
- The target is on track or has already been achieved
- No or too few data are available to judge progress
- ▨ Multiple indicators show both absence of data and progress being made

Figure 14 shows our summary of progress on implementation of the CoIA recommendations (Annex 2, 4). We have included our assessments from the previous two years for comparison. Our 2015 assessments are based on 75 Country Profiles we provide for the first time with this report. These Profiles benchmark progress at the end of the MDG era (and at the conclusion of the iERG’s work). Each Country Profile consists of two pages. The first page gives basic demographic data for each country, information

on reproductive health and health systems, and data on health coverage, including, where available, data on health equity. Progress towards MDGs 4 and 5 is shown, specifically the three impact indicators of Maternal mortality ratio, Under-5 and Neonatal mortality rates, and Under-5 stunting. The second page provides information on progress against each of the CoIA recommendations that are relevant for countries (thus excluding recommendations on reporting aid and global oversight). This information is intended to help

policymakers and their partners assess progress and prioritise further actions to save women's and children's lives. When reading Figure 14, several clarifications and explanations are important.

- We have introduced a new category of descriptor—a grey panel—indicating no or too few data are available to judge progress.
- The introduction of this new category has changed our assessments in 5 CoIA areas—for Reaching Women and Children (percentage of national expenditure used for RMNCH) and for Transparency (a health sector performance report for the preceding year is available in the public domain), we had previously reported that progress was being made. We have now changed that judgement. In both areas, we believe there are insufficient data to draw any reliable conclusions on progress.
- In 3 further categories—Vital Events, Resource Tracking, and National Oversight—we had previously made judgements based on what we believed were available data. However, it is now clearer that in all 3 cases, critical data are missing. Given this partial lack of data, we are marking partial progress with grey colour coding indicating lack of information.
- In 3 categories, based on a fuller appreciation of the available data, we have revised our appraisal downwards compared with 2014—in Vital Events, Health Indicators, and Reporting Aid.
- Overall, we judge that only one CoIA recommendation has been fully delivered—the establishment of the iERG. Progress is being made in 6 CoIA areas. One area demonstrates considerable resistance to progress. And in 5 areas, lack of data is stopping a fuller evaluation.

Leadership globally to implement the CoIA recommendations has fallen especially to the H4+,

a partnership of UN agencies including UNICEF, UNFPA, WHO, the World Bank, UNAIDS, and UN Women. The H4+ leads collectively at the global level, and coordinates technical assistance in countries. Its work is broad, encompassing initiatives such as *A Promise Renewed*, the Commission on Life-Saving Commodities, the Every Newborn Action Plan, and *Every Woman, Every Child*. In their submission to the iERG, the H4+ helpfully sets out the obstacles to delivering the aspirations of CoIA. In summary, these obstacles are:

- Coordination: a continuous challenge, especially in countries lacking compacts and health sector reviews.
- Inclusion: of external partner organisations, especially civil society.
- Resource mobilisation: to fund joint work plans.
- Monitoring and evaluation: to learn lessons and document best practices.
- Scaling up: to achieve adequate reach and coverage.
- Capacity: countries report challenges of being forced to choose among multiple priorities.
- Instability: political shifts and humanitarian crises can disrupt RMNCH activities.
- Human resources: a further capacity challenge, to implement, provide, and lead RMNCH services.

For the first time, we report the financial and policy commitments of key donors to women's and children's health (see page 255). The single page reports total ODA, health, and RMNCH expenditures. It lists major pledges, and reports the latest Aid Transparency Index assessment. The results reported here deserve careful assessment and discussion among all key constituencies involved in women's and children's health in order to judge whether partners are living up to their promises.

POST-2015: ACCOUNTABILITY FOR SUSTAINABLE DEVELOPMENT

The place of health in the post-2015 development arena is very different from the place it occupied during the MDG era. Health dominated the MDGs—3 out of 8 goals were health related, based on the notion that poverty was substantially precipitated, driven, and perpetuated by poor health. The poverty-reduction focus of the MDGs put health in pole position in development policy and practice. The era of sustainable development represents a sea change in perspective. The triple helix of sustainable development has economic, social, and environmental strands—health is a part of this framework, but it is not the major part. The SDGs (Panel 1; see main report) cover a far-reaching and daunting range of issues. But, despite this recalibration, the health sector should

not feel disenfranchised. Although health has been decentred from the development conversation, SDG-3 expands the health agenda considerably. In addition to securing the importance of the “unfinished business” of the MDGs—reproductive, maternal, newborn, and child health, together with major infectious diseases—the new health SDG opens up territory on, for example, non-communicable diseases, universal health coverage, the health workforce and financing, and global health risks and security. The universality of the health goal—“Ensure healthy lives and promote wellbeing for all at all ages”—gives a new Global Strategy the best possible opportunity to craft a vision that encompasses a broad range of health and non-health determinants. It makes equity its guiding

principle. And it makes health political. Universal Health Coverage cannot be delivered through market mechanisms. It is the responsibility of governments, who must themselves respond to the demand for good quality health services from their electorates. The central importance of the health system for governments means that health becomes a Head of State issue, not simply a subject for the Minister of Health.

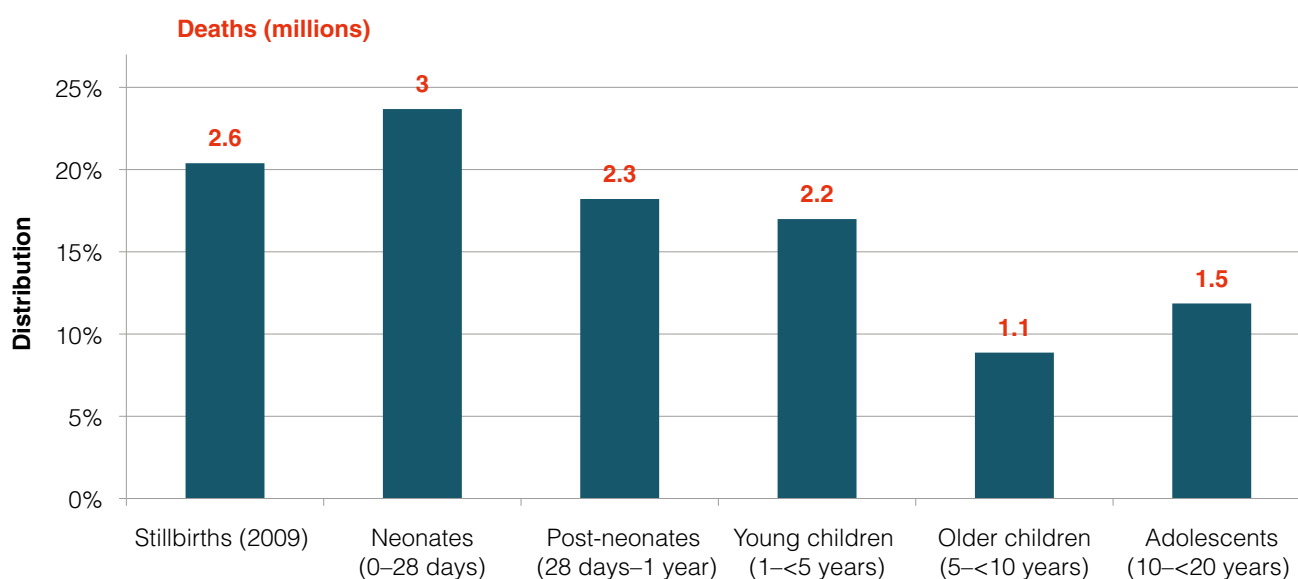
Adolescents are the main new challenge for any post-2015 Global Strategy. The new Global Strategy has explicitly included adolescents in its post-2015 vision. The iERG drew attention to the importance of adolescents in its 2013 report. Adolescents often get little attention from the health sector since they are wrongly thought to be healthy and unimportant to development. But adolescents are central to the major challenges in global health. There are approximately 1.2 billion adolescents aged 10-19 years. Adolescence is a critical stage in life, characterised by rapid biological, emotional, and social development and during which every person can develop the capabilities required for a productive, healthy, and fulfilled life. Figure 15 shows the age distribution of child and adolescent mortality in low- and middle-income countries. The considerable number of deaths among adolescents draws attention to a very different pattern of ill-health in this important group.

- Unintentional injuries
- Harmful alcohol use
- Tobacco use
- Overweight and obesity

- Mental ill-health
- Infectious diseases, including HIV
- Sexual and reproductive health disorders
- Risks from pregnancy and childbirth, including in the context of forced marriage
- Unsafe abortion

Attention to adolescent health will be essential if maternal mortality goals are to be met (28). Adolescence provides a critical interface in global health between women’s and children’s health and non-communicable diseases and mental health. Mental health will assume an increasingly important place in our thinking about health and wellbeing post-2015, and there will be no more important area where this is so than for the adolescent (29). The concern for adolescent health also opens up linkages with early child development, since many of the determinants of adolescent health begin well before adolescence starts. Early child development will therefore be a further important dimension for the new agenda for women’s and children’s health post-2015. The new Global Strategy has given adolescents an independent place in the continuum of care. But although health interventions will be important, adolescent health is about more than the health sector. Adolescent health in some ways needs to be demedicalised. The main drivers of adolescent health are largely outside of the health system—education, labour markets, economic policies, legislative and political systems, food systems, and the built environment. Education is especially important—not only because of its overall impact on health, but also because of the clear opportunity to prevent many of the adverse

Figure 15. Age distribution of under-20 mortality in low- and middle-income countries, 2010



Source: Jamison et al, 2013. Global health 2035: a world converging within a generation. *Lancet*.

effects related to reproductive health through comprehensive sexuality education, about which there is new momentum with countries committing to making it universally accessible. How the SDGs and a new Global Strategy engage with these broader sectors will be one of the greatest challenges for the health community post-2015. We see hopeful signs. The World Bank has prioritised gender equality as a means to reduce poverty and promote prosperity. The Bank sees gender equality as a core development objective in its own right. But there are clouds to consider too. We note concerns that sexual and reproductive health and rights may be deprioritised in the new Global Strategy. We therefore urge those charged with implementing the Global Strategy to make sexual and reproductive health a priority for women and adolescents post-2015.

A further issue that has been even more neglected than adolescent health is stillbirths. A stillbirth is strictly a pregnancy loss after 22 weeks of gestation. The WHO definition is different—WHO defines a stillbirth as the death of a child whose birthweight is at least 1000g or whose gestational age is at least 28 weeks (a third-trimester stillbirth). Little or no funding is dedicated to stillbirth prevention. Yet 2.6 million women each year experience a stillbirth. Most babies who die in the last 3 months of pregnancy should have survived. 1.2 million babies begin labour alive and die before birth—an intrapartum stillbirth. These intrapartum stillbirths are a highly sensitive marker of the quality of care in a health system. The causes of stillbirth are known and they can be mostly addressed through good quality care. It is an entirely reasonable goal to make 2030 the deadline for preventing stillbirths in all settings. Yet stillbirths have remained uncounted in global frameworks for women’s and children’s health. No longer. A new series of papers to be published in *The Lancet* in 2015 will try to ignite the concern of the global community into this deeply neglected area. New estimates of stillbirth deaths will be reported, together with risk factors and the economic costs of stillbirth. Evidence of what works to prevent stillbirths will be reviewed, and an implementation plan will be designed. The goal will be to offer a roadmap for addressing stillbirths, one that will make a major impact by 2030, the deadline for the SDGs.

There is no single perfect model of global accountability. In our 2014 report, we set out 12 principles for accountability rather than endorse a single approach—legitimacy, independence, framework, terms of reference, reliable data, parsimony, country engagement, review mechanisms, participation, regular reporting, resourcing, and monitoring impact. These principles still seem to us to have merit. For example, although a Progress

Report on the Global Strategy was published in 2015, that report was not independently researched and written, thus weakening its force as a document measuring the impact of *Every Woman, Every Child*. WHO recognises the importance of independence. In its evidence to the iERG, WHO notes that,

“Independent accountability remains essential for the post-2015 period: There is multi-stakeholder consensus on the need for independent accountability for women’s and children’s health post-2015, and this is a priority in the development of the new Global Strategy for Women’s, Children’s, and Adolescents’ Health.”

The model for independent global accountability should include the following key elements:

- A framework definition of independent accountability: Monitoring, Review, Act
- Legitimacy established through a UN agency governing body or related political process
- Full administrative and technical resourcing
- Clear roles and responsibilities for reporting among, and working with, partners
- Indicators that measure impact and that are sensitive to change, disaggregated for equity considerations and aligned with related global processes (eg, SDGs)
- Emphasis on donor as well as country accountability
- Attention to implementation of the findings and recommendations from the independent accountability mechanism
- Host the administration of the independent accountability mechanism within an existing entity engaged in delivering the Global Strategy, but ensure the independence of the accountability research and writing process
- Establish a reporting line between the independent accountability mechanism and the UN Secretary-General, through the Director-General of WHO
- Ensure that accountability reports and recommendations are presented in high-level fora with sufficient time and engagement to allow debate and discussion
- Link global and national accountability mechanisms

The iERG’s proposal for independent accountability for a renewed Global Strategy is reproduced in Annex 6. All parties in the discussion recognise and accept the importance of an Independent Advisory Panel to replace the iERG. The disagreement relates to who has primary responsibility for producing the independent assessment of the Global Strategy’s progress—should it be, for example, the Independent Advisory Panel itself, with technical and administrative support from PMNCH or should it be PMNCH, with advisory input from the Independent Advisory Panel. We prefer the first option: we see a critically important role for PMNCH, but we see their comparative advantage as one of technical

and logistical support, an important gap in the current accountability arrangements of which the iERG is a part.

Two particular groups have an important part to play in strengthening any independent accountability process, globally or nationally—civil society and the research community. The engagement of civil society strengthens social accountability. It also builds community trust and confidence about programmes and policies. The meaningful participation of civil society in accountability mechanisms changes the dynamics of power in decision making. Greater attention can be given to equity, dignity, human rights, and quality, together with groups or issues that may have been marginalised—eg, adolescents, donors, unsafe abortion, sexual and reproductive health and rights, and mental

health. The participation of civil society will also make transparency and data availability priority concerns. The research community also has a neglected part to play in strengthening accountability. Through their attention to reliable data and independent analysis, scientists can use research methods—and tools of research, such as peer review, presentation, publication, and, not least, academic freedom—to hold policymakers accountable for their programmes and decisions. This work ranges from the calculation of estimates of mortality to the evaluation of specific health programmes. The engagement of the scientific community in calling for stronger accountability in global health is one example of research recognising its larger social and political role in society (39).

CONCLUSIONS AND RECOMMENDATIONS

When young children observe something unexpected, their learning is enhanced (40). This finding should encourage us. The expectation of *Every Woman, Every Child* was that 16 million lives would be saved across 49 countries from 2010 to 2015. Unexpectedly, that figure was incautious. The actual number of deaths averted was 2.4 million. This discrepancy should propel us to think harder, to use this disappointing result to learn how to do better. As we enter the era of sustainable development, our approach to the health of women, children, and adolescents will be challenged and tested still further. Complexity, fragility, and uncertainty are the hallmarks of our world today. Populations are growing rapidly in regions of the world already under severe demographic pressure. Multilateralism is in decline. Globalisation is increasing inequalities within countries. Political, economic, environmental, and health crises are overwhelming institutions we once relied on to protect us. Public trust in governments is falling. Technological advances are inspiring, but also disruptive. This is the context in which we have to consider the future of women and children.

Surveying the SDGs, the health of women, children, and adolescents is not confined to SDG-3. Rather, it is distributed across many SDGs—SDG-1 (poverty reduction and social protection); SDG-2 (food security and nutrition); SDG-4 (education and early childhood development); SDG-5 (sexual and reproductive health and rights, sexual violence, forced marriage, and female genital mutilation); SDG-6 (water, sanitation, and hygiene); SDG-8 (economic growth); SDG-10 (inequality and social protection); SDG-11 (urban health, disasters); SDG-16 (homicide, conflict, violence, accountable institutions, and CRVS). How sensible is

it to create an accountability mechanism that focuses either on one SDG or a narrow interpretation of a new Global Strategy? Instead, would it not be more productive to monitor and review issues that directly or indirectly influence the health of women, children, and adolescents? For example, many of the multilateral institutions charged with a health responsibility also have strong commitments to other areas of the SDGs. To take one particular instance of cross-linkage: WHO/UNICEF produce an appraisal of progress towards MDG-7 on environmental sustainability. MDG-7 is not a core health MDG, but it incorporates targets on water and sanitation, clearly important determinants of health. The global MDG target for drinking water was met in 2010, whereas the target for sanitation was missed by almost 700 million people. The need for integration of accountability across the spectrum of health and the determinants of health therefore seems compelling. In taking account of these various factors, we have formulated 3 final recommendations from the iERG:

Global accountability: By 2016, establish and implement a global independent accountability mechanism to monitor, review, and act on results and resources for women's, children's, and adolescents' health, working across all 17 SDGs, reporting annually to the UN Secretary-General.

National accountability: By 2016, in all countries establish and implement transparent, participatory, democratic, and independent national accountability mechanisms to monitor, review, and act on results and resources for women's, children's, and adolescents' health, with special attention to the translation of recommendations into action and reporting to Heads of State.

Accountability for sustainability: In 2017, convene a global ministerial summit to report on progress towards the goals both of the new Global Strategy for Women's, Children's, and Adolescents' Health and the SDGs relevant to women, children, and adolescents; and to report on how national accountability informs and strengthens global accountability.

We believe that implementation of these recommendations could do much to create the conditions for one of the most remarkable successes global health is likely to see during the SDG era. The global community is developing ambitious targets for reduction in child and maternal mortality for the SDG period. Different studies and different agencies have put forward different goals, but all are ambitious. As we discuss in the main report, one goal is a two-thirds reduction in both maternal and child mortality rates over the 20-year period 2010-30 (24). The iERG commissioned the same team that derived the "40 by 30" target to project how many deaths would be averted globally, relative to a 2015 baseline, if the goals from their *Lancet* paper were to be met. Applying the methodology of that paper, but adjusting the base year to 2015, 34 million child deaths and about 1.5 million maternal deaths would be averted globally in the SDG period. These numbers assume that the world will meet its ambitious goals. The iERG believes that this striking outcome is both technically and financially feasible for the world to meet. But the question remains as to whether it is politically feasible too. See Panel 9 for a fuller description of these estimations.

In concluding our work, we ourselves need to be accountable to the *Every Woman, Every Child* movement, and most importantly, to the women, children, and adolescents who are the subject of our concern. Two questions demand answers:

Since the launch of the work of the Commission on Information and Accountability and iERG, do countries and partners have better information to track results and resources?

Do those countries and partners have stronger and more sustainable systems of accountability, nationally and globally?

On the first question, we believe we have shown (Figure 14) that progress has been achieved in several critical areas—notably, acceleration of CRVS strengthening, innovation, agreement of country compacts, and awareness and advocacy for global and national accountability. In other areas, there are simply too little data to make confident judgements either way (on resource tracking,

reaching women and children, and transparency). And in a few domains, we have been disappointed by lack of progress—eg, on the uptake and use of indicators to monitor change, and on the energy and commitment given to addressing inequalities (41). But on the second question, we are even more cautious. Globally, the iERG concludes its work in 2015. Although accountability is much discussed and partners seem committed to the principles of accountability, the precise arrangements for creating a sustainable mechanism to deliver independent global accountability for women's, children's, and adolescents' health are unclear. We are concerned that the gains made in establishing independent accountability as a central part of the Global Strategy and SDG process post-2015 are at risk. In countries, although there has been considerable discussion of, and advocacy for, accountability, the evidence that resilient processes for monitoring, reviewing, and acting are in place is not available. There are documented examples of successful country accountability mechanisms (42). We believe that countries have an extraordinary opportunity to make accountability the foundation for their accelerating development.

As we complete our term of office, we have looked back over the past 4 years to reflect on the lessons learned from the idea and practice of independent accountability.

- Independent accountability can be done and delivered, despite often challenging limitations of information and resources.
- Although global accountability was strengthened with the advent of an iERG, the connection with country accountability was weak. Indeed, our country level activity was the least developed part of our work. The country visits we undertook in 2014 were an important step in the right direction, one that we hope will be repeated and developed in future years. These visits allowed much more comprehensive national assessments of progress. But country visits by the iERG cannot substitute for strengthened national capacities for independent accountability. Such country accountability systems should be more formally linked to whatever global mechanism is put in place.
- The independent accountability mechanism needs to be supported in developing stronger relationships with country development partners. One possible solution is to designate a national accountability representative within each country WHO team whose responsibility is to survey and shepherd progress on CoIA recommendations.
- Accountability must be accompanied by tangible actions and remedies at global and national levels for its full value to be realised. The link between the

sensory inputs of independent accountability and the effector outputs of action must be strengthened.

- Between its global and country concerns, independent accountability can also operate regionally. It would have been helpful if the iERG had been able to take fuller advantage of regional health institutions (eg, with the Regional Offices of WHO).
- The iERG was constantly aware of the value of the independence it was granted by CoIA. That independence is partly guaranteed from the broad array and diversity of its members in age, professional background, philosophy, expertise, and geography. The complementarities of backgrounds and skills within the iERG membership were a major advantage to its work. The independence we were given enabled us to commission reports and case studies to illustrate critical points of concern.

- We learned that to make the most of the evidence we received, we should not only measure and report on progress in our monitoring role, but also develop policy proposals for action and remedy.
- We were repeatedly made aware that for our recommendations to have maximum impact, our reports had to be channelled to the highest reaches of global decision-making. Although we sought more formal presentation and discussion of our annual reports at key global meetings, we were disappointed with the progress we made in this regard.
- The hosting, resourcing, and autonomy of the mechanism for independent accountability are critical to its success. The secretariat function of the iERG is a vital part of its work. We believe that the technical capacity of this secretariat should be strengthened in future iterations of independent accountability.



Panel 9. Estimates of child and maternal deaths averted for the period 2015–2030

The iERG sought to calculate an estimate for the number of child and maternal deaths averted globally between 2015 and 2030 if the SDG targets proposed by Norheim et al were achieved (24). We commissioned Professor Ole Norheim to make this calculation. He has previously proposed that an overarching target for the health SDGs could be a 40% reduction of all premature deaths (deaths before 70), and a two-thirds reduction of child and maternal deaths (compared with 2010 death rates, adjusted by population size for the year 2030).

For the period 2015–30, we estimated child and maternal deaths that would occur annually, adjusted by the number of live births for the year 2030, assuming a linear decrease in mortality from the year 2015 to 2030. This adjustment is necessary to get comparable numbers when population size changes over time. We used the same method as described by Norheim et al (24). The “40 by 30” sub-target proposed for child and maternal mortality is a two-thirds reduction of deaths that would have occurred if 2010 death rates were applied to the 2030 population. The only difference in this calculation is that we used 2015 as the baseline for estimating deaths averted. We calculated deaths averted by comparing the (adjusted) number of deaths in 2015 with each year up to 2030, and then adding them up.

When we look at projections from 2015 to 2030, we see that about 34 million child deaths could be averted in the period 2015 to 2030 if the “40 by 30” target is achieved by 2030 (Table A). About 1.5 million maternal deaths could be averted in the same period (Table B).

Table A. Estimated child deaths averted globally (2015–2030), if 2/3 of 2010 deaths are averted by 2030*

Year	Child deaths	Live births	Annual targets (adjusted to 2030 population)	Deaths averted compared to 2015
2010	6 900 000	131 900 000	6 800 000	...
...
2015		135 400 000	6 000 000	
2016		135 200 000	5 600 000	400 000
2017		134 700 000	5 200 000	700 000
2018		134 000 000	4 900 000	1 000 000
2019		133 400 000	4 600 000	1 400 000
2020		133 000 000	4 300 000	1 600 000
2021		132 900 000	4 000 000	1 900 000
2022		132 900 000	3 800 000	2 200 000
2023		133 100 000	3 600 000	2 400 000
2024		133 300 000	3 300 000	2 600 000
2025		133 500 000	3 100 000	2 800 000
2026		133 600 000	2 900 000	3 000 000
2027		133 700 000	2 700 000	3 200 000
2028		133 800 000	2 600 000	3 400 000
2029		133 900 000	2 400 000	3 500 000
2030		134 000 000	2 300 000	3 700 000
Sum				34 000 000

Table B. Estimated maternal deaths averted globally (2015–2030), if 2/3 of 2010 deaths are averted by 2030*

Year	Maternal mortality ratio (per 100 000 live births)	Live births	Annual targets (adjusted to 2030 population)	Deaths averted compared to 2015
2010	230	131 900 000	308 000	...
...
2015		135 400 000	264 000	
2016		135 200 000	248 000	16 000
2017		134 700 000	233 000	31 000
2018		134 000 000	219 000	45 000
2019		133 400 000	205 000	59 000
2020		133 000 000	193 000	71 000
2021		132 900 000	181 000	83 000
2022		132 900 000	170 000	94 000
2023		133 100 000	160 000	104 000
2024		133 300 000	150 000	114 000
2025		133 500 000	141 000	123 000
2026		133 600 000	132 000	132 000
2027		133 700 000	124 000	140 000
2028		133 800 000	116 000	147 000
2029		133 900 000	109 000	155 000
2030		134 000 000	103 000	161 000
Sum				1 476 000

* = Adjusted to live births in 2030 (UN Population Division medium fertility projections).

Note: This panel is adapted from a submission by Professor Ole Norheim to the IERG.



1. INTRODUCTION

Fatima died this afternoon. She was 25 years old and about to give birth to her first child. She was brought to the hospital in the early hours of the morning. At home, she had suffered several seizures and did not regain consciousness. When she came to the hospital, only three midwives and one junior doctor were present for the night shift, looking after about 30 patients in the maternity ward. Many women shared their beds with one, or even two, other women. Fatima was seen by one of the health workers and diagnosed with eclampsia. It was also noticed that her baby was dead. She was put on the “eclampsia protocol.” Hours went by without her being checked again, in the very busy ward. She fell unconscious, alone, with no way to make it known to those around her that she needed their attention and help. When she was discovered by another junior doctor around midday, she was bleeding profusely and underwent an emergency Caesarean section. She was not yet ready to deliver vaginally but the bleeding was too serious to wait. The bleeding stopped after surgery but Fatima did not wake up. She showed signs of a cerebral bleed, but no bed was available in the Intensive Care Unit. She passed away in the late afternoon. That evening, the family arrived to collect her body and that of her baby. They paid for the suture materials and did not ask questions.



Following high school, Magutsa was trained as an Assistant Officer in Human Resources Management. She got a job in Nairobi where her fiancé, Amuchuku, worked and soon after, they were married. By 2009, Magutsa and Amuchuku were the happy parents of two children—a son, Amos, aged 5, and a daughter, Elima, aged 3. Magutsa kept up with the children’s immunisation schedule and all the advice she received at the clinic. When the children got colds and coughs, she was assured that these symptoms were nothing to worry about unless they continued for a long time. Sure enough, the episodes would soon pass. Unlike the villages in which they had grown up, where malaria was endemic, there was no malaria in Nairobi, and this made them happy. Whenever the family went to the village, they bought anti-malarials from the clinic. Magutsa and Amuchuku believed their children would grow into healthy adults. Then came the sudden death of Amuchuku’s father. With their children, they hurriedly took the bus to the upcountry village, where they would stay for two weeks. On the way, Magutsa realised that she had not bought anti-malarials from the clinic. They agreed to buy them in the town nearest their home. But upon reaching their village, the usual desperation and grief that comes with death took over. They were not reminded of the medicine until Elima’s body began burning on the seventh night after their arrival. Soon, Amos too had a temperature. By dawn of the next day, heavy rain had begun and no vehicles entered the road where Amuchuku and Magutsa

waited. Not even bicycles or motorcycles dared to pass. They considered walking to the hospital in town, twenty miles away, but knew that they were unlikely to make it. They would have to try again tomorrow. But by the next morning, Elima was dead. Amuchuku and Magutsa could hardly breathe. How could life go on without Elima? What would they do with her belongings? What would they say to her play group? What were they going to do with Amos, whose distress seemed even greater than their own? They thought they were all going to die, as preparations were made to bury Elima next to her grandfather. What if there had been a community health worker in their village with anti-malarial supplies? What if they had left the children in Nairobi with the house help? What if...what if? They had gone to their village with two children. If they were lucky, they would be going back with one. What was life about if you could lose your children like this?



In Luque, Paraguay, a 10-year-old girl shared a rented room with her two siblings, her mother, and her stepfather. When she began to complain of stomach aches and swelling, her mother brought her to the local hospital, fearing she may have a tumour. In fact, the child was 21 weeks pregnant, after repeated sexual abuse at the hands of her stepfather. Over a year earlier, her mother had reported the suspected abuse to authorities, who failed to take any action. Now, when her mother appealed to the hospital to allow her to have an abortion, the request was denied. Instead, her mother spent weeks in jail, accused of complicity in the abuse, while the 10-year-old girl lived in a shelter. In Paraguay, a country with strong Catholic influences, abortions are allowed only when the life of the pregnant woman is at risk. Medical experts from around the world, including the World Health Organization, have presented evidence that pregnancy at her age is four times more life-threatening than an adult pregnancy, with risk of haemorrhage, anemia, eclampsia, and damage to her reproductive system. Moreover, the repercussions to her mental health, as she carries out an unwanted pregnancy, have been called “tantamount to torture.” And still, Paraguayan Health Minister Antonio Barrios claims that the 34 kg child faces no risk to her health, and the ministry has “already completely ruled out abortion.” The anonymous young girl was violated by her stepfather, ignored by authorities in a position to intervene, and finally abandoned to carry out the sentence that her abuse invoked. Her voice has been repeatedly omitted and both health and dignity overlooked, as she falls victim to the political and religious frictions plaguing her country. In the absence of government protection, civil society has responded on the young girl’s behalf, with petitions and marches that have prompted a national debate. Can civil society give

voice to those forsaken by their protectors, if not for this child, then for the millions like her worldwide? Soon after her 11th birthday, she will give birth to her first child. Still, we cannot hear her.



At the beginning of December, 2013, Emile Ouamouno was a happy little 2-year-old boy, born to his mother Sia and father Etienne. They lived in the forest village of Meliandou, near Guinea's borders with Sierra Leone and Liberia. Though they lived two hours away from the nearest hospital, there was a clinic in the village, and Emile's parents worked hard to get him and his sister immunised, as well as access to insecticide-treated nets where and when possible. Emile was not allowed to play in the forest. He and his three-year-old sister loved listening to the radio, dancing and playing near their house under a large tree, which was a roosting place to hundreds of free-tail fruit bats. His mother was eight months pregnant with their next sibling, and his parents planned to have the baby delivered by the midwife at the local clinic. Sometimes women could not make it to the health facility, and a traditional birth attendant stepped in. On December 2, 2013, Emile developed a very high fever and vomiting; his parents suspected malaria. He had bad bloody diarrhoea, which they had never seen before, and his grandmother, Koumba Ouamouno, could not explain it. Within four days, Emile died. Three-year-old Philomena was next to fall ill. Both Sia and Koumba nursed her, treating her with the normal malaria medicine from the clinic. Their efforts failed, and before the New Year, Emile's sister was dead. Both Sia and Koumba, mother and grandmother, followed the traditional funeral rites, just as they had with Emile, washing her small body carefully and kissing her farewell. When Sia became sick, the midwife got involved, but on the January 11, 2014, both Sia and her unborn baby died. Etienne was grief-stricken. Barely six weeks earlier, he had been an expectant father with a happy wife and two young children. Now he was a childless widower. The pain when he lost his mother to the same affliction left him numb. News later reached him that the midwife had also died. Meliandou was ground zero for the first Ebola (Zaire) virus disease outbreak in West Africa, and his precious Emile was patient zero. It was too late for his family to be rescued from the nightmare.



March 1992: a busy late morning in the postnatal ward of one of the largest maternity clinics in Africa. Women were talking, laughing, and packing to go home with their newborn babies, wrapped in colourful khangas. Over ninety women had given birth in the past 24 hours, and two mothers were still in intensive care. Six babies had died: three were very preterm births, one had a congenital birth defect, and two were stillbirths. Many mothers had already left the facility.

A few were waiting for their husbands or families to pay the hospital bills and take them home. One young woman was sitting alone in a corner, without a baby, crying silently while she covered her face and turned away from the crowd around her. She had given birth to a stillborn male baby, term, birthweight 3.1 kg. She was a G5P3A2—gravida 5, para 3, abortion 2. In plain language, this was her fifth pregnancy—she had delivered 3 times and had 2 miscarriages, but the 3 term deliveries had all ended in stillborn babies. One of the midwives explained that the young lady was waiting for her husband, but she was afraid he would not show up because of the third stillbirth. A second nurse joined with a prescription and told the patient that she should leave now and buy some iron tablets. The youngest nurse asked her colleague: “Why is she crying? She did not even know this baby. How can you cry for a person you don't know?” “Indeed, no idea,” said the midwife, glancing at the medical file. “But she has no children alive yet; they all died and the husband might send her back to her family. What can he do with a woman who does not deliver?” “Oh, in that case I understand her grief,” said the first nurse, and both of them now looked at her with compassion. All too often, dead babies are not counted and do not count.



After years of talking, teaching, praising, criticising, and learning, a clinic in Zanzibar still finds each day that women have been delayed in labour for 6, 8, 10, or more hours. This is true for women with both low and high risks of complications in childbirth, including the risk of rupturing the uterus with an almost certain death of the baby and a high risk of losing the uterus or even the mother's own life. Why does this distressing situation resist change? The young intern doctors who report these delays each and every day gave their answer in four points, which resonated with everyone in the department. These points reflect all there is to say at the global level too. The only difference between the experiences in the clinic and the discussions that take place globally is that the mothers who enter the clinic have faces and stories, their suffering unbearable when they stand before you. The four points put forward by the interns were: we need more health workers; we need more consumables; we need to communicate much better; and we need accountability.



In Afghanistan, it became clear that a war against the Taliban, like any war, could not be won with weapons alone. It was important to win the trust of the people, to win their hearts and minds. Thus the military, diplomats, and development workers began a dialogue with the people—for example, in Uruzgan province—to find out their most pressing needs. It was immediately obvious that there was an urgent

need for a hospital. Many children in the area suffered from burns, and died when the hospital in the military compound proved insufficient. Meanwhile, women were forced to try in secret to see one of the military doctors. For most women in Uruzgan, professional health care was just not available, not only because there was no doctor, but also because they required permission from men (fathers, brothers, or partners) to see a health professional. Moreover, women could never share the hospital space with men, not even the waiting area. So, a 3-D coalition—closer cooperation between Defence, Diplomacy, and Development—built a small hospital, with separate entrances, waiting areas, examination rooms, and infirmaries for women. The women were happy, but not so the men. One of them said: “Why should we worry about the health of a woman? Why should I ever pay for a doctor for my wife? If she dies, I can easily get another woman. When my cow dies, then I have a problem, because then I would have to buy a new cow.” Merely the presence of a hospital is not enough, if the health of women is not considered important, as is too often the case in conflict situations.



The baby of Maria died four days after he was born. He was the first child of Maria, who was 20 years old and suffered severe pre-eclampsia, high blood pressure, and loss of protein in her urine. Maria delivered her son vaginally without complications, but she later developed puerperal sepsis. It could have been treated successfully. Her son was small but mature, just over 2 kg at term, and he was admitted for observation to the neonatal unit. Babies who are doing reasonably well are looked after in the corridor since the neonatal unit is in a very small and overcrowded room. The baby of Maria did well initially and was cared for in the corridor. But on day four, he developed diarrhoea. He was seen by a doctor in the evening, who was unaware that Maria had developed puerperal sepsis. At night, there is only one nurse looking after 30 to 40 patients. The baby of Maria passed away six hours later. The child was collected by the family for burial before Maria could leave the hospital. Maria was too sick to say farewell to her nameless child, who was recorded only as “baby of Maria.” She had no chance to speak about her loss with anyone in the hospital. She was looked after in the midst of mothers nursing their newborns. She seemed very lonely in this crowded place.



1. The independent Expert Review Group on Information and Accountability (iERG) was created in 2011 as a mechanism to strengthen accountability for women's and children's health (see Annex 1). It was a body invented by the Commission on Information and Accountability (CoIA), chaired by President Kikwete of Tanzania and Prime Minister Harper of Canada (see Annex 2) (1). The idea of accountability is rooted in human rights. But sometimes the concept of accountability can seem far removed from the lived experiences of women, children, and adolescents. Measurement of progress, tracking of resources, and the construction of structures to deliver accountability in countries and globally can feel dry and abstract. In this, the iERG's fourth and final report, we wish to put the lived experiences of women and children at the heart of our concerns.

The failure to deliver accountability is not merely a failure to meet the norms and standards of a political process. It is a fundamental violation of the dignity of the most vulnerable citizens living in our communities. For hundreds of millions of women and children worldwide, the promises and commitments of national political leaders, as well as global heads of health agencies and development organisations, have fallen short of expectations. Our final report will certainly document successes. But as the true stories we begin with in this Introduction show, the egregious betrayals of the poor by the powerful continue to distort the history of women's and children's health. These deceptions are unacceptable. Accountability must make the realities of life for women and children worldwide its central concern. We hope this report goes at least some way to doing so.

Panel 1. Sustainable Development Goals

- Goal 1.** End poverty in all its forms everywhere
- Goal 2.** End hunger, achieve food security and improved nutrition and promote sustainable agriculture
- Goal 3.** Ensure healthy lives and promote well-being for all at all ages
- Goal 4.** Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all
- Goal 5.** Achieve gender equality and empower all women and girls
- Goal 6.** Ensure availability and sustainable management of water and sanitation for all
- Goal 7.** Ensure access to affordable, reliable, sustainable and modern energy for all
- Goal 8.** Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all
- Goal 9.** Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation
- Goal 10.** Reduce inequality within and among countries
- Goal 11.** Make cities and human settlements inclusive, safe, resilient and sustainable
- Goal 12.** Ensure sustainable consumption and production patterns
- Goal 13.** Take urgent action to combat climate change and its impacts
- Goal 14.** Conserve and sustainably use the oceans, seas and marine resources for sustainable development
- Goal 15.** Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss
- Goal 16.** Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels
- Goal 17.** Strengthen the means of implementation and revitalize the global partnership for sustainable development

2. 2015 has been a year of reflection. The UN Secretary-General's signature health initiative, *Every Woman, Every Child*, was launched in 2010 (2). It has become one of the fastest growing movements in global health, attracting over 400 commitments by 300 partners, together with US\$60 billion of financing (3). Ban Ki-moon was right to say this year that, "The world is currently reducing under-5 and maternal deaths faster than at any time in history." In 49 priority countries targeted by *Every Woman, Every Child*, achievements have been historic. 870 000 new health workers. A 49% increase in oral rehydration therapy for treating diarrhoeal disease. A 25% increase in skilled birth attendance. Progress has accelerated, and the Secretary-General's Global Strategy for Women's and Children's Health has made a crucial contribution to this acceleration.

3. But there is always a reckoning. As much as the global community should admire the achievements of the Global Strategy, it left substantial room for improvement. In 2010, a commitment was made, one that should not be forgotten (2):

"In the 49 countries of the world with the lowest income, progress would be incredible. Between 2011 and 2015, we could prevent the deaths of more than 15 million children under 5, including more than 3 million newborns. We could prevent...about 570 000 women from dying from complications relating to pregnancy and childbirth."

This headline promise was turned into an advocacy campaign for the Global Strategy: "Saving 16 million lives by 2015." But in the Progress Report on the Global Strategy, published earlier this year, the true figure was revealed—2.4 million deaths averted since 2010 (3). This substantial difference between what was promised and what was delivered is hard to comprehend. There are at least two possible explanations. First, that the Global Strategy failed. Second, that the calculation of 16 million deaths was exaggerated or an error. If the former explanation is true, the global community needs to conduct a careful autopsy on what went wrong and why. If the latter explanation is correct, how did the full technical capacity of WHO and partner agencies make such a mistake? It is not good enough, as the Progress Report does, to gloss over this discrepancy in numbers by saying that the Global Strategy has delivered "substantial gains."

4. 2015 has also been a year of transition. Ban Ki-moon has called the process leading to the post-2015 Sustainable Development Goals (SDGs), "The Road to Dignity" (4). 17 SDGs have been agreed upon, and health is one of those Goals (SDG-3) (Panels 1 and 2). Women's and children's health is embedded within that Goal. In parallel, a new Global Strategy has been

drafted to meet the challenge of a more inclusive and complex era (5). Agreement about the SDGs and the elements of a new Global Strategy does not mean that the approach to women and children is "business as usual." There are already several critical differences in the approach and attitudes to women and children.

5. First, the scope of the women's and children's health movement has expanded to include adolescents and stillbirths. Adolescents make up over 20% of national populations. Most adolescents are concentrated in low- and middle-income settings. Adolescents matter in and of themselves, but also because their futures are very much determined by the events that take place during this time of change from child to adult. Including adolescents within the scope of *Every Woman, Every Child* changes the agenda of action considerably. In addition to maternal deaths—the second most frequent cause of mortality in 15-19-year-old women globally (after HIV/AIDS)—the global community and countries will now need to give more prominence to issues such as violence against women and girls, self-harm, the effects of war and conflict, and road traffic injuries.

6. Second, the place of women in our understanding of health is also changing. 2015 is the twentieth anniversary of the Beijing Declaration and Platform for Action. In March, 2015, the Commission on the Status of Women met to review progress since 1995 and to look ahead to opportunities for achieving gender equality in the post-2015 development agenda. Five priorities were identified: transforming discriminatory social norms and gender stereotypes; transforming the economy to achieve gender equality and sustainable development; ensuring full and equal participation of women in decision-making; increasing investments in gender equality; and strengthening accountability for gender equality. But these priorities were articulated on a background of slow and uneven progress, with major gaps and obstacles for women and girls in all countries. The position of women and girls in societies worldwide is often precarious. As the political declaration emerging from the March meeting noted, "no country has fully achieved equality and empowerment for women and girls [and] significant levels of inequality between women and men and girls and boys persist globally." The broader social and political determinants of health for women and children will be a higher priority post-2015.

7. Third, there is renewed global and country commitment to taking data seriously. This commitment was expressed most forcefully in *A World That Counts*, which proposed a vision for a data revolution for sustainable development. The process of putting that vision in place began in June, 2015 in Washington, DC, at a conference led by USAID, WHO, and the World

Panel 2. Targets for SDG-3

Goal 3. Ensure healthy lives and promote well-being for all at all ages

- 3.1** By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births
- 3.2** By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births
- 3.3** By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases
- 3.4** By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being
- 3.5** Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
- 3.6** By 2030, halve the number of global deaths and injuries from road traffic accidents and, in the interim, by 2020, stabilize and then reduce global deaths and injuries from road traffic accidents
- 3.7** By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
- 3.8** Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
- 3.9** By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination
- 3.a** Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate
- 3.b** Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all
- 3.c** Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States
- 3.d** Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks

Bank on measurement and accountability for health results in the post-2015 era.

8. Fourth, the outbreak of Ebola in west Africa, and the slow and inadequate global response that followed, have made global health security a pressing issue of international concern (7). The 2015 G7 meeting held in Germany put Ebola high on the political agendas of heads of state. G7 leaders reaffirmed the central role of WHO for international health security. But they also endorsed further WHO reforms to strengthen its capacity to respond to health crises. Meanwhile, the World Bank is pressing ahead with a Pandemic Emergency Facility. The UN Secretary-General has commissioned a process to design new and effective mechanisms for health crisis responses. And the G7 itself has offered to assist 60 countries over the next 5 years as part of its Global Health Security Agenda. The lessons of Ebola are multiple. Mounting a response to an epidemic such as Ebola leaves the world acutely vulnerable. Events that begin as local crises can quickly become global threats. Weak health systems in countries leave all peoples open to danger. Early recognition of potential threats should enable a global response to quell risks. Finally, global health security needs to be embedded and prioritised much more powerfully in the international systems for health than at present. Speaking at the World Health Assembly in Geneva in May, 2015, Angela Merkel, Germany's Chancellor, argued that the global community "should have acted sooner" (8). While she confirmed that "WHO is the only international organisation that enjoys universal political legitimacy on global health matters," she noted that its decentralised structure "can also impede decision-making and hinder good functioning," a view confirmed by the Interim Ebola

Assessment Panel (9). Women and children are especially vulnerable when disease outbreaks turn into epidemics. In evidence submitted to the iERG, WHO acknowledged that "women and children are among the groups most affected by the Ebola Virus Disease outbreak." In the case of Ebola, children experienced a shorter incubation period, a higher risk of death under 5 years of age, and a more rapid progression to death (10). How the world now constructs a global rapid response system to prevent an Ebola-type epidemic again will have critical importance for the sustainability of advances in women's and children's health.

9. Fifth, the opportunity afforded by a new global commitment to Universal Health Coverage means that resilient and sustainable health services for women and children will be a priority post-2015. The availability, accessibility, and acceptability of high-quality health services is a fundamental right of every citizen. Universal Health Coverage integrates ideas of health system strengthening with poverty reduction (financial risk protection) and the right to health. The human rights basis of Universal Health Coverage is included in the constitutions of more than two-thirds of all countries. Universal Health Coverage offers the prospect of ending preventable child, newborn, and maternal mortality within a generation.

10. Finally, two issues that are of crucial importance to the future of women, children, and adolescents remain unresolved—first, the means of implementation of commitments embodied in the SDGs and, second, the mechanism for holding all partners accountable for those commitments. In our final report, we will set out our vision for post-2015 accountability.



Political decisions and their impact on India's Family Planning Programme

In keeping with its commitments towards the ratified International Conference on Population and Development (ICPD) Programme of Action, India adopted the target-free approach in family planning in 1996. This meant that family planning uptake would be guided by the needs of the population and decided by clients through informed choice. In 2012, in response to the London Summit on Family Planning, India also decided to reposition its Family Planning Programme: it is now an integral component of the reproductive, maternal, newborn, child, and adolescent health (RMNCH+A) strategy, which was launched in 2013 and reasserts a target-free approach (1). The strategy emphasises addressing the unmet need for contraception by introducing newer contraceptives and distributing them through Accredited Social Health Activists (ASHAs), who are trained female community-based health workers.

Despite these policy and programmatic changes, there has been insufficient political commitment to put in place the management tools necessary for their implementation on the ground. In reality, several issues remain, of which three have particularly deleterious effects on the quality of family planning services and on women's ability to exercise their reproductive rights (2).

Continuing emphasis on targets. Although India is officially supposed to be in the "target-free" era, the expected levels of achievement (ELAs), set by the state and district health authorities on the basis of past performance, determine what the peripheral health workers are expected to achieve. Lower-level health workers are reported to have been sanctioned punitively when these ELAs are not met, by threats, and sometimes by the withholding of salaries and increments.

Continuing reliance on camp-based sterilisation services. Sterilisation is still the most common form of contraception in India: in 2008, 34% of currently married women aged 15–44 years were sterilised (3). Sterilisations are usually performed in camps, where the quality of services has been much criticised.

Incentives for sterilisations. Indian states offer inducements for sterilisations.

The tragic deaths of 16 young women and the critical condition of several others after tubectomies at a sterilisation camp in Bilaspur, Chhattisgarh,

in November, 2014, highlighted the effects of India's weak political commitment to implement changes in its Family Planning Programme. A total of 83 women were operated upon within one and a half hours by one team, flouting quality standards set by the national government. A fact-finding enquiry reported widespread violations of the standard protocols for performing laparoscopic sterilisation, and of the guidelines set by the Ministry of Health and Family Welfare for sterilisation in camp settings (4). These included violations in the selection of the camp site, the number of procedures performed, the equipment and number of instruments used, and the screening and care of the women. The camp was situated in a non-functional health facility and compromised the basic standards of cleanliness and care both during and after surgical procedures. Although the laparoscopic surgeon was competent, the support staff seemed to be untrained, with no knowledge of nationally required quality standards and procedures. Basic infection prevention practices were also missing.

The report also analysed the national government's expenditure on the Family Planning Programme for 2013–2014, and found that 85% of the total expenditure was on female sterilisation and only 15% on birth spacing methods. Of the ₹ 3389.1 million (US\$52.94 million) spent on female sterilisation, ₹ 144.2 million (\$2.25 million) was spent on the camps and ₹ 3244.9 million (\$50.69 million) on compensation and incentives.

The amount spent on compensation and incentives was 2.5 times higher than the untied grant given to primary health centres to improve infrastructure and quality of care. This disproportionate spending is ironic because desired fertility in India is now low. The continued use of incentives not only constitutes a threat to the exercise of rights, but is also an antiquated practice based on the fear of population growth and the erroneous perception that perceived population growth is due to wanted fertility and needs to be curbed by incentives. In fact, such growth as now exists is due to the population momentum and the unmet need for contraceptives, and not to wanted fertility. Incentives for sterilisation are a waste of money that could be more usefully spent on improving the quality of services.

The Government of India needs to adhere to the commitments set out in the ICPD Programme of Action and to its own policies

and strategy documents. The issues listed above must be addressed in a phased manner and with commensurate budgetary provisions. The recommendations contained in the WHO guidelines “Ensuring human rights in the provision of contraceptive information and services: Guidance and recommendations” are aimed at

policy makers and programme managers and must be followed (5). Civil society organisations in India must continue to monitor the policies and programmes and the provision of contraceptive services and information, and must hold the government accountable for carrying out its commitments.

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2. PROGRESS IN WOMEN'S AND CHILDREN'S HEALTH IN COUNTRIES



11. According to the latest figures available to the iERG, 6.3 million children under 5 died in 2013 (11, 12). Figures for the 75 iERG countries, taken from the Global Burden of Disease (GBD), are shown in Table 1 (11). An alternative presentation, using data from the UN Interagency Group for Child Mortality Estimation, is shown in Figure 1. The headline message from these numbers is that although the 2013 estimate represents a 64% reduction in child mortality since 1970 (when 17.6 million deaths took place), most countries will not achieve the MDG-4 target—which requires a 4.4% rate of mortality decline annually. The GBD collaboration singles out five countries that have made especially strong progress—in Southeast Asia, Cambodia, Lao PDR, and Viet Nam; and in eastern sub-Saharan Africa, Ethiopia and Rwanda. With annualised rates of decline in child mortality above 4%, these countries show that political commitment and judicious investments in health and (especially) maternal education can deliver results above expectation. The global causes of child death are shown in Figure 2 (12). An alternative presentation

of selected causes of child deaths is shown in Table 2 (13). A particular concern is the growing importance of newborn mortality. In 2013, 2.8 million neonatal deaths occurred globally (14). Most of these deaths were preventable. Newborn mortality is falling, but more slowly than for under-5 deaths. The result is that newborn deaths now account for 44% of total under-5 deaths. Deaths in newborns can be divided into two categories—early (0-6 days of age) and late (7-28 days of age). Most early neonatal deaths are caused by preterm birth (41%) or intrapartum (27%) complications. For late neonatal deaths, infections are the largest cause (almost half of newborn deaths). Equity analyses reveal severe disparities, despite often impressive average reductions in child deaths. Figure 3 displays the proportion of under-5 deaths in the poorest and richest quintiles for a selection of iERG countries, together with several other nations included as comparators. The countries are ranked according to the percentage of all under-5 deaths that occur in the poorest quintile. Almost half of Brazil's under-5 deaths take place in this poorest quintile.



Table 1. Under-5 mortality, number of deaths, and annualised rates of change, for 75 iERG countries (with 95% CI), 2013

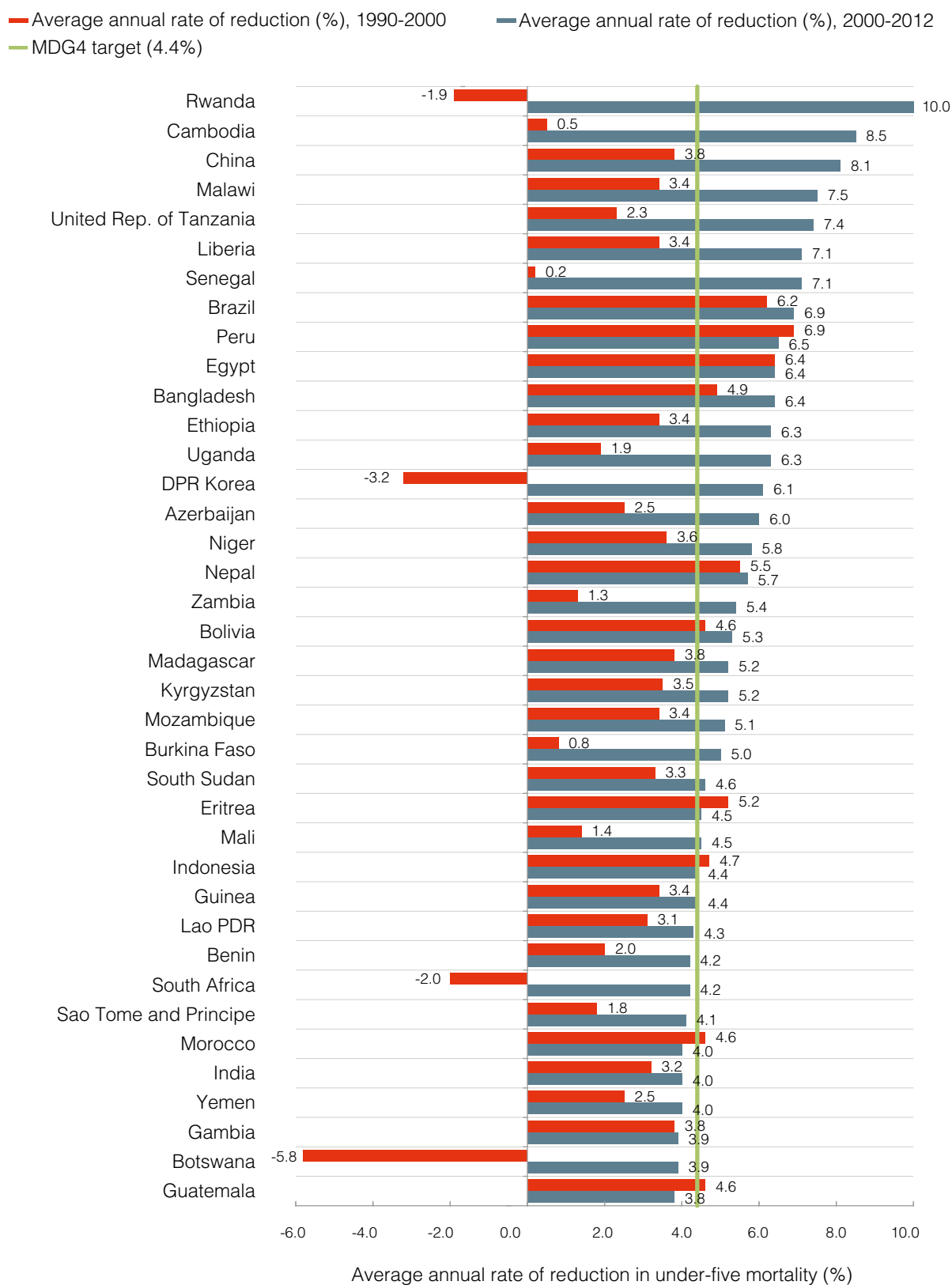
	Mortality rate (per 1000 live births)					Number of under-5 deaths (thousands)	Annualised rate of change in U5MR (%)		
	Early Neonatal (0–6 days)	Late Neonatal (7–28 days)	Post-Neonatal (29–364 days)	Childhood (1–4 years)	Total under-5 (0–4 years)		1990–2000	2000–2013	1990–2013
AFRO									
Angola	16.6 (14.0 to 19.7)	8.6 (6.9 to 10.5)	29.5 (21.3 to 39.6)	38.3 (26.4 to 54.4)	90.1 (72.2 to 109.9)	83.4 (67.2 to 101.5)	-2.0 (-1.0 to -2.8)	-4.1 (-2.4 to -5.8)	-3.2 (-2.3 to -4.2)
Benin	18.1 (16.0 to 20.3)	3.6 (3.2 to 4.1)	18.9 (15.8 to 22.2)	20.8 (16.1 to 26.7)	60.1 (54.1 to 67.1)	22.3 (20.0 to 24.9)	-3.1 (-2.6 to -3.6)	-5.9 (-4.9 to -6.8)	-4.7 (-4.1 to -5.1)
Botswana	12.5 (10.1 to 14.8)	2.6 (2.0 to 3.7)	9.6 (6.3 to 15.1)	6.6 (3.9 to 10.5)	30.9 (22.4 to 41.9)	1.5 (1.1 to 2.0)	2.0 (3.3 to 0.7)	-6.0 (-3.1 to -8.4)	-2.5 (-1.2 to -4.0)
Burkina Faso	20.2 (17.5 to 23.1)	8.7 (7.8 to 9.9)	32.3 (26.9 to 38.6)	46.6 (36.7 to 57.0)	104.0 (93.0 to 116.6)	70.6 (63.1 to 79.4)	-1.3 (-0.8 to -1.9)	-4.3 (-3.4 to -5.2)	-3.0 (-2.5 to -3.5)
Burundi	19.4 (16.6 to 22.4)	7.2 (6.1 to 8.5)	28.5 (22.8 to 34.7)	36.4 (27.0 to 49.1)	88.7 (75.3 to 104.8)	39.1 (33.2 to 46.3)	0.2 (0.9 to -0.5)	-5.4 (-4.1 to -6.8)	-3.0 (-2.2 to -3.8)
Cameroon	25.1 (22.5 to 28.4)	7.5 (6.8 to 8.5)	30.3 (25.9 to 35.5)	41.8 (33.5 to 52.5)	100.9 (91.9 to 113.9)	82.5 (75.1 to 93.2)	0.3 (0.9 to -0.2)	-2.5 (-1.5 to -3.4)	-1.3 (-0.7 to -1.7)
Central African Republic	29.6 (24.8 to 35.8)	11.6 (8.9 to 15.1)	50.3 (38.5 to 65.9)	53.4 (34.3 to 76.5)	137.7 (107.4 to 176.5)	21.5 (16.8 to 27.6)	-0.8 (0.1 to -1.7)	-1.4 (0.7 to -3.2)	-1.1 (0.0 to -2.2)
Chad	29.6 (25.2 to 34.5)	12.1 (10.0 to 14.6)	46.3 (34.9 to 59.9)	66.5 (47.9 to 84.6)	146.5 (128.2 to 170.3)	84.5 (74.0 to 98.5)	-0.7 (-0.1 to -1.3)	-2.0 (-0.7 to -3.1)	-1.4 (-0.8 to -2.0)
Comoros	18.2 (14.8 to 22.3)	6.3 (4.5 to 9.2)	13.6 (8.7 to 20.4)	8.5 (5.4 to 13.3)	45.8 (33.2 to 63.1)	1.2 (0.9 to 1.6)	-3.8 (-1.9 to -5.7)	-4.7 (-2.0 to -7.0)	-4.3 (-2.9 to -5.6)
Congo	17.7 (15.5 to 19.9)	4.8 (4.0 to 5.6)	21.8 (16.7 to 26.9)	18.1 (12.3 to 24.5)	61.1 (51.8 to 69.9)	10.0 (8.5 to 11.5)	1.9 (2.6 to 1.0)	-4.6 (-3.4 to -6.0)	-1.8 (-1.2 to -2.6)
Côte d'Ivoire	27.0 (24.0 to 30.1)	9.4 (8.4 to 10.7)	31.9 (27.0 to 38.0)	31.3 (24.8 to 40.5)	96.0 (86.7 to 108.9)	70.2 (63.3 to 79.5)	-0.8 (-0.2 to -1.4)	-3.0 (-1.9 to -3.8)	-2.0 (-1.4 to -2.5)
DRC	24.7 (20.8 to 29.1)	7.5 (5.9 to 9.5)	44.2 (33.6 to 57.0)	49.3 (33.8 to 71.2)	120.3 (96.1 to 150.2)	340.4 (272.3 to 425.8)	-0.4 (0.2 to -1.1)	-2.8 (-1.0 to -4.5)	-1.7 (-0.7 to -2.7)
Equatorial Guinea	23.9 (19.7 to 28.2)	8.4 (6.3 to 11.3)	40.4 (28.4 to 54.5)	41.1 (26.0 to 63.8)	109.4 (82.5 to 142.6)	2.9 (2.2 to 3.8)	0.1 (1.6 to -1.1)	-3.4 (-0.8 to -5.6)	-1.9 (-0.6 to -3.2)
Eritrea	15.9 (13.4 to 18.9)	4.1 (3.0 to 5.7)	16.9 (11.7 to 24.0)	22.6 (14.0 to 36.7)	58.2 (41.9 to 79.9)	13.3 (9.6 to 18.2)	-2.8 (-2.1 to -3.6)	-5.3 (-2.8 to -7.7)	-4.2 (-2.7 to -5.5)
Ethiopia	22.9 (20.0 to 26.1)	7.0 (5.8 to 8.4)	23.3 (18.3 to 28.9)	23.2 (16.7 to 32.6)	74.4 (62.7 to 88.4)	229.3 (193.4 to 273.0)	-3.5 (-2.9 to -4.1)	-5.1 (-3.8 to -6.5)	-4.4 (-3.6 to -5.2)
Gabon	19.1 (16.5 to 21.4)	3.9 (3.2 to 4.6)	20.7 (16.1 to 25.1)	17.9 (13.0 to 23.7)	60.4 (50.5 to 71.2)	3.2 (2.7 to 3.8)	-1.9 (-1.0 to -2.8)	-1.3 (-0.1 to -2.8)	-1.5 (-0.8 to -2.3)
Gambia	20.6 (18.1 to 23.7)	6.1 (5.0 to 7.6)	23.4 (17.9 to 29.9)	26.5 (17.9 to 36.1)	74.6 (62.2 to 90.0)	5.7 (4.8 to 6.9)	-2.6 (-1.4 to -3.7)	-4.0 (-2.5 to -5.5)	-3.4 (-2.5 to -4.2)
Ghana	21.9 (19.1 to 24.8)	5.9 (5.1 to 6.8)	18.3 (14.9 to 22.1)	27.2 (21.5 to 34.2)	71.4 (62.4 to 82.3)	56.6 (49.4 to 65.2)	-1.8 (-1.3 to -2.3)	-2.8 (-1.7 to -3.8)	-2.3 (-1.7 to -2.9)
Guinea	26.1 (22.9 to 29.2)	8.6 (7.8 to 9.5)	33.6 (28.0 to 38.9)	44.6 (35.8 to 53.6)	108.6 (99.6 to 117.7)	46.3 (42.4 to 50.3)	-2.8 (-2.3 to -3.4)	-3.6 (-2.9 to -4.3)	-3.3 (-2.9 to -3.7)
Guinea-Bissau	30.0 (25.2 to 35.5)	12.3 (10.0 to 14.9)	47.6 (36.4 to 60.6)	71.2 (52.3 to 92.2)	152.5 (130.6 to 177.4)	9.6 (8.2 to 11.2)	-1.3 (-0.3 to -2.5)	-1.9 (-0.3 to -3.2)	-1.6 (-0.8 to -2.4)
Kenya	17.5 (15.1 to 20.5)	4.4 (3.4 to 5.6)	21.1 (15.4 to 28.7)	16.6 (11.2 to 23.2)	58.3 (46.5 to 73.4)	89.5 (71.4 to 112.8)	0.1 (0.8 to -0.6)	-3.9 (-1.9 to -5.6)	-2.2 (-1.0 to -3.1)
Lesotho	31.3 (26.3 to 37.2)	7.4 (5.8 to 9.7)	35.0 (26.9 to 47.6)	18.8 (12.5 to 27.0)	89.6 (71.3 to 113.8)	5.1 (4.0 to 6.5)	1.1 (2.0 to 0.1)	-1.1 (0.9 to -2.9)	-0.1 (1.0 to -1.2)
Liberia	20.4 (18.2 to 22.8)	5.9 (5.0 to 7.0)	32.6 (26.9 to 39.6)	20.8 (15.0 to 27.8)	77.5 (66.2 to 91.4)	11.6 (9.9 to 13.7)	-3.4 (-2.8 to -4.0)	-5.6 (-4.3 to -6.9)	-4.6 (-3.9 to -5.3)
Madagascar	14.6 (12.5 to 17.0)	5.3 (4.2 to 6.7)	21.6 (16.2 to 28.4)	18.3 (12.5 to 26.2)	58.5 (46.5 to 73.7)	45.7 (36.3 to 57.7)	-4.1 (-3.5 to -4.8)	-3.9 (-2.1 to -5.8)	-4.0 (-3.0 to -5.0)
Malawi	19.7 (16.9 to 22.1)	6.5 (5.5 to 7.4)	30.6 (24.7 to 36.5)	36.1 (26.8 to 46.9)	89.9 (76.5 to 103.4)	57.2 (48.7 to 65.9)	-3.1 (-2.6 to -3.7)	-4.8 (-3.5 to -5.9)	-4.0 (-3.4 to -4.7)
Mali	31.4 (26.0 to 36.9)	11.5 (9.6 to 13.9)	38.8 (30.4 to 48.6)	75.0 (58.5 to 96.3)	148.8 (126.4 to 176.0)	104.2 (88.5 to 123.0)	-1.5 (-1.0 to -2.0)	-3.0 (-1.7 to -4.3)	-2.4 (-1.7 to -3.1)

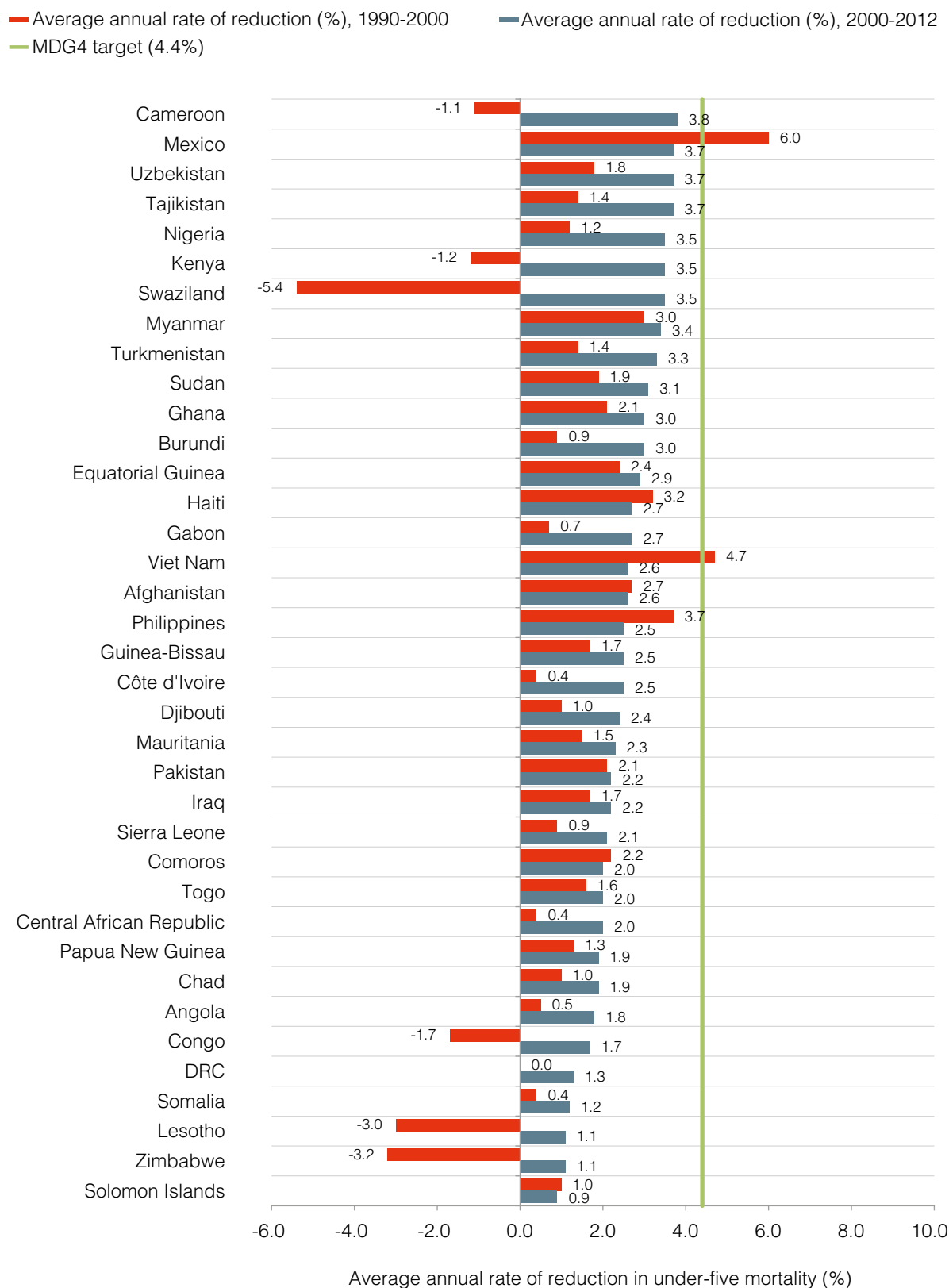
	Mortality rate (per 1000 live births)					Number of under-5 deaths (thousands)	Annualised rate of change in U5MR (%)		
	Early Neonatal (0-6 days)	Late Neonatal (7-28 days)	Post-Neonatal (29-364 days)	Childhood (1-4 years)	Total under-5 (0-4 years)		1990-2000	2000-2013	1990-2013
Mauritania	26.8 (23.5 to 30.7)	6.7 (5.5 to 8.1)	16.0 (12.6 to 20.4)	21.6 (15.7 to 28.5)	69.3 (58.4 to 82.5)	9.1 (7.7 to 10.8)	-0.7 (0.2 to -1.6)	-2.7 (-1.2 to -4.0)	-1.8 (-1.0 to -2.6)
Mozambique	21.0 (18.4 to 23.9)	6.8 (5.7 to 7.8)	33.5 (26.6 to 41.0)	30.1 (21.4 to 39.8)	88.4 (76.9 to 101.5)	87.9 (76.3 to 101.1)	-3.4 (-2.9 to -4.0)	-4.4 (-3.3 to -5.5)	-4.0 (-3.4 to -4.6)
Niger	17.7 (15.1 to 20.5)	8.3 (7.4 to 9.2)	31.3 (25.6 to 37.6)	62.6 (51.6 to 75.5)	115.4 (104.9 to 127.4)	97.8 (88.7 to 108.1)	-2.9 (-2.4 to -3.4)	-5.1 (-4.3 to -5.9)	-4.1 (-3.7 to -4.6)
Nigeria	27.9 (23.9 to 31.7)	9.2 (8.1 to 10.4)	34.8 (28.6 to 41.1)	62.0 (49.8 to 76.1)	128.0 (114.3 to 142.0)	892.6 (796.1 to 991.6)	-1.2 (-0.7 to -1.7)	-2.8 (-1.9 to -3.8)	-2.1 (-1.6 to -2.6)
Rwanda	17.6 (15.4 to 20.3)	5.4 (4.3 to 6.8)	21.6 (16.3 to 29.2)	19.5 (12.5 to 28.4)	62.6 (50.7 to 78.2)	25.7 (20.8 to 32.1)	-0.3 (0.2 to -1.0)	-7.2 (-5.4 to -8.8)	-4.2 (-3.2 to -5.1)
Sao Tome and Principe	15.2 (13.3 to 17.0)	3.2 (2.7 to 4.0)	11.7 (8.7 to 15.3)	11.2 (8.1 to 15.2)	40.7 (34.5 to 48.2)	0.3 (0.2 to 0.3)	-2.4 (-1.5 to -3.3)	-4.8 (-3.4 to -6.1)	-3.8 (-3.0 to -4.5)
Senegal	18.0 (15.9 to 20.1)	5.6 (5.0 to 6.3)	14.8 (12.3 to 17.7)	22.4 (17.6 to 27.7)	59.5 (53.4 to 66.8)	31.1 (27.9 to 35.0)	-1.5 (-1.0 to -2.0)	-5.7 (-4.9 to -6.6)	-3.9 (-3.4 to -4.4)
Sierra Leone	27.7 (24.1 to 31.4)	9.8 (8.5 to 11.4)	48.9 (40.2 to 58.7)	46.4 (34.3 to 60.0)	126.8 (111.6 to 144.3)	28.1 (24.7 to 32.0)	-1.4 (-0.9 to -2.0)	-3.5 (-2.5 to -4.5)	-2.6 (-2.0 to -3.2)
South Africa	11.4 (9.5 to 13.3)	3.2 (2.5 to 4.2)	14.7 (9.2 to 20.3)	8.2 (5.3 to 12.2)	37.0 (27.8 to 47.8)	40.6 (30.6 to 52.6)	1.4 (3.6 to -1.0)	-6.1 (-3.6 to -8.5)	-2.8 (-1.6 to -4.1)
South Sudan	23.0 (19.8 to 26.9)	9.0 (6.9 to 11.8)	36.9 (27.6 to 48.8)	41.1 (26.2 to 59.9)	105.9 (83.8 to 135.1)	41.8 (33.2 to 53.5)	-3.0 (-0.8 to -5.0)	-2.7 (-0.3 to -4.8)	-2.8 (-1.6 to -4.0)
Swaziland	16.8 (14.4 to 19.9)	5.0 (3.9 to 6.4)	34.5 (26.1 to 45.0)	20.1 (13.0 to 28.4)	74.4 (58.1 to 96.0)	2.8 (2.1 to 3.5)	2.9 (3.8 to 2.1)	-2.4 (-0.4 to -4.3)	-0.1 (1.2 to -1.2)
Togo	25.2 (22.0 to 28.6)	6.1 (5.1 to 7.4)	26.2 (21.0 to 32.1)	38.4 (27.8 to 50.2)	92.8 (77.5 to 111.8)	22.6 (18.9 to 27.2)	-1.6 (-0.8 to -2.4)	-2.3 (-0.6 to -3.7)	-2.0 (-1.2 to -2.7)
Uganda	20.2 (17.6 to 22.7)	5.7 (4.9 to 6.6)	27.9 (22.4 to 33.1)	28.8 (21.7 to 37.0)	80.1 (69.4 to 93.1)	127.3 (110.3 to 147.9)	-1.7 (-1.2 to -2.3)	-4.2 (-2.9 to -5.3)	-3.1 (-2.4 to -3.7)
United Rep. of Tanzania	18.0 (15.7 to 20.4)	5.8 (4.8 to 6.9)	30.2 (23.2 to 37.2)	24.6 (18.0 to 33.1)	76.5 (63.8 to 90.4)	145.2 (121.1 to 171.8)	-2.1 (-1.6 to -2.7)	-3.6 (-2.2 to -5.0)	-3.0 (-2.2 to -3.7)
Zambia	15.2 (13.2 to 17.7)	6.9 (5.5 to 8.6)	29.5 (22.8 to 37.9)	31.2 (20.7 to 43.6)	80.5 (63.4 to 101.2)	48.7 (38.3 to 61.3)	-1.4 (-0.8 to -1.9)	-4.9 (-3.3 to -6.7)	-3.4 (-2.4 to -4.4)
Zimbabwe	17.7 (15.4 to 20.8)	6.5 (5.3 to 8.1)	23.3 (18.5 to 30.6)	23.1 (16.0 to 31.0)	69.0 (56.3 to 84.7)	30.3 (24.7 to 37.2)	1.0 (1.6 to 0.3)	-0.6 (1.0 to -2.3)	0.1 (0.9 to -0.7)
EMRO									
Afghanistan	20.9 (18.7 to 23.1)	10.7 (9.5 to 12.1)	34.9 (28.0 to 41.9)	26.7 (19.3 to 35.2)	90.2 (81.6 to 100.0)	94.7 (85.6 to 105.2)	-1.7 (-0.9 to -2.5)	-3.6 (-2.6 to -4.4)	-2.7 (-2.2 to -3.3)
Djibouti	17.6 (15.1 to 21.0)	5.4 (4.0 to 7.1)	21.8 (15.1 to 29.7)	19.5 (12.3 to 30.9)	62.9 (47.3 to 82.1)	1.5 (1.1 to 2.0)	-0.9 (0.6 to -2.1)	-3.8 (-1.3 to -6.0)	-2.5 (-1.3 to -3.7)
Egypt	7.3 (6.4 to 8.2)	3.5 (3.3 to 3.8)	6.5 (5.4 to 7.8)	4.7 (3.6 to 6.0)	21.8 (19.6 to 24.3)	41.3 (37.2 to 46.1)	-6.5 (-5.9 to -7.0)	-5.4 (-4.5 to -6.2)	-5.8 (-5.3 to -6.3)
Iraq	11.3 (10.3 to 12.4)	3.3 (3.0 to 3.7)	8.8 (7.0 to 10.7)	5.7 (3.9 to 7.8)	28.8 (26.2 to 31.7)	29.9 (27.3 to 33.0)	-2.1 (-1.4 to -2.8)	-3.1 (-2.2 to -3.9)	-2.7 (-2.2 to -3.1)
Morocco	10.5 (9.3 to 11.8)	4.1 (3.7 to 4.6)	7.4 (5.9 to 9.0)	4.5 (3.4 to 6.0)	26.3 (23.2 to 29.8)	19.4 (17.2 to 22.1)	-3.9 (-3.2 to -4.5)	-4.6 (-3.7 to -5.5)	-4.3 (-3.7 to -4.9)
Pakistan	26.3 (24.2 to 28.6)	10.2 (9.3 to 11.3)	26.5 (22.8 to 30.7)	14.9 (11.1 to 19.4)	75.8 (70.1 to 82.5)	348.5 (321.9 to 379.2)	-1.4 (-1.1 to -1.9)	-1.8 (-1.1 to -2.5)	-1.7 (-1.3 to -2.1)
Somalia	23.8 (19.8 to 28.2)	10.0 (7.5 to 13.0)	39.2 (27.3 to 53.1)	45.5 (29.5 to 67.2)	113.7 (88.9 to 144.5)	51.3 (40.1 to 65.3)	-1.8 (-0.7 to -2.8)	-2.6 (-0.5 to -4.4)	-2.2 (-1.2 to -3.3)
Sudan	15.5 (14.0 to 17.4)	4.7 (4.1 to 5.4)	14.2 (11.6 to 17.2)	13.4 (9.9 to 17.1)	47.1 (41.6 to 53.4)	59.5 (52.7 to 67.5)	-3.1 (-2.2 to -4.1)	-4.1 (-3.1 to -5.0)	-3.6 (-3.1 to -4.2)
Yemen	15.3 (13.0 to 17.6)	5.7 (4.8 to 6.8)	20.7 (16.0 to 25.3)	9.6 (7.2 to 12.7)	50.4 (44.5 to 57.5)	38.0 (33.6 to 43.4)	-3.4 (-2.8 to -4.0)	-4.2 (-3.2 to -5.1)	-3.9 (-3.3 to -4.4)

	Mortality rate (per 1000 live births)					Number of under-5 deaths (thousands)	Annualised rate of change in U5MR (%)		
	Early Neonatal (0–6 days)	Late Neonatal (7–28 days)	Post-Neonatal (29–364 days)	Childhood (1–4 years)	Total under-5 (0–4 years)		1990–2000	2000–2013	1990–2013
EURO									
Azerbaijan	14.5 (13.4 to 15.8)	3.4 (3.0 to 3.8)	12.5 (10.5 to 14.9)	5.1 (3.7 to 6.9)	35.1 (31.8 to 39.0)	5.9 (5.3 to 6.5)	-2.0 (-1.1 to -3.1)	-4.6 (-3.6 to -5.4)	-3.5 (-2.9 to -4.0)
Kyrgyzstan	14.5 (13.3 to 15.6)	2.2 (2.0 to 2.4)	9.1 (7.8 to 10.5)	4.1 (3.1 to 5.4)	29.6 (27.0 to 32.2)	4.4 (4.0 to 4.8)	-3.8 (-2.7 to -4.7)	-3.9 (-3.0 to -4.9)	-3.9 (-3.4 to -4.3)
Tajikistan	14.4 (13.0 to 15.5)	3.3 (2.9 to 3.6)	16.1 (13.7 to 18.4)	8.6 (6.3 to 11.6)	41.7 (37.9 to 45.2)	11.1 (10.1 to 12.1)	-2.5 (-1.6 to -3.3)	-4.4 (-3.6 to -5.3)	-3.6 (-3.1 to -4.0)
Turkmenistan	17.5 (16.0 to 19.0)	4.7 (4.1 to 5.4)	19.6 (15.9 to 23.3)	11.5 (8.2 to 15.9)	52.3 (46.7 to 58.9)	5.8 (5.2 to 6.6)	-2.1 (-0.8 to -3.4)	-3.3 (-2.1 to -4.3)	-2.8 (-2.2 to -3.4)
Uzbekistan	14.0 (12.5 to 15.5)	3.4 (3.0 to 3.8)	10.9 (9.0 to 13.1)	8.1 (6.2 to 10.3)	35.9 (32.5 to 39.9)	22.3 (20.2 to 24.8)	-0.9 (0.0 to -1.8)	-2.6 (-1.7 to -3.7)	-1.9 (-1.4 to -2.4)
PAHO									
Bolivia	13.1 (12.0 to 14.2)	4.1 (3.8 to 4.4)	15.5 (13.3 to 17.8)	9.9 (7.5 to 12.9)	41.9 (39.0 to 45.2)	11.4 (10.7 to 12.3)	-4.5 (-4.0 to -5.1)	-3.9 (-3.2 to -4.5)	-4.2 (-3.8 to -4.5)
Brazil	7.5 (6.6 to 8.4)	2.6 (2.4 to 2.7)	6.1 (5.4 to 6.9)	1.9 (1.3 to 2.7)	18.0 (16.6 to 19.7)	54.1 (49.8 to 59.0)	-5.1 (-4.3 to -6.0)	-4.3 (-3.5 to -5.1)	-4.6 (-4.2 to -5.1)
Guatemala	6.5 (5.9 to 7.3)	2.8 (2.6 to 3.0)	10.4 (8.8 to 12.2)	8.6 (6.9 to 10.7)	28.1 (25.5 to 30.9)	13.3 (12.1 to 14.7)	-4.0 (-3.0 to -4.9)	-4.6 (-3.7 to -5.5)	-4.3 (-3.9 to -4.8)
Haiti	16.7 (14.7 to 18.8)	8.8 (7.6 to 10.4)	25.4 (20.6 to 31.4)	16.9 (11.7 to 22.9)	66.1 (56.8 to 77.6)	17.4 (14.9 to 20.5)	-4.0 (-3.3 to -4.8)	-3.0 (-1.8 to -4.2)	-3.5 (-2.8 to -4.2)
Mexico	5.8 (5.1 to 6.6)	2.4 (2.2 to 2.6)	5.6 (4.8 to 6.6)	3.1 (2.3 to 3.8)	16.8 (15.3 to 18.6)	38.1 (34.7 to 42.0)	-4.6 (-3.6 to -5.7)	-3.6 (-2.6 to -4.5)	-4.0 (-3.5 to -4.5)
Peru	8.0 (7.1 to 8.9)	2.7 (2.6 to 2.8)	6.6 (5.7 to 7.6)	4.9 (3.7 to 6.3)	22.0 (20.5 to 23.8)	13.2 (12.3 to 14.3)	-6.4 (-5.7 to -6.9)	-4.5 (-3.8 to -5.1)	-5.3 (-4.9 to -5.7)
SEARO									
Bangladesh	19.3 (17.6 to 21.1)	5.4 (4.8 to 6.2)	9.0 (7.5 to 10.8)	7.6 (5.8 to 9.8)	40.8 (36.9 to 45.4)	128.2 (116.0 to 142.7)	-4.7 (-4.3 to -5.1)	-5.6 (-4.7 to -6.4)	-5.2 (-4.7 to -5.6)
DPR Korea	8.8 (6.8 to 10.9)	2.0 (1.7 to 2.3)	5.5 (3.9 to 7.5)	5.1 (3.5 to 7.2)	21.2 (17.2 to 26.3)	7.6 (6.1 to 9.4)	-2.1 (-0.1 to -4.0)	-5.7 (-3.9 to -7.5)	-4.1 (-2.9 to -5.4)
India	22.4 (20.4 to 24.5)	5.7 (4.9 to 6.8)	12.0 (10.0 to 14.6)	9.6 (7.1 to 12.9)	48.8 (43.1 to 56.4)	1249.7 (1103.8 to 1443.7)	-3.0 (-2.7 to -3.4)	-4.3 (-3.2 to -5.1)	-3.7 (-3.1 to -4.3)
Indonesia	11.1 (9.9 to 12.3)	3.8 (3.4 to 4.3)	10.0 (8.2 to 12.3)	7.0 (5.2 to 9.0)	31.5 (28.1 to 35.6)	148.8 (132.2 to 168.2)	-4.7 (-4.1 to -5.3)	-4.1 (-3.1 to -5.1)	-4.4 (-3.8 to -4.9)
Myanmar	14.3 (12.7 to 16.1)	3.9 (3.2 to 4.7)	11.1 (8.4 to 14.6)	8.3 (5.6 to 11.8)	37.1 (31.6 to 43.7)	34.1 (29.0 to 40.2)	-3.5 (-1.6 to -5.6)	-5.5 (-3.7 to -7.1)	-4.6 (-3.7 to -5.5)
Nepal	17.7 (16.1 to 19.4)	4.3 (3.8 to 5.0)	9.2 (7.6 to 11.2)	7.0 (5.2 to 9.1)	37.7 (33.9 to 42.1)	22.2 (20.0 to 24.9)	-5.4 (-5.0 to -5.9)	-6.1 (-5.2 to -6.9)	-5.8 (-5.3 to -6.3)
WPRO									
Cambodia	15.5 (14.0 to 17.1)	4.8 (4.1 to 5.6)	15.6 (12.4 to 19.0)	7.9 (5.6 to 10.5)	43.2 (37.4 to 49.5)	16.7 (14.4 to 19.2)	-1.4 (-0.6 to -2.1)	-6.6 (-5.3 to -7.7)	-4.3 (-3.6 to -5.0)
China	4.9 (4.3 to 5.5)	1.4 (1.3 to 1.6)	3.5 (2.9 to 4.1)	3.2 (2.3 to 4.2)	13.0 (12.0 to 13.8)	238.8 (220.9 to 256.0)	-4.7 (-3.9 to -5.5)	-8.1 (-7.4 to -8.7)	-6.6 (-6.2 to -7.0)
Lao PDR	18.6 (16.6 to 20.7)	6.7 (5.6 to 7.8)	20.6 (16.2 to 25.5)	16.7 (11.8 to 23.8)	61.3 (52.8 to 69.4)	11.1 (9.5 to 12.6)	-2.6 (-1.5 to -3.8)	-5.3 (-4.1 to -6.6)	-4.1 (-3.5 to -4.9)
Papua New Guinea	17.1 (13.6 to 21.7)	5.3 (3.3 to 8.3)	19.9 (11.5 to 30.6)	15.8 (7.5 to 30.5)	57.0 (36.7 to 86.4)	12.0 (7.7 to 18.1)	-1.4 (0.9 to -3.6)	-2.8 (-0.1 to -5.4)	-2.2 (-0.3 to -4.1)
Philippines	9.9 (8.4 to 11.3)	2.6 (2.3 to 3.0)	6.9 (5.4 to 8.9)	8.2 (6.2 to 10.7)	27.3 (23.2 to 32.2)	65.1 (55.4 to 76.9)	-3.3 (-2.3 to -4.3)	-2.7 (-1.3 to -4.2)	-3.0 (-2.2 to -3.7)
Solomon Islands	9.0 (5.0 to 13.5)	2.2 (1.5 to 3.2)	5.8 (3.3 to 10.9)	5.0 (2.8 to 8.4)	21.8 (13.2 to 35.1)	0.4 (0.2 to 0.6)	-2.7 (0.2 to -5.6)	-3.1 (0.4 to -6.0)	-2.9 (-0.8 to -5.1)
Viet Nam	6.9 (5.4 to 8.5)	2.6 (2.4 to 2.9)	3.7 (3.0 to 4.6)	5.4 (4.1 to 7.1)	18.6 (15.8 to 21.9)	26.6 (22.6 to 31.5)	-5.0 (-3.7 to -6.2)	-3.4 (-1.9 to -5.1)	-4.1 (-3.3 to -4.8)

Source: Wang et al, 2014. Global, regional, and national levels of neonatal, infant, and under-5 mortality during 1990–2013, Global Burden of Disease Study 2013. *Lancet*.

Figure 1. Trends in child mortality in the 75 iERG countries, by average annual rate of reduction, 2000-2012

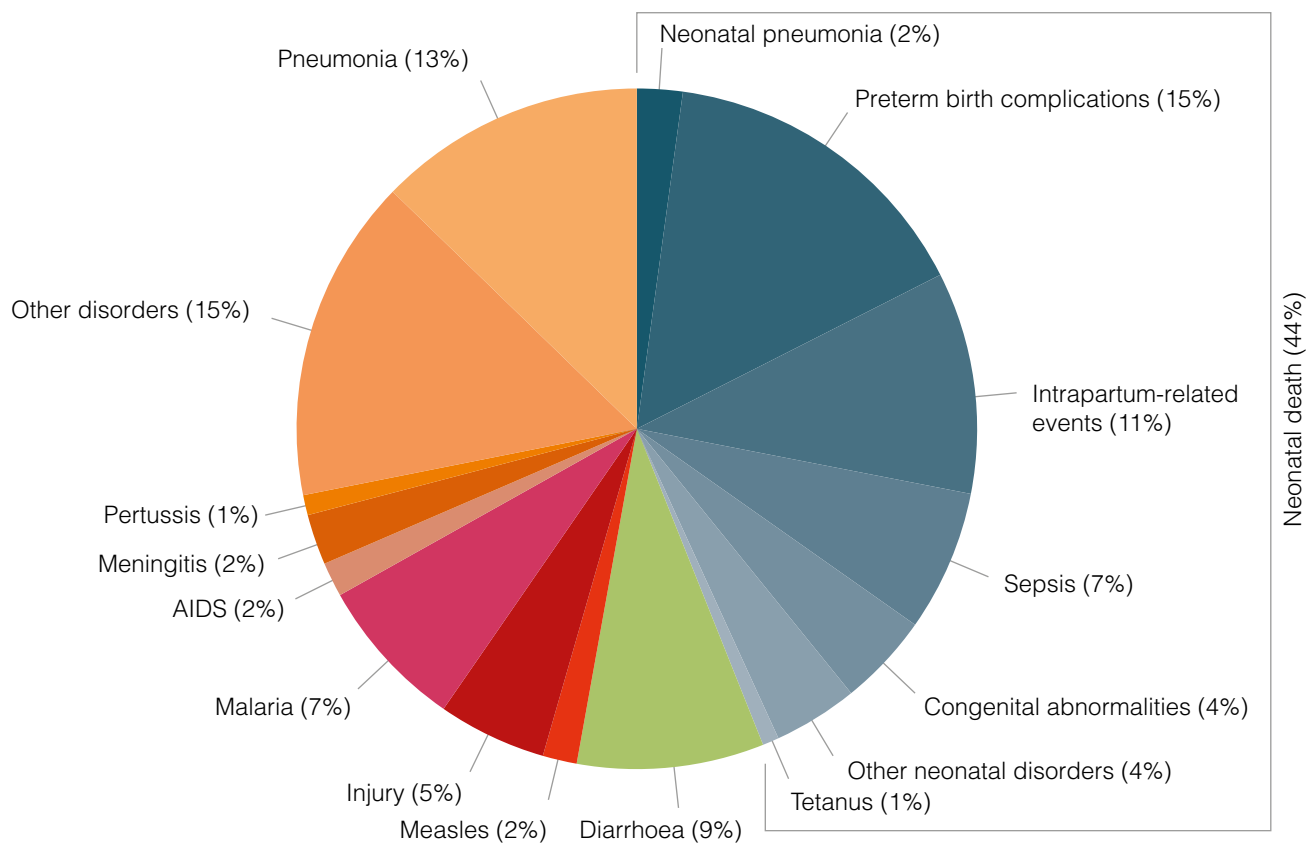




The goal for MDG4 was for countries to achieve a 4.4% average annual rate of reduction (AAR) in child mortality. In most iERG countries, the AAR for child mortality was faster in the years after 2000. However, in 10 countries, the AAR for child mortality was faster during the period from 1990-2000 compared to 2000-2012.

Source: UN Inter-agency Group for Child Mortality Estimation, 2013. Figure adapted from "Fulfilling the Health Agenda for Women and Children: The 2014 Report," Countdown to 2015.

Figure 2. Global causes of child deaths in 2013



Source: Liu et al, 2015. Global, regional, and national causes of child mortality in 2000–13, with projections to inform post-2015 priorities. *Lancet*.

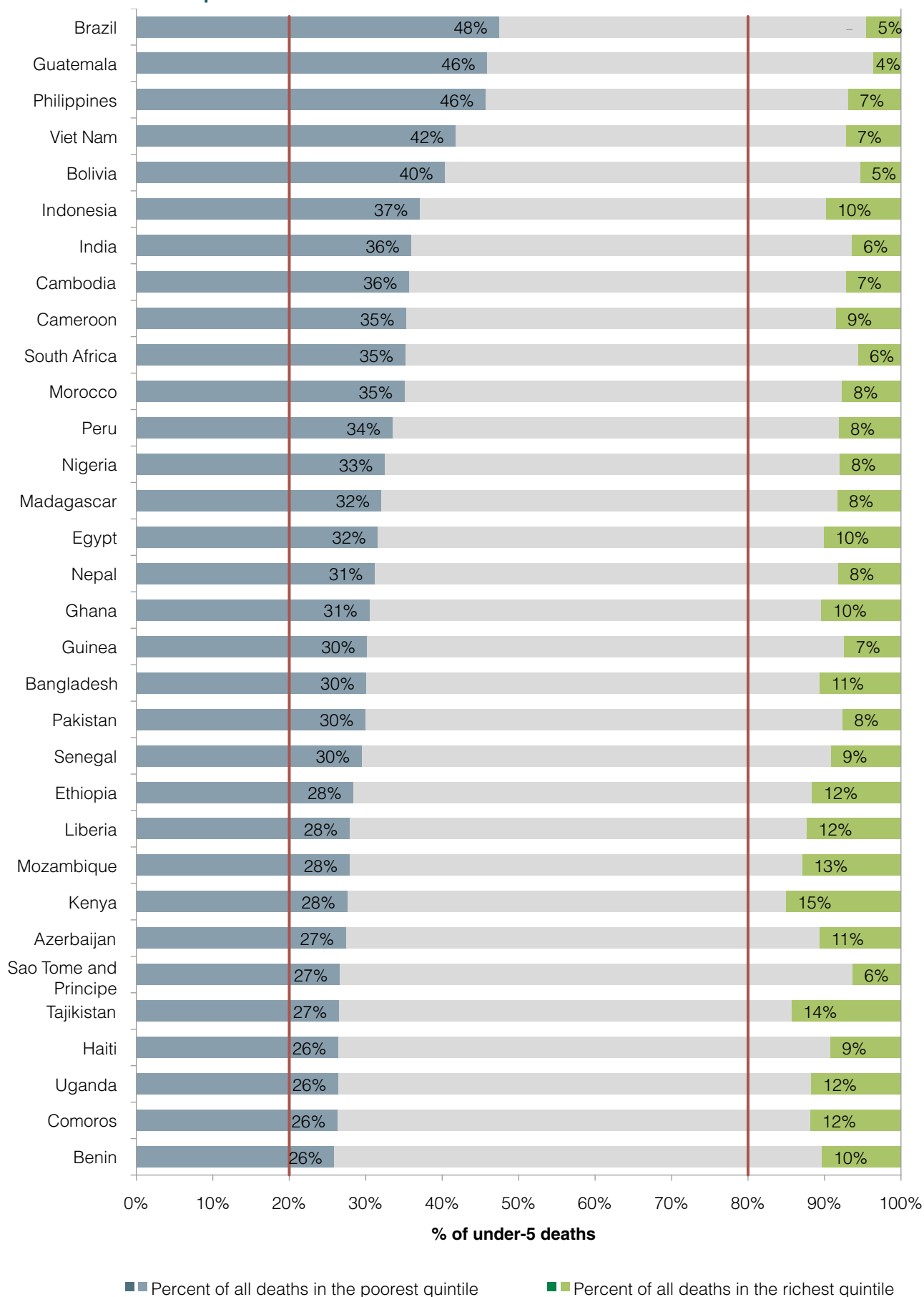


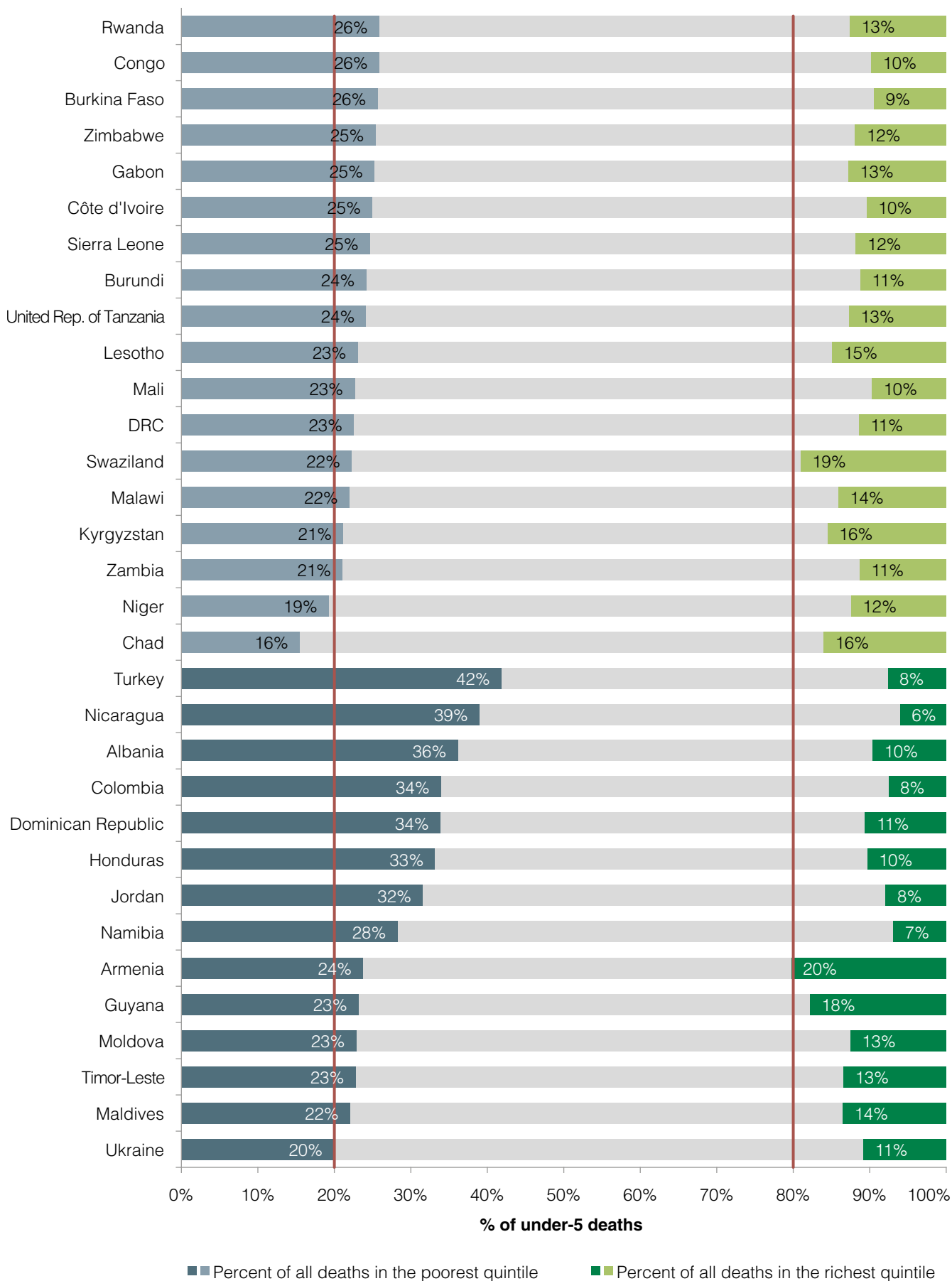
Table 2. Selected causes of global child deaths in 1990 and 2013

	Neonates aged <1 month			Children aged 1–59 months		
	1990 (thousands)	2013 (thousands)	Median % change	1990 (thousands)	2013 (thousands)	Median % change
All causes	4506.8 (4394.5 to 4612.8)	2614.3 (2506.4 to 2723.2)	-42.0 (-44.5 to -39.5)	7608.5 (7447.7 to 7757.3)	3665.7 (3449.4 to 3905.8)	-52.0 (-54.7 to -48.6)
Communicable, maternal, neonatal, and nutritional diseases	4063.8 (3935.0 to 4181.4)	2275.5 (2163.6 to 2374.6)	-44.0 (-46.6 to -41.4)	6012.6 (5724.0 to 6256.5)	2766.2 (2528.6 to 3010.5)	-54.0 (-57.5 to -50.4)
HIV/AIDS	..	..	..	35.2 (32.3 to 38.3)	63.8 (58.5 to 71.6)	81.1 (64.5 to 99.9)
Diarrhoeal diseases	124.8 (110.5 to 140.5)	44.8 (36.8 to 53.3)	-64.2 (-70.6 to -56.7)	1482.4 (1339.7 to 1633.3)	474.9 (398.1 to 545.0)	-68.0 (-72.8 to -62.5)
Intestinal infectious diseases	..	..	..	82.0 (46.7 to 135.2)	62.4 (33.0 to 103.6)	-24.2 (-37.2 to -8.1)
Lower respiratory infections	399.3 (362.2 to 436.9)	196.5 (169.3 to 224.5)	-50.9 (-57.3 to -43.7)	1768.8 (1597.7 to 1926.6)	708.6 (628.6 to 791.4)	-59.9 (-64.8 to -54.5)
Meningitis	35.6 (27.7 to 47.0)	20.6 (14.9 to 26.8)	-42.6 (-52.7 to -28.4)	262.5 (212.1 to 346.3)	121.4 (90.2 to 157.0)	-54.0 (-63.4 to -41.5)
Whooping cough	..	..	..	129.8 (49.9 to 280.7)	56.4 (20.7 to 127.0)	-57.1 (-83.9 to 12.7)
Tetanus	216.9 (174.8 to 370.5)	26.0 (12.3 to 38.9)	-87.0 (-95.8 to -80.1)	65.4 (48.2 to 121.6)	5.5 (3.9 to 7.7)	-91.2 (-95.5 to -86.9)
Measles	..	..	..	472.4 (265.3 to 749.9)	82.1 (41.7 to 145.0)	-83.1 (-90.3 to -68.5)
Malaria	18.1 (13.4 to 23.5)	16.8 (11.0 to 26.4)	-9.6 (-42.6 to 52.8)	566.3 (470.8 to 662.0)	570.0 (437.5 to 733.2)	-1.3 (-27.7 to 40.9)
Neonatal preterm birth complications	1452.1 (1190.6 to 1677.3)	693.0 (553.6 to 853.9)	-52.5 (-58.6 to -45.0)	118.4 (80.1 to 157.3)	49.4 (34.5 to 69.8)	-58.3 (-69.4 to -41.3)
Neonatal encephalopathy due to birth asphyxia/trauma	820.8 (651.3 to 993.1)	611.5 (491.9 to 724.0)	-25.3 (-38.1 to -9.8)	53.3 (35.5 to 72.6)	32.3 (21.4 to 48.7)	-40.6 (-58.2 to -9.0)
Neonatal sepsis and other neonatal infections	328.3 (186.3 to 462.1)	342.2 (214.9 to 479.3)	4.6 (-17.3 to 38.5)	18.1 (9.2 to 28.3)	23.8 (13.3 to 38.0)	30.3 (-15.9 to 114.6)
Other neonatal disorders	489.9 (381.6 to 654.9)	238.2 (187.7 to 297.0)	-51.3 (-62.5 to -35.0)	87.7 (58.5 to 123.5)	38.1 (25.0 to 59.8)	-57.4 (-73.9 to -27.8)
Nutritional deficiencies	..	..	..	451.6 (376.5 to 560.5)	260.7 (197.9 to 316.6)	-42.3 (-52.4 to -30.1)
Syphilis	122.6 (68.9 to 194.3)	63.7 (37.0 to 98.4)	-47.9 (-58.6 to -35.5)	100.9 (56.9 to 157.6)	56.9 (32.5 to 90.9)	-43.3 (-56.8 to -28.5)
Other communicable diseases	55.3 (37.9 to 79.1)	22.4 (16.4 to 30.7)	-59.0 (-70.6 to -44.7)	317.7 (283.8 to 355.0)	159.9 (134.5 to 192.6)	-49.7 (-58.7 to -39.8)
Non-communicable diseases	366.4 (316.1 to 443.9)	292.3 (258.4 to 349.7)	-19.8 (-32.4 to 4.3)	906.4 (766.4 to 1138.2)	578.8 (462.6 to 739.5)	-36.6 (-43.4 to -23.6)
Congenital anomalies	303.6 (256.8 to 375.4)	246.6 (219.0 to 280.0)	-17.6 (-33.1 to -0.1)	343.6 (255.5 to 493.5)	248.7 (198.8 to 322.9)	-25.7 (-40.6 to -13.7)
Sudden infant death syndrome	3.0 (1.2 to 6.1)	2.4 (1.1 to 4.5)	-13.8 (-60.1 to 54.0)	19.1 (11.2 to 34.3)	12.7 (8.4 to 18.4)	-32.2 (-55.5 to -4.9)
Other non-communicable diseases	59.8 (52.3 to 70.5)	43.3 (32.4 to 76.9)	-31.3 (-43.3 to 18.7)	543.7 (469.1 to 642.8)	317.4 (244.2 to 422.8)	-42.8 (-52.6 to -23.3)
Injuries	76.6 (58.5 to 95.1)	46.4 (37.5 to 63.5)	-41.7 (-53.4 to -2.9)	689.5 (567.1 to 776.3)	320.7 (277.8 to 371.5)	-54.6 (-61.1 to -41.9)
Road injuries	4.1 (3.3 to 5.1)	3.8 (2.6 to 5.3)	-6.6 (-30.8 to 30.5)	105.2 (88.7 to 128.2)	64.5 (51.3 to 79.5)	-38.3 (-52.6 to -23.7)
Drowning	2.7 (1.9 to 3.5)	1.8 (1.1 to 2.8)	-38.2 (-56.7 to 16.9)	212.3 (132.4 to 275.1)	80.1 (61.7 to 111.4)	-63.3 (-74.1 to -20.4)
Other injuries	69.9 (52.2 to 88.2)	40.8 (32.1 to 58.0)	-44.1 (-55.9 to -1.0)	372.0 (280.9 to 424.3)	176.2 (153.1 to 203.7)	-53.7 (-60.8 to -37.6)

Source: Global Burden of Disease Study 2013, 2014. Global, regional, and national age–sex specific all-cause and cause-specific mortality for 240 causes of death, 1990–2013. *Lancet*.

Figure 3. Percent of under-5 deaths in the poorest and richest quintiles, in 50 of the 75 iERG countries and select countries of comparison





Source: International Center for Equity in Health, 2015. Socioeconomic, gender, and urban/rural inequalities in RMNCH indicators in 98 countries. Report commissioned by iERG, included as Annex 3. Data from latest available survey since 1998.

12. For maternal mortality (MDG-5a), the GBD study has reported estimates for 2013: 292 982 deaths, compared with 376 034 deaths in 1990 (15). Table 3 shows their maternal mortality data for the 75 iERG countries of concern. Figure 4 shows data from the Maternal Mortality Estimate Interagency Group, with trends in maternal mortality in the 75 iERG countries. These data are divided by average annual rate of reduction for two periods: 1990-2000 and 2000-2013. Although not universally consistent, one can see many examples of acceleration in reductions in maternal mortality (in 56 countries, although with 19 nations showing decadal decelerations in progress). Figure 5 shows countries ranked by reduction trends in under-5 and maternal mortality, from best to worst. Countries that rank highly on both measures fall into the lower left of the diagram. If rankings on under-5 and maternal mortality were highly correlated, the points in the figure would cluster along the 45 degree line, which they quite evidently do not. The fact that they are as scattered as they are suggests that very different policies and influences may be affecting success in these two domains.

Much has been said about China's one-child policy, and concerns raised about human rights. China's response to critics has been to defend its achievements in social and economic development and the important role of its population policy therein. China has now entered a new phase of below-replacement fertility which may be hard to reverse. Some social and demographic impacts of the one-child policy will have long lasting societal consequences—notably the sex ratio at birth in favor of males and the high dependency ratio of the elderly to working age population—possibly undermining China's economic competitiveness. Other negative effects are also ongoing, including new forms of discrimination against women and girls. The widening economic and social disparities lead to urban and rural poverty and concomitant health problems, environmental pollution, rapid urbanization, and changing youth sexual behavior and reproductive attitudes. This last point means a new threat of sexually transmitted infectious diseases such as HIV/AIDS.

China: Impressive efforts to improve maternal and child health

With one of the most successful stories of improvements to maternal and child health, China has made impressive strides in reducing its under-5 mortality rate (U5MR) and maternal mortality ratio (MMR) in the past 25 years. U5MR declined from 59 per 1000 live births in 1990 to 13 per 1000 in 2013 (1). In fact, by all accounts, China achieved the MDG-4 target of reducing U5MR by two-thirds from its 1990 level well before 2015 (1-3). A similar reduction in MMR has also been observed, with a decrease from 141.7 per 100 000 live births to 17.2 per 100 000 in the same period (4). Improvements in U5MR and MMR have accelerated since the 1995 passage of the Law of the People's Republic of China on the Maternal and Infant Health Care.

Studies have pointed to the importance of social policy, public health policy, and investment in the public health sector in reducing U5MR and MMR. The specific policies and programmes implemented by the Chinese government, aimed at increasing investment in mothers and children, have played a key part in China's success. Its compulsory nine-year education policy has helped to improve the average maternal education level from 5.8 years in 1990 to 9.2 years in 2013 (5). There are important links between maternal education and maternal and child health (5,6). For example, higher maternal education level alone

accounted for 15.3% of the reduction in under-5 deaths from 1990 to 2013 (1).

Even after controlling for improvements in income and education, a significant proportion of counties in China have shown a faster decline in U5MR than was to be expected given their level of socioeconomic development, which suggests that a greater part was played by public health policy and intervention programmes (7). Many effective interventions to reduce maternal and under-5 mortality have been carried out since the early 2000s. The "Reducing Maternal Mortality and Eliminate Neonatal Tetanus" programme, introduced in 2000, had been implemented in over 2200 counties by 2012, especially in economically backward regions of China (8). In close collaboration with international agencies (including WHO, UNICEF, UNFPA, and the World Bank), many other interventions have been implemented at the sub-national and national levels in the past two decades, including: baby-friendly hospitals; free services to improve children's physical and mental health; conditional cash transfers to women giving birth in hospitals; strengthening maternal, child and reproductive health services at the grassroots level; treating acute respiratory infection in children; and improving essential health services in poor rural areas (9).

However, substantial health disparities still remain within China. For example, a recent study shows U5MR in 2012 ranged from 3.3 per 1000 live births in Huangpu District of Shanghai to 104.4 per 1000 in Zamtang County of Sichuan (7). This regional heterogeneity, and similar disparities by urbanicity and income level, means that in order to achieve further reductions in U5MR and MMR, much larger investments are required from governments at all levels, together with continued efforts by policy makers to direct resources to regions that are lagging behind. Local governments have played a pivotal part in improving maternal and child health in the recent past, but the decentralised financing of public health programmes has had a negative impact on many interventions at the local level (10). A more coordinated financing strategy, emphasising the roles of both central and provincial governments, is needed to minimise the gap between sub-national regions within China, as well as the gap between China and high-income countries.

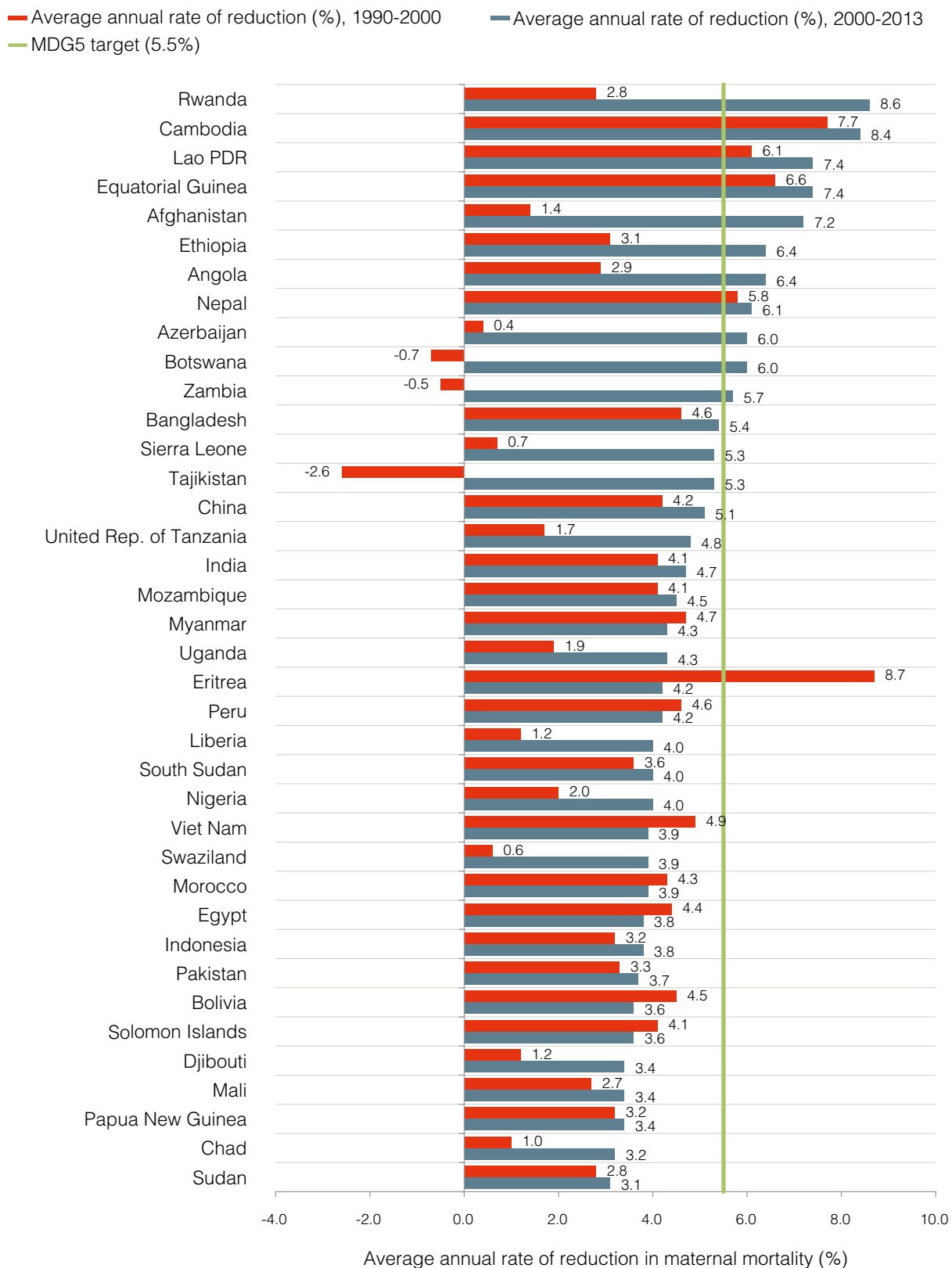
Indeed, the Chinese government is taking significant steps to further improve the health of its population. In 2009, the then Ministry of Health (now the National Health and Family Planning Commission) announced a comprehensive reform of the health system, in recognition of the inequality and inefficiency of health services in China. While the impact of those reforms, especially the establishment and expansion of the New Rural Cooperative Medical Scheme, remains to be seen, they are likely to help further reduce maternal and child mortality in China, given their emphasis on providing essential public health services.

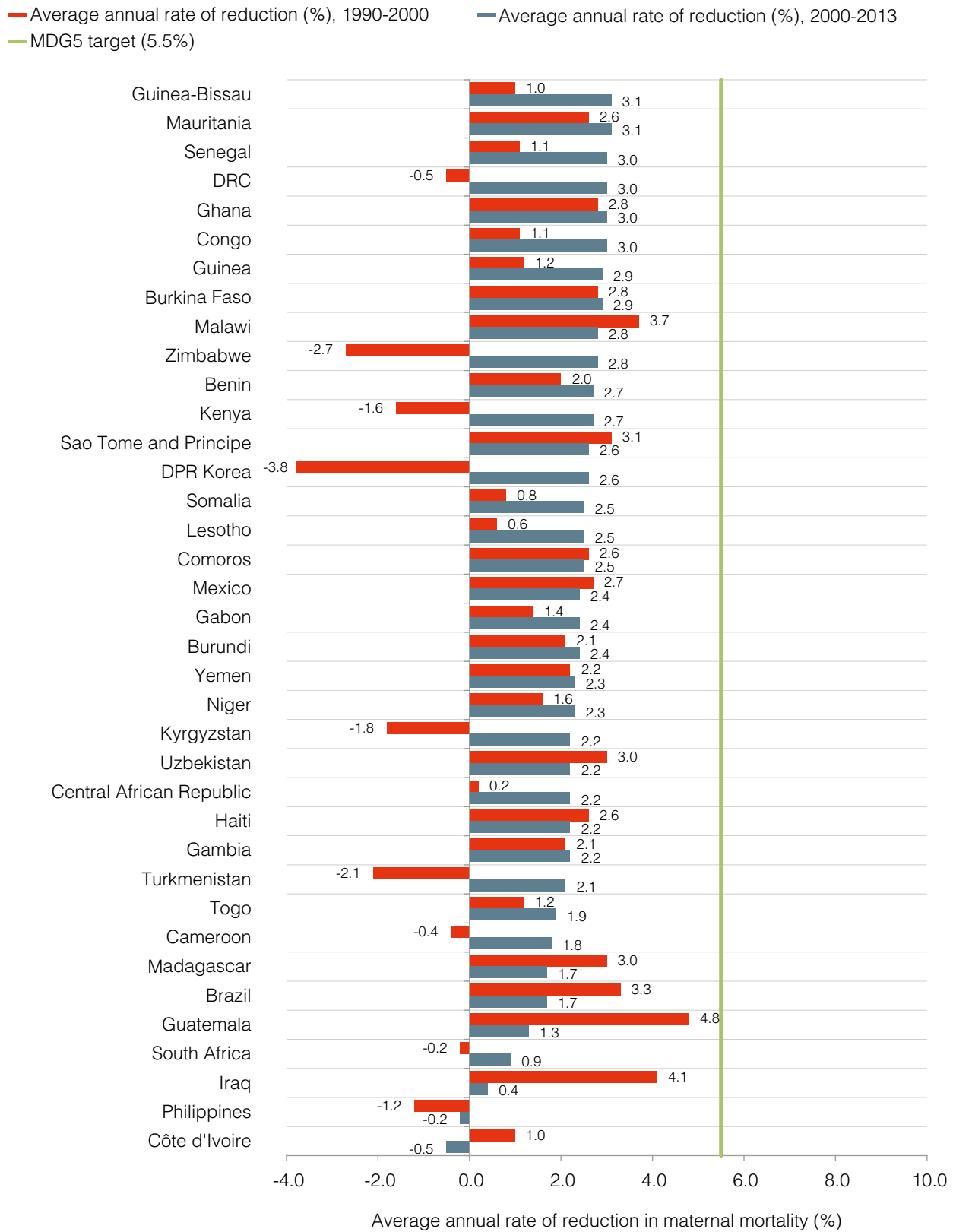
In summary, while China has made significant progress in improving maternal and child health, disparities remain among regions, between urban and rural areas, and by income level. To minimise these gaps and further improve the well-being of mothers and children, both society and government need to make a concerted effort to ensure that maternal and child health remains one of the country's top public health priorities.

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Figure 4. Trends in maternal mortality in the 75 iERG countries, by average annual rate of reduction, 2000-2013





The goal for MDG5 was for countries to achieve a 5.5% average annual rate of reduction (AAR) in maternal mortality. In most iERG countries, the AAR for maternal mortality was faster in the years after 2000. However, in 19 countries, the AAR for maternal mortality was faster during the period from 1990-2000 compared to 2000-2012.

Source: Maternal Mortality Estimate Inter-agency Group, 2014. Figure adapted from "Fulfilling the Health Agenda for Women and Children: The 2014 Report," Countdown to 2015.

Table 3. MMR, number of maternal deaths, and annualised rates of change, for 75 iERG countries (with 95% CI)

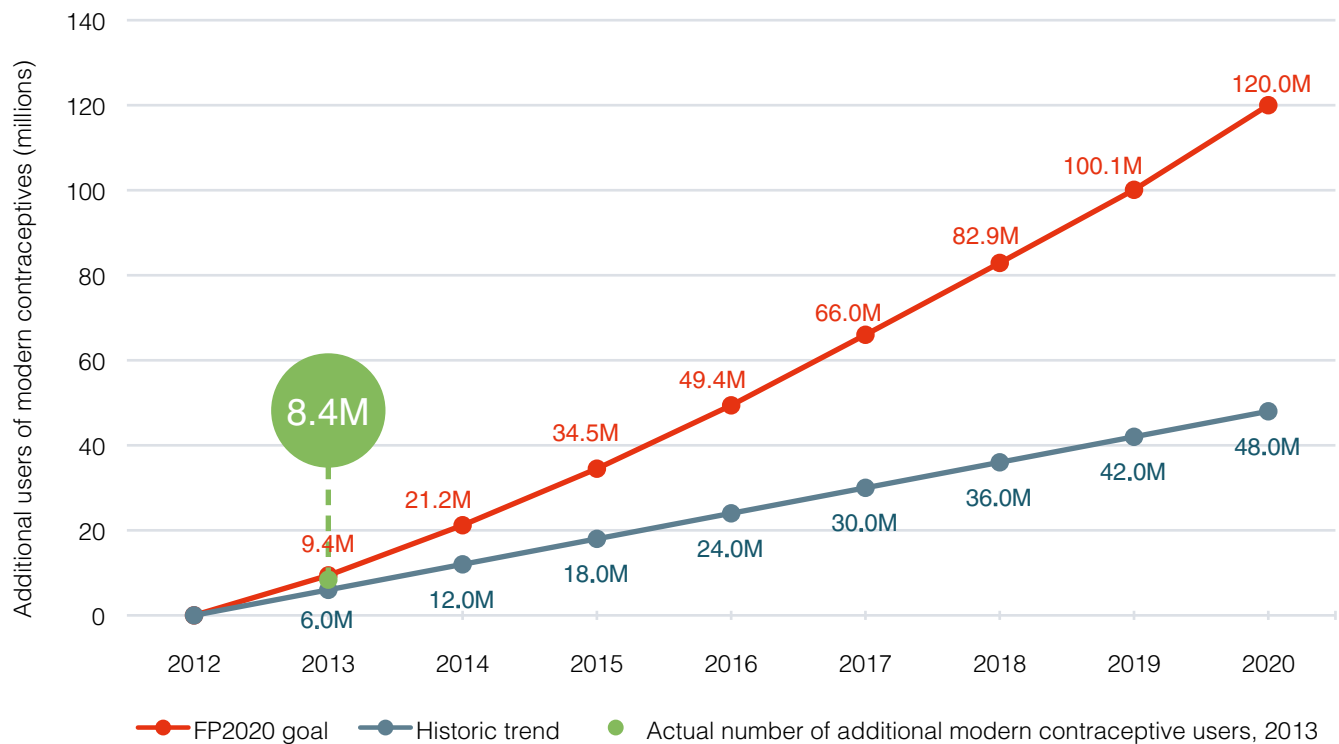
	Maternal mortality ratio (per 100 000 livebirths)			Number of maternal deaths			Annualised rate of change in MMR (%)		
	1990	2003	2013	1990	2003	2013	1990– 2003	2003– 2013	1990– 2013
AFRO									
Angola	510.6 (324.9 to 747.3)	451.1 (308.9 to 657.8)	310.1 (198.3 to 472.2)	2976 (1894 to 4356)	3672 (2515 to 5355)	3032 (1939 to 4618)	-0.9 (-3.7 to 1.8)	-3.8 (-7.1 to -0.5)	-2.2 (-4.0 to -0.0)
Benin	523.5 (418.4 to 619.6)	415.8 (311.4 to 522.8)	328.6 (229.2 to 441.3)	1259 (1006 to 1490)	1347 (1009 to 1694)	1246 (869 to 1674)	-1.8 (-4.1 to 0.5)	-2.4 (-5.2 to 0.2)	-2.1 (-3.6 to -0.6)
Botswana	205.8 (101.3 to 325.6)	1061.1 (523.3 to 1793.6)	480.8 (211.8 to 828.4)	95 (47 to 151)	504 (249 to 852)	228 (100 to 393)	12.6 (6.9 to 18.0)	-8.1 (-12.5 to -3.7)	3.6 (-0.1 to 6.7)
Burkina Faso	301.5 (224.9 to 383.1)	409.2 (307.2 to 517.5)	310.5 (223.1 to 406.2)	1325 (989 to 1684)	2443 (1834 to 3090)	2185 (1570 to 2858)	2.3 (0.1 to 4.6)	-2.8 (-6.1 to 0.3)	0.1 (-1.5 to 1.6)
Burundi	757.1 (560.5 to 977.3)	712.3 (538.5 to 899.9)	370.8 (240.4 to 504.3)	2122 (1571 to 2739)	2240 (1693 to 2830)	1683 (1091 to 2289)	-0.5 (-3.0 to 1.9)	-6.6 (-10.2 to -3.7)	-3.1 (-5.1 to -1.4)
Cameroon	436.4 (351.7 to 510.0)	614.4 (472.3 to 789.3)	564.6 (414.0 to 743.6)	2451 (1975 to 2865)	4476 (3441 to 5750)	4772 (3499 to 6285)	2.6 (0.5 to 5.0)	-0.9 (-3.4 to 1.4)	1.1 (-0.4 to 2.6)
Central African Republic	788.7 (576.4 to 1020.1)	999.4 (636.2 to 1415.6)	910.5 (578.3 to 1293.2)	973 (711 to 1258)	1473 (937 to 2086)	1459 (926 to 2072)	1.8 (-0.7 to 3.9)	-0.9 (-3.8 to 1.7)	0.6 (-1.0 to 2.0)
Chad	429.8 (352.9 to 510.2)	659.2 (506.9 to 808.4)	597.6 (408.4 to 809.5)	1424 (1170 to 1691)	3245 (2496 to 3980)	3593 (2456 to 4868)	3.3 (1.3 to 5.3)	-1.1 (-3.8 to 1.3)	1.4 (-0.3 to 2.9)
Comoros	527.4 (319.7 – 830.5)	383.0 (219.8 – 646.7)	329.2 (171.9 – 584.5)	82 (50 – 130)	88 (50 – 148)	85 (45 – 152)	-2.5 (-6.0 to 1.1)	-1.7 (-6.6 to 2.6)	-2.2 (-4.9 to 0.7)
Congo	397.2 (275.6 to 545.1)	482.8 (322.1 to 673.7)	287.3 (189.6 to 427.1)	379 (263 to 519)	678 (452 to 946)	494 (326 to 735)	1.5 (-1.1 to 3.9)	-5.2 (-8.5 to -2.0)	-1.4 (-3.4 to 0.4)
Côte d'Ivoire	496.9 (374.7 to 606.4)	729.8 (521.8 to 968.7)	501.5 (354.3 to 653.9)	2539 (1915 to 3099)	4771 (3411 to 6333)	3824 (2702 to 4987)	2.9 (0.5 to 5.2)	-3.7 (-6.8 to -0.9)	0.0 (-1.4 to 1.3)
DRC	420.1 (323.5 to 521.5)	369.5 (295.0 to 451.4)	342.3 (251.4 to 446.7)	7616 (5865 to 9455)	9069 (7241 to 11 081)	10 125 (7437 to 13 213)	-1.0 (-3.1 to 1.3)	-0.8 (-3.7 to 1.8)	-0.9 (-2.6 to 0.7)
Equatorial Guinea	599.9 (376.2 to 897.0)	487.3 (280.4 to 736.7)	369.6 (199.8 to 620.0)	109 (68 to 163)	110 (63 to 166)	100 (54 to 168)	-1.6 (-5.4 to 2.3)	-2.9 (-6.9 to 1.4)	-2.2 (-4.9 to 0.9)
Eritrea	614.2 (493.7 to 747.0)	679.9 (475.9 to 902.1)	566.0 (351.2 to 817.7)	949 (763 to 1154)	1241 (868 to 1646)	1313 (814 to 1896)	0.7 (-1.8 to 3.1)	-1.9 (-5.1 to 0.9)	-0.4 (-2.3 to 1.3)
Ethiopia	708.0 (600.4 to 815.0)	657.8 (486.3 to 839.6)	497.4 (371.5 to 648.8)	16 740 (14 197 to 19 271)	18 941 (14 001 to 24 173)	15 234 (11 378 to 19 871)	-0.6 (-3.1 to 1.4)	-2.8 (-5.2 to -0.2)	-1.6 (-2.8 to -0.3)
Gabon	345.7 (265.2 to 438.6)	413.0 (301.0 to 541.8)	267.3 (184.1 to 370.3)	126 (96 to 159)	189 (138 to 248)	144 (99 to 199)	1.3 (-1.3 to 4.0)	-4.4 (-7.9 to -1.3)	-1.2 (-2.9 to 0.6)
Gambia	444.4 (230.1 to 685.5)	368.2 (191.4 to 580.8)	264.5 (135.5 to 434.7)	205 (106 to 316)	232 (121 to 366)	216 (111 to 356)	-1.4 (-5.0 to 2.4)	-3.3 (-6.9 to 0.6)	-2.2 (-5.0 to 0.6)
Ghana	374.3 (247.7 to 528.1)	418.1 (309.6 to 532.9)	293.4 (193.5 to 410.4)	2143 (1418 to 3024)	2933 (2172 to 3739)	2343 (1545 to 3277)	0.9 (-2.6 to 4.7)	-3.6 (-7.3 to -0.3)	-1.1 (-3.6 to 1.4)
Guinea	660.4 (564.4 to 768.8)	676.3 (542.1 to 811.8)	615.4 (470.5 to 781.9)	1966 (1680 to 2289)	2642 (2118 to 3171)	2720 (2080 to 3457)	0.2 (-1.7 to 1.8)	-1.0 (-3.1 to 1.0)	-0.3 (-1.6 to 0.9)

	Maternal mortality ratio (per 100 000 livebirths)			Number of maternal deaths			Annualised rate of change in MMR (%)		
	1990	2003	2013	1990	2003	2013	1990– 2003	2003– 2013	1990– 2013
Guinea-Bissau	708.1 (417.3 to 1052.9)	837.7 (573.6 to 1154.5)	885.3 (616.5 to 1230.2)	334 (197 to 497)	478 (327 to 659)	576 (401 to 800)	1.4 (-1.6 to 4.5)	0.6 (-2.3 to 3.5)	1.0 (-1.0 to 3.0)
Kenya	315.5 (250.1 to 382.2)	559.2 (375.0 to 773.0)	277.2 (175.4 to 414.1)	3047 (2416 to 3692)	7628 (5115 to 10 543)	4361 (2759 to 6514)	4.3 (1.3 to 7.4)	-7.1 (-10.8 to -3.9)	-0.6 (-2.6 to 1.4)
Lesotho	189.5 (130.9 to 255.2)	606.5 (419.2 to 849.2)	510.6 (303.5 to 772.7)	107 (74 to 144)	343 (237 to 480)	295 (175 to 446)	8.9 (5.5 to 12.7)	-1.8 (-5.1 to 1.5)	4.3 (1.9 to 6.6)
Liberia	630.1 (487.9 to 782.0)	779.5 (605.3 to 962.1)	627.3 (467.5 to 793.2)	624 (483 to 775)	1038 (806 to 1281)	974 (726 to 1232)	1.6 (-0.8 to 4.1)	-2.2 (-4.6 to 0.1)	-0.0 (-1.6 to 1.4)
Madagascar	314.0 (246.9 to 375.5)	378.0 (255.9 to 480.7)	297.7 (174.3 to 448.6)	1723 (1355 to 2061)	2610 (1766 to 3319)	2455 (1438 to 3699)	1.4 (-1.0 to 3.4)	-2.6 (-6.4 to 1.6)	-0.3 (-2.3 to 1.5)
Malawi	550.3 (440.5 to 669.6)	815.3 (567.4 to 1111.1)	334.7 (224.5 to 465.1)	2627 (2103 to 3197)	4542 (3161 to 6189)	2260 (1516 to 3140)	3.0 (0.7 to 5.3)	-8.9 (-12.5 to -6.1)	-2.2 (-3.8 to -0.6)
Mali	573.0 (500.0 to 649.8)	506.7 (415.9 to 603.8)	388.3 (300.6 to 487.3)	2326 (2030 to 2638)	2936 (2410 to 3499)	2966 (2295 to 3722)	-1.0 (-2.5 to 0.7)	-2.7 (-5.0 to -0.5)	-1.7 (-2.9 to -0.5)
Mauritania	680.6 (585.6 to 789.8)	681.0 (501.2 to 856.1)	568.8 (363.6 to 793.6)	580 (499 to 673)	772 (568 to 971)	761 (487 to 1062)	-0.0 (-2.4 to 1.8)	-1.9 (-4.6 to 0.6)	-0.8 (-2.7 to 0.7)
Mozambique	363.4 (262.6 to 463.2)	250.0 (184.3 to 322.0)	248.7 (151.4 to 365.4)	2190 (1583 to 2791)	2339 (1724 to 3012)	2574 (1567 to 3783)	-2.9 (-5.7 to 0.2)	-0.2 (-3.9 to 3.0)	-1.7 (-4.0 to 0.5)
Niger	481.0 (394.4 to 567.6)	427.3 (348.3 to 523.0)	406.5 (308.2 to 505.0)	2217 (1818 to 2616)	2920 (2379 to 3573)	3873 (2936 to 4811)	-0.9 (-2.7 to 0.9)	-0.5 (-2.9 to 1.7)	-0.7 (-2.1 to 0.5)
Nigeria	483.2 (359.9 to 608.4)	585.7 (445.6 to 717.8)	496.4 (335.9 to 666.2)	21 233 (15 814 to 26 737)	34 810 (26 480 to 42 656)	36 698 (24 829 to 49 252)	1.5 (-1.2 to 4.0)	-1.7 (-4.4 to 0.9)	0.1 (-1.8 to 1.9)
Rwanda	656.1 (528.6 to 791.5)	612.6 (477.4 to 766.5)	291.0 (189.9 to 400.7)	2021 (1628 to 2438)	2142 (1669 to 2680)	1185 (773 to 1631)	-0.5 (-2.6 to 1.6)	-7.6 (-11.6 to -4.0)	-3.6 (-5.6 to -1.9)
Sao Tome and Principe	297.5 (211.4 to 395.6)	195.7 (133.1 to 251.6)	134.9 (65.2 to 208.6)	13 (9 to 18)	11 (8 to 14)	9 (4 to 14)	-3.2 (-6.6 to -0.1)	-4.0 (-9.5 to 0.9)	-3.6 (-6.5 to -1.0)
Senegal	518.8 (441.9 to 601.7)	462.2 (366.1 to 557.3)	347.2 (249.2 to 455.2)	1727 (1471 to 2003)	2018 (1598 to 2433)	1881 (1350 to 2466)	-0.9 (-2.9 to 0.9)	-2.9 (-5.5 to -0.5)	-1.8 (-3.2 to -0.5)
Sierra Leone	521.4 (383.9 to 668.2)	665.1 (535.3 to 795.8)	622.6 (447.9 to 790.5)	943 (694 to 1209)	1360 (1095 to 1627)	1399 (1006 to 1776)	1.9 (-0.6 to 4.3)	-0.7 (-3.4 to 1.6)	0.8 (-1.0 to 2.3)
South Africa	134.0 (93.3 to 175.2)	341.8 (227.8 to 481.0)	174.1 (96.3 to 274.9)	1403 (977 to 1835)	3739 (2492 to 5262)	1925 (1065 to 3041)	7.2 (3.3 to 11.1)	-6.9 (-11.1 to -2.7)	1.0 (-1.6 to 3.8)
South Sudan	763.8 (432.8 to 1129.7)	872.9 (602.8 to 1172.3)	956.8 (685.1 to 1262.8)	2138 (1211 to 3162)	2718 (1877 to 3650)	3912 (2801 to 5163)	1.2 (-2.3 to 4.9)	0.9 (-2.5 to 4.8)	1.1 (-1.2 to 3.8)
Swaziland	111.2 (78.1 to 151.1)	272.9 (191.9 to 385.2)	148.5 (91.1 to 229.1)	41 (29 to 56)	97 (68 to 137)	55 (34 to 85)	6.9 (3.2 to 10.5)	-6.2 (-10.1 to -2.2)	1.2 (-1.3 to 3.6)
Togo	496.7 (407.1 to 603.8)	477.4 (332.4 to 644.0)	326.2 (210.7 to 473.0)	807 (662 to 981)	1001 (697 to 1350)	817 (528 to 1185)	-0.4 (-3.1 to 2.2)	-3.9 (-7.4 to -0.4)	-1.9 (-3.8 to -0.1)
Uganda	296.3 (215.6 to 392.4)	461.5 (319.6 to 615.9)	324.9 (213.8 to 450.2)	2800 (2037 to 3708)	6159 (4265 to 8219)	5385 (3544 to 7461)	3.4 (1.0 to 5.9)	-3.5 (-6.6 to -0.6)	0.4 (-1.4 to 2.2)

	Maternal mortality ratio (per 100 000 livebirths)			Number of maternal deaths			Annualised rate of change in MMR (%)		
	1990	2003	2013	1990	2003	2013	1990– 2003	2003– 2013	1990– 2013
United Rep. of Tanzania	498.0 (399.2 to 593.4)	622.9 (449.6 to 812.0)	389.6 (266.5 to 548.7)	5814 (4661 to 6929)	10 148 (7324 to 13 228)	7745 (5298 to 10 908)	1.7 (-0.7 to 3.9)	-4.7 (-7.9 to -1.7)	-1.1 (-2.7 to 0.4)
Zambia	354.6 (256.2 to 464.3)	475.1 (301.7 to 697.1)	315.1 (206.7 to 459.3)	1283 (927 to 1679)	2435 (1547 to 3574)	2044 (1341 to 2980)	2.2 (-0.5 to 4.5)	-4.1 (-7.3 to -0.7)	-0.6 (-2.1 to 1.0)
Zimbabwe	185.8 (143.8 to 232.9)	840.9 (490.4 to 1238.2)	520.7 (313.5 to 786.2)	719 (556 to 901)	3539 (2064 to 5212)	2306 (1388 to 3481)	11.5 (8.3 to 14.4)	-4.8 (-8.3 to -1.4)	4.4 (2.6 to 6.3)
EMRO									
Afghanistan	501.0 (324.4 to 739.0)	716.3 (441.3 to 1123.4)	885.0 (508.7 to 1445.1)	3261 (2112 to 4811)	7726 (4760 to 12 117)	8794 (5055 to 14 360)	2.7 (-0.6 to 5.8)	2.1 (-1.8 to 5.4)	2.4 (0.1 to 4.7)
Djibouti	526.3 (334.8 to 788.7)	629.3 (405.3 to 962.4)	523.5 (329.8 to 821.8)	124 (79 to 186)	138 (89 to 211)	123 (77 to 193)	1.4 (-1.9 to 4.6)	-1.9 (-5.2 to 1.5)	-0.0 (-2.2 to 2.2)
Egypt	83.7 (69.9 to 100.1)	44.8 (39.1 to 51.9)	32.6 (24.5 to 42.3)	1385 (1157 to 1656)	765 (668 to 888)	619 (465 to 803)	-4.8 (-6.5 to -3.0)	-3.2 (-6.2 to -0.3)	-4.1 (-5.5 to -2.8)
Iraq	110.6 (68.7 to 157.0)	88.0 (62.0 to 126.8)	65.8 (40.4 to 110.7)	736 (457 to 1045)	816 (574 to 1175)	695 (427 to 1170)	-1.7 (-5.6 to 2.5)	-3.1 (-8.1 to 2.3)	-2.3 (-4.8 to 0.7)
Morocco	279.5 (236.0 to 338.9)	98.3 (75.2 to 120.8)	63.9 (45.1 to 85.8)	1971 (1664 to 2390)	603 (462 to 741)	472 (334 to 635)	-8.1 (-10.2 to -6.0)	-4.4 (-7.5 to -1.3)	-6.5 (-8.1 to -5.0)
Pakistan	423.9 (317.2 to 521.6)	486.5 (360.7 to 595.6)	400.6 (233.0 to 560.8)	18 673 (13 973 to 22 976)	20 875 (15 477 to 25 557)	17 876 (10 397 to 25 026)	1.1 (-1.6 to 3.7)	-2.1 (-7.7 to 2.4)	-0.3 (-2.9 to 1.8)
Somalia	486.9 (276.2 to 766.6)	422.4 (264.4 to 706.2)	407.7 (247.4 to 684.2)	1574 (893 to 2479)	1673 (1047 to 2797)	1903 (1155 to 3194)	-1.1 (-4.2 to 1.9)	-0.4 (-3.5 to 2.9)	-0.8 (-2.8 to 1.6)
Sudan	407.8 (304.2 to 502.9)	356.5 (237.6 to 478.8)	275.2 (181.1 to 377.5)	3558 (2654 to 4388)	4193 (2794 to 5631)	3528 (2322 to 4840)	-1.1 (-3.5 to 1.1)	-2.6 (-5.4 to 0.2)	-1.8 (-3.3 to -0.2)
Yemen	342.6 (182.1 to 519.2)	322.2 (182.7 to 524.9)	308.8 (168.6 to 555.4)	2151 (1143 to 3260)	2172 (1232 to 3538)	2279 (1244 to 4099)	-0.5 (-3.5 to 2.7)	-0.5 (-3.8 to 3.3)	-0.5 (-2.8 to 2.2)
EURO									
Azerbaijan	42.4 (36.6 to 49.0)	37.3 (31.4 to 44.2)	23.9 (17.1 to 33.9)	84 (72 to 97)	57 (48 to 67)	40 (29 to 57)	-1.0 (-2.8 to 0.8)	-4.6 (-8.2 to -0.4)	-2.5 (-4.0 to -1.0)
Kyrgyzstan	62.5 (54.3 to 71.4)	58.3 (50.6 to 66.8)	46.8 (35.9 to 59.2)	84 (73 to 95)	66 (58 to 76)	69 (53 to 88)	-0.5 (-2.1 to 1.0)	-2.3 (-5.2 to 0.5)	-1.3 (-2.5 to -0.1)
Tajikistan	74.6 (65.3 to 86.4)	49.4 (42.2 to 57.8)	30.4 (22.2 to 39.3)	154 (135 to 178)	98 (84 to 115)	82 (60 to 106)	-3.2 (-4.9 to -1.6)	-4.9 (-8.2 to -1.9)	-3.9 (-5.4 to -2.7)
Turkmenistan	72.9 (63.2 to 83.1)	61.2 (41.1 to 83.7)	38.2 (22.9 to 55.5)	91 (79 to 103)	64 (43 to 88)	42 (25 to 61)	-1.4 (-4.6 to 1.3)	-4.8 (-9.7 to -0.1)	-2.9 (-5.0 to -1.1)
Uzbekistan	50.7 (45.4 to 56.8)	42.4 (36.6 to 48.9)	30.5 (21.0 to 42.6)	353 (315 to 395)	249 (215 to 287)	187 (129 to 262)	-1.4 (-2.8 to -0.1)	-3.4 (-6.8 to 0.4)	-2.3 (-3.9 to -0.7)
PAHO									
Bolivia	382.4 (312.1 to 458.1)	229.9 (178.7 to 281.9)	179.6 (110.4 to 257.2)	977 (798 to 1171)	616 (479 to 755)	499 (307 to 715)	-3.9 (-6.3 to -1.7)	-2.6 (-6.9 to 1.3)	-3.4 (-5.6 to -1.5)
Brazil	73.1 (65.0 to 82.0)	66.0 (58.4 to 73.7)	58.7 (45.8 to 73.5)	2609 (2320 to 2925)	2265 (2003 to 2530)	1813 (1414 to 2267)	-0.8 (-1.9 to 0.3)	-1.2 (-4.0 to 1.4)	-1.0 (-2.2 to 0.2)
Guatemala	112.8 (101.0 to 126.2)	91.8 (81.2 to 104.2)	86.7 (65.8 to 110.8)	409 (367 to 458)	400 (353 to 454)	423 (321 to 541)	-1.6 (-2.8 to -0.4)	-0.6 (-3.5 to 2.0)	-1.2 (-2.4 to -0.0)
Haiti	492.4 (363.4 to 619.7)	495.7 (351.1 to 662.0)	333.0 (219.1 to 480.1)	1290 (952 to 1624)	1289 (913 to 1722)	868 (571 to 1251)	0.0 (-2.0 to 2.1)	-4.0 (-7.2 to -1.0)	-1.7 (-3.2 to -0.1)
Mexico	73.8 (70.4 to 77.1)	57.9 (55.0 to 60.5)	54.0 (50.3 to 58.2)	1774 (1691 to 1851)	1429 (1357 to 1493)	1224 (1139 to 1320)	-1.9 (-2.3 to -1.5)	-0.7 (-1.5 to 0.1)	-1.4 (-1.7 to -1.0)

	Maternal mortality ratio (per 100 000 livebirths)			Number of maternal deaths			Annualised rate of change in MMR (%)		
	1990	2003	2013	1990	2003	2013	1990– 2003	2003– 2013	1990– 2013
Peru	131.5 (114.1 to 152.6)	75.7 (64.6 to 88.4)	63.7 (45.6 to 85.4)	842 (731 to 977)	468 (400 to 547)	383 (274 to 513)	-4.3 (-5.9 to -2.6)	-1.8 (-5.2 to 1.6)	-3.2 (-4.8 to -1.7)
SEARO									
Bangladesh	551.9 (436.4 to 659.5)	333.1 (250.9 to 427.6)	242.7 (171.2 to 326.9)	20 669 (16 345 to 24 701)	11 327 (8532 to 14 541)	7737 (5459 to 10 422)	-3.9 (-6.4 to -1.3)	-3.2 (-7.0 to 0.8)	-3.6 (-5.1 to -1.9)
DPR Korea	136.3 (70.2 to 226.7)	100.5 (67.8 to 144.1)	77.4 (48.3 to 111.9)	546 (281 to 908)	386 (260 to 554)	275 (172 to 398)	-2.2 (-6.5 to 2.5)	-2.6 (-7.4 to 2.5)	-2.4 (-5.6 to -1.1)
India	480.8 (384.9 to 583.6)	382.0 (315.3 to 472.8)	281.8 (207.0 to 371.2)	128 695 (103 026 to 156 193)	100 014 (82 553 to 123 801)	71 792 (52 723 to 94 564)	-1.8 (-4.0 to 0.6)	-3.1 (-6.6 to 0.3)	-2.3 (-3.9 to -0.8)
Indonesia	368.3 (311.6 to 432.9)	262.0 (224.3 to 308.2)	199.3 (149.4 to 257.4)	16 519 (13 975 to 19 416)	12 734 (10 902 to 14 982)	9352 (7010 to 12 079)	-2.6 (-4.2 to -1.0)	-2.8 (-6.1 to -0.0)	-2.7 (-4.3 to -1.4)
Myanmar	897.3 (513.3 to 1460.4)	645.6 (332.2 to 1145.2)	390.9 (196.3 to 731.7)	9465 (5414 to 15 405)	6108 (3144 to 10 835)	3531 (1773 to 6609)	-2.6 (-6.1 to 0.6)	-5.1 (-8.8 to -1.0)	-3.7 (-6.0 to -0.9)
Nepal	417.4 (295.9 to 540.8)	365.0 (262.6 to 464.3)	272.3 (190.9 to 363.5)	3012 (2136 to 3903)	2623 (1886 to 3336)	1588 (1113 to 2119)	-1.0 (-3.6 to 1.5)	-3.0 (-6.0 to -0.1)	-1.9 (-3.7 to 0.1)
WPRO									
Cambodia	355.9 (290.5 to 415.7)	399.0 (277.9 to 486.8)	220.9 (155.6 to 286.5)	1290 (1053 to 1507)	1355 (944 to 1654)	862 (607 to 1118)	0.8 (-1.8 to 2.8)	-5.9 (-9.3 to -2.9)	-2.1 (-3.6 to -0.6)
China	141.7 (114.4 to 170.8)	64.1 (58.2 to 70.1)	17.2 (14.0 to 20.3)	31 042 (25 074 to 37 428)	10 652 (9667 to 11 643)	3233 (2633 to 3815)	-6.1 (-7.8 to -4.3)	-13.2 (-15.2 to -11.1)	-9.2 (-10.4 to -7.8)
Lao PDR	514.4 (276.7 to 767.0)	490.7 (251.3 to 779.6)	303.8 (154.7 to 521.5)	942 (506 to 1404)	814 (417 to 1293)	543 (277 to 932)	-0.4 (-4.1 to 2.7)	-4.8 (-8.3 to -1.1)	-2.3 (-4.7 to 0.3)
Papua New Guinea	765.9 (456.7 to 1255.9)	702.6 (396.4 to 1197.8)	594.2 (312.7 to 1030.8)	1148 (684 to 1882)	1382 (779 to 2355)	1260 (663 to 2187)	-0.7 (-3.8 to 2.4)	-1.7 (-5.4 to 2.3)	-1.1 (-3.6 to 1.5)
Philippines	116.3 (103.4 to 130.2)	81.5 (72.0 to 91.5)	80.9 (54.9 to 115.0)	2374 (2112 to 2658)	1876 (1657 to 2105)	1959 (1328 to 2784)	-2.7 (-3.9 to -1.5)	-0.2 (-4.3 to 3.5)	-1.6 (-3.3 to -0.1)
Solomon Islands	254.0 (127.4 to 454.4)	214.5 (112.5 to 379.3)	183.0 (95.9 to 338.5)	32 (16 to 56)	34 (18 to 60)	32 (17 to 59)	-1.3 (-5.2 to 2.7)	-1.6 (-6.0 to 3.2)	-1.4 (-4.5 to 1.6)
Viet Nam	174.5 (124.5 to 239.1)	88.5 (59.4 to 122.0)	56.6 (34.1 to 89.5)	3275 (2337 to 4487)	1281 (860 to 1766)	800 (482 to 1265)	-5.2 (-8.3 to -2.2)	-4.6 (-9.1 to 0.0)	-5.0 (-7.5 to -2.3)

Source: Kassebaum et al., 2014. Global, regional, and national levels and causes of maternal mortality during 1990–2013, Global Burden of Disease Study 2013. *Lancet*.

Figure 6. Global contraceptive users: FP2020 goal vs. historic trend

In the 69 FP2020 focus countries, 8.4 million more women and girls used modern methods of contraception in 2013 as compared to 2012. This falls below the 2013 benchmark goal of 9.4 million, and above what was projected from historical growth patterns (6.0 million). About half of the additional users stemmed from increases in contraceptive prevalence, and the other half can be attributed to an increase in the number of women of reproductive age.

Source: Brown et al, 2014. Developing the '120 by 2020' Goal for the Global FP2020 initiative. *Stud Fam Plann*. Figure adapted from "2015 Report to the independent Expert Review Group," FP2020.

14. The iERG commissioned Professor Cesar Victora (University of Pelotas, Brazil) to examine socioeconomic, gender, and urban/rural inequalities for women's and children's health. His full findings are reported in Annex 3. The key findings from this equity analysis are:

- Pro-rich inequalities are observed for all indicators, except for breastfeeding.
- The widest gaps are seen for skilled birth attendance.
- Postnatal care coverage is especially low across all quintiles.
- Pro-urban inequalities are seen for all indicators, except for exclusive breastfeeding.
- Boys and girls show similar coverage levels for postnatal care, exclusive breastfeeding, DPT3 vaccine, and pneumonia care seeking.
- For family planning, there are consistent pro-rich coverage patterns.
- Inequalities are largest in Africa.
- Adolescents have a much greater unmet need for contraception.
- For antenatal care, in every region there are pro-rich coverage patterns.

- At the global level, there are important inequalities in total fertility: ranging from 2.8 children/woman in the richest quintile to 5.4 in the poorest quintile.
- At the global level, the average number of children per urban woman is 3.1, compared with 4.6 among rural women.
- In all regions, fertility and stunting are inversely related to wealth.

Issues of equity received insufficient attention during the era of the MDGs, as these findings starkly and shockingly indicate. Although equity is frequently discussed, it is seldom prioritised in policies and programmes. Post-2015, whatever mechanism for accountability is chosen for women, children, and adolescents, equity must be made a supreme priority. UNICEF has put equity-focused programming at the heart of its recent work on reducing child mortality, to its enormous credit and largely thanks to the personal leadership of its Executive Director, Anthony Lake. As Lake wrote in UNICEF's analysis of equity in the MDGs, "If development is to be truly sustainable, it must be truly equitable—and seek to reach every child. For children who have equal

opportunities will in turn create greater opportunities for their own children and the generations that follow” (16b).

15. As already discussed, the promise of 16 million lives saved by *Every Woman, Every Child* has not been delivered. In retrospect, these projections may have been far too high. According to the Progress Report on the Global Strategy, the actual figure of deaths averted was 2.4 million. The iERG commissioned its own analysis of global lives saved from 2008 to 2015 from Professor Ole Norheim. He calculated that during this period globally, some 6.3 million under-5 child deaths were averted, and 214 000 maternal

deaths were averted. These figures show far fewer deaths averted globally than had been projected for just the 49 focus countries of the Global Strategy, underscoring the excessive hopefulness of those early estimates. However, we would be unfair if we did not acknowledge the tremendous efforts of the *Every Woman, Every Child* team. As Nana Taona Kuo (Senior Manager of *Every Woman, Every Child*, in the Executive Office of the UN Secretary-General) wrote in her submission to the iERG, “Maternal and child mortality is falling faster than at any time in history. Each day 17 000 more children survive, and the number of maternal deaths has been reduced by almost half than in 1990.”

Panel 3. Life-saving commodities

Commodity by life stage	Examples of key barriers	Recommendations	Potential 5-year impact
Maternal health commodities			
1. Oxytocin – post-partum haemorrhage (PPH)	Often poor quality	1, 4, 5	15 000 maternal lives saved
2. Misoprostol – post-partum haemorrhage	Often not included in national essential medicine lists	5	
3. Magnesium sulfate – eclampsia and severe pre-eclampsia	Lack of demand by health workers	1, 9, 10		55 000 maternal lives saved
Newborn health commodities			
4. Injectable antibiotics – newborn sepsis	Poor compliance by health workers	1, 9, 10	1.22 million neonatal lives saved
5. Antenatal corticosteroids (ANCs) – preterm respiratory distress syndrome	Low awareness of product and impact	9	466 000 neonatal lives saved
6. Chlorhexidine – newborn cord care	Limited awareness and demand	2, 5	422 000 neonatal lives saved
7. Resuscitation devices – newborn asphyxia	Requires trained health workers	1, 9, 10	336 000 neonatal lives saved
Child health commodities			
8. Amoxicillin – pneumonia	Limited availability of child-friendly product	2, 7, 9, 10	1.56 million lives saved
9. Oral rehydration salts (ORS) – diarrhoea	Poor understanding of products by mothers/ caregivers	2, 5, 7, 9, 10	1.89 million lives saved
10. Zinc – diarrhoea			
Reproductive health commodities			
11. Female condoms	Low awareness among women and health workers	1, 7	Almost 230 000 maternal deaths averted
12. Contraceptive implants – family planning/contraception	High cost	1, 7	
13. Emergency contraception – family planning/contraception	Low awareness among women	2, 7	

16. The iERG has been tasked with reporting on progress in delivering the recommendations from the UN Commission on Life-Saving Commodities for Women and Children (UNCoLSC). 13 underused, low-cost, and high-impact commodities are shown in Panel 3. The 10 recommendations of the Commission are shown in Panel 4. In its submission to the iERG, the UNCoLSC team provided a comprehensive appraisal of progress, with an emphasis on activities between January, 2014, and April, 2015. Here are its key findings:

- Multi-country assessments have revealed major bottlenecks to expanding access to key commodities. Newborn and reproductive health commodities are doing especially badly. Specific gaps include: misaligned essential medicines lists, commodity registration, and treatment guidelines; challenges in assuring the quantity and quality of medicines; supply chain issues; and health worker performance.
- Global Technical Resource Teams have made several advances: all life-saving commodities are now included on the WHO Essential Medicines List; 23 countries are part of an accelerated registration process for pre-qualified products; the number of prequalified products has been expanded; chlorhexidine manufacturing has been enhanced; amoxicillin procurement has improved; quality assurance procedures have been strengthened (eg,

in Ghana); supply chain optimisation is underway in countries; demand-generation toolkits have been finalised and are being disseminated; and training materials have been upgraded.

- The RMNCH country engagement process has been expanded, with investments in supply chains, health worker training, and improved guidelines.
- As the life of the Commission comes to an end, a “lessons learned” process has been undertaken. There is a great deal of “unfinished business” to carry forward into the post-2015 SDG era—notably, around global market shaping, quality assurance for commodities, procurement and supply chain management, standardised monitoring platforms, and knowledge transfer into countries.

Although the iERG has not received submissions advocating for particular commodities, we were grateful to the Universal Access to Female Condoms Joint Programme for submitting a business case for female condoms to the iERG. Their submission made clear that female condoms are the only woman-initiated, dual STI/HIV and pregnancy protection method available today. The evidence for the return on investment, cost effectiveness, and wider economic advantages is powerfully set out. Female condoms are one of the life-saving commodities identified by the UN Commission. It is the one intervention that provides women with control over safer sex, their health, and the health of their families.



Panel 4. Recommendations of the UN Commission on Life-Saving Commodities for Women's and Children's Health

Improved markets:

- 1. Shaping global markets:** By 2013, effective global mechanisms such as pooled procurement and aggregated demand are in place to increase the availability of quality, life-saving commodities at an optimal price and volume.
- 2. Shaping local delivery markets:** By 2014, local health providers and private sector actors in all *Every Woman Every Child* countries are incentivized to increase production, distribution, and appropriate promotion of the 13 commodities.
- 3. Innovative financing:** By the end of 2013, innovative, results-based financing is in place to rapidly increase access to the 13 commodities by those most in need and foster innovations.
- 4. Quality strengthening:** By 2015, at least three manufacturers per commodity are manufacturing and marketing quality-certified and affordable products.
- 5. Regulatory efficiency:** By 2015, all *Every Woman Every Child* countries have standardized and streamlined their registration requirements and assessment processes for the 13 life-saving commodities with support from stringent regulatory authorities, the WHO, and regional collaboration.

Improved national delivery:




- 6. Supply and awareness:** By 2015, all *Every Woman Every Child* countries have improved the supply of life-saving commodities and build on information and communication technology (ICT) best practices for making these improvements.
- 7. Demand and utilization:** By 2014, all *Every Woman Every Child* countries in conjunction with the private sector and civil society have developed plans to implement at scale appropriate interventions to increase demand for and utilization of health services and products, particularly among under-served populations.
- 8. Reaching women and children:** By 2014, all *Every Woman Every Child* countries are addressing financial barriers to ensure the poorest members of society have access to the life-saving commodities.
- 9. Performance and accountability:** By the end of 2013, all *Every Woman Every Child* countries have proven mechanisms such as checklists in place to ensure that health-care providers are knowledgeable about the latest national guidelines.



Improved integration of private sector and consumer needs:

- 10. Product innovation:** By 2014, research and development for improved life-saving commodities has been prioritised, funded, and commenced.

Table 4. Progress towards national newborn health plans in those iERG countries with the highest newborn mortality rate and/or burden of neonatal deaths

Country	Newborn deaths (2013)	Newborn mortality rate (2013)	National Newborn Plan	Newborn component strengthened in RMNCH plan	National plan costed	Neonatal mortality rate target	Stillbirth rate target
Angola	42,700	47					
Bangladesh	76,800	24	✓		✓	✓	✓
Central African Republic	6,700	43					
Chad	22,600	40		✓	✓		
China	143,300	8	○		○		
DRC	104,700	38		✓	✓	✓	
Ethiopia	84,500	28		○	○	¢	
Guinea-Bissau	2,700	44	○				
India	747,600	29	✓		○	✓	✓
Indonesia	65,900	14	✓		○	✓	✓
Kenya	39,600	26	✓		○	✓	
Lesotho	2,600	44		○	○	✓	
Mali	27,800	40		✓			
Nigeria	261,600	37	○			○	
Pakistan	193,800	42	○		○	✓	
Sierra Leone	9,500	44	○				
Somalia	20,800	46					
Zimbabwe	17,400	39	○			✓	

 Countries with the highest number of newborn deaths
 Countries with the highest newborn mortality rate
 Included in both categories

 indicates completed
 indicates in progress

Source: UNICEF, 2014. State of the World's Children 2015. Progress data tracked through specific outreach with UNICEF regional and country offices. Table adapted from "Every Newborn Action Plan: Progress Report," 2015.

17. In 2014, WHO and UNICEF launched their ambitious Every Newborn Action Plan (17). The vision was "a world in which there are no preventable deaths of newborns or stillbirths, where every pregnancy is wanted, every birth celebrated, and women, babies, and children survive, thrive, and reach their full potential." The two goals of the Action Plan were, first, to end preventable newborn deaths, and, second, to end preventable stillbirths. The deadline for these goals was set at 2035. Strategic objectives included: strengthening and investing in care during labour, birth, and the first day and week of life; improving the quality of maternal and newborn care; reaching every woman and newborn to reduce inequities; harnessing the power of parents, families, and communities; and counting every newborn through measurement, programme tracking, and accountability. The Action Plan was adopted by the World Health Assembly in May, 2014, and launched in South Africa in June, 2014. But in a submission to the iERG, Save the Children,

which has been a tireless advocate for newborn health, signalled warnings that the Plan has several critical weaknesses. For example, the Plan underplays the importance of skilled birth attendants, its message on empowering women is absent, and it does not include an accountability mechanism. In May, 2015, WHO reported progress on implementing its Plan, claiming remarkable and rapid progress. Innovative partnerships have advanced country efforts. Over 50 new commitments to newborn health have been made. Countries have led progress by developing stand-alone action plans or by incorporating Every Newborn recommendations into existing plans (see Table 4). The Every Newborn team argued that, "Ending preventable deaths for mothers and newborns is within reach." The iERG certainly welcomes these formidable claims of success. The proof will be seen in accelerated declines in newborn deaths, which are yet to be documented.

18. Vaccines are a critical component of efforts to reduce child mortality. The Global Vaccine Action Plan was endorsed by the World Health Assembly in 2012. Its goal is to deliver vaccination to all. But in 2015, the Strategic Advisory Group of Experts on Immunisation (SAGE) concluded that “progress is far off-track.” SAGE identified five priority problems—weak implementation of the action plan; poor data quality and use; vaccine affordability and supply; failures of basic integration; and situations disrupting immunisation. By contrast, Gavi, the Vaccine Alliance, boasts success. Gavi supports 73 low-income countries with a gross national income per capita below or equal to US\$1580. Since 2000, Gavi estimates that it has reached an additional 500 million children with vaccines, preventing 7 million future deaths. Since 2011, Gavi has pursued four goals: to accelerate uptake and use of vaccines; to strengthen health systems; to improve the predictability and sustainability of financing for vaccination; and to shape vaccine markets. Gavi has supported over 140 vaccine introductions and campaigns since 2011. It will support 100 more in 2015. By the end of 2015, 3.9 million deaths will have been averted since 2011. While targets have been surpassed, ensuring high coverage of vaccination remains a challenge. Poor preparedness, vaccine supply constraints, lack of funding, weak human resource capacities, and insufficient community engagement have all played a part. Health systems strengthening is an important part of Gavi’s work too—78 grants for health system strengthening are currently active in 66 countries. 2015 is a transition year for Gavi, with its 2011-15 strategy closing, and a new 2016-20 plan awaiting. January, 2015, saw Gavi secure US\$7.5 billion in new pledges, making the Alliance well prepared for the SDG era. From 2016-20, Gavi aims to avert 5-6 million future deaths, emphasising enhanced coverage, equity, and sustainability.

19. 2014 saw the publication of the first Global Nutrition Report by the Independent Expert Group (18). In the run-up to a new era of sustainable development, its findings were a warning.

- Improving people’s nutritional status is essential to attaining sustainable development.
- Malnutrition affects nearly every country.
- The world is not on course to meet global nutrition targets set by the World Health Assembly.
- However, many countries are making good progress in improving nutrition outcomes.
- More challenging targets for nutrition could be set.
- The face of malnutrition is changing—from stunting and anaemia to overweight.
- Coverage of nutrition-specific interventions is low.

- Determinants of nutrition status (eg, food supply, clean water, education, and health care) are improving.
- Opportunities exist to expand resources to nutrition-sensitive programmes.
- Countries cannot currently track their financial commitments to nutrition.
- Policies, laws, and institutions are important for scaling up nutrition.
- Reporting on the 2013 Nutrition for Growth commitments was challenging.
- Nutrition accountability can and must be built.
- There are many gaps in data on nutrition outcomes, programmes, and resources.



This first report demonstrates well the value of independent accountability in global health. The test will be translation of this independent review process into actions. It is not yet clear how review will become remedy.

20. One of the most ambitious goals in child health has been the Global Plan towards the Elimination of New HIV Infections among Children and Keeping their Mothers Alive. The objective of this plan is in its title. UNAIDS submitted a preliminary report to the iERG describing progress towards these goals. 2009 is the base year by which success is being measured. In 2009, 15.7 million women over age 15 lived with HIV, of whom 1.4 million became pregnant. 90% of these mothers were from 22 countries. All 22 countries (except one, Namibia) are within the iERG’s remit of concern. The specific global targets are:

- Reduce the number of new HIV infections among children by 90%.
- Reduce the number of AIDS-related maternal and paediatric deaths by 50%.

For the first time since the 1990s, the number of new HIV infections among children in 21 priority countries (data for India were unavailable) fell below 200 000 in 2013, a 43% decline since 2009.

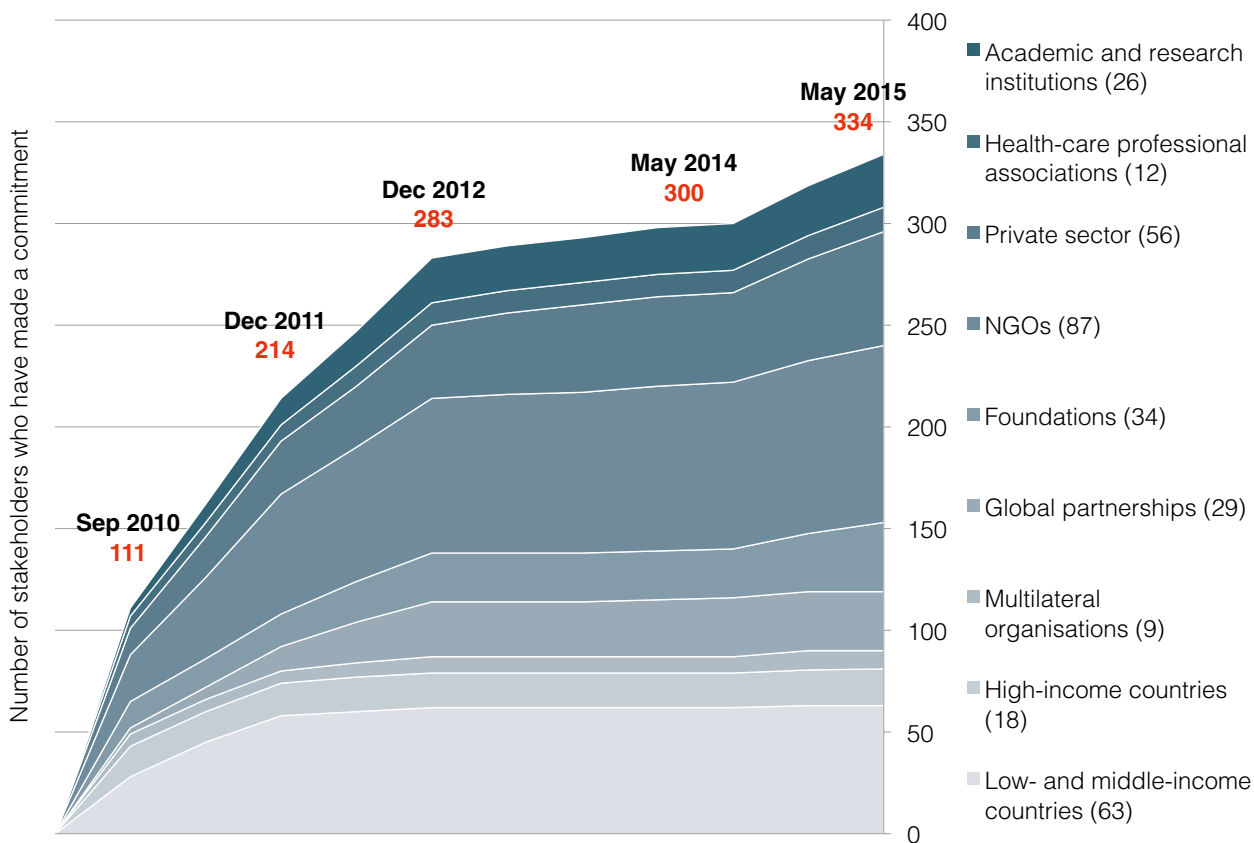
In 2013, 8 countries had reduced new HIV infections among children by over 50%—Botswana, Ethiopia, Ghana, Malawi, Mozambique, Namibia, South Africa, and Zimbabwe. Since then, progress seems to have stalled in Botswana, South Africa, Tanzania, Uganda, and Zimbabwe; and it has reversed in Chad, Ghana, Lesotho, and Zambia. Gains therefore seem to be fragile. In 2009, the mother-to-child transmission rate (including through breastfeeding) was 26% in 21 Global Plan countries (again, excluding India). By 2013, that rate had fallen to 16%. The main risk is now concentrated on breastfeeding. Botswana is the one country that seems to have reached the Plan's milestone of a transmission rate below 2%. In terms of treating children, the main bottleneck is diagnosis. Only 6 countries provide early infant diagnosis to more than 50% of children exposed to HIV. And only Botswana has achieved universal access (defined as 80% coverage). Other priority countries are doing much worse. Cameroon, Chad, Côte d'Ivoire, DRC, and Ethiopia provide treatment to less than 10% of their children living with HIV. Clearly, there is considerable unfinished business relating to mother-to-child transmission of HIV to take into the SDG era.

21. In our previous 3 annual surveys of women's and children's health, we have used carefully selected case studies to illustrate key points of concern to us—eg, civil society accountability in Nigeria, donor accountability at the World Bank, or quality of care in Brazil. This year is no exception. We were especially inspired by the University of Oslo Commission on Political Determinants of Health. As such, we selected 3 case studies of reproductive health (India, Philippines, DRC) where political determinants of health played an important part. Reproductive health is especially influenced by political factors because of ideological resistance to evidence-based solutions. The case studies we have chosen for our 2015 report are India's failing policies in family planning, with horrific consequences for women who endure grave dangers in sterilisation camps; DRC's long history of sexual violence and the government's first steps to address this pervasive societal atrocity; the gradual easing of the Catholic Church's oppressive effects in the Philippines regarding access to reproductive health services; China's impressive gains in maternal and child health, but with deeply ingrained sub-national disparities; and Argentina's successful conditional cash transfer programmes, which now need much greater coordination. The message from these case studies, 29 in total since we began our work, is that whatever the global generalisations we are encouraging in our recommendations, accountability begins and ends for women and children in countries.

22. The architecture of accountability for *Every Woman, Every Child* has led to a strong collaboration between the Partnership for Maternal, Newborn, and Child Health (PMNCH) and the iERG. In three past PMNCH reports, commitments to the Global Strategy have been documented and issues investigated in ways that have been synergistic and complementary to the work of the iERG. In 2015, PMNCH is not producing an annual report. However, we are fortunate that the Partnership has continued tracking financial flows to RMNCH. Here, we present a summary of their latest findings:

- The number of stakeholders committing to women's and children's health has increased from 111 in 2010 to 334 in 2015 (Figure 7).
- Since May, 2014, an additional 34 commitment makers made pledges to the Global Strategy—17 of them in support of the Every Newborn Action Plan.
- Financial commitments to the Global Strategy have reached US\$45 billion (once double-counting has been removed); 9 financial commitments have been made since May, 2014.
- As of May, 2015, US\$31 billion of the US\$45 billion committed has been disbursed (Figures 8 and 9).
- Annual disbursements for women's and children's health have increased substantially since the launch of the Global Strategy: donors disbursed US\$11.9 billion for RMNCH in 75 priority countries in 2013, an increase of 25% since 2010; in 2013, RMNCH ODA to these 75 countries grew by 15%, a substantially higher figure than 2011 (0.5%) and 2012 (7.8%) (Figure 10).
- Previously underfunded areas, such as family planning, have seen steep increases in financial support—50.5% since the launch of the Global Strategy (from US\$452.9 in 2010 to US\$681.6 in 2013) (Figure 11).
- There are persistent geographic inequities in RMNCH funding—DRC and Guinea, for example, continue to receive relatively small amounts of ODA (Figure 12).
- However, there are signs that for some countries, advocacy around equity may be having an impact—eg, countries with high maternal mortality (such as Sierra Leone, Chad, and Côte d'Ivoire) saw rises in RMNCH support in 2013 after a phase of decline.
- Countries are increasingly demonstrating their commitment to women's and children's health—domestic public sector spending on RMNCH increased 115% from 2006 to 2013 for our 75 countries of concern (Figure 13).

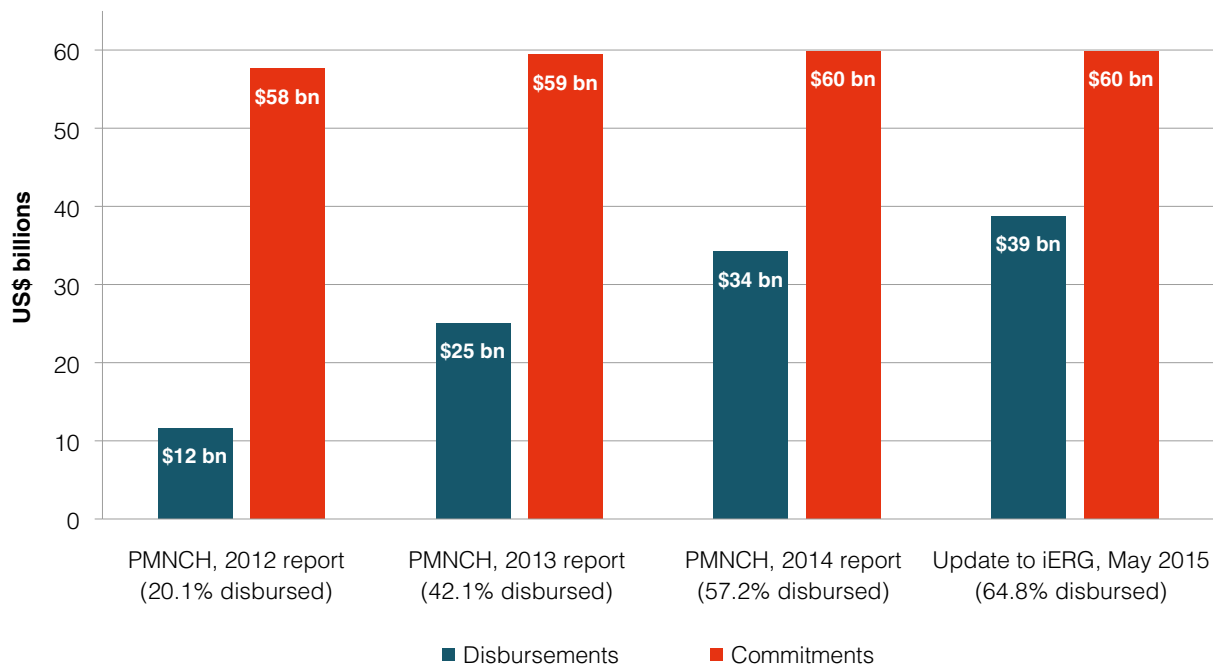
Figure 7. Stakeholders with commitments to the Global Strategy, by constituency, September 2010–May 2015



Source: *Every Woman Every Child* website. Figure adapted from “Global Strategy: Update on Implementation of Financial Commitments,” PMNCH, 2015.

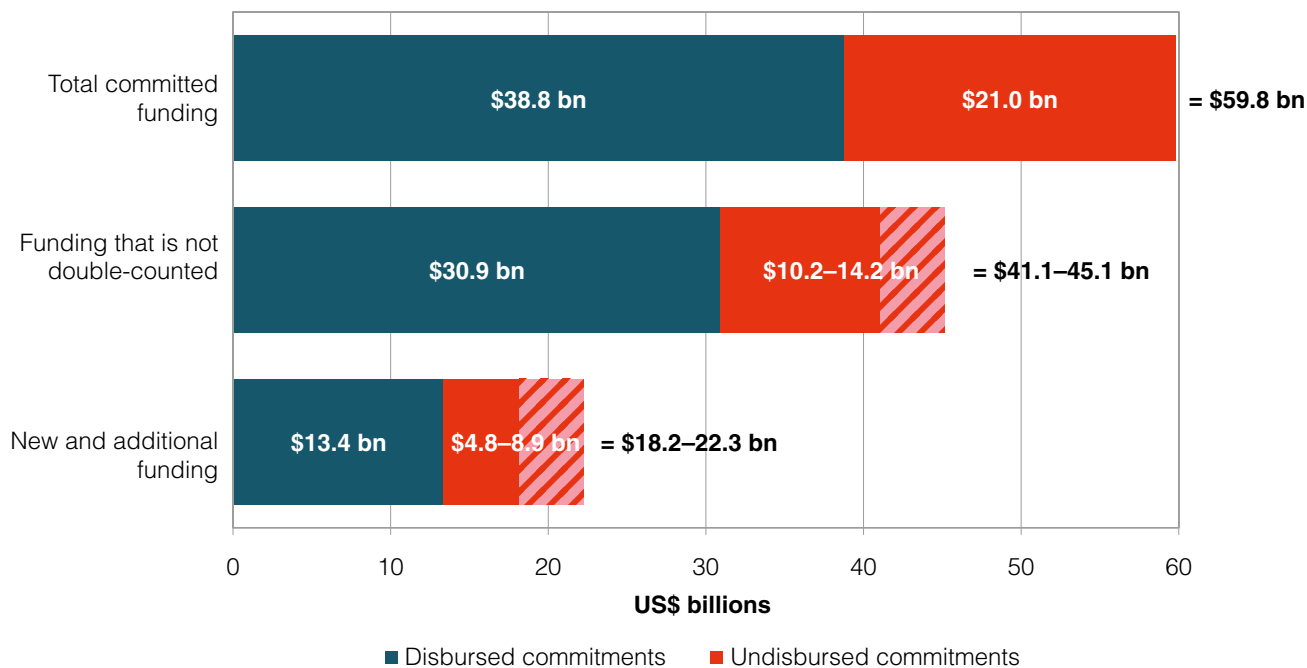


Figure 8. Trends in Global Strategy disbursements



Source: Figure adapted from "Global Strategy: Update on Implementation of Financial Commitments," PMNCH, 2015.

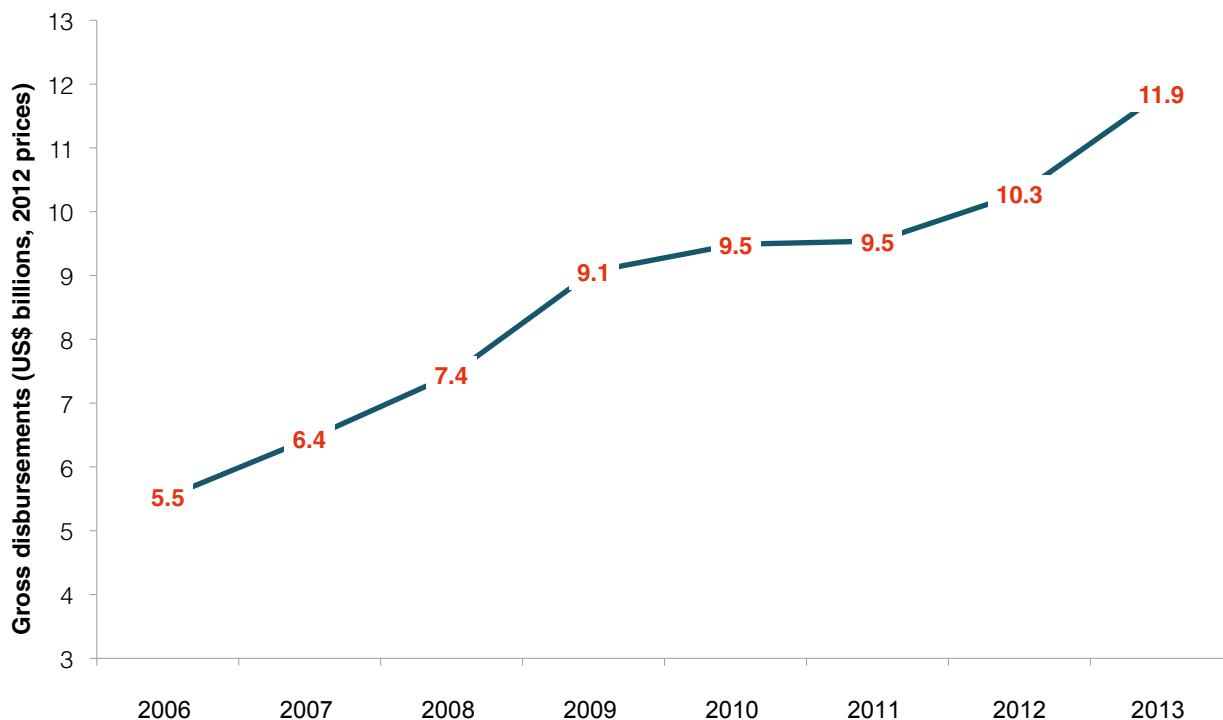
Figure 9. Disbursements against Global Strategy commitments



Note: Striped pink color visualises range of commitments. "Double counting" refers to funding committed twice by different stakeholders. "New and additional funding" refers to investments that stakeholders committed in addition to their RMNCH spending levels prior to the Global Strategy.

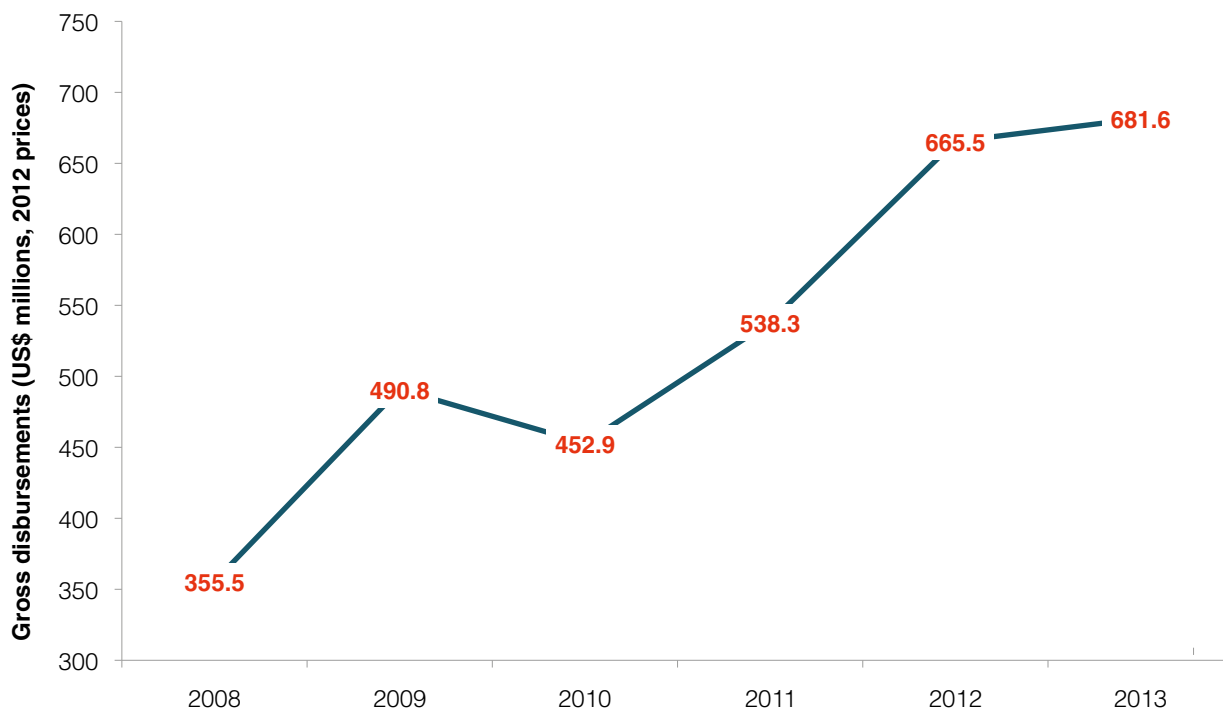
Source: SEEK Development analysis. Figure adapted from "Global Strategy: Update on Implementation of Financial Commitments," PMNCH, 2015.

Figure 10. ODA for RMNCH in the 75 iERG countries, 2006–2013



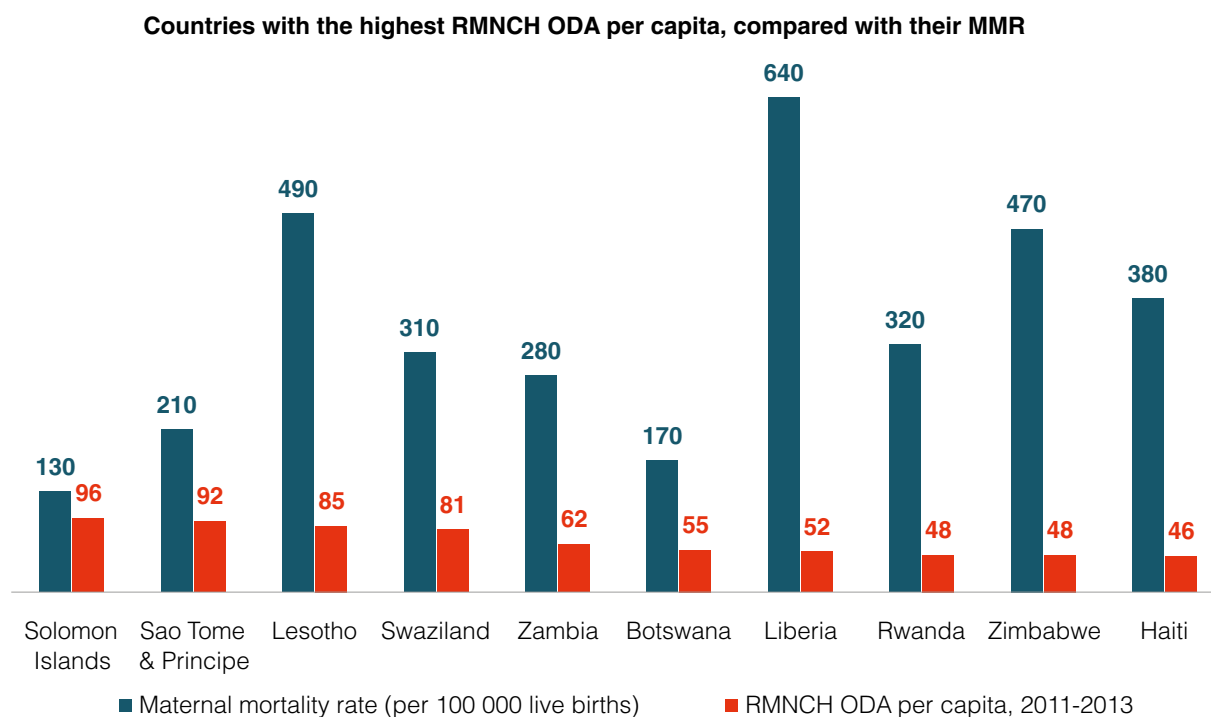
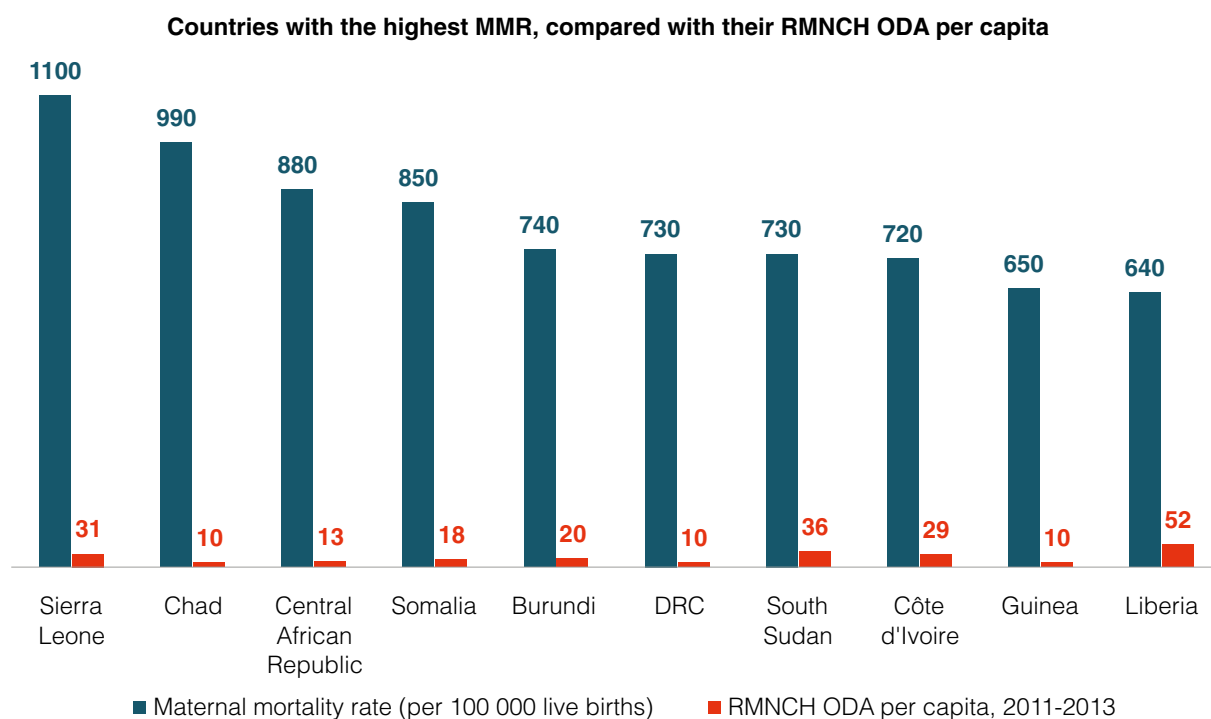
Source: OECD CRS, calculated using Muskoka methodology. Figure adapted from “Global Strategy: Update on Implementation of Financial Commitments,” PMNCH, 2015.

Figure 11. ODA for family planning in the 75 iERG countries, 2008–2013



Source: OECD CRS. Figure adapted from “Global Strategy: Update on Implementation of Financial Commitments,” PMNCH, 2015.

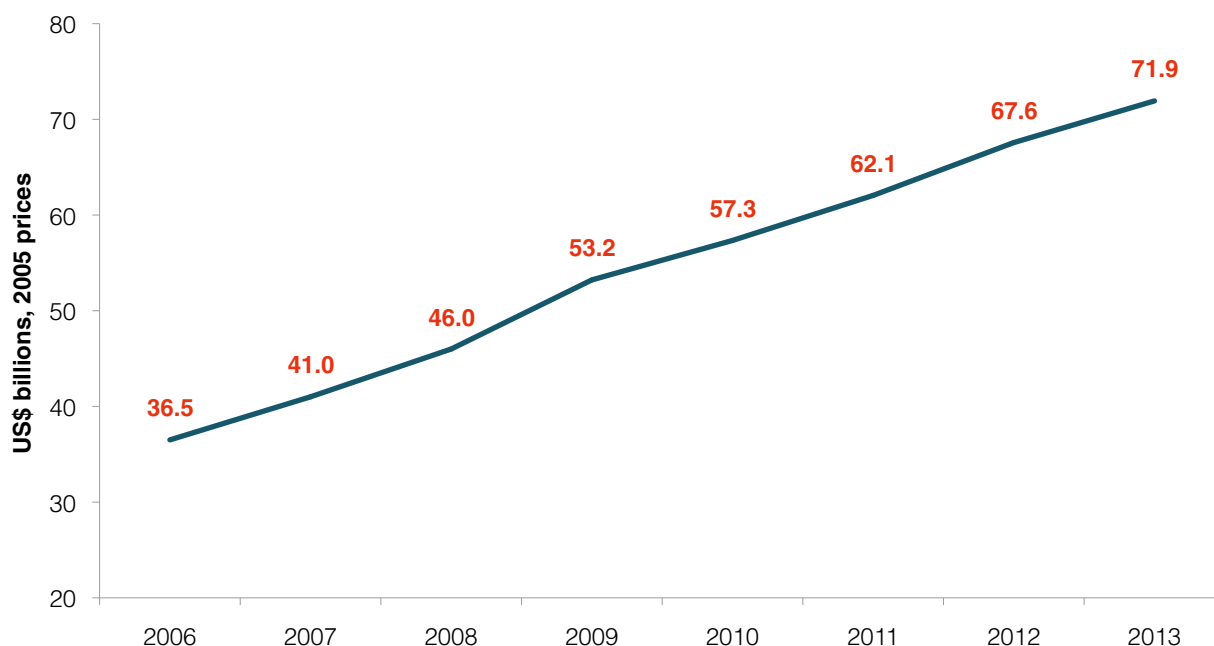
Figure 12. Geographic targeting of donor funding and countries' needs, 2011–2013



Note: There are similar geographic inequities when analysing RMNCH ODA and countries' under-five mortality burden.

Source: OECD CRS & WHO, UNICEF, UNFPA, World Bank: Trends in maternal mortality, 1990-2013. Figure adapted from "Global Strategy: Update on Implementation of Financial Commitments," PMNCH, 2015.

Figure 13. Government RMNCH expenditures in the 75 iERG countries, 2006–2013



Source: GHED & OECD CRS. Figure adapted from “Global Strategy: Update on Implementation of Financial Commitments,” PMNCH, 2015.

23. What have we learned from studying RMNCH programmes in countries? The Overseas Development Institute recently published an analysis of how systems for maternal and child health were strengthened in 3 countries—Mozambique, Nepal, and Rwanda (19). In this study, Fiona Samuels and colleagues examined macro, meso, and micro drivers of progress. Macro-level factors (national policies and strategies) included good governance and effective leadership, which built confidence, trust, and long-term (financial) support among donors. This favourable environment fostered sustained, coordinated technical and investment partnerships. Meso-level factors mean policies implemented as specific programmes at the

sub-national level—key drivers for success included integrating maternal and child health within existing health programmes, together with task-shifting and alliances with other sectors. Finally, at the micro level (the intersection between health systems and users), both community health workers and community delivery platforms are key for stimulating awareness and demand, promoting prevention, and providing basic services. One cross-cutting issue that can also accelerate success was found to be effective accountability. Weak accountability arrangements are associated with weak health services. Clear frameworks of accountability at all 3 levels can strengthen services for women and children.



3. THE COMMISSION ON INFORMATION AND ACCOUNTABILITY: A FINAL REPORT CARD

24. Figure 14 shows our summary of progress on implementation of the CoIA recommendations (Annex 2, 4). We have included our assessments from the previous two years for comparison. Our 2015 assessments are based on 75 Country Profiles we provide for the first time with this report. These Profiles benchmark progress at the end of the MDG era (and at the conclusion of the iERG’s work). Each Country Profile consists of two pages. The first page gives basic demographic data for each country, information on reproductive health and health systems, and data on health coverage, including, where available, data on health equity. Progress towards MDGs 4 and 5 is shown, specifically the three impact indicators of Maternal mortality ratio, Under-5 and Neonatal mortality rates, and Under-5 stunting. The second page provides information on progress against each of the CoIA recommendations that are relevant for countries (thus excluding recommendations on reporting aid and global oversight). This information is intended to help policymakers and their partners assess progress and prioritise further actions to save women’s and children’s lives. When reading Figure 14, several clarifications and explanations are important.

- We have introduced a new category of descriptor—a grey panel—indicating no or too few data are available to judge progress.

- The introduction of this new category has changed our assessments in 5 CoIA areas—for Reaching Women and Children (percentage of national expenditure used for RMNCH) and for Transparency (a health sector performance report for the preceding year is available in the public domain), we had previously reported that progress was being made. We have now changed that judgement. In both areas, we believe there are insufficient data to draw any reliable conclusions on progress.
- In 3 further categories—Vital Events, Resource Tracking, and National Oversight—we had previously made judgements based on what we believed were available data. However, it is now clearer that in all 3 cases, critical data are missing. Given this partial lack of data, we are marking partial progress with grey colour coding, indicating lack of information.
- In 3 categories, based on a fuller appreciation of the available data, we have revised our appraisal downwards compared with 2014—in Vital Events, Health Indicators, and Reporting Aid.
- Overall, we judge that only one CoIA recommendation has been fully delivered—the establishment of the iERG. Progress is being made in 6 CoIA areas. One area demonstrates considerable resistance to progress. And in 5 areas, lack of data is stopping a fuller evaluation. Further detail is provided in the ensuing paragraphs.

Figure 14. Summary of global progress on implementation of the recommendations from CoIA

Recommendation	Target year	2013	2014	2015
Vital events	2015	Red	Green	Diagonal lines
Health indicators	2012	Yellow	Yellow	Red
Innovation	2015	Red	Yellow	Yellow
Resource tracking	2015	Yellow	Yellow	Diagonal lines
Country compacts	2012	Red	Yellow	Yellow
Reaching women and children	2015	Red	Yellow	Grey
National oversight	2012	Yellow	Yellow	Diagonal lines
Transparency	2013	Red	Yellow	Grey
Reporting aid	2012	Yellow	Green	Yellow
Global oversight	2012	Green	Green	Green

- The target will be difficult to achieve
- Progress is being made, but continued and concerted effort is needed to achieve the target
- The target is on track or has already been achieved
- No or too few data are available to judge progress
- Multiple indicators show both absence of data and progress being made

Panel 5. 11 health indicators for women and children adopted by the Commission on Information and Accountability

Health status indicators

1. Maternal mortality ratio (deaths per 100 000 live births)
2. Under-5 child mortality, with the proportion of newborn deaths (deaths per 1000 live births)
3. Children under 5 who are stunted (percentage of children under 5 years of age whose height-for-age is below minus two standard deviations from the median of the WHO Child Growth Standards)

Coverage indicators

1. Met need for contraception (proportion of women aged 15–49 years who are married or in union and who have met their need for family planning—ie, who do not want any more children or want to wait at least two years before having a baby, and are using contraception)
2. Antenatal care coverage (percentage of women aged 15–49 years with a live birth who received antenatal care by a skilled health provider at least four times during pregnancy)
3. Antiretroviral prophylaxis among HIV-positive pregnant women to prevent vertical transmission of HIV, and antiretroviral therapy for women who are treatment-eligible
4. Skilled attendant at birth (percentage of live births attended by skilled health personnel)
5. Postnatal care for mothers and babies (percentage of mothers and babies who received a postnatal care visit within two days of childbirth)
6. Exclusive breastfeeding for six months (percentage of infants aged 0–5 months who are exclusively breastfed)
7. Three doses of the combined diphtheria-pertussis-tetanus (DPT3) vaccine (percentage of infants aged 12–23 months who received three doses of diphtheria-pertussis-tetanus vaccine)
8. Antibiotic treatment for pneumonia (percentage of children aged 0–59 months with suspected pneumonia receiving antibiotics)

25. Vital events. The four metrics we have used for monitoring progress are: % of births registered; % of deaths registered; a maternal death surveillance response (MDSR) in place; and a civil registration and vital statistics systems (CRVS) improvement plan in place. Data are available in almost all countries for birth registration, although the proportion of births registered varies greatly, from 100% (eg, DPR Korea) to 2% (eg, Malawi). However, for death registration, most countries have no available data. Over two-thirds of countries have in place, fully or partially, a MDSR. In its evidence to the iERG, WHO argued that there had been “significant investments” by countries into MDSR systems. The picture is even more positive for CRVS, with the majority of countries either fully or partially having a CRVS improvement plan in place. In WHO’s submission to the iERG, they identify “a clearly discernible global shift towards investing in the universal registration of births, deaths, and causes of death.” The evidence mostly bears out that confident observation. For this reason, despite concerns over lack of data for death registration, we judge this recommendation “yellow/grey”—where data are available, progress is being made.

26. Health indicators. CoIA’s recommendation was that 11 indicators on RMNCH, disaggregated for gender and other equity considerations, should be used to monitor progress towards the Global Strategy. The indicators are shown in Panel 5. We used two measures to judge

progress. First, that statistics for all 3 impact indicators are available, disaggregated by equity stratifiers. Second, that data for all 8 coverage indicators are available, also disaggregated by equity stratifiers. The available data we have make disappointing reading. Only 10 countries satisfy both measures: Guinea, Gabon, Haiti, Indonesia, Kyrgyzstan, Niger, Nigeria, Pakistan, Senegal, and Tajikistan. The majority of countries do not have available up-to-date and disaggregated data for either impact or coverage indicators. For this reason we mark this recommendation as “red”—the target will be difficult or impossible to achieve by the deadline of 2015.

27. Innovation. We used the metric of a national eHealth strategy and plan being in place and implemented in countries. Our Country Profiles report a mixed picture of success. Around a third of countries report having such a strategy and plan in place and implemented. A third of countries report partial success. And a third of countries report no progress. For this reason, we judge this CoIA recommendation as “yellow”—progress is being made.

28. Resource tracking. CoIA recommended that countries track and report at least 2 aggregate resource indicators—total health expenditure by financing source, per capita; and total RMNCH health expenditure by financing source, per capita. We used 4 metrics to judge progress towards meeting this recommendation: total health expenditure per capita tracked by financing source; total public sector health expenditure per



capita; total RMNCH expenditure per capita tracked by financing source; and total annual RMNCH expenditure. First, there are almost no data available at all on total annual RMNCH expenditure. On total and RMNCH expenditures per capita, the picture is mixed: a third of countries do not report either total or RMNCH health expenditure per capita by financing source. For these reasons, although we have concerns about lack of data, we judge this CoIA recommendation as “yellow”—progress is being made.

29. Country compacts. CoIA recommended that to facilitate resource tracking, “compacts” between countries and development partners should be put in place. The measure we used to judge progress towards this recommendation was that a country-led reporting system was in place for externally funded expenditures and predictable commitments. Our Country Profiles show that about two-thirds of countries have fulfilled this recommendation. We therefore judge this category “yellow”—progress is being made.

30. Reaching women and children. CoIA recommended that by 2015 all governments have the capacity to regularly review health spending (including RMNCH spending) and to relate that spending to commitments, human rights, gender, and other equity goals and results. As our Country Profiles show, there is a total absence

of data from countries to address this recommendation. We cannot make any accurate assessment of progress towards this CoIA recommendation and so we have labelled it “grey.”

31. National oversight. One of the earliest milestones for CoIA was that all countries would establish (by 2012) national accountability mechanisms that are transparent, inclusive, and recommend actions to improve the health of women and children. We used two metrics to judge progress: first, that the country had conducted an annual national health sector review in the past year; and second, that there was a mutual assessment of progress in implementing agreed health sector commitments. On mutual assessment, there was almost a complete lack of data from countries. On an annual health sector review, over two-thirds of countries had completed such a review in the past year. For these reasons, we judge this recommendation to be “yellow/grey”—progress is being made, although, once again, we are concerned about lack of data.

32. Transparency. CoIA envisaged that by 2013, all stakeholders would be publicly sharing information on commitments, resources provided, and results achieved nationally and globally. As our Country Profiles show, there is a complete absence of data to measure progress towards this recommendation.

Panel 6. Bilateral sector-allocable ODA by RMNCH marker score (in US\$ millions)

Donor	ODA by RMNCH marker score					Total screened ODA	Total unscreened ODA	Total ODA
	0	1	2	3	4			
Australia	8.5	12.8	57.8	37.7	179.8	296.7	2,902.8	3,199.5
Austria	..	1.7	..	..	0.3	2.0	490.9	492.8
Belgium	..	30.7	..	..	4.9	35.5	849.6	885.1
Canada	465.0	10.2	7.7	26.6	113.0	622.6	1,586.2	2,208.8
Czech Republic	33.9	1.1	0.7	0.1	0.6	36.3	..	36.3
Denmark	10.3	0.4	..	..	..	10.8	1,353.1	1,363.9
Finland	..	..	..	..	..	..	475.2	475.2
France	..	..	..	..	..	..	6,427.6	6,427.6
Germany	..	..	..	..	..	..	12,461.3	12,461.3
Greece	4.4	..	..	..	..	4.4	9.4	13.9
Iceland	19.9	0.7	1.5	2.3	0.5	24.8	..	24.8
Ireland	..	70.4	81.3	..	..	151.6	188.7	340.3
Italy	52.0	7.2	15.4	4.7	13.9	93.3	293.7	387.0
Japan	11,702.8	1,308.4	285.6	1.2	38.4	13,336.3	1,733.8	15,070.0
Republic of Korea	655.7	2.1	26.2	2.7	136.4	823.2	1,271.1	2,094.3
Luxembourg	198.7	..	..	..	..	198.7	..	198.7
Netherlands	2,328.1	..	0.3	..	136.2	2,464.6	..	2,464.6
Norway	3,167.6	25.0	72.7	..	168.7	3,434.1	..	3,434.1
New Zealand	..	..	..	..	..	..	258.9	258.9
Poland	..	..	..	..	..	..	63.9	63.9
Portugal	14.9	..	0.4	..	..	15.3	158.8	174.1
Slovak Republic	9.2	0.2	0.3	..	..	9.8	..	9.8
Slovenia	12.7	..	..	..	..	12.7	..	12.7
Spain	395.5	36.5	..	..	15.3	447.4	0.2	447.6
Sweden	1,832.8	..	175.0	..	213.1	2,220.9	144.3	2,365.2
Switzerland	..	..	..	..	..	..	2,163.0	2,163.0
United Kingdom	..	..	..	..	..	..	4,730.8	4,730.8
United States	..	..	..	..	1,608.1	1,608.1	18,012.9	19,621.0
Total DAC countries	20,912.1	1,507.6	724.9	75.3	2,629.1	25,849.0	55,576.4	81,425.4
EU Institutions	..	..	..	..	..	..	20,698.2	20,698.2
Total DAC + EU	20,912.1	1,507.6	724.9	75.3	2,629.1	25,849.0	76,274.6	102,123.6

RMNCH Marker Scores:

- 4=RMNCH is the explicit primary objective
 3=Most, but not all of the funding is targeted to RMNCH
 2=Close to half of the funding is targeted to RMNCH
 1=At least a quarter of the funding is targeted to RMNCH
 0=Negligible or no funding is targeted to RMNCH

Screened=ODA reported against RMNCH marker
 Unscreened=ODA not reported against RMNCH marker

To determine ODA in support of RMNCH, the OECD's Development Assistance Committee (DAC) implemented a new policy marker in 2014, for a two-year trial period. This RMNCH marker screens all bilateral sector-allocable ODA with a score of "4", "3", "2", "1", or "0", corresponding to 100%, 75%, 50%, 25%, and 0% respectively of a project's funding being targeted to RMNCH activities.

An activity is classified as RMNCH if it contributes to any one of the following:

- a) Improved access for women and children to a comprehensive, integrated package of essential health interventions and services along the continuum of care;

- b) Strengthening health systems in order to improve access to and deliver integrated high-quality RMNCH specific services;
 c) RMNCH-specific workforce capacity building, ensuring skilled and motivated health workers in the right place at the right time, with the necessary infrastructure, drugs, equipment, and regulations.

The RMNCH marker is designed to facilitate approximate quantitative estimation of ODA targeted to RMNCH activities; the resulting data should not be interpreted as precise and comprehensive amounts of RMNCH-related contributions. Notably, much ODA remains unscreened against the marker at this time.

Though 21 countries above began reporting on the RMNCH marker, Luxembourg and Slovenia reported all of their sector-allocable ODA with a score of "0". This may suggest that none of their ODA was in fact screened, but was mistakenly reported as "0" by default, rather than "null" (left blank). Thus, the OECD considers that only 19 countries began reporting on the marker, 6 of which screened less than 10% of their sector-allocable ODA.

33. Reporting aid for women's and children's health. CoIA wanted OECD-DAC to improve the Creditor Reporting System (CRS) so that it could capture all RMNCH spending by development partners. The Development Advisory Committee (DAC) has 29 members who each year report aid flows, together with 17 non-DAC countries, multilateral organisations, and the Gates Foundation. The CRS is the recognised source of comprehensive data for aid-recipient countries. Panel 6 sets out the first data from CoIA's request to capture data on RMNCH support. This work will be monitored and evaluated over a two-year trial period. It has been emphasised to the iERG that we should be cautious when interpreting these numbers. The reported data are incomplete since this was the first year of reporting on a test basis. Many donors had not yet implemented the marker in their systems. Concerning the 21 donors in the panel, two (Luxembourg and Slovenia) reported all of their sector-allocable ODA with a score of "0," which likely suggests they did not screen their aid and reported "0" by default instead of "null." Therefore, 19 countries began reporting on the marker, 6 of which screened less than 10% of their sector-allocable aid. The main message of these early and preliminary data is that a marker is now in place to identify activities targeting RMNCH, but more donors need to begin screening their aid in order to get an idea of how much is going to RMNCH.

34. Global oversight. This CoIA recommendation concerned the creation of a time-limited iERG to report regularly on results and resources related to the Global Strategy and on progress in implementing CoIA's recommendations. This 2015 report will be our final review of progress towards the CoIA goals, together with the achievements of *Every Woman, Every Child* and the Commission on Life-Saving Commodities. We note here that in its evidence to the iERG, WHO wrote that, "Independent accountability remains essential for the post-2015 period." They continued: "There is multi-stakeholder consensus on the need for independent accountability for women's and children's health post-2015, and this is a priority in the development of the new Global Strategy for Women's, Children's, and Adolescents' Health."

35. Leadership globally to implement the CoIA recommendations has fallen especially to the H4+, a partnership of UN agencies including UNICEF, UNFPA, WHO, the World Bank, UNAIDS, and UN Women. The H4+ leads collectively at the global level, and coordinates technical assistance in countries. Its work is broad, encompassing initiatives such as *A Promise Renewed*, the Commission on Life-Saving Commodities, the Every Newborn Action Plan, and *Every Woman, Every Child*. In their submission to the iERG, the H4+ helpfully sets out the obstacles to

delivering the aspirations of CoIA. In summary, these obstacles are:

- Coordination: a continuous challenge, especially in countries lacking compacts and health sector reviews.
- Inclusion: of external partner organisations, especially civil society.
- Resource mobilisation: to fund joint work plans.
- Monitoring and evaluation: to learn lessons and document best practices.
- Scaling up: to achieve adequate reach and coverage.
- Capacity: countries report challenges of being forced to choose among multiple priorities.
- Instability: political shifts and humanitarian crises can disrupt RMNCH activities.
- Human resources: a further capacity challenge, to implement, provide, and lead RMNCH services.

36. One of the most important positive effects of the CoIA process has been the culture of transparency and accountability it has fostered among partners. The iERG has been a fortunate beneficiary of this effect. We now receive submissions from a wide variety of partners to the Global Strategy, detailing their experiences, successes, and challenges (see Annex 5). Although these are self-reports and not independently verified, they have enriched the culture of accountability enormously.

37. In its evidence to the iERG, The Global Fund to Fight AIDS, Tuberculosis, and Malaria reported how disease-specific investments have improved health for women and children, and helped to strengthen health systems. The Fund also described how innovative financing partnerships in countries are advancing its work still further. The New Funding Model adopted by the Global Fund has offered new opportunities to strengthen its commitment to women and children. The Global Fund is already an important contributor to women's and children's health. For example, in 2010, the Fund contributed about 12% of ODA for maternal, newborn, and child health programmes for 74 priority countries. Following the Fund's replenishment in 2013, around 8.6% of total allocations have been for RMNCAH interventions. Countries have been encouraged to link their AIDS, TB, and malaria programmes to RMNCAH. Examples include: 1.4 million long-lasting insecticidal nets for pregnant women and children in Indonesia; and investments in community health nurses to provide maternal and child health services in Afghanistan. Partnerships with the World Bank, UNICEF, UNFPA, and the Global Financing Facility leverage the part played by the Global Fund still further. As the Fund plans its new 2017-21 strategy, the contribution it can make to RMNCAH is one of the "key components being considered."

38. Another example of transparency and accountability is provided by World Vision. In its submission to the iERG, World Vision explains how it has aligned its programmes in nutrition, HIV, and water and sanitation with the Global Strategy. Since 2010, World Vision has invested US\$1.6 billion in programming initiatives aligned with *Every Woman, Every Child*. It has invested US\$3 million in operations research to support women's and children's health. It has spent US\$10 million on advocacy for women's and children's health. And World Vision has been an important contributor to social accountability by tracking commitments and parliamentary engagement for women's and children's health.

39. For the first time, we report the financial and policy commitments of key donors to women's and children's health (see page 255). The single page reports total ODA, health expenditures, and RMNCH expenditures. It lists major pledges, and reports the latest Aid Transparency Index assessment. The results reported here deserve careful assessment and discussion among all key constituencies involved in women's and children's health in order to judge whether partners are living up to their promises.

40. One institution that is sometimes neglected as a key instrument for strengthening accountability is the national parliament. The movement for women's and children's health has been especially fortunate to have had the full commitment of the Inter-Parliamentary Union (IPU) in its work. Women's and children's health has been a core part of the IPU's strategy. In their evidence to the iERG, the IPU sets out the three levels at which it operates. Globally, the IPU has been an active participant and contributor to the production of a new Global Strategy for Women's, Children's, and Adolescents' Health. In partnership with WHO and PMNCH, the IPU has been able to bring parliamentarians to the policy dialogue about the future of *Every Woman, Every Child* for the first time. And through the IPU's work on AIDS and nutrition, it has been able to broaden its contribution to women's and children's health still further. Regionally, the IPU has focused on violence against girls and child marriage (in Asia-Pacific). Nationally, its work in Uganda, Rwanda, Bangladesh, and Chile has deepened its commitments. In reflecting on lessons learned from its engagement in women's and children's health, the IPU recognises that its pivotal role as a bridge between member parliaments and global agencies has given it a special advantage. It has used that advantage wisely and effectively. For example,



IPU acknowledges that the issues of reproductive health and family planning can be sensitive for some parliaments. However, by focusing on maternal and child health, IPU has built trust and confidence in this field of work, enabling parliaments to engage even on the most sensitive matters. Reproductive health is on the agenda of most IPU activities with national parliaments. IPU has been an indispensable partner in amplifying the work of the Global Strategy.

41. Panel 7 sets out the iERG's past recommendations. We reviewed the recommendations from our 2012 and 2013 reports last year and, as we approach the end of the MDG era, we have little to add to those

conclusions. Here we describe the responses to the recommendations set out in our 2014 report.

- **Develop, secure wide political support for, and begin to implement a global plan during 2014-15 to end all preventable RMNCA mortality for the 2016-30 period—a new, broader, and more inclusive Global Strategy for Women's and Children's Health.**

Work to develop a new Global Strategy has intensified since an initial stakeholder's meeting held in Geneva in November, 2014. In Delhi in February, 2015, hosted by the Government of India, a new conceptual framework for women's, children's, and adolescents' health was



Cleaning boots after emergency surgery for life-threatening post-partum haemorrhage

presented at a further stakeholders' consultation, and drafting of the new strategy was initiated. The new Global Strategy has been driven by strong country ownership, high-level political support, coordinated multi-stakeholder action, and it is closely aligned with the SDGs. A parallel 5-year implementing plan is being developed alongside the strategy. The draft—with its three pillars of survive, thrive, and transform—was refined during a series of high-level and working meetings, together with extensive consultations, throughout 2015. It will be launched in September, 2015, alongside the SDGs. The vision for the new Global Strategy will be discussed further in the next chapter of this report.

- ***In 2015, create a results-based financing facility to support and sustain this new Global Strategy.***

A Global Financing Facility (GFF) in support of *Every Woman, Every Child* has been designed to meet this objective. It was announced in September, 2014, and its aim is to accelerate efforts to end preventable maternal, newborn, child, and adolescent deaths. The business plan for the GFF was published in May, 2015 (20). The Facility aims to encourage greater domestic spending on women's and children's health and attract greater external financing. Its focus will be on family planning, nutrition, health information systems, and adolescents. The work of the GFF will be complemented by a multi-donor GFF Trust Fund, located at the World Bank. 63 of 75 iERG countries will be eligible to receive GFF Trust Fund financing. The precise details of how the GFF will work remain unclear. Will the GFF be offering new money, or will it be simply repurposing existing World Bank assistance? And the Facility has not been universally welcomed (21). Norway has been one of the leading countries advocating for the GFF. But its neighbour, Sweden, argues that the GFF "is a bad idea and we are not planning to fund it." They see the GFF as contributing to greater fragmentation in global health. And Sweden is not comfortable about the leading part played by the World Bank in the GFF. Our view is that more discussion and consultation is needed to clarify the part to be played by the GFF.

- ***Between now and 2016, convene a Special Session of the UN General Assembly, led by the Secretary-General, to accelerate international collective action for women's and children's health—to align and harmonise the actions of partners, to promote leadership and stewardship, to ensure provision of global public goods, to manage externalities, and to provide direct country assistance.***

The iERG approached the Chair of the UN General Assembly (UNGA), which is Denmark for 2015-16.

We were advised that no such Special Session could take place in 2016. There are already two Special Sessions planned, and there is no space for a third. The idea of a mechanism to deliver greater alignment and harmonisation was deemed interesting and useful, but there were questions about whether the UNGA was the best place to do so.

- ***In 2015, establish a Global Commission on the Health and Human Rights of Women and Children to propose ways to protect, augment, and sustain their health and wellbeing.***

The iERG wrote to the Director-General of WHO, Dr Margaret Chan, and the UN High Commissioner for Human Rights, Dr Zeid Ra'ad Al Hussein, to propose such a Commission. Dr Chan replied, welcoming our proposal for greater collaboration between WHO and the Office of the High Commissioner for Human Rights. But she stopped short of endorsing the idea of a Commission. Dr Al Hussein responded with support for a human rights based approach to women's and children's health. But he too stopped short of supporting a Commission. At present, we do not see any enthusiasm among partners for a Commission to bring the health and human rights communities together to accelerate progress for women's and children's health. We are disappointed by this outcome, which we see as a missed opportunity. We are unsure how to interpret the signal that leaders from the health and human rights communities do not wish to work more closely together.

- ***From 2015 onwards, hold a civil-society led World Health Forum adjacent to the World Health Assembly to strengthen political accountability for women's and children's health.***

During the May, 2015 World Health Assembly, the White Ribbon Alliance held the first ever Global Dialogue between Citizens and Governments (22). This Dialogue, supported by the Governments of Bangladesh and Sweden, was the first formal civil society forum held on site at the World Health Assembly to improve accountability for women's and children's health. We hope that it signalled an important cultural and political shift within the World Health Assembly.

- ***In 2015, establish and fully resource a new Independent Expert Review Group to monitor, review, and propose actions to accelerate global and country progress towards improved women's and children's health during the period of the Sustainable Development Goals.***

The mechanism of accountability for a new Global Strategy is uncertain. The iERG has submitted its own proposal (see Annex 6).

Panel 7. Recommendations from the iERG, 2012-2014

iERG 2012 Recommendations

1. Strengthen the global governance framework for women's and children's health.
2. Devise a global investment framework for women's and children's health.
3. Set clearer country-specific strategic priorities for implementing the Global Strategy and test innovative mechanisms for delivering those priorities.
4. Accelerate the uptake and evaluation of eHealth and mHealth technologies.
5. Strengthen human rights tools and frameworks to achieve better health and accountability for women and children.
6. Expand the commitment and capacity to evaluate initiatives for women's and children's health.

iERG 2013 Recommendations

1. Strengthen country accountability: Ministers of Health, together with partners, must demonstrably prioritise and evaluate country-led, inclusive, transparent, and participatory national oversight mechanisms to advance women's and children's health.
2. Demand global accountability for women and children: Advocate for and win an independent accountability mechanism to monitor, review, and continuously improve actions to deliver the post-2015 sustainable development agenda.
3. Take adolescents seriously: Include an adolescent indicator in all monitoring mechanisms for women's and children's health, and meaningfully involve young people on all policymaking bodies affecting women and children.
4. Prioritise quality to reinforce the value of a human-rights-based approach to women's and children's health: Make the quality of care the route to equity and dignity for women and children.
5. Make health professionals count: Deliver an expanded and skilled health workforce, especially in sub-Saharan Africa, which serves women and children with measurable impact.
6. Launch a new movement for better data: Make universal and effective Civil Registration and Vital Statistics systems a post-2015 development target.

iERG 2014 Recommendations

1. Develop, secure wide political support for, and begin to implement a global plan during 2014–15 to end all preventable reproductive, maternal, newborn, child, and adolescent mortality for the 2016–30 period—a new, broader, and more inclusive Global Strategy for Women's and Children's Health.
2. In 2015, create a results-based financing facility to support and sustain this new Global Strategy.
3. Between now and 2016, convene a Special Session of the UN General Assembly, led by the Secretary-General, to accelerate international collective action for women's and children's health—to align and harmonise the actions of partners, to promote leadership and stewardship, to ensure provision of global public goods, to manage externalities, and to provide direct country assistance.
4. In 2015, establish a Global Commission on the Health and Human Rights of Women and Children to propose ways to protect, augment, and sustain their health and wellbeing.
5. From 2015 onwards, hold a civil-society-led World Health Forum adjacent to the World Health Assembly to strengthen political accountability for women's and children's health.
6. In 2015, establish and fully resource a new Independent Expert Review Group to monitor, review, and propose actions to accelerate global and country progress towards improved women's and children's health during the period of the Sustainable Development Goals.



Philippines: The politics of family planning and its implications for the health of current and future generations

As the lifespan of the Millennium Development Goals (MDGs) draws to an end, the Philippines is far from achieving MDG-5b: universal access to reproductive health. Modern methods of contraception were used by only 37.6% of married women aged 15–49 in 2013 (1), substantially below the average of 55% for Southeast Asia (2). Unmet need for contraception remained high at 18% (1). The fertility rate in 2013 was 3.0 compared with a total wanted fertility rate of 2.2 (1). Unsurprisingly, unintended pregnancies account for over half of all pregnancies in the country, at around 2 million per year (2).

Around one-third of these unintended pregnancies end in abortion (2,3), often by untrained providers because abortion is illegal in the Philippines. Unsafe induced abortion is a leading cause of maternal mortality in the country: of around 4700 maternal deaths in 2008, nearly 1000 were from complications following abortion (4). If every woman at risk of an unintended pregnancy used a modern method of contraception, 500 000

abortions and 2100 maternal deaths could be avoided (4). Access to contraception would also allow for birth spacing and help to prevent teenage pregnancies, which would be of benefit to newborn, child, and adolescent health.

In a country where the Catholic Church is a powerful authority, access to contraception has been heavily determined by political factors. Due to pressure from the Church, President Gloria Macapagal Arroyo (2001–2010) promoted natural methods of family planning over modern methods. During the same period, the then mayor of Manila, Lito Atienza, banned the distribution of contraceptives in all health facilities in the city. Atienza is quoted as saying that “the contraceptive mentality is not correct,” and women were to leave their “reproductive system to function naturally” (5).

The tide turned under current President Benigno S Aquino III: the Responsible Parenthood and Reproductive Health Act of 2012, among other provisions, called for universal and free access

to family planning methods in public facilities, the inclusion of sexual and reproductive health education in school curricula, and women's right to the prevention and management of abortion and its complications. The bill was supported by WHO and other development partners. Although the law came into force in December, 2012, staunch opposition, primarily from Catholic groups, led the Supreme Court to halt its implementation in March, 2013 (6). A year later, in April, 2014, the Court upheld the constitutionality of the statute, but removed three of its major provisions. Health-care providers may now deny services based on their personal or religious beliefs in non-emergency situations; women require spousal consent to access reproductive health services in non-life-threatening situations; and minors including those who have been pregnant or had a miscarriage require parental consent to receive such services.

Although the adoption of the law is an important milestone for reproductive health services in the Philippines, only time will reveal its impact on the health of women and families. Several actions need to be taken to promote and sustain access to and use of family planning methods, all of which require an enabling political environment:

- debunking myths and misconceptions relating to family planning methods;
- ensuring the availability of long-term methods of contraception, particularly for the poor;
- reviewing the functionality of commodity procurement and distribution systems to ensure that these are effective;
- advocacy with local authorities and groups who oppose family planning initiatives;
- advocacy to allow unrestricted access to family planning services for adolescents; and
- reviewing the adoption of the Reproductive Health Act by lower levels of government.

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A young child with dark skin and short hair is sitting on a patch of green grass. The child is wearing a pink short-sleeved shirt and a blue bib. They are smiling broadly, showing their teeth, and holding a piece of green grass in their mouth. To the left, the side of an adult's face is partially visible, looking towards the child. The background is dark and out of focus. A semi-transparent teal box is overlaid on the bottom left of the image, containing white text.

4. POST-2015:
ACCOUNTABILITY FOR
SUSTAINABLE DEVELOPMENT

42. The place of health in the post-2015 development arena is very different from the place it occupied during the MDG era. Health dominated the MDGs—3 out of 8 goals were health related, based on the notion that poverty was substantially precipitated, driven, and perpetuated by poor health. The poverty-reduction focus of the MDGs put health in pole position in development policy and practice. The era of sustainable development represents a sea change in perspective. The triple helix of sustainable development has economic, social, and environmental strands—health is a part of this framework, but it is not the major part. The SDGs (Panel 1) cover a far-reaching and daunting range of issues. But, despite this recalibration, the health sector should not feel disenfranchised. Although health has been decentred from the development conversation, SDG-3 expands the health agenda considerably. In addition to securing the importance of the “unfinished business” of the MDGs—reproductive, maternal, newborn, and child health, together with major infectious diseases—the new health SDG opens up territory on, for example, non-communicable diseases, universal health coverage, the health workforce and financing, and global health risks and security. The universality of the health goal—“Ensure healthy lives and promote wellbeing for all at all ages”—gives a new Global Strategy the best possible opportunity to craft a vision that encompasses a broad range of health and non-health determinants. It makes equity its guiding principle. And it makes health political. Universal Health Coverage cannot be delivered through market mechanisms. It is the responsibility of governments, who must themselves respond to the demand for good quality health services from their electorates. The central importance of the health system for governments means that health becomes a Head of State issue, not simply a subject for the Minister of Health.

43. The opportunity for women’s, children’s, and adolescents’ health is therefore great—to eliminate preventable mortality within one generation (23). Practically, this commitment has been translated into an overall quantitative goal—40 by 30, or avoiding 40% of premature deaths by 2030. In the context of women and children, the sub-goal would be avoiding two-thirds of maternal and child deaths by 2030 (24).

44. Several strategies have been written to support these goals and targets—*A Promise Renewed*; *Born Too Soon*; *Family Planning 2020*; the *Decade of Vaccines*; global plans for nutrition, diarrhoea, and pneumonia; and the *Every Newborn Action Plan*. Maternal mortality is one of the most off-track MDGs and will, in particular, need new approaches and

commitments if it is to meet the expectations of “grand convergence.” WHO has brought together the best available evidence for Ending Preventable Maternal Mortality (EPMM) (25). Its guiding principles are to empower women, girls, and communities; to protect and support the mother-baby dyad; to ensure country ownership and leadership; and to apply a human rights framework to ensure that high-quality reproductive, maternal, and newborn health care is available, accessible, and acceptable to all who need it. The strategic objectives of EPMM are:

- To improve metrics, measurement systems, and data quality, ensuring that all maternal and newborn deaths are counted
- To address inequities in access to and quality of reproductive, maternal, and newborn health care services
- To ensure universal health coverage for comprehensive reproductive, maternal, and newborn health care
- To address all causes of maternal mortality, reproductive and maternal morbidities and disabilities
- To strengthen health systems to respond to the needs and priorities of women and girls
- To ensure accountability to improve quality of care and equity

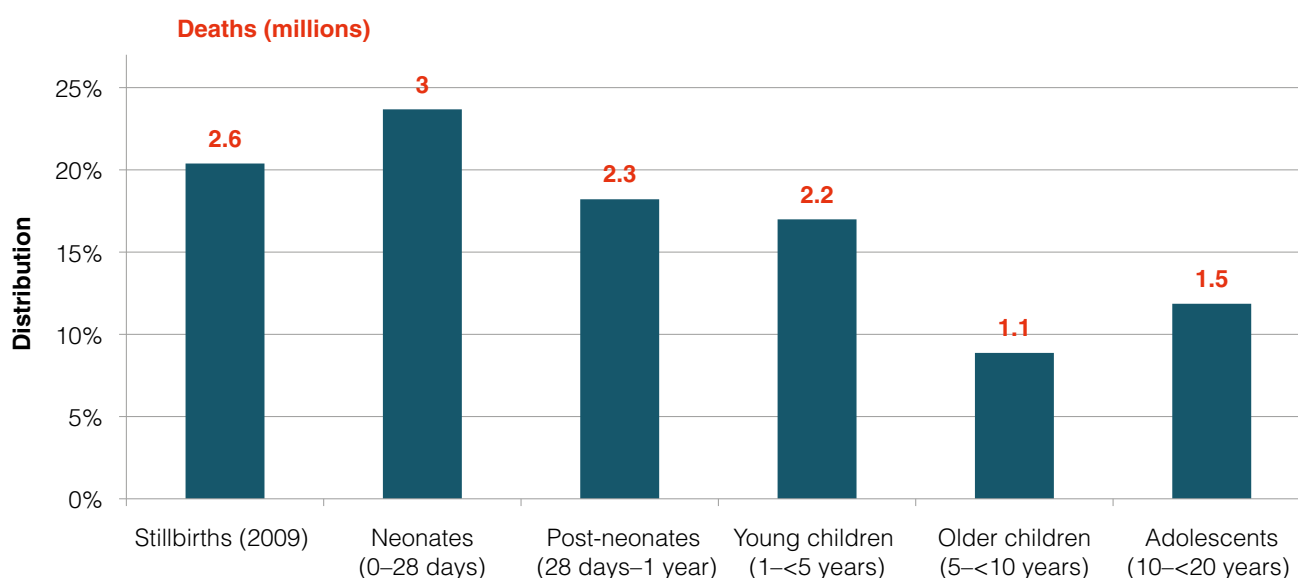
But this post-2015 work cannot be “business as usual.” Innovative approaches are needed, such as mobilising communities through women’s groups and facilitated participatory learning (26). And our responses should not simply be about reaching high and equitable levels of “coverage.” As important is quality—which includes the prevention and elimination of disrespect and abuse for women, children, and adolescents. It has become increasingly clear in recent years that many women experience disrespectful, abusive, and neglectful treatment during childbirth. These experiences—which include physical abuse, humiliation, coercive or unconsented medical procedures, lack of confidentiality, and violations of privacy—can have direct adverse consequences for the mother and child. Addressing quality of care therefore means that programmes should have a strong focus on respectful care, emphasising the rights of women and their families to dignified health care throughout pregnancy and childbirth. It will also be crucial to link these disparate initiatives. One of the main challenges facing *Every Woman, Every Child* has been the multiple initiatives led by different donors and partners. However, there are signs that accountability might be a useful force for integration. For example, the *Every Newborn Action Plan* and the EPMM initiative have several common goals. Work is underway to harmonise the monitoring frameworks for both programmes.



45. A focus on sustainability also means that new communities of women, children, and adolescents must be embraced. Humanitarian and fragile settings have typically been excluded from development concerns for women and children. But in 2015, the Abu Dhabi Declaration for the first time emphasised the importance of Every Woman, Every Child, *Everywhere*. Some 60% of preventable maternal deaths and 53% of under-5 deaths take place in settings of conflict, displacement, and natural disaster. If the SDGs are

to be achieved, and especially the goals for women and children, these humanitarian and fragile settings need to be a major new priority for the international community (27). In their submission to the iERG, WHO emphasised these special settings and argued that progress can be made despite challenges of instability and conflict. For example, according to WHO, 39 of 51 fragile states have developed accountability frameworks for women’s and children’s health.

Figure 15. Age distribution of under-20 mortality in low- and middle-income countries, 2010



Source: Jamison et al, 2013. Global health 2035: a world converging within a generation. *Lancet*.

46. Adolescents are the main new challenge for any post-2015 Global Strategy. The new Global Strategy has explicitly included adolescents in their post-2015 vision. The iERG drew attention to the importance of adolescents in its 2013 report. Adolescents often get little attention from the health sector since they are wrongly thought to be healthy and unimportant to development. But adolescents are central to the major challenges in global health. There are approximately 1.2 billion adolescents aged 10-19 years. Adolescence is a critical stage in life, characterised by rapid biological, emotional, and social development and during which every person can develop the capabilities required for a productive, healthy, and fulfilled life. Figure 15 shows the age distribution of child and adolescent mortality in low- and middle-income countries. The considerable number of deaths among adolescents draws attention to a very different pattern of ill-health in this important group.

- Tobacco use
- Overweight and obesity
- Mental ill-health
- Infectious diseases, including HIV
- Sexual and reproductive health disorders
- Risks from pregnancy and childbirth, including in the context of forced marriage
- Unsafe abortion

Attention to adolescent health will be essential if maternal mortality goals are to be met (28). Adolescence provides a critical interface in global health between women’s and children’s health and non-communicable diseases and mental health. Mental health will assume an increasingly important place in our thinking about health and wellbeing post-2015, and there will be no more important area where this is so than for the adolescent (29). The concern for adolescent health also opens up linkages with early child development, since many of the determinants of adolescent health begin well before adolescence starts. Early child development will therefore be a

- Unintentional injuries
- Harmful alcohol use

further important dimension for the new agenda for women's and children's health post-2015. The new Global Strategy has given adolescents an independent place in the continuum of care. But although health interventions will be important, adolescent health is about more than the health sector. Adolescent health in some ways needs to be demedicalised. The main drivers of adolescent health are largely outside of the health system—education, labour markets, economic policies, legislative and political systems, food systems, and the built environment. Education is especially important—not only because of its overall impact on health, but also because of the clear opportunity to prevent many of the adverse effects related to reproductive health through comprehensive sexuality education, about which there is new momentum with countries committing to making it universally accessible. How the SDGs and a new Global Strategy engage with these broader sectors will be one of the greatest challenges for the health community post-2015. We see hopeful signs. The World Bank has prioritised gender equality as a means to reduce poverty and promote prosperity. The Bank sees gender equality as a core development objective in its own right. But there are clouds to consider too. We note concerns that sexual and reproductive health and rights may be deprioritised in the new Global Strategy. We therefore urge those charged with implementing the Global Strategy to make sexual and reproductive health a priority for women and adolescents post-2015.

47. A further issue that has been even more neglected than adolescent health is stillbirths. A stillbirth is strictly a pregnancy loss after 22 weeks of gestation. The WHO definition is different—WHO defines a stillbirth as the death of a child whose birthweight is at least 1000g or whose gestational age is at least 28 weeks (a third-trimester stillbirth). Little or no funding is dedicated to stillbirth prevention. Yet 2.6 million women each year experience a stillbirth. Most babies who die in the last 3 months of pregnancy should have survived. 1.2 million babies begin labour alive and die before birth—an intrapartum stillbirth. These intrapartum stillbirths are a highly sensitive marker of the quality of care in a health system. The causes of stillbirth are known and they can be mostly addressed through good quality care. It is an entirely reasonable goal to make 2030 the deadline for preventing stillbirths in all settings. Yet stillbirths have remained uncounted in global frameworks for women's and children's health. No longer. A new series of papers to be published in *The Lancet* in 2015 will try to ignite the concern of the global community into this deeply neglected area. New estimates of stillbirth deaths will be reported, together with risk factors and the economic costs of stillbirth. Evidence of what works to prevent stillbirths will be reviewed, and an implementation plan will be designed. The goal will be to offer a roadmap for addressing stillbirths, one that will make a major impact by 2030, the deadline for the SDGs.



48. One of the key interventions to reduce the risk of stillbirth, and to end preventable maternal deaths, is emergency obstetric care (EmOC). Pregnant women and girls must have access to EmOC at the onset of every obstetric emergency. The components of basic EmOC include treatment for sepsis and eclampsia, treatment of prolonged labour and prevention and treatment of obstructed labour, post-abortion care, treatment for incomplete miscarriage, removal of the placenta, and assisted delivery using forceps or suction. Comprehensive EmOC requires access to surgery (specifically, Caesarean section), anaesthesia, and safe blood transfusion. The global health community has largely failed to make progress in mobilising action for EmOC. However, there is an opportunity to change the trajectory for EmOC. That opportunity comes with the launch of a new movement for global surgery (30). An alliance of health professionals launched the findings of a Commission on Global Surgery in 2015. The Commission found that:

- 5 billion people do not have access to safe, affordable, surgical and anaesthesia care when needed.
- 143 million additional surgical procedures are needed in low- and middle-income countries each year.

- 33 million individuals face catastrophic health expenditures due to payment for surgery and anaesthesia care each year.
- Investing in surgical services in low- and middle-income countries is affordable, saves lives, and promotes economic growth.
- Surgery is an indivisible, indispensable part of health care.

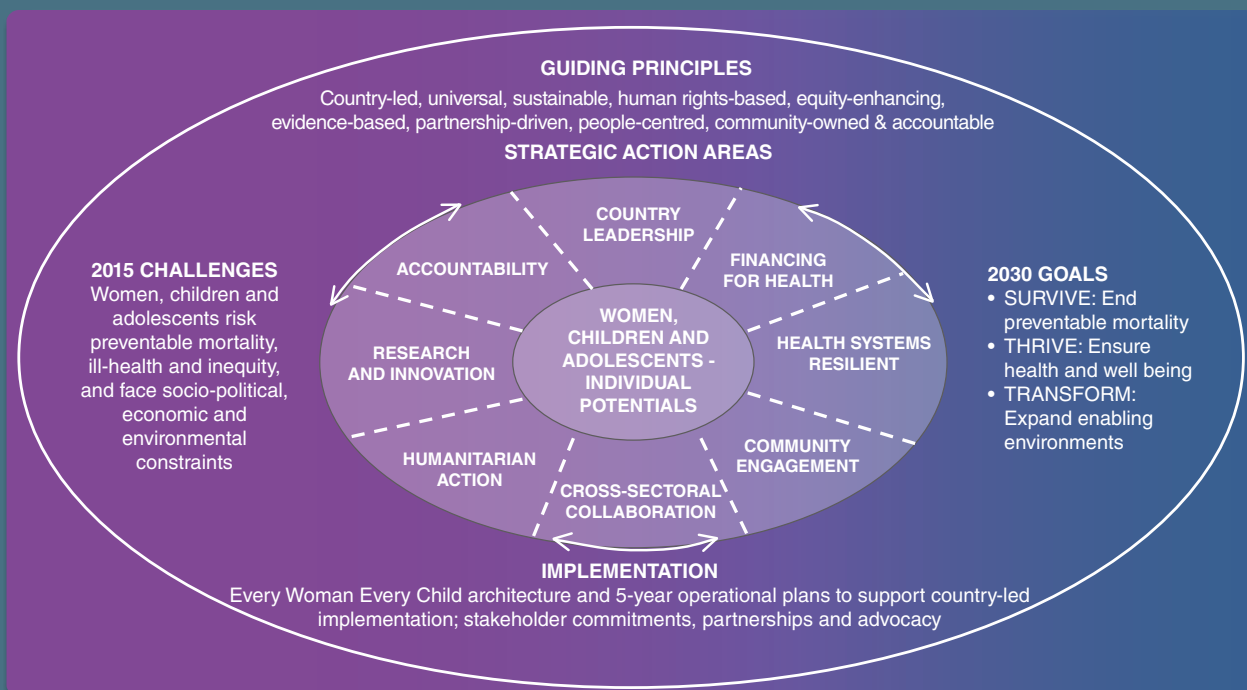
In May, 2015, the World Health Assembly recognised the importance of surgery by passing a resolution entitled, “Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage” (31). The combination of global commitments to deliver universal health coverage and new advocacy for essential surgical care offers a unique opportunity to expand high-quality health services for women and girls to reduce both maternal and stillbirth mortality.

49. One of the most neglected determinants of health for women and children is violence (32). Women and children bear the brunt of non-fatal physical, sexual, and psychological abuse.

- 1 in 5 women reports having been sexually abused as a child.
- 1 in 3 women has been a victim of physical and/or sexual violence by an intimate partner at some point in her lifetime.



Panel 8. Conceptual framework for the new Global Strategy for Women's, Children's, and Adolescents' Health



- An estimated 11.4 million women and girls are trafficked worldwide.
- 125 million women and girls in 29 countries have undergone female genital mutilation.
- Over 60 million women aged 20-24 years worldwide have been married before the age of 18.
- Women are killed due to a perpetrator's belief that the victim has brought dishonour on a family or community.

Violence against women and girls contributes to lifelong ill-health and premature death. Heart disease, stroke, cancer, and AIDS can partly be the result of victims of violence adopting high-risk behaviours in an effort to cope with the effects of violence. For women and girls post-2015, violence needs to be high on the agenda for action. Violence against women and girls must be publicly condemned at every opportunity. Countries should have well-resourced national plans of action to address violence against women and girls. Laws must be developed and enforced, policies implemented, and institutional capacities strengthened. Governments must invest in violence prevention. The health sector—through awareness, advocacy, and its practices and services—has an essential part to play in this work (33).

50. This broader context for women, children, and adolescents means that the conceptual framework for the new Global Strategy will be very different. The proposed framework is shown in Panel 8. Women's, children's, and adolescents' health will be addressed in the twin settings of sustainable development and humanitarian crises. It will be based on the principles of equity, human rights, and gender equality. It will begin with women, children, and adolescents within their families and communities. The health sector will clearly be a core focus. But the health-influencing sectors will be no less important—the socioeconomic, political, and environmental determinants of health; education; water and sanitation; and women's political and economic participation. The new global strategy has many virtues. But it has several potential weaknesses too. It needs to acknowledge more openly the failings of the first Global Strategy. It needs to give more explicit attention to newborns and stillbirths. The thin discussion on sexual and reproductive health and rights, together with the absence of unsafe abortion, should raise a signal of alarm that, once again, reproductive health is being sacrificed to political exigency. The issue of women in society has been grossly neglected by the health sector. Unless the contribution women make to

society is fully recognised, achieving the post-2015 SDGs will never be a serious possibility. Women's contributions to work and care are drivers of the wealth and health of nations, but these contributions are still under-appreciated. One estimate put the contributions of women at over US\$3 trillion a year (34). As Ana Langer has noted,

“Sustainable development needs women's social, economic, and environmental contributions, which will increase when women are healthy, valued, enabled, and empowered to reach their full potential in all aspects of their lives.”

The challenge for everyone engaged with women's, children's, and adolescents' health will be how to turn this statement of aspiration into practical policy.

51. Given this framework and the new challenges ahead for women and children, what is the future of accountability post-2015? Accountability is a fashionable idea in development debates today. Amnesty International, Human Rights Watch, the Center for Reproductive Rights, and the Center for Economic and Social Rights have argued that, “Accountability for the post-2015 agenda is a matter of universality, not conditionality.” Others have suggested that, “Accountability in global health is a commonly invoked though less commonly questioned concept” (35). The Global Respectful Maternity Care Community of Concern has called on the iERG to make specific recommendations to governments to create and implement participatory accountability mechanisms for respectful maternity care that are informed by women's experiences. Whatever perspective one takes, what is certain is that data have never been so important an issue in global health as today. As the Independent Expert Advisory Group on a Data Revolution for Sustainable Development noted last year,

“Data are the lifeblood of decision-making and the raw material for accountability. Without high-quality data providing the right information on the right things at the right time, designing, monitoring, and evaluating effective policies becomes almost impossible” (6).

Universal civil registration and vital statistics systems (CRVS) are central to this vision (36). We believe we have good grounds to be hopeful about progress towards more reliable data for strengthening accountability. In evidence submitted to the iERG by the Africa Programme on Accelerated Improvement of CRVS, it is clear that in the most data-challenged region, Africa is implementing a major continent-wide programme to improve CRVS. African governments have recognised CRVS as a development imperative, and a critical element for health advances in particular. 22 African countries have undertaken CRVS

assessments and developed national plans of action based on those assessments.

52. If data are the raw material for accountability, what about accountability itself? The iERG received several case studies of examples of accountability in action—from using evidence to drive action on the quality of maternal, newborn, and child health care (37), to using scorecards to achieve improvements in facilities for maternal and newborn health (38). These experiences were drawn together in a milestone meeting held in June, 2015—Measurement and Accountability for Results in Health: A Common Agenda for the Post-2015 Era. Led by the World Bank, WHO, and USAID, 5 important commitments were made:

- To increase the level and efficiency of investments by governments and development partners to strengthen the country health information system in line with international standards and commitments
- To strengthen country institutional capacity to collect, compile, share, disaggregate, analyse, disseminate, and use data at all levels of the health system
- To ensure that countries have well-functioning sources for generating population health data, including CRVS, censuses, and health surveys tailored to country needs, in line with international standards
- To maximise effective use of the data revolution, based on open standards, to improve health facility and community health information systems, including disease and risk surveillance and financial and health workforce accounts, empowering decision makers at all levels with real-time access to information
- To promote country and global governance with citizens' and community's participation for accountability through monitoring and regular, inclusive transparent reviews of progress and performance at the facility, subnational, national, regional, and global levels, linked to the health-related SDGs

The meeting called for a global coordination and accountability mechanism to be in place by 2016 to monitor progress on this health measurement roadmap. The iERG supports these commitments—which are fully aligned with the recommendations we too have been making. We suggest they be extended to cover three additional issues: donor accountability, inclusion of new categories of data, and more attention to action in the framework of “monitor, review and action.” First, donor accountability was core to the original vision of CoIA and is increasingly becoming a strong demand from donor recipient countries. Lack of attention to donor accountability might fuel resistance to accountability itself, and undermine its implementation



within the SDG framework. Second, data on quality of care, gender inequalities, mental health, adolescents, reproductive health, and unsafe abortion have seen some progress, but need to be collected and analysed in a much more systematic way. Third, action is the most neglected component of the three components of our accountability framework. While there is an increased emphasis on usability of data by decision makers, it is important to establish mechanisms for enforceability of remedial actions, not only at the much needed local and national levels, but also taking into consideration the political determinants of health inequity. Many of the root causes of health inequity require more than technical band-aids.

53. There is no single perfect model of global accountability. In our 2014 report, we set out 12 principles for accountability rather than endorse a single approach—legitimacy, independence, framework, terms of reference, reliable data, parsimony, country engagement, review mechanisms, participation, regular reporting, resourcing, and monitoring impact. These principles still seem to us to have merit. For example, although a Progress Report on the Global Strategy was published in

2015, that report was not independently researched and written, thus weakening its force as a document measuring the impact of *Every Woman, Every Child*. WHO recognises the importance of independence. In its evidence to the iERG, WHO notes that,

“Independent accountability remains essential for the post-2015 period: There is multi-stakeholder consensus on the need for independent accountability for women’s and children’s health post-2015, and this is a priority in the development of the new Global Strategy for Women’s, Children’s, and Adolescents’ Health.”

The model for independent global accountability should include the following key elements:

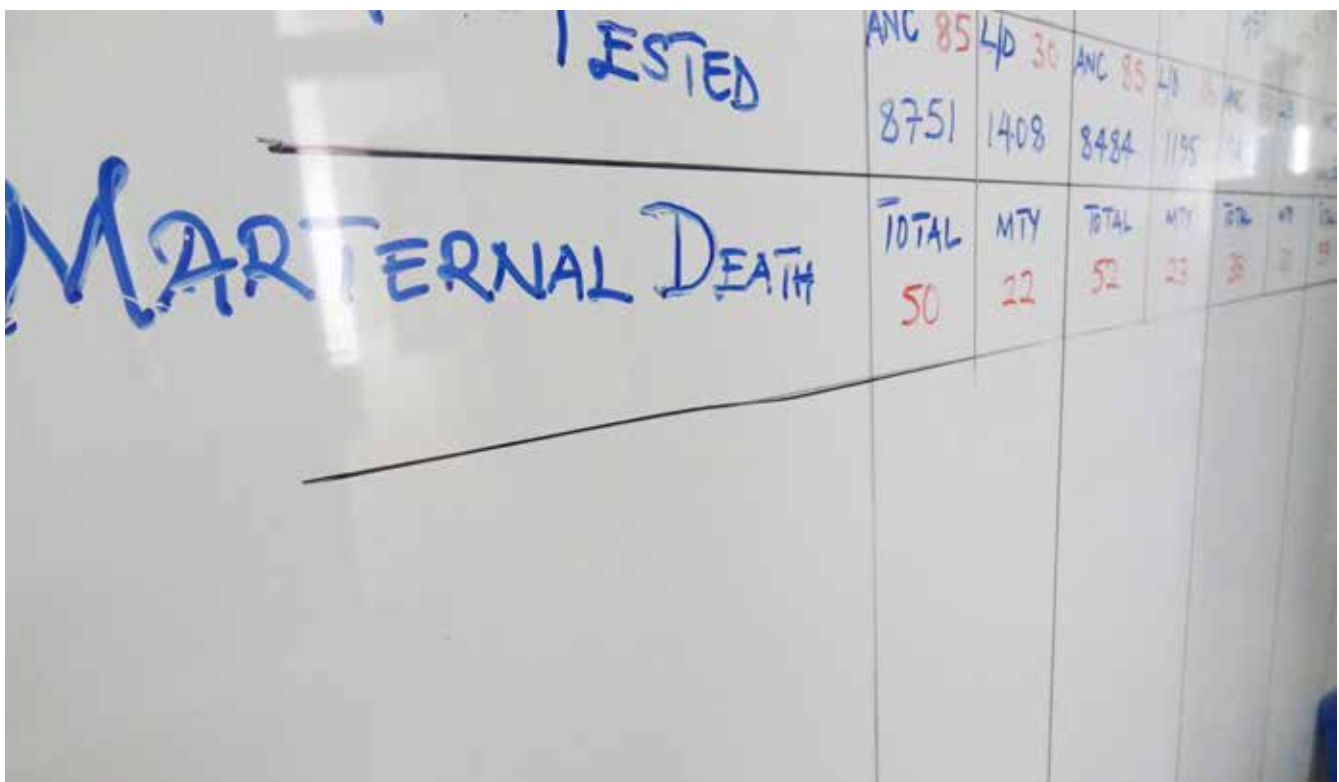
- A framework definition of independent accountability: Monitoring, Review, Act
- Legitimacy established through a UN agency governing body or related political process
- Full administrative and technical resourcing
- Clear roles and responsibilities for reporting among, and working with, partners
- Indicators that measure impact and that are sensitive to change, disaggregated for equity considerations and aligned with related global processes (eg, SDGs)

- Emphasis on donor as well as country accountability
- Attention to implementation of the findings and recommendations from the independent accountability mechanism
- Host the administration of the independent accountability mechanism within an existing entity engaged in delivering the Global Strategy, but ensure the independence of the accountability research and writing process
- Establish a reporting line between the independent accountability mechanism and the UN Secretary-General, through the Director-General of WHO
- Ensure that accountability reports and recommendations are presented in high-level fora with sufficient time and engagement to allow debate and discussion
- Link global and national accountability mechanisms

The iERG's proposal for independent accountability for a renewed Global Strategy is reproduced in Annex 6. All parties in the discussion recognise and accept the importance of an Independent Advisory Panel to replace the iERG. The disagreement relates to who has primary responsibility for producing the independent assessment of the Global Strategy's progress—should it be, for example, the Independent Advisory Panel itself, with technical and administrative support from PMNCH or should it be PMNCH, with advisory input from the Independent Advisory Panel. We prefer the first option: we see a critically important role for PMNCH, but we see their comparative advantage as one of technical

and logistical support, an important gap in the current accountability arrangements of which the iERG is a part.

54. Two particular groups have an important part to play in strengthening any independent accountability process, globally or nationally—civil society and the research community. The engagement of civil society strengthens social accountability. It also builds community trust and confidence about programmes and policies. The meaningful participation of civil society in accountability mechanisms changes the dynamics of power in decision making. Greater attention can be given to equity, dignity, human rights, and quality, together with groups or issues that may have been marginalised—eg, adolescents, donors, unsafe abortion, sexual and reproductive health and rights, and mental health. The participation of civil society will also make transparency and data availability priority concerns. The research community also has a neglected part to play in strengthening accountability. Through their attention to reliable data and independent analysis, scientists can use research methods—and tools of research, such as peer review, presentation, publication, and, not least, academic freedom—to hold policymakers accountable for their programmes and decisions. This work ranges from the calculation of estimates of mortality to the evaluation of specific health programmes. The engagement of the scientific community in calling for stronger accountability in global health is one example of research recognising its larger social and political role in society (39).



Daily reminder of the unacceptable reality in the Maternity Department

Rape and access to abortion in the Democratic Republic of the Congo

Raped, pregnant, and unable to access safe abortion services: the extent of these atrocities in the Democratic Republic of the Congo (DRC) has received considerable international attention in recent years. The focus has been on the widespread use of sexual violence as a weapon of war. Less attention has been paid to the high incidence of intimate partner sexual violence and to the fact that rape survivors have no access to safe abortion.

Data on rape, sexual violence, and abortion in the DRC are unreliable and widely perceived to be underestimates, as many cases remain unreported; up-to-date data do not exist (1). In 2008, WHO estimated that the unsafe abortion rate was 36 per 1000 women aged 15–44 years, and that 12% of maternal deaths were due to complications following unsafe abortion (2). In 2008, UNFPA reported that 15 996 new cases of sexual violence were registered throughout the country, that more than 65% of the victims were under 18 years of age (most of them adolescent girls), and that an estimated 10% of victims were children under 10 years old (3). A study in 2011 estimated that every hour, 48 women are raped in the DRC—more than 420 000 per year—and that the conflict-ridden eastern provinces have the highest prevalence of rape in the world (4). Official sources recorded 7075 cases of sexual violence in North Kivu province in 2012, up from 4689 cases in 2011 (5).

The 2013–2014 Demographic and Health Survey (DHS) reports that 27% of women in the DRC have ever experienced sexual violence and that 16% have experienced sexual violence in the last 12 months (6). Among ever-married women aged 15–49, 57% have ever experienced intimate partner violence (emotional, physical, or sexual). The DHS also reports that the maternal mortality ratio is 846 per 100 000 live births, up from 549 in 2007.

Induced abortions are illegal in the DRC, punishable by 5 to 15 years' imprisonment. Exceptions are made when a woman's life is in danger, but not for victims of rape. This grim reality violates the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol), which the DRC has signed and ratified. The Protocol instructs states parties to "protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the fetus" (7).

The plight of rape survivors in the DRC is exacerbated by a long-standing United States policy that prohibits humanitarian aid organisations from using funding from the United States Agency for International Development (USAID) to provide abortion services (8). On May 11, 2015, as part of the universal periodic review process of a country's human rights record, Belgium, France, the Netherlands, Norway, and the United Kingdom called on the American government to take steps to limit the impact of these restrictions and ensure access to safe abortion for rape victims (9). The United States has three months to respond formally.

Over the past year, the DRC's government and courts have taken their first steps towards ending conflict-related sexual violence. In September, 2014, the Forces Armées de la République Démocratique du Congo (FARDC) launched a national action plan against sexual violence in conflict. Since then, there have been several convictions of military and police officers for rapes of women and girls and other sexual violence crimes (10). For example, in November, 2014, FARDC general Jerome Kakwavu was sentenced to 10 years in prison for rape, murder, and torture, and in December, 2014, FARDC lieutenant colonel Bedi Mobuli Engangela received a 20-year sentence for rape and a 15-year sentence for sexual slavery.

On March 31, 2015, FARDC commanders signed a landmark declaration to combat rape in war (11). Actions required of military leaders include, among several others: "respecting human rights and international humanitarian law in relation to sexual violence in conflict; ensuring prosecution of alleged perpetrators of sexual violence under their command; and sensitizing soldiers under their command about the zero tolerance policy on sexual violence in conflict." In addition to signing the declaration, the Defence Minister also established a Commission to oversee the implementation of the FARDC's action plan against sexual violence. It remains to be seen if the plan will be fully implemented and what difference it will make.

Given that the epidemic of sexual violence in the DRC is not restricted to conflict zones, a whole-of-society approach is needed, including policies and programmes aimed at ending the culture of acceptance and impunity surrounding intimate partner sexual violence (1,4). A top priority should be a new law that criminalises domestic violence, including marital rape.

In addition, in accordance with international human rights law and humanitarian law (including the Geneva Conventions), the government of the DRC has a legal obligation to ensure that all survivors of rape have equal and effective access to accountability mechanisms, reparations, and non-discriminatory counselling and medical care (1,4,12). This means that the Penal Code must be amended to

allow rape victims access to legal and safe abortion and post-abortion care.

Changing the trajectory of sexual violence in the DRC will require a wide range of national and international actions. National legal reforms to prevent sexual violence and ensure both justice and medical care for victims are a necessary first step.

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5. CONCLUSIONS AND RECOMMENDATIONS

55. When young children observe something unexpected, their learning is enhanced (40). This finding should encourage us. The expectation of *Every Woman, Every Child* was that 16 million lives would be saved across 49 countries from 2010 to 2015. Unexpectedly, that figure was incautious. The actual number of deaths averted was 2.4 million. This discrepancy should propel us to think harder, to use this disappointing result to learn how to do better. As we enter the era of sustainable development, our approach to the health of women, children, and adolescents will be challenged and tested still further. Complexity, fragility, and uncertainty are the hallmarks of our world today. Populations are growing rapidly in regions of the world already under severe demographic pressure. Multilateralism is in decline. Globalisation is increasing inequalities within countries. Political, economic, environmental, and health crises are overwhelming institutions we once relied on to protect us. Public trust in governments is falling. Technological advances are inspiring, but also disruptive. This is the context in which we have to consider the future of women and children.

56. In its evidence to the iERG, WHO places great emphasis on the importance of accountability—“there is consensus on the need for both mutual and independent accountability, the need to strengthen support for country-level accountability, the need to further coordinate and harmonise accountability efforts at the country and global level, for greater engagement at regional level, and the need to strengthen remedial action.” WHO identifies 8 insights from its experience of implementing the recommendations of CoIA:

- Country ownership is vital for success.
- Equity and human rights are at the heart of the accountability agenda.
- Independent accountability mechanisms remain important.
- Communication and dissemination must be enhanced.
- Engagement of civil society is key and must be strengthened.
- Parliamentarians are important for enhanced transparency.
- Data need to be transparent and freely accessible, in usable formats.
- There need to be much stronger linkages between the three parts of the accountability framework: monitor, review, and act.

57. The continuing importance of accountability was emphasised repeatedly in evidence to the iERG. For example, WHO’s Regional Office for Africa argued that “the CoIA process has been successful in most

African countries so far” and that the Commission’s recommendations “remain very valid in the African region, even beyond 2015.” The challenges for the future will be improving the quality of information available for delivering accountability, obtaining political commitment, ensuring regular reporting, and strengthening civil society engagement.

58. Surveying the SDGs, the health of women, children, and adolescents is not confined to SDG-3. Rather, it is distributed across many SDGs—SDG-1 (poverty reduction and social protection); SDG-2 (food security and nutrition); SDG-4 (education and early childhood development); SDG-5 (sexual and reproductive health and rights, sexual violence, forced marriage, and female genital mutilation); SDG-6 (water, sanitation, and hygiene); SDG-8 (economic growth); SDG-10 (inequality and social protection); SDG-11 (urban health, disasters); SDG-16 (homicide, conflict, violence, accountable institutions, and CRVS). How sensible is it to create an accountability mechanism that focuses either on one SDG or a narrow interpretation of a new Global Strategy? Instead, would it not be more productive to monitor and review issues that directly or indirectly influence the health of women, children, and adolescents? For example, many of the multilateral institutions charged with a health responsibility also have strong commitments to other areas of the SDGs. To take one particular instance of cross-linkage: WHO/ UNICEF produce an appraisal of progress towards MDG-7 on environmental sustainability. MDG-7 is not a core health MDG, but it incorporates targets on water and sanitation, clearly important determinants of health. The global MDG target for drinking water was met in 2010, whereas the target for sanitation was missed by almost 700 million people. The need for integration of accountability across the spectrum of health and the determinants of health therefore seems compelling. In taking account of these various factors, we have formulated 3 final recommendations from the iERG:

59. Global accountability: By 2016, establish and implement a global independent accountability mechanism to monitor, review, and act on results and resources for women’s, children’s, and adolescents’ health, working across all 17 SDGs, reporting annually to the UN Secretary-General.

60. National accountability: By 2016, in all countries establish and implement transparent, participatory, democratic, and independent national accountability mechanisms to monitor, review, and act on results and resources for women’s, children’s, and adolescents’ health, with special attention to the translation of recommendations into action and reporting to Heads of State.

61. Accountability for sustainability: In 2017, convene a global ministerial summit to report on progress towards the goals both of the new *Global Strategy for Women’s, Children’s, and Adolescents’ Health and the SDGs relevant to women, children, and adolescents; and to report on how national accountability informs and strengthens global accountability.*

62. We believe that implementation of these recommendations could do much to create the conditions for one of the most remarkable successes global health is likely to see during the SDG era. The global community is developing ambitious targets for reduction in child and maternal mortality for the SDG period. Different studies and different agencies have put forward different goals, but all are

ambitious. As we have discussed, one goal is a two-thirds reduction in both maternal and child mortality rates over the 20-year period 2010-30 (24). The iERG commissioned the same team that derived the “40 by 30” target to project how many deaths would be averted globally, relative to a 2015 baseline, if the goals from their *Lancet* paper were to be met. Applying the methodology of that paper, but adjusting the base year to 2015, 34 million child deaths and about 1.5 million maternal deaths would be averted globally in the SDG period. These numbers assume that the world will meet its ambitious goals. The iERG believes that this striking outcome is both technically and financially feasible for the world to meet. But the question remains as to whether it is politically feasible too. See Panel 9 for a fuller description of these estimations.



Panel 9. Estimates of child and maternal deaths averted for the period 2015–2030

The iERG sought to calculate an estimate for the number of child and maternal deaths that would be averted globally between 2015 and 2030 if the SDG targets proposed by Norheim et al were achieved (24). We commissioned Professor Ole Norheim to make this calculation. He has previously proposed that an overarching target for the health SDGs could be a 40% reduction of all premature deaths (deaths before 70), and a two-thirds reduction of child and maternal deaths (compared with 2010 death rates, adjusted by population size for the year 2030).

For the period 2015–30, we estimated child and maternal deaths that would occur annually, adjusted by the number of live births for the year 2030, assuming a linear decrease in mortality from the year 2015 to 2030. This adjustment is necessary to get comparable numbers when population size changes over time. We used the same method as described by Norheim et al (24). The “40 by 30” sub-target proposed for child and maternal mortality is a two-thirds reduction of deaths that would have occurred if 2010 death rates were applied to the 2030 population. The only difference in this calculation is that we used 2015 as the baseline for estimating deaths averted. We calculated deaths averted by comparing the (adjusted) number of deaths in 2015 with each year up to 2030, and then adding them up.

When we look at projections from 2015 to 2030, we see that about 34 million child deaths could be averted in the period 2015 to 2030 if the “40 by 30” target is achieved by 2030 (Table A). About 1.5 million maternal deaths could be averted in the same period (Table B).

Table A. Estimated child deaths averted globally (2015–2030), if 2/3 of 2010 deaths are averted by 2030*

Year	Child deaths	Live births	Annual targets (adjusted to 2030 population)	Deaths averted compared to 2015
2010	6 900 000	131 900 000	6 800 000	...
...
2015		135 400 000	6 000 000	
2016		135 200 000	5 600 000	400 000
2017		134 700 000	5 200 000	700 000
2018		134 000 000	4 900 000	1 000 000
2019		133 400 000	4 600 000	1 400 000
2020		133 000 000	4 300 000	1 600 000
2021		132 900 000	4 000 000	1 900 000
2022		132 900 000	3 800 000	2 200 000
2023		133 100 000	3 600 000	2 400 000
2024		133 300 000	3 300 000	2 600 000
2025		133 500 000	3 100 000	2 800 000
2026		133 600 000	2 900 000	3 000 000
2027		133 700 000	2 700 000	3 200 000
2028		133 800 000	2 600 000	3 400 000
2029		133 900 000	2 400 000	3 500 000
2030		134 000 000	2 300 000	3 700 000
Sum				34 000 000

Table B. Estimated maternal deaths averted globally (2015–2030), if 2/3 of 2010 deaths are averted by 2030*

Year	Maternal mortality ratio (per 100 000 live births)	Live births	Annual targets (adjusted to 2030 population)	Deaths averted compared to 2015
2010	230	131 900 000	308 000	...
...
2015		135 400 000	264 000	
2016		135 200 000	248 000	16 000
2017		134 700 000	233 000	31 000
2018		134 000 000	219 000	45 000
2019		133 400 000	205 000	59 000
2020		133 000 000	193 000	71 000
2021		132 900 000	181 000	83 000
2022		132 900 000	170 000	94 000
2023		133 100 000	160 000	104 000
2024		133 300 000	150 000	114 000
2025		133 500 000	141 000	123 000
2026		133 600 000	132 000	132 000
2027		133 700 000	124 000	140 000
2028		133 800 000	116 000	147 000
2029		133 900 000	109 000	155 000
2030		134 000 000	103 000	161 000
Sum				1 476 000

* = Adjusted to live births in 2030 (UN Population Division medium fertility projections).

Note: This panel is adapted from a submission by Professor Ole Norheim to the iERG.

63. The iERG does have concerns that this important opportunity will be missed unless ten critical enabling factors are prioritised:

- Promoting greater country leadership globally, delivering knowledge and knowhow to accelerate national progress
- Achieving equity
- Prioritising sexual and reproductive health and rights
- Attending to the social, economic, and political determinants of women's, children's, and adolescents' health
- Improving the quality of health care for women and children
- Filling disturbing gaps in data to strengthen decision-making
- Documenting and acting upon the prolific indignities of care suffered by women and children worldwide
- Selecting and monitoring the most important indicators shaping the health and outcomes for women, children, and adolescents

- Ensuring that the means of implementation for health goals—financing, human resources, governance, information systems—are given as much attention as the goals themselves
- Engaging young people in leadership and implementation

The iERG also recognises that concerns for women's and children's health should not focus exclusively on mortality. In evidence submitted to the iERG, for example, the Global Respectful Maternity Council urged us to put the provision of respectful maternity care at the centre of our recommendations on accountability. The Council called on us to ask again for a Global Commission on the Health and Human Rights of Women and Children.

64. But perhaps the most important determining factor for the future of accountability will be financing. In evidence submitted to the iERG, we have heard repeatedly that the main constraint is lack of funding.

Here, for example, is the Africa Programme on Accelerated Improvement of CRVS:

“The core challenge faced by the regional programme is the lack of systematic funding...The funding for the programme, largely sourced from development partners, has been inadequate and ad hoc in nature. The unpredictability of resources has affected the smooth implementation of the programme...Although the bulk of the funding for the plans will come from Governments, some countries will require catalytic funds to kick-start implementation. The availability of such funding has critical implications for the success of the regional initiative.”

Their point is well made. Countries recognise that in the future, resources for improving women’s, children’s, and adolescents’ health, and resources for strengthening accountability too, will be mobilised domestically. But countries still need critical externally sourced investments to support their own programmes for development. The funding gap does not only affect countries. International agencies are hit too. For example, in evidence submitted to the iERG by WHO’s Western Pacific Region, a key remaining challenge was limited financial resources: “Development partners have limited financial resources for RMNCAH programmes...This has hindered the scale and scope of technical support that can be provided to implement CoIA and CoLSC recommendations.”

65. One of the most heralded meetings of 2015 was the Third Financing for Development conference (FFD3), held in Ethiopia in July, 2015. The Addis Ababa Action Agenda that followed was called historic and ground-breaking by some observers. But our view is that FFD3 was a serious disappointment for health, and surprisingly vague on the promises made for women and children specifically. First, on health. Of 134 paragraphs in the final outcome document, only one was dedicated to health—where no explicit commitments were offered. WHO’s role was reaffirmed. The Global Fund and Gavi were urged to take health systems more seriously. And the Framework Convention on Tobacco Control was supported. There was an additional note about the value of research into vaccines. But overall, FFD3 was empty of substantive content. The language of bureaucracy and compromise strangled any possibility of an inspiring vision to deliver the SDGs. Instead, there were only imprecise calls for more domestic resource mobilisation, greater contributions from the private sector and philanthropy, and stronger trade. On women and children, the centrepiece in Addis was the launch of the Global Financing Facility. The iERG supports

all efforts to expand the funding envelope for women and children. But there was surprise and confusion when Jim Kim, President of the World Bank, reported that US\$12 billion had been mobilised to support new financing for women and children, when the actual figure of known pledges was US\$1 billion—a good beginning, but only incremental, and certainly not transformative, financing. The impact of the Global Financing Facility remains uncertain. We wish the Facility well, but we are not yet convinced it has the broad support or resources to be successful.

66. In concluding our work, we ourselves need to be accountable to the *Every Woman, Every Child* movement, and most importantly, to the women, children, and adolescents who are the subject of our concern. Two questions demand answers:

Since the launch of the work of the Commission on Information and Accountability and iERG, do countries and partners have better information to track results and resources?

Do those countries and partners have stronger and more sustainable systems of accountability, nationally and globally?

On the first question, we believe we have shown (Figure 14) that progress has been achieved in several critical areas—notably, acceleration of CRVS strengthening, innovation, agreement of country compacts, and awareness and advocacy for global and national accountability. In other areas, there are simply too little data to make confident judgements either way (on resource tracking, reaching women and children, and transparency). And in a few domains, we have been disappointed by lack of progress—eg, on the uptake and use of indicators to monitor change, and on the energy and commitment given to addressing inequalities (41). But on the second question, we are even more cautious. Globally, the iERG concludes its work in 2015. Although accountability is much discussed and partners seem committed to the principles of accountability, the precise arrangements for creating a sustainable mechanism to deliver independent global accountability for women’s, children’s, and adolescents’ health are unclear. We are concerned that the gains made in establishing independent accountability as a central part of the Global Strategy and SDG process post-2015 are at risk. In countries, although there has been considerable discussion of, and advocacy for, accountability, the evidence that resilient processes for monitoring, reviewing, and acting are in place is not available. There are documented examples of successful country accountability mechanisms

(42). We believe that countries have an extraordinary opportunity to make accountability the foundation for their accelerating development.

67. As we complete our term of office, we have looked back over the past 4 years to reflect on the lessons learned from the idea and practice of independent accountability.

- Independent accountability can be done and delivered, despite often challenging limitations of information and resources.
- Although global accountability was strengthened with the advent of an iERG, the connection with country accountability was weak. Indeed, our country level activity was the least developed part of our work. The country visits we undertook in 2014 were an important step in the right direction, one that we hope will be repeated and developed in future years. These visits allowed much more comprehensive national assessments of progress. But country visits by the iERG cannot substitute for strengthened national capacities for independent accountability. Such country accountability systems should be more formally linked to whatever global mechanism is put in place.
- The independent accountability mechanism needs to be supported in developing stronger relationships with country development partners. One possible solution is to designate a national accountability representative within each country WHO team whose responsibility is to survey and shepherd progress on CoIA recommendations.
- Accountability must be accompanied by tangible actions and remedies at global and national levels for its full value to be realised. The link between the sensory inputs of independent accountability and the effector outputs of action must be strengthened.
- Between its global and country concerns, independent accountability can also operate regionally. It would have been helpful if the iERG had been able to take fuller advantage of regional health institutions (eg, with the Regional Offices of WHO).

- The iERG was constantly aware of the value of the independence it was granted by CoIA. That independence is partly guaranteed from the broad array and diversity of its members in age, professional background, philosophy, expertise, and geography. The complementarities of backgrounds and skills within the iERG membership were a major advantage to its work. The independence we were given enabled us to commission reports and case studies to illustrate critical points of concern.
- We learned that to make the most of the evidence we received, we should not only measure and report on progress in our monitoring role, but also develop policy proposals for action and remedy.
- We were repeatedly made aware that for our recommendations to have maximum impact, our reports had to be channelled to the highest reaches of global decision-making. Although we sought more formal presentation and discussion of our annual reports at key global meetings, we were disappointed with the progress we made in this regard.
- The hosting, resourcing, and autonomy of the mechanism for independent accountability are critical to its success. The secretariat function of the iERG is a vital part of its work. We believe that the technical capacity of this secretariat should be strengthened in future iterations of independent accountability.

68. We began our report with the stories of, among others, Fatima, Elima, Emile, and Maria. Each story told a truth about the lives of women and children in the world today. The death of a newborn baby. Health in a conflict zone. A stillbirth. Sexual violence. A preventable maternal death. The victims of Ebola. The death of a child. The indignities inflicted by a failing health system. Amid the charts, research papers, reports, evidence, numbers, estimates, projections, assessments, and scorecards we have reviewed and interpreted, it is these stories we wish to conclude with—the lived experiences of women and children everywhere. These stories and experiences should provoke not only shock, compassion, and outrage, but also commitment, action, and results.

Argentina: Conditional cash transfer programmes and their impact on women's and children's health and gender roles

Since the 2001 economic downturn, the Argentinian government's increased focus on conditional cash transfer (CCT) programmes has played an important part in expanding the provision of social protection and welfare to Argentina's most vulnerable women and children.

The Universal Child Allowance programme (*Asignación Universal por Hijo*; AUH) was launched in 2009 for children under the age of 18 whose parents or guardians were either unemployed or working in the informal economy, thereby expanding the reach of benefits provided under the social insurance system to the disproportionately poorer population. By focusing on the intended beneficiaries, AUH differs from other CCT programmes in Latin America, which have historically focused on poverty alleviation. AUH provides cash benefits, conditional on children receiving routine health check-ups, including vaccinations, and on their school attendance. It covers around 3.5 million children and 1.9 million households, representing 29% of all children and 15% of all households in Argentina (1,2).

A simulation exercise in 2009 to assess the impact of AUH's implementation calculated that poverty was reduced by 21.9%, extreme poverty by 42.3%, and inequality by 20% (2). Impacts are of course difficult to attribute to AUH alone, since the government has other programmes aimed at improving women's and children's health and welfare. However, a study from the National Scientific and Technical Research Council (CONICET) states that AUH has reduced extreme poverty by up to 70% and poverty by 13–32%, calling it the “most successful social policy measure of the last 50 years” (3).

In terms of education, the programme created incentives for individuals to change their behaviour. Since its introduction, attendance by both primary and secondary school students has increased and the school drop-out rate has fallen. The Ministry of Education reported a 51% increase in student enrolment from the programme's inception to May, 2010, and a 15% increase in attendance. School directors have attributed these improvements to AUH (4).

CCT programmes have also been reported to foster a sense of empowerment among women (5).

Women from poor households, many of whom are socially subservient and uneducated, are instead perceived as “co-responsible and active” partners working to address the poverty of their households (6). Argentina's social inclusion programmes, such as *Plan Jefas*, have in the past provided women with opportunities to enter the active labour market through participation in community projects, allowing them greater avenues for self-development, unlike the traditional human development approach of other CCT programmes in the region, which focused primarily on attainment of children's educational and health outcomes.

However, it has been noted that CCT programmes have also unintentionally reinforced patterns of gender segmentation, perpetuating poor skill growth and inhibiting low-income women workers from graduating to formal work (6). While CCT programmes such as *Plan Familias* and *Seguro* later emerged to address these gaps, by providing more targeted assistance to vulnerable populations of poor women and the elderly, the focus eventually narrowed to address child poverty alone, culminating in the launch of the AUH in 2009.

Thus, while Argentina has achieved modest success in improving health and education for children and adolescents as a result of AUH (4), it has had less success in improving gender imbalances and giving women opportunities to escape traditional gender roles and low-skilled jobs (7).

Going forward, and learning from successful designs of CCT programmes in the past, a future direction for AUH and CCT programmes in general could be to reincorporate a focus on training and skill development for women, and to make direct payments only to women (instead of the current system in which both men and women can receive cash), fostering empowerment especially for women in unstable unions (8). Similarly, adopting a more multidimensional and psychological vision of poverty that utilises CCTs as “an extension of women's individual responsibilities in managing household poverty with no collective component” (as in Chile's *Puente* programme) may produce a more equitable adjustment of gender roles in their approach to reducing poverty (9).

Additionally, better coordination and integration with other social welfare programmes and the National

Social Security Programme (*Obras Sociales*) will help address concerns about AUH's long-term sustainability and cost-effectiveness. Some steps are already being taken in this direction, such as the creation of a unified electronic database of beneficiaries to improve targeting and tracking (10) and especially to address documentation and newborn registration problems. This database will also enable the measurement of health outcomes and more accurate estimates of the overall impact of AUH (albeit in coordination with other welfare programmes).

Other innovations are helping to address delays in the uptake of benefits among eligible households and across age groups. For example, making benefits conditional on enrolment in *Programa Sumar* (previously *Plan Nacer*) has

improved uptake among the infant age group, and adolescents aged 10–18 are now being engaged through activities such as karate classes that promote a healthy lifestyle (11).

Finally, AUH further highlights the need to ensure the availability of health centres and educational establishments in the beneficiaries' local neighbourhoods, and places a crucial emphasis on the quality of services provided. While supply-side programmes like *Plan Nacer* have had more success in this regard (12), and provide better services in line with their results-based financing frameworks, AUH is still essential in order to motivate demand-side behaviour more directly. In the future, these programmes should be more closely coordinated in order to achieve the best possible results.

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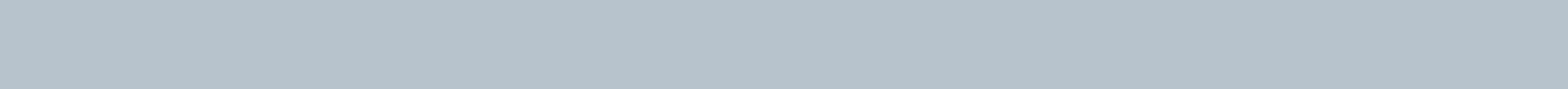
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individuals and organisations who submitted evidence to the iERG. Without their enthusiastic collaboration with, and support for, independent accountability, we could not have completed our work over the past 4 years. Finally, the iERG thanks our dedicated secretariat without whom this final report would never have been possible: Ramesh Shademani, Natasha Shapovalova, Alex Gaina, Alexandra Rosado Miguel, Nupur Mital, and Nadia Day.





COUNTRY PROFILES

iERG COUNTRY PROFILE: MEASURING PROGRESS ON ACCOUNTABILITY

The iERG country profile presents a snapshot picture of a country's progress towards the nine recommendations of the Commission on Information and Accountability (CoIA). The first page of the profile presents the demographic data with progress towards MDGs 4 and 5, specifically the 3 impact indicators Maternal mortality ratio, Under-five and Neonatal mortality rates, and Under-five stunting. It also presents key data on reproductive health and health systems, and progress in the 8 coverage indicators across the continuum of care, with a focus on equity. The second page of the profile highlights progress on the recommendations, grouped into Better Information; Better Resources; and Better Oversight. The information is intended to help policy makers and their partners assess progress and prioritise further actions to save women's and children's lives.


Latest publicly available data are presented, which vary considerably country by country, and for each indicator. Most of the data for the coverage indicators come from household surveys: mainly the USAID-supported Demographic and Health Surveys (DHS) and the UNICEF-supported Multiple Indicator Cluster Surveys (MICS). Other data sources include the WHO Global Health Observatory, OECD datasets (OECD.Stat), the UN Population Division, and WHO MNCH survey data. See details under each profile. More information on the indicator definitions and data sources can be found in the annexes to the Countdown to 2015 reports (<http://www.countdown2015mnch.org/reports-and-articles>), in the WHO Global Health Observatory (<http://www.who.int/gho/en/>), and in the WHO Global Health Expenditure database (<http://apps.who.int/nha/database>).


Profiles are presented for the 75 iERG countries with high burden of maternal and/or child mortality, including the 49 lowest-income countries covered by the Global Strategy for Women's and Children's Health.


Afghanistan	Lesotho
Angola	Liberia
Azerbaijan	Madagascar
Bangladesh	Malawi
Benin	Mali
Bolivia (Plurinational State of)	Mauritania
Botswana	Mexico
Brazil	Morocco
Burkina Faso	Mozambique
Burundi	Myanmar
Cambodia	Nepal
Cameroon	Niger
Central African Republic	Nigeria
Chad	Pakistan
China	Papua New Guinea
Comoros	Peru
Congo	Philippines
Congo, Democratic Republic of the	Rwanda
Côte d'Ivoire	Sao Tome and Principe
Djibouti	Senegal
Egypt	Sierra Leone
Equatorial Guinea	Solomon Islands
Eritrea	Somalia
Ethiopia	South Africa
Gabon	South Sudan
Gambia	Sudan
Ghana	Swaziland
Guatemala	Tajikistan
Guinea	Tanzania, United Republic of
Guinea-Bissau	Togo
Haiti	Turkmenistan
India	Uganda
Indonesia	Uzbekistan
Iraq	Viet Nam
Kenya	Yemen
Korea, Democratic People's Republic of	Zambia
Kyrgyzstan	Zimbabwe
Lao People's Democratic Republic	

Summary

Demographic Data

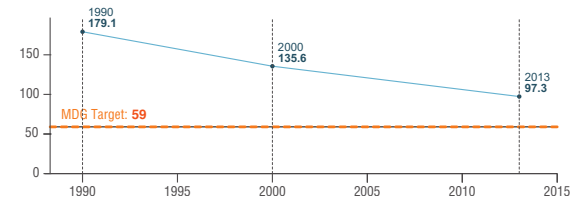
 Total population ('000) **30 552**

 Total under-5 population ('000) **4 847**

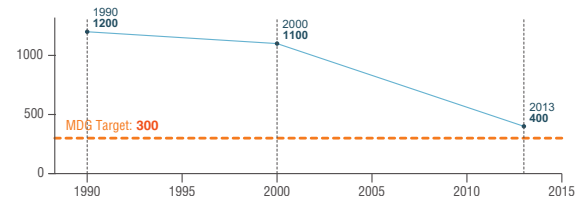
 Total births ('000) **1 053**

 Adolescent birth rate (per 1000 girls) **117**

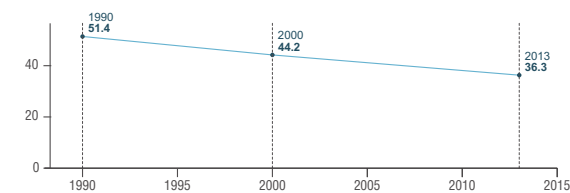
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

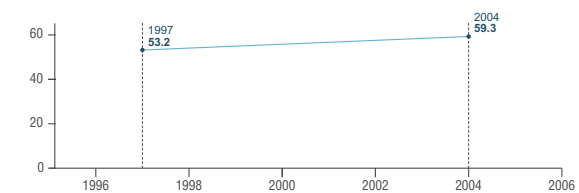


Neonatal mortality rate
per 1000 live births

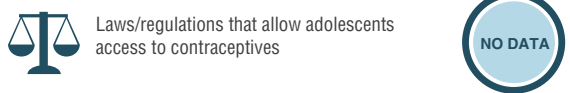
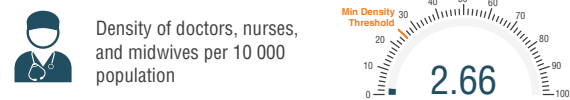


Stunting

% of children under 5 who are moderately or severely stunted



Reproductive Health and Health Systems Data



Health Coverage Indicators

● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

Met need for contraception

0 | 20 | 40 | 60 | 80 | 100

No data

Antenatal care coverage (4 visits)

0 | 20 | 40 | 60 | 80 | 100

14.7%

Prevention of mother to child transmission of HIV

0 | 20 | 40 | 60 | 80 | 100

2.5%

Skilled attendant at birth

0 | 20 | 40 | 60 | 80 | 100

38.7%

Postnatal care coverage

0 | 20 | 40 | 60 | 80 | 100

No data

Exclusive breastfeeding

0 | 20 | 40 | 60 | 80 | 100

51.4%

DTP3 coverage

0 | 20 | 40 | 60 | 80 | 100

30.4%

Pneumonia care seeking

0 | 20 | 40 | 60 | 80 | 100

60.5%

The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
- 2015 Progress report on implementing the Commission on Information and Accountability Recommendations: Birth registration, Death registration, MDSR, CRVS, National eHealth strategy, Total health expenditure per capita tracked by financing source, Country conducted annual health sector review, Health sector performance report available in the public domain.
- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).



Better Information



Vital Events

% of births registered	37
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	YES
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO



Innovation and eHealth

National eHealth strategy and plan in place and implemented	PARTIAL
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	NO
Total public sector health expenditure per capita (US\$)	10.7
Total RMNCH expenditure per capita tracked by financing source	NO
Total annual RMNCH expenditure (US\$)	NO DATA



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA





Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

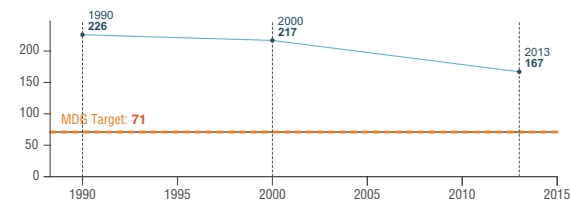
 Total population ('000) **21 472**

 Total under-5 population ('000) **4 072**

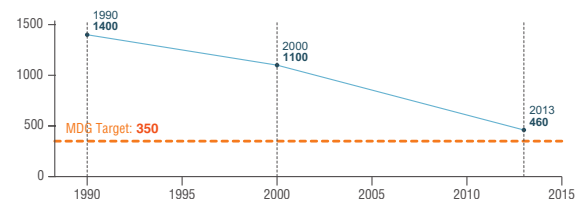
 Total births ('000) **934**

 Adolescent birth rate (per 1000 girls) **192**

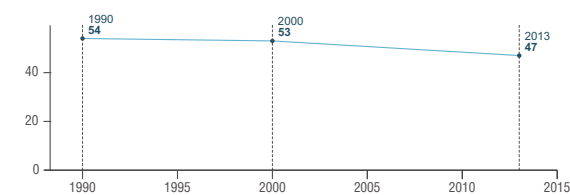
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

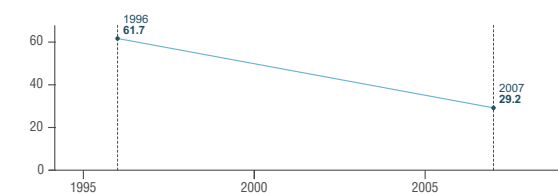


Neonatal mortality rate
per 1000 live births

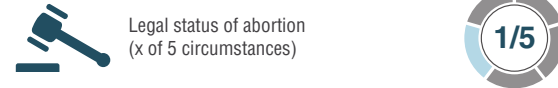
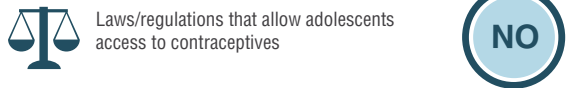
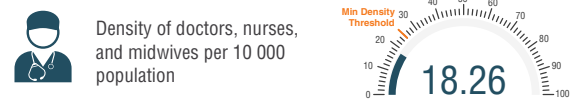


Stunting

% of children under 5 who are moderately or severely stunted



Reproductive Health and Health Systems Data

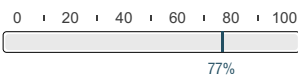


Health Coverage Indicators

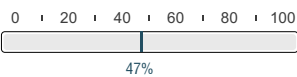
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

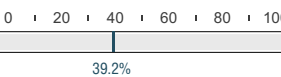
Met need for contraception



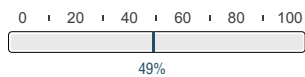
Antenatal care coverage (4 visits)



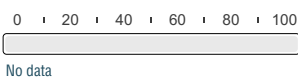
Prevention of mother to child transmission of HIV



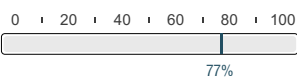
Skilled attendant at birth



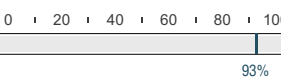
Postnatal care coverage



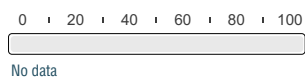
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
- 2015 Progress report on implementing the Commission on Information and Accountability Recommendations: Birth registration, Death registration, MDSR, CRVS, National eHealth strategy, Total health expenditure per capita tracked by financing source, Country conducted annual health sector review, Health sector performance report available in the public domain.
- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).

Better Information

 Vital Events

% of births registered	NO DATA
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	YES
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES

 Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO

 Innovation and eHealth

National eHealth strategy and plan in place and implemented	NO
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Better Resources

 Resource Tracking

Total health expenditure per capita tracked by financing source	PARTIAL
Total public sector health expenditure per capita (US\$)	118.4
Total RMNCH expenditure per capita tracked by financing source	PARTIAL
Total annual RMNCH expenditure (US\$)	NO DATA

 Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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 Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

 National Oversight


Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA


 Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

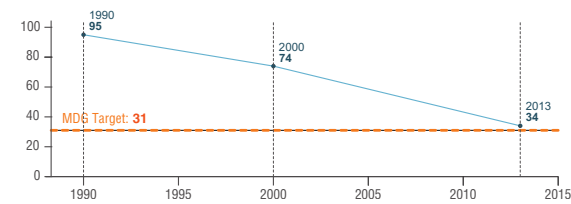
 Total population ('000) **9 413**

 Total under-5 population ('000) **796**

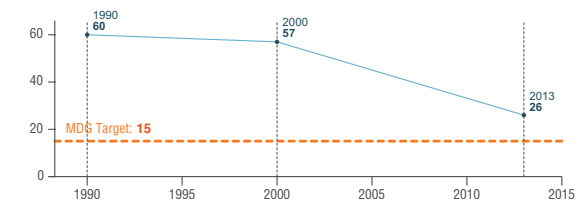
 Total births ('000) **168**

 Adolescent birth rate (per 1000 girls) **41**

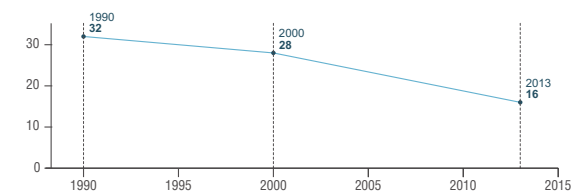
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

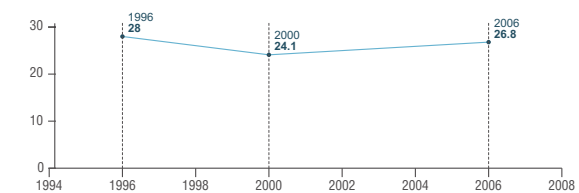


Neonatal mortality rate
per 1000 live births



Stunting

% of children under 5 who are moderately or severely stunted



Reproductive Health and Health Systems Data



Density of doctors, nurses, and midwives per 10 000 population



Demand for family planning satisfied



Laws/regulations that allow adolescents access to contraceptives



Legal status of abortion (x of 5 circumstances)

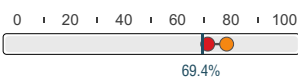


Health Coverage Indicators

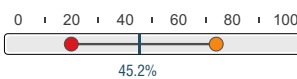
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

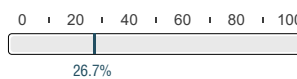
Met need for contraception



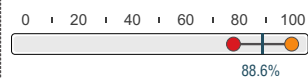
Antenatal care coverage (4 visits)



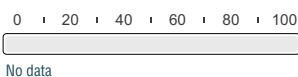
Prevention of mother to child transmission of HIV



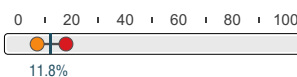
Skilled attendant at birth



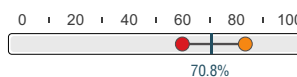
Postnatal care coverage



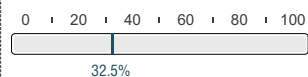
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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Better Information

 Vital Events

% of births registered	>90
% of deaths registered	93
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	YES
Civil Registration and Vital Statistics (CRVS) improvement plan in place	PARTIAL

 Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO

 Innovation and eHealth

National eHealth strategy and plan in place and implemented	YES
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Better Resources

 Resource Tracking

Total health expenditure per capita tracked by financing source	NO
Total public sector health expenditure per capita (US\$)	90.6
Total RMNCH expenditure per capita tracked by financing source	NO
Total annual RMNCH expenditure (US\$)	NO DATA

 Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	NO
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 Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

 National Oversight


Country has conducted annual national health sector review process in the past year	NO
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA


 Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

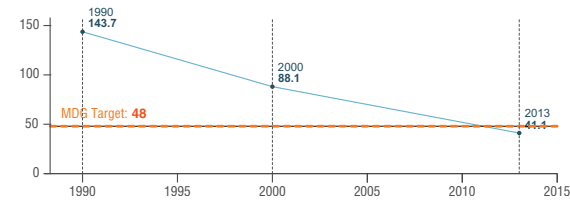
 Total population ('000) **156 595**

 Total under-5 population ('000) **15 216**

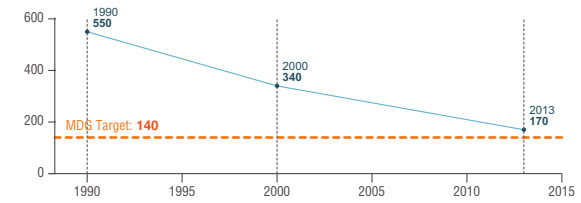
 Total births ('000) **3 150**

 Adolescent birth rate (per 1000 girls) **89**

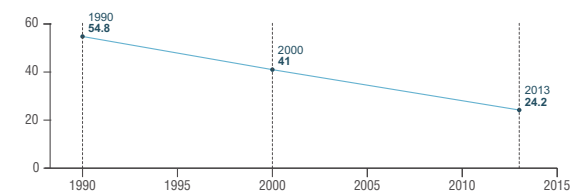
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

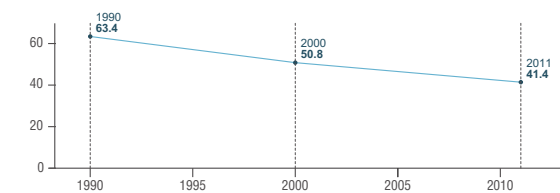


Neonatal mortality rate
per 1000 live births




Stunting

% of children under 5 who are moderately or severely stunted




Reproductive Health and Health Systems Data

 Density of doctors, nurses, and midwives per 10 000 population




 Demand for family planning satisfied



 Laws/regulations that allow adolescents access to contraceptives



 Legal status of abortion (x of 5 circumstances)

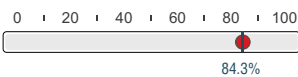


Health Coverage Indicators

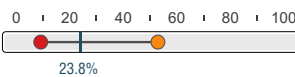
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

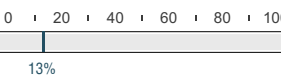
Met need for contraception



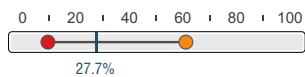
Antenatal care coverage (4 visits)



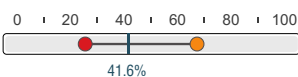
Prevention of mother to child transmission of HIV



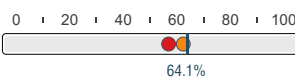
Skilled attendant at birth



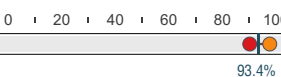
Postnatal care coverage



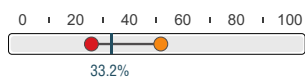
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
- 2015 Progress report on implementing the Commission on Information and Accountability Recommendations: Birth registration, Death registration, MDSR, CRVS, National eHealth strategy, Total health expenditure per capita tracked by financing source, Country conducted annual health sector review, Health sector performance report available in the public domain.
- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).



Better Information



Vital Events

% of births registered	31
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	NO
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO



Innovation and eHealth

National eHealth strategy and plan in place and implemented	PARTIAL
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	PARTIAL
Total public sector health expenditure per capita (US\$)	9
Total RMNCH expenditure per capita tracked by financing source	PARTIAL
Total annual RMNCH expenditure (US\$)	NO DATA



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA





Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

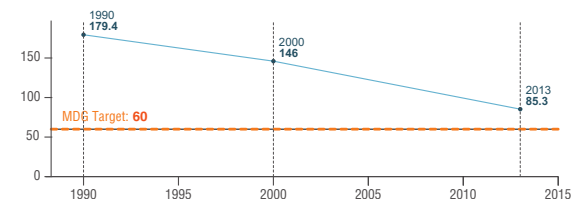
 Total population ('000) **10 323**

 Total under-5 population ('000) **1 681**

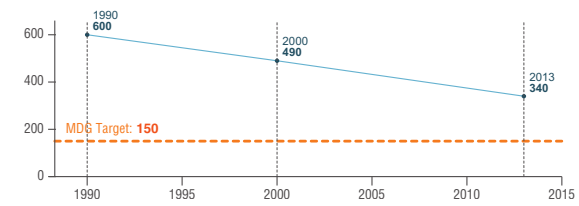
 Total births ('000) **371**

 Adolescent birth rate (per 1000 girls) **105**

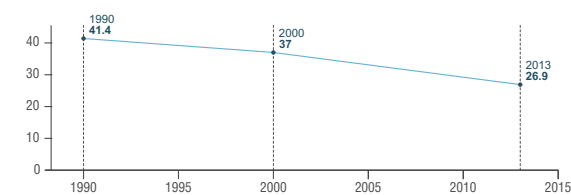
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

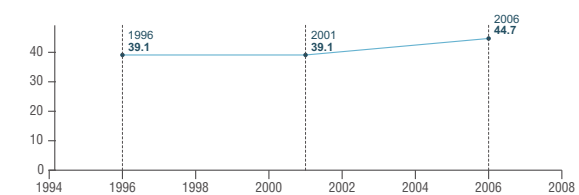


Neonatal mortality rate
per 1000 live births



Stunting

% of children under 5 who are moderately or severely stunted



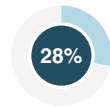
Reproductive Health and Health Systems Data



Density of doctors, nurses, and midwives per 10 000 population



Demand for family planning satisfied



Laws/regulations that allow adolescents access to contraceptives



Legal status of abortion (x of 5 circumstances)

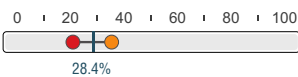


Health Coverage Indicators

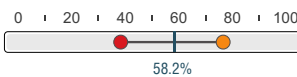
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

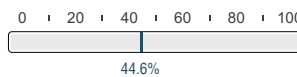
Met need for contraception



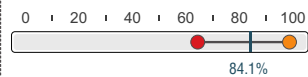
Antenatal care coverage (4 visits)



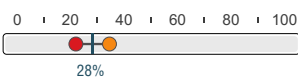
Prevention of mother to child transmission of HIV



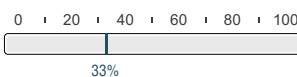
Skilled attendant at birth



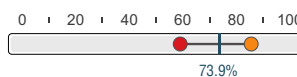
Postnatal care coverage



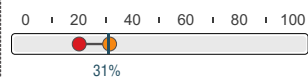
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
- 2015 Progress report on implementing the Commission on Information and Accountability Recommendations: Birth registration, Death registration, MDSR, CRVS, National eHealth strategy, Total health expenditure per capita tracked by financing source, Country conducted annual health sector review, Health sector performance report available in the public domain.
- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).

Better Information



Vital Events

% of births registered	80
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	YES
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO



Innovation and eHealth

National eHealth strategy and plan in place and implemented	NO
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	YES
Total public sector health expenditure per capita (US\$)	17
Total RMNCH expenditure per capita tracked by financing source	YES
Total annual RMNCH expenditure (US\$)	90 456 318



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	YES



Transparency

A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

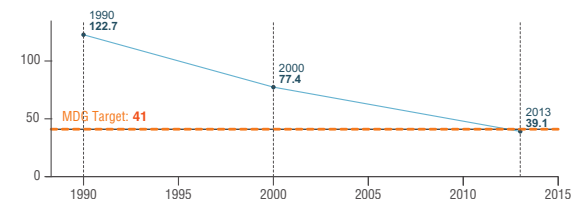
Total population ('000) **10 671**

Total under-5 population ('000) **1 296**

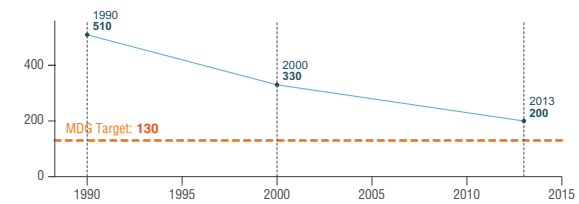
Total births ('000) **273**

Adolescent birth rate (per 1000 girls) **78**

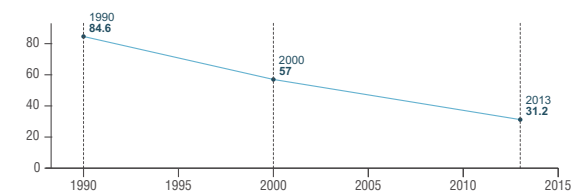
Under-5 mortality rate per 1000 live births



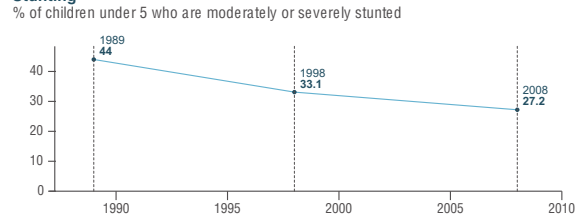
Maternal mortality rate per 100 000 live births



Neonatal mortality rate per 1000 live births



Stunting



Reproductive Health and Health Systems Data



Density of doctors, nurses, and midwives per 10 000 population



Demand for family planning satisfied



Laws/regulations that allow adolescents access to contraceptives



Legal status of abortion (x of 5 circumstances)

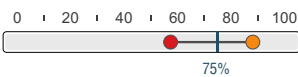


Health Coverage Indicators

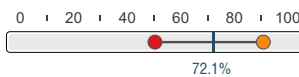
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

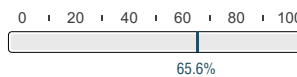
Met need for contraception



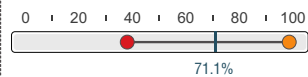
Antenatal care coverage (4 visits)



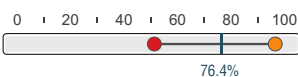
Prevention of mother to child transmission of HIV



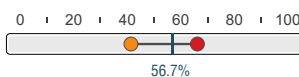
Skilled attendant at birth



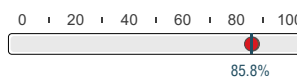
Postnatal care coverage



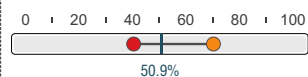
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).



Better Information



Vital Events

% of births registered	76
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	YES
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO



Innovation and eHealth

National eHealth strategy and plan in place and implemented	NO
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	NO
Total public sector health expenditure per capita (US\$)	106.7
Total RMNCH expenditure per capita tracked by financing source	NO
Total annual RMNCH expenditure (US\$)	NO DATA



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA







Transparency

A health sector performance report for the preceding year is available in the public domain	NO DATA
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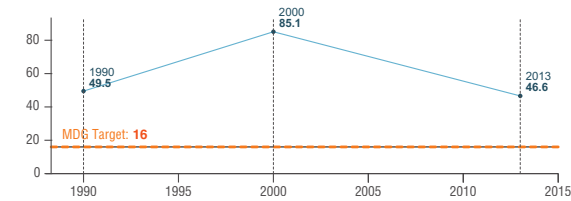
Summary

Demographic Data

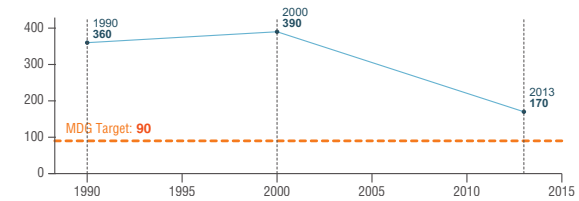
 Total population ('000)	2 021
 Total births ('000)	48

 Total under-5 population ('000)	230
 Adolescent birth rate (per 1000 girls)	52

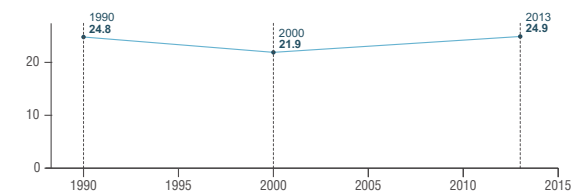
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

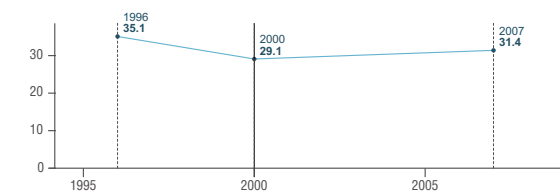


Neonatal mortality rate
per 1000 live births



Stunting

% of children under 5 who are moderately or severely stunted



Reproductive Health and Health Systems Data



Density of doctors, nurses, and midwives per 10 000 population



Demand for family planning satisfied



Laws/regulations that allow adolescents access to contraceptives



Legal status of abortion (x of 5 circumstances)

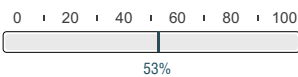


Health Coverage Indicators

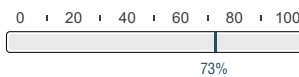
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

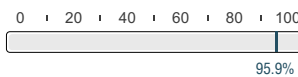
Met need for contraception



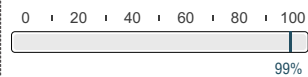
Antenatal care coverage (4 visits)



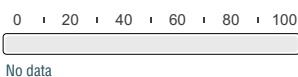
Prevention of mother to child transmission of HIV



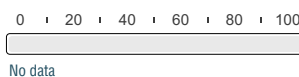
Skilled attendant at birth



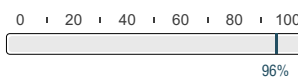
Postnatal care coverage



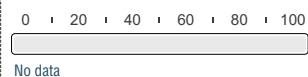
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
- 2015 Progress report on implementing the Commission on Information and Accountability Recommendations: Birth registration, Death registration, MDSR, CRVS, National eHealth strategy, Total health expenditure per capita tracked by financing source, Country conducted annual health sector review, Health sector performance report available in the public domain.
- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
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Better Information

Vital Events

% of births registered	72
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	YES
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES

Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO

Innovation and eHealth

National eHealth strategy and plan in place and implemented	YES
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Better Resources

Resource Tracking

Total health expenditure per capita tracked by financing source	PARTIAL
Total public sector health expenditure per capita (US\$)	216.5
Total RMNCH expenditure per capita tracked by financing source	PARTIAL
Total annual RMNCH expenditure (US\$)	NO DATA

Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

National Oversight


Country has conducted annual national health sector review process in the past year	NO
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA


Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

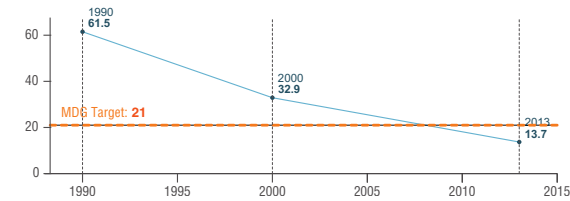
 Total population ('000) **200 362**

 Total under-5 population ('000) **14 796**

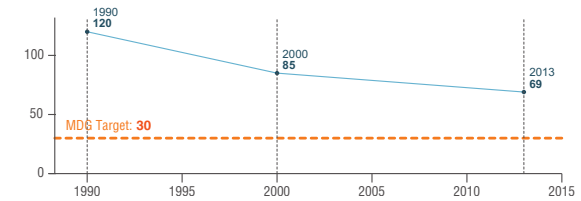
 Total births ('000) **3 009**

 Adolescent birth rate (per 1000 girls) **76**

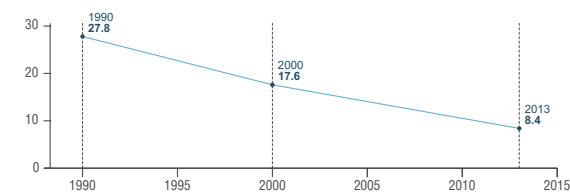
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

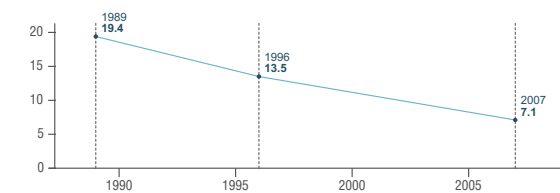


Neonatal mortality rate
per 1000 live births

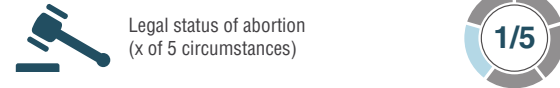
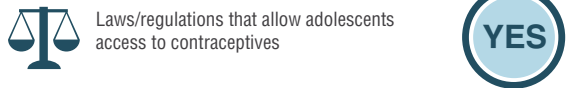
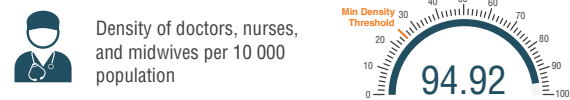


Stunting

% of children under 5 who are moderately or severely stunted



Reproductive Health and Health Systems Data

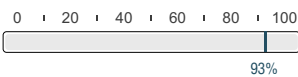


Health Coverage Indicators

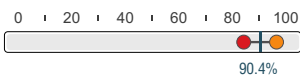
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

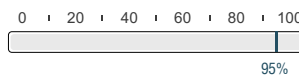
Met need for contraception



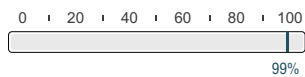
Antenatal care coverage (4 visits)



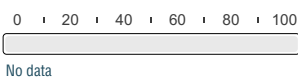
Prevention of mother to child transmission of HIV



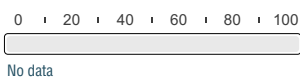
Skilled attendant at birth



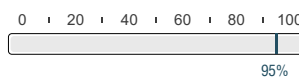
Postnatal care coverage



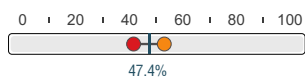
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
- 2015 Progress report on implementing the Commission on Information and Accountability Recommendations: Birth registration, Death registration, MDSR, CRVS, National eHealth strategy, Total health expenditure per capita tracked by financing source, Country conducted annual health sector review, Health sector performance report available in the public domain.
- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).

Better Information

 Vital Events

% of births registered	93
% of deaths registered	93
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	PARTIAL
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES

 Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO

 Innovation and eHealth

National eHealth strategy and plan in place and implemented	PARTIAL
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Better Resources

 Resource Tracking

Total health expenditure per capita tracked by financing source	NO
Total public sector health expenditure per capita (US\$)	490.4
Total RMNCH expenditure per capita tracked by financing source	NO
Total annual RMNCH expenditure (US\$)	NO DATA

 Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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 Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

 National Oversight


Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA


 Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

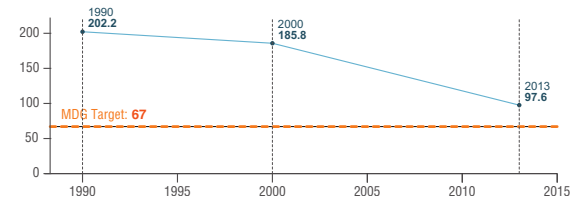
 Total population ('000) **16 935**

 Total under-5 population ('000) **3 031**

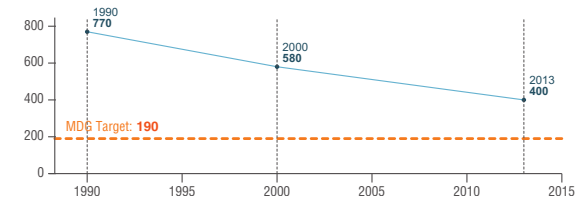
 Total births ('000) **683**

 Adolescent birth rate (per 1000 girls) **130**

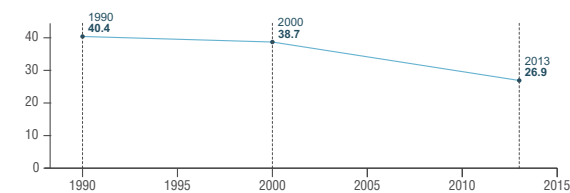
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

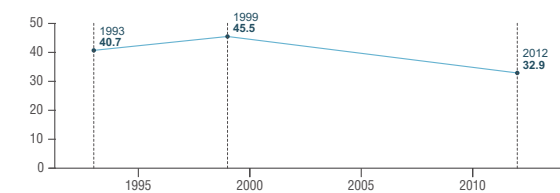


Neonatal mortality rate
per 1000 live births

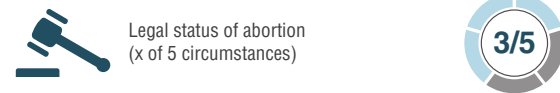
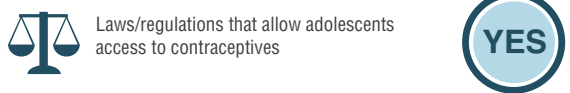
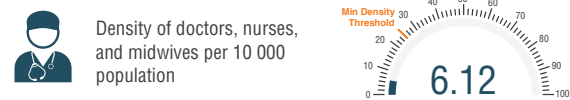


Stunting

% of children under 5 who are moderately or severely stunted



Reproductive Health and Health Systems Data

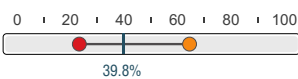


Health Coverage Indicators

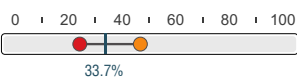
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

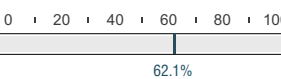
Met need for contraception



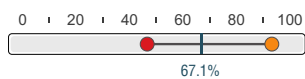
Antenatal care coverage (4 visits)



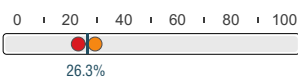
Prevention of mother to child transmission of HIV



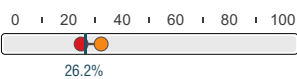
Skilled attendant at birth



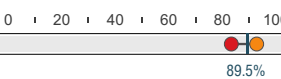
Postnatal care coverage



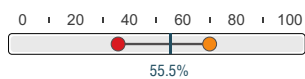
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
- 2015 Progress report on implementing the Commission on Information and Accountability Recommendations: Birth registration, Death registration, MDSR, CRVS, National eHealth strategy, Total health expenditure per capita tracked by financing source, Country conducted annual health sector review, Health sector performance report available in the public domain.
- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
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- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).



Better Information

Vital Events

% of births registered	77
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	NO
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES

Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	YES
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO

Innovation and eHealth

National eHealth strategy and plan in place and implemented	PARTIAL
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Better Resources

Resource Tracking

Total health expenditure per capita tracked by financing source	YES
Total public sector health expenditure per capita (US\$)	20.5
Total RMNCH expenditure per capita tracked by financing source	YES
Total annual RMNCH expenditure (US\$)	237 087 760

Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

National Oversight


Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	YES


Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

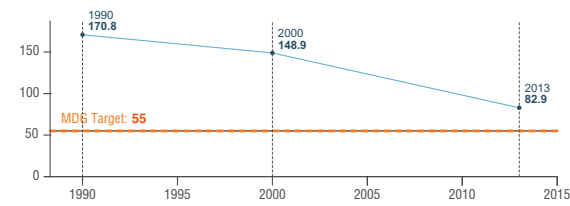
 Total population ('000) **10 163**

 Total under-5 population ('000) **1 947**

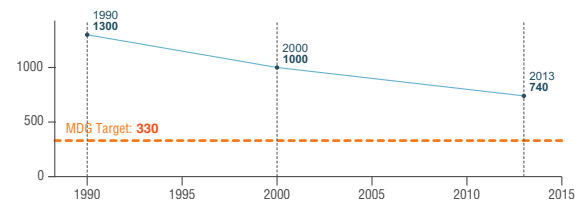
 Total births ('000) **443**

 Adolescent birth rate (per 1000 girls) **34**

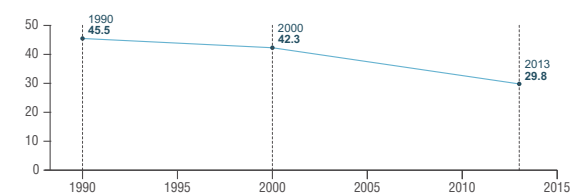
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

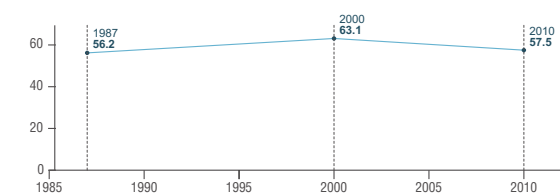


Neonatal mortality rate
per 1000 live births




Stunting

% of children under 5 who are moderately or severely stunted

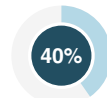



Reproductive Health and Health Systems Data

 Density of doctors, nurses, and midwives per 10 000 population




 Demand for family planning satisfied



 Laws/regulations that allow adolescents access to contraceptives



 Legal status of abortion (x of 5 circumstances)

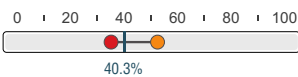


Health Coverage Indicators

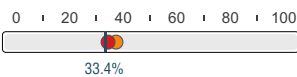
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

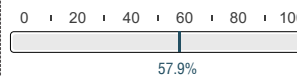
Met need for contraception



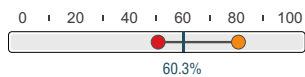
Antenatal care coverage (4 visits)



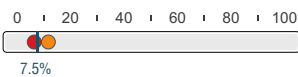
Prevention of mother to child transmission of HIV



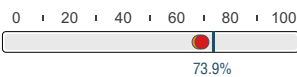
Skilled attendant at birth



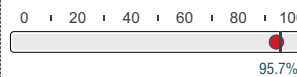
Postnatal care coverage



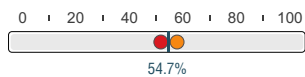
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
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Better Information

 Vital Events

% of births registered	75
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	NO
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES

 Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO

 Innovation and eHealth

National eHealth strategy and plan in place and implemented	NO
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Better Resources

 Resource Tracking

Total health expenditure per capita tracked by financing source	YES
Total public sector health expenditure per capita (US\$)	11.9
Total RMNCH expenditure per capita tracked by financing source	YES
Total annual RMNCH expenditure (US\$)	NO DATA

 Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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 Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

 National Oversight

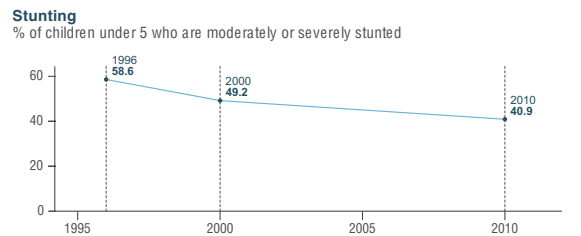
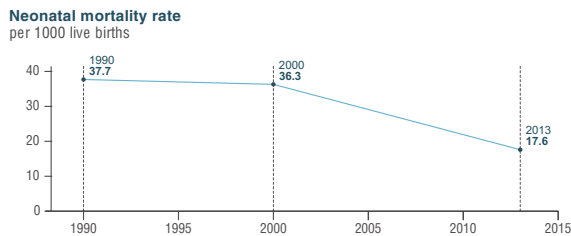
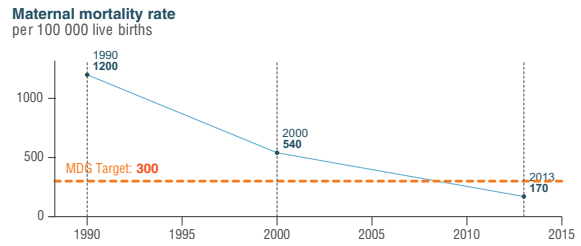
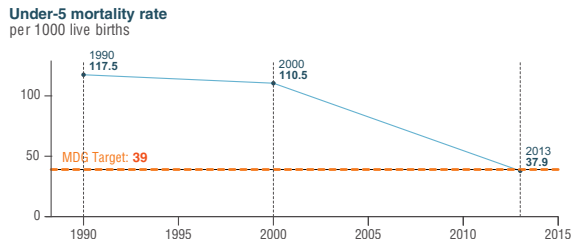
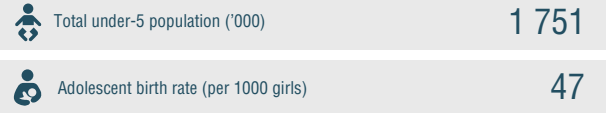
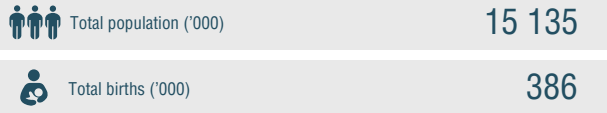
Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	YES

 Transparency

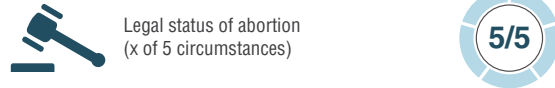
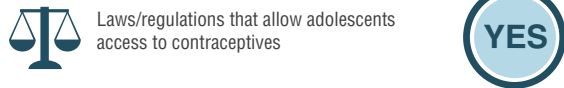
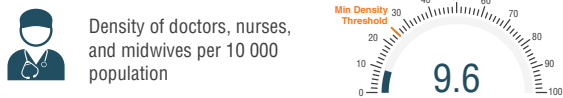
A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data



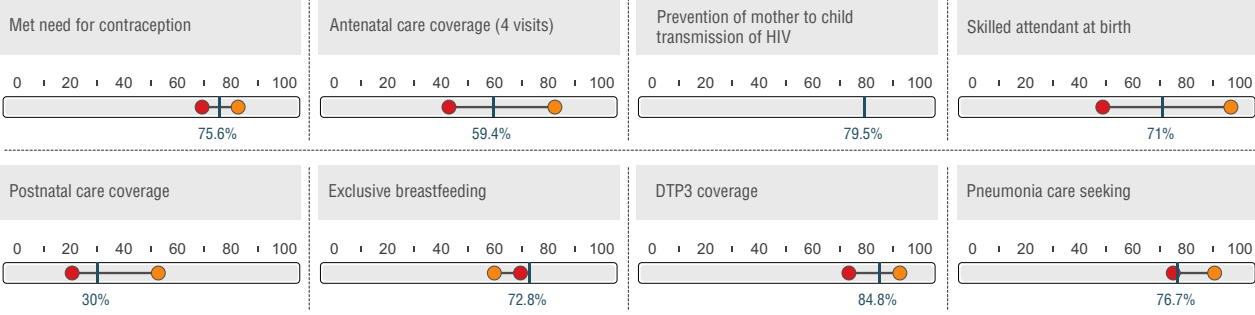
Reproductive Health and Health Systems Data



Health Coverage Indicators

● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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Better Information

Vital Events

% of births registered	62
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	PARTIAL
Civil Registration and Vital Statistics (CRVS) improvement plan in place	PARTIAL

Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO

Innovation and eHealth

National eHealth strategy and plan in place and implemented	PARTIAL
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Better Resources

Resource Tracking

Total health expenditure per capita tracked by financing source	YES
Total public sector health expenditure per capita (US\$)	12.7
Total RMNCH expenditure per capita tracked by financing source	YES
Total annual RMNCH expenditure (US\$)	NO DATA

Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

National Oversight


Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	YES


Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

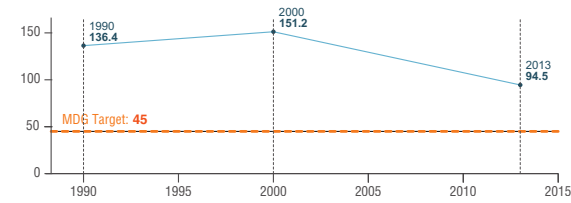
 Total population ('000) **22 254**

 Total under-5 population ('000) **3 686**

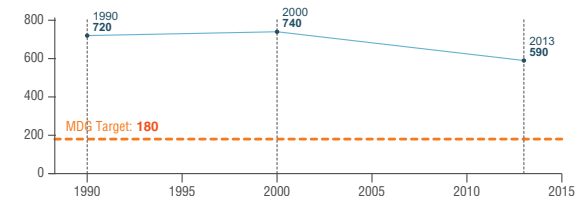
 Total births ('000) **820**

 Adolescent birth rate (per 1000 girls) **131**

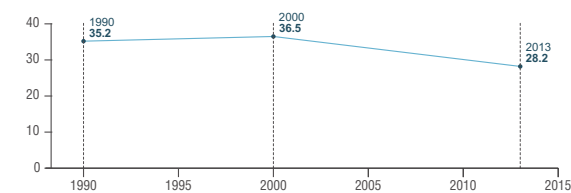
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

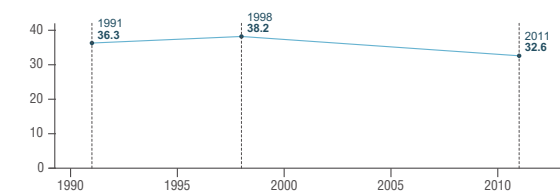


Neonatal mortality rate
per 1000 live births



Stunting

% of children under 5 who are moderately or severely stunted



Reproductive Health and Health Systems Data



Density of doctors, nurses, and midwives per 10 000 population



Demand for family planning satisfied



Laws/regulations that allow adolescents access to contraceptives



Legal status of abortion (x of 5 circumstances)

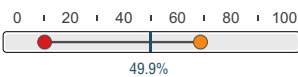


Health Coverage Indicators

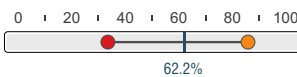
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

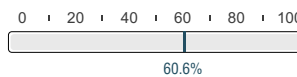
Met need for contraception



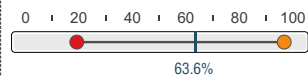
Antenatal care coverage (4 visits)



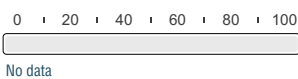
Prevention of mother to child transmission of HIV



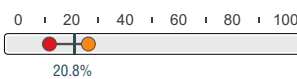
Skilled attendant at birth



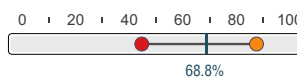
Postnatal care coverage



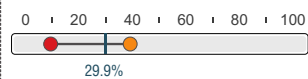
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
- 2015 Progress report on implementing the Commission on Information and Accountability Recommendations: Birth registration, Death registration, MDSR, CRVS, National eHealth strategy, Total health expenditure per capita tracked by financing source, Country conducted annual health sector review, Health sector performance report available in the public domain.
- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).



Better Information



Vital Events

% of births registered	61
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	PARTIAL
Civil Registration and Vital Statistics (CRVS) improvement plan in place	PARTIAL



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO



Innovation and eHealth

National eHealth strategy and plan in place and implemented	PARTIAL
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	YES
Total public sector health expenditure per capita (US\$)	19.8
Total RMNCH expenditure per capita tracked by financing source	YES
Total annual RMNCH expenditure (US\$)	NO DATA



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	YES





Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

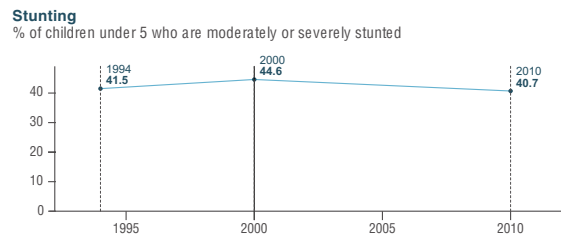
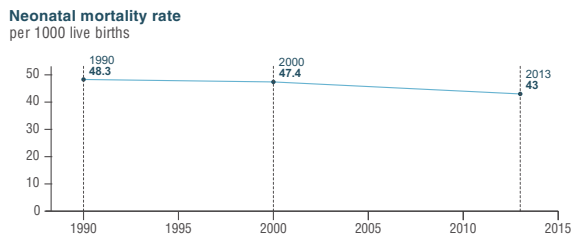
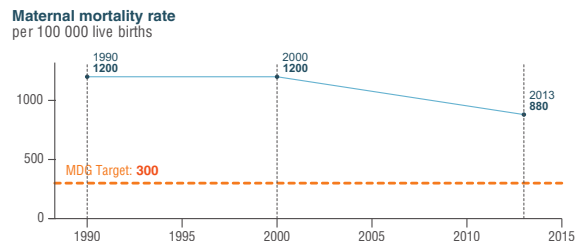
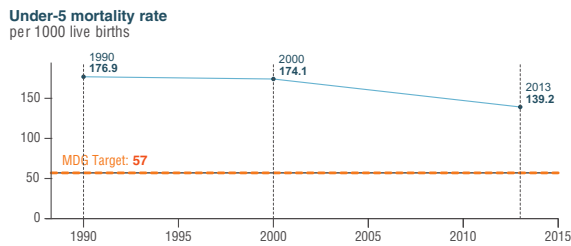
Demographic Data

 Total population ('000) **4 616**

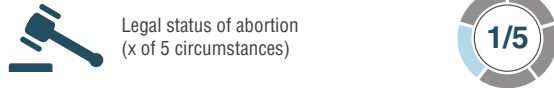
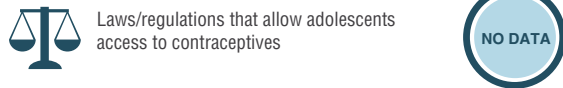
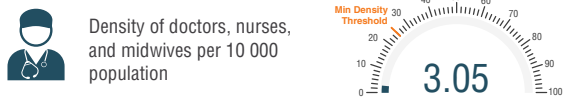
 Total under-5 population ('000) **685**

 Total births ('000) **156**

 Adolescent birth rate (per 1000 girls) **107**



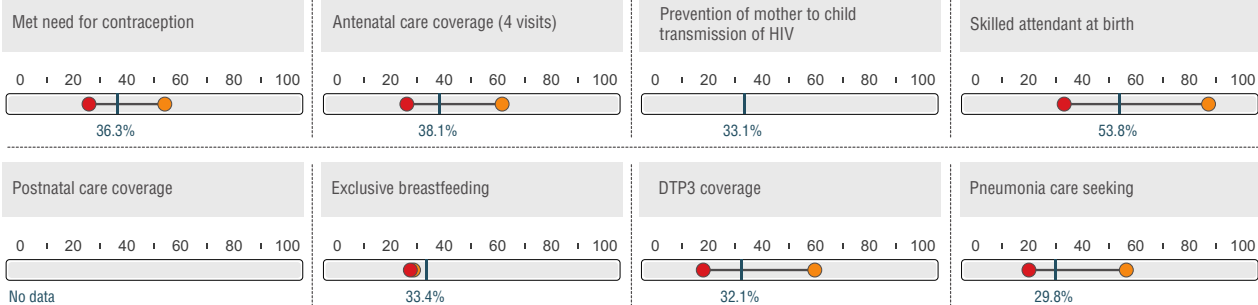
Reproductive Health and Health Systems Data



Health Coverage Indicators

● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).



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- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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Better Information



Vital Events

% of births registered	61
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	NO
Civil Registration and Vital Statistics (CRVS) improvement plan in place	NO



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO



Innovation and eHealth

National eHealth strategy and plan in place and implemented	NO
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	NO
Total public sector health expenditure per capita (US\$)	8.8
Total RMNCH expenditure per capita tracked by financing source	NO
Total annual RMNCH expenditure (US\$)	NO DATA



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	NO
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	NO
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA

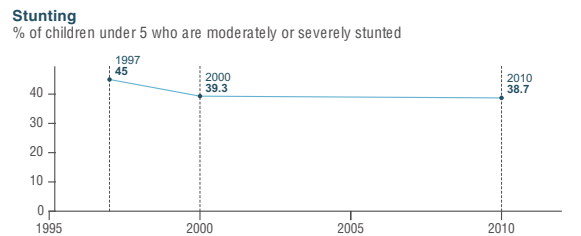
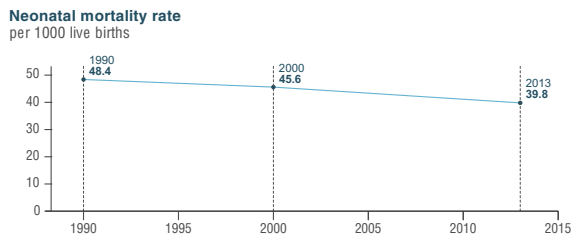
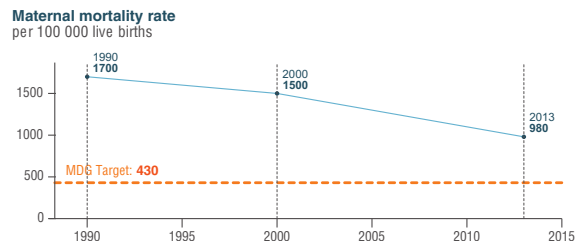
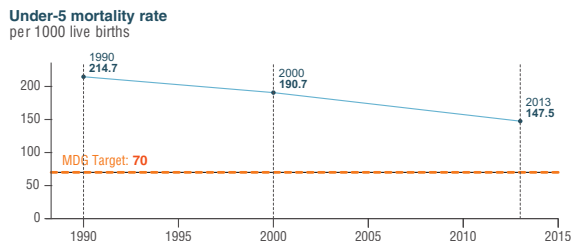
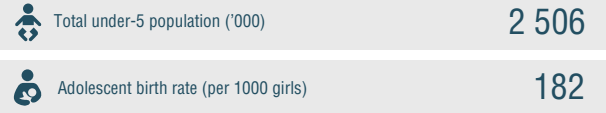
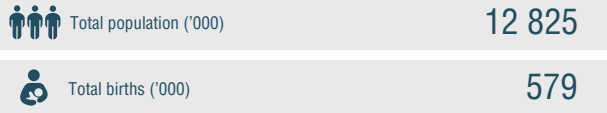


Transparency

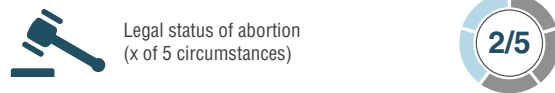
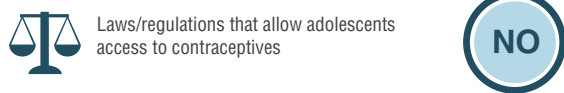
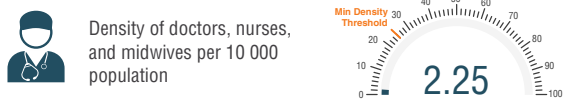
A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data



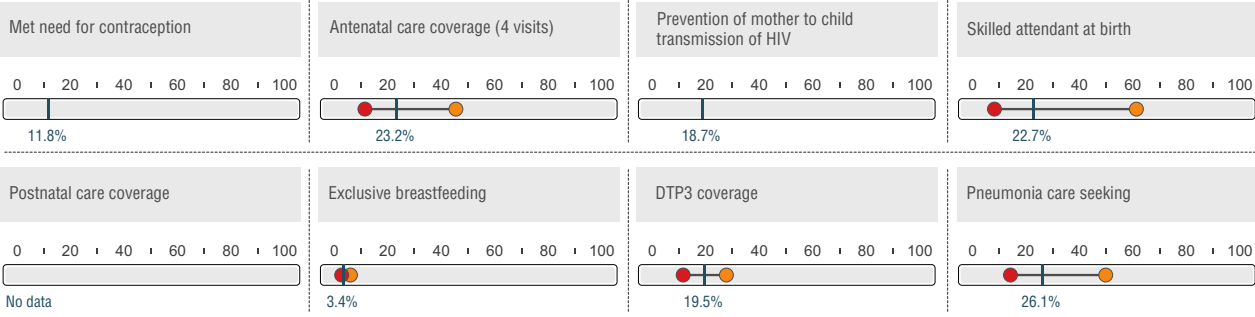
Reproductive Health and Health Systems Data



Health Coverage Indicators

● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).



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- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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Better Information

 Vital Events

% of births registered	16
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	NO
Civil Registration and Vital Statistics (CRVS) improvement plan in place	NO

 Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO

 Innovation and eHealth

National eHealth strategy and plan in place and implemented	NO
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Better Resources

 Resource Tracking

Total health expenditure per capita tracked by financing source	PARTIAL
Total public sector health expenditure per capita (US\$)	7.8
Total RMNCH expenditure per capita tracked by financing source	PARTIAL
Total annual RMNCH expenditure (US\$)	NO DATA

 Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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 Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

 National Oversight


Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA


 Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

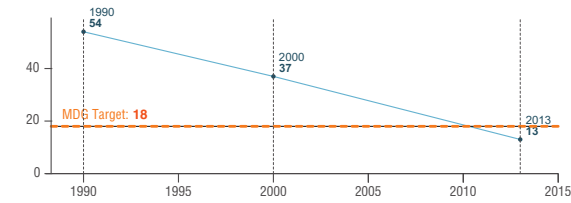
 Total population ('000) **1 393 337**

 Total under-5 population ('000) **91 306**

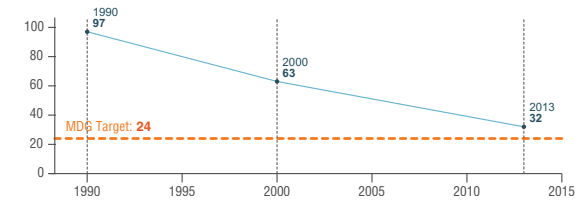
 Total births ('000) **18 455**

 Adolescent birth rate (per 1000 girls) **8**

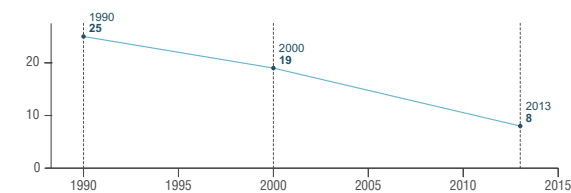
Under-5 mortality rate
per 1000 live births



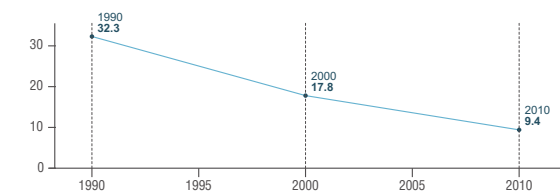
Maternal mortality rate
per 100 000 live births



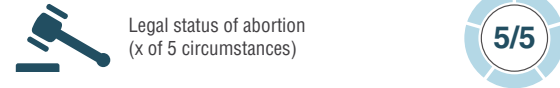
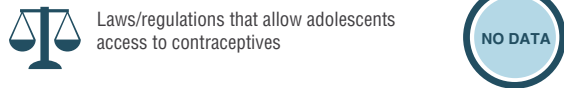
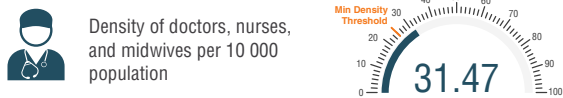
Neonatal mortality rate
per 1000 live births



Stunting
% of children under 5 who are moderately or severely stunted



Reproductive Health and Health Systems Data

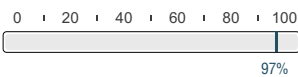


Health Coverage Indicators

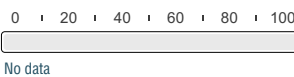
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

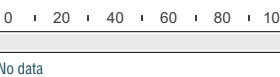
Met need for contraception



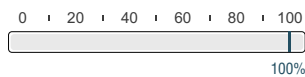
Antenatal care coverage (4 visits)



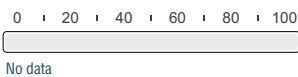
Prevention of mother to child transmission of HIV



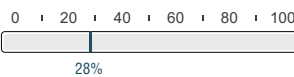
Skilled attendant at birth



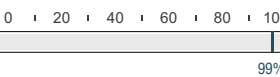
Postnatal care coverage



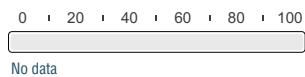
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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Better Information

Vital Events

% of births registered	NO DATA
% of deaths registered	4
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	NO
Civil Registration and Vital Statistics (CRVS) improvement plan in place	PARTIAL

Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO

Innovation and eHealth

National eHealth strategy and plan in place and implemented	YES
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Better Resources

Resource Tracking

Total health expenditure per capita tracked by financing source	PARTIAL
Total public sector health expenditure per capita (US\$)	180
Total RMNCH expenditure per capita tracked by financing source	PARTIAL
Total annual RMNCH expenditure (US\$)	NO DATA

Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	NO
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

National Oversight


Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA


Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

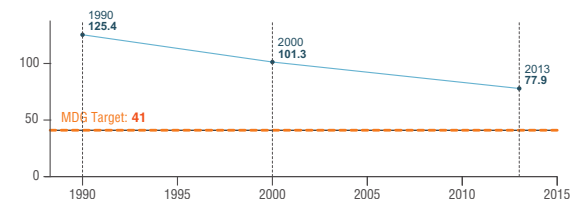
 Total population ('000) **735**

 Total under-5 population ('000) **117**

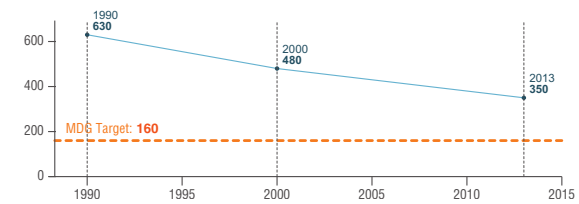
 Total births ('000) **26**

 Adolescent birth rate (per 1000 girls) **58**

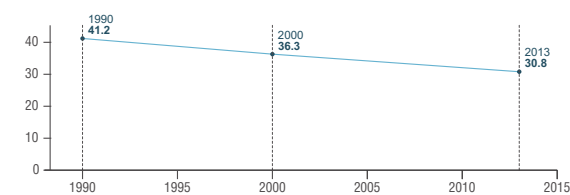
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

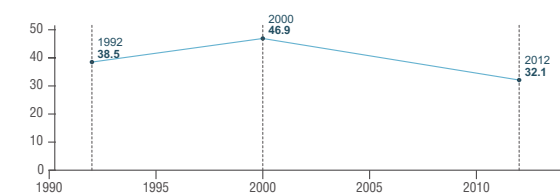


Neonatal mortality rate
per 1000 live births




Stunting

% of children under 5 who are moderately or severely stunted

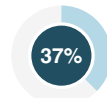



Reproductive Health and Health Systems Data

 Density of doctors, nurses, and midwives per 10 000 population




 Demand for family planning satisfied



 Laws/regulations that allow adolescents access to contraceptives



 Legal status of abortion (x of 5 circumstances)

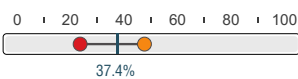


Health Coverage Indicators

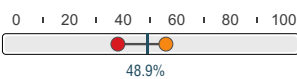
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

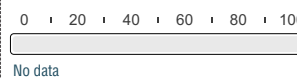
Met need for contraception



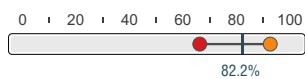
Antenatal care coverage (4 visits)



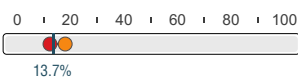
Prevention of mother to child transmission of HIV



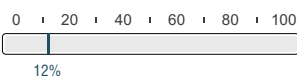
Skilled attendant at birth



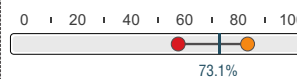
Postnatal care coverage



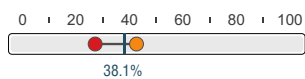
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
- 2015 Progress report on implementing the Commission on Information and Accountability Recommendations: Birth registration, Death registration, MDSR, CRVS, National eHealth strategy, Total health expenditure per capita tracked by financing source, Country conducted annual health sector review, Health sector performance report available in the public domain.
- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).

Better Information



Vital Events

% of births registered	87
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	YES
Civil Registration and Vital Statistics (CRVS) improvement plan in place	PARTIAL



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO DATA
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO



Innovation and eHealth

National eHealth strategy and plan in place and implemented	NO
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	YES
Total public sector health expenditure per capita (US\$)	21.1
Total RMNCH expenditure per capita tracked by financing source	YES
Total annual RMNCH expenditure (US\$)	NO DATA



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA





Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

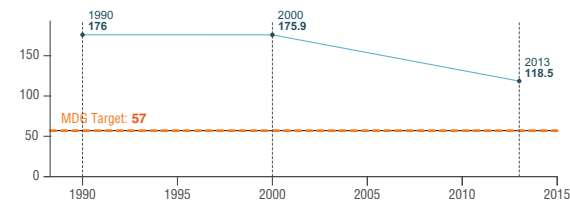
 Total population ('000) **67 514**

 Total under-5 population ('000) **12 118**

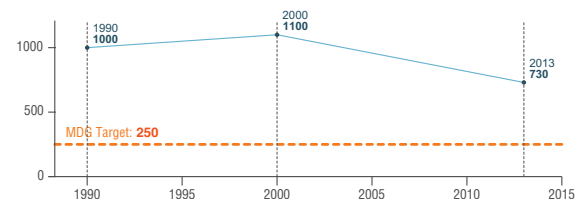
 Total births ('000) **2 839**

 Adolescent birth rate (per 1000 girls) **132**

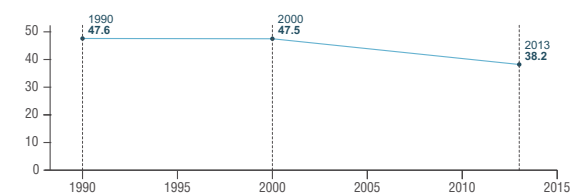
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

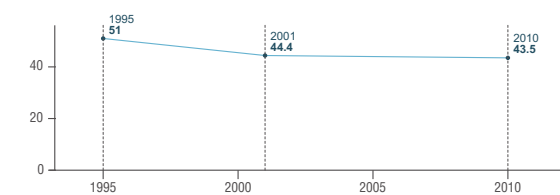


Neonatal mortality rate
per 1000 live births




Stunting

% of children under 5 who are moderately or severely stunted

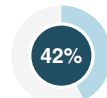



Reproductive Health and Health Systems Data

 Density of doctors, nurses, and midwives per 10 000 population




 Demand for family planning satisfied



 Laws/regulations that allow adolescents access to contraceptives



 Legal status of abortion (x of 5 circumstances)

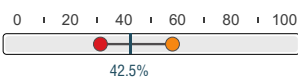


Health Coverage Indicators

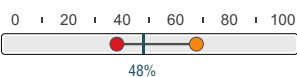
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

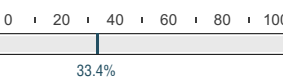
Met need for contraception



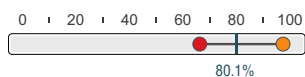
Antenatal care coverage (4 visits)



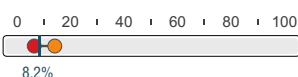
Prevention of mother to child transmission of HIV



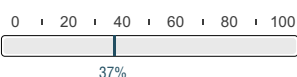
Skilled attendant at birth



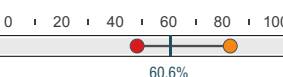
Postnatal care coverage



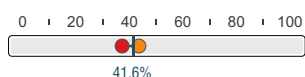
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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Better Information

 Vital Events

% of births registered	28
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	PARTIAL
Civil Registration and Vital Statistics (CRVS) improvement plan in place	PARTIAL

 Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	YES

 Innovation and eHealth

National eHealth strategy and plan in place and implemented	NO
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Better Resources

 Resource Tracking

Total health expenditure per capita tracked by financing source	YES
Total public sector health expenditure per capita (US\$)	7.8
Total RMNCH expenditure per capita tracked by financing source	YES
Total annual RMNCH expenditure (US\$)	540 109 440

 Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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 Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

 National Oversight


Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	YES


 Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

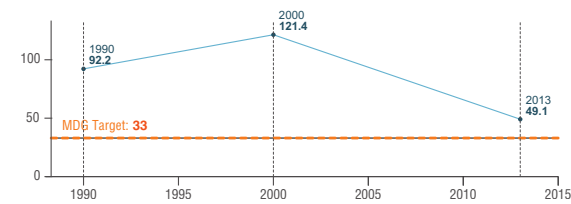
 Total population ('000) **4 448**

 Total under-5 population ('000) **752**

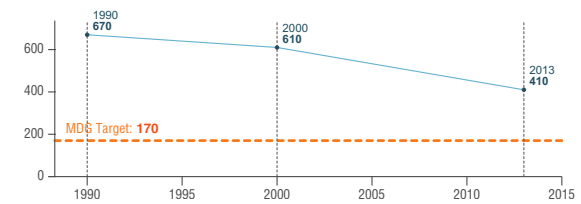
 Total births ('000) **165**

 Adolescent birth rate (per 1000 girls) **130**

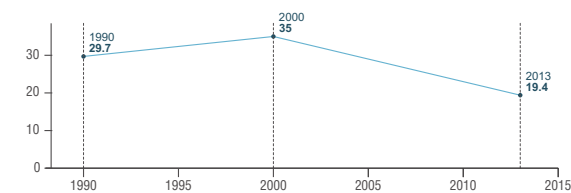
Under-5 mortality rate
per 1000 live births



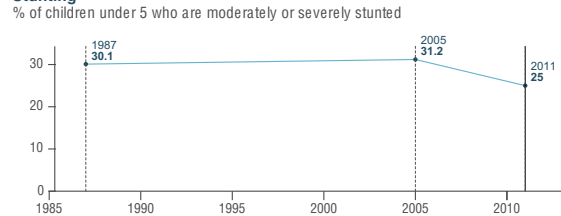
Maternal mortality rate
per 100 000 live births



Neonatal mortality rate
per 1000 live births



Stunting



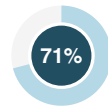
Reproductive Health and Health Systems Data



Density of doctors, nurses, and midwives per 10 000 population



Demand for family planning satisfied



Laws/regulations that allow adolescents access to contraceptives



Legal status of abortion (x of 5 circumstances)

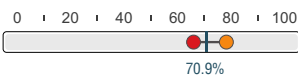


Health Coverage Indicators

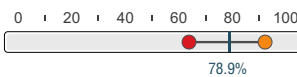
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

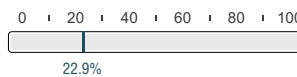
Met need for contraception



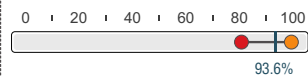
Antenatal care coverage (4 visits)



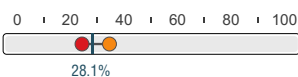
Prevention of mother to child transmission of HIV



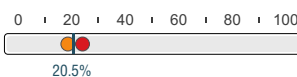
Skilled attendant at birth



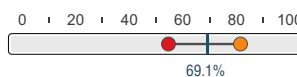
Postnatal care coverage



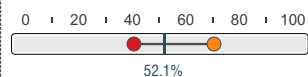
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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Better Information

 Vital Events

% of births registered	91
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	YES
Civil Registration and Vital Statistics (CRVS) improvement plan in place	PARTIAL

 Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO

 Innovation and eHealth

National eHealth strategy and plan in place and implemented	NO
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Better Resources

 Resource Tracking

Total health expenditure per capita tracked by financing source	NO
Total public sector health expenditure per capita (US\$)	73.7
Total RMNCH expenditure per capita tracked by financing source	NO
Total annual RMNCH expenditure (US\$)	NO DATA

 Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	NO
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 Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

 National Oversight

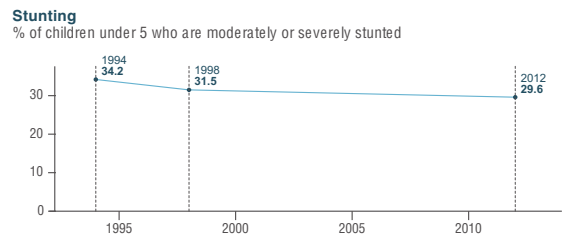
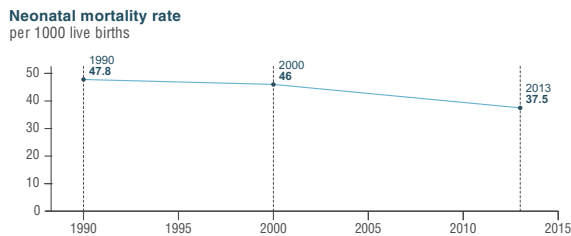
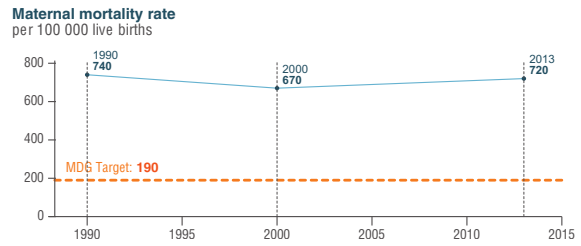
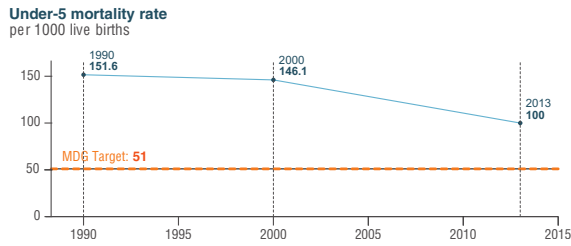
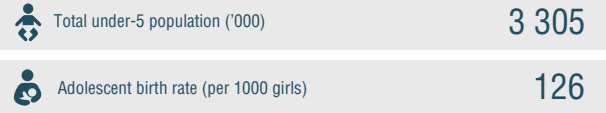
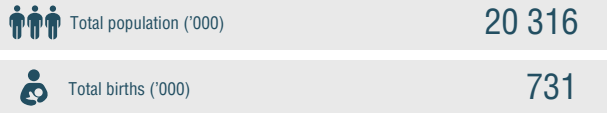
Country has conducted annual national health sector review process in the past year	NO
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA

 Transparency

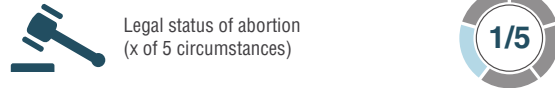
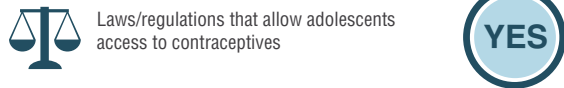
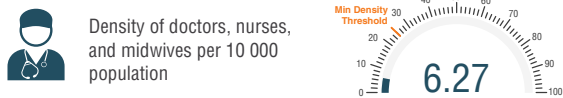
A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data



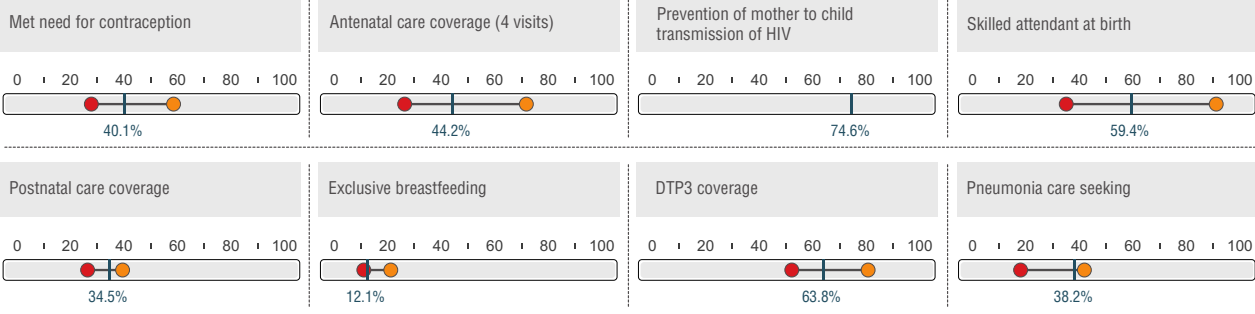
Reproductive Health and Health Systems Data



Health Coverage Indicators

● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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Better Information

Vital Events

% of births registered	65
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	YES
Civil Registration and Vital Statistics (CRVS) improvement plan in place	PARTIAL

Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	YES
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO

Innovation and eHealth

National eHealth strategy and plan in place and implemented	PARTIAL
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Better Resources

Resource Tracking

Total health expenditure per capita tracked by financing source	YES
Total public sector health expenditure per capita (US\$)	24.2
Total RMNCH expenditure per capita tracked by financing source	YES
Total annual RMNCH expenditure (US\$)	NO DATA

Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	NO
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

National Oversight



Country has conducted annual national health sector review process in the past year	PARTIAL
Mutual assessment of progress in implementing agreed health sector commitments exists	NO



Transparency

A health sector performance report for the preceding year is available in the public domain	NO DATA
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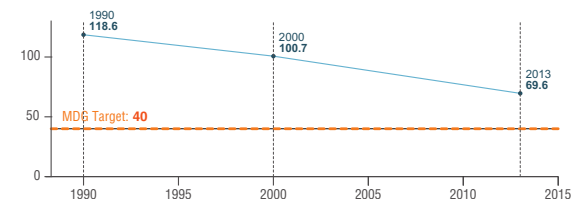
Summary

Demographic Data

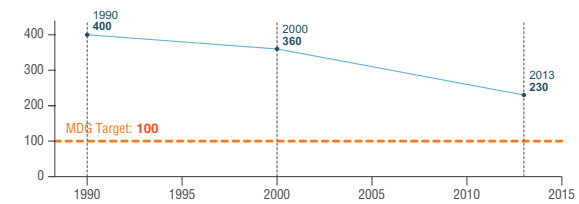
 Total population ('000)	873
 Total births ('000)	24

 Total under-5 population ('000)	109
 Adolescent birth rate (per 1000 girls)	22

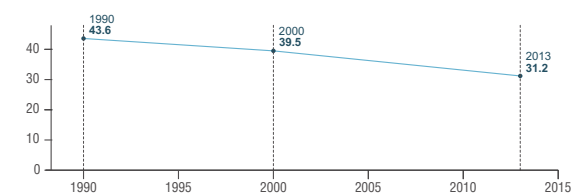
Under-5 mortality rate
per 1000 live births



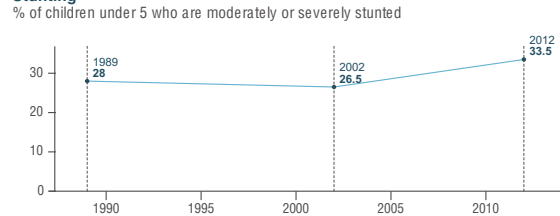
Maternal mortality rate
per 100 000 live births



Neonatal mortality rate
per 1000 live births



Stunting



Reproductive Health and Health Systems Data



Density of doctors, nurses, and midwives per 10 000 population



Demand for family planning satisfied

15%



Laws/regulations that allow adolescents access to contraceptives



Legal status of abortion (x of 5 circumstances)

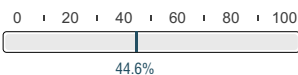
1/5

Health Coverage Indicators

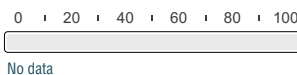
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

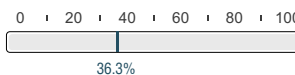
Met need for contraception



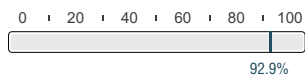
Antenatal care coverage (4 visits)



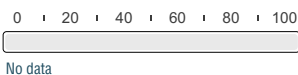
Prevention of mother to child transmission of HIV



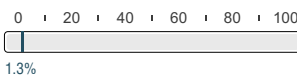
Skilled attendant at birth



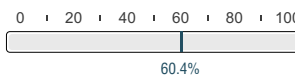
Postnatal care coverage



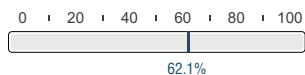
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
- 2015 Progress report on implementing the Commission on Information and Accountability Recommendations: Birth registration, Death registration, MDSR, CRVS, National eHealth strategy, Total health expenditure per capita tracked by financing source, Country conducted annual health sector review, Health sector performance report available in the public domain.
- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).

Better Information

 Vital Events

% of births registered	NO DATA
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	PARTIAL
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES

 Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO DATA
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO DATA

 Innovation and eHealth

National eHealth strategy and plan in place and implemented	NO
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Better Resources

 Resource Tracking

Total health expenditure per capita tracked by financing source	NO
Total public sector health expenditure per capita (US\$)	77.2
Total RMNCH expenditure per capita tracked by financing source	NO
Total annual RMNCH expenditure (US\$)	NO DATA

 Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	NO
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 Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

 National Oversight


Country has conducted annual national health sector review process in the past year	NO
Mutual assessment of progress in implementing agreed health sector commitments exists	NO


 Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

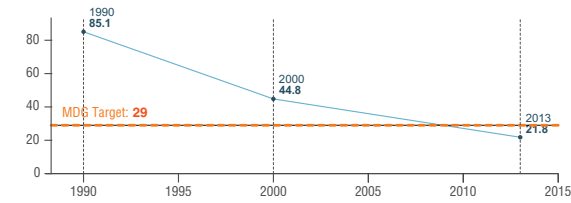
 Total population ('000) **82 056**

 Total under-5 population ('000) **9 252**

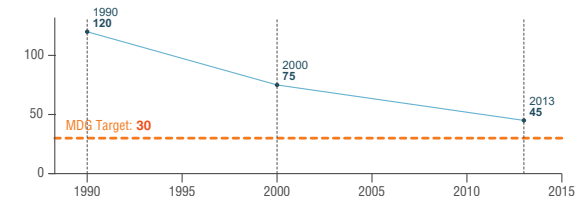
 Total births ('000) **1 898**

 Adolescent birth rate (per 1000 girls) **49**

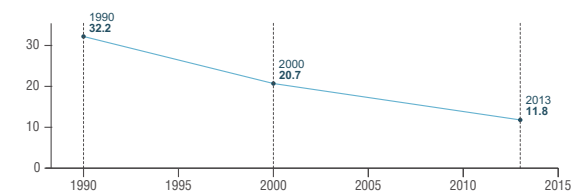
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

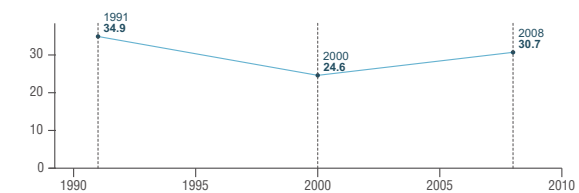


Neonatal mortality rate
per 1000 live births



Stunting

% of children under 5 who are moderately or severely stunted



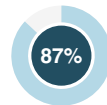
Reproductive Health and Health Systems Data



Density of doctors, nurses, and midwives per 10 000 population



Demand for family planning satisfied



Laws/regulations that allow adolescents access to contraceptives



Legal status of abortion (x of 5 circumstances)

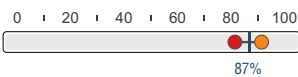


Health Coverage Indicators

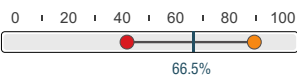
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

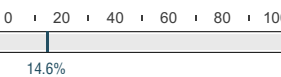
Met need for contraception



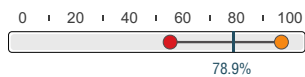
Antenatal care coverage (4 visits)



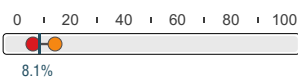
Prevention of mother to child transmission of HIV



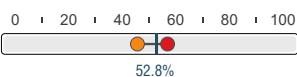
Skilled attendant at birth



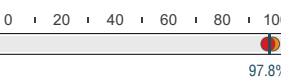
Postnatal care coverage



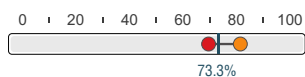
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).

Better Information



Vital Events

% of births registered	>90
% of deaths registered	95
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	YES
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO



Innovation and eHealth

National eHealth strategy and plan in place and implemented	YES
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	YES
Total public sector health expenditure per capita (US\$)	59.2
Total RMNCH expenditure per capita tracked by financing source	YES
Total annual RMNCH expenditure (US\$)	NO DATA



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	NO
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA





Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

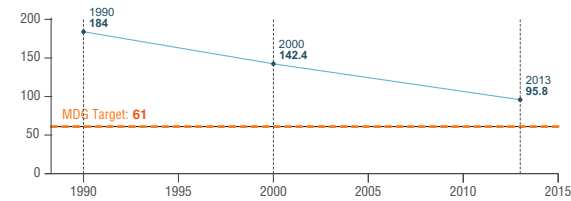
 Total population ('000) **757**

 Total under-5 population ('000) **116**

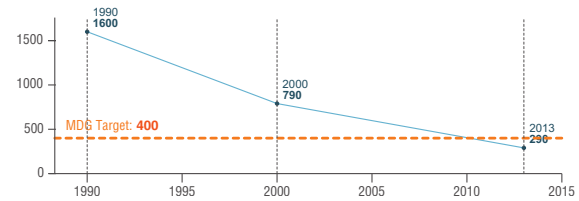
 Total births ('000) **26**

 Adolescent birth rate (per 1000 girls) **123**

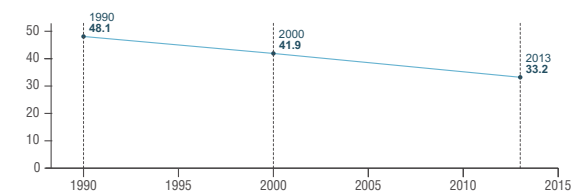
Under-5 mortality rate
per 1000 live births



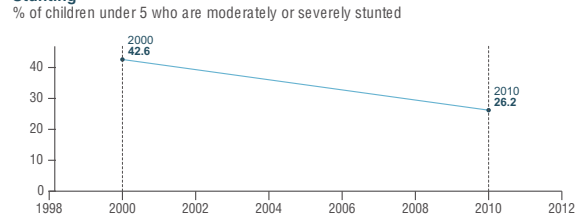
Maternal mortality rate
per 100 000 live births



Neonatal mortality rate
per 1000 live births



Stunting



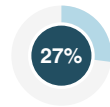
Reproductive Health and Health Systems Data



Density of doctors, nurses, and midwives per 10 000 population



Demand for family planning satisfied



Laws/regulations that allow adolescents access to contraceptives



Legal status of abortion (x of 5 circumstances)

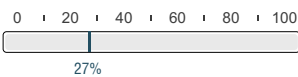


Health Coverage Indicators

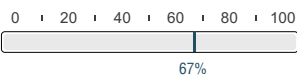
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

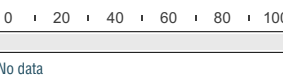
Met need for contraception



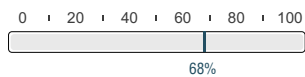
Antenatal care coverage (4 visits)



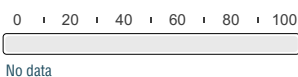
Prevention of mother to child transmission of HIV



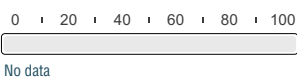
Skilled attendant at birth



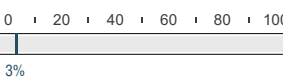
Postnatal care coverage



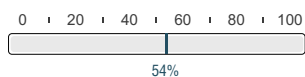
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
- 2015 Progress report on implementing the Commission on Information and Accountability Recommendations: Birth registration, Death registration, MDSR, CRVS, National eHealth strategy, Total health expenditure per capita tracked by financing source, Country conducted annual health sector review, Health sector performance report available in the public domain.
- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).



Better Information



Vital Events

% of births registered	54
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	PARTIAL
Civil Registration and Vital Statistics (CRVS) improvement plan in place	NO



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO



Innovation and eHealth

National eHealth strategy and plan in place and implemented	NO
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	NO
Total public sector health expenditure per capita (US\$)	617.8
Total RMNCH expenditure per capita tracked by financing source	NO
Total annual RMNCH expenditure (US\$)	NO DATA



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	NO
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA





Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

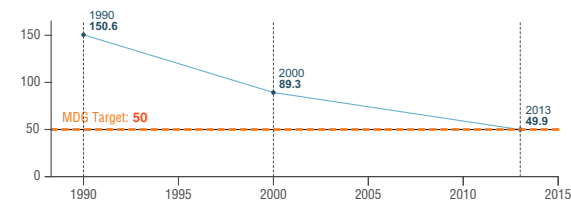
 Total population ('000) **6 333**

 Total under-5 population ('000) **1 084**

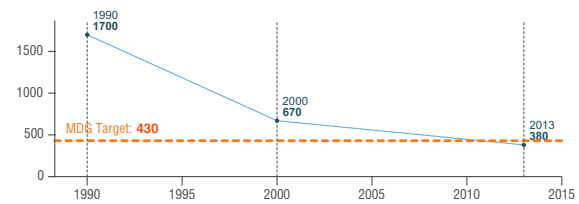
 Total births ('000) **230**

 Adolescent birth rate (per 1000 girls) **77**

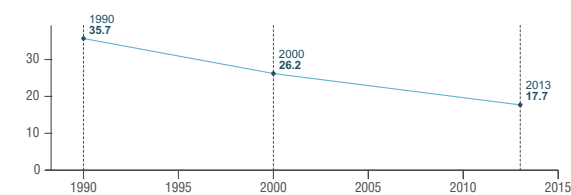
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

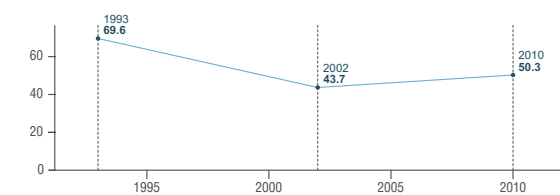


Neonatal mortality rate
per 1000 live births



Stunting

% of children under 5 who are moderately or severely stunted



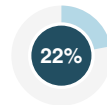
Reproductive Health and Health Systems Data



Density of doctors, nurses, and midwives per 10 000 population



Demand for family planning satisfied



Laws/regulations that allow adolescents access to contraceptives



Legal status of abortion (x of 5 circumstances)

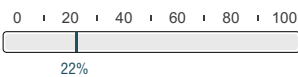


Health Coverage Indicators

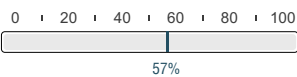
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

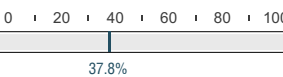
Met need for contraception



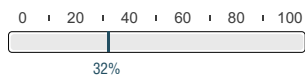
Antenatal care coverage (4 visits)



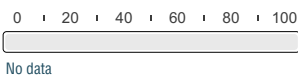
Prevention of mother to child transmission of HIV



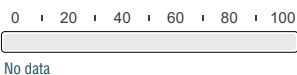
Skilled attendant at birth



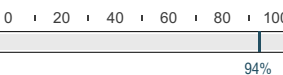
Postnatal care coverage



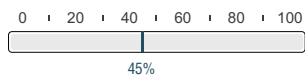
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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Better Information

 Vital Events

% of births registered	NO DATA
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	PARTIAL
Civil Registration and Vital Statistics (CRVS) improvement plan in place	PARTIAL

 Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO

 Innovation and eHealth

National eHealth strategy and plan in place and implemented	NO
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Better Resources

 Resource Tracking

Total health expenditure per capita tracked by financing source	PARTIAL
Total public sector health expenditure per capita (US\$)	7
Total RMNCH expenditure per capita tracked by financing source	PARTIAL
Total annual RMNCH expenditure (US\$)	NO DATA

 Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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 Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

 National Oversight


Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA


 Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

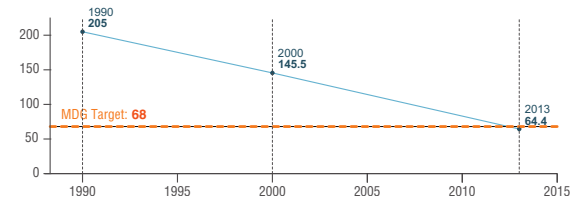
 Total population ('000) **94 101**

 Total under-5 population ('000) **14 415**

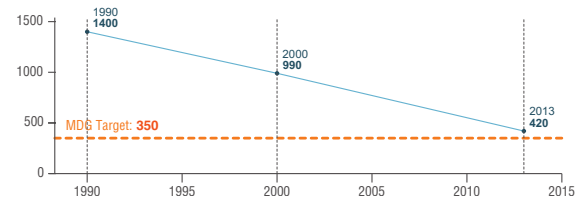
 Total births ('000) **3 084**

 Adolescent birth rate (per 1000 girls) **90**

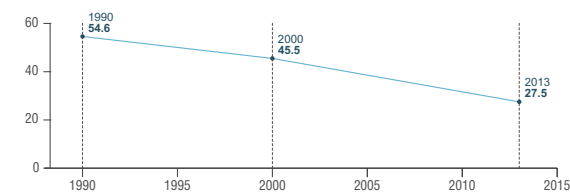
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

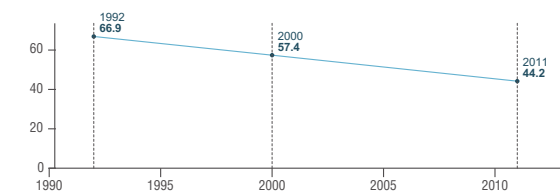


Neonatal mortality rate
per 1000 live births




Stunting

% of children under 5 who are moderately or severely stunted




Reproductive Health and Health Systems Data

 Density of doctors, nurses, and midwives per 10 000 population




 Demand for family planning satisfied



 Laws/regulations that allow adolescents access to contraceptives



 Legal status of abortion (x of 5 circumstances)

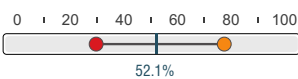


Health Coverage Indicators

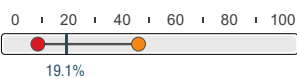
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

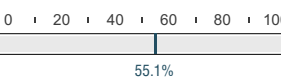
Met need for contraception



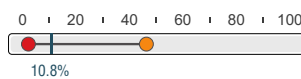
Antenatal care coverage (4 visits)



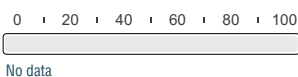
Prevention of mother to child transmission of HIV



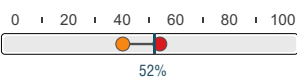
Skilled attendant at birth



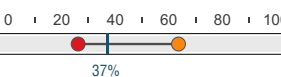
Postnatal care coverage



Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
- 2015 Progress report on implementing the Commission on Information and Accountability Recommendations: Birth registration, Death registration, MDSR, CRVS, National eHealth strategy, Total health expenditure per capita tracked by financing source, Country conducted annual health sector review, Health sector performance report available in the public domain.
- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).

Better Information

 Vital Events

% of births registered	NO DATA
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	PARTIAL
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES

 Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO

 Innovation and eHealth

National eHealth strategy and plan in place and implemented	PARTIAL
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Better Resources

 Resource Tracking

Total health expenditure per capita tracked by financing source	NO
Total public sector health expenditure per capita (US\$)	8.5
Total RMNCH expenditure per capita tracked by financing source	NO
Total annual RMNCH expenditure (US\$)	NO DATA

 Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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 Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

 National Oversight


Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	YES


 Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

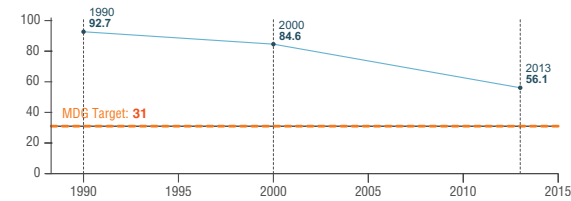
 Total population ('000) **1 672**

 Total under-5 population ('000) **247**

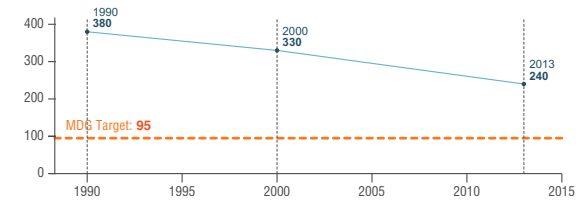
 Total births ('000) **53**

 Adolescent birth rate (per 1000 girls) **115**

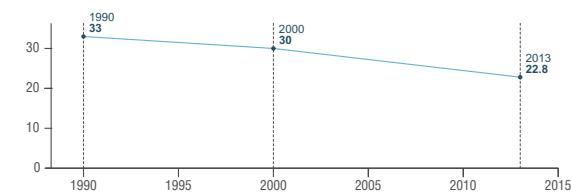
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

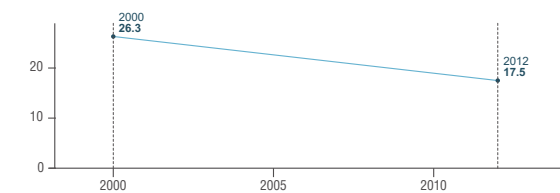


Neonatal mortality rate
per 1000 live births



Stunting

% of children under 5 who are moderately or severely stunted



Reproductive Health and Health Systems Data



Density of doctors, nurses, and midwives per 10 000 population



Demand for family planning satisfied

54%



Laws/regulations that allow adolescents access to contraceptives



Legal status of abortion (x of 5 circumstances)

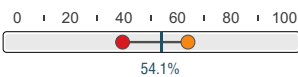
1/5

Health Coverage Indicators

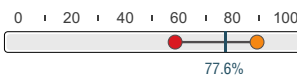
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

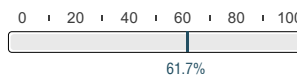
Met need for contraception



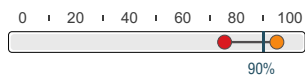
Antenatal care coverage (4 visits)



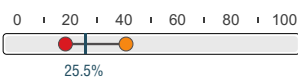
Prevention of mother to child transmission of HIV



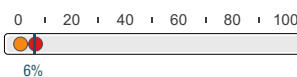
Skilled attendant at birth



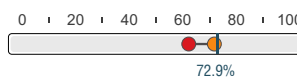
Postnatal care coverage



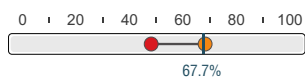
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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Better Information

 Vital Events

% of births registered	90
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	YES
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES

 Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	YES
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	YES

 Innovation and eHealth

National eHealth strategy and plan in place and implemented	NO
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Better Resources

 Resource Tracking

Total health expenditure per capita tracked by financing source	YES
Total public sector health expenditure per capita (US\$)	203.1
Total RMNCH expenditure per capita tracked by financing source	YES
Total annual RMNCH expenditure (US\$)	NO DATA

 Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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 Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

 National Oversight

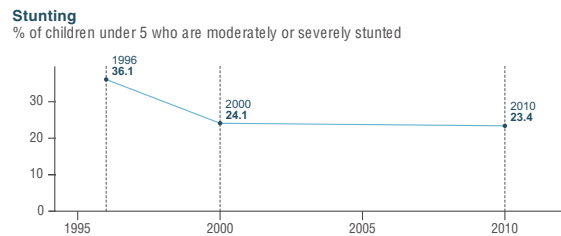
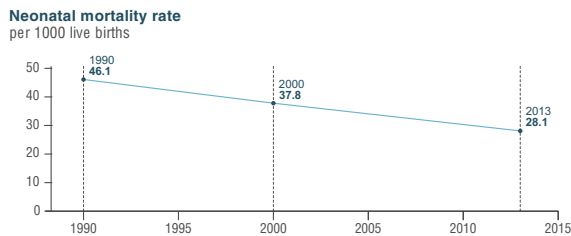
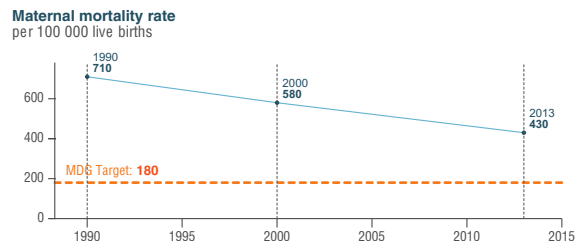
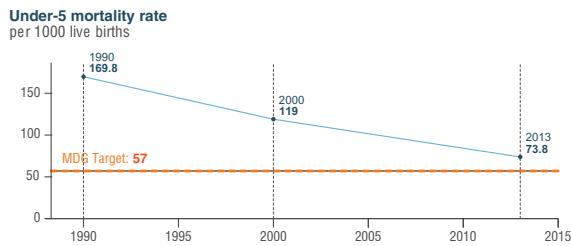
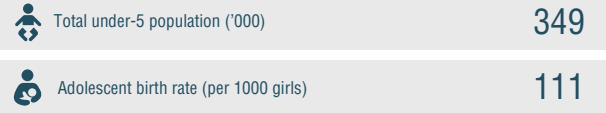
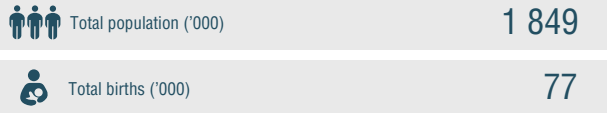
Country has conducted annual national health sector review process in the past year	PARTIAL
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA

 Transparency

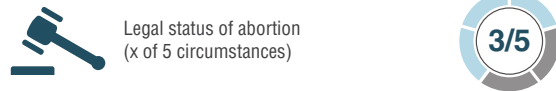
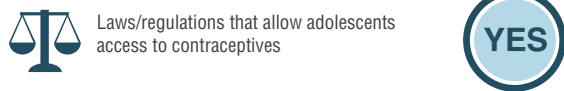
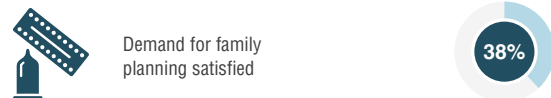
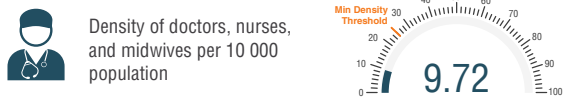
A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data



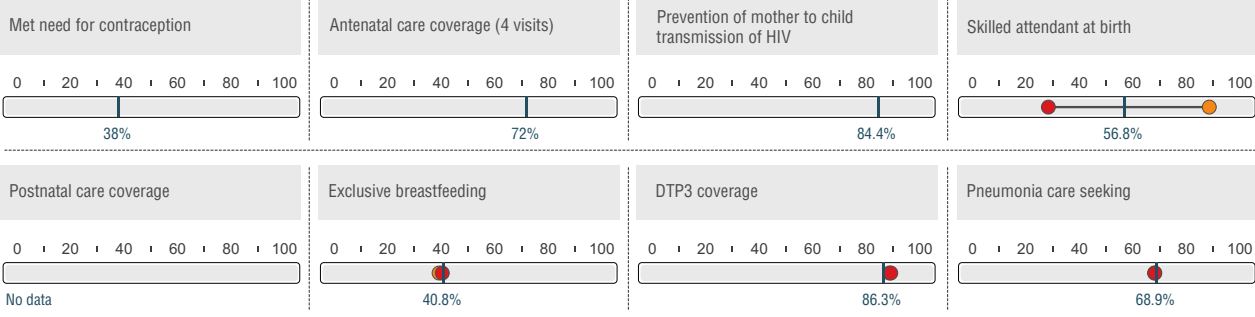
Reproductive Health and Health Systems Data



Health Coverage Indicators

● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
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Better Information



Vital Events

% of births registered	53
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	YES
Civil Registration and Vital Statistics (CRVS) improvement plan in place	NO



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO



Innovation and eHealth

National eHealth strategy and plan in place and implemented	NO
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	YES
Total public sector health expenditure per capita (US\$)	17
Total RMNCH expenditure per capita tracked by financing source	YES
Total annual RMNCH expenditure (US\$)	14 794 320



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	PARTIAL
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA





Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

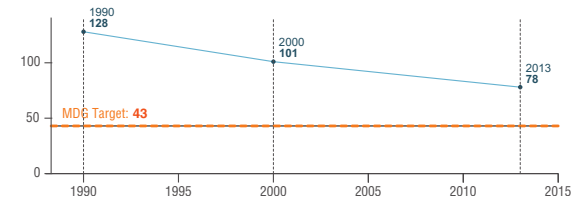
 Total population ('000) **25 905**

 Total under-5 population ('000) **3 704**

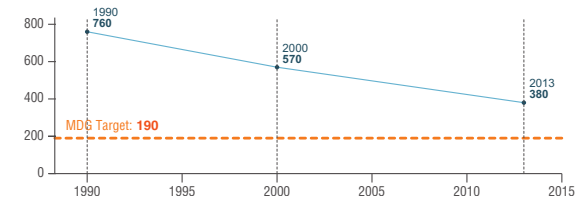
 Total births ('000) **794**

 Adolescent birth rate (per 1000 girls) **68**

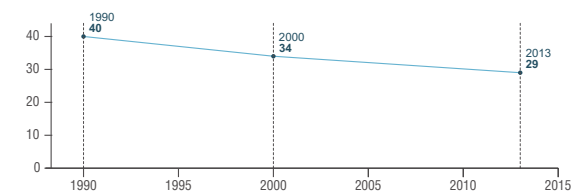
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

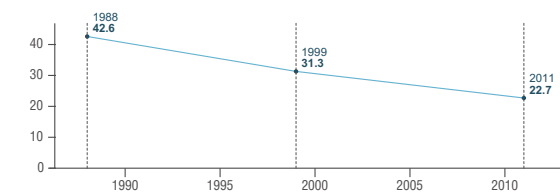


Neonatal mortality rate
per 1000 live births



Stunting

% of children under 5 who are moderately or severely stunted



Reproductive Health and Health Systems Data



Density of doctors, nurses, and midwives per 10 000 population



Demand for family planning satisfied

15%



Laws/regulations that allow adolescents access to contraceptives



Legal status of abortion (x of 5 circumstances)

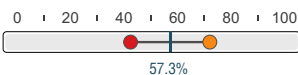
3/5

Health Coverage Indicators

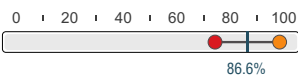
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

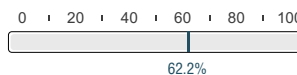
Met need for contraception



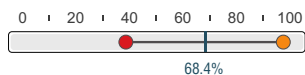
Antenatal care coverage (4 visits)



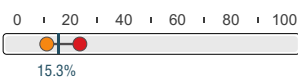
Prevention of mother to child transmission of HIV



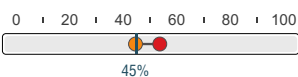
Skilled attendant at birth



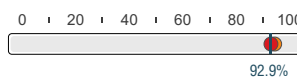
Postnatal care coverage



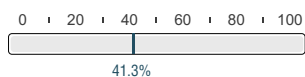
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
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- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).

Better Information

 Vital Events

% of births registered	63
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	PARTIAL
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES

 Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO

 Innovation and eHealth

National eHealth strategy and plan in place and implemented	YES
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Better Resources

 Resource Tracking

Total health expenditure per capita tracked by financing source	YES
Total public sector health expenditure per capita (US\$)	47.4
Total RMNCH expenditure per capita tracked by financing source	YES
Total annual RMNCH expenditure (US\$)	NO DATA

 Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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 Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

 National Oversight


Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA


 Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

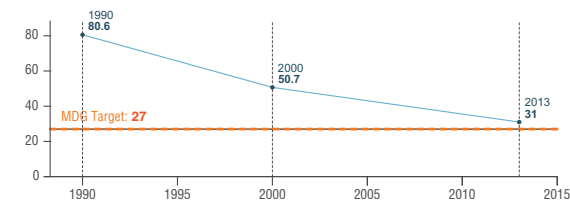
 Total population ('000) **15 468**

 Total under-5 population ('000) **2 288**

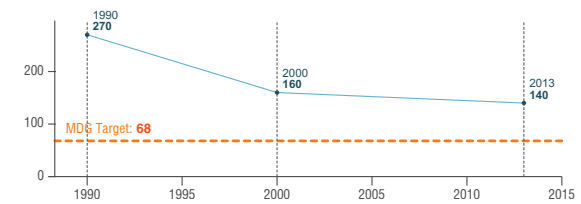
 Total births ('000) **474**

 Adolescent birth rate (per 1000 girls) **107**

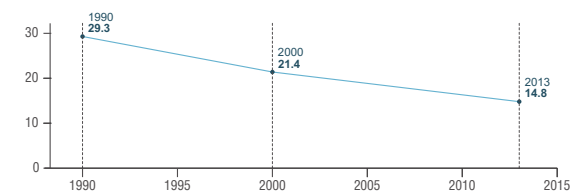
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

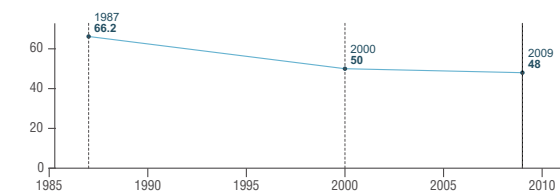


Neonatal mortality rate
per 1000 live births

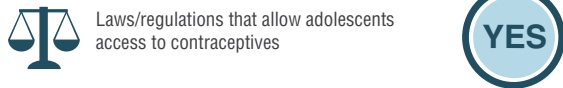
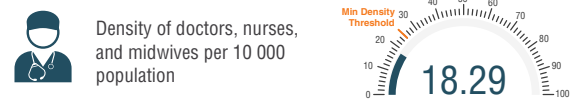


Stunting

% of children under 5 who are moderately or severely stunted



Reproductive Health and Health Systems Data

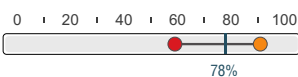


Health Coverage Indicators

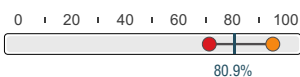
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

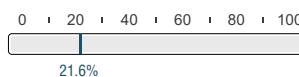
Met need for contraception



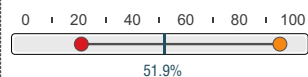
Antenatal care coverage (4 visits)



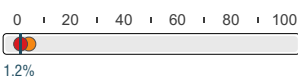
Prevention of mother to child transmission of HIV



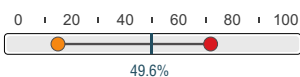
Skilled attendant at birth



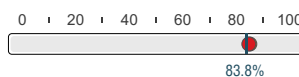
Postnatal care coverage



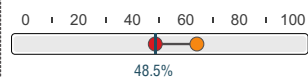
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
- 2015 Progress report on implementing the Commission on Information and Accountability Recommendations: Birth registration, Death registration, MDSR, CRVS, National eHealth strategy, Total health expenditure per capita tracked by financing source, Country conducted annual health sector review, Health sector performance report available in the public domain.
- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).

Better Information



Vital Events

% of births registered	97
% of deaths registered	92
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	YES
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO



Innovation and eHealth

National eHealth strategy and plan in place and implemented	YES
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	NO
Total public sector health expenditure per capita (US\$)	80.4
Total RMNCH expenditure per capita tracked by financing source	NO
Total annual RMNCH expenditure (US\$)	NO DATA



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	NO
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA





Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

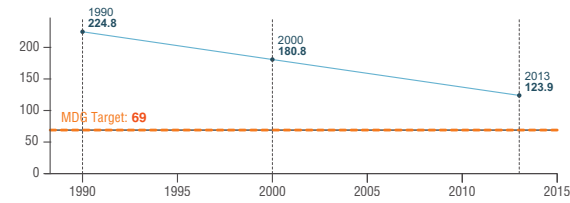
 Total population ('000) **1 704**

 Total under-5 population ('000) **274**

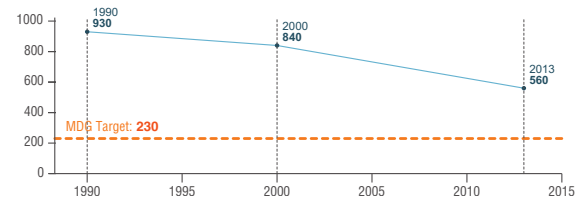
 Total births ('000) **63**

 Adolescent birth rate (per 1000 girls) **123**

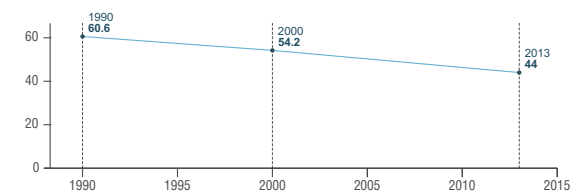
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

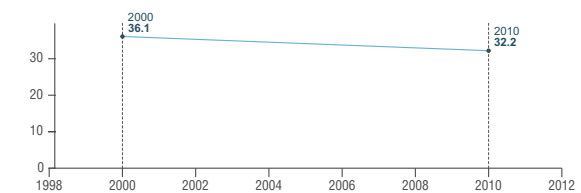


Neonatal mortality rate
per 1000 live births




Stunting

% of children under 5 who are moderately or severely stunted




Reproductive Health and Health Systems Data

 Density of doctors, nurses, and midwives per 10 000 population




 Demand for family planning satisfied



 Laws/regulations that allow adolescents access to contraceptives



 Legal status of abortion (x of 5 circumstances)

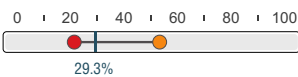


Health Coverage Indicators

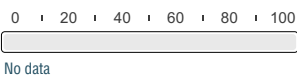
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

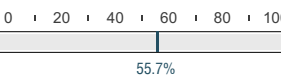
Met need for contraception



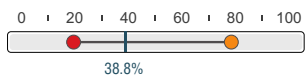
Antenatal care coverage (4 visits)



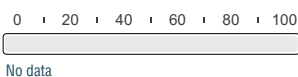
Prevention of mother to child transmission of HIV



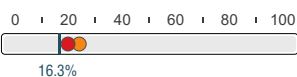
Skilled attendant at birth



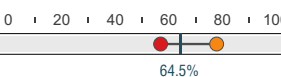
Postnatal care coverage



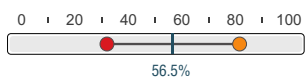
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
- 2015 Progress report on implementing the Commission on Information and Accountability Recommendations: Birth registration, Death registration, MDSR, CRVS, National eHealth strategy, Total health expenditure per capita tracked by financing source, Country conducted annual health sector review, Health sector performance report available in the public domain.
- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).

Better Information

 Vital Events

% of births registered	24
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	NO
Civil Registration and Vital Statistics (CRVS) improvement plan in place	PARTIAL

 Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO

 Innovation and eHealth

National eHealth strategy and plan in place and implemented	NO
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Better Resources

 Resource Tracking

Total health expenditure per capita tracked by financing source	NO
Total public sector health expenditure per capita (US\$)	6.8
Total RMNCH expenditure per capita tracked by financing source	NO
Total annual RMNCH expenditure (US\$)	NO DATA

 Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	NO
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 Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

 National Oversight

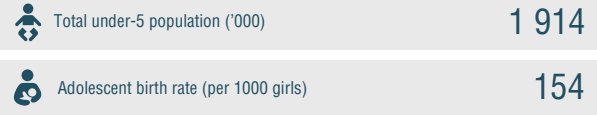
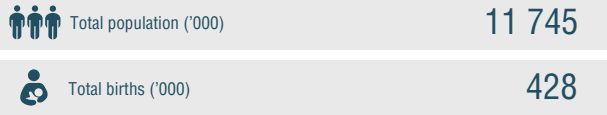
Country has conducted annual national health sector review process in the past year	PARTIAL
Mutual assessment of progress in implementing agreed health sector commitments exists	NO

 Transparency

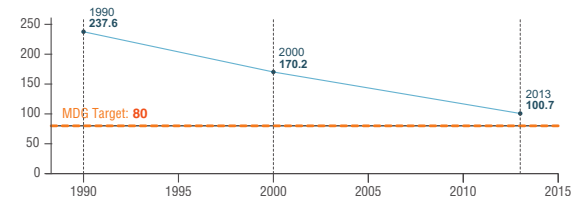
A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

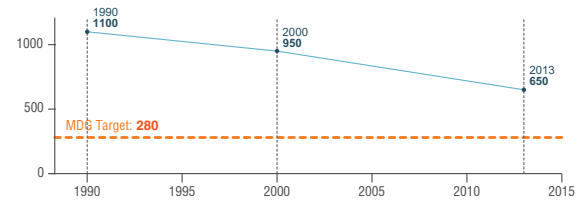
Demographic Data



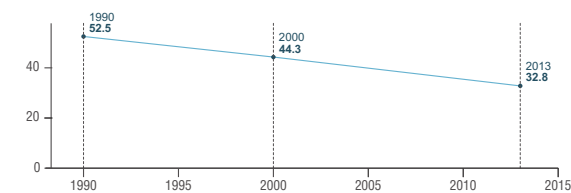
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

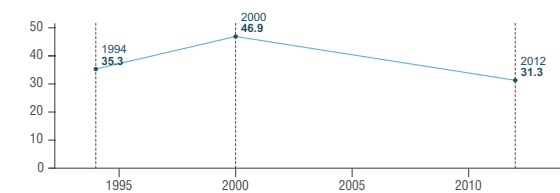


Neonatal mortality rate
per 1000 live births



Stunting

% of children under 5 who are moderately or severely stunted



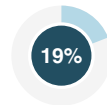
Reproductive Health and Health Systems Data



Density of doctors, nurses, and midwives per 10 000 population



Demand for family planning satisfied



Laws/regulations that allow adolescents access to contraceptives



Legal status of abortion (x of 5 circumstances)

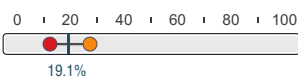


Health Coverage Indicators

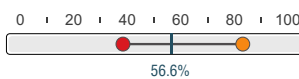
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

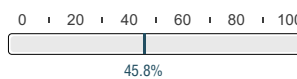
Met need for contraception



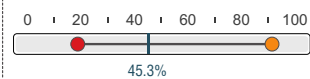
Antenatal care coverage (4 visits)



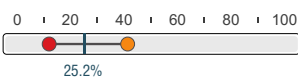
Prevention of mother to child transmission of HIV



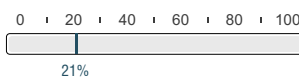
Skilled attendant at birth



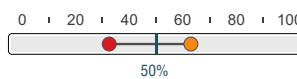
Postnatal care coverage



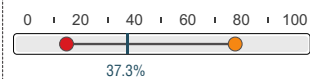
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
- 2015 Progress report on implementing the Commission on Information and Accountability Recommendations: Birth registration, Death registration, MDSR, CRVS, National eHealth strategy, Total health expenditure per capita tracked by financing source, Country conducted annual health sector review, Health sector performance report available in the public domain.
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- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).

Better Information

 Vital Events

% of births registered	58
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	NO
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES

 Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	YES
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	YES

 Innovation and eHealth

National eHealth strategy and plan in place and implemented	NO
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Better Resources

 Resource Tracking

Total health expenditure per capita tracked by financing source	PARTIAL
Total public sector health expenditure per capita (US\$)	9
Total RMNCH expenditure per capita tracked by financing source	PARTIAL
Total annual RMNCH expenditure (US\$)	NO DATA

 Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	NO
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 Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

 National Oversight


Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO


 Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

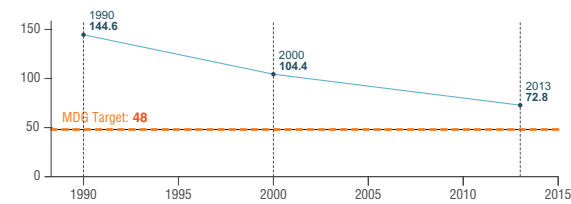
 Total population ('000) **10 317**

 Total under-5 population ('000) **1 249**

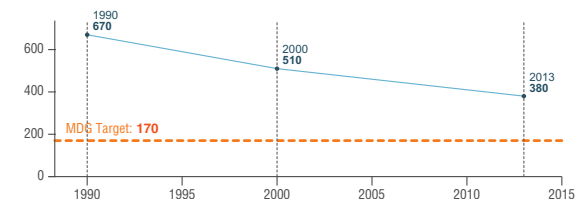
 Total births ('000) **265**

 Adolescent birth rate (per 1000 girls) **46**

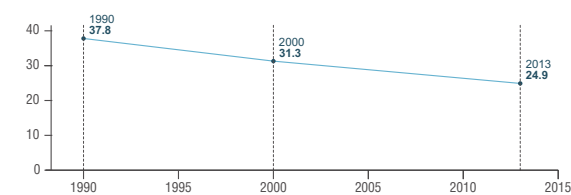
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

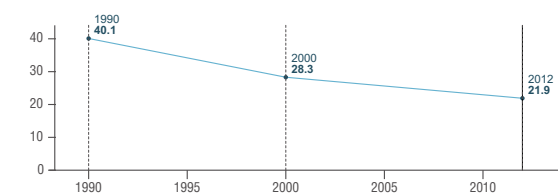


Neonatal mortality rate
per 1000 live births



Stunting

% of children under 5 who are moderately or severely stunted



Reproductive Health and Health Systems Data



Density of doctors, nurses, and midwives per 10 000 population



Demand for family planning satisfied

49%



Laws/regulations that allow adolescents access to contraceptives



Legal status of abortion (x of 5 circumstances)

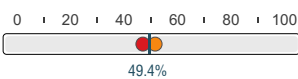
1/5

Health Coverage Indicators

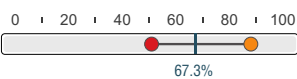
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

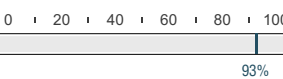
Met need for contraception



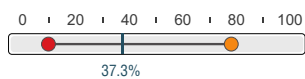
Antenatal care coverage (4 visits)



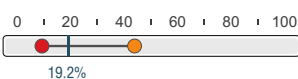
Prevention of mother to child transmission of HIV



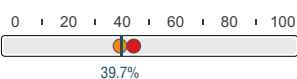
Skilled attendant at birth



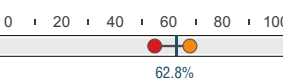
Postnatal care coverage



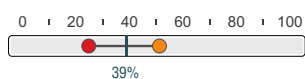
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
- 2015 Progress report on implementing the Commission on Information and Accountability Recommendations: Birth registration, Death registration, MDSR, CRVS, National eHealth strategy, Total health expenditure per capita tracked by financing source, Country conducted annual health sector review, Health sector performance report available in the public domain.
- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
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Better Information



Vital Events

% of births registered	80
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	NO
Civil Registration and Vital Statistics (CRVS) improvement plan in place	NO



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	YES
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	YES



Innovation and eHealth

National eHealth strategy and plan in place and implemented	NO
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	YES
Total public sector health expenditure per capita (US\$)	12
Total RMNCH expenditure per capita tracked by financing source	YES
Total annual RMNCH expenditure (US\$)	NO DATA



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	NO
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA





Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

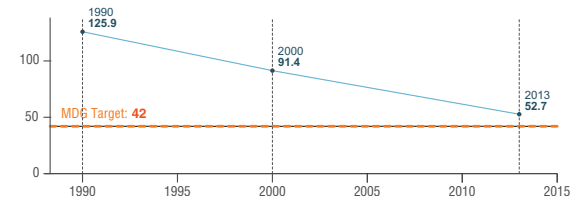
 Total population ('000) **1 252 140**

 Total under-5 population ('000) **122 128**

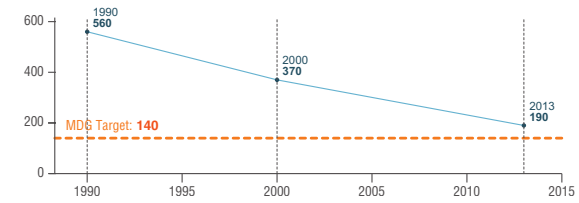
 Total births ('000) **25 642**

 Adolescent birth rate (per 1000 girls) **51**

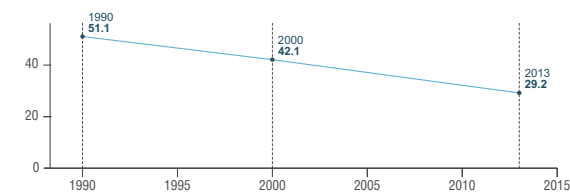
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

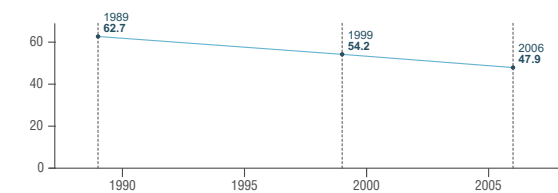


Neonatal mortality rate
per 1000 live births

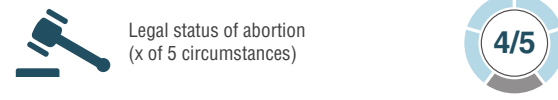
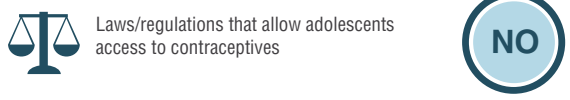
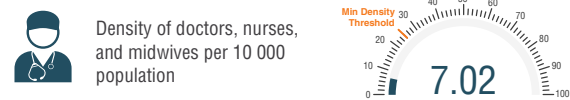


Stunting

% of children under 5 who are moderately or severely stunted



Reproductive Health and Health Systems Data

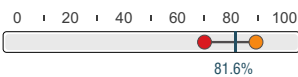


Health Coverage Indicators

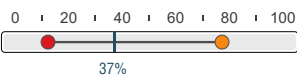
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

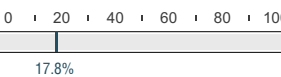
Met need for contraception



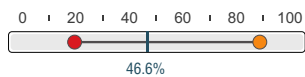
Antenatal care coverage (4 visits)



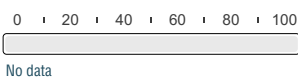
Prevention of mother to child transmission of HIV



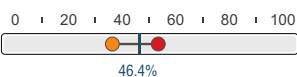
Skilled attendant at birth



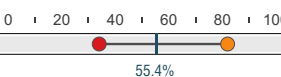
Postnatal care coverage



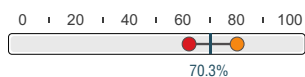
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
- 2015 Progress report on implementing the Commission on Information and Accountability Recommendations: Birth registration, Death registration, MDSR, CRVS, National eHealth strategy, Total health expenditure per capita tracked by financing source, Country conducted annual health sector review, Health sector performance report available in the public domain.
- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).

Better Information

 Vital Events

% of births registered	84
% of deaths registered	8
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	PARTIAL
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES

 Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO

 Innovation and eHealth

National eHealth strategy and plan in place and implemented	YES
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Better Resources

 Resource Tracking

Total health expenditure per capita tracked by financing source	PARTIAL
Total public sector health expenditure per capita (US\$)	20.3
Total RMNCH expenditure per capita tracked by financing source	PARTIAL
Total annual RMNCH expenditure (US\$)	NO DATA

 Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	NO
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 Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

 National Oversight


Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA


 Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

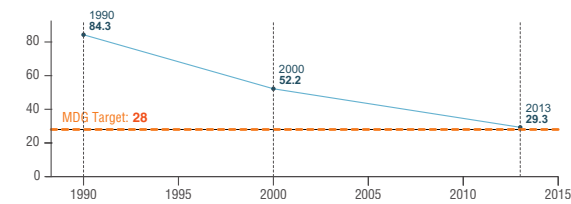
 Total population ('000) **249 866**

 Total under-5 population ('000) **23 275**

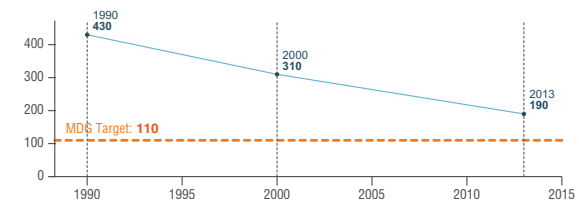
 Total births ('000) **4 736**

 Adolescent birth rate (per 1000 girls) **52**

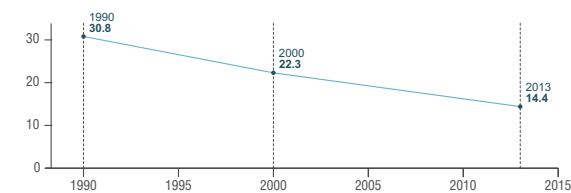
Under-5 mortality rate
per 1000 live births



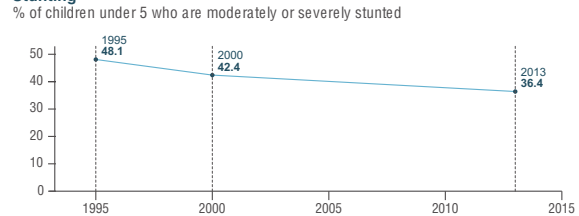
Maternal mortality rate
per 100 000 live births



Neonatal mortality rate
per 1000 live births



Stunting



Reproductive Health and Health Systems Data



Density of doctors, nurses, and midwives per 10 000 population



Demand for family planning satisfied

15%



Laws/regulations that allow adolescents access to contraceptives



Legal status of abortion (x of 5 circumstances)

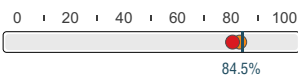
1/5

Health Coverage Indicators

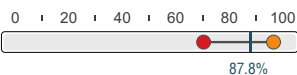
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

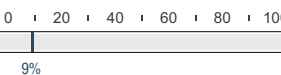
Met need for contraception



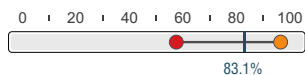
Antenatal care coverage (4 visits)



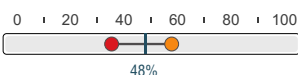
Prevention of mother to child transmission of HIV



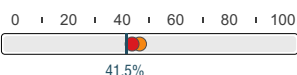
Skilled attendant at birth



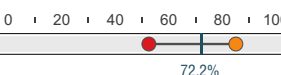
Postnatal care coverage



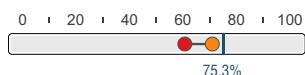
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).



Better Information

Vital Events

% of births registered	67
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	YES
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES

Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO DATA
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO DATA

Innovation and eHealth

National eHealth strategy and plan in place and implemented	YES
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Better Resources

Resource Tracking

Total health expenditure per capita tracked by financing source	PARTIAL
Total public sector health expenditure per capita (US\$)	42.7
Total RMNCH expenditure per capita tracked by financing source	PARTIAL
Total annual RMNCH expenditure (US\$)	NO DATA

Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	NO
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

National Oversight


Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA


Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

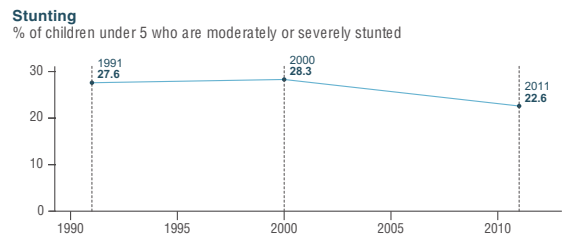
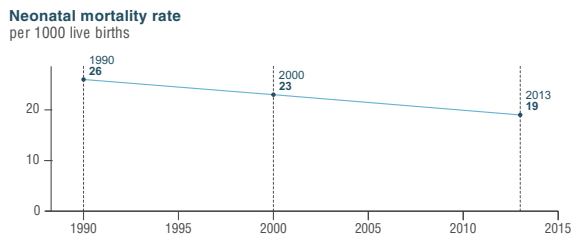
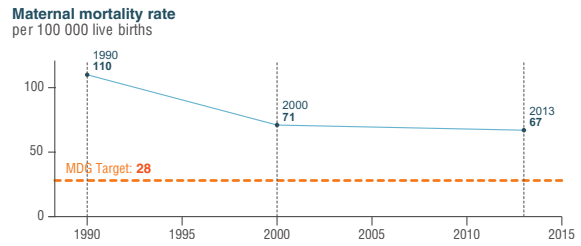
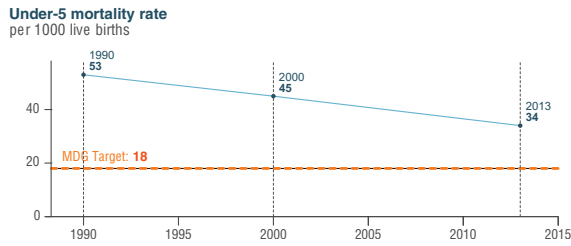
Demographic Data

 Total population ('000) **33 765**

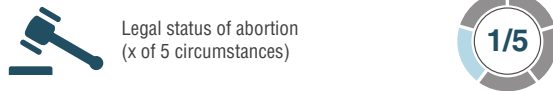
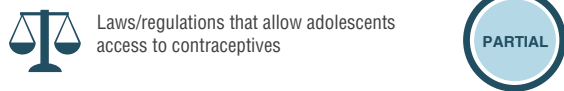
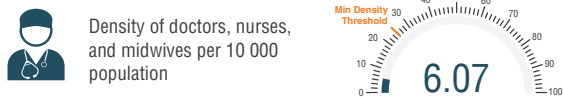
 Total under-5 population ('000) **4 996**

 Total births ('000) **1 037**

 Adolescent birth rate (per 1000 girls) **74**



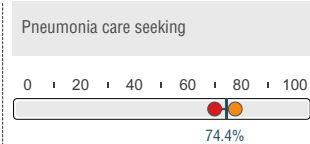
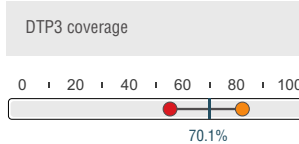
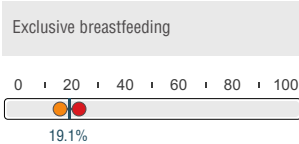
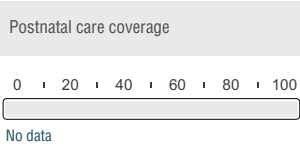
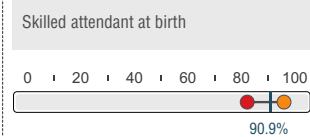
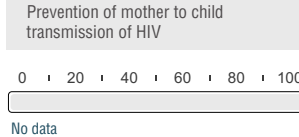
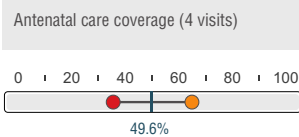
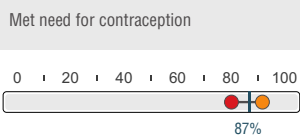
Reproductive Health and Health Systems Data



Health Coverage Indicators

● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).

Better Information



Vital Events

% of births registered	99
% of deaths registered	65
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	YES
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO



Innovation and eHealth

National eHealth strategy and plan in place and implemented	PARTIAL
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	YES
Total public sector health expenditure per capita (US\$)	121.2
Total RMNCH expenditure per capita tracked by financing source	YES
Total annual RMNCH expenditure (US\$)	NO DATA



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA





Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

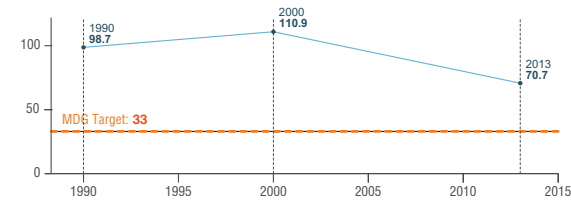
 Total population ('000) **44 354**

 Total under-5 population ('000) **7 137**

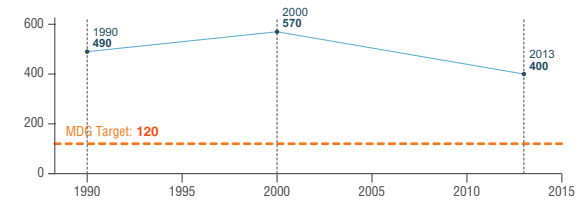
 Total births ('000) **1 535**

 Adolescent birth rate (per 1000 girls) **100**

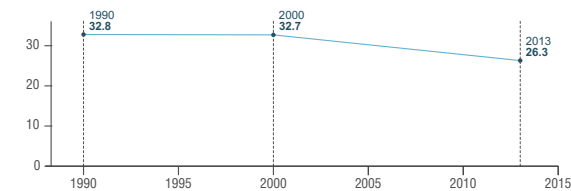
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

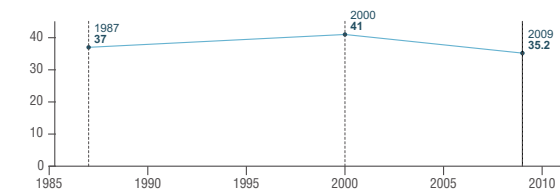


Neonatal mortality rate
per 1000 live births



Stunting

% of children under 5 who are moderately or severely stunted



Reproductive Health and Health Systems Data



Density of doctors, nurses, and midwives per 10 000 population



Demand for family planning satisfied

64%



Laws/regulations that allow adolescents access to contraceptives



Legal status of abortion (x of 5 circumstances)

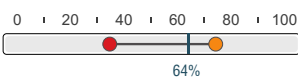
3/5

Health Coverage Indicators

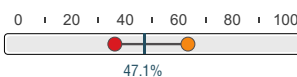
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

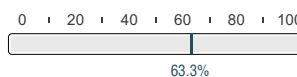
Met need for contraception



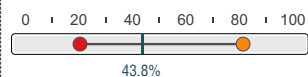
Antenatal care coverage (4 visits)



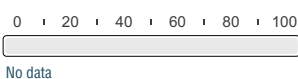
Prevention of mother to child transmission of HIV



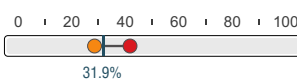
Skilled attendant at birth



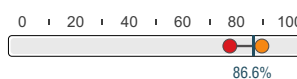
Postnatal care coverage



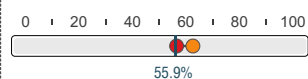
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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Better Information

 Vital Events

% of births registered	60
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	YES
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES

 Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO

 Innovation and eHealth

National eHealth strategy and plan in place and implemented	YES
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Better Resources

 Resource Tracking

Total health expenditure per capita tracked by financing source	YES
Total public sector health expenditure per capita (US\$)	17
Total RMNCH expenditure per capita tracked by financing source	YES
Total annual RMNCH expenditure (US\$)	NO DATA

 Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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 Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

 National Oversight


Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA


 Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

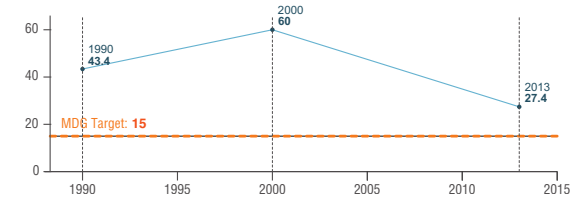
 Total population ('000) **24 895**

 Total under-5 population ('000) **1 735**

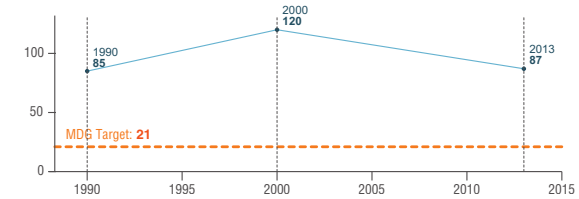
 Total births ('000) **356**

 Adolescent birth rate (per 1000 girls) **1**

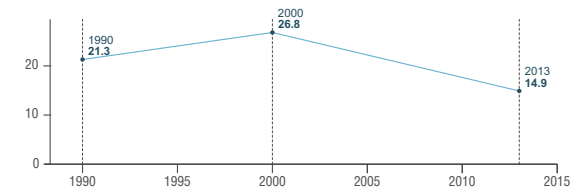
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

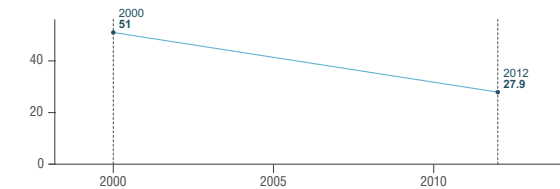


Neonatal mortality rate
per 1000 live births

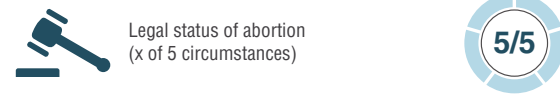
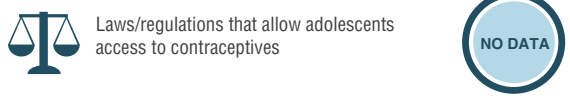
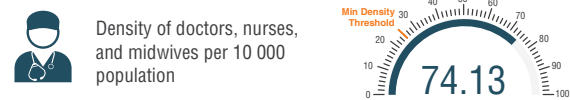


Stunting

% of children under 5 who are moderately or severely stunted



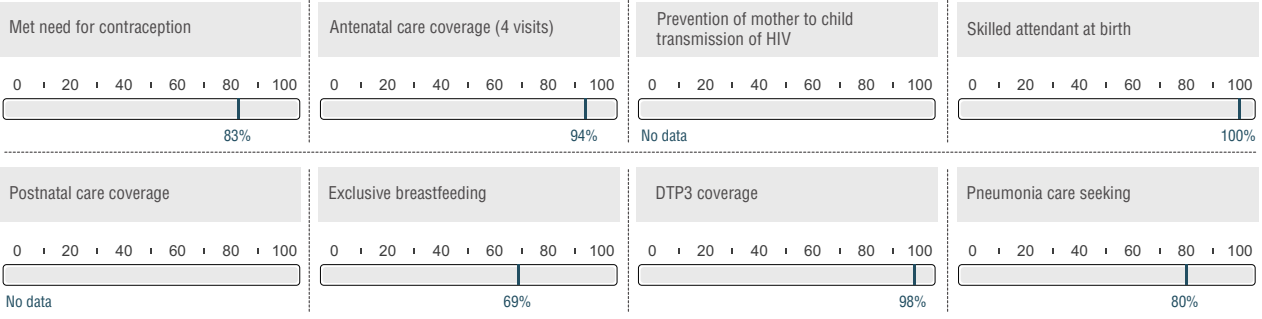
Reproductive Health and Health Systems Data



Health Coverage Indicators

● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
- 2015 Progress report on implementing the Commission on Information and Accountability Recommendations: Birth registration, Death registration, MDSR, CRVS, National eHealth strategy, Total health expenditure per capita tracked by financing source, Country conducted annual health sector review, Health sector performance report available in the public domain.
- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).

Better Information



Vital Events

% of births registered	100
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	NO
Civil Registration and Vital Statistics (CRVS) improvement plan in place	PARTIAL



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	YES
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO



Innovation and eHealth

National eHealth strategy and plan in place and implemented	PARTIAL
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	NO
Total public sector health expenditure per capita (US\$)	4.1
Total RMNCH expenditure per capita tracked by financing source	NO
Total annual RMNCH expenditure (US\$)	NO DATA



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	NO
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA





Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

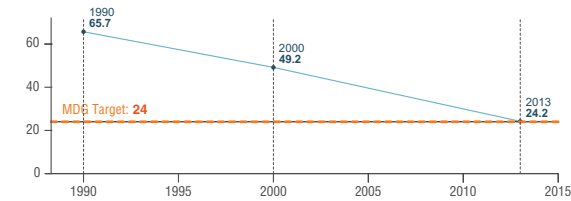
 Total population ('000) **5 548**

 Total under-5 population ('000) **696**

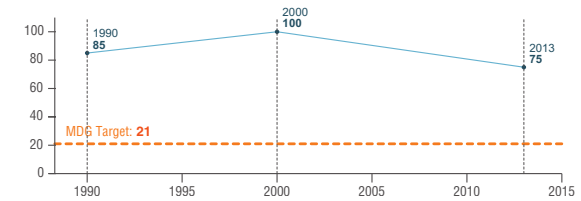
 Total births ('000) **148**

 Adolescent birth rate (per 1000 girls) **30**

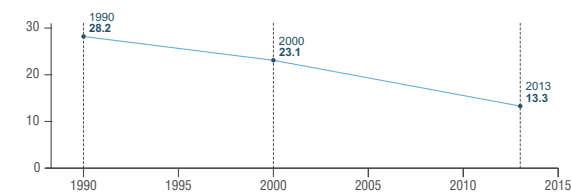
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

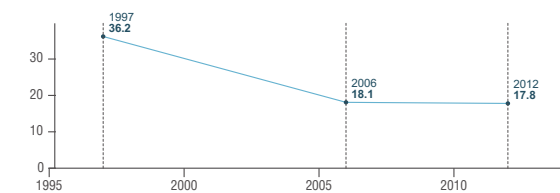


Neonatal mortality rate
per 1000 live births



Stunting

% of children under 5 who are moderately or severely stunted



Reproductive Health and Health Systems Data



Density of doctors, nurses, and midwives per 10 000 population



Demand for family planning satisfied

67%



Laws/regulations that allow adolescents access to contraceptives



Legal status of abortion (x of 5 circumstances)

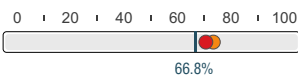
5/5

Health Coverage Indicators

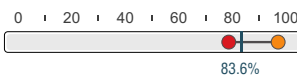
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

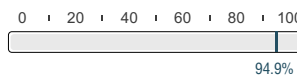
Met need for contraception



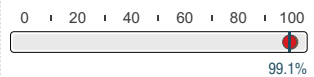
Antenatal care coverage (4 visits)



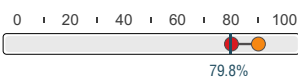
Prevention of mother to child transmission of HIV



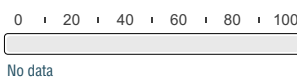
Skilled attendant at birth



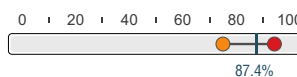
Postnatal care coverage



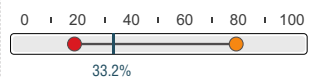
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
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Better Information



Vital Events

% of births registered	98
% of deaths registered	96
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	PARTIAL
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	YES
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	YES



Innovation and eHealth

National eHealth strategy and plan in place and implemented	PARTIAL
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	NO
Total public sector health expenditure per capita (US\$)	50.6
Total RMNCH expenditure per capita tracked by financing source	NO
Total annual RMNCH expenditure (US\$)	NO DATA



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA





Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

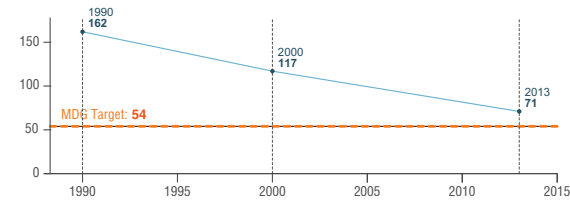
 Total population ('000) **6 770**

 Total under-5 population ('000) **862**

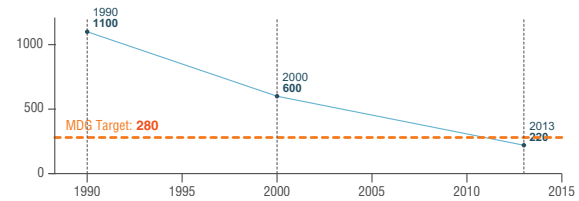
 Total births ('000) **181**

 Adolescent birth rate (per 1000 girls) **75**

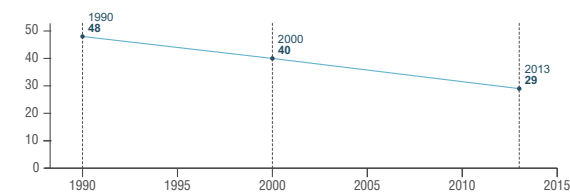
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

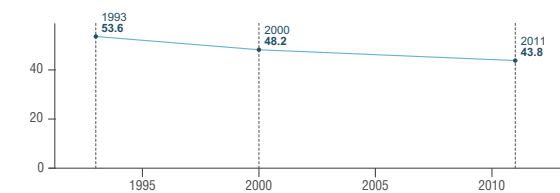


Neonatal mortality rate
per 1000 live births

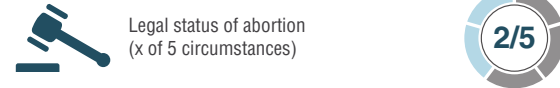
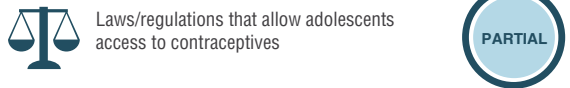
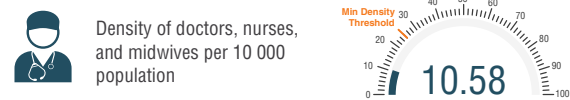


Stunting

% of children under 5 who are moderately or severely stunted



Reproductive Health and Health Systems Data

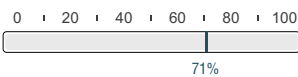


Health Coverage Indicators

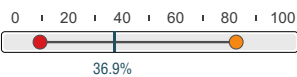
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

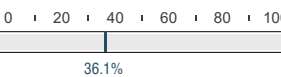
Met need for contraception



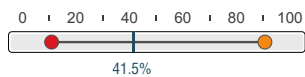
Antenatal care coverage (4 visits)



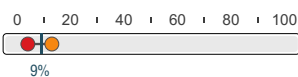
Prevention of mother to child transmission of HIV



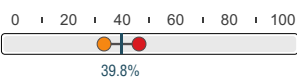
Skilled attendant at birth



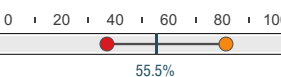
Postnatal care coverage



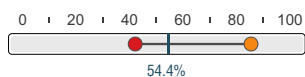
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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Better Information



Vital Events

% of births registered	75
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	PARTIAL
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO



Innovation and eHealth

National eHealth strategy and plan in place and implemented	PARTIAL
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	YES
Total public sector health expenditure per capita (US\$)	20.6
Total RMNCH expenditure per capita tracked by financing source	YES
Total annual RMNCH expenditure (US\$)	NO DATA



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA





Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

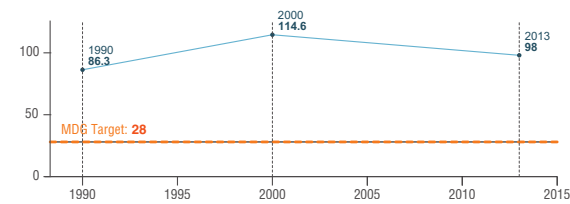
 Total population ('000) **2 074**

 Total under-5 population ('000) **262**

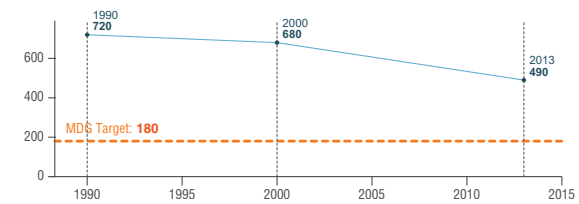
 Total births ('000) **57**

 Adolescent birth rate (per 1000 girls) **90**

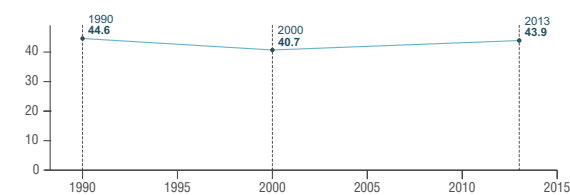
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

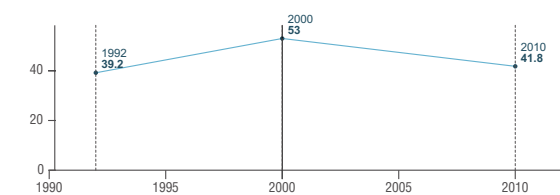


Neonatal mortality rate
per 1000 live births

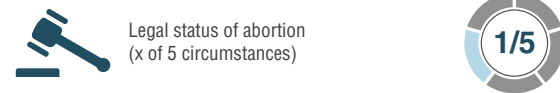
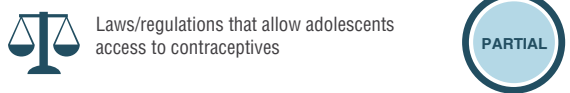
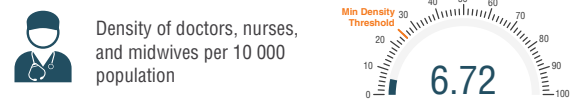


Stunting

% of children under 5 who are moderately or severely stunted



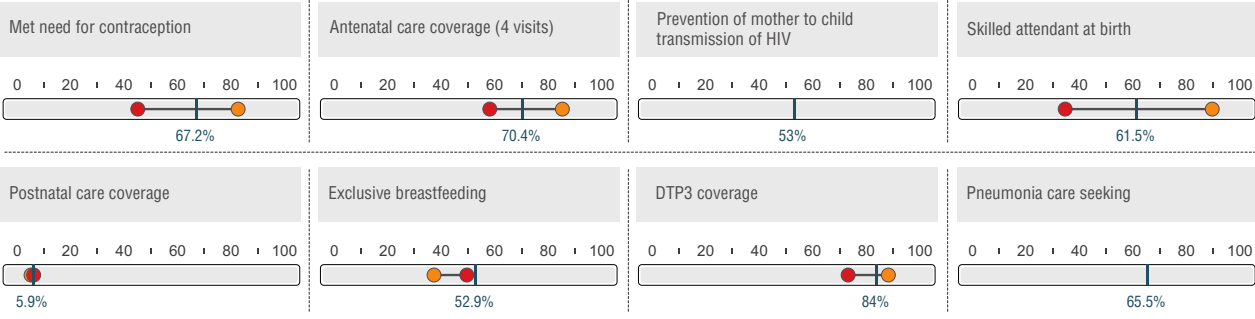
Reproductive Health and Health Systems Data



Health Coverage Indicators

● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).



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- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).

Better Information



Vital Events

% of births registered	45
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	YES
Civil Registration and Vital Statistics (CRVS) improvement plan in place	PARTIAL



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO



Innovation and eHealth

National eHealth strategy and plan in place and implemented	PARTIAL
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	PARTIAL
Total public sector health expenditure per capita (US\$)	108.3
Total RMNCH expenditure per capita tracked by financing source	PARTIAL
Total annual RMNCH expenditure (US\$)	NO DATA



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	NO
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA





Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

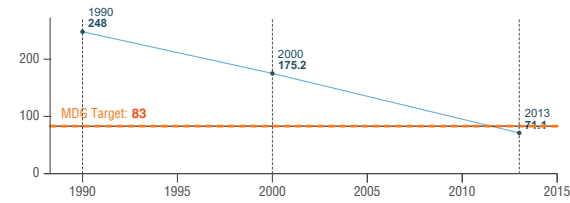
 Total population ('000) **4 294**

 Total under-5 population ('000) **693**

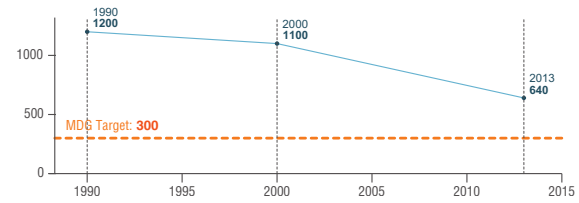
 Total births ('000) **150**

 Adolescent birth rate (per 1000 girls) **142**

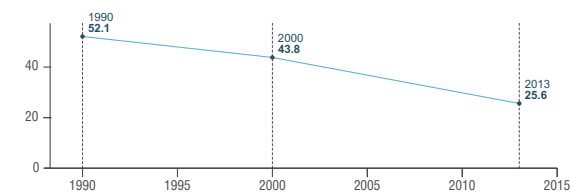
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

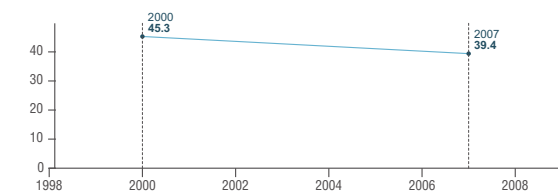


Neonatal mortality rate
per 1000 live births




Stunting

% of children under 5 who are moderately or severely stunted

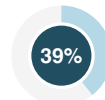



Reproductive Health and Health Systems Data

 Density of doctors, nurses, and midwives per 10 000 population




 Demand for family planning satisfied



 Laws/regulations that allow adolescents access to contraceptives



 Legal status of abortion (x of 5 circumstances)

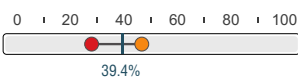


Health Coverage Indicators

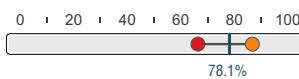
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

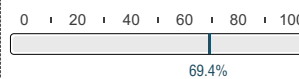
Met need for contraception



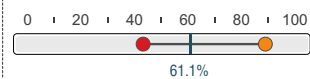
Antenatal care coverage (4 visits)



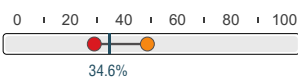
Prevention of mother to child transmission of HIV



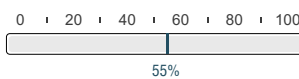
Skilled attendant at birth



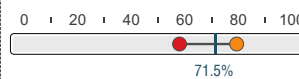
Postnatal care coverage



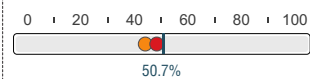
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
- 2015 Progress report on implementing the Commission on Information and Accountability Recommendations: Birth registration, Death registration, MDSR, CRVS, National eHealth strategy, Total health expenditure per capita tracked by financing source, Country conducted annual health sector review, Health sector performance report available in the public domain.
- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).

Better Information

 Vital Events

% of births registered	4
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	YES
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES

 Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	YES

 Innovation and eHealth

National eHealth strategy and plan in place and implemented	PARTIAL
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Better Resources

 Resource Tracking

Total health expenditure per capita tracked by financing source	YES
Total public sector health expenditure per capita (US\$)	19.5
Total RMNCH expenditure per capita tracked by financing source	YES
Total annual RMNCH expenditure (US\$)	NO DATA

 Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	NO
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 Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

 National Oversight


Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA



 Transparency

A health sector performance report for the preceding year is available in the public domain	NO DATA
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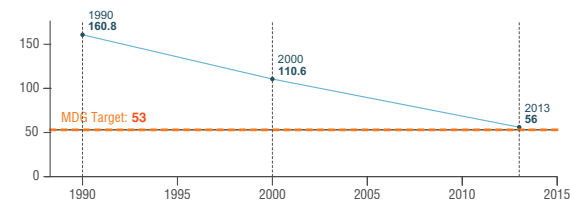
Summary

Demographic Data

 Total population ('000)	22 925
 Total births ('000)	781

 Total under-5 population ('000)	3 686
 Adolescent birth rate (per 1000 girls)	134

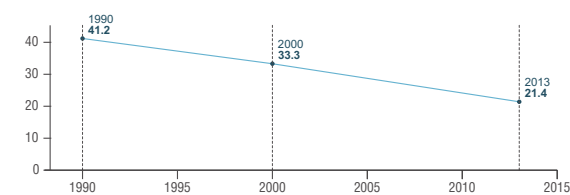
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

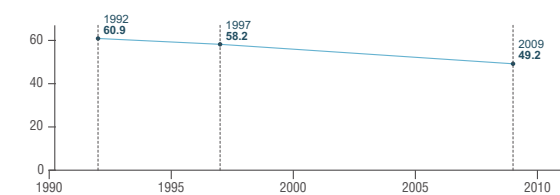


Neonatal mortality rate
per 1000 live births

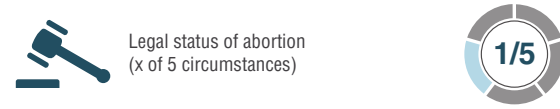
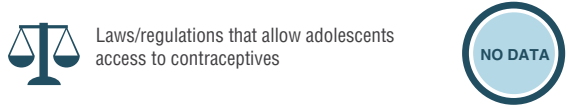
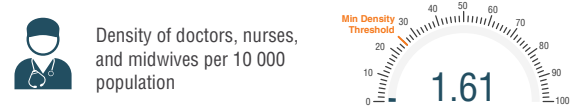


Stunting

% of children under 5 who are moderately or severely stunted



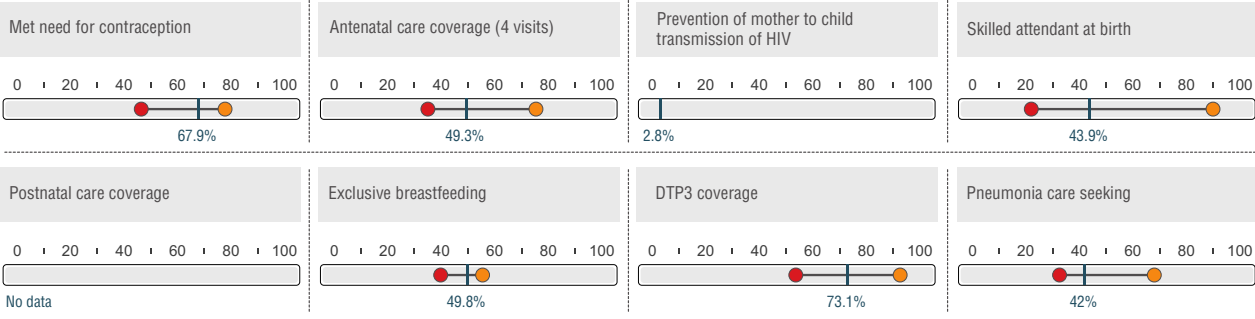
Reproductive Health and Health Systems Data



Health Coverage Indicators

● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
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Better Information



Vital Events

% of births registered	83
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	NO
Civil Registration and Vital Statistics (CRVS) improvement plan in place	PARTIAL



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO DATA
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO DATA



Innovation and eHealth

National eHealth strategy and plan in place and implemented	PARTIAL
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	PARTIAL
Total public sector health expenditure per capita (US\$)	11.1
Total RMNCH expenditure per capita tracked by financing source	PARTIAL
Total annual RMNCH expenditure (US\$)	NO DATA



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	NO
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA

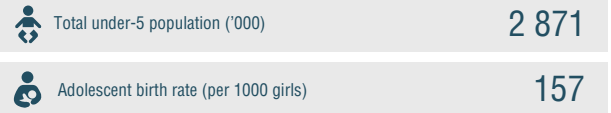
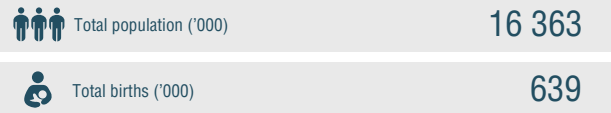


Transparency

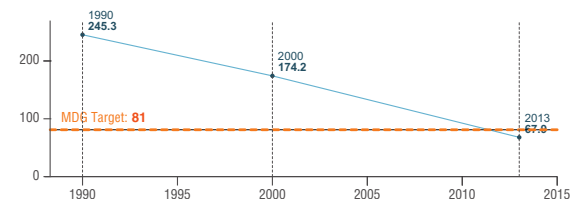
A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

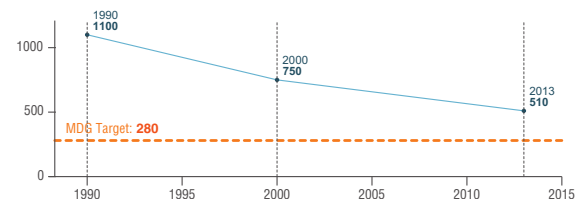
Demographic Data



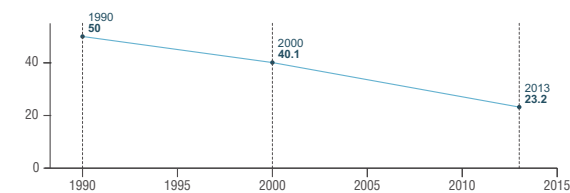
Under-5 mortality rate
per 1000 live births



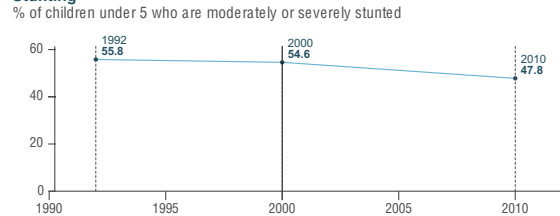
Maternal mortality rate
per 100 000 live births



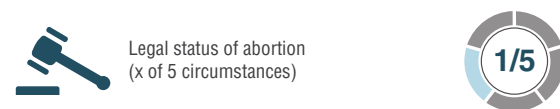
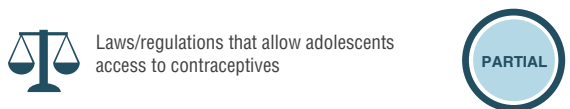
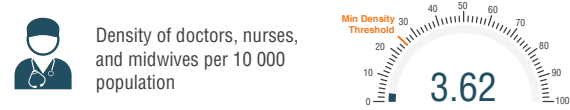
Neonatal mortality rate
per 1000 live births



Stunting



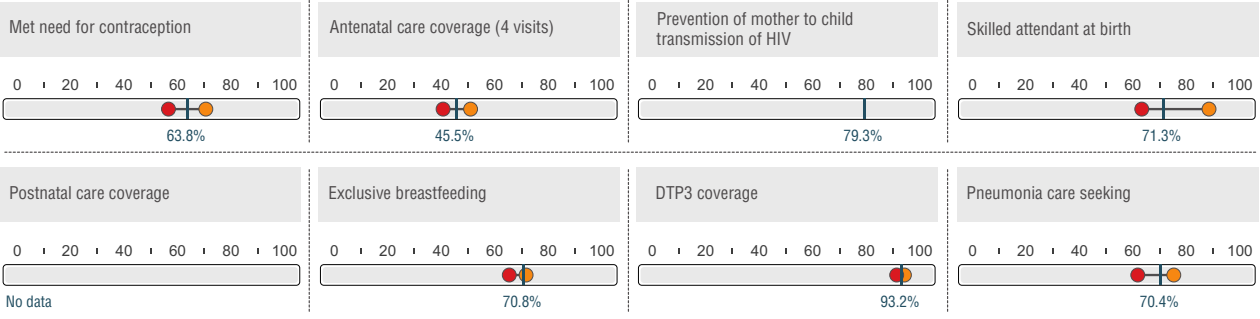
Reproductive Health and Health Systems Data



Health Coverage Indicators

● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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Better Information

 Vital Events

% of births registered	2
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	YES
Civil Registration and Vital Statistics (CRVS) improvement plan in place	PARTIAL

 Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO

 Innovation and eHealth

National eHealth strategy and plan in place and implemented	PARTIAL
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Better Resources

 Resource Tracking

Total health expenditure per capita tracked by financing source	YES
Total public sector health expenditure per capita (US\$)	18.8
Total RMNCH expenditure per capita tracked by financing source	YES
Total annual RMNCH expenditure (US\$)	NO DATA

 Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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 Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

 National Oversight


Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA


 Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

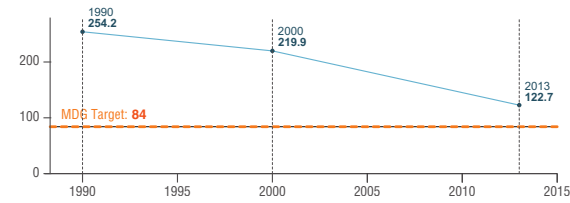
 Total population ('000) **15 302**

 Total under-5 population ('000) **3 037**

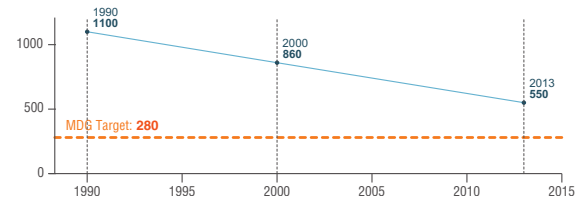
 Total births ('000) **705**

 Adolescent birth rate (per 1000 girls) **181**

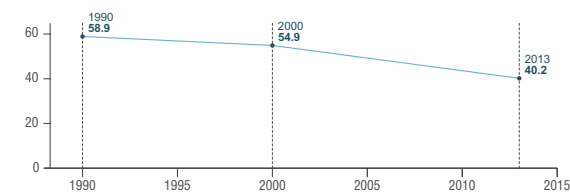
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

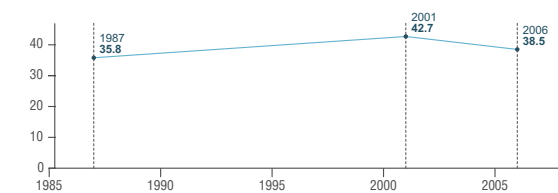


Neonatal mortality rate
per 1000 live births




Stunting

% of children under 5 who are moderately or severely stunted

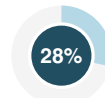



Reproductive Health and Health Systems Data

 Density of doctors, nurses, and midwives per 10 000 population




 Demand for family planning satisfied



 Laws/regulations that allow adolescents access to contraceptives



 Legal status of abortion (x of 5 circumstances)

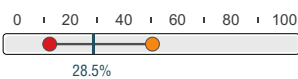


Health Coverage Indicators

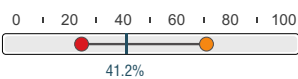
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

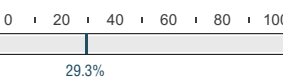
Met need for contraception



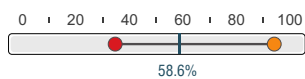
Antenatal care coverage (4 visits)



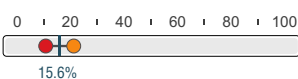
Prevention of mother to child transmission of HIV



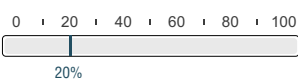
Skilled attendant at birth



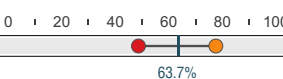
Postnatal care coverage



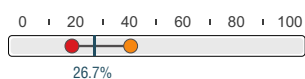
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).

Better Information

 Vital Events

% of births registered	81
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	PARTIAL
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES

 Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	YES

 Innovation and eHealth

National eHealth strategy and plan in place and implemented	PARTIAL
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Better Resources

 Resource Tracking

Total health expenditure per capita tracked by financing source	YES
Total public sector health expenditure per capita (US\$)	230.4
Total RMNCH expenditure per capita tracked by financing source	YES
Total annual RMNCH expenditure (US\$)	NO DATA

 Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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 Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

 National Oversight


Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO


 Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

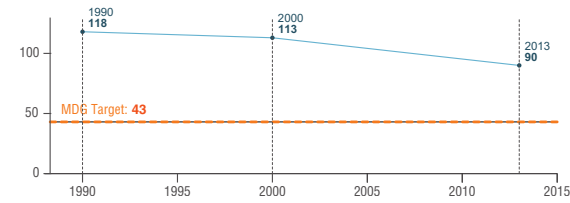
 Total population ('000) **3 890**

 Total under-5 population ('000) **592**

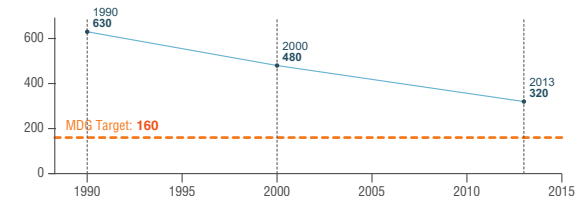
 Total births ('000) **131**

 Adolescent birth rate (per 1000 girls) **83**

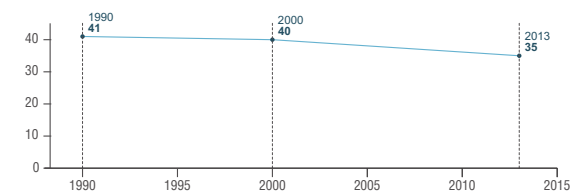
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

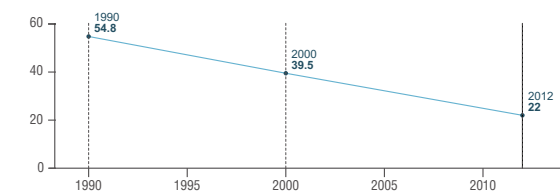


Neonatal mortality rate
per 1000 live births




Stunting

% of children under 5 who are moderately or severely stunted

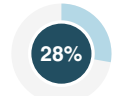



Reproductive Health and Health Systems Data

 Density of doctors, nurses, and midwives per 10 000 population




 Demand for family planning satisfied



 Laws/regulations that allow adolescents access to contraceptives



 Legal status of abortion (x of 5 circumstances)

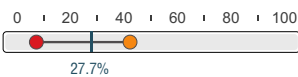


Health Coverage Indicators

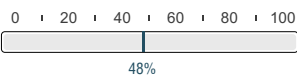
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

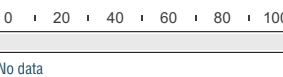
Met need for contraception



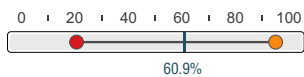
Antenatal care coverage (4 visits)



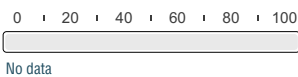
Prevention of mother to child transmission of HIV



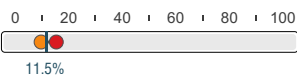
Skilled attendant at birth



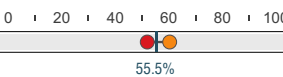
Postnatal care coverage



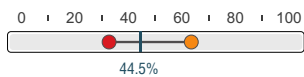
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
- 2015 Progress report on implementing the Commission on Information and Accountability Recommendations: Birth registration, Death registration, MDSR, CRVS, National eHealth strategy, Total health expenditure per capita tracked by financing source, Country conducted annual health sector review, Health sector performance report available in the public domain.
- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).



Better Information



Vital Events

% of births registered	59
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	NO
Civil Registration and Vital Statistics (CRVS) improvement plan in place	PARTIAL



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	YES
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO



Innovation and eHealth

National eHealth strategy and plan in place and implemented	YES
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	YES
Total public sector health expenditure per capita (US\$)	33.1
Total RMNCH expenditure per capita tracked by financing source	YES
Total annual RMNCH expenditure (US\$)	NO DATA



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO





Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

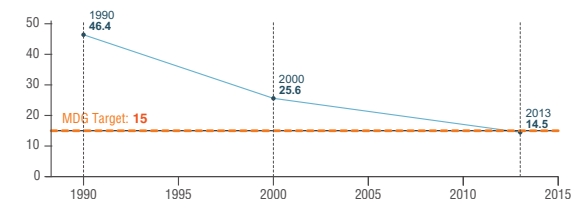
 Total population ('000) **122 332**

 Total under-5 population ('000) **11 172**

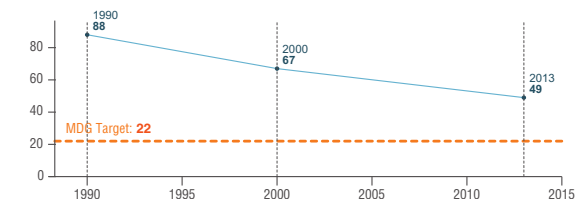
 Total births ('000) **2 269**

 Adolescent birth rate (per 1000 girls) **69**

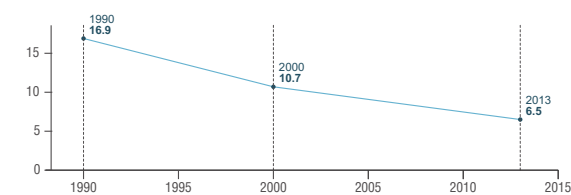
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

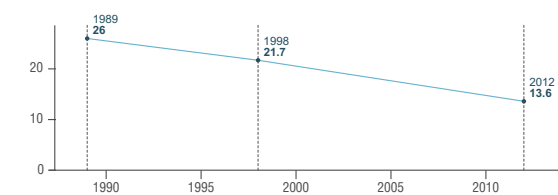


Neonatal mortality rate
per 1000 live births



Stunting

% of children under 5 who are moderately or severely stunted



Reproductive Health and Health Systems Data



Density of doctors, nurses, and midwives per 10 000 population



Demand for family planning satisfied



Laws/regulations that allow adolescents access to contraceptives



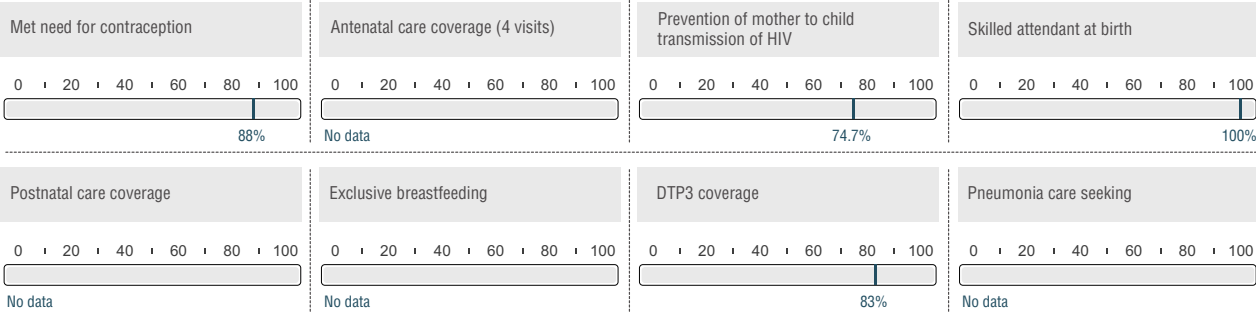
Legal status of abortion (x of 5 circumstances)



Health Coverage Indicators

● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).



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Better Information



Vital Events

% of births registered	93
% of deaths registered	99
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	YES
Civil Registration and Vital Statistics (CRVS) improvement plan in place	PARTIAL



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	YES
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO



Innovation and eHealth

National eHealth strategy and plan in place and implemented	YES
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	NO
Total public sector health expenditure per capita (US\$)	320.3
Total RMNCH expenditure per capita tracked by financing source	NO
Total annual RMNCH expenditure (US\$)	NO DATA



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	NO
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA

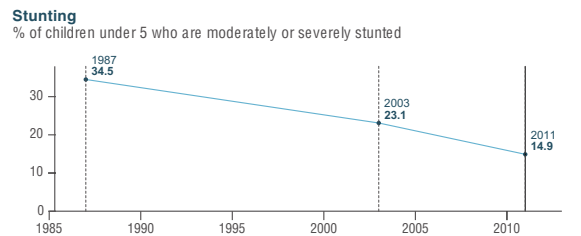
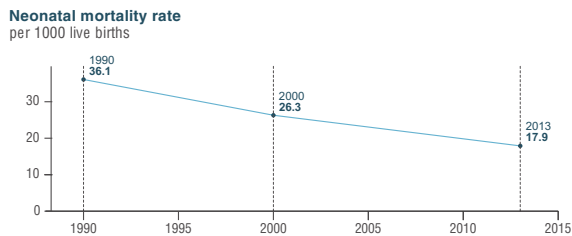
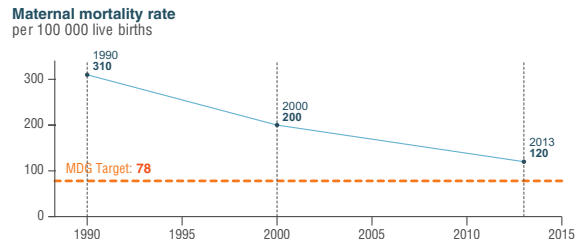
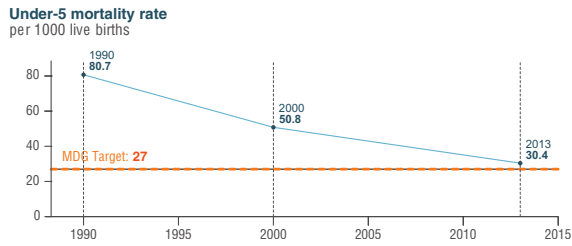
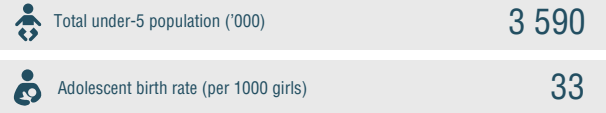
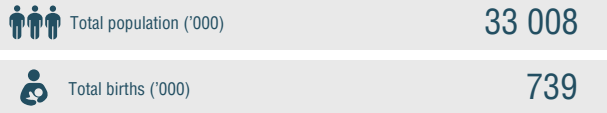


Transparency

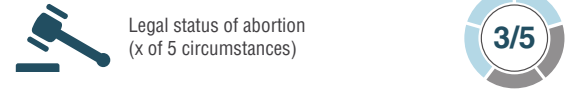
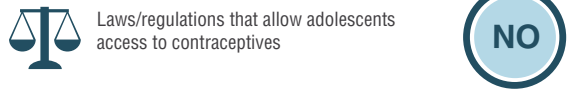
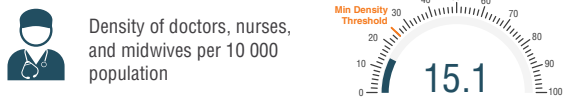
A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data



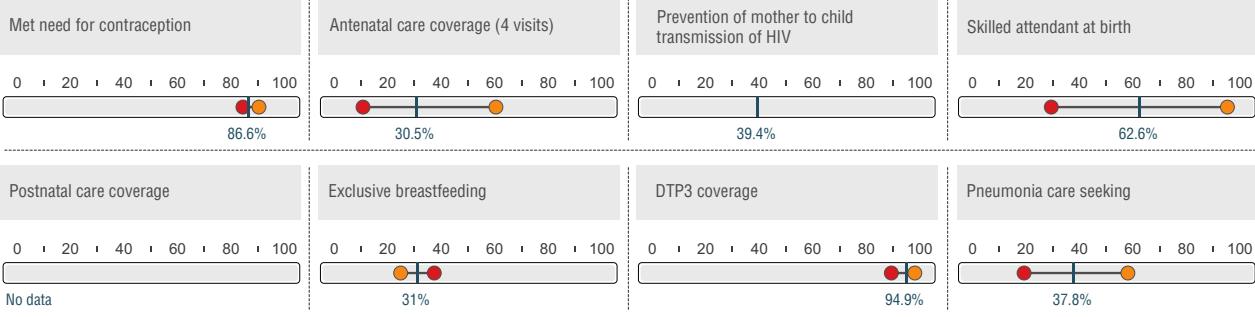
Reproductive Health and Health Systems Data



Health Coverage Indicators

● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).



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- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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Better Information

Vital Events

% of births registered	94
% of deaths registered	25
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	YES
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES

Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO

Innovation and eHealth

National eHealth strategy and plan in place and implemented	PARTIAL
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Better Resources

Resource Tracking

Total health expenditure per capita tracked by financing source	YES
Total public sector health expenditure per capita (US\$)	63.7
Total RMNCH expenditure per capita tracked by financing source	YES
Total annual RMNCH expenditure (US\$)	NO DATA

Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	NO
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

National Oversight


Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA


Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

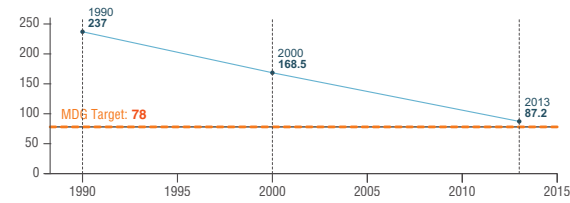
 Total population ('000) **25 834**

 Total under-5 population ('000) **4 475**

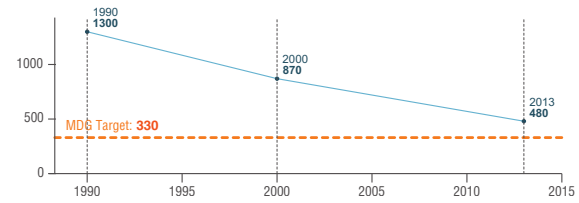
 Total births ('000) **995**

 Adolescent birth rate (per 1000 girls) **163**

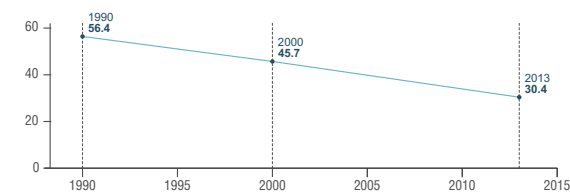
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

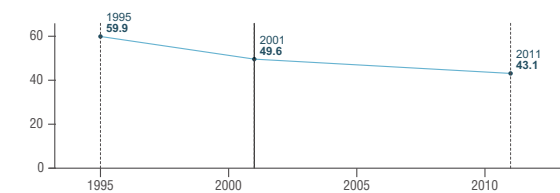


Neonatal mortality rate
per 1000 live births




Stunting

% of children under 5 who are moderately or severely stunted

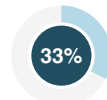



Reproductive Health and Health Systems Data

 Density of doctors, nurses, and midwives per 10 000 population




 Demand for family planning satisfied



 Laws/regulations that allow adolescents access to contraceptives



 Legal status of abortion (x of 5 circumstances)

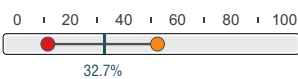


Health Coverage Indicators

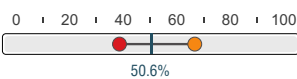
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

Met need for contraception



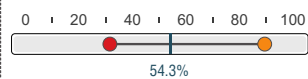
Antenatal care coverage (4 visits)



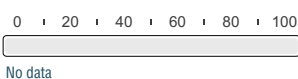
Prevention of mother to child transmission of HIV



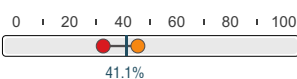
Skilled attendant at birth



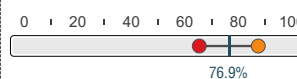
Postnatal care coverage



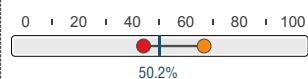
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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Better Information

 Vital Events

% of births registered	48
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	PARTIAL
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES

 Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO

 Innovation and eHealth

National eHealth strategy and plan in place and implemented	NO
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Better Resources

 Resource Tracking

Total health expenditure per capita tracked by financing source	YES
Total public sector health expenditure per capita (US\$)	16.5
Total RMNCH expenditure per capita tracked by financing source	YES
Total annual RMNCH expenditure (US\$)	NO DATA

 Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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 Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

 National Oversight

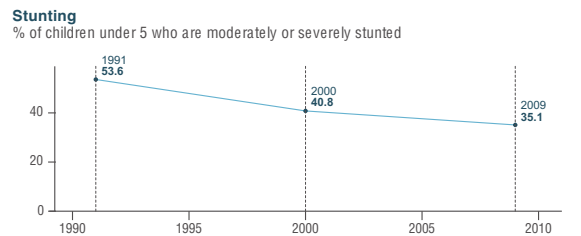
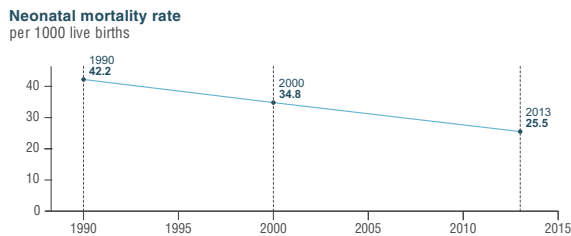
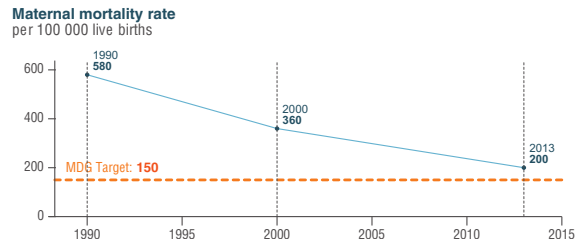
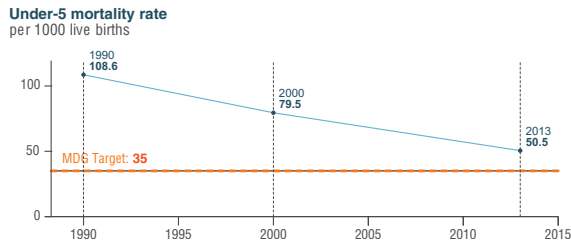
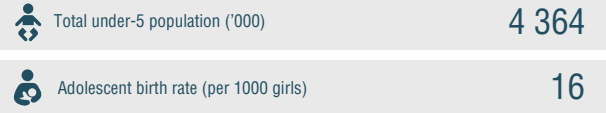
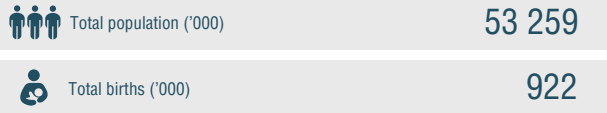
Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	YES

 Transparency

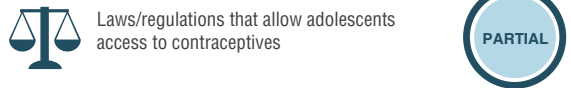
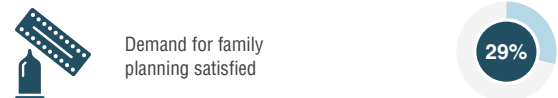
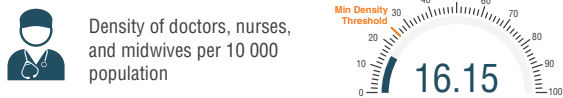
A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data



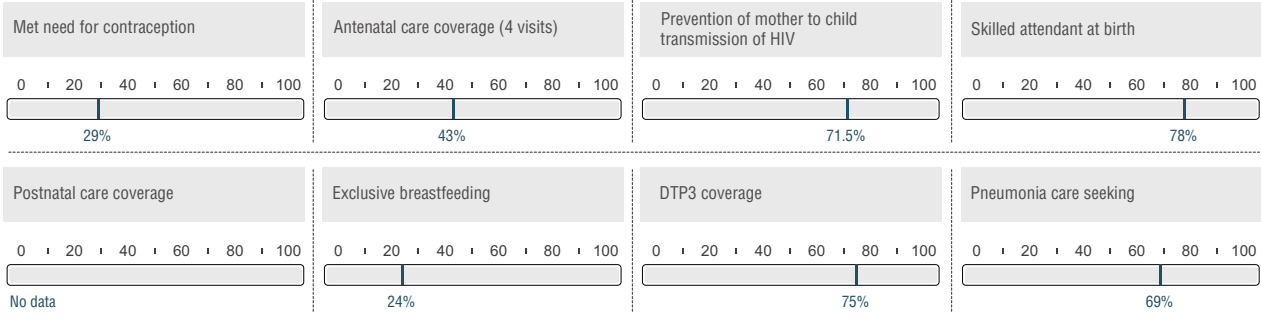
Reproductive Health and Health Systems Data



Health Coverage Indicators

● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).



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Better Information



Vital Events

% of births registered	72
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	NO
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO



Innovation and eHealth

National eHealth strategy and plan in place and implemented	PARTIAL
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	PARTIAL
Total public sector health expenditure per capita (US\$)	4.7
Total RMNCH expenditure per capita tracked by financing source	PARTIAL
Total annual RMNCH expenditure (US\$)	NO DATA



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	NO
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA





Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

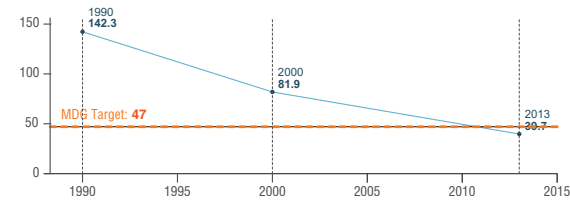
 Total population ('000) **27 797**

 Total under-5 population ('000) **2 857**

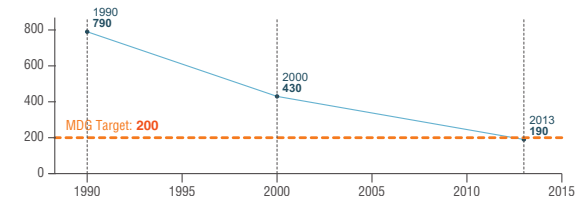
 Total births ('000) **593**

 Adolescent birth rate (per 1000 girls) **95**

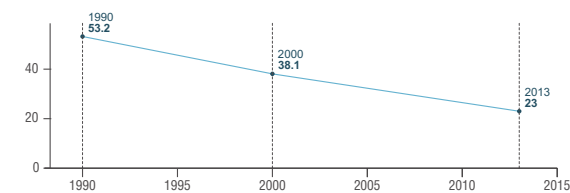
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

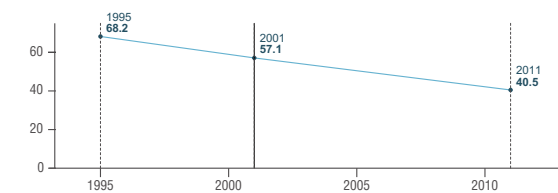


Neonatal mortality rate
per 1000 live births




Stunting

% of children under 5 who are moderately or severely stunted

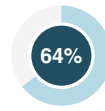



Reproductive Health and Health Systems Data

 Density of doctors, nurses, and midwives per 10 000 population




 Demand for family planning satisfied



 Laws/regulations that allow adolescents access to contraceptives



 Legal status of abortion (x of 5 circumstances)

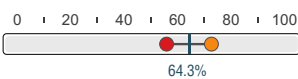


Health Coverage Indicators

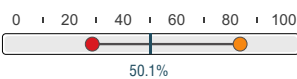
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

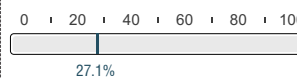
Met need for contraception



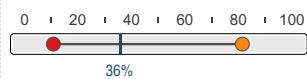
Antenatal care coverage (4 visits)



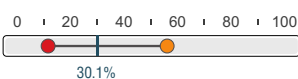
Prevention of mother to child transmission of HIV



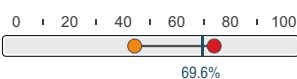
Skilled attendant at birth



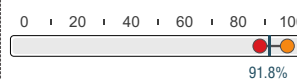
Postnatal care coverage



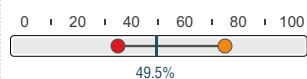
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
- 2015 Progress report on implementing the Commission on Information and Accountability Recommendations: Birth registration, Death registration, MDSR, CRVS, National eHealth strategy, Total health expenditure per capita tracked by financing source, Country conducted annual health sector review, Health sector performance report available in the public domain.
- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).

Better Information

 Vital Events

% of births registered	42
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	PARTIAL
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES

 Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO

 Innovation and eHealth

National eHealth strategy and plan in place and implemented	PARTIAL
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Better Resources

 Resource Tracking

Total health expenditure per capita tracked by financing source	PARTIAL
Total public sector health expenditure per capita (US\$)	14.2
Total RMNCH expenditure per capita tracked by financing source	PARTIAL
Total annual RMNCH expenditure (US\$)	NO DATA

 Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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 Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

 National Oversight

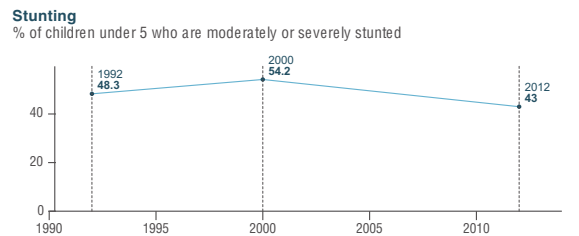
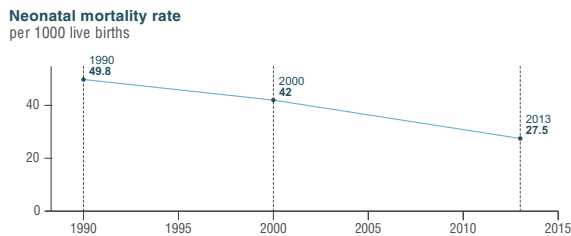
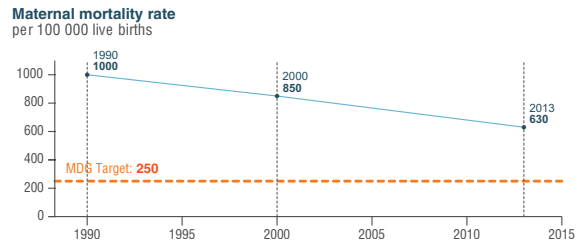
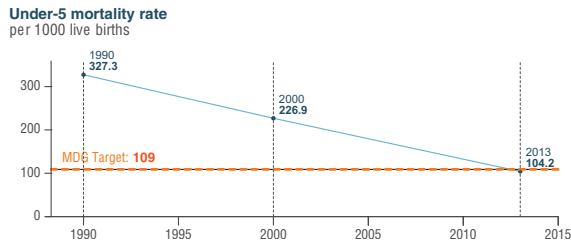
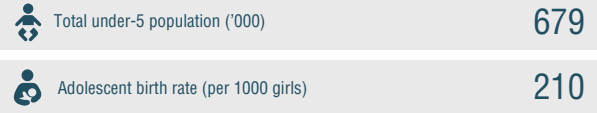
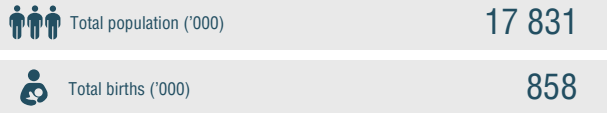
Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	YES

 Transparency

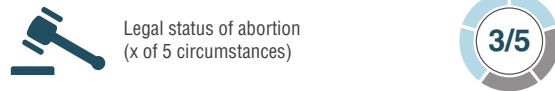
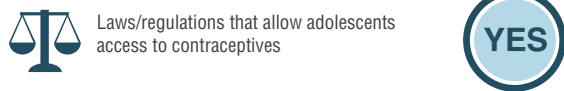
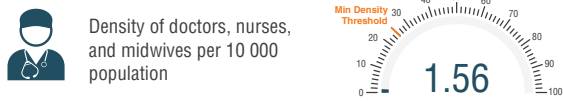
A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data



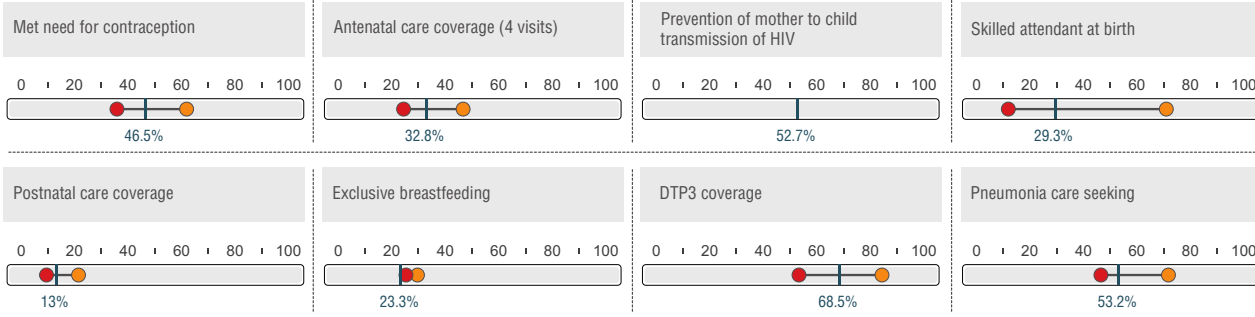
Reproductive Health and Health Systems Data



Health Coverage Indicators

● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).

Better Information



Vital Events

% of births registered	64
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	NO
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	YES
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	YES



Innovation and eHealth

National eHealth strategy and plan in place and implemented	NO
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	YES
Total public sector health expenditure per capita (US\$)	10.1
Total RMNCH expenditure per capita tracked by financing source	YES
Total annual RMNCH expenditure (US\$)	124 818 890



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	YES



Transparency

A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

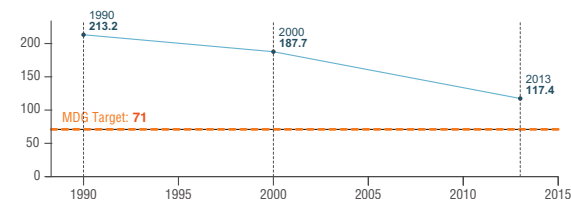
Total population ('000) 173 615

Total under-5 population ('000) 3 838

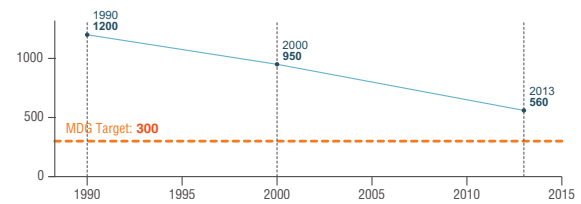
Total births ('000) 7 028

Adolescent birth rate (per 1000 girls) 124

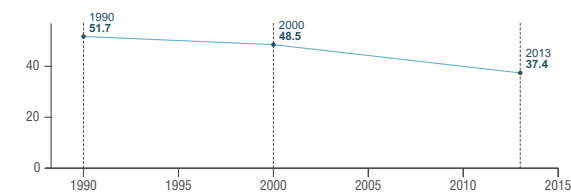
Under-5 mortality rate per 1000 live births



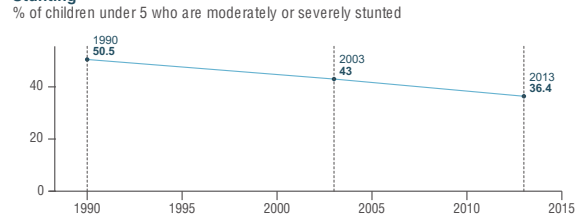
Maternal mortality rate per 100 000 live births



Neonatal mortality rate per 1000 live births



Stunting



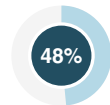
Reproductive Health and Health Systems Data



Density of doctors, nurses, and midwives per 10 000 population



Demand for family planning satisfied



Laws/regulations that allow adolescents access to contraceptives



Legal status of abortion (x of 5 circumstances)

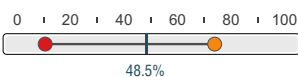


Health Coverage Indicators

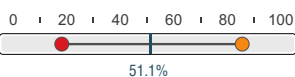
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

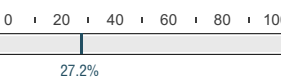
Met need for contraception



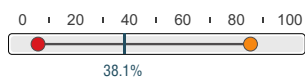
Antenatal care coverage (4 visits)



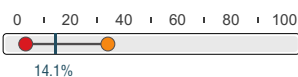
Prevention of mother to child transmission of HIV



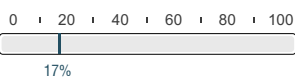
Skilled attendant at birth



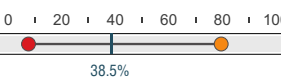
Postnatal care coverage



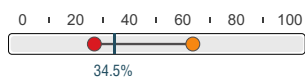
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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Better Information

 Vital Events

% of births registered	30
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	YES
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES

 Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	YES
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	YES

 Innovation and eHealth

National eHealth strategy and plan in place and implemented	YES
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Better Resources

 Resource Tracking

Total health expenditure per capita tracked by financing source	PARTIAL
Total public sector health expenditure per capita (US\$)	29.4
Total RMNCH expenditure per capita tracked by financing source	PARTIAL
Total annual RMNCH expenditure (US\$)	NO DATA

 Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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 Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

 National Oversight


Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO


 Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

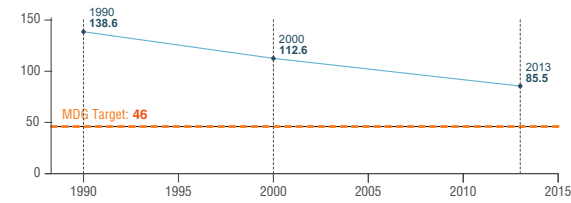
 Total population ('000) **182 143**

 Total under-5 population ('000) **31 376**

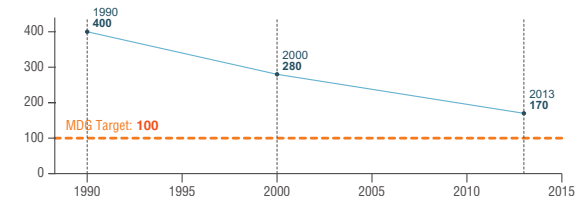
 Total births ('000) **4 604**

 Adolescent birth rate (per 1000 girls) **31**

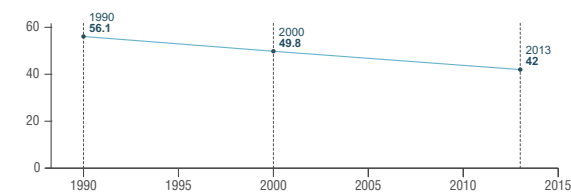
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

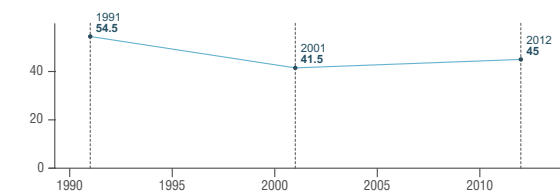


Neonatal mortality rate
per 1000 live births



Stunting

% of children under 5 who are moderately or severely stunted



Reproductive Health and Health Systems Data



Density of doctors, nurses, and midwives per 10 000 population



Demand for family planning satisfied

15%



Laws/regulations that allow adolescents access to contraceptives



Legal status of abortion (x of 5 circumstances)

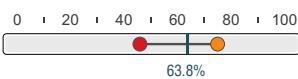


Health Coverage Indicators

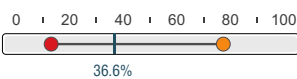
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

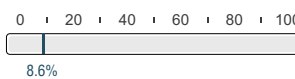
Met need for contraception



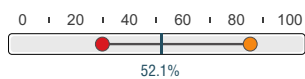
Antenatal care coverage (4 visits)



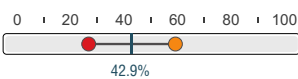
Prevention of mother to child transmission of HIV



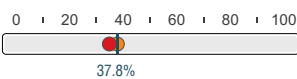
Skilled attendant at birth



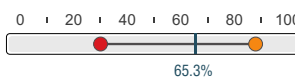
Postnatal care coverage



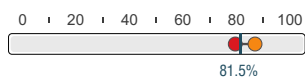
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
- 2015 Progress report on implementing the Commission on Information and Accountability Recommendations: Birth registration, Death registration, MDSR, CRVS, National eHealth strategy, Total health expenditure per capita tracked by financing source, Country conducted annual health sector review, Health sector performance report available in the public domain.
- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).



Better Information

Vital Events

% of births registered	34
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	PARTIAL
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES

Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO DATA
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO DATA

Innovation and eHealth

National eHealth strategy and plan in place and implemented	PARTIAL
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Better Resources

Resource Tracking

Total health expenditure per capita tracked by financing source	NO
Total public sector health expenditure per capita (US\$)	12.4
Total RMNCH expenditure per capita tracked by financing source	NO
Total annual RMNCH expenditure (US\$)	NO DATA

Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	NO
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

National Oversight


Country has conducted annual national health sector review process in the past year	NO
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA


Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

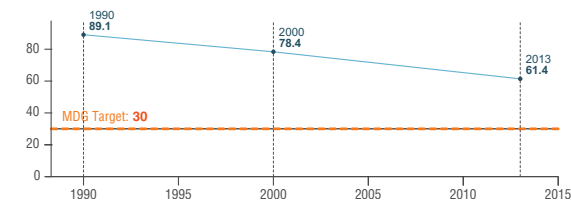
 Total population ('000) **7 321**

 Total under-5 population ('000) **21 377**

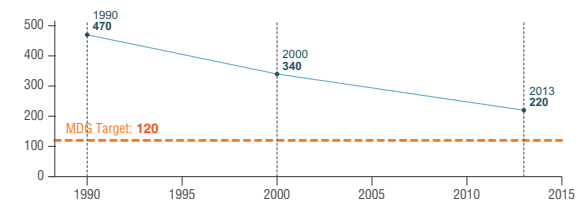
 Total births ('000) **210**

 Adolescent birth rate (per 1000 girls) **67**

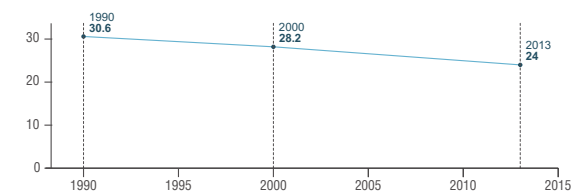
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

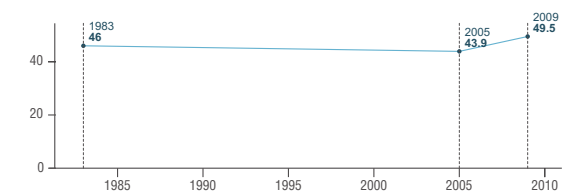


Neonatal mortality rate
per 1000 live births



Stunting

% of children under 5 who are moderately or severely stunted



Reproductive Health and Health Systems Data



Density of doctors, nurses, and midwives per 10 000 population



Demand for family planning satisfied



Laws/regulations that allow adolescents access to contraceptives



Legal status of abortion (x of 5 circumstances)

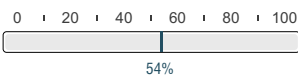


Health Coverage Indicators

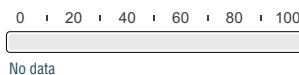
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

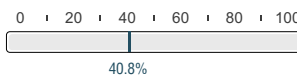
Met need for contraception



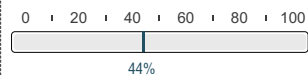
Antenatal care coverage (4 visits)



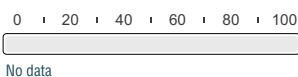
Prevention of mother to child transmission of HIV



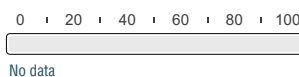
Skilled attendant at birth



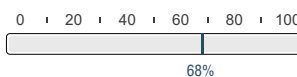
Postnatal care coverage



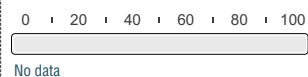
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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Better Information



Vital Events

% of births registered	NO DATA
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	PARTIAL
Civil Registration and Vital Statistics (CRVS) improvement plan in place	NO



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO



Innovation and eHealth

National eHealth strategy and plan in place and implemented	PARTIAL
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	PARTIAL
Total public sector health expenditure per capita (US\$)	94.4
Total RMNCH expenditure per capita tracked by financing source	PARTIAL
Total annual RMNCH expenditure (US\$)	NO DATA



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA



Transparency

A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

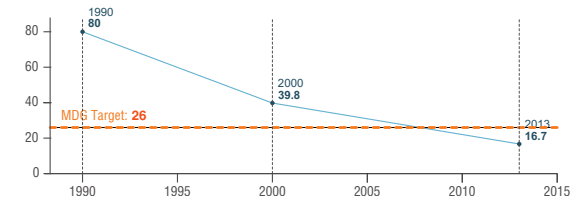
Total population ('000) **30 376**

Total under-5 population ('000) **2 925**

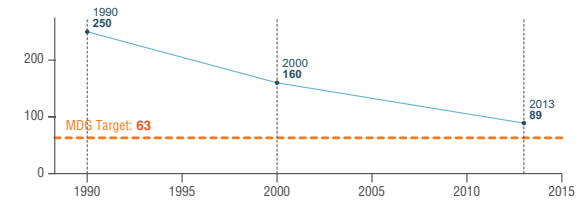
Total births ('000) **600**

Adolescent birth rate (per 1000 girls) **55**

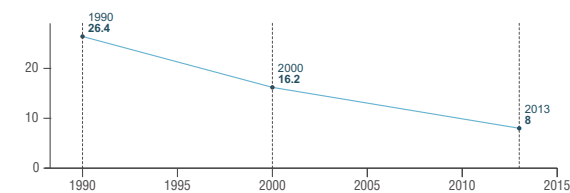
Under-5 mortality rate per 1000 live births



Maternal mortality rate per 100 000 live births

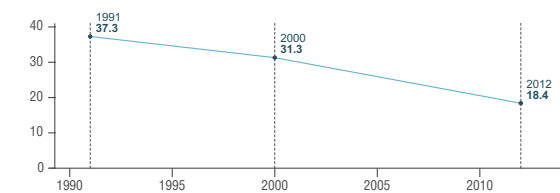


Neonatal mortality rate per 1000 live births

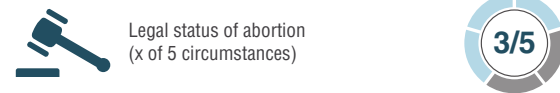
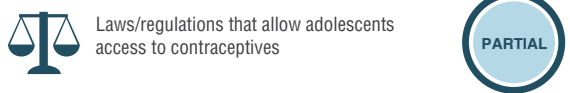
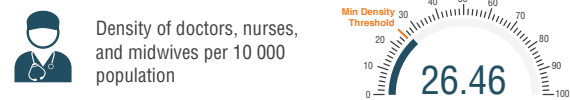


Stunting

% of children under 5 who are moderately or severely stunted



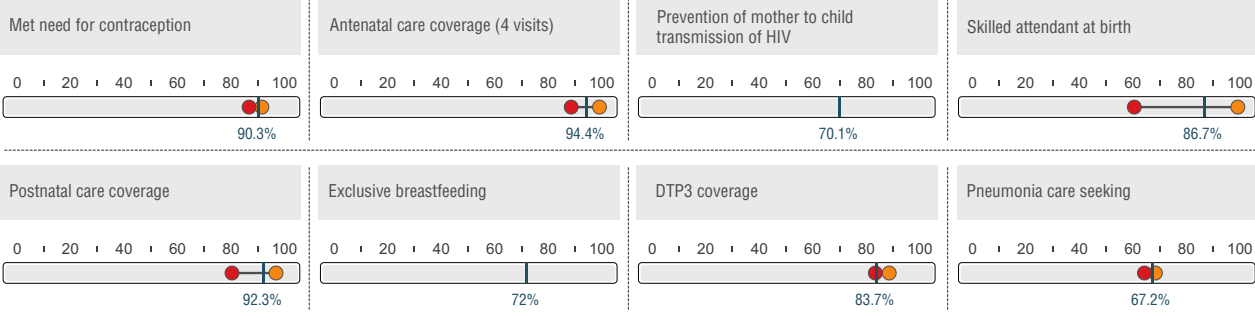
Reproductive Health and Health Systems Data



Health Coverage Indicators

● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).



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- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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Better Information



Vital Events

% of births registered	96
% of deaths registered	69
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	NO
Civil Registration and Vital Statistics (CRVS) improvement plan in place	NO



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	YES
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO



Innovation and eHealth

National eHealth strategy and plan in place and implemented	YES
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	NO
Total public sector health expenditure per capita (US\$)	198.7
Total RMNCH expenditure per capita tracked by financing source	NO
Total annual RMNCH expenditure (US\$)	NO DATA



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	NO
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA





Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

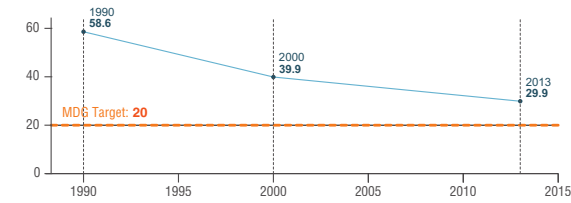
 Total population ('000) **98 394**

 Total under-5 population ('000) **11 548**

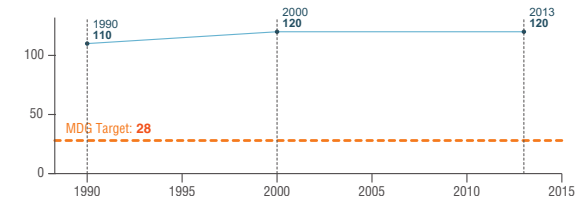
 Total births ('000) **2 383**

 Adolescent birth rate (per 1000 girls) **54**

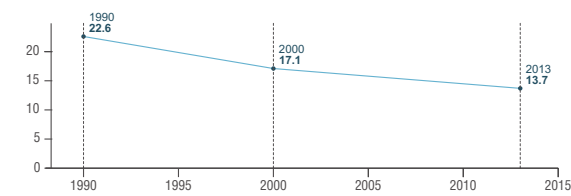
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

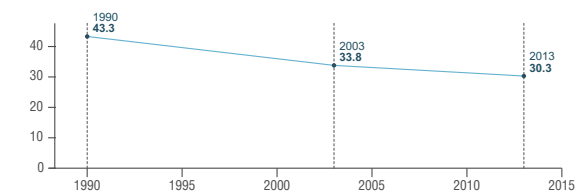


Neonatal mortality rate
per 1000 live births



Stunting

% of children under 5 who are moderately or severely stunted



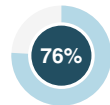
Reproductive Health and Health Systems Data



Density of doctors, nurses, and midwives per 10 000 population



Demand for family planning satisfied



Laws/regulations that allow adolescents access to contraceptives



Legal status of abortion (x of 5 circumstances)

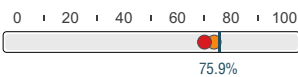


Health Coverage Indicators

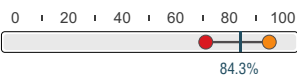
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

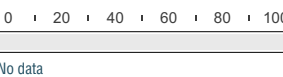
Met need for contraception



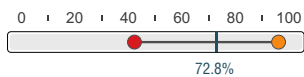
Antenatal care coverage (4 visits)



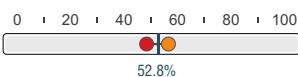
Prevention of mother to child transmission of HIV



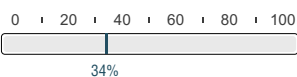
Skilled attendant at birth



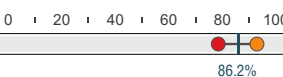
Postnatal care coverage



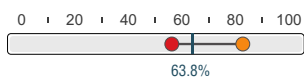
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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Better Information

 Vital Events

% of births registered	90
% of deaths registered	90
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	PARTIAL
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES

 Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	YES
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO

 Innovation and eHealth

National eHealth strategy and plan in place and implemented	YES
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Better Resources

 Resource Tracking

Total health expenditure per capita tracked by financing source	YES
Total public sector health expenditure per capita (US\$)	44.8
Total RMNCH expenditure per capita tracked by financing source	YES
Total annual RMNCH expenditure (US\$)	NO DATA

 Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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 Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

 National Oversight

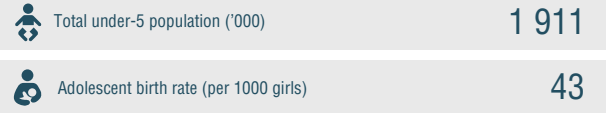
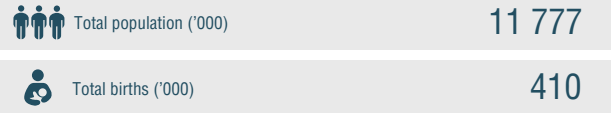
Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA

 Transparency

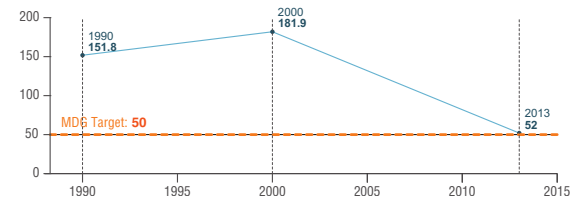
A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

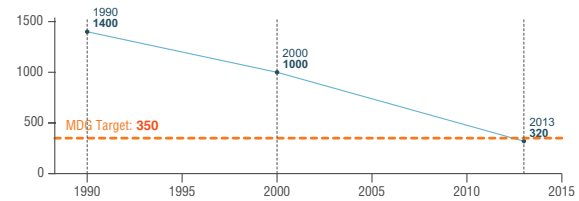
Demographic Data



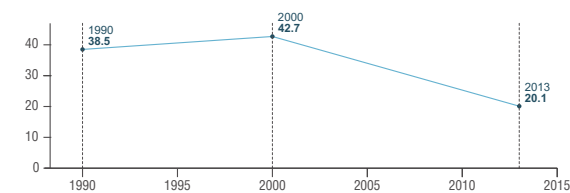
Under-5 mortality rate per 1000 live births



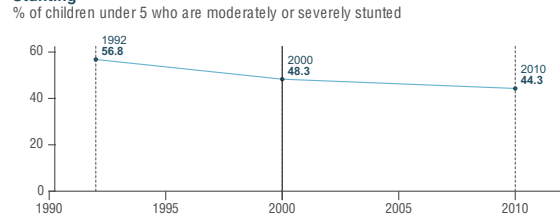
Maternal mortality rate per 100 000 live births



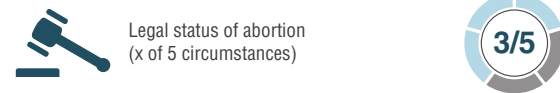
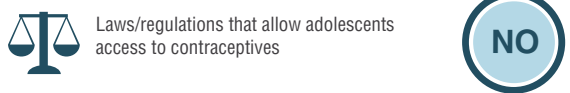
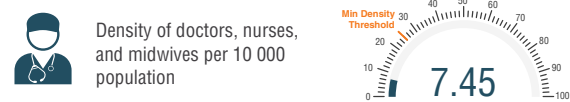
Neonatal mortality rate per 1000 live births



Stunting



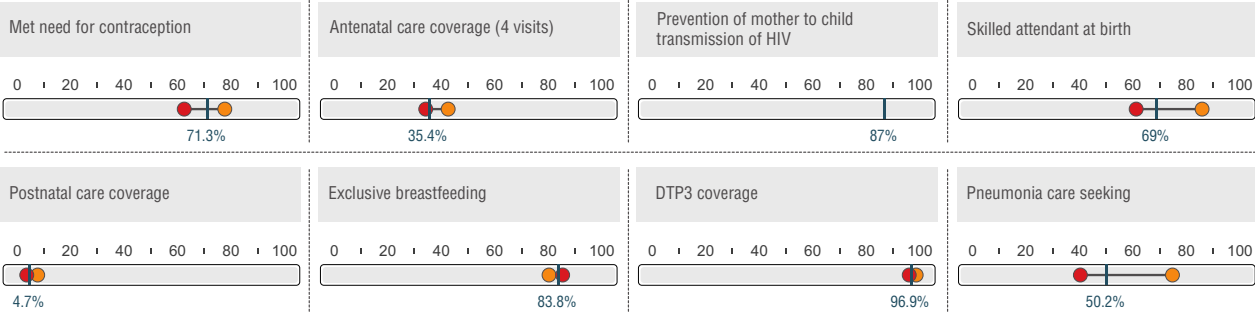
Reproductive Health and Health Systems Data



Health Coverage Indicators

● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).



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Better Information



Vital Events

% of births registered	63
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	YES
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO



Innovation and eHealth

National eHealth strategy and plan in place and implemented	YES
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	NO
Total public sector health expenditure per capita (US\$)	37.9
Total RMNCH expenditure per capita tracked by financing source	NO
Total annual RMNCH expenditure (US\$)	NO DATA



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO

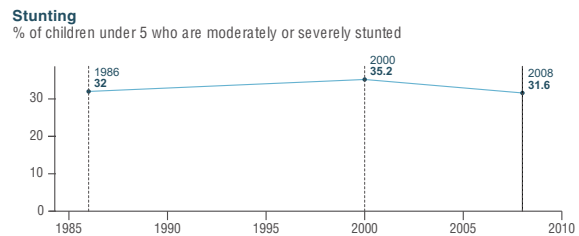
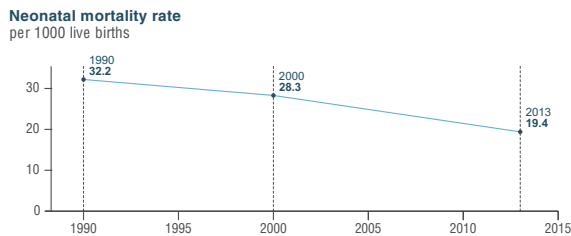
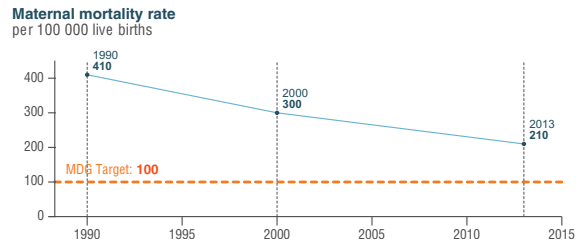
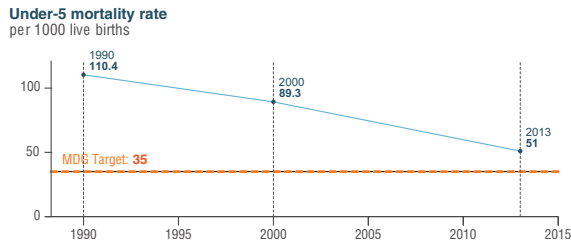
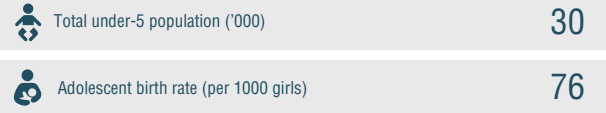
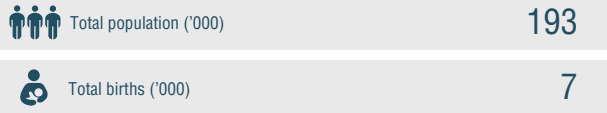


Transparency

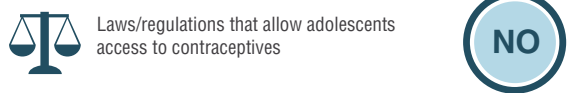
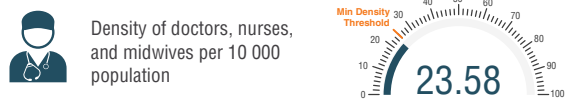
A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data



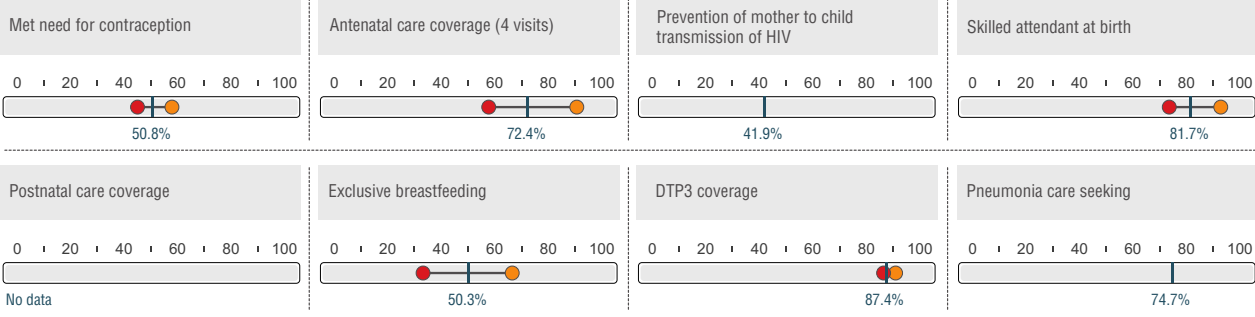
Reproductive Health and Health Systems Data



Health Coverage Indicators

● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).



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- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).

Better Information



Vital Events

% of births registered	75
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	YES
Civil Registration and Vital Statistics (CRVS) improvement plan in place	PARTIAL



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO DATA
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO



Innovation and eHealth

National eHealth strategy and plan in place and implemented	NO
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	PARTIAL
Total public sector health expenditure per capita (US\$)	34.6
Total RMNCH expenditure per capita tracked by financing source	PARTIAL
Total annual RMNCH expenditure (US\$)	NO DATA



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	NO
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	NO
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA





Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

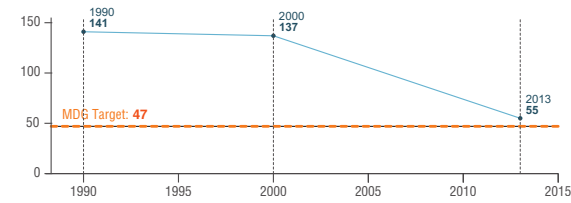
 Total population ('000) **14 133**

 Total under-5 population ('000) **2 441**

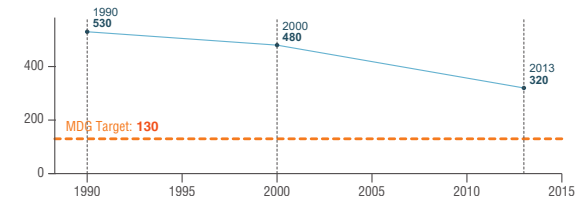
 Total births ('000) **524**

 Adolescent birth rate (per 1000 girls) **98**

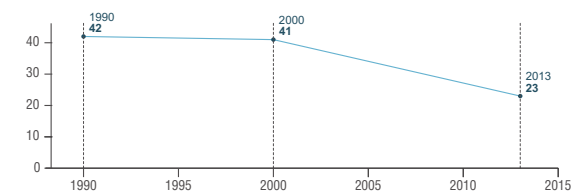
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

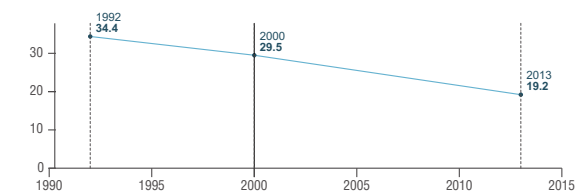


Neonatal mortality rate
per 1000 live births



Stunting

% of children under 5 who are moderately or severely stunted



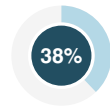
Reproductive Health and Health Systems Data



Density of doctors, nurses, and midwives per 10 000 population



Demand for family planning satisfied



Laws/regulations that allow adolescents access to contraceptives



Legal status of abortion (x of 5 circumstances)

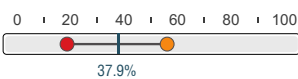


Health Coverage Indicators

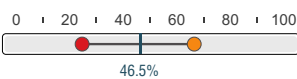
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

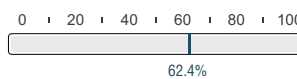
Met need for contraception



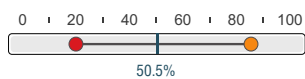
Antenatal care coverage (4 visits)



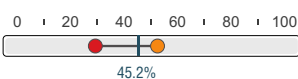
Prevention of mother to child transmission of HIV



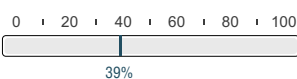
Skilled attendant at birth



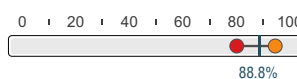
Postnatal care coverage



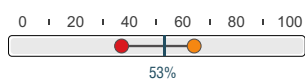
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
- 2015 Progress report on implementing the Commission on Information and Accountability Recommendations: Birth registration, Death registration, MDSR, CRVS, National eHealth strategy, Total health expenditure per capita tracked by financing source, Country conducted annual health sector review, Health sector performance report available in the public domain.
- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).

Better Information

 Vital Events

% of births registered	73
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	YES
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES

 Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	YES
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	YES

 Innovation and eHealth

National eHealth strategy and plan in place and implemented	PARTIAL
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Better Resources

 Resource Tracking

Total health expenditure per capita tracked by financing source	PARTIAL
Total public sector health expenditure per capita (US\$)	28.6
Total RMNCH expenditure per capita tracked by financing source	PARTIAL
Total annual RMNCH expenditure (US\$)	NO DATA

 Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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 Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

 National Oversight


Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	YES


 Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

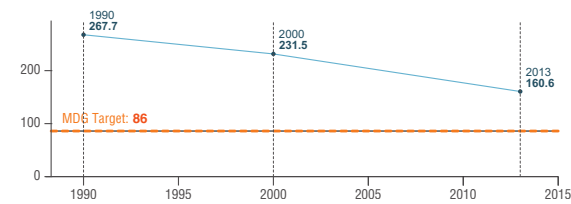
 Total population ('000) **6 092**

 Total under-5 population ('000) **942**

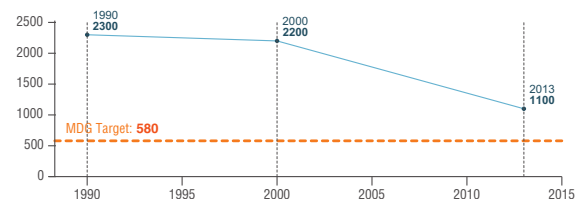
 Total births ('000) **222**

 Adolescent birth rate (per 1000 girls) **119**

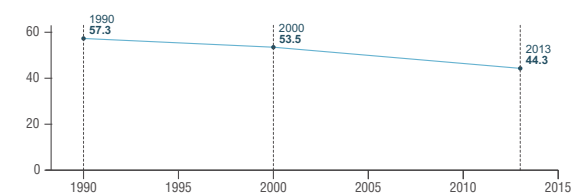
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

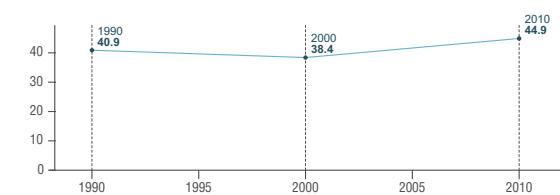


Neonatal mortality rate
per 1000 live births



Stunting

% of children under 5 who are moderately or severely stunted



Reproductive Health and Health Systems Data



Density of doctors, nurses, and midwives per 10 000 population



Demand for family planning satisfied



Laws/regulations that allow adolescents access to contraceptives



Legal status of abortion (x of 5 circumstances)

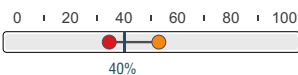


Health Coverage Indicators

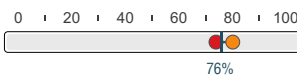
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

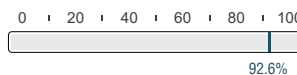
Met need for contraception



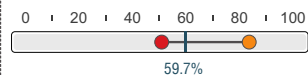
Antenatal care coverage (4 visits)



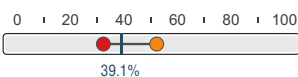
Prevention of mother to child transmission of HIV



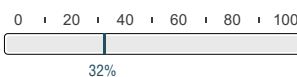
Skilled attendant at birth



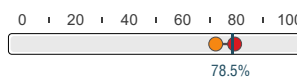
Postnatal care coverage



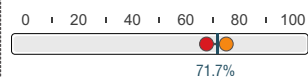
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).



Better Information



Vital Events

% of births registered	78
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	YES
Civil Registration and Vital Statistics (CRVS) improvement plan in place	PARTIAL



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	YES



Innovation and eHealth

National eHealth strategy and plan in place and implemented	PARTIAL
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	YES
Total public sector health expenditure per capita (US\$)	15.9
Total RMNCH expenditure per capita tracked by financing source	YES
Total annual RMNCH expenditure (US\$)	NO DATA



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO







Transparency

A health sector performance report for the preceding year is available in the public domain	NO DATA
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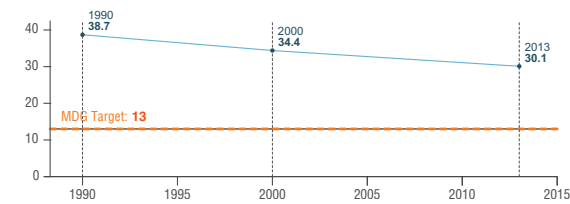
Summary

Demographic Data

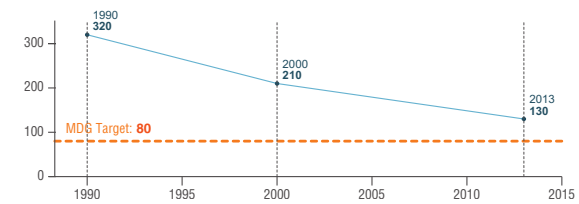
 Total population ('000)	561
 Total births ('000)	17

 Total under-5 population ('000)	82
 Adolescent birth rate (per 1000 girls)	70

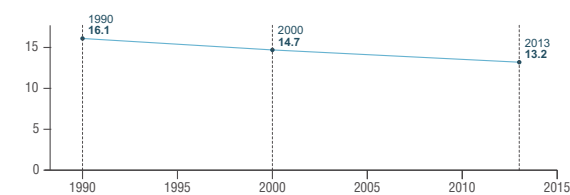
Under-5 mortality rate per 1000 live births



Maternal mortality rate per 100 000 live births

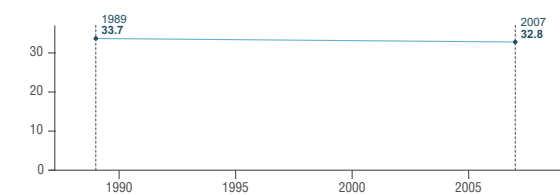


Neonatal mortality rate per 1000 live births

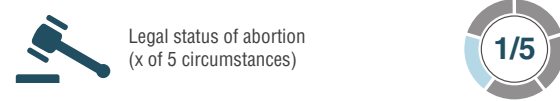
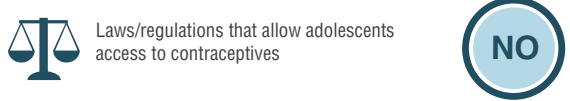
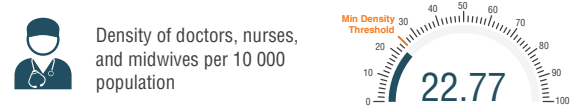


Stunting

% of children under 5 who are moderately or severely stunted



Reproductive Health and Health Systems Data



Health Coverage Indicators

● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

<p>Met need for contraception</p> <p>0 | 20 | 40 | 60 | 80 | 100</p> <p>76%</p>	<p>Antenatal care coverage (4 visits)</p> <p>0 | 20 | 40 | 60 | 80 | 100</p> <p>65%</p>	<p>Prevention of mother to child transmission of HIV</p> <p>0 | 20 | 40 | 60 | 80 | 100</p> <p>No data</p>	<p>Skilled attendant at birth</p> <p>0 | 20 | 40 | 60 | 80 | 100</p> <p>94%</p>
<p>Postnatal care coverage</p> <p>0 | 20 | 40 | 60 | 80 | 100</p> <p>No data</p>	<p>Exclusive breastfeeding</p> <p>0 | 20 | 40 | 60 | 80 | 100</p> <p>74%</p>	<p>DTP3 coverage</p> <p>0 | 20 | 40 | 60 | 80 | 100</p> <p>83%</p>	<p>Pneumonia care seeking</p> <p>0 | 20 | 40 | 60 | 80 | 100</p> <p>No data</p>

The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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Better Information



Vital Events

% of births registered	NO DATA
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	NO
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO



Innovation and eHealth

National eHealth strategy and plan in place and implemented	PARTIAL
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	NO
Total public sector health expenditure per capita (US\$)	142
Total RMNCH expenditure per capita tracked by financing source	NO
Total annual RMNCH expenditure (US\$)	NO DATA



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA

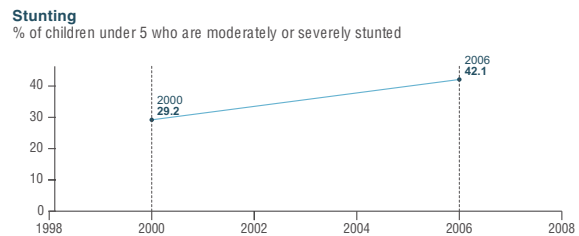
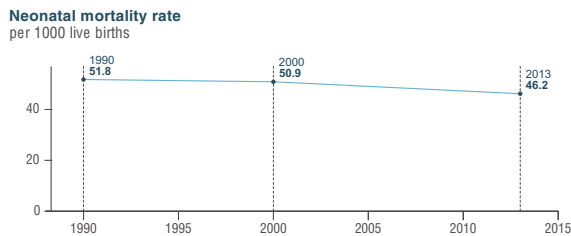
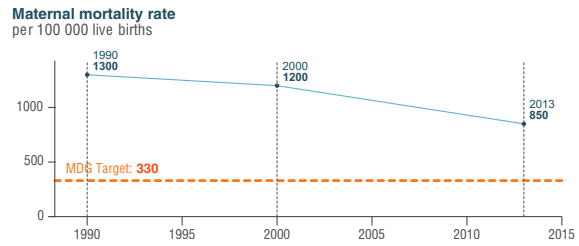
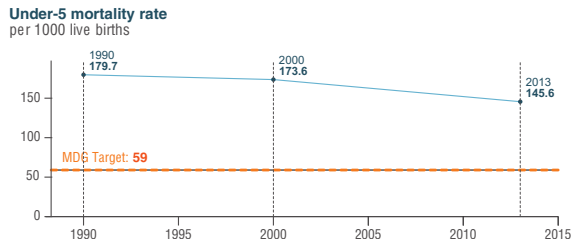
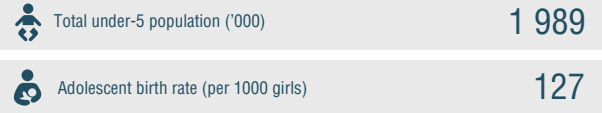
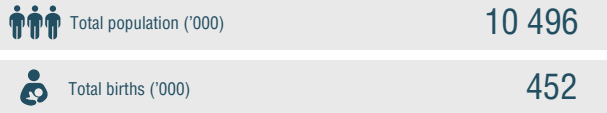


Transparency

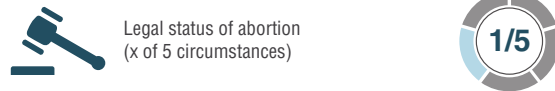
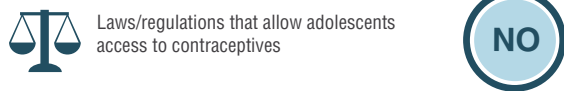
A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data



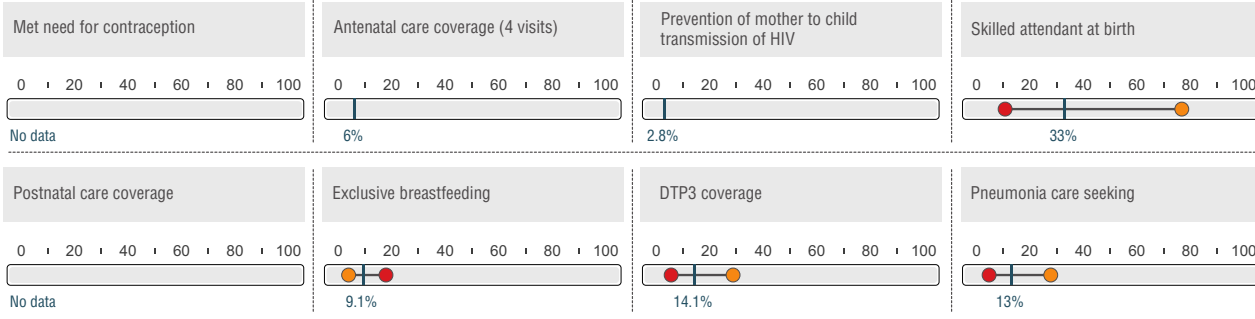
Reproductive Health and Health Systems Data



Health Coverage Indicators

● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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Better Information

 Vital Events

% of births registered	NO DATA
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	NO
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES

 Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO

 Innovation and eHealth

National eHealth strategy and plan in place and implemented	NO
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Better Resources

 Resource Tracking

Total health expenditure per capita tracked by financing source	NO
Total public sector health expenditure per capita (US\$)	1.7
Total RMNCH expenditure per capita tracked by financing source	NO
Total annual RMNCH expenditure (US\$)	NO DATA

 Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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 Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

 National Oversight


Country has conducted annual national health sector review process in the past year	NO
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA


 Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

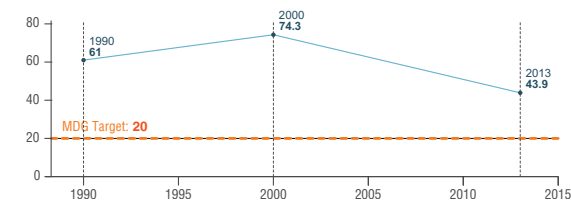
 Total population ('000) **52 776**

 Total under-5 population ('000) **5 330**

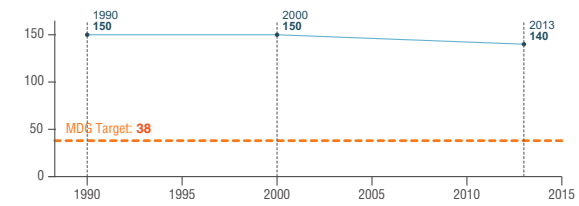
 Total births ('000) **1 102**

 Adolescent birth rate (per 1000 girls) **59**

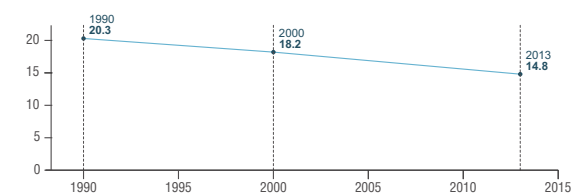
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

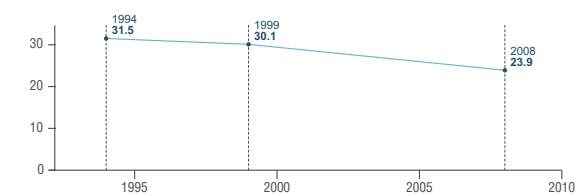


Neonatal mortality rate
per 1000 live births



Stunting

% of children under 5 who are moderately or severely stunted



Reproductive Health and Health Systems Data



Density of doctors, nurses, and midwives per 10 000 population



Demand for family planning satisfied



Laws/regulations that allow adolescents access to contraceptives



Legal status of abortion (x of 5 circumstances)

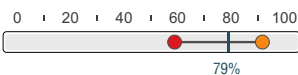


Health Coverage Indicators

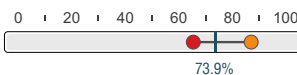
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

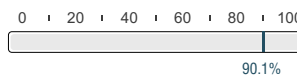
Met need for contraception



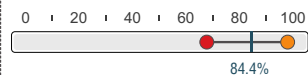
Antenatal care coverage (4 visits)



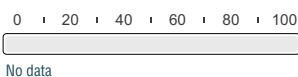
Prevention of mother to child transmission of HIV



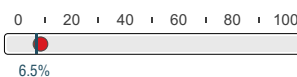
Skilled attendant at birth



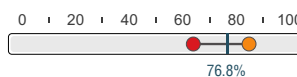
Postnatal care coverage



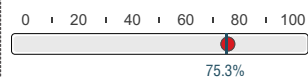
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
- 2015 Progress report on implementing the Commission on Information and Accountability Recommendations: Birth registration, Death registration, MDSR, CRVS, National eHealth strategy, Total health expenditure per capita tracked by financing source, Country conducted annual health sector review, Health sector performance report available in the public domain.
- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).

Better Information

 Vital Events

% of births registered	85
% of deaths registered	91
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	PARTIAL
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES

 Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO

 Innovation and eHealth

National eHealth strategy and plan in place and implemented	YES
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Better Resources

 Resource Tracking

Total health expenditure per capita tracked by financing source	PARTIAL
Total public sector health expenditure per capita (US\$)	308.7
Total RMNCH expenditure per capita tracked by financing source	PARTIAL
Total annual RMNCH expenditure (US\$)	NO DATA

 Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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 Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

 National Oversight

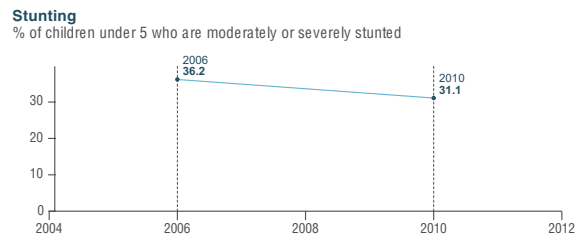
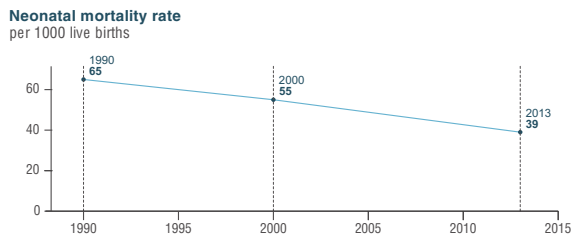
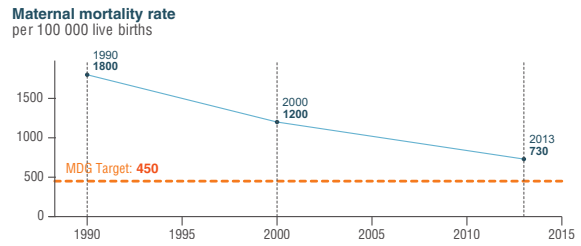
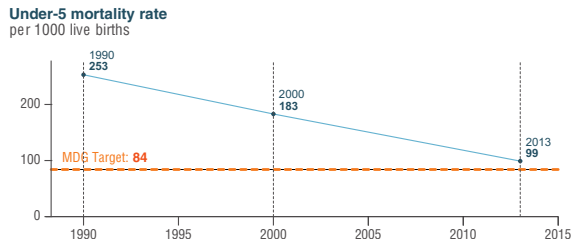
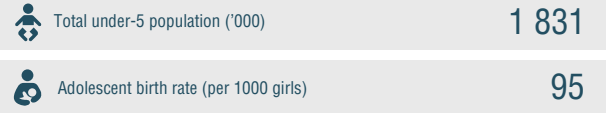
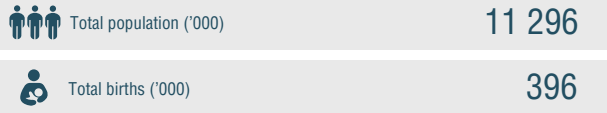
Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA

 Transparency

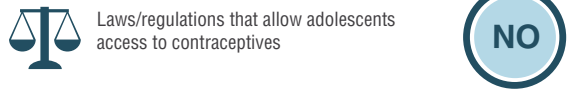
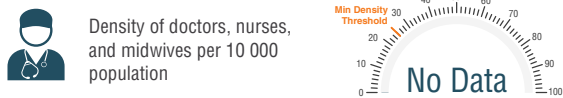
A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data



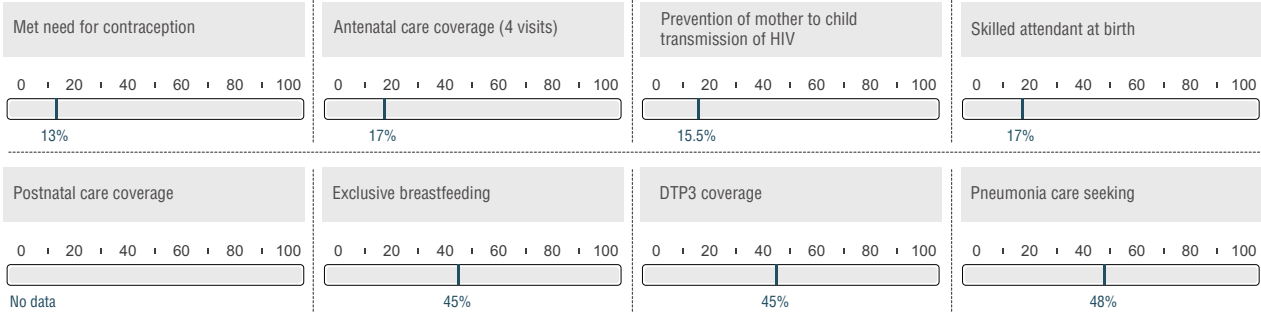
Reproductive Health and Health Systems Data



Health Coverage Indicators

● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
- 2015 Progress report on implementing the Commission on Information and Accountability Recommendations: Birth registration, Death registration, MDSR, CRVS, National eHealth strategy, Total health expenditure per capita tracked by financing source, Country conducted annual health sector review, Health sector performance report available in the public domain.
- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).

Better Information



Vital Events

% of births registered	35
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	NO
Civil Registration and Vital Statistics (CRVS) improvement plan in place	PARTIAL



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO DATA
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO



Innovation and eHealth

National eHealth strategy and plan in place and implemented	NO
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	PARTIAL
Total public sector health expenditure per capita (US\$)	10.6
Total RMNCH expenditure per capita tracked by financing source	PARTIAL
Total annual RMNCH expenditure (US\$)	NO DATA



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	NO
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	NO
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA





Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

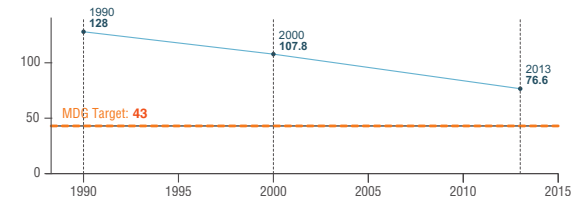
 Total population ('000) **37 964**

 Total under-5 population ('000) **5 789**

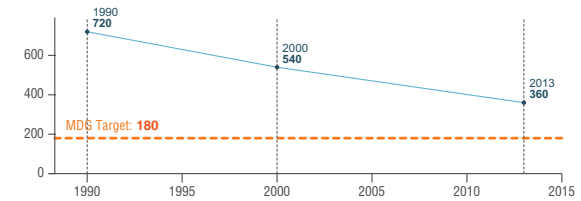
 Total births ('000) **1 263**

 Adolescent birth rate (per 1000 girls) **107**

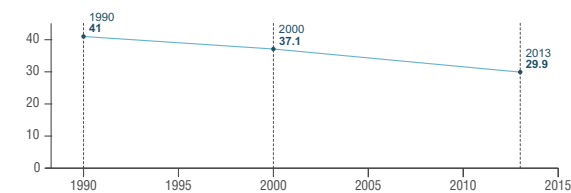
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

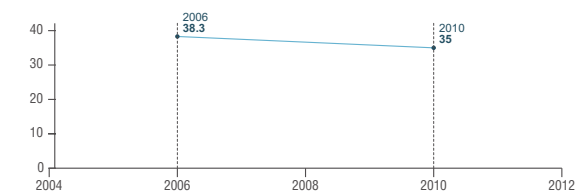


Neonatal mortality rate
per 1000 live births



Stunting

% of children under 5 who are moderately or severely stunted



Reproductive Health and Health Systems Data



Density of doctors, nurses, and midwives per 10 000 population



Demand for family planning satisfied

24%



Laws/regulations that allow adolescents access to contraceptives



Legal status of abortion (x of 5 circumstances)

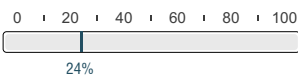
1/5

Health Coverage Indicators

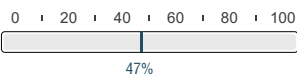
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

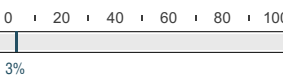
Met need for contraception



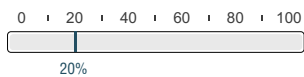
Antenatal care coverage (4 visits)



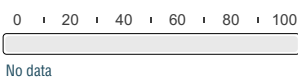
Prevention of mother to child transmission of HIV



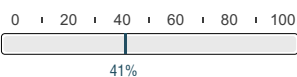
Skilled attendant at birth



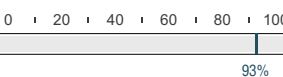
Postnatal care coverage



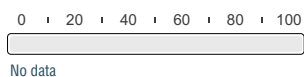
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).

Better Information

 Vital Events

% of births registered	59
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	PARTIAL
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES

 Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO DATA
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO

 Innovation and eHealth

National eHealth strategy and plan in place and implemented	YES
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Better Resources

 Resource Tracking

Total health expenditure per capita tracked by financing source	NO
Total public sector health expenditure per capita (US\$)	26.8
Total RMNCH expenditure per capita tracked by financing source	NO
Total annual RMNCH expenditure (US\$)	NO DATA

 Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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 Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

 National Oversight

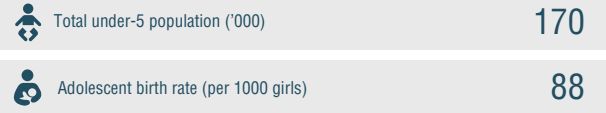
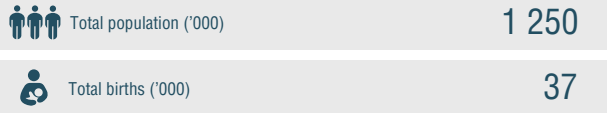
Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO

 Transparency

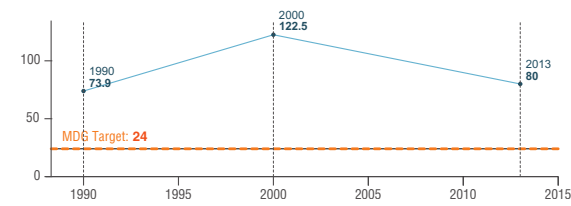
A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

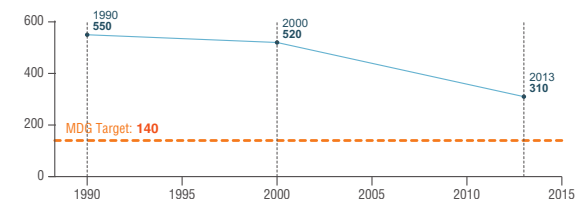
Demographic Data



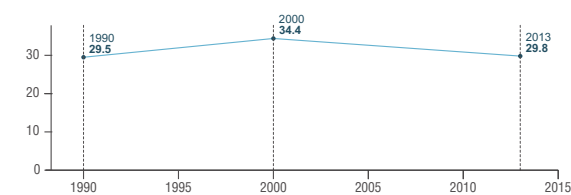
Under-5 mortality rate per 1000 live births



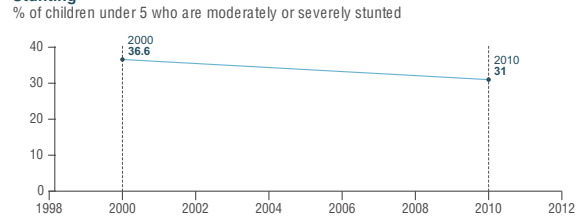
Maternal mortality rate per 100 000 live births



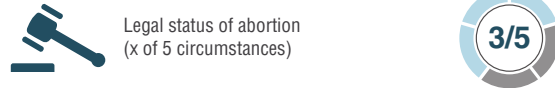
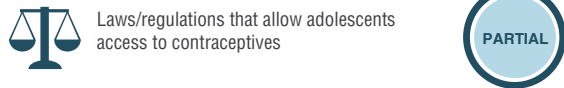
Neonatal mortality rate per 1000 live births



Stunting



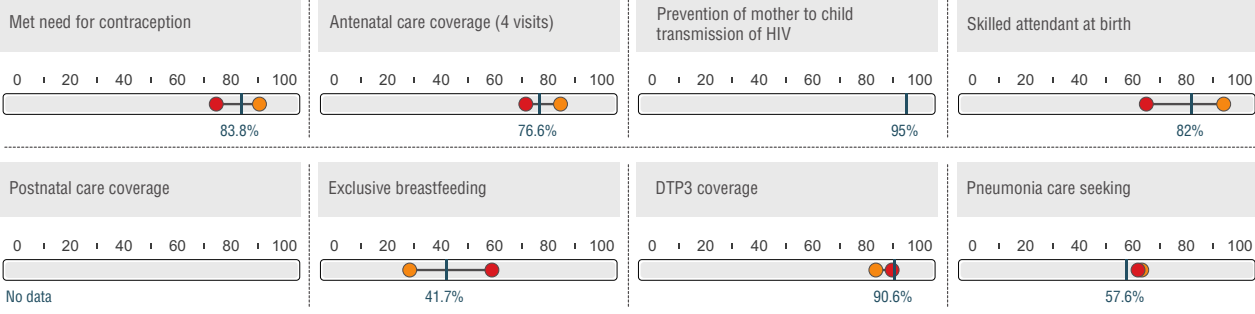
Reproductive Health and Health Systems Data



Health Coverage Indicators

● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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Better Information



Vital Events

% of births registered	50
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	YES
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO



Innovation and eHealth

National eHealth strategy and plan in place and implemented	YES
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	PARTIAL
Total public sector health expenditure per capita (US\$)	192.3
Total RMNCH expenditure per capita tracked by financing source	PARTIAL
Total annual RMNCH expenditure (US\$)	NO DATA



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	NO
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA





Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

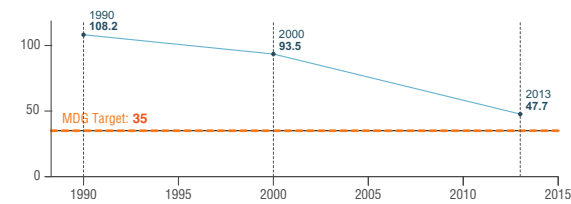
 Total population ('000) **8 208**

 Total under-5 population ('000) **1 227**

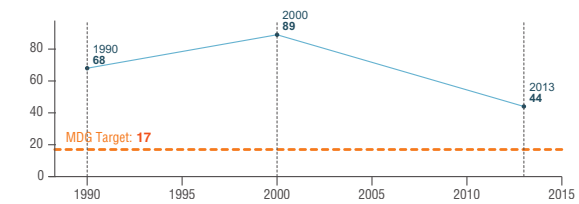
 Total births ('000) **265**

 Adolescent birth rate (per 1000 girls) **45**

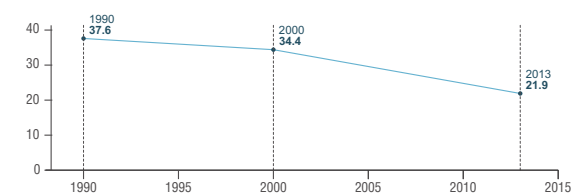
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

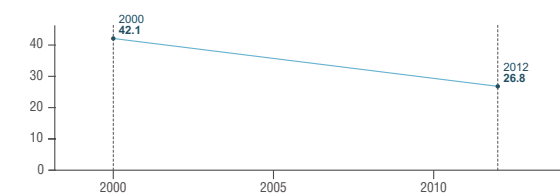


Neonatal mortality rate
per 1000 live births



Stunting

% of children under 5 who are moderately or severely stunted



Reproductive Health and Health Systems Data



Density of doctors, nurses, and midwives per 10 000 population



Demand for family planning satisfied

15%



Laws/regulations that allow adolescents access to contraceptives



Legal status of abortion (x of 5 circumstances)

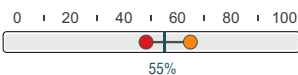
5/5

Health Coverage Indicators

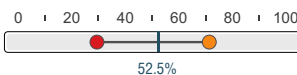
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

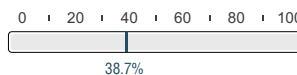
Met need for contraception



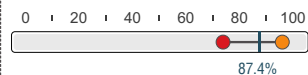
Antenatal care coverage (4 visits)



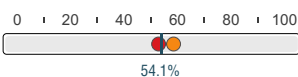
Prevention of mother to child transmission of HIV



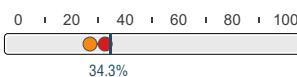
Skilled attendant at birth



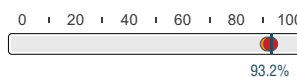
Postnatal care coverage



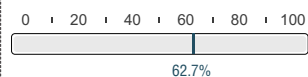
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
- 2015 Progress report on implementing the Commission on Information and Accountability Recommendations: Birth registration, Death registration, MDSR, CRVS, National eHealth strategy, Total health expenditure per capita tracked by financing source, Country conducted annual health sector review, Health sector performance report available in the public domain.
- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).

Better Information



Vital Events

% of births registered	88
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	PARTIAL
Civil Registration and Vital Statistics (CRVS) improvement plan in place	NO



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	YES
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	YES



Innovation and eHealth

National eHealth strategy and plan in place and implemented	YES
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	YES
Total public sector health expenditure per capita (US\$)	16.3
Total RMNCH expenditure per capita tracked by financing source	YES
Total annual RMNCH expenditure (US\$)	NO DATA



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	NO
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA





Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

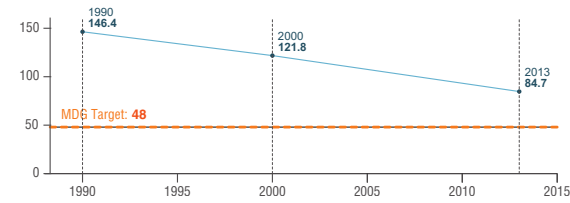
 Total population ('000) **6 817**

 Total under-5 population ('000) **1 115**

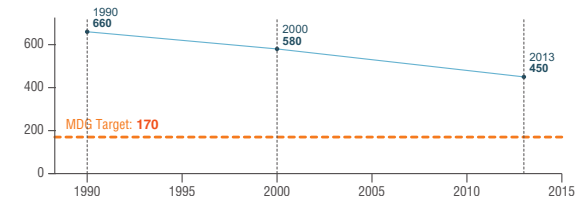
 Total births ('000) **245**

 Adolescent birth rate (per 1000 girls) **90**

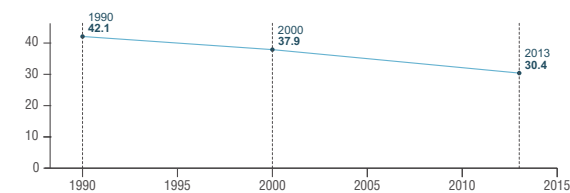
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

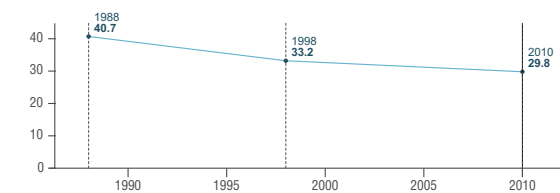


Neonatal mortality rate
per 1000 live births




Stunting

% of children under 5 who are moderately or severely stunted




Reproductive Health and Health Systems Data

 Density of doctors, nurses, and midwives per 10 000 population




 Demand for family planning satisfied

15%

 Laws/regulations that allow adolescents access to contraceptives

PARTIAL

 Legal status of abortion (x of 5 circumstances)

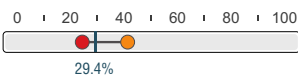
2/5

Health Coverage Indicators

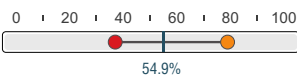
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

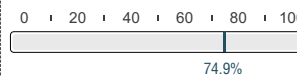
Met need for contraception



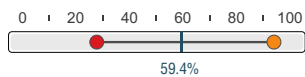
Antenatal care coverage (4 visits)



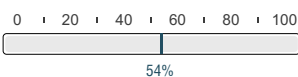
Prevention of mother to child transmission of HIV



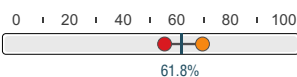
Skilled attendant at birth



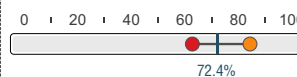
Postnatal care coverage



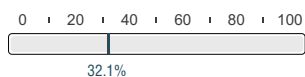
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).

Better Information

 Vital Events

% of births registered	78
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	YES
Civil Registration and Vital Statistics (CRVS) improvement plan in place	NO

 Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO

 Innovation and eHealth

National eHealth strategy and plan in place and implemented	YES
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Better Resources

 Resource Tracking

Total health expenditure per capita tracked by financing source	YES
Total public sector health expenditure per capita (US\$)	21
Total RMNCH expenditure per capita tracked by financing source	YES
Total annual RMNCH expenditure (US\$)	75 672 168

 Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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 Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

 National Oversight


Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	YES


 Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

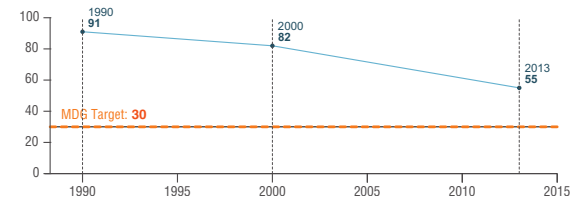
 Total population ('000) **5 240**

 Total under-5 population ('000) **524**

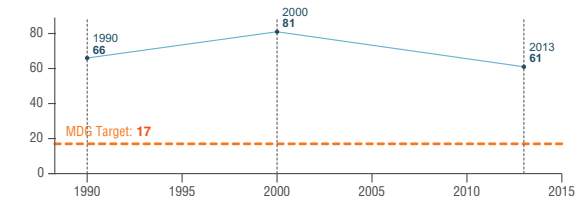
 Total births ('000) **111**

 Adolescent birth rate (per 1000 girls) **21**

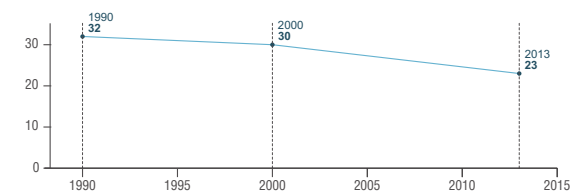
Under-5 mortality rate
per 1000 live births



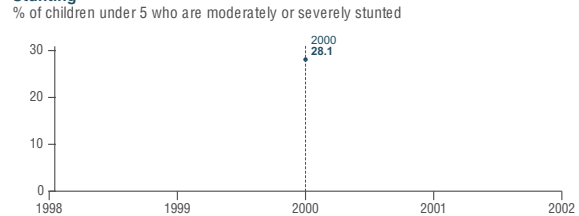
Maternal mortality rate
per 100 000 live births



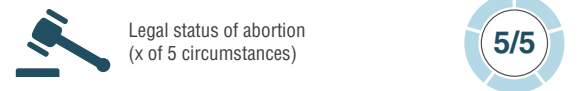
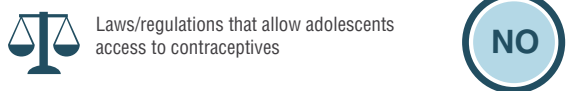
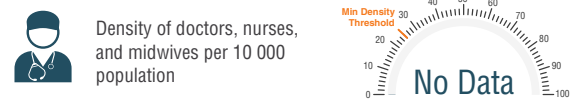
Neonatal mortality rate
per 1000 live births



Stunting



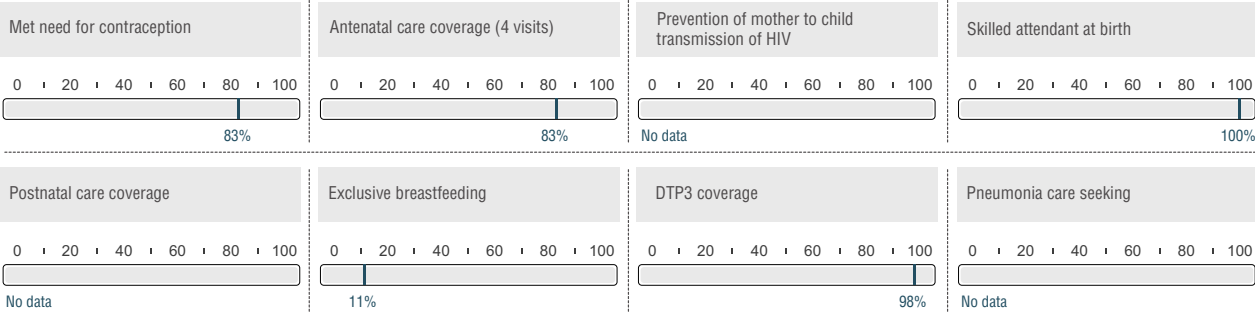
Reproductive Health and Health Systems Data



Health Coverage Indicators

● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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Better Information



Vital Events

% of births registered	NO DATA
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	NO
Civil Registration and Vital Statistics (CRVS) improvement plan in place	NO



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	YES
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO



Innovation and eHealth

National eHealth strategy and plan in place and implemented	YES
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	NO
Total public sector health expenditure per capita (US\$)	81.5
Total RMNCH expenditure per capita tracked by financing source	NO
Total annual RMNCH expenditure (US\$)	NO DATA



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	NO
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	NO
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA





Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

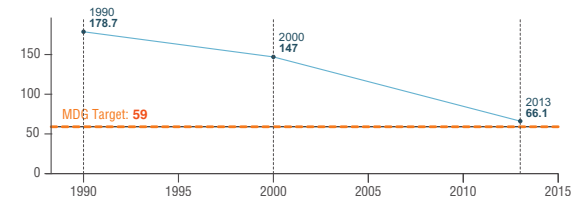
 Total population ('000) **37 579**

 Total under-5 population ('000) **7 291**

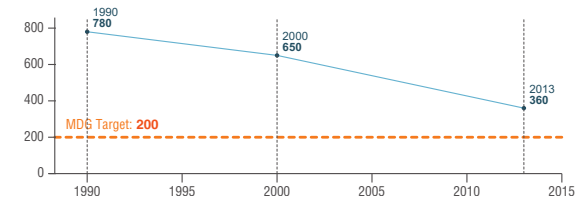
 Total births ('000) **1 591**

 Adolescent birth rate (per 1000 girls) **150**

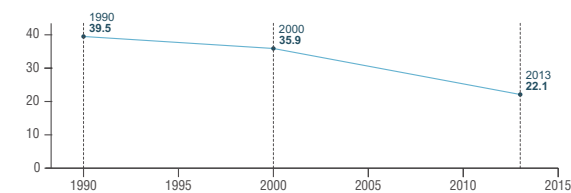
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

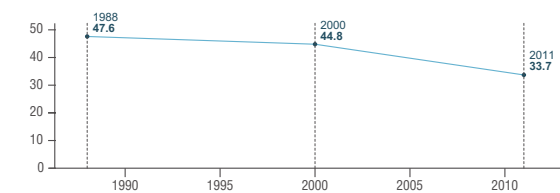


Neonatal mortality rate
per 1000 live births



Stunting

% of children under 5 who are moderately or severely stunted



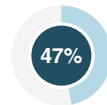
Reproductive Health and Health Systems Data



Density of doctors, nurses, and midwives per 10 000 population



Demand for family planning satisfied



Laws/regulations that allow adolescents access to contraceptives



Legal status of abortion (x of 5 circumstances)

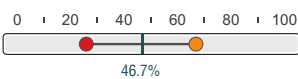


Health Coverage Indicators

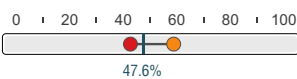
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

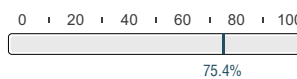
Met need for contraception



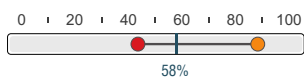
Antenatal care coverage (4 visits)



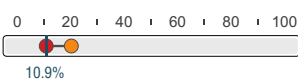
Prevention of mother to child transmission of HIV



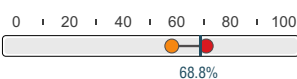
Skilled attendant at birth



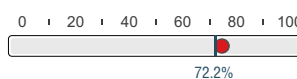
Postnatal care coverage



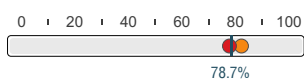
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
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Better Information



Vital Events

% of births registered	30
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	YES
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO



Innovation and eHealth

National eHealth strategy and plan in place and implemented	YES
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	YES
Total public sector health expenditure per capita (US\$)	10.4
Total RMNCH expenditure per capita tracked by financing source	YES
Total annual RMNCH expenditure (US\$)	508 842 040



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	YES



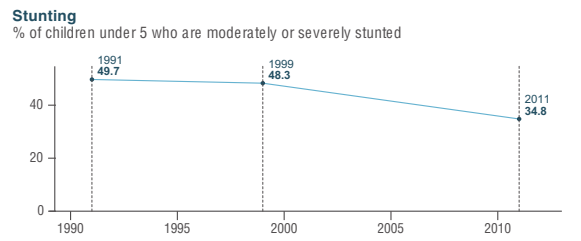
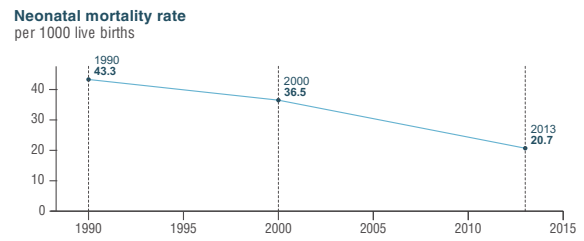
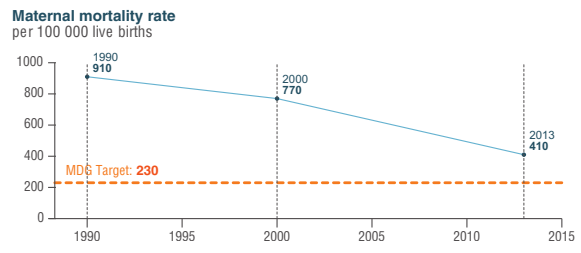
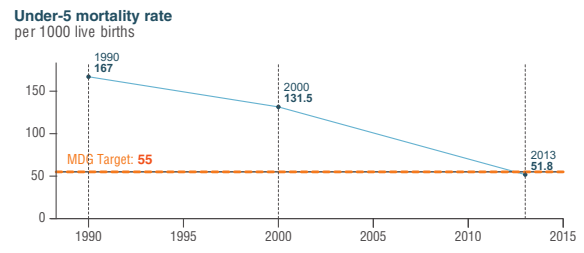
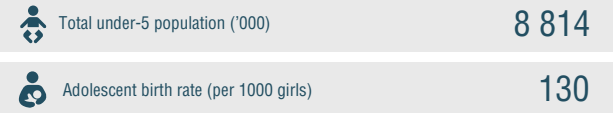
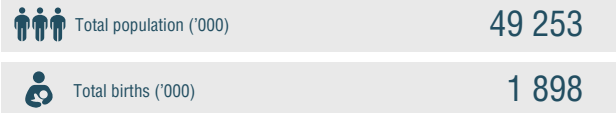
Transparency

A health sector performance report for the preceding year is available in the public domain	NO DATA
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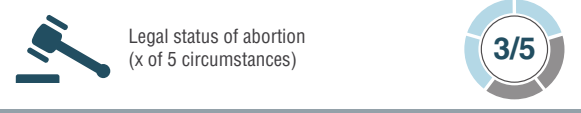
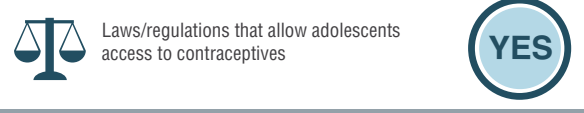


Summary

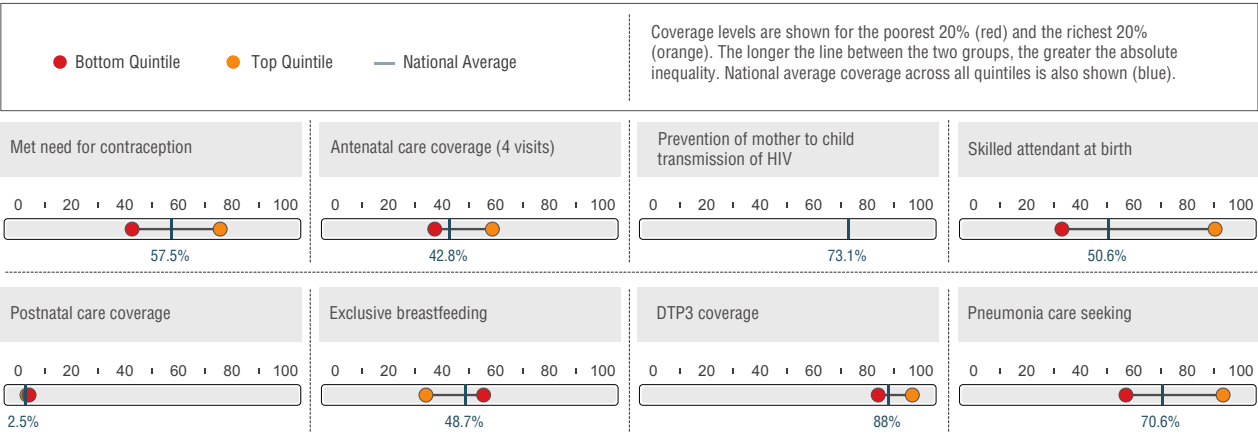
Demographic Data



Reproductive Health and Health Systems Data



Health Coverage Indicators



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Better Information



Vital Events

% of births registered	16
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	PARTIAL
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO



Innovation and eHealth

National eHealth strategy and plan in place and implemented	NO
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	YES
Total public sector health expenditure per capita (US\$)	16.3
Total RMNCH expenditure per capita tracked by financing source	YES
Total annual RMNCH expenditure (US\$)	525 614 210



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA



Transparency

A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

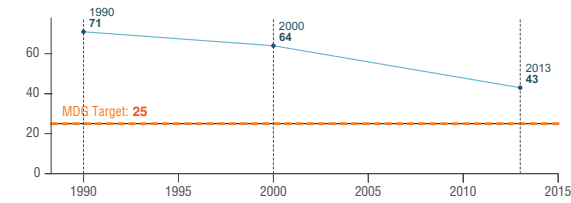
Total population ('000) 28 934

Total under-5 population ('000) 2 941

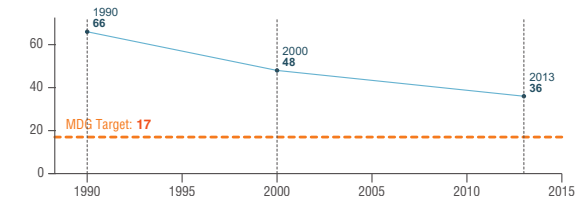
Total births ('000) 623

Adolescent birth rate (per 1000 girls) 49

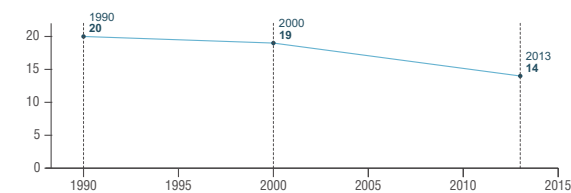
Under-5 mortality rate per 1000 live births



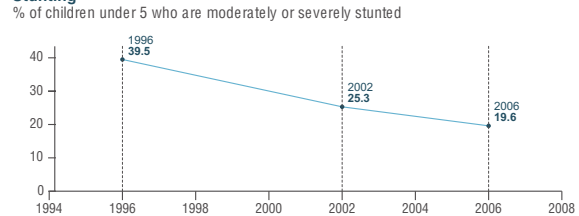
Maternal mortality rate per 100 000 live births



Neonatal mortality rate per 1000 live births



Stunting



Reproductive Health and Health Systems Data



Density of doctors, nurses, and midwives per 10 000 population



Demand for family planning satisfied

15%



Laws/regulations that allow adolescents access to contraceptives



Legal status of abortion (x of 5 circumstances)

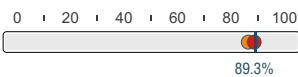
5/5

Health Coverage Indicators

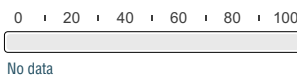
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

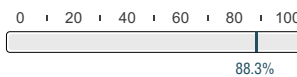
Met need for contraception



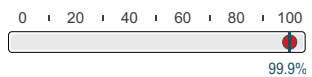
Antenatal care coverage (4 visits)



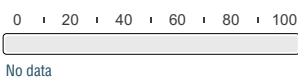
Prevention of mother to child transmission of HIV



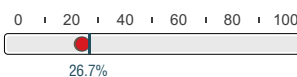
Skilled attendant at birth



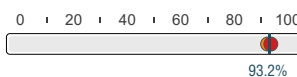
Postnatal care coverage



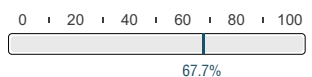
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
- 2015 Progress report on implementing the Commission on Information and Accountability Recommendations: Birth registration, Death registration, MDSR, CRVS, National eHealth strategy, Total health expenditure per capita tracked by financing source, Country conducted annual health sector review, Health sector performance report available in the public domain.
- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).

Better Information

 Vital Events

% of births registered	>90
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	YES
Civil Registration and Vital Statistics (CRVS) improvement plan in place	NO

 Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO

 Innovation and eHealth

National eHealth strategy and plan in place and implemented	YES
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Better Resources

 Resource Tracking

Total health expenditure per capita tracked by financing source	PARTIAL
Total public sector health expenditure per capita (US\$)	56
Total RMNCH expenditure per capita tracked by financing source	PARTIAL
Total annual RMNCH expenditure (US\$)	NO DATA

 Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	NO
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 Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

 National Oversight


Country has conducted annual national health sector review process in the past year	NO
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA


 Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

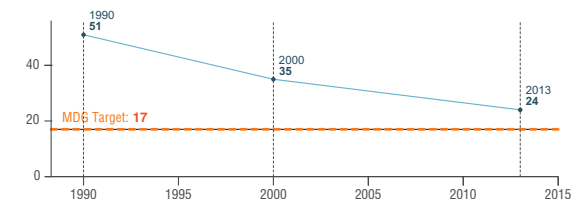
 Total population ('000) **91 680**

 Total under-5 population ('000) **7 083**

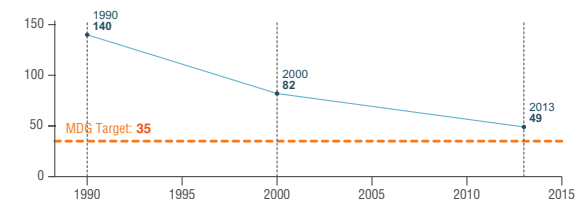
 Total births ('000) **1 440**

 Adolescent birth rate (per 1000 girls) **32**

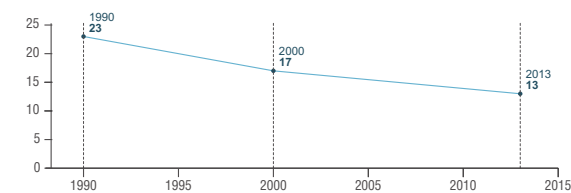
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

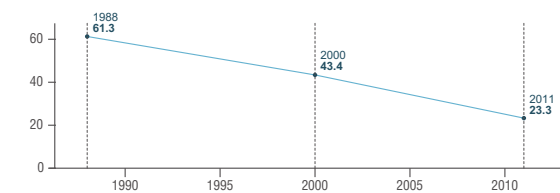


Neonatal mortality rate
per 1000 live births



Stunting

% of children under 5 who are moderately or severely stunted



Reproductive Health and Health Systems Data



Density of doctors, nurses, and midwives per 10 000 population



Demand for family planning satisfied

15%



Laws/regulations that allow adolescents access to contraceptives



Legal status of abortion (x of 5 circumstances)

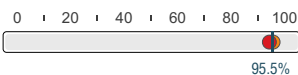
5/5

Health Coverage Indicators

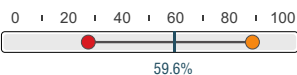
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

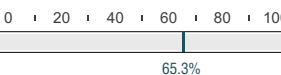
Met need for contraception



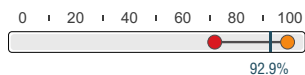
Antenatal care coverage (4 visits)



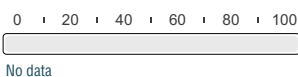
Prevention of mother to child transmission of HIV



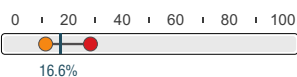
Skilled attendant at birth



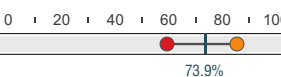
Postnatal care coverage



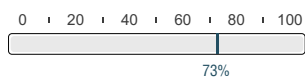
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
- 2015 Progress report on implementing the Commission on Information and Accountability Recommendations: Birth registration, Death registration, MDSR, CRVS, National eHealth strategy, Total health expenditure per capita tracked by financing source, Country conducted annual health sector review, Health sector performance report available in the public domain.
- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).

Better Information

 Vital Events

% of births registered	95
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	PARTIAL
Civil Registration and Vital Statistics (CRVS) improvement plan in place	PARTIAL

 Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO

 Innovation and eHealth

National eHealth strategy and plan in place and implemented	YES
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Better Resources

 Resource Tracking

Total health expenditure per capita tracked by financing source	PARTIAL
Total public sector health expenditure per capita (US\$)	43.6
Total RMNCH expenditure per capita tracked by financing source	PARTIAL
Total annual RMNCH expenditure (US\$)	NO DATA

 Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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 Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

 National Oversight

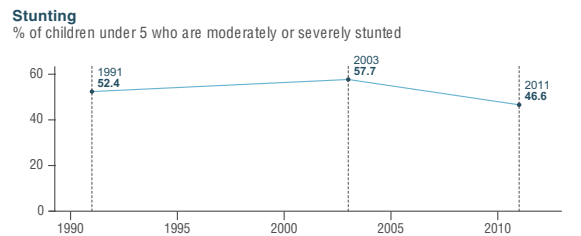
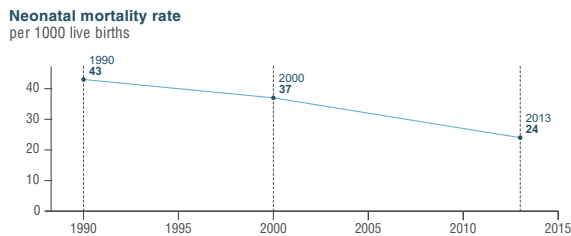
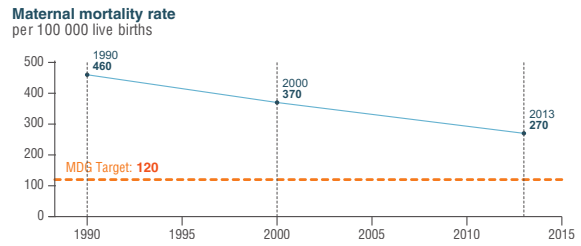
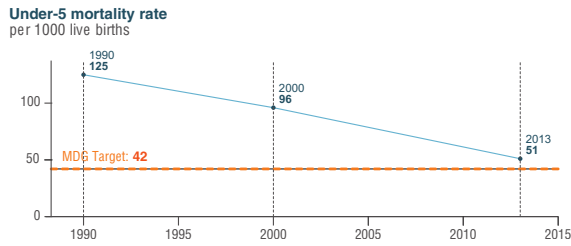
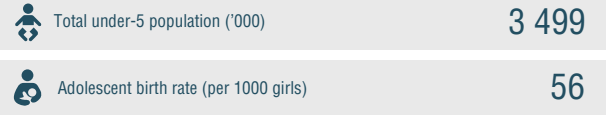
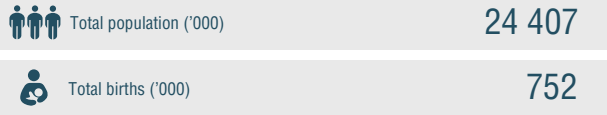
Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	YES

 Transparency

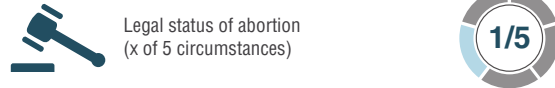
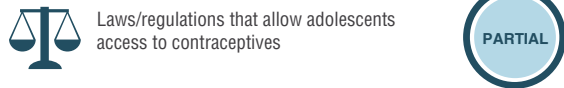
A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data



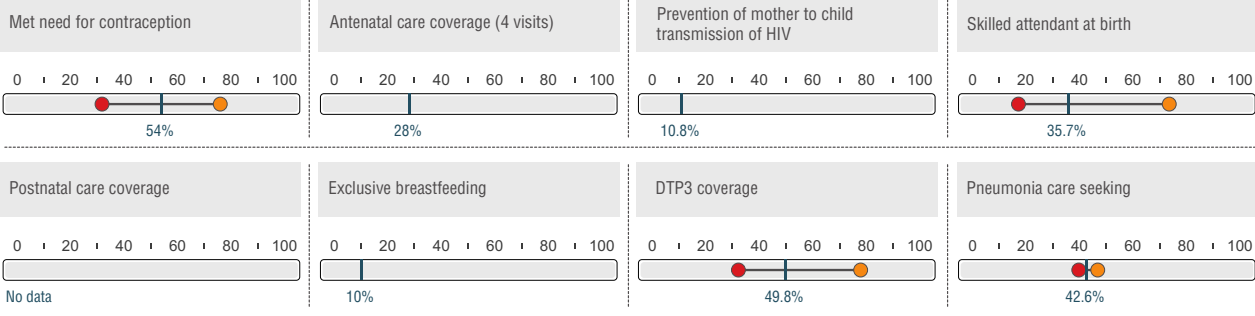
Reproductive Health and Health Systems Data



Health Coverage Indicators

● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
- 2015 Progress report on implementing the Commission on Information and Accountability Recommendations: Birth registration, Death registration, MDSR, CRVS, National eHealth strategy, Total health expenditure per capita tracked by financing source, Country conducted annual health sector review, Health sector performance report available in the public domain.
- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).

Better Information



Vital Events

% of births registered	17
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	NO
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES



Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO



Innovation and eHealth

National eHealth strategy and plan in place and implemented	PARTIAL
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Better Resources



Resource Tracking

Total health expenditure per capita tracked by financing source	NO
Total public sector health expenditure per capita (US\$)	19.4
Total RMNCH expenditure per capita tracked by financing source	NO
Total annual RMNCH expenditure (US\$)	NO DATA



Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight



National Oversight

Country has conducted annual national health sector review process in the past year	NO
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA





Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

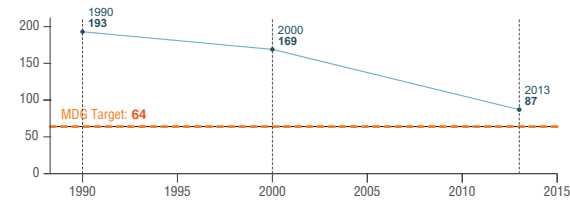
 Total population ('000) **14 539**

 Total under-5 population ('000) **2 753**

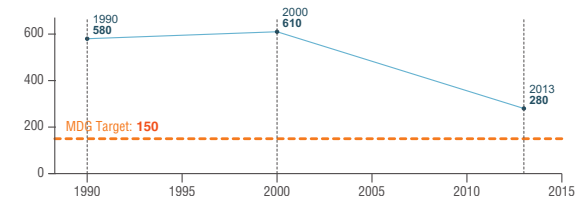
 Total births ('000) **608**

 Adolescent birth rate (per 1000 girls) **140**

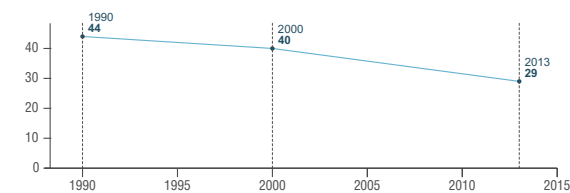
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

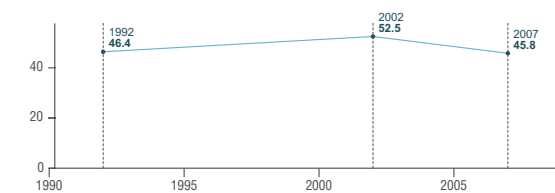


Neonatal mortality rate
per 1000 live births




Stunting

% of children under 5 who are moderately or severely stunted




Reproductive Health and Health Systems Data

 Density of doctors, nurses, and midwives per 10 000 population




 Demand for family planning satisfied



 Laws/regulations that allow adolescents access to contraceptives



 Legal status of abortion (x of 5 circumstances)

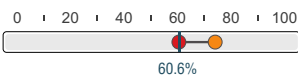


Health Coverage Indicators

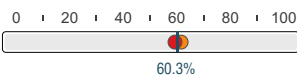
● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).

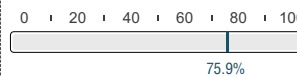
Met need for contraception



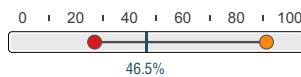
Antenatal care coverage (4 visits)



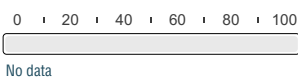
Prevention of mother to child transmission of HIV



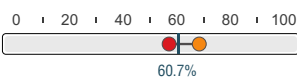
Skilled attendant at birth



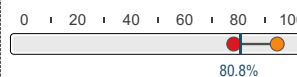
Postnatal care coverage



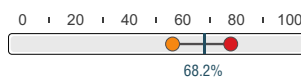
Exclusive breastfeeding



DTP3 coverage



Pneumonia care seeking



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
- 2015 Progress report on implementing the Commission on Information and Accountability Recommendations: Birth registration, Death registration, MDSR, CRVS, National eHealth strategy, Total health expenditure per capita tracked by financing source, Country conducted annual health sector review, Health sector performance report available in the public domain.
- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).



Better Information

Vital Events

% of births registered	14
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	PARTIAL
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES

Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO

Innovation and eHealth

National eHealth strategy and plan in place and implemented	YES
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Better Resources

Resource Tracking

Total health expenditure per capita tracked by financing source	PARTIAL
Total public sector health expenditure per capita (US\$)	61.6
Total RMNCH expenditure per capita tracked by financing source	PARTIAL
Total annual RMNCH expenditure (US\$)	NO DATA

Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
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Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
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Better Oversight

National Oversight


Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA


Transparency


A health sector performance report for the preceding year is available in the public domain	NO DATA
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Summary

Demographic Data

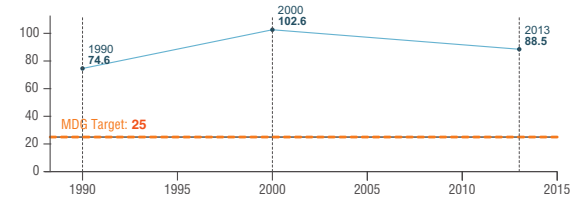
 Total population ('000) **14 150**

 Total under-5 population ('000) **2 080**

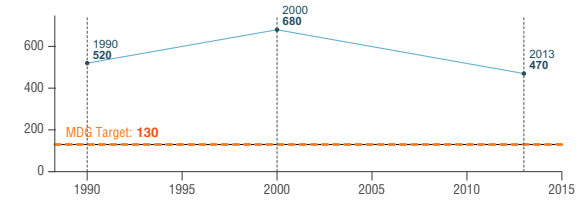
 Total births ('000) **439**

 Adolescent birth rate (per 1000 girls) **73**

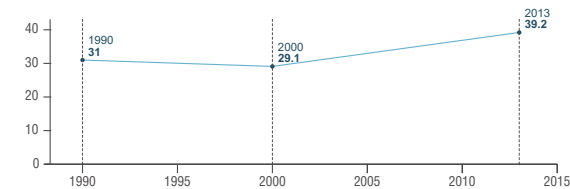
Under-5 mortality rate
per 1000 live births



Maternal mortality rate
per 100 000 live births

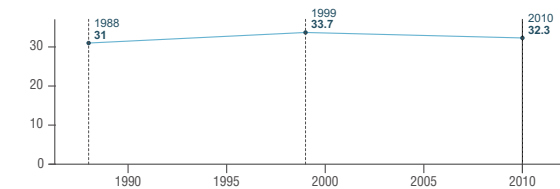


Neonatal mortality rate
per 1000 live births

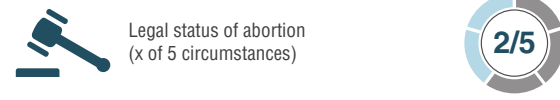
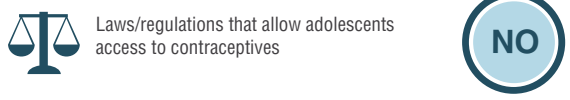


Stunting

% of children under 5 who are moderately or severely stunted



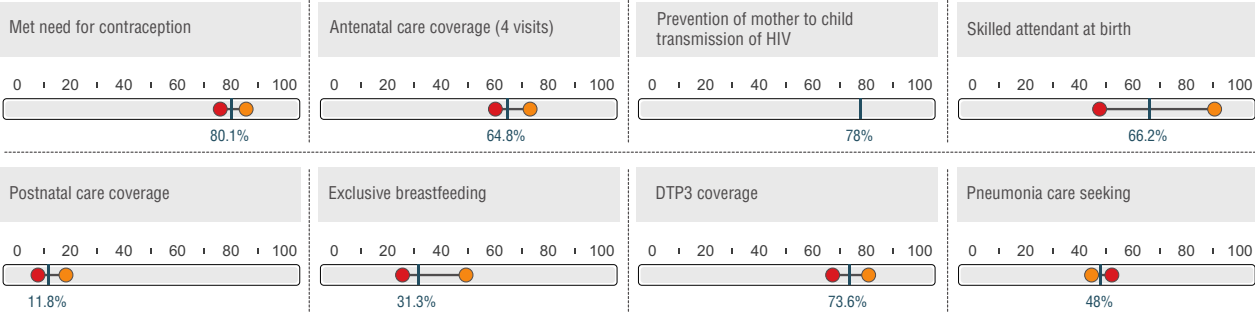
Reproductive Health and Health Systems Data



Health Coverage Indicators

● Bottom Quintile ● Top Quintile — National Average

Coverage levels are shown for the poorest 20% (red) and the richest 20% (orange). The longer the line between the two groups, the greater the absolute inequality. National average coverage across all quintiles is also shown (blue).



The data presented in this country profile have been collated from publicly available sources.

- Global Health Observatory (<http://www.who.int/gho/en/>): Total population, Total births, Density of doctors, nurses and midwives, Maternal mortality ratio, Under-5 mortality rate, Neonatal mortality rate, Met need for contraception, Demand for family planning satisfied, Antenatal care coverage, Prevention of mother to child transmission of HIV (Antiretroviral prophylaxis for PMTCT), Skilled attendant at birth, Exclusive breastfeeding (for six months), DTP3 coverage, Total health expenditure per capita.
- 2015 Progress report on implementing the Commission on Information and Accountability Recommendations: Birth registration, Death registration, MDSR, CRVS, National eHealth strategy, Total health expenditure per capita tracked by financing source, Country conducted annual health sector review, Health sector performance report available in the public domain.
- Countdown to 2015: MDG targets for MMR and U5MR, Postnatal care coverage, Pneumonia care seeking (antibiotic treatment for pneumonia), Quintile data for all 8 health coverage indicators.
- System of Health Accounts 2011: Total RMNCH expenditure per capita, expenditure tracked by financing source, Total annual RMNCH expenditure.
- The remaining indicators were taken from various sources (in brackets): Mutual assessment of progress exists (IHP+Results, 2014); Legal status of abortion, Under-5 population (UN Population Division); Adolescent birth rate (per 1000 girls) (UN Population Division); Stunting (data.unicef.org); Laws/regulations that allow adolescents access to contraceptives (WHO MNCAH Key Informant Policy Questionnaire).

Better Information

 Vital Events

% of births registered	49
% of deaths registered	NO DATA
Maternal Death Surveillance and Response (MDSR) policy in place, including notification within 24 hrs	YES
Civil Registration and Vital Statistics (CRVS) improvement plan in place	YES

 Health Indicators

Data for all 3 impact indicators are available, based on data collected in the preceding 3 years, disaggregated by equity stratifiers	NO
Statistics for all 8 coverage indicators are available, disaggregated by equity stratifiers	NO

 Innovation and eHealth

National eHealth strategy and plan in place and implemented	YES
---	-----

Better Resources

 Resource Tracking

Total health expenditure per capita tracked by financing source	PARTIAL
Total public sector health expenditure per capita (US\$)	NO DATA
Total RMNCH expenditure per capita tracked by financing source	PARTIAL
Total annual RMNCH expenditure (US\$)	NO DATA

 Country Compacts

Country-led reporting system is in place for externally funded expenditures and predictable commitments	YES
---	-----

 Reaching Women and Children

% of national health expenditure used for RMNCH	NO DATA
---	---------

Better Oversight

 National Oversight

Country has conducted annual national health sector review process in the past year	YES
Mutual assessment of progress in implementing agreed health sector commitments exists	NO DATA

 Transparency

A health sector performance report for the preceding year is available in the public domain	NO DATA
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DONOR PROFILES

iERG DONOR PROFILE: MEASURING PROGRESS ON ACCOUNTABILITY

The iERG donor profile presents a snapshot picture of a donor's financial and policy commitments to women's and children's health. The profile consists of one page which presents the financial expenditure for Official Development Assistance (ODA) and percent of GDP spent on ODA with trends over time; similar charts are presented for health ODA including as a percent of overall ODA, and for RMNCH expenditure. It also presents data, where available and relevant, for the proportion of resources that flows through intermediaries; on the transparency of each donor; and on the major pledges made for women's and children's health. The information is intended to help policy makers and their partners assess progress and prioritise further actions to save women's and children's lives.

Most of the data come from OECD datasets (OECD Stat). Data on RMNCH expenditure is taken from Arregoces et al, Countdown to 2015: changes in official development assistance to reproductive, maternal, newborn, and child health, and assessment of progress between 2003 and 2012; *The Lancet Global Health*. Data on transparency come from the International Aid Transparency Index 2013 and 2014 (<http://ati.publishwhatyoufund.org/>); and information on major pledges comes from the *Every Woman Every Child* commitments database (<http://www.everywomaneverychild.org/commitments/all-commitments>).

Profiles are presented for 15 donors with strong commitments to women's and children's health.

Australia
Bill & Melinda Gates Foundation
Canada
France
GAVI Alliance

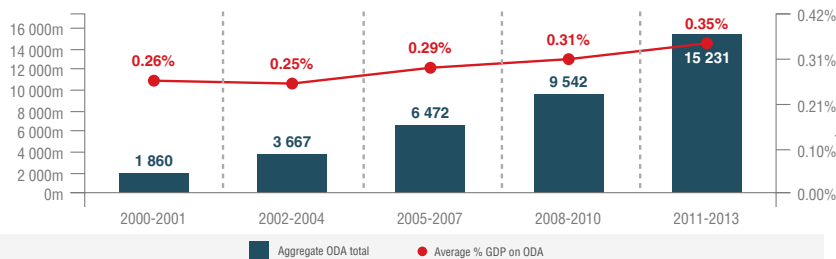
Germany
Global Fund
Italy
Japan
Norway

Russian Federation
Sweden
United Kingdom
United States
World Bank



Resource Commitments

Total ODA 2000-2013 (US\$ millions)

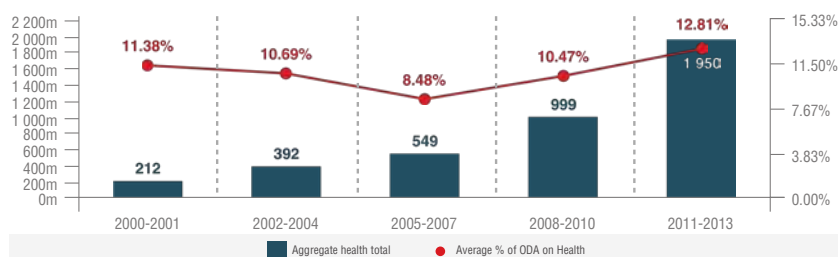


The bar chart shows aggregate ODA figures. Note that figures are presented in groups of three years, except for the first bar which shows only two years.

The line chart shows % of GDP spent on ODA as an average across the years shown. The pie chart highlights latest performance (2011-13).

NB: Where no bar is shown, no data was available for this indicator.

Total health expenditure 2000-2013 (US\$ millions)

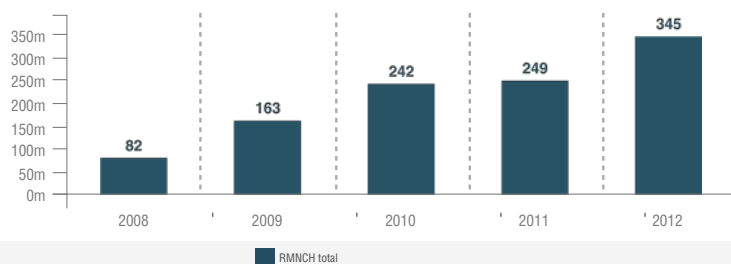


The bar chart shows aggregate health expenditure figures. Note that figures are presented in groups of three years, except for the first bar which shows only two years.

The line chart shows % of ODA spent on health as an average across the years shown. The pie chart highlights latest performance (2011-13).

NB: Where no bar is shown, no data was available for this indicator.

Total RMNCH expenditure 2008-2012 (US\$ millions)

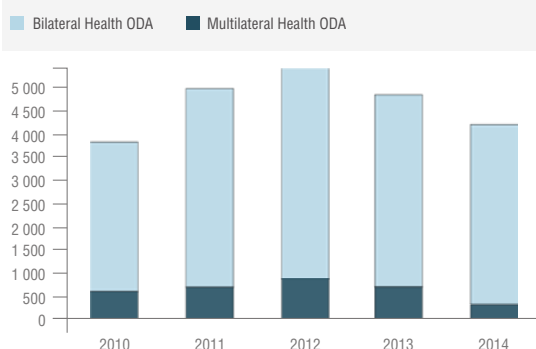


The bar chart shows RMNCH figures.

NB: Where no bar is shown, no data was available for this indicator.

Resources through financial intermediaries

Bilateral and Multilateral ODA to Health (US\$ millions)



Transparency

25/68 on the Aid Transparency Index 2014
 ✓ from the year 2013

Major Pledges

1. Born Too Soon: Australia will spend \$1.6 billion over five years to 2015 under the Global Strategy for Women's and Children's Health on interventions evidence shows will improve maternal and child health outcomes.
2. London Family Planning Summit: Australia commits to spending an additional AUD 58 million over five years on family planning, doubling annual contributions to AUD 53 million by 2016.
3. Read more at: <http://www.everywomaneverychild.org/commitments/all-commitments/australia#sthash.pvW1PJd.dpuf>

Australia

R.G. Casey Building, John McEwen Crescent, Barton ACT 0221
 Australia

<http://dfat.gov.au/>

Type of donor

- > ✓ Primary Source of funds?
- > ✗ Financial intermediary?
- > ✓ Member of DAC?
- > ✓ Reports available on CRS?

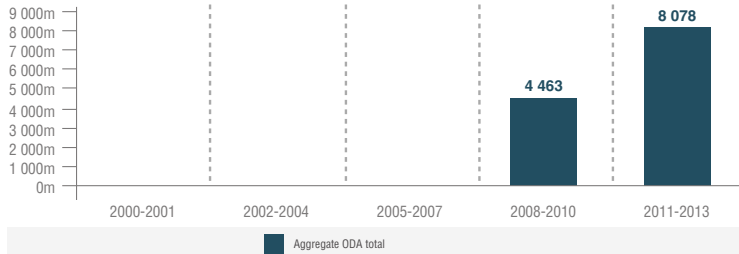
The data presented in this donor profile have been collated from publicly available sources.

- OECD Total flows by donor (ODA+OOF+Private) [DAC1]: ODA total, resources through intermediaries (codes I.A and I.B)
- OECD Aid (ODA) by sector and donor [DAC5]: Health ODA total. Note that these figures are an aggregate of figures for sector codes I.2, I.3 and I.4
- Arregoces et al, Countdown to 2015: changes in official development assistance to reproductive, maternal, newborn, and child health, and assessment of progress between 2003 and 2012; The Lancet Global Health [http://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X\(15\)00057-1.pdf](http://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X(15)00057-1.pdf); RMNCH expenditure
- International Aid Transparency Index 2013 and 2014: Transparency
- Every Woman Every Child commitments database (<http://www.everywomaneverychild.org/commitments/all-commitments>): Major pledges



Resource Commitments

Total ODA 2000-2013 (US\$ millions)



% of GDP spent on ODA

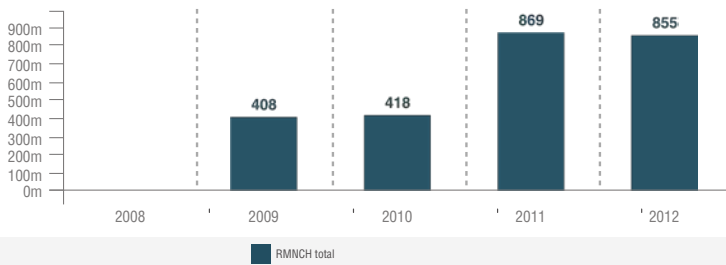
The bar chart shows aggregate ODA figures. Note that figures are presented in groups of three years, except for the first bar which shows only two years.

NB: Where no bar is shown, no data was available for this indicator.

Total health expenditure 2000-2013 (US\$ millions)

No health expenditure data available

Total RMNCH expenditure 2008-2012 (US\$ millions)



The bar chart shows RMNCH figures.

NB: Where no bar is shown, no data was available for this indicator.

Resources through financial intermediaries

Bilateral and Multilateral ODA to Health (US\$ millions)

No bilateral and multilateral data available

Transparency

23/68

on the Aid Transparency Index 2014
from the year 2013

Major Pledges

- In 2010, The Bill & Melinda Gates Foundation committed US\$1.5 billion over 5 years for women's and children's health. This funding includes an annual investment of US\$130 million on behalf of maternal and newborn survival.
- In 2012, the foundation added US\$1 billion to aid in providing 120 million additional women with contraceptives, information and services by 2020, reaffirming this commitment as part of the Every Newborn Action Plan in 2014.
- This investment does not reflect the foundation's grant making for vaccines, or for the prevention of pneumonia, diarrhea, malaria or HIV/AIDS—all of which are closely linked to child health.
- The Foundation is committed to supporting country leadership in addressing barriers that prevent women from accessing lifesaving contraceptives, and supports research to create new contraceptives that can better serve meet women's needs.

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- OECD Aid (ODA) by sector and donor [DAC5]: Health ODA total. Note that these figures are an aggregate of figures for sector codes I.2, I.3 and I.4
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- International Aid Transparency Index 2013 and 2014: Transparency
- Every Woman Every Child commitments database (<http://www.everywomaneverychild.org/commitments/all-commitments>): Major pledges

Bill & Melinda Gates Foundation

500 Fifth Avenue North
Seattle, WA 98109

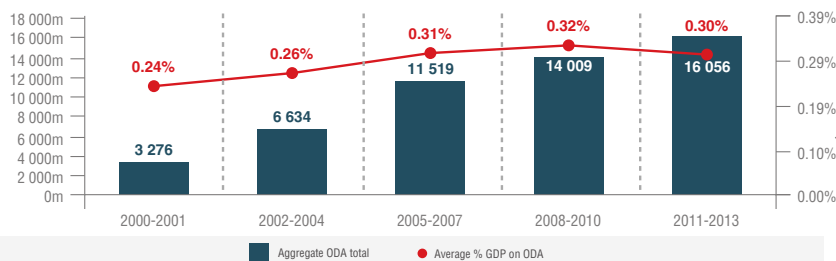
<http://www.gatesfoundation.org/>

Type of donor

- > Primary Source of funds?
- > Financial intermediary?
- > Member of DAC?
- > Reports available on CRS?

Resource Commitments

Total ODA 2000-2013 (US\$ millions)

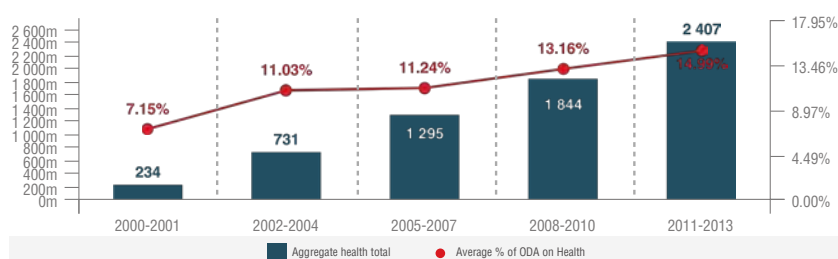


The bar chart shows aggregate ODA figures. Note that figures are presented in groups of three years, except for the first bar which shows only two years.

The line chart shows % of GDP spent on ODA as an average across the years shown. The pie chart highlights latest performance (2011-13).

NB: Where no bar is shown, no data was available for this indicator.

Total health expenditure 2000-2013 (US\$ millions)

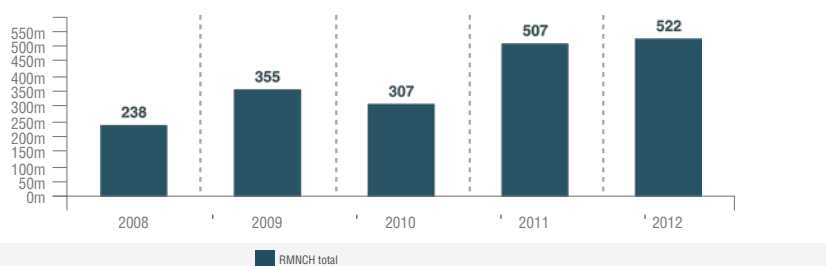


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The line chart shows % of ODA spent on health as an average across the years shown. The pie chart highlights latest performance (2011-13).

NB: Where no bar is shown, no data was available for this indicator.

Total RMNCH expenditure 2008-2012 (US\$ millions)

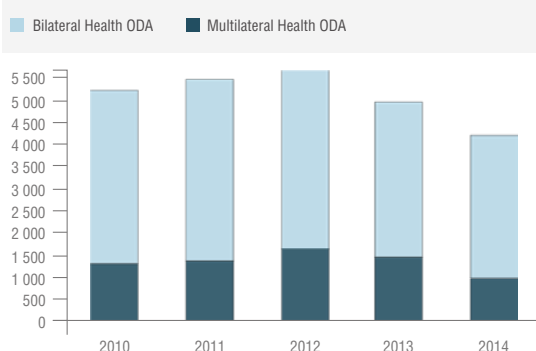


The bar chart shows RMNCH figures.

NB: Where no bar is shown, no data was available for this indicator.

Resources through financial intermediaries

Bilateral and Multilateral ODA to Health (US\$ millions)



Transparency

 **11/68** on the Aid Transparency Index 2014  from the year 2013

Major Pledges

- Canada made maternal, newborn and child health (MNCH) a priority for the G8 Muskoka Summit in June 2010, and has since pledged to provide Can\$2.85 billion for the MNCH Programme by 2015.
- Canada will focus its efforts on improving the services and care needed to ensure healthy pregnancies and safe delivery, placing emphasis on meeting the nutritional needs of pregnant women, mothers, newborns and young children.
- Canada will work to increase access to the high-impact, cost-effective interventions that address the leading killers of children under the age of five.
- Canada will also commit an additional Can\$540 million over three years to the Global Fund to Fight AIDS, Tuberculosis and Malaria. This is in addition to a total of Can\$978.4 million that Canada has committed and disbursed to the Global Fund since 2002.





The data presented in this donor profile have been collated from publicly available sources.

Canada

Foreign Affairs, Trade and Development Canada, 125 Sussex Drive, Ottawa, ON, K1A 0G2
Canada

<http://www.international.gc.ca/>

Type of donor

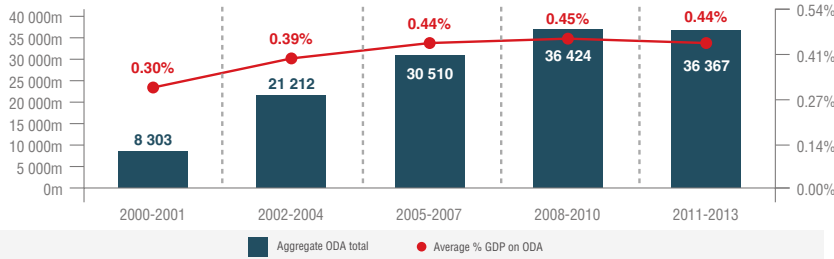
- >  Primary Source of funds?
- >  Financial intermediary?
- >  Member of DAC?
- >  Reports available on CRS?

- OECD Total flows by donor (ODA+OOF+Private) [DAC1]: ODA total, resources through intermediaries (codes I.A and I.B)
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- Arregoces et al, Countdown to 2015: changes in official development assistance to reproductive, maternal, newborn, and child health, and assessment of progress between 2003 and 2012; The Lancet Global Health [http://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X\(15\)00057-1.pdf](http://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X(15)00057-1.pdf); RMNCH expenditure
- International Aid Transparency Index 2013 and 2014: Transparency
- Every Woman Every Child commitments database (<http://www.everywomaneverychild.org/commitments/all-commitments>): Major pledges



Resource Commitments

Total ODA 2000-2013 (US\$ millions)

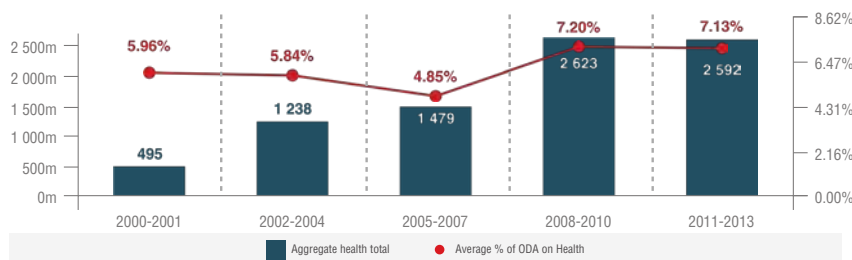


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Total health expenditure 2000-2013 (US\$ millions)

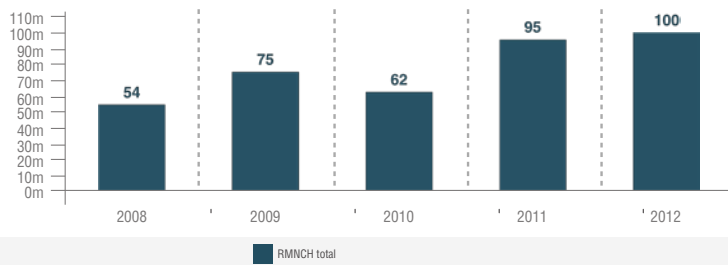


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Total RMNCH expenditure 2008-2012 (US\$ millions)

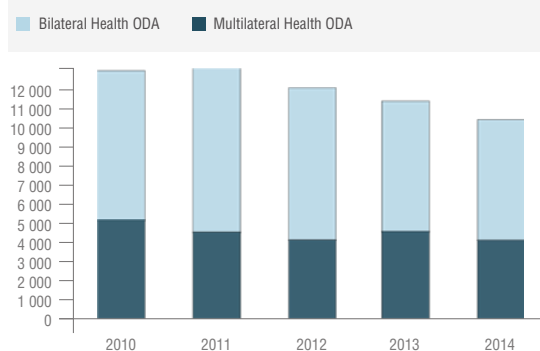


The bar chart shows RMNCH figures.

NB: Where no bar is shown, no data was available for this indicator.

Resources through financial intermediaries

Bilateral and Multilateral ODA to Health (US\$ millions)



Transparency

44/68 on the Aid Transparency Index 2014 from the year 2013

Major Pledges

- In 2011, France pledged to spend an additional €100m on family planning within the context of reproductive health through to 2015, in nine countries in francophone Africa.
- France announced €500 million commitment for the period 2011-2015 to support the Muskoka initiative.
- France announced an increase by 20% of its contribution to the Global Fund to fight AIDS, TB and Malaria over the period 2011-2013 (€1.080 billion).
- In addition, France increased its contribution to the GAVI Alliance for the period 2011-2015 by €100 million, 100% of which directly supports MDGs 4 and 5.

France

The Ministry of Foreign Affairs (Paris) 37, Quai d'Orsay
F - 75351 PARIS

www.diplomatie.gouv.fr/en/

Type of donor

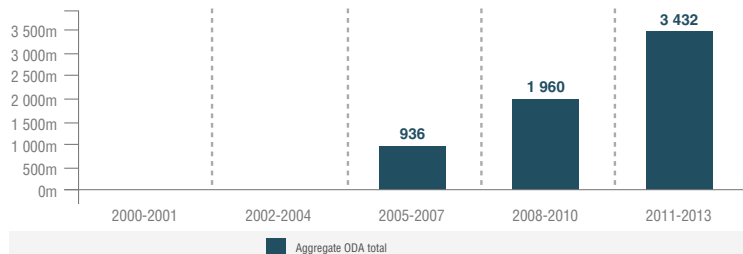
- > Primary Source of funds?
- > Financial intermediary?
- > Member of DAC?
- > Reports available on CRS?

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- OECD Aid (ODA) by sector and donor [DAC5]: Health ODA total. Note that these figures are an aggregate of figures for sector codes I.2, I.3 and I.4
- Arregoces et al. Countdown to 2015: changes in official development assistance to reproductive, maternal, newborn, and child health, and assessment of progress between 2003 and 2012; The Lancet Global Health [http://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X\(15\)00057-1.pdf](http://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X(15)00057-1.pdf); RMNCH expenditure
- International Aid Transparency Index 2013 and 2014: Transparency
- Every Woman Every Child commitments database (<http://www.everywomaneverychild.org/commitments/all-commitments>): Major pledges

Resource Commitments

Total ODA 2000-2013 (US\$ millions)

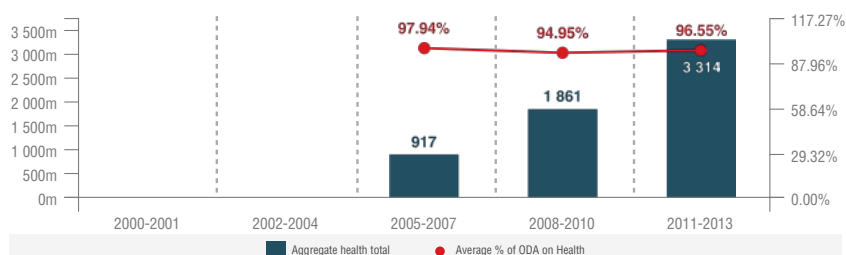


No Data 2011-13

The bar chart shows aggregate ODA figures. Note that figures are presented in groups of three years, except for the first bar which shows only two years.

% of GDP spent on ODA NB: Where no bar is shown, no data was available for this indicator.

Total health expenditure 2000-2013 (US\$ millions)



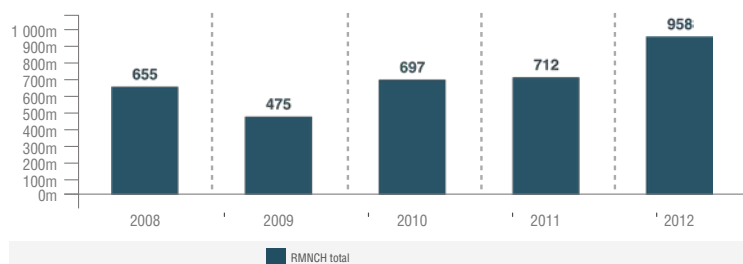
97% 2011-13

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% of ODA spent on health The line chart shows % of ODA spent on health as an average across the years shown. The pie chart highlights latest performance (2011-13).

NB: Where no bar is shown, no data was available for this indicator.

Total RMNCH expenditure 2008-2012 (US\$ millions)



The bar chart shows RMNCH figures.

NB: Where no bar is shown, no data was available for this indicator.

Resources through financial intermediaries

Bilateral and Multilateral ODA to Health (US\$ millions)

This chart is not relevant for this agency

Transparency

 **4/68**

on the Aid Transparency Index 2014
 from the year 2013

Major Pledges

- By 2015, over 700 million children will be immunised through campaigns and routine immunisation with combined measles-rubella vaccine.
- Rubella vaccines alone will avert an estimated 140,000 deaths and will protect hundreds of thousands of babies against severe birth defects from congenital rubella syndrome, and help to prevent stillbirths and miscarriages caused by rubella infection.
- Since the initial GAVI commitment in September 2010, an additional US\$4.3 billion were committed to support GAVI's new vaccines and health systems strengthening programs in furtherance of the goals articulated in Every Woman Every Child.
- Through the power of innovation—vaccines, public-private partnership and financing mechanisms—GAVI will help the UN address leading childhood killers, pneumonia and diarrhoea, by increasing access to life-saving vaccines for children.

The data presented in this donor profile have been collated from publicly available sources.





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- International Aid Transparency Index 2013 and 2014: Transparency
- Every Woman Every Child commitments database (<http://www.everywomaneverychild.org/commitments/all-commitments>): Major pledges

GAVI Alliance

2 Chemin des Mines, 1202 Geneva
 Switzerland

<http://www.gavi.org/>

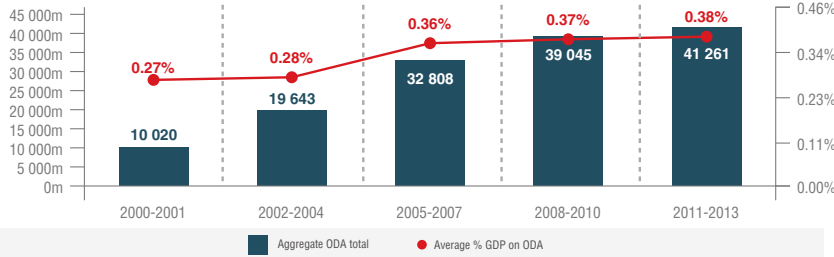
Type of donor

- >  Primary Source of funds?
- >  Financial intermediary?
- >  Member of DAC?
- >  Reports available on CRS?



Resource Commitments

Total ODA 2000-2013 (US\$ millions)

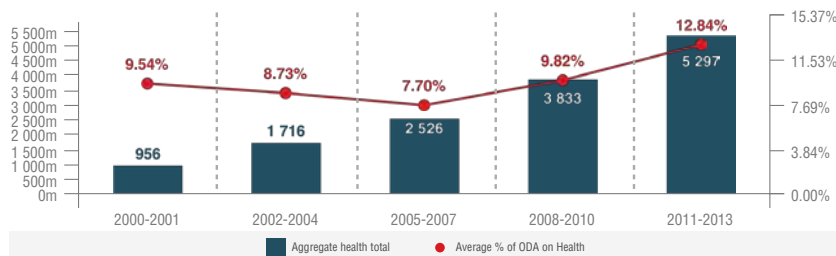


The bar chart shows aggregate ODA figures. Note that figures are presented in groups of three years, except for the first bar which shows only two years.

The line chart shows % of GDP spent on ODA as an average across the years shown. The pie chart highlights latest performance (2011-13).

NB: Where no bar is shown, no data was available for this indicator.

Total health expenditure 2000-2013 (US\$ millions)

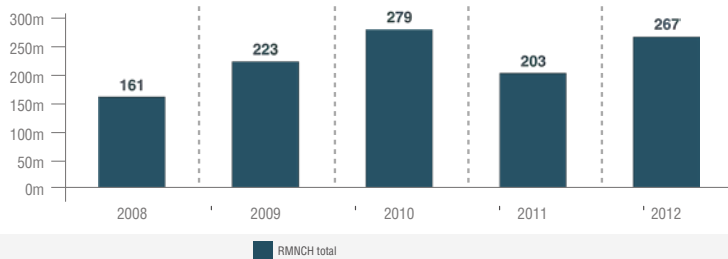


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NB: Where no bar is shown, no data was available for this indicator.

Total RMNCH expenditure 2008-2012 (US\$ millions)

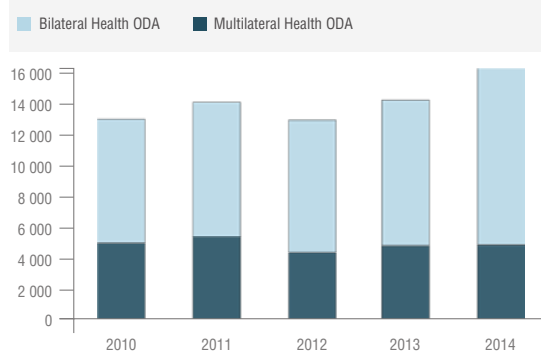


The bar chart shows RMNCH figures.

NB: Where no bar is shown, no data was available for this indicator.

Resources through financial intermediaries

Bilateral and Multilateral ODA to Health (US\$ millions)



Transparency

17/68 on the Aid Transparency Index 2014
 (up arrow) from the year 2013

Major Pledges

- At the London Family Planning Summit, Germany pledged €400 million to reproductive health and family planning over four years, of which 25% was likely to be dedicated to family planning, depending on partner countries' priorities.
- Germany is developing the Voluntary Family Planning initiative as part of Germany's ongoing annual commitment in the area of mother and child health of €300 million per year.
- Read more at: <http://www.everywomaneverychild.org/commitments/all-commitments/germany#sthash.zR2tjXV.dpuf>

Germany

Federal Ministry for Economic Cooperation and Development, Postfach 12 03 22
 53045 Bonn, Germany
<https://www.bmz.de/en/>

Type of donor

- > ✓ Primary Source of funds?
- > ✗ Financial intermediary?
- > ✓ Member of DAC?
- > ✓ Reports available on CRS?

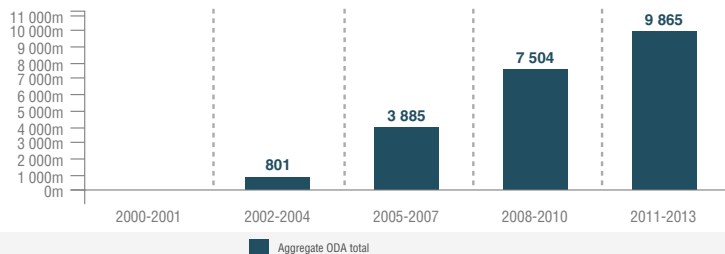
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- Arregoces et al, Countdown to 2015: changes in official development assistance to reproductive, maternal, newborn, and child health, and assessment of progress between 2003 and 2012; The Lancet Global Health [http://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X\(15\)00057-1.pdf](http://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X(15)00057-1.pdf); RMNCH expenditure
- International Aid Transparency Index 2013 and 2014: Transparency
- Every Woman Every Child commitments database (<http://www.everywomaneverychild.org/commitments/all-commitments/>): Major pledges



Resource Commitments

Total ODA 2000-2013 (US\$ millions)

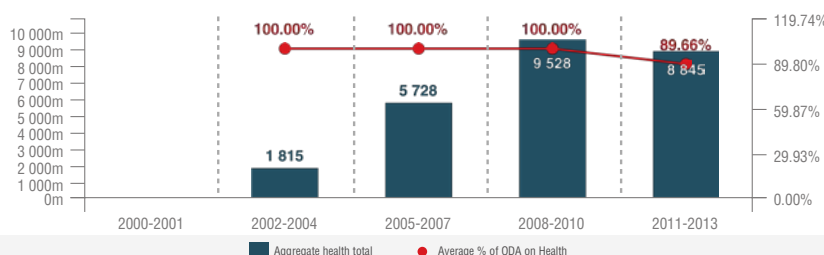


No Data 2011-13

The bar chart shows aggregate ODA figures. Note that figures are presented in groups of three years, except for the first bar which shows only two years.

% of GDP spent on ODA NB: Where no bar is shown, no data was available for this indicator.

Total health expenditure 2000-2013 (US\$ millions)



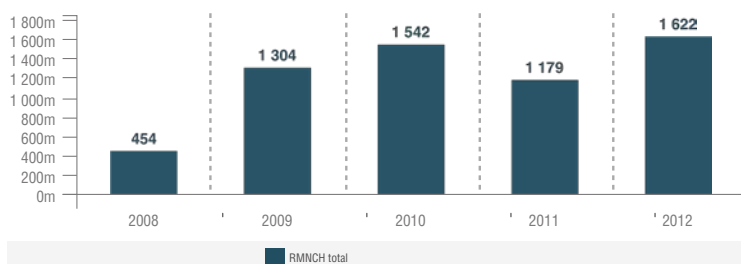
90% 2011-13

The bar chart shows aggregate health expenditure figures. Note that figures are presented in groups of three years, except for the first bar which shows only two years.

% of ODA spent on health The line chart shows % of ODA spent on health as an average across the years shown. The pie chart highlights latest performance (2011-13).

NB: Where no bar is shown, no data was available for this indicator.

Total RMNCH expenditure 2008-2012 (US\$ millions)



The bar chart shows RMNCH figures.

NB: Where no bar is shown, no data was available for this indicator.

Resources through financial intermediaries

Bilateral and Multilateral ODA to Health (US\$ millions)

This chart is not relevant for this agency

Transparency

10/68 on the Aid Transparency Index 2014
 from the year 2013

Major Pledges

- The Global Fund is contributing to improving the health of women and children through supporting a range of high-impact HIV, TB and malaria interventions across the continuum of pre-pregnancy, pregnancy, birth and child care.
- The Global Fund is also working with partners to facilitate new and innovative financing to close specific funding gaps in interventions benefitting women and children.
- In 2012, The Global Fund estimated that the disbursements on 12 high-impact interventions that benefit women and children constitute 30% of total disbursements. Another 12% of the total disbursements contribute to MDGs 4 and 5.
- The Global Fund is facilitating new and innovative financing schemes in partnership with national governments in implementing countries, bilateral partners and multilateral partners, to close specific funding gaps in interventions benefitting women and children.

The data presented in this donor profile have been collated from publicly available sources.

Global Fund

The Global Fund to Fight AIDS, Tuberculosis and Malaria
 Geneva Secretariat, Chemin de Blandonnet 8, 1214 Vernier, Geneva, Switzerland
<http://www.theglobalfund.org/>

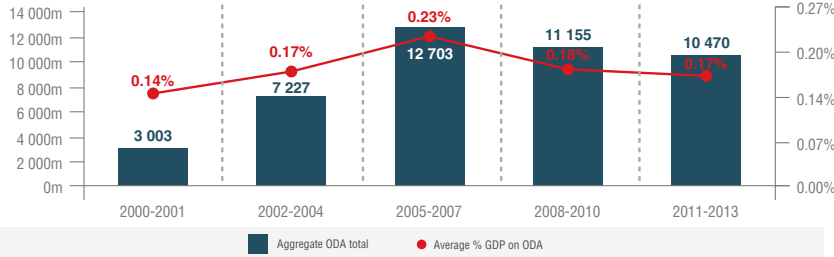
Type of donor

- > Primary Source of funds?
- > Financial intermediary?
- > Member of DAC?
- > Reports available on CRS?

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Resource Commitments

Total ODA 2000-2013 (US\$ millions)



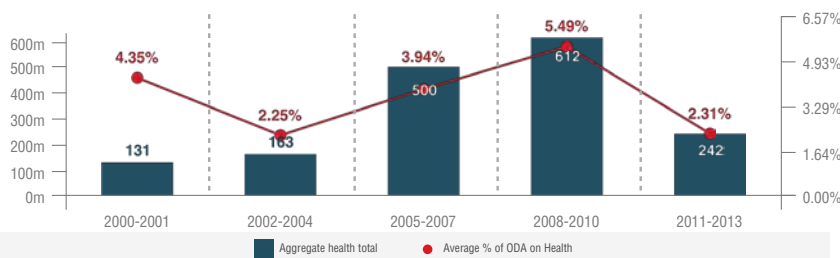
% of GDP spent on ODA

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The line chart shows % of GDP spent on ODA as an average across the years shown. The pie chart highlights latest performance (2011-13).

NB: Where no bar is shown, no data was available for this indicator.

Total health expenditure 2000-2013 (US\$ millions)



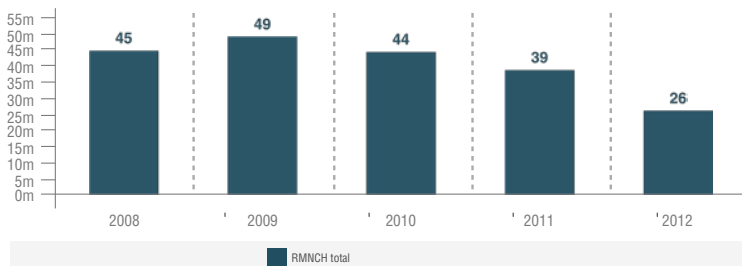
% of ODA spent on health

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The line chart shows % of ODA spent on health as an average across the years shown. The pie chart highlights latest performance (2011-13).

NB: Where no bar is shown, no data was available for this indicator.

Total RMNCH expenditure 2008-2012 (US\$ millions)

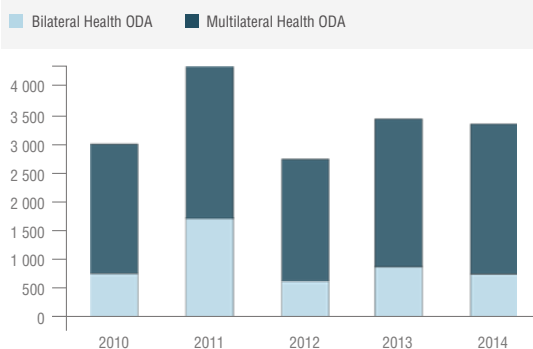


The bar chart shows RMNCH figures.

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Resources through financial intermediaries

Bilateral and Multilateral ODA to Health (US\$ millions)



Transparency

 **54/68**

on the Aid Transparency Index 2014
 from the year 2013

Major Pledges





No commitments have been publicly made. See: <http://www.everywomaneverychild.org/commitments/all-commitments>

Italy

Ministry of Foreign Affairs, and International Cooperation, Piazzale della Farnesina, 100 00135 Rome

<http://www.esteri.it/mae/en/>

Type of donor

- >  Primary Source of funds?
- >  Financial intermediary?
- >  Member of DAC?
- >  Reports available on CRS?

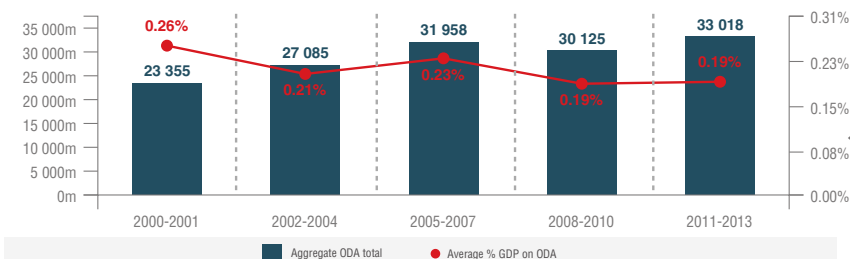
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- International Aid Transparency Index 2013 and 2014: Transparency
- Every Woman Every Child commitments database (<http://www.everywomaneverychild.org/commitments/all-commitments>): Major pledges



Resource Commitments

Total ODA 2000-2013 (US\$ millions)



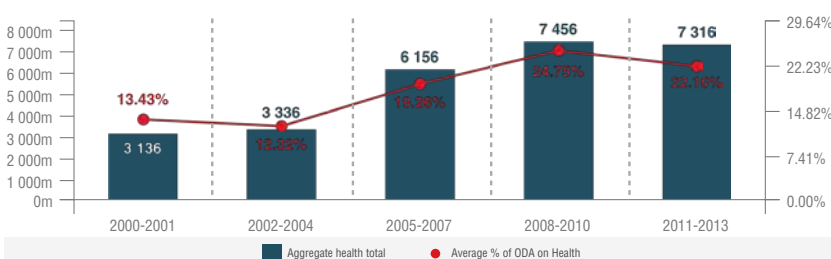
% of GDP spent on ODA

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The line chart shows % of GDP spent on ODA as an average across the years shown. The pie chart highlights latest performance (2011-13).

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Total health expenditure 2000-2013 (US\$ millions)



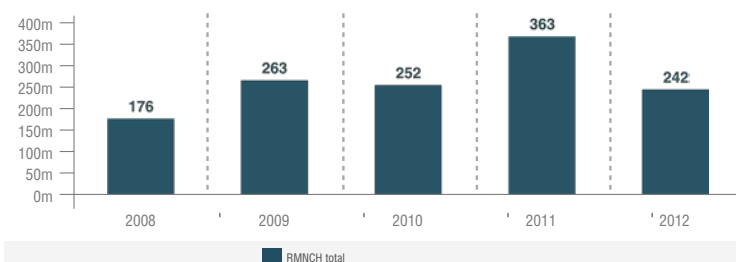
% of ODA spent on health

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Total RMNCH expenditure 2008-2012 (US\$ millions)

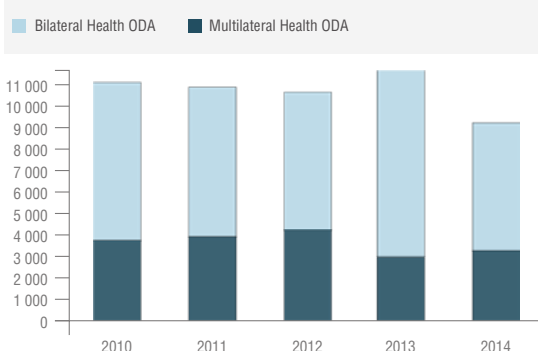


The bar chart shows RMNCH figures.

NB: Where no bar is shown, no data was available for this indicator.

Resources through financial intermediaries

Bilateral and Multilateral ODA to Health (US\$ millions)



Transparency



on the Aid Transparency Index 2014
▲ from the year 2013

Major Pledges

1. Japan gave more than US\$ 570 million (2000-12) toward assistance in family planning. At the London Family Planning Summit, Japan announced it would continue that commitment by funding US\$ 5 billion over five years.
2. JICA will contribute to achieving the goals expressed in Japan's Global Health Policy 2011-2015, which commits to saving approximately 11.3 million children's lives and 430,000 maternal lives in cooperation with other donors.
3. Every year, JICA implements technical cooperation and grant aid projects for MNCH at the level of 3 billion and 3-16 billion Japanese yen respectively.
4. Japan's Global Health Policy supports the Global Strategy by implementing the "EMBRACE" project, which ensures the continuum of care from pregnancy to post natal stage.

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- International Aid Transparency Index 2013 and 2014: Transparency
- Every Woman Every Child commitments database (<http://www.everywomaneverychild.org/commitments/all-commitments>): Major pledges

Japan

Nibancho Center Building 5-25,, Niban-cho, Chiyoda-ku Tokyo 102-8012

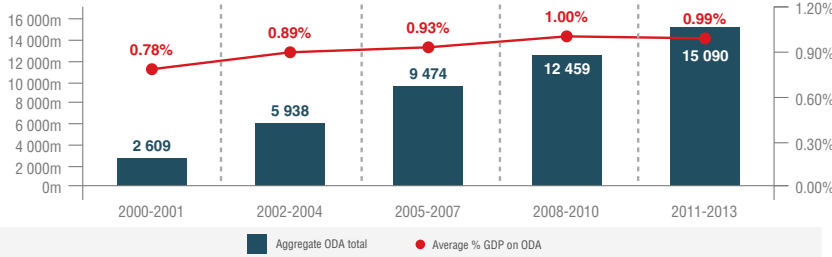
<http://www.jica.go.jp/english/index.html>

Type of donor

- > Primary Source of funds?
- > Financial intermediary?
- > Member of DAC?
- > Reports available on CRS?

Resource Commitments

Total ODA 2000-2013 (US\$ millions)

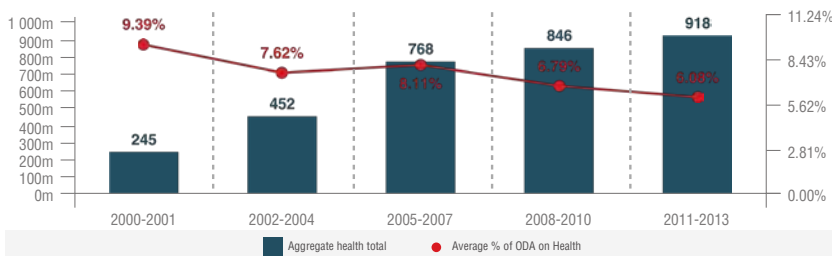


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The line chart shows % of GDP spent on ODA as an average across the years shown. The pie chart highlights latest performance (2011-13).

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Total health expenditure 2000-2013 (US\$ millions)

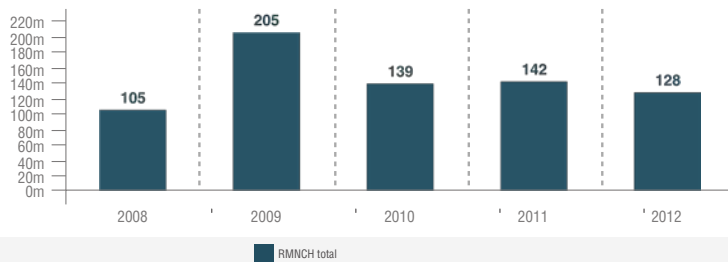


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Total RMNCH expenditure 2008-2012 (US\$ millions)

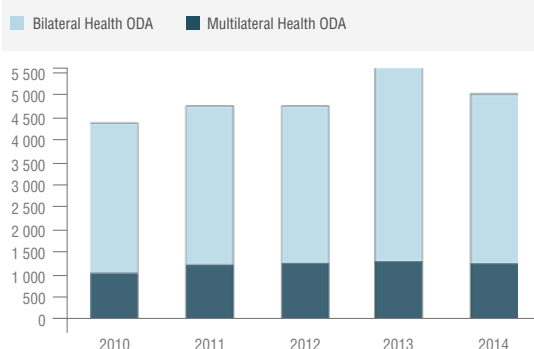


The bar chart shows RMNCH figures.

NB: Where no bar is shown, no data was available for this indicator.

Resources through financial intermediaries

Bilateral and Multilateral ODA to Health (US\$ millions)



Transparency

 **42/68** on the Aid Transparency Index 2014  from the year 2013

Major Pledges

- Norway committed to doubling its annual contribution to GAVI between 2010-2015, from NOK 500 million in 2010 to NOK 1000 million in 2015. This amounts to an increase of NOK 100 million in 2012.
- At the London Family Planning Summit, Norway committed to more than double support over eight years for family planning and to provide an additional US\$ 200 million over the period 2013-2020.
- Norway committed up to NOK 500 million (approx. US\$ 80 million) over five years to the Saving Mothers, Giving Life partnership.
- continuum of care from pregnancy to post natal stage.

The data presented in this donor profile have been collated from publicly available sources.

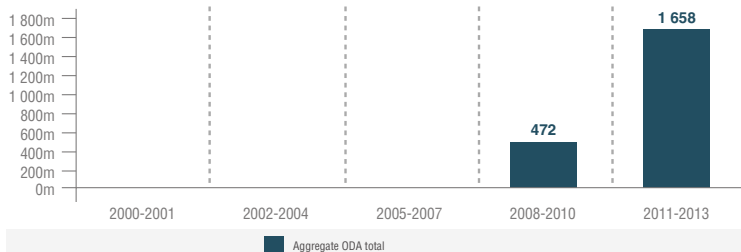
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- International Aid Transparency Index 2013 and 2014: Transparency
- Every Woman Every Child commitments database (<http://www.everywomaneverychild.org/commitments/all-commitments>): Major pledges

Norway
 Pb 8034 Dep. 0030 Oslo
 Norway
<http://www.norad.no/en/front/>
Type of donor
 >  Primary Source of funds?
 >  Financial intermediary?
 >  Member of DAC?
 >  Reports available on CRS?



Resource Commitments

Total ODA 2000-2013 (US\$ millions)



% of GDP spent on ODA

The bar chart shows aggregate ODA figures. Note that figures are presented in groups of three years, except for the first bar which shows only two years.

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Total health expenditure 2000-2013 (US\$ millions)

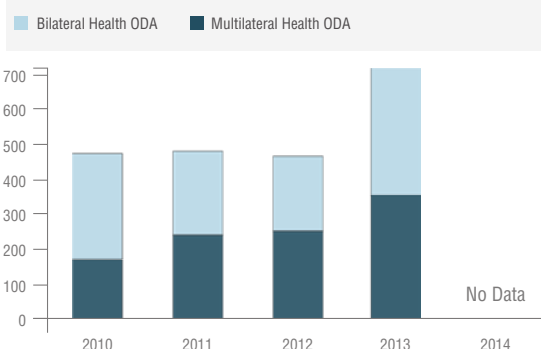
No health expenditure data available

Total RMNCH expenditure 2008-2012 (US\$ millions)

No RMNCH expenditure data available

Resources through financial intermediaries

Bilateral and Multilateral ODA to Health (US\$ millions)



Transparency



on the Aid Transparency Index 2014 from the year 2013

Major Pledges

No commitments have been publicly made: <http://www.everywomaneverychild.org/commitments/all-commitments>

Russian Federation
 32/34 Smolenskaya-Sennaya pl.
 119200, Moscow G-200
http://www.mid.ru/brp_4.nsf/main_eng

- Type of donor
- > Primary Source of funds?
 - > Financial intermediary?
 - > Member of DAC?
 - > Reports available on CRS?

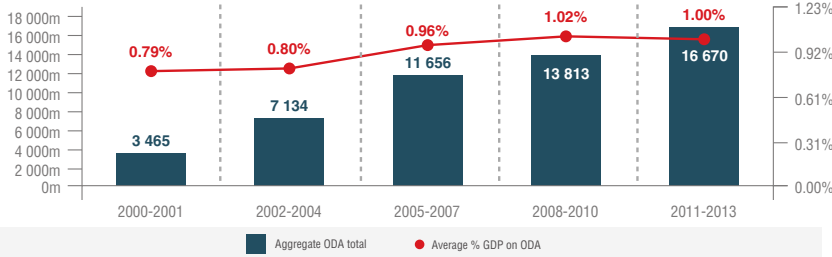
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Resource Commitments

Total ODA 2000-2013 (US\$ millions)

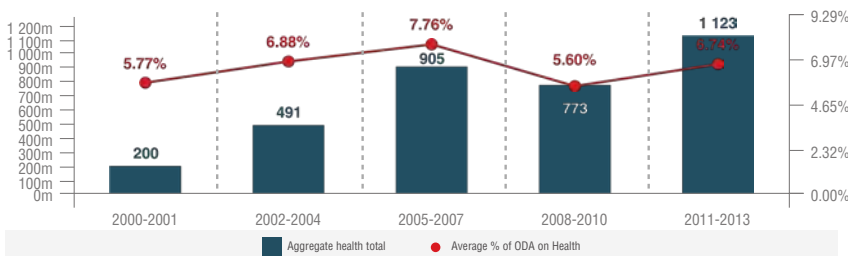


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Total health expenditure 2000-2013 (US\$ millions)

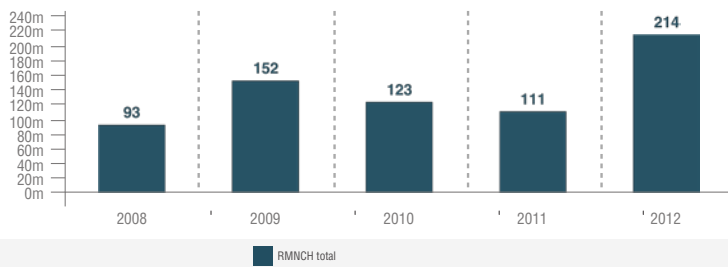


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Total RMNCH expenditure 2008-2012 (US\$ millions)

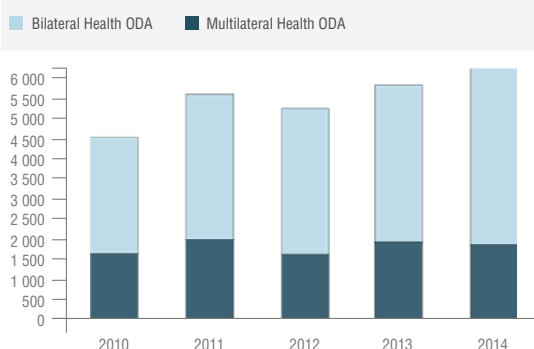


The bar chart shows RMNCH figures.

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Resources through financial intermediaries

Bilateral and Multilateral ODA to Health (US\$ millions)



Transparency



on the Aid Transparency Index 2014
 ▲ from the year 2013

Major Pledges

- Sweden will increase spending on contraceptives from its 2010 level of US\$ 32 million per year to US \$40 million per year, totalling an additional US \$40 million between 2011 and 2015.
- Sweden's commitment to Women's and Children's health is clearly reflected in Sweden's policy for global development, in its policy on Sexual and Reproductive Health and Rights (SRHR) and its policy for Gender Equality and the Rights and Role of Women.
- Globally, Sweden supports the UN system, global initiatives and civil society. To further strengthen the commitment, a special effort on MDG5 has been developed, to raise awareness and build capacity to improve maternal health.
- Sweden also endorses the G8 Muskoka Initiative, and has made a substantial allocation in the budget bill proposed to parliament for 2011 to further strengthen work to improve child health.

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- International Aid Transparency Index 2013 and 2014: Transparency
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Sweden

Valhallavägen 199, 105 25 Stockholm
 SE - SWEDEN

<http://www.sida.se/English/>

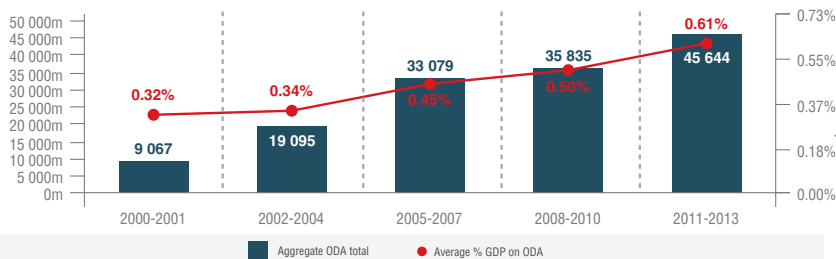
Type of donor

- > Primary Source of funds?
- > Financial intermediary?
- > Member of DAC?
- > Reports available on CRS?



Resource Commitments

Total ODA 2000-2013 (US\$ millions)

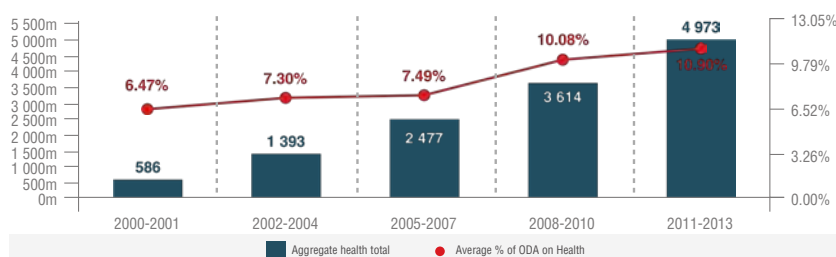


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Total health expenditure 2000-2013 (US\$ millions)

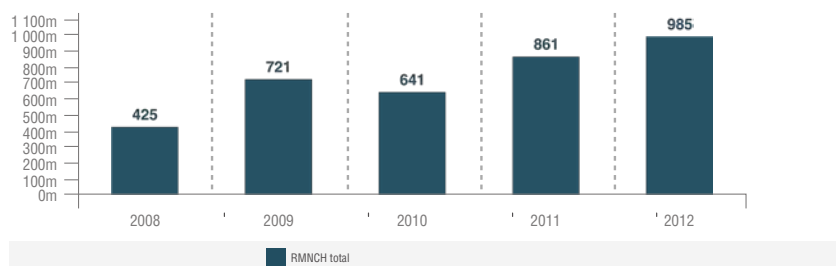


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Total RMNCH expenditure 2008-2012 (US\$ millions)

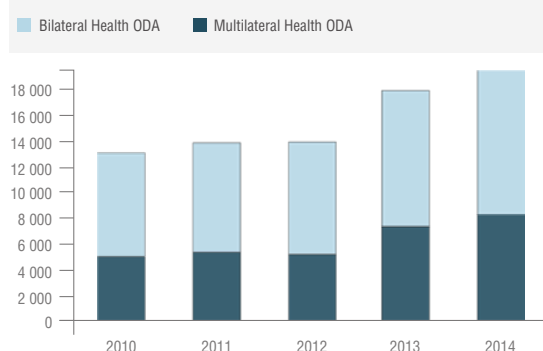


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Resources through financial intermediaries

Bilateral and Multilateral ODA to Health (US\$ millions)



Transparency



on the Aid Transparency Index 2014
 ▲ from the year 2013

Major Pledges

- The UK has set out clear plans to help improve the health of women and young children in many of the poorest countries pledging to help save the lives of at least 250,000 newborn babies and 50,000 women during pregnancy and childbirth by 2015.
- The UK is committing £516 million (US\$ 800 million) over eight years towards the goal of enabling an additional 120 million women and girls in the world's poorest countries to be using modern methods of family planning by 2020.
- The UK has committed to double efforts on family planning, increasing investments from £90 million per year (average spending over 2010/11 and 2011/12) to £180 million per year over the eight years from 2012/13 to 2019/20.
- Between now and 2020, UK support to the Family Planning Summit Goal will enable an additional 24 million girls and women in the world's poorest countries, who wish to avoid an unintended pregnancy, to use voluntary family planning information, services and supplies.

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- Every Woman Every Child commitments database (<http://www.everywomaneverychild.org/commitments/all-commitments>): Major pledges

United Kingdom

22 Whitehall
 London, SW1A 2EG
<https://www.gov.uk/government/organisations/department-for-international-development>

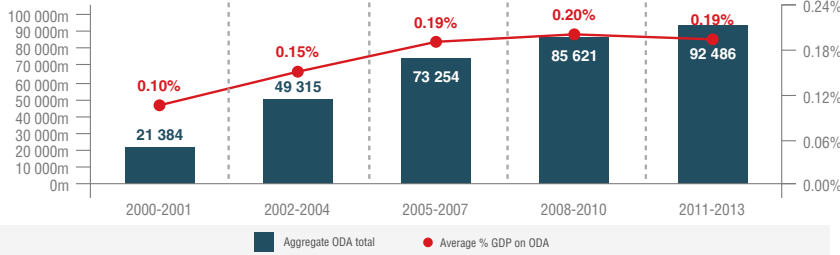
Type of donor

- > Primary Source of funds?
- > Financial intermediary?
- > Member of DAC?
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Resource Commitments

Total ODA 2000-2013 (US\$ millions)

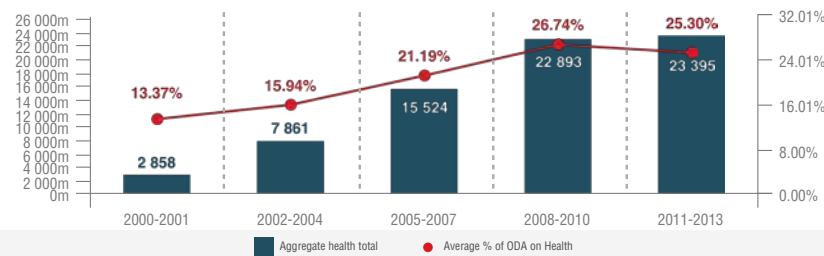


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Total health expenditure 2000-2013 (US\$ millions)

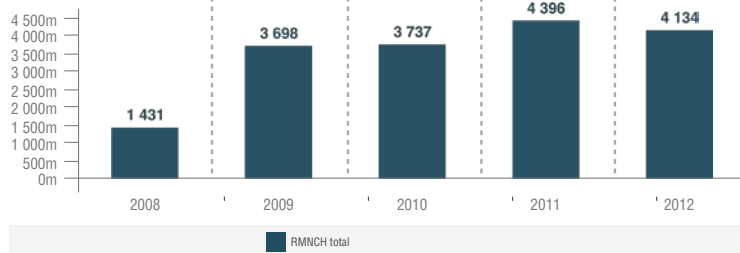


The bar chart shows aggregate health expenditure figures. Note that figures are presented in groups of three years, except for the first bar which shows only two years.

The line chart shows % of ODA spent on health as an average across the years shown. The pie chart highlights latest performance (2011-13).

NB: Where no bar is shown, no data was available for this indicator.

Total RMNCH expenditure 2008-2012 (US\$ millions)

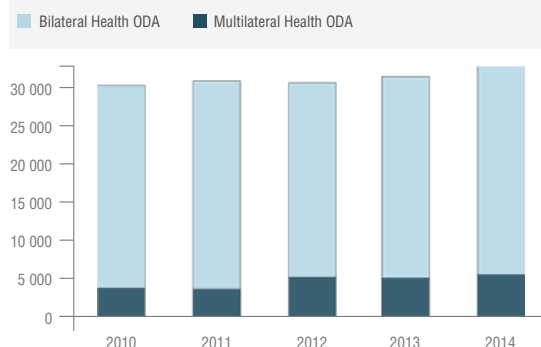


The bar chart shows RMNCH figures.

NB: Where no bar is shown, no data was available for this indicator.

Resources through financial intermediaries

Bilateral and Multilateral ODA to Health (US\$ millions)



Transparency

30/68 on the Aid Transparency Index 2014
 ▲ from the year 2013

Major Pledges

- In 24 priority countries USAID will strengthen community-based approaches and increase coverage of skilled birth attendance, intensify efforts to improve quality of care, and support a comprehensive approach to prevention of mother-to-child transmission (PMTCT).
- USAID will promote zero tolerance for preventable maternal and newborn deaths by changing social norms and expectations; equipping families to practice optimal newborn practices; increasing demand for quality care; and strengthening the links between community and health facilities.
- The Global Health Initiative (GHI) sets out ambitious targets to: reduce maternal mortality by 30% across assisted countries; reduce mortality rates for children under 5 by 35% across assisted countries.
- The GHI also sets targets to reduce child under-nutrition by 30% across assisted food insecure countries; double the number of at-risk babies born HIV-free; and reach a modern contraceptive prevalence rate of 35% across assisted countries.

The data presented in this donor profile have been collated from publicly available sources.

- OECD Total flows by donor (ODA+OOF+Private) [DAC1]: ODA total, resources through intermediaries (codes I.A and I.B)
- OECD Aid (ODA) by sector and donor [DAC5]: Health ODA total. Note that these figures are an aggregate of figures for sector codes I.2, I.3 and I.4
- Arregoces et al, Countdown to 2015: changes in official development assistance to reproductive, maternal, newborn, and child health, and assessment of progress between 2003 and 2012; The Lancet Global Health [http://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X\(15\)00057-1.pdf](http://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X(15)00057-1.pdf); RMNCH expenditure
- International Aid Transparency Index 2013 and 2014: Transparency
- Every Woman Every Child commitments database (<http://www.everywomaneverychild.org/commitments/all-commitments>): Major pledges

United States

Ronald Reagan Building
 Washington, DC 20523-1000
<http://www.usaid.gov/>

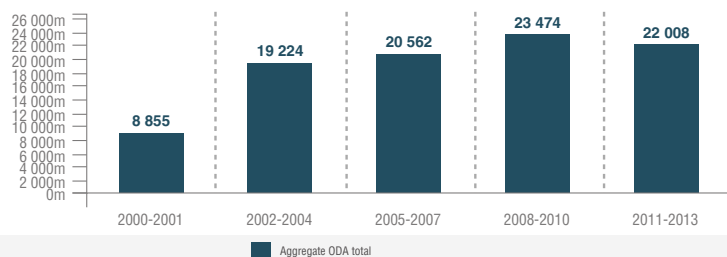
Type of donor

- > Primary Source of funds?
- > Financial intermediary?
- > Member of DAC?
- > Reports available on CRS?



Resource Commitments

Total ODA 2000-2013 (US\$ millions)

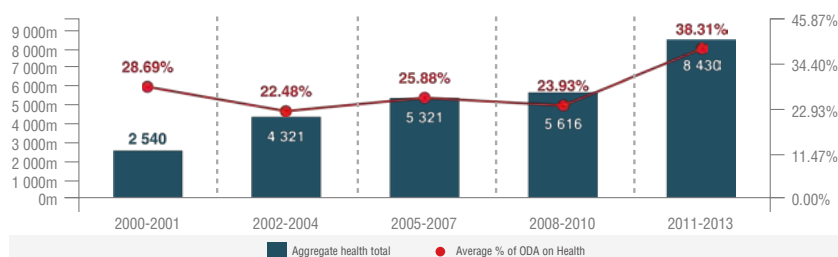


% of GDP spent on ODA

The bar chart shows aggregate ODA figures. Note that figures are presented in groups of three years, except for the first bar which shows only two years.

NB: Where no bar is shown, no data was available for this indicator.

Total health expenditure 2000-2013 (US\$ millions)



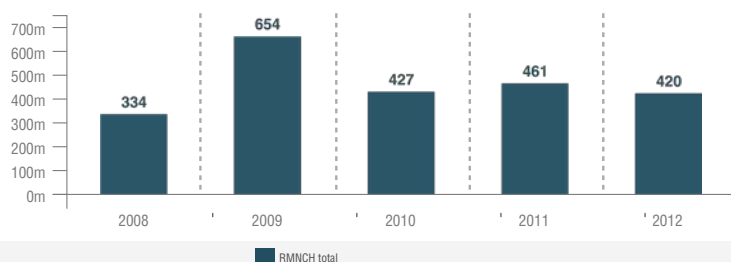
% of ODA spent on health

The bar chart shows aggregate health expenditure figures. Note that figures are presented in groups of three years, except for the first bar which shows only two years.

The line chart shows % of ODA spent on health as an average across the years shown. The pie chart highlights latest performance (2011-13).

NB: Where no bar is shown, no data was available for this indicator.

Total RMNCH expenditure 2008-2012 (US\$ millions)



The bar chart shows RMNCH figures.

NB: Where no bar is shown, no data was available for this indicator.

Resources through financial intermediaries

Bilateral and Multilateral ODA to Health (US\$ millions)

This chart is not relevant for this agency

Transparency



on the Aid Transparency Index 2014
 ✓ from the year 2013

Major Pledges

- The World Bank pledged at least US\$ 700 million in financing through the end of 2015 to help developing countries reach the Millennium Development Goals (MDGs) for women's and children's health.
- This is on top of the September 2010 World Bank pledge to provide US\$ 600 million in IDA results-based financing for MDGs 4 and 5 which has contributed to declines in maternal and child mortality.
- The World Bank supports family planning and reproductive health through its five-year Reproductive Health Action Plan.
- The World Bank will focus on women's and children's health in 35 countries. This will expand the reach of the World Bank's results-based programs by more than US\$ 600 million.

The data presented in this donor profile have been collated from publicly available sources.

- OECD Total flows by donor (ODA+OOF+Private) [DAC1]: ODA total, resources through intermediaries (codes I.A and I.B)
- OECD Aid (ODA) by sector and donor [DAC5]: Health ODA total. Note that these figures are an aggregate of figures for sector codes I.2, I.3 and I.4
- Arregoces et al, Countdown to 2015: changes in official development assistance to reproductive, maternal, newborn, and child health, and assessment of progress between 2003 and 2012; The Lancet Global Health [http://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X\(15\)00057-1.pdf](http://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X(15)00057-1.pdf); RMNCH expenditure
- International Aid Transparency Index 2013 and 2014: Transparency
- Every Woman Every Child commitments database (<http://www.everywomaneverychild.org/commitments/all-commitments>): Major pledges

World Bank

1818 H Street, NW
 USA, Washington, DC 20433
<http://www.worldbank.org/>

Type of donor

- > Primary Source of funds?
- > Financial intermediary?
- > Member of DAC?
- > Reports available on CRS?



ANNEXES

ANNEX 1. TERMS OF REFERENCE OF THE iERG AND ITS COUNTRIES OF CONCERN

The UN Commission on Information and Accountability for Women's and Children's Health was established by WHO at the request of the United Nations Secretary-General to accelerate progress on the Global Strategy for Women's and Children's Health. The Commission was chaired by H.E. Jakaya Kikwete, President of the United Republic of Tanzania and Rt. Hon. Stephen Harper, Prime Minister of Canada, with the Director-General of WHO and the Secretary-General of ITU as vice-chairs. The Final Report of the Commission proposed an accountability framework and ten recommendations. The full Report is available online at www.everywomaneverychild.org/accountability_commission. On the issue of global reporting, the Commission proposed a time-limited independent Expert Review Group be established and operate until 2015:

"Global oversight: Starting in 2012 and ending in 2015, an independent Expert Review Group is reporting regularly to the United Nations Secretary-General on the results and resources related to the Global Strategy and on progress in implementing this Commission's recommendations."

In response to Recommendation 10 (Global oversight), starting in 2012 and ending in 2015, the independent Expert Review Group (iERG) will serve as the principal global review group and report to the UN Secretary-General, through WHO Director-General.

The independent ERG will:

- assess the extent to which all stakeholders honour their commitments to the Global Strategy and the Commission; including the US\$ 40 billion of commitments made in September, 2010;
- review progress in implementation of the recommendations of the Commission;
- assess progress towards greater transparency in the flow of resources and achieving results;
- identify obstacles to implementing both the Global Strategy and the Commission's recommendations;
- identify good practice, including in policy and service delivery, accountability arrangements and value-for-money approaches relating to the health of women and children;
- make recommendations to improve the effectiveness of the accountability framework developed by the Commission.

Countries

The global oversight covers 75 low and middle income countries with 98% of the world's maternal and child mortality. As stated in the Strategic Workplan, these include 49 countries in the UN Global Strategy and 26 additional countries in the Countdown to 2015 (marked with *). The countries are grouped according to WHO regional classification.

African Region (AFRO)

Angola*, Benin, Botswana*, Burkina Faso, Burundi, Cameroon*, Central African Republic, Chad, Comoros, Congo*, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea*, Eritrea, Ethiopia, Gabon*, The Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho*, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Africa*, South Sudan*, Swaziland*, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe

Pan American Health Organization (PAHO)

Bolivia (Plurinational State of)*, Brazil*, Guatemala*, Haiti, Mexico*, Peru*

Eastern Mediterranean Region (EMRO)

Afghanistan, Djibouti*, Egypt*, Iraq*, Morocco*, Pakistan, Somalia, Sudan*, Yemen

European Region (EURO)

Azerbaijan*, Kyrgyzstan, Tajikistan, Turkmenistan*, Uzbekistan

South-East Asia Region (SEARO)

Bangladesh, Democratic People's Republic of Korea, India*, Indonesia*, Myanmar, Nepal

Western Pacific Region (WPRO)

Cambodia, China*, Lao People's Democratic Republic, Papua New Guinea, Philippines*, Solomon Islands, Viet Nam

ANNEX 2: RECOMMENDATIONS OF THE COMMISSION ON INFORMATION AND ACCOUNTABILITY FOR WOMEN'S AND CHILDREN'S HEALTH

Better information for better results

- *Recommendation 1 – Vital events:* By 2015, all countries have taken significant steps to establish a system for registration of births, deaths, and causes of death and have well-functioning health information systems that combine data from facilities, administrative sources, and surveys.
- *Recommendation 2 – Health indicators:* By 2012, the same 11 indicators on reproductive, maternal, and child health, disaggregated for gender and other equity considerations, are being used for the purpose of monitoring progress towards the goals of the Global Strategy.
- *Recommendation 3 – Innovation:* By 2015, all countries have integrated the use of Information and Communication Technologies in their national health information systems and health infrastructure.

Better tracking of resources for women's and children's health

- *Recommendation 4 – Resource tracking:* By 2015, all 75 countries where 98% of maternal and child deaths take place are tracking and reporting, at a minimum, two aggregate resource indicators: (i) total health expenditure by financing source, per capita and (ii) total reproductive, maternal, newborn, and child health expenditure by financing source, per capita.
- *Recommendation 5 – Country compacts:* By 2012, in order to facilitate resource tracking, “compacts” between country governments and all major development partners are in place that require reporting, based on a format to be agreed in each country, on externally funded expenditures and predictable commitments.

- *Recommendation 6 – Reaching women and children:* By 2015, all governments have the capacity to regularly review health spending (including spending on reproductive, maternal, newborn, and child health) and to relate spending to commitments, human rights, gender, and other equity goals and results.

Better oversight of results and resources: nationally and globally

- *Recommendation 7 – National oversight:* By 2012, all countries have established national accountability mechanisms that are transparent, that are inclusive of all stakeholders, and that recommend remedial action, as required.
- *Recommendation 8 – Transparency:* By 2013, all stakeholders are publicly sharing information on commitments, resources provided, and results achieved annually at both national and international levels.
- *Recommendation 9 – Reporting aid for women's and children's health:* By 2012, development partners request the OECD-DAC to agree on how to improve the Creditor Reporting System so that it can capture, in a timely manner, all reproductive, maternal, newborn, and child health spending by development partners. In the interim, development partners and the OECD implement a simple method for reporting such expenditures.
- *Recommendation 10 – Global oversight:* Starting in 2012 and ending in 2015, an independent “Expert Review Group” is reporting regularly to the United Nations Secretary-General on the results and resources related to the Global Strategy and on progress in implementing this Commission's recommendations.

ANNEX 3: SOCIOECONOMIC, GENDER AND URBAN/ RURAL INEQUALITIES IN RMNCH INDICATORS IN 98 COUNTRIES

International Center for Equity in Health
Federal University of Pelotas, Brazil, April 2013

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Summary

This report includes four sets of analyses of inequalities in the health of mothers and children, based on survey data from 98 low- and middle-income countries. The main results are presented in the body of the report, and detailed results for all countries are provided as appendices.

Part 1 of the report describes the background and objectives of the analyses, and **Part 2** the data sources and methodology.

Part 3 reports on the breakdowns of 11 indicators of interest to the iERG according to wealth quintiles, sex of the child, and urban/rural residence. Seven indicators of intervention coverage were analysed: family planning needs satisfied; antenatal care; skilled birth attendance; postnatal care; exclusive breastfeeding; DPT3 vaccine; and pneumonia care-seeking. Except for breastfeeding, all other indicators showed clear pro-rich and pro-urban inequalities. Sex differences in coverage were virtually non-existent. Skilled attendance at birth and antenatal care were the most inequitable, and exclusive breastfeeding the most equitable, but at low levels in all wealth quintiles. DPT3 vaccine showed the best combination of high coverage and small inequalities. The magnitude of inequalities in coverage varied by region, with smaller gaps in CEE/CIS, Latin America & Caribbean, and the Middle East & North Africa, and wider gaps in South Asia and sub-Saharan Africa.

There were twice as many children per women in rural than in urban areas, and wealth-related gaps were also large. The largest inequalities in fertility were observed in sub-Saharan Africa.

Stunting and underfive mortality rates were about twice as high in the poorest quintile compared to the richest. Meanwhile, inequalities in neonatal mortality were less marked.

Important inequalities in stunting and underfive mortality were observed within all regions of the world.

In **Part 4**, all indicators are broken down into ten population subgroups according to place of residence

(urban or rural) and wealth quintiles (five groups). When results from all countries are averaged, skilled birth attendance coverage is higher, and fertility lower, in urban compared to rural areas within each wealth quintile. Stunting prevalence is similar in urban and rural children in any given quintile. Underfive mortality rates are also similar, except for in the richest quintile where urban children are less likely to die than rural children. Detailed analyses of the 10 countries of interest to the iERG confirm these general patterns, but also indicate that there may be substantial variations from country to country.

Part 5 shows analyses of the time trends in inequalities for these 10 countries. Inequalities increased for skilled birth attendance in Bangladesh and fertility in Rwanda. In all other analyses, inequalities were unchanged or reduced. Notably, absolute inequalities in underfive mortality fell in all 10 countries, including Kenya where the reduction was small. As mentioned earlier, reductions in absolute inequalities (difference in U5MR between poor and rich) are not always accompanied by reductions in relative inequalities (ratio of U5MR between poor and rich). Of eight countries with data on stunting, inequalities fell in only two, Colombia and Egypt, and possibly in Senegal. Overall, the best performing countries were Colombia and Egypt, where inequalities fell for all four indicators under study, and the worst performers were Kenya and Nigeria.

Part 6 includes a ranking of countries with available data, according to the proportion of all underfive deaths that occur in the poorest quintile. This proportion is affected both by differential fertility and by differential mortality across the wealth quintiles. The leading countries were Brazil, Guatemala, Philippines, Turkey, Viet Nam, and Bolivia, whereas the most equitable countries were Kyrgyzstan, Zambia, Ukraine, Niger, and Chad.

Part 7 shows an analysis of family planning according to the woman's age, showing how adolescent women tend to have lower coverage levels in many countries, particularly adolescents aged under 18 years.

Part 1. Introduction and scope of work

The present analyses were commissioned by the iERG to the International Center for Equity in Health (ICEH) at the Federal University of Pelotas, Brazil.

Our objective is to document inequalities in child mortality and nutrition, fertility, and coverage of RMNCH interventions. We provide findings from the most recent surveys available for 98 countries from all regions of the world.

The following RMNCH indicators of interest to the iERG were studied:

1. Under-five child mortality rate (U5MR)
2. Neonatal mortality rate (NMR)
3. Children under five who are stunted (STUNTING)
4. Total fertility rate (TFR)
5. Family planning needs satisfied (FPS)
6. Antenatal care, 4+ visits with any provider (ANC)
7. Skilled attendant at birth (SBA)
8. Postnatal care for babies within 2 days of childbirth (PNC)
9. Exclusive breastfeeding among infants 0–5 months (EBF)

10. DTP3 vaccination among children 12–23 months (DPT3)
11. Careseeking for suspected pneumonia (CAREP)

Note: Maternal mortality and prevention of mother-to-child transmission of HIV are not available in the surveys included in these analyses.

These indicators were stratified according to:

- Wealth quintiles (based on household asset indices)
- Urban/rural residence
- Sex of the child
- Combinations of wealth quintiles and urban/rural residence

Analyses of time trends in inequalities were carried out for the following 10 countries: Bangladesh, Colombia, Egypt, Ghana, Kenya, Indonesia, Nigeria, Philippines, Rwanda, and Senegal.

Full definitions of the indicators used in the analyses are available in Appendix I.

Part 2. Methods

Our overall approach to the study of coverage inequalities was outlined in 2013 (Barros and Victora 2013). The primary data sources include the Demographic and Health Surveys (DHS) (<http://www.measuredhs.com/aboutsurveys/dhs/start.cfm>) and Multiple Indicator Cluster Surveys (MICS) (<http://www.childinfo.org/>), as well as a few other types of surveys. The analyses include the most recent survey for which the full datasets are in the public domain; the vast majority of surveys were carried out after 2005. The full list of countries, types of surveys, and their dates is available in Appendix II.

Mean values for each world region are presented for illustrative purposes but these should be interpreted with caution because (a) not every country is represented and (b) these means are not weighted by country population size. Also, we did not carry out significance tests for the differences among regions or among different indicators.

Mean global results are presented first, followed by results stratified by wealth, sex of the child, and area of residence (urban/rural). Last, results of the double stratification (wealth and residence) are provided.

Wealth quintiles are derived from asset indices (Filmer and Pritchett 1988; Rutstein and Johnson 2004; Barros and Victora 2013). These are based on presence of household possessions (radio, television, refrigerator, etc.) and characteristics of the house (building materials, toilet, electricity, etc.). These variables, available in surveys such as DHS and MICS, are subjected to principal component analysis, a data reduction technique that produces linear combinations of the variables, the components. The first component, or factor, is extracted in a way that retains as much variability as possible from all of the variables (Jolliffe 2002) from which a continuous score is derived. Each household is then assigned a score that can be broken down into quintiles or other equal-sized groups of households. By convention, Q1 refers to the poorest and Q5 to the wealthiest quintile. Children are then classified into these quintiles based on the wealth status of the household to which they belong. Because fertility is usually higher in the poorest households, the actual number of children for analyses tends to be higher in the poorer than in the richer quintiles. In DHS datasets, typically about 25% of the children belong to Q1 and 15% to Q5 (Victora and Barros, unpublished analyses).

Stratification by sex of the child was not carried out for total fertility rate, family planning needs satisfied, antenatal care, or skilled attendance at birth, because it was assumed that these would not be affected by the child's sex.

Urban or rural residence was defined on a country-by-country basis, according to the local census bureaus.

Mortality and fertility were estimated for DHS using the full birth histories recorded from each woman aged 15–49 years, using the standard methods described in the Guide to DHS Statistics (<http://goo.gl/9xhl4x>). These estimates are not available for MICS since they do not include a full birth history. In order to improve precision, mortality rates are based on all deaths that occurred in the 10 years before the survey; this is the standard DHS method of analysis, but it means that mortality levels tend to be higher than current rates in countries where mortality is declining.

In the Excel spreadsheets included in the appendices, results are blank (marked with N/A or not available) if a given survey did not provide information on a particular variable. For example, some Indonesian surveys did not include measurement of anthropometry, so information on stunting is missing. According to usual practice, we also omitted information when the denominator for coverage was below 50 women or children. For mortality and fertility, we omitted information when based on fewer than 250 births (or women). However, when calculating global averages (e.g., mortality by quintile) we used all the available information, even if the denominator for a particular category was small; this was done in order to avoid excluding a whole country from the analyses because of small numbers in one subgroup. Small sample sizes were particularly common in the analyses resulting from the double breakdown by wealth and residence, which produced estimates for 10 subgroups (2 places of residence times 5 quintiles).

Part 3. Results from cross-sectional analyses of the most recent surveys in 98 countries

This report contains results from surveys available by early 2015. Several national surveys are being carried out in 2014–15 for MDG endline assessments, but our analyses are restricted to those with publicly available datasets. We used UNICEF regions in this report.

Part 3 of the report is divided in three components: coverage indicators; fertility; and mortality and undernutrition.

Full results of the analyses of the 10 indicators in the 98 countries, broken down into 19 subgroups (2 quintiles; 2 sexes; 2 places of residence; and 10 combinations of quintiles and places of residence) are presented in Appendix II.

Not all variables are available for all countries. In particular, MICS do not allow calculation of mortality and fertility using full birth histories, so these results are not presented.

Next, we present 2 tables and 19 graphs, each followed by a few bullets summarizing their main results.

Note: the graphs included in this report are known as “equiplots,” developed at the International Center for Equity in Health at the Federal University of Pelotas (Brazil). Each circle represents one group (wealth quintile, residence, or sex of the child). The distance between the circles shows the absolute gap between the subgroups (poor and rich; urban and rural; boys and girls).

UNICEF Region	U5MR	NMR	TFR	Stunting	FPS	ANC	SBA	PNC	EBF	DPT3	CAREP
CEE & CIS	8	8	8	14	14	13	16	5	15	14	16
East Asia & Pacific	5	5	5	7	5	7	9	4	8	9	9
Eastern & Southern Africa	16	16	16	16	16	16	17	7	16	17	17
Latin America & Caribbean (LAC)	10	10	10	13	15	17	14	8	16	15	18
Middle East & North Africa	3	3	3	8	9	6	9	3	8	9	9
South Asia	5	5	5	7	6	7	7	3	7	6	7
West & Central Africa	17	17	17	22	21	19	22	14	14	22	22
Total	64	64	64	87	86	85	94	44	84	92	98

Table 1. Number of countries/surveys available for analyses by wealth quintile (by UNICEF regions)

- The number of countries available for analyses by wealth quintile ranges from 34 (for postnatal care, a recently introduced indicator) to 98 (for pneumonia careseeking).
- Results for some of the regions have to be interpreted with caution due to the small number of countries with available information on some indicators.
- Breakdowns for urban/rural residence are available for up to 94 countries, and for sex of the child for up to 87 countries (data not shown in Table 1).

Indicator	Global	Wealth quintile					Child's sex		Residence	
		Q1	Q2	Q3	Q4	Q5	Male	Female	Urban	Rural
Underfive mortality rate (per 1000 live births)	76.5	91.0	83.8	77.4	68.7	51.6	82.0	70.8	62.4	82.5
Neonatal mortality rate (per 1000 live births)	27.2	29.1	28.7	28.3	26.4	21.6	30.8	23.4	24.2	28.2
Total fertility rate (children per woman)	4.0	5.4	4.7	4.2	3.6	2.8			3.1	4.6
Stunting (%)	28.4	36.3	31.6	28.0	23.8	17.9	29.9	26.8	22.3	31.4
Family planning needs satisfied (%)	64.9	55.6	59.8	63.2	67.8	73.9			70.6	60.8
Antenatal care (4+ visits) (%)	65.5	53.3	60.4	65.0	80.7	79.4			73.8	60.0
Skilled birth attendant (%)	72.7	56.5	65.9	73.2	82.2	92.2			88.0	65.1
Postnatal care (%)	29.3	24.4	28.0	28.5	31.8	36.5	32.4	31.5	34.4	27.4
Exclusive breastfeeding (%)	33.5	36.3	35.3	34.4	30.9	32.2	33.1	34.8	32.0	35.5
DPT3 vaccine (%)	76.5	69.1	75.2	77.1	80.1	83.2	76.8	76.3	80.6	74.3
Pneumonia careseeking (%)	60.5	51.7	55.4	58.6	62.7	67.9	60.2	59.7	66.0	56.5

Table 2. Global mean levels of 11 indicators studied, according to wealth quintile, sex of the child, and urban/rural residence

- All mean values (global and regional) are unweighted; that is, all countries with available data—regardless of population size—are given equal weights.
- Inequalities according to sex of the child were not investigated for fertility (as the unit of analysis is the woman), family planning, antenatal care, or skilled birth attendance.
- The widest gaps are observed for skilled birth attendance: average coverage is close to 100% in the richest quintile and lower than 50% in the poorest quintile.
- Postnatal care coverage for the baby is particularly low in all quintiles.
- There is a discrete pro-poor pattern for exclusive breastfeeding.

Part 3.1. Analyses of intervention coverage

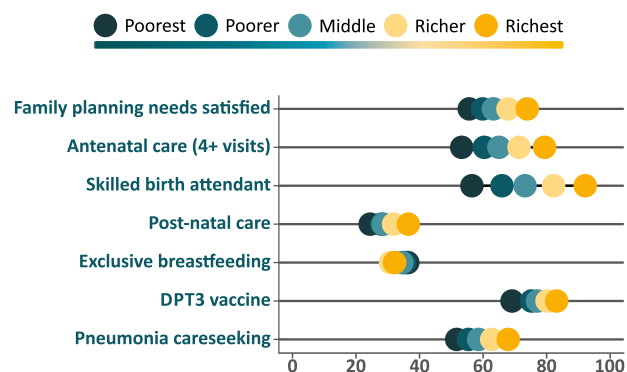


Figure 1. Global mean levels of coverage indicators by wealth quintile

- Pro-rich inequalities are observed for all indicators except for exclusive breastfeeding.
- The widest gaps are observed for skilled birth attendance: average coverage is close to 100% in the richest quintile and lower than 50% in the poorest quintile.
- Postnatal care coverage for the baby is particularly low in all quintiles.
- There is a discrete pro-poor pattern for exclusive breastfeeding.

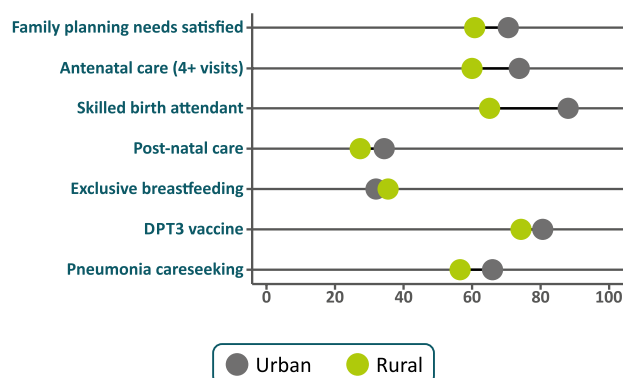


Figure 2. Global mean levels of coverage indicators by residence

- Pro-urban inequalities are observed for all indicators except for exclusive breastfeeding.
- The largest gaps are observed for skilled birth attendance.

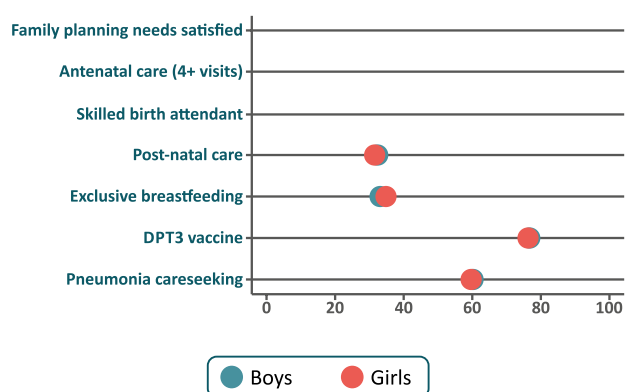


Figure 3. Global mean levels of coverage indicators by sex

- Boys and girls show similar coverage levels.
- Sex stratification was not carried out for family planning needs satisfied, antenatal care, or skilled attendant at delivery.

We now present breakdowns of the coverage of the iERG interventions by wealth quintile, for each UNICEF region.

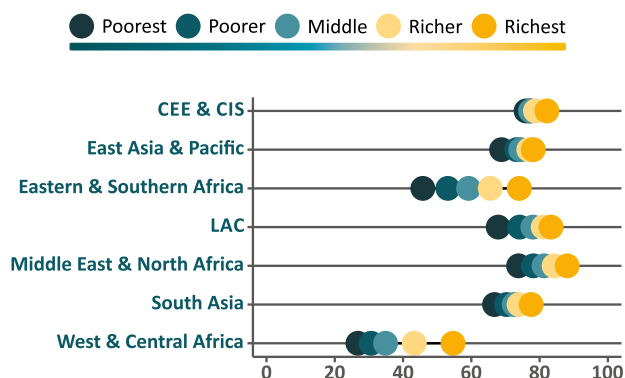


Figure 4. Demand for family planning satisfied by wealth quintile, according to UNICEF regions

- In every region, there are consistent pro-rich coverage patterns.
- Coverage levels are lowest in West & Central Africa, followed by Eastern & Southern Africa.
- Inequalities are largest in the two sub-Saharan African regions, and smallest in CEE & CIS.

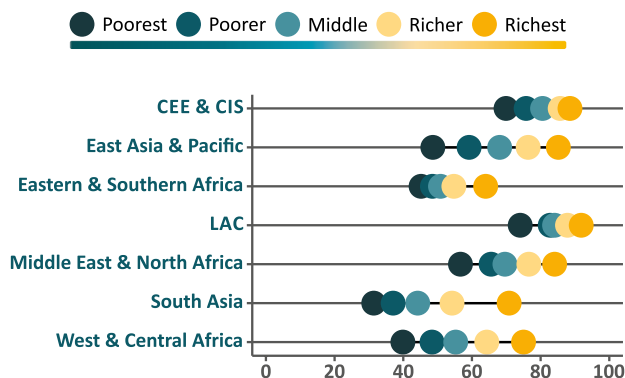


Figure 5. Antenatal care (4+ visits) by wealth quintile, according to UNICEF regions

- In every region, there are consistent pro-rich coverage patterns.
- Coverage levels are highest in CEE & CIS and Latin America & Caribbean, and lowest in South Asia and Sub-Saharan Africa.
- The widest inequalities are observed in the two Asian regions and in West & Central Africa, and the smallest in CEE & CIS and Latin America & Caribbean.
- In every region except for Eastern & Southern Africa, the richest quintile has coverage levels above 70%.

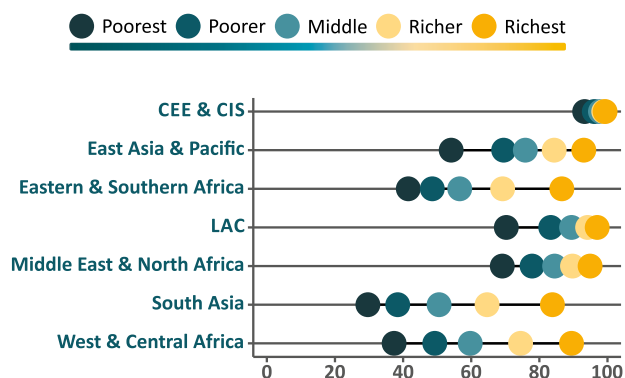


Figure 6. Skilled birth attendance by wealth quintile, according to UNICEF regions

- Skilled birth attendance shows larger inequalities than any other indicator included in the present analyses.
- In every region, there are consistent pro-rich coverage patterns.
- Coverage levels are highest in CEE & CIS, followed by Latin America & Caribbean and Middle East & North Africa.
- The lowest coverage is observed in South Asia.
- Inequalities are largest in the two African regions and in South Asia, and smallest in CEE & CIS.
- In every region, the richest quintile has coverage levels equal to or greater than 85%.

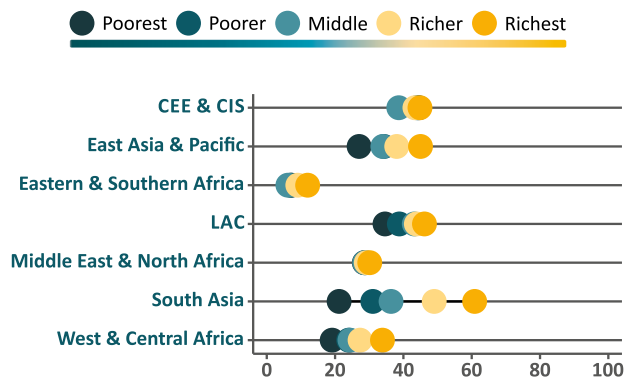


Figure 7. Postnatal care for the baby by wealth quintile, according to UNICEF regions

- Results must be interpreted with caution because of the small number of countries with available information (see Table 1).
- Overall coverage is lower than 50% in most regions.
- Inequalities tend to be small in most regions, with the notable exception of South Asia.

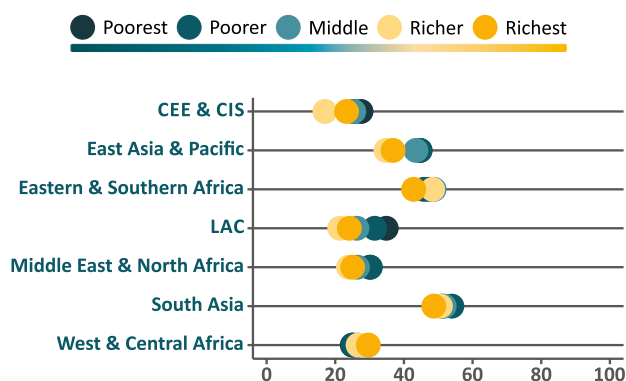


Figure 8. Exclusive breastfeeding by wealth quintile, according to UNICEF regions

- EBF is the most equitable of all indicators studied.
- Overall frequency is 50% or lower in most regions.
- Latin American and CEE & CIS show pro-poor patterns, which to a lesser extent are also seen in the two Asian regions.
- West & Central Africa is the only region to show a discrete pro-rich pattern.

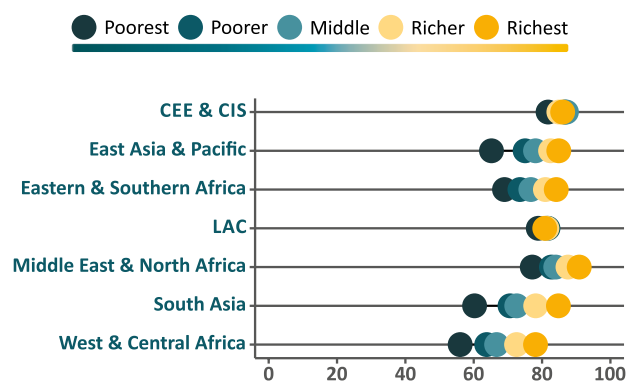


Figure 9. DPT3 vaccine coverage by wealth quintile, according to UNICEF regions

- Overall coverage tends to be above 80% in most regions, except for Eastern & Southern Africa and South Asia.
- Pro-rich coverage patterns are present in most regions.
- Inequalities are very small in Latin America & Caribbean and CEE & CIS.
- The largest inequalities are observed in the two Asian regions and in West & Southern Africa.
- In all regions except for South Asia, coverage in the richest quintile is between 80% and 90%.

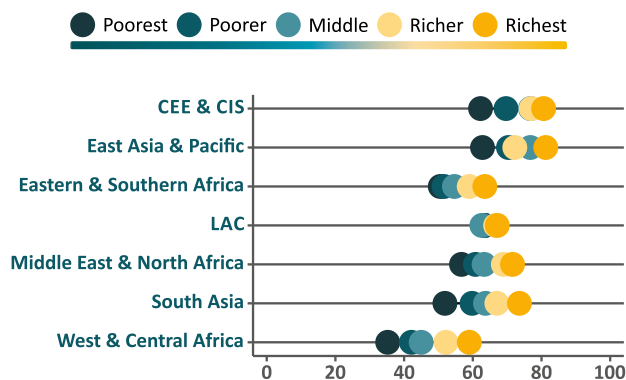


Figure 10. Careseeking for suspected pneumonia by wealth quintile, according to UNICEF regions

- Overall coverage is variable, ranging from 40% to 80% in all regions.
- CEE & CIS and East Asia & Pacific tend to show the highest overall coverage levels, while West & Central Africa shows the lowest.
- Pro-rich coverage patterns are observed in all regions.
- The smallest inequalities are seen in Latin America & Caribbean.
- The largest inequalities are observed in West & Central Africa and in South Asia.
- Coverage levels in the richest quintile are more variable across regions than for most other coverage indicators studied, ranging from <60% to >80%.

Part 3.2. Fertility analyses



Figure 11. Global mean levels of total fertility rate by wealth quintile

- At the global level, there are important inequalities in total fertility, ranging from 2.8 children per woman in the richest quintile to 5.4 in the poorest quintile (see also Table 2).

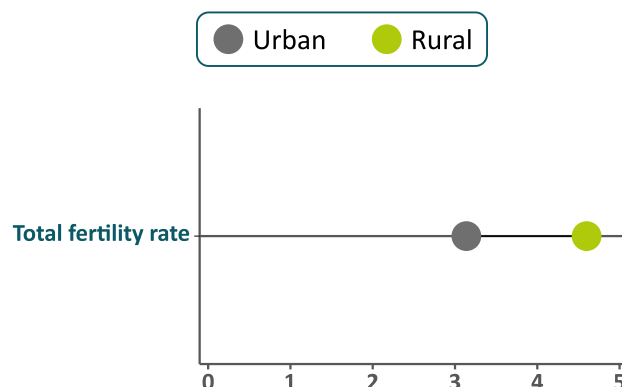


Figure 12. Global mean levels of total fertility rate by place of residence

- At the global level, the average number of children per urban women is 3.1, compared to 4.6 among rural women (see also Table 2).

We now present breakdowns of the total fertility rate by wealth quintile, for each UNICEF region.

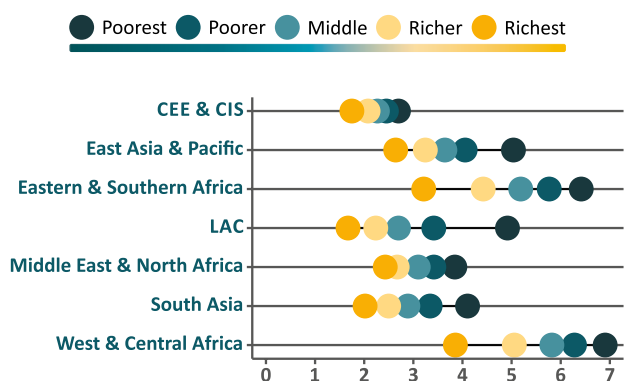


Figure 13. Mean levels of total fertility rate by wealth quintile, according to UNICEF regions

- Fertility is highly variable at the national level, ranging from about 2 children per woman in CEE & CIS to over 5 in the sub-Saharan African regions.
- In all regions, fertility is inversely related to wealth.
- Inequalities are smallest in CEE & CIS and widest in sub-Saharan Africa and Latin America & Caribbean.
- Even among women from the wealthiest quintile, there is substantial variability in fertility among regions.

Part 3.3. Mortality analyses

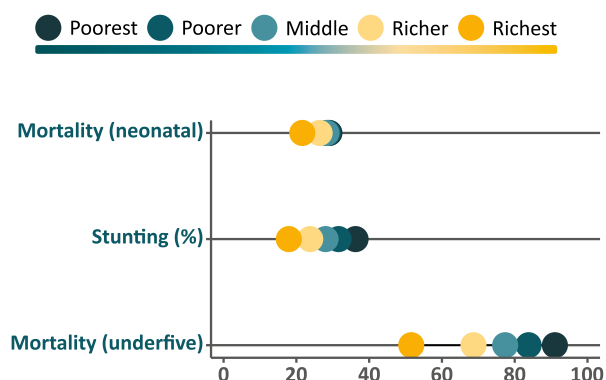


Figure 14. Global mean levels of mortality (per 1000 live births) and undernutrition (%) by wealth quintile

- At the global level, there are important inequalities in underfive mortality and in stunting prevalence by wealth; for both indicators, levels in the poorest quintile are about twice as high as in the richest quintile (see Table 2).
- Inequalities in neonatal mortality are also present, but are not as marked as for underfive mortality.
- In several countries, the absolute numbers of neonatal deaths by quintile were small, so that results must be interpreted with caution.
- As mentioned in the Methods (Part 2), mortality rates are based on all deaths that occurred in the 10 years before the survey; this means that mortality levels tend to be higher than current rates in most countries.

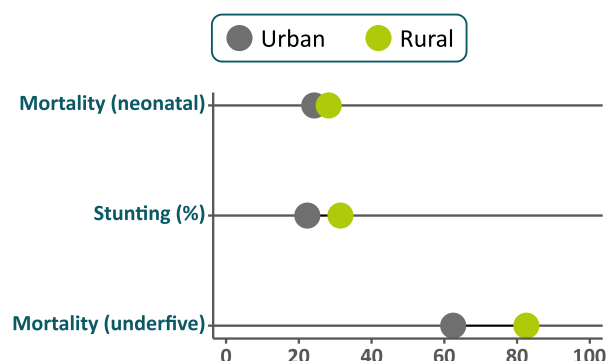


Figure 15. Global mean levels of mortality (per 1000 live births) and undernutrition (%) by residence

- At the global level, urban children are less likely to die and to become stunted than rural children.
- Inequalities in neonatal mortality are less marked than for overall underfive mortality.

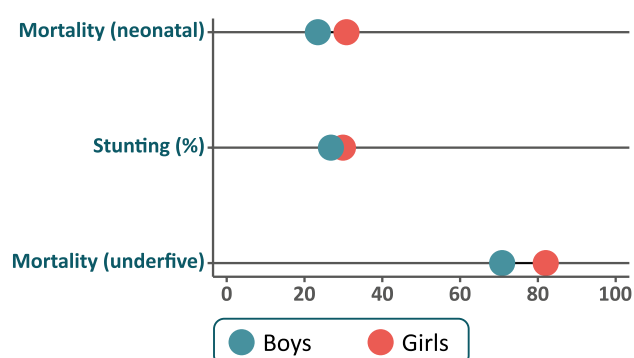


Figure 16. Global mean levels of mortality (per 1000 live births) and undernutrition (%) by sex

- At the global level, boys have higher neonatal and underfive mortality rates than girls.
- These results have not been corrected for the higher biological risk of death among boys, which may obscure higher mortality than expected among girls.
- Stunting prevalence tends to be slightly higher among boys than for girls.

We now present breakdowns of the mortality and stunting indicators by wealth quintile, for each UNICEF region.

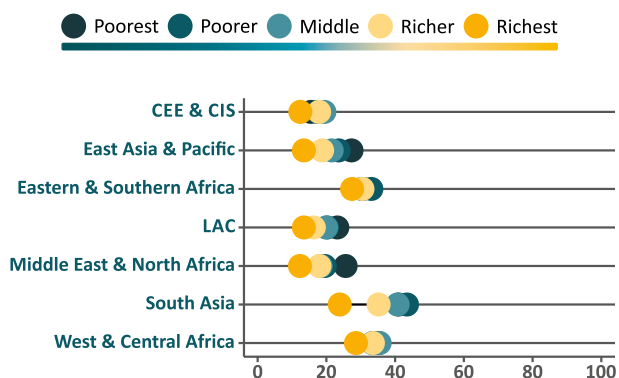


Figure 17. Mean levels of neonatal mortality by wealth quintile, according to UNICEF regions

- In general, inequalities in neonatal mortality are not as wide as for most other indicators studied.
- In all regions, the lowest mortality rates are in the richest quintile.
- In five of the seven regions, the highest mortality rates are in the poorest quintile, whereas in the other two regions, the second quintile shows the highest mortality.
- The largest inequalities tend to be in South Asia, where the richest have much lower rates than the other four quintiles.
- In several countries, the absolute numbers of neonatal deaths by quintile were small, so that results must be interpreted with caution.

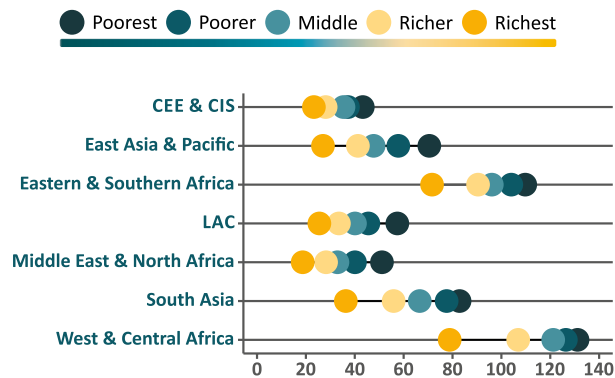


Figure 18. Mean levels of underfive mortality by wealth quintile, according to UNICEF regions

- In all regions, there are clear inverse associations between wealth and underfive mortality; rates in the poorest quintile tend to be 2-3 times larger than in the richest quintile.
- The smallest inequalities are in CEE & CIS, followed by Latin America & Caribbean and Middle East & North Africa.
- The largest inequalities tend to be in the two Asian regions and in West & Central Africa.
- In the two sub-Saharan African regions, even the richest quintile shows high mortality rates.

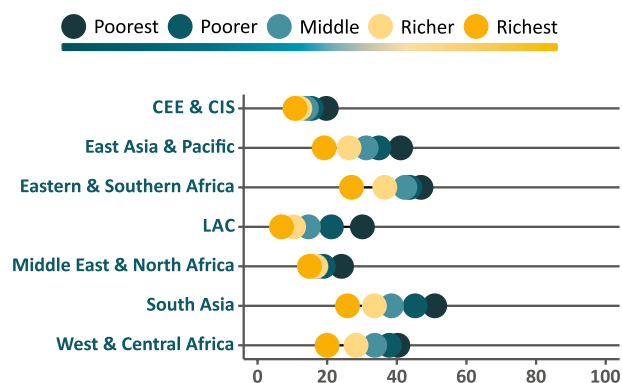


Figure 19. Mean prevalence of stunting by wealth quintile, according to UNICEF regions

- In all regions, there are clear inverse associations between wealth and stunting; rates in the poorest quintile tend to be 2-3 times larger than in the richest quintile.
- The smallest inequalities are in CEE & CIS and in the Middle East & North Africa.

- The other five regions show wide inequalities.
- Prevalence in the richest quintile varies markedly across regions, from about 5% in Latin America & Caribbean to almost 30% in Eastern & Southern Africa.

SUMMARY OF PART 3.

Seven indicators of intervention coverage were analysed: family planning needs satisfied; antenatal care; skilled birth attendance; postnatal care; exclusive breastfeeding; DPT3 vaccine; and pneumonia care-seeking. Except for breastfeeding, all other indicators showed clear pro-rich and pro-urban inequalities. Sex differences in coverage were virtually non-existent. Skilled attendance at birth and antenatal care were the most inequitable, and exclusive breastfeeding the most equitable, but with low levels in all wealth quintiles. DPT3 vaccine showed the best combination of high coverage and small inequalities.

The magnitude of inequalities in coverage varied by region, with smaller gaps in CEE/CIS, Latin America

& Caribbean, and the Middle East & North Africa, and wider gaps in South Asia and sub-Saharan Africa.

There were twice as many children per women in rural than in urban areas, and wealth-related gaps were also large. The largest inequalities in fertility were observed in sub-Saharan Africa.

Stunting and underfive mortality rates were about twice as high in the poorest quintile compared to the richest. Meanwhile, inequalities in neonatal mortality were less marked.

Important inequalities in stunting and underfive mortality were observed within all regions of the world.

Part 4. Results from the double breakdown by wealth and place of residence

We now present some illustrative results of the analyses of the iERG indicators stratified both by wealth and place of residence. The full analyses for the 98 countries are included in Appendix II. As mentioned in the Methods, we ran into sample size problems in several surveys, particularly due to the small number of women and children in the urban poor and rural rich quintiles.

Figures 20-23 show the mean values across all countries with available information for skilled birth attendance (SBA), stunting, fertility, and underfive mortality, for the 10 subgroups.

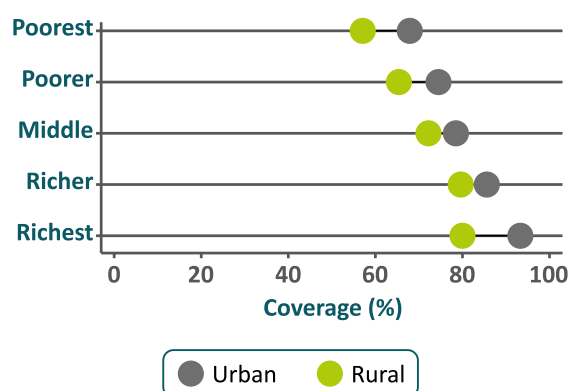


Figure 20. Mean skilled birth attendant coverage according to wealth quintile and place of residence (average values for all countries with available information)

- Within each wealth quintile, SBA coverage is higher among urban than rural residents.
- The widest gap is among the richest, followed by the poorest.

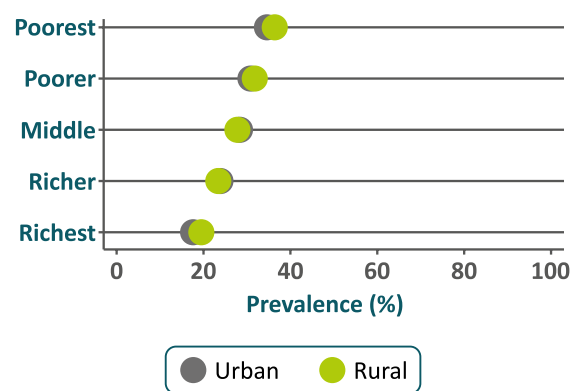


Figure 21. Mean stunting prevalence according to wealth quintile and place of residence (average values for all countries with available information)

- Stunting prevalence is virtually identical in urban and rural children from the same wealth quintile.

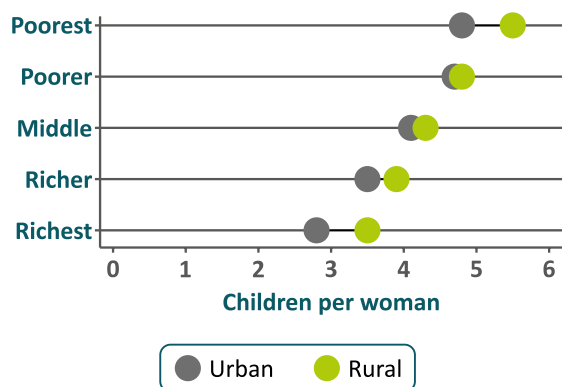


Figure 22. Mean total fertility rates according to wealth quintile and place of residence (average values for all countries with available information)

- Fertility is higher among rural than urban women, particularly among the very rich and the very poor.

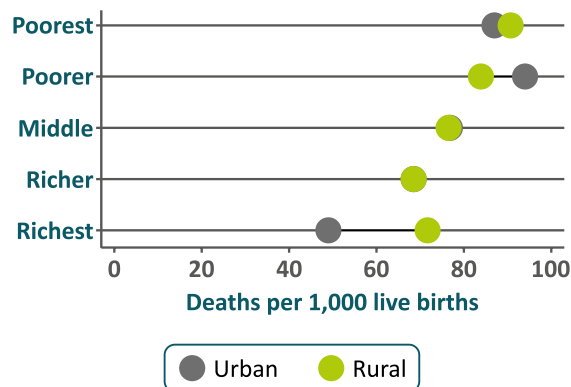


Figure 23a. Mean underfive mortality rate according to wealth quintile and place of residence (average values for all countries with available information)

- In the richest quintile, mortality rates are substantially higher in rural compared to urban areas.
- For all other quintiles, differences are smaller or non-existent. In the second quintile (“poorer”), mortality is higher in urban areas; we cannot think of an obvious explanation for this finding.
- Results for mortality must be interpreted with caution because of poor precision when rates are stratified into 10 categories; mortality rates are mostly below 100 per thousand, so that estimates are less precise than for coverage, stunting, or fertility.

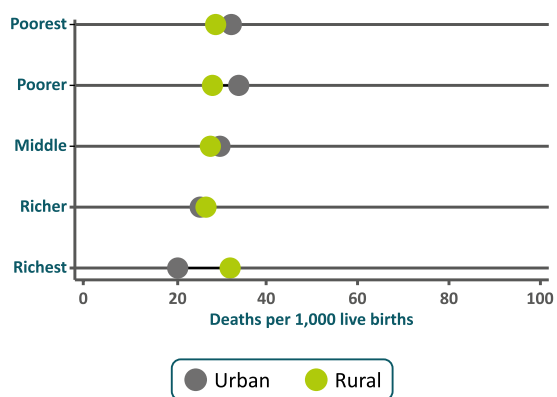


Figure 23b. Mean neonatal mortality rate according to wealth quintile and place of residence (average values for all countries with available information)

- Results are similar for the ones reported above for the U5MR.
- In the richest quintile, mortality rates are substantially higher in rural compared to urban areas.
- For all other quintiles, differences are smaller or non-existent. In the second quintile (“poorer”), mortality is higher in urban areas; we cannot think of an obvious explanation for this finding.
- Results for mortality must be interpreted with caution because of poor precision when rates are stratified into 10 categories; neonatal mortality rates are all below 40 per thousand, so that estimates are less precise than for coverage, stunting, or fertility.

Because global averages may hide important within-country differentials, we investigated rural/urban differences in 10 countries of special interest to the iERG. Figures 24-27 display rural/urban ratios in mortality, fertility, stunting, and skilled birth attendance prevalence, by wealth quintile in these countries. Ratios greater than 1.0 indicate higher values of the indicator

in rural than in urban areas, whereas ratios below 1.0 indicate higher values in urban areas.

These analyses are restricted to countries with at least 50 women and children in each of the 10 strata for SBA coverage and stunting, and with at least 250 births for fertility and mortality.

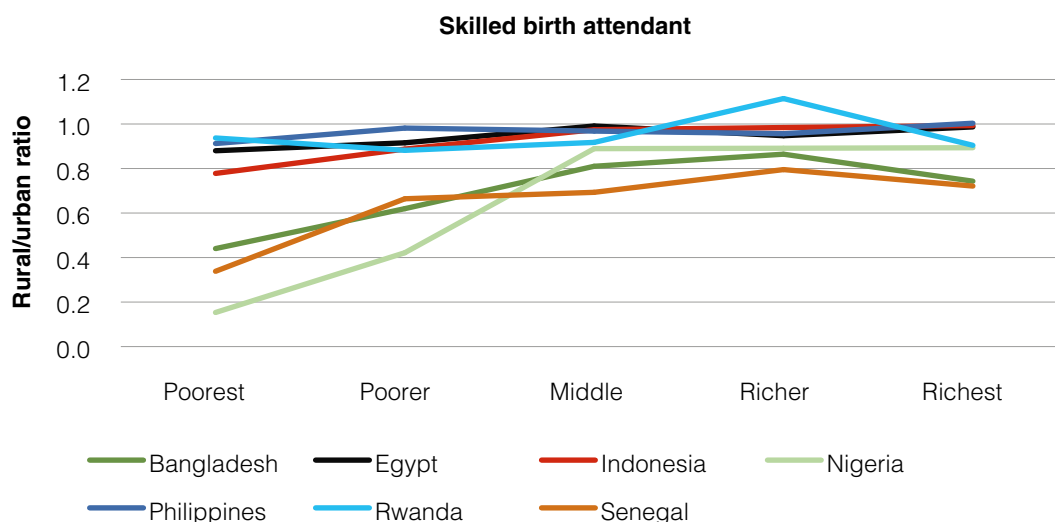


Figure 24. Rural/urban ratios for skilled birth attendance by wealth quintile, in the most recent survey from selected countries

- Of the 10 countries of particular interest to the iERG, seven had more than 50 children in each cell of the double stratification by wealth and residence.
- With a single exception (fourth quintile in Rwanda), more urban than rural children are delivered by a skilled attendant.
- In most countries, the rural/urban gap is narrower as income increases.
- The most extreme pattern is observed in Nigeria, where the rural/urban ratio is less than 0.2 in the poorest quintile and 0.9 in the richest. Senegal and Bangladesh also present important variations in the rural/urban ratios by quintile.

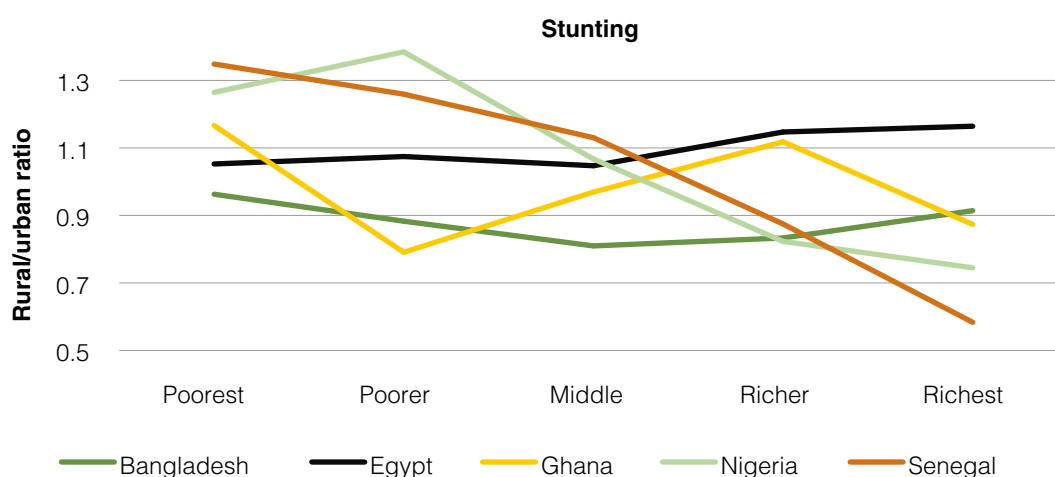


Figure 25. Rural/urban ratios for stunting prevalence by wealth quintile, in the most recent survey from selected countries

- Of the 10 countries of particular interest to the iERG, five had more than 50 children in each cell of the double stratification by wealth and residence.
- Nigeria and Senegal have higher stunting prevalence in the rural poor compared to the urban poor, but among the rich the ratio is reversed, with higher prevalence among the rich.
- For Egypt, Ghana, and Bangladesh, the patterns are not so clear; stunting prevalence in rural and urban areas are within 20% of one another in all quintiles.

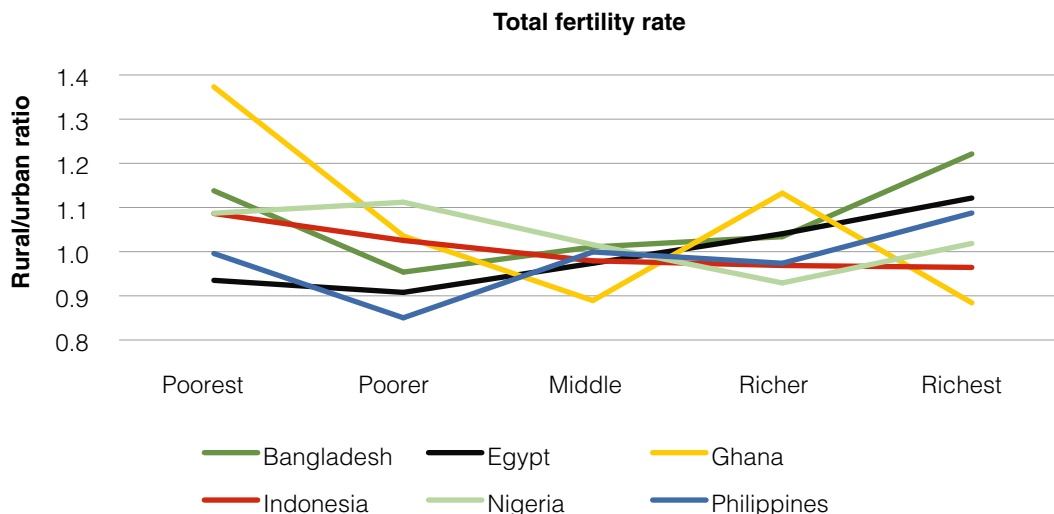


Figure 26. Rural/urban ratios for total fertility rate by wealth quintile, in the most recent survey from selected countries

- Of the 10 countries of particular interest to the iERG, six had sufficient sample sizes in each cell of the double stratification by wealth and residence.
- In four countries, fertility is higher in the rural poor than in the urban poor.
- In three countries, fertility is higher in the rural rich compared to the urban rich.
- In the three intermediate quintiles, the differences tend to be small.

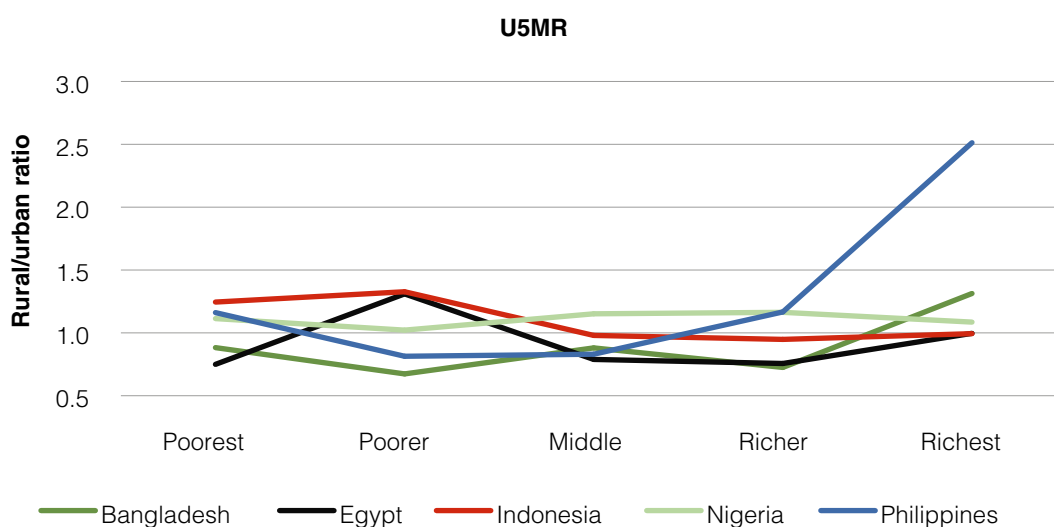


Figure 27. Rural/urban ratios for U5MR by wealth quintile, in the most recent survey from selected countries

- Of the 10 countries of particular interest to the iERG, five had more than 50 births in each cell of the double stratification by wealth and residence.
- In the Philippines, mortality among rural children in the richest quintile is substantially higher than among urban children in the same category.
- None of the other four countries show clear patterns.

SUMMARY OF PART 4.

When results from all countries are averaged, skilled birth attendance coverage is higher, and fertility lower, in urban compared to rural areas within each wealth quintile. Stunting prevalence is similar in urban and rural children in any given quintile. Under-five mortality rates are also similar, except for in the richest quintile where urban children are less likely to die than rural children.

Analyses of the 10 countries of particular interest to the iERG confirm these general patterns, but also indicate that there may be substantial variations from country to country.

Part 5. Results from time trends in 10 selected countries

In Part 5, we present information on time trends for 10 countries of interest to the iERG, all of which have had at least three surveys since the 1990s.

Even within the same country, the number of data points may vary from one indicator to another. Some of the surveys are MICS, that do not allow for calculation of mortality or fertility based on birth histories. Some surveys, for example in Indonesia, did not include anthropometry, so that information on stunting is not available. Regarding fertility, some DHS are restricted to samples of ever-married women. This requires a correction factor in order to estimate fertility rates. This factor is not available for older surveys, thus precluding the analysis of fertility by wealth quintile, even though other indicators—such as mortality or stunting—can still be broken down by quintile.

Appendix III (an Excel spreadsheet) contains the equity analyses of the 10 indicators for each survey available in the 10 countries.

To illustrate the data available in Appendix III, we show time trends in wealth-related inequalities in four indicators (skilled birth attendance coverage; stunting prevalence; total fertility rate; and under-five mortality rate) for the 10 countries. Appendix III provides similar results regarding inequalities according to place of residence and sex of the child.

We focus the interpretation of results on absolute inequalities—that is, differences between the wealth quintiles. Time trends in relative inequalities (the ratios between quintiles) may on occasion lead to different conclusions regarding whether inequalities are increasing or decreasing.



Figure 28. Time trends in wealth-related inequalities for selected indicators, Bangladesh

- Skilled birth attendance: Inequalities increased over time due to a markedly faster rise in coverage among the rich than for the poor.
- Stunting: Absolute inequalities remained unchanged as prevalence fell for all groups.
- Fertility: Inequalities were reduced as the number of births fell more rapidly among the poorest, particularly between 2004 and 2007.
- Underfive mortality: Absolute inequalities were markedly reduced over time.

All surveys are DHS with the exception of 2006 (MICS). The following indicators could not be calculated in some of the surveys: skilled birth attendance (1993); stunting (1993, 2006); total fertility rate (1993, 1996, 1999, 2006); and underfive mortality rate (2006).

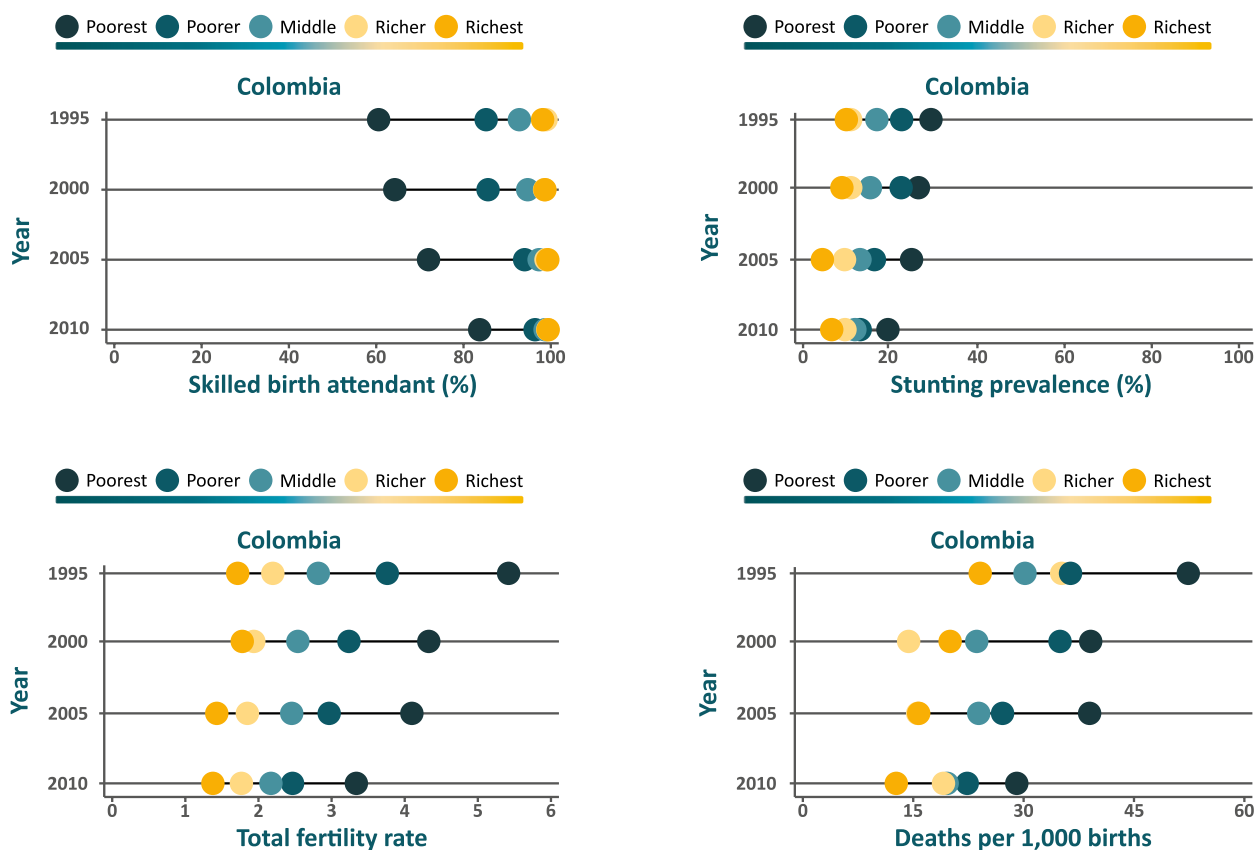


Figure 29. Time trends in wealth-related inequalities for selected indicators, Colombia

- Skilled birth attendance: Inequalities were markedly decreased, as full coverage was reached among the rich and the poor are gradually catching up.
- Stunting: Inequalities were reduced due to improved nutrition among the poor; prevalence among the rich is already at a very low level.
- Fertility: Inequalities were reduced as the number of births fell more rapidly among the poorest than for other groups.
- Under-five mortality: Rates have declined in all groups and inequalities have been reduced.

All surveys are DHS.

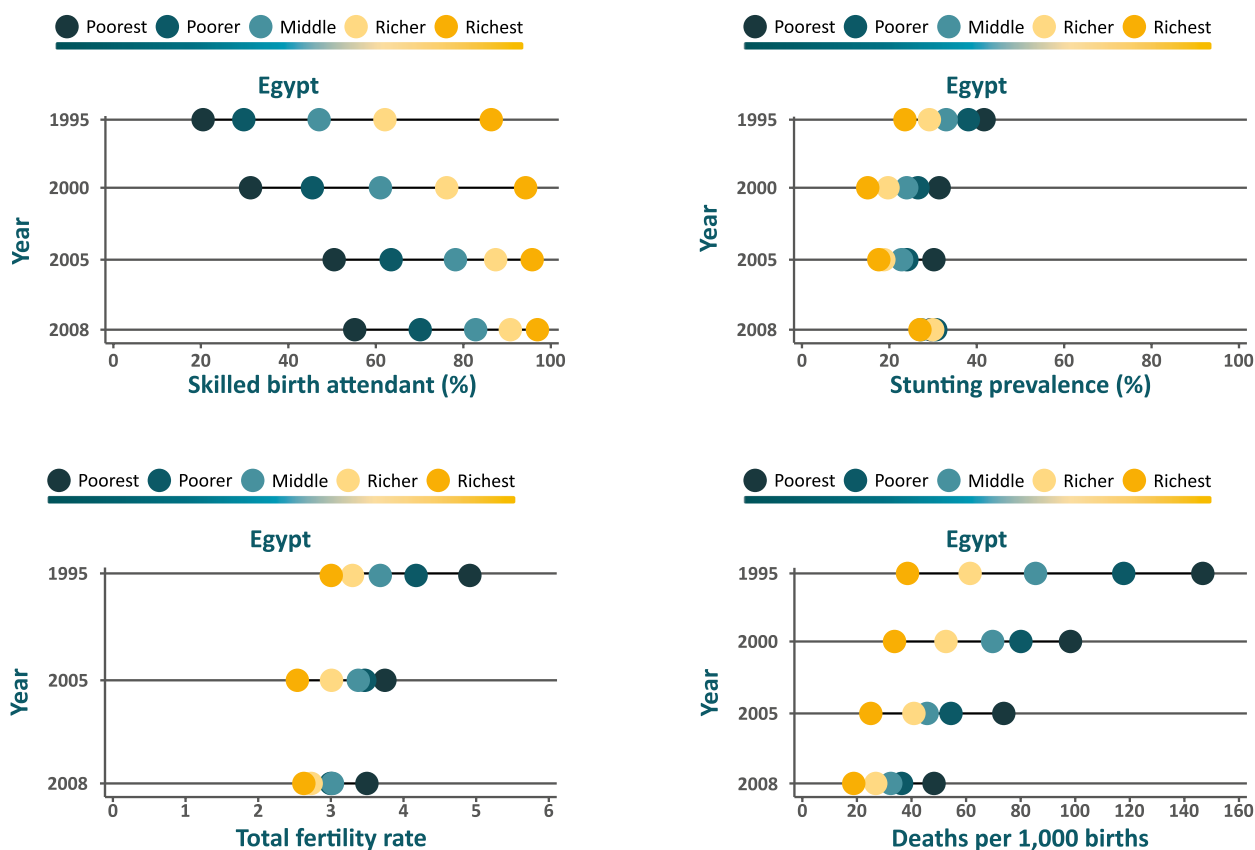


Figure 30. Time trends in wealth-related inequalities for selected indicators, Egypt

- Skilled birth attendance: Inequalities were reduced due to a substantial increase among the poor, while near 100% coverage has been achieved by the rich.
- Stunting: Inequalities were reduced due to an increase in prevalence among the rich. (Note: This is a very unusual finding—prevalence at the national level increased from 23% to 29% in the three years between 2005 and 2008.)
- Fertility: Inequalities were reduced as the number of births fell rapidly among the poorest, particularly between 1995 and 2005.
- Under-five mortality: Absolute inequalities were markedly reduced over time.

All surveys are DHS. Information on fertility for 2000 could not be calculated because the sample was restricted to ever-married women.

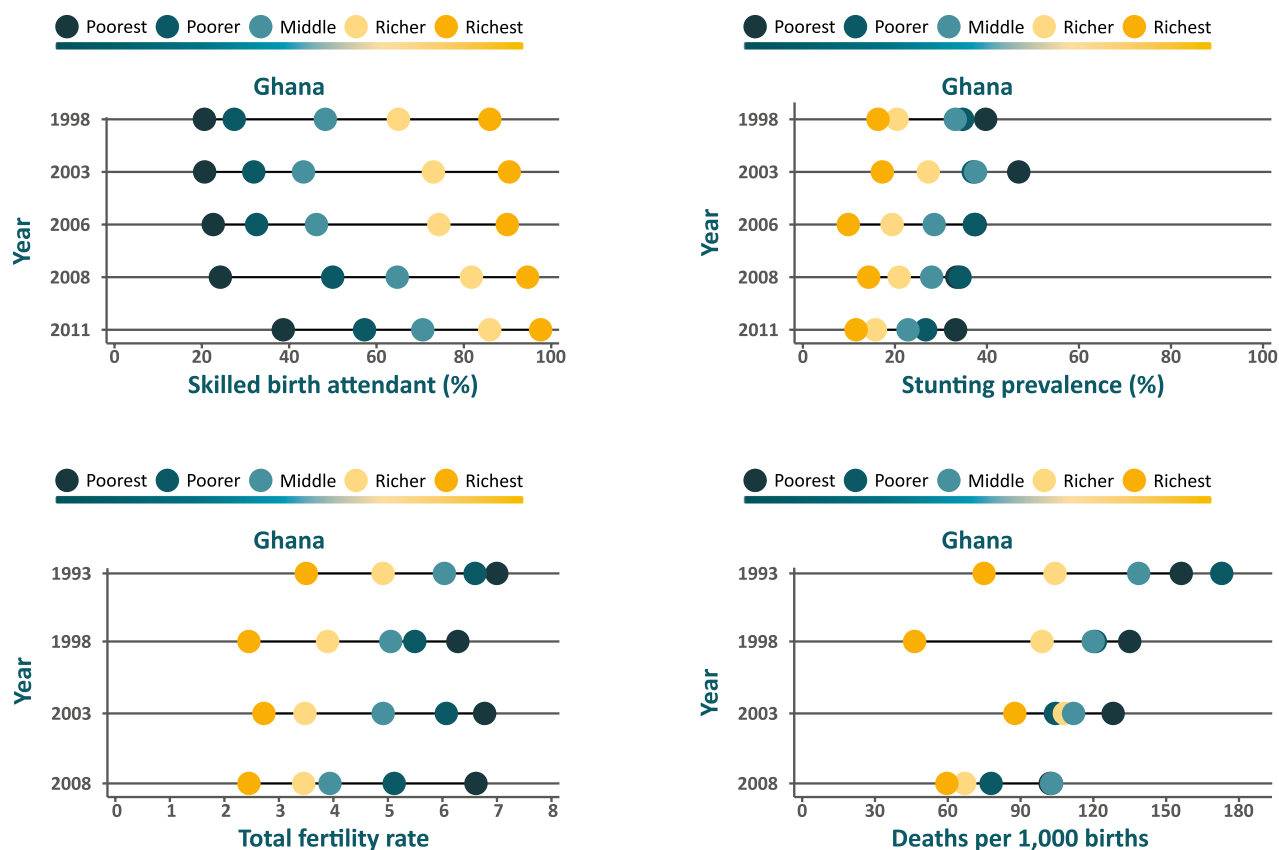
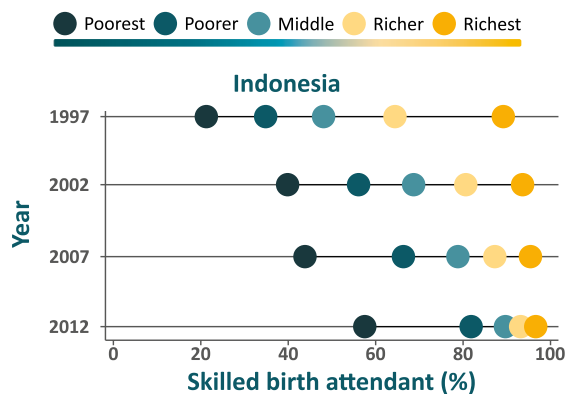


Figure 31. Time trends in wealth-related inequalities for selected indicators, Ghana

- Skilled birth attendance: Very wide inequalities remained unchanged up to 2008, with some evidence of a reduction in the most recent survey (2011).
- Stunting: Absolute inequalities persisted as prevalence levels remained almost constant over time.
- Fertility: Wide inequalities remained constant over time.
- Under-five mortality: Absolute inequalities were reduced over time. (Note that mortality rates in the richest quintile are imprecise due to small sample size.)

All surveys are DHS with the exception of 2006 and 2011 (MICS). The following indicators could not be calculated in some of the surveys: skilled birth attendance (1993); stunting (1993); total fertility rate (2006, 2011); and under-five mortality rate (2006, 2011).



Information on stunting is not available

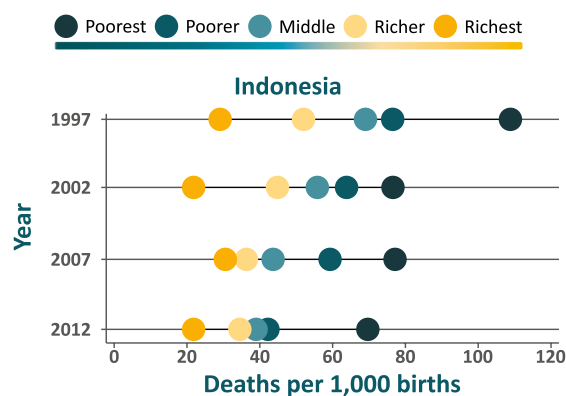
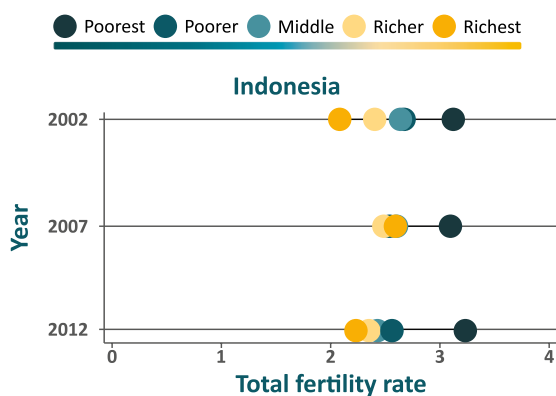


Figure 32. Time trends in wealth-related inequalities for selected indicators, Indonesia

- Skilled birth attendance: Inequalities were reduced as coverage among the rich is close to 100% and continues to increase among the poor.
- Stunting: Information is not available because the DHS did not include anthropometry.
- Fertility: No clear time trends in inequalities.
- Underfive mortality: Inequalities were somewhat reduced up to the 2002 surveys, with little change thereafter.

All surveys are DHS. Data on stunting are not available from any of the surveys. Fertility could not be calculated for 1997.

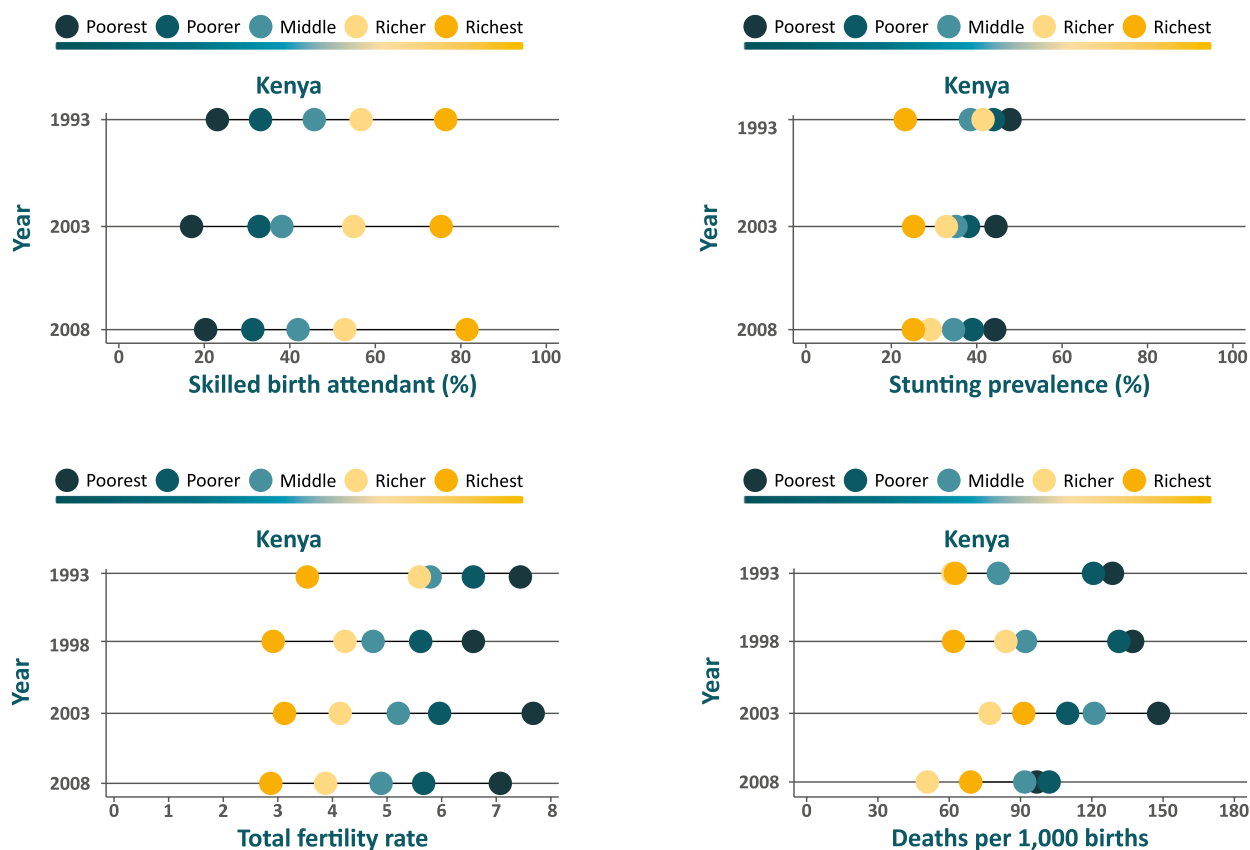


Figure 33. Time trends in wealth-related inequalities for selected indicators, Kenya

- Skilled birth attendance: Inequalities are very wide and remained unchanged over time.
- Stunting: No clear time trends in inequalities.
- Fertility: Inequalities remained constant, with very wide gaps between rich and poor.
- Under-five mortality: Mortality rates and inequalities were unchanged up to 2003; since then, mortality rates fell in all groups with a possible small reduction in inequalities.

All surveys are DHS. Data on skilled birth attendance and stunting were not collected in 1998.

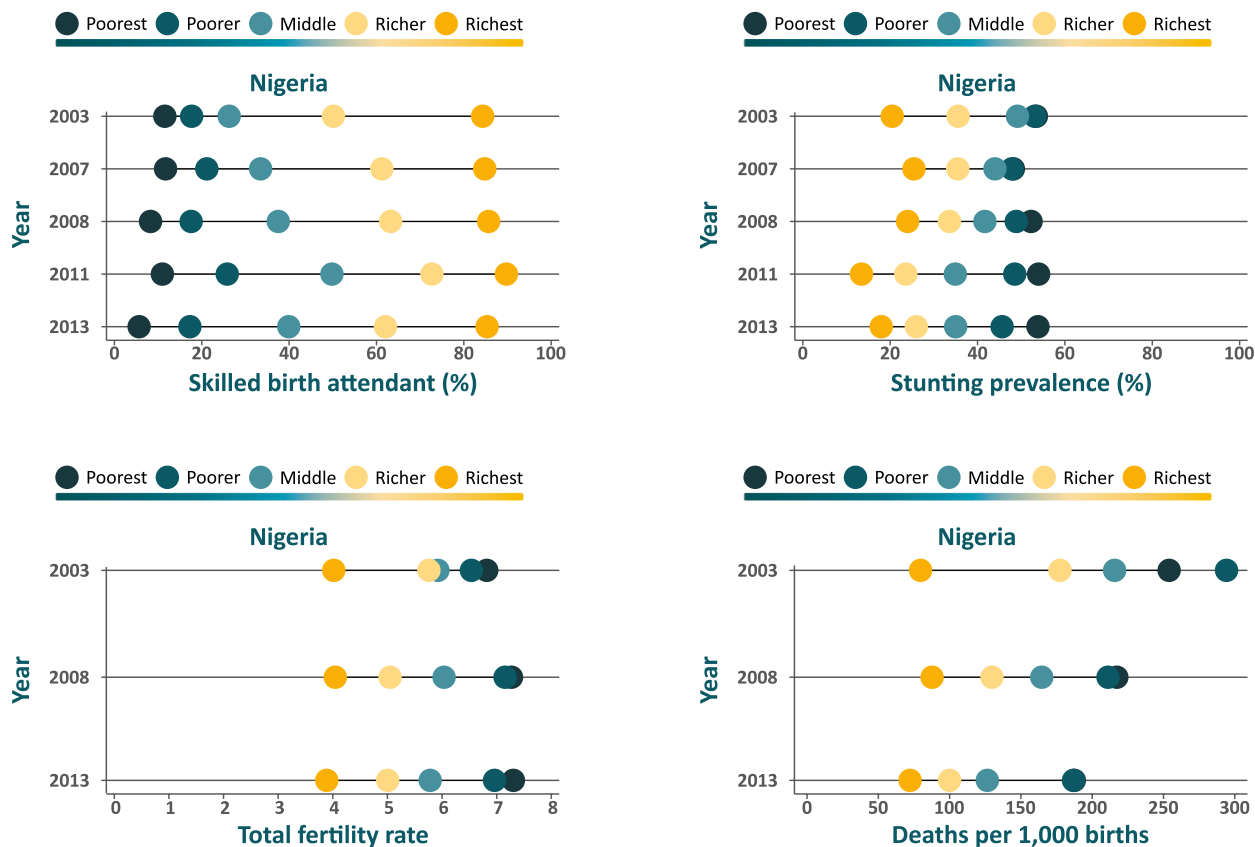
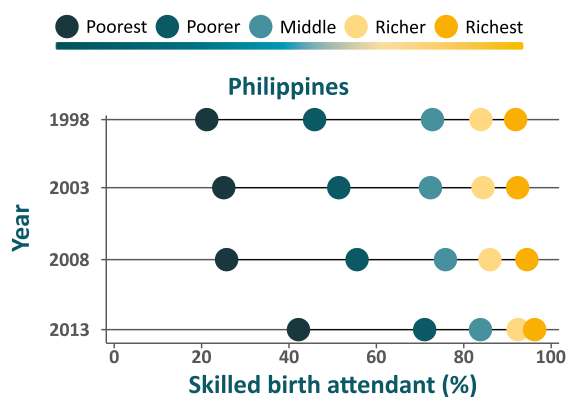


Figure 34. Time trends in wealth-related inequalities for selected indicators, Nigeria

- Skilled birth attendance: Inequalities are very wide and have remained unchanged over time.
- Stunting: Wide inequalities persisted as prevalence remained almost constant.
- Fertility: Inequalities are wide, with no evidence of change.
- Underfive mortality: Absolute inequalities were reduced as rates fell among the poor.

All surveys are DHS with the exception of 2007 and 2011 (MICS). Fertility and mortality cannot be calculated for these surveys as birth histories were not collected.



Information on stunting is not available

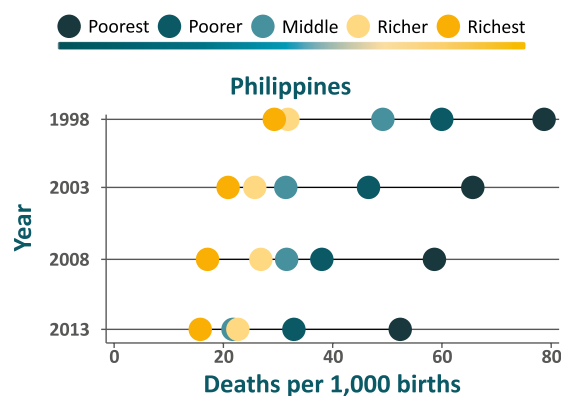
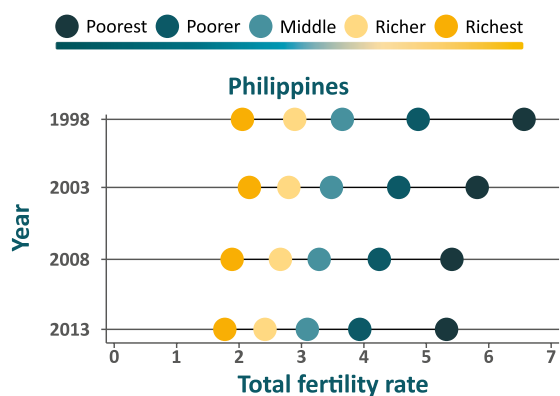


Figure 35. Time trends in wealth-related inequalities for selected indicators, Philippines

- Skilled birth attendance: Inequalities were reduced as coverage increased among the poor.
- Stunting: No data.
- Fertility: Inequalities were slightly reduced as the number of births fell among the poorest.
- Underfive mortality: Absolute inequalities were reduced over time.

All surveys are DHS, but did not include anthropometry.



Figure 36. Time trends in wealth-related inequalities for selected indicators, Rwanda

- Skilled birth attendance: Inequalities fell over time as the increase among the poor was faster than for the rich.
- Stunting: No evidence of a time trend in inequalities.
- Fertility: Inequalities increased over time as the reduction among the rich was faster than for other groups.
- Underfive mortality: Absolute inequalities were markedly reduced over time.

All surveys are DHS with the exception of 2006 (MICS). The following indicators could not be calculated in some of the surveys: skilled birth attendance (1993); stunting (1993, 2006); total fertility rate (1993, 1996, 1999, 2006); and underfive mortality rate (2006).

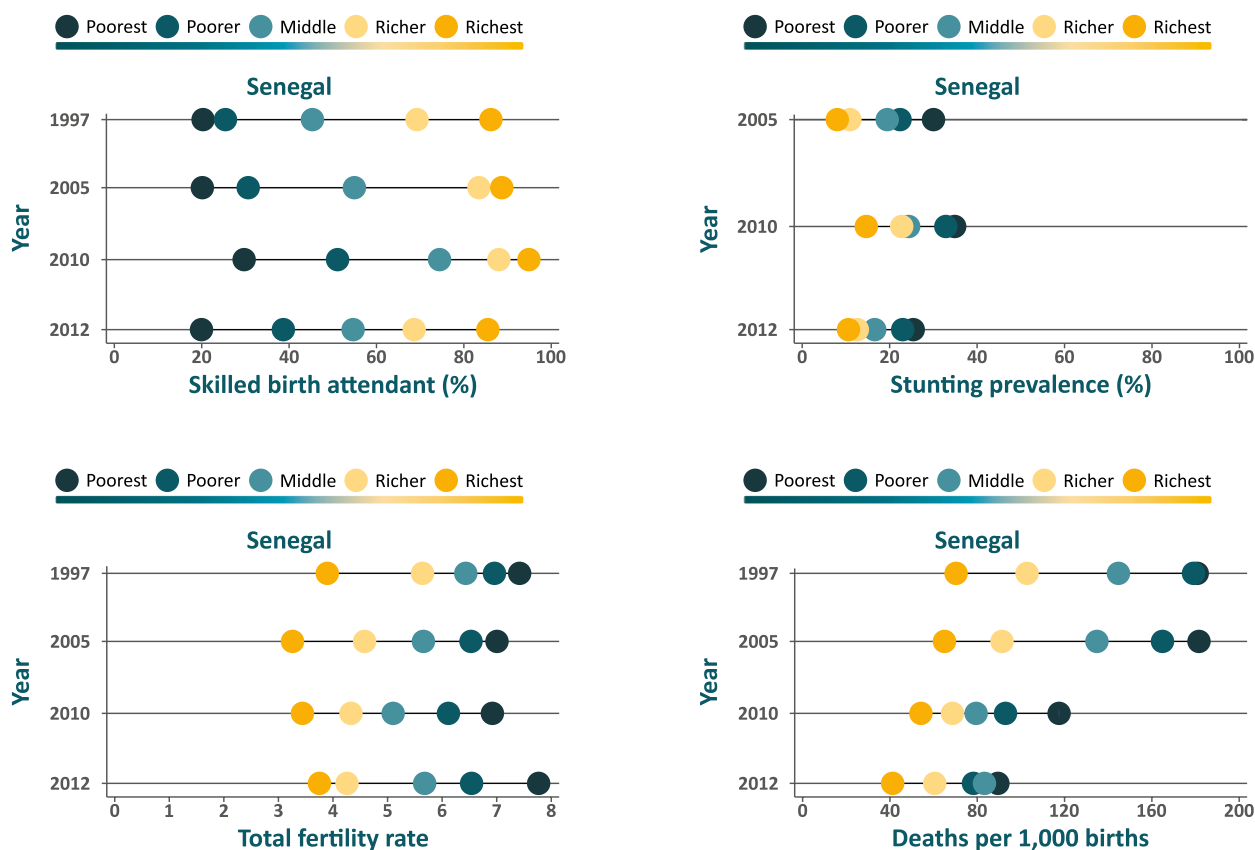


Figure 37. Time trends in wealth-related inequalities for selected indicators, Senegal

- Skilled birth attendance: Inequalities are very wide and have remained constant over time.
- Stunting: Inequalities were slightly reduced in the most recent (2012) survey, compared to earlier surveys.
- Fertility: Rates and inequalities remained constant at very high levels.
- Underfive mortality: Inequalities were markedly reduced after the 2005 survey.

All surveys are DHS. Information on stunting was not collected in 1997.

SUMMARY OF PART 5.

Table 3 summarises the time trends in inequalities. These increased for only two indicators: skilled birth attendance in Bangladesh and fertility in Rwanda. In all other analyses, inequalities were unchanged or reduced. Notably, absolute inequalities in underfive mortality fell in all 10 countries, including Kenya where the reduction was small. As mentioned earlier, reductions in absolute inequalities (difference in U5MR between poor and rich) are not always accompanied by reductions in relative inequalities (ratio of U5MR between poor and rich).

Of the eight countries with data on stunting, inequalities fell in only two, Colombia and Egypt, and possibly in Senegal.

The best performing countries were Colombia and Egypt, where inequalities fell for all four indicators under study, and the worst performers were Kenya and Nigeria.

Table 3. Time trends in inequalities in four indicators, for 10 countries

Country	Skilled birth attendance	Stunting	Fertility	Underfive mortality
Bangladesh	Increased	Unchanged	Reduced	Reduced
Colombia	Reduced	Reduced	Reduced	Reduced
Egypt	Reduced	Reduced	Reduced	Reduced
Ghana	Reduced (?)	Unchanged	Unchanged	Reduced
Indonesia	Reduced	No data	Unchanged	Reduced
Kenya	Unchanged	Unchanged	Unchanged	Reduced (?)
Nigeria	Unchanged	Unchanged	Unchanged	Reduced
Philippines	Reduced	No data	Reduced	Reduced
Rwanda	Reduced	Unchanged	Increased	Reduced
Senegal	Unchanged	Reduced (?)	Unchanged	Reduced

Part 6. Ranking of countries according to inequalities in underfive deaths

In this final section we rank countries according to wealth-related inequalities in underfive mortality. In Table 3, countries are ranked according to a simple indicator, the proportion of the absolute number of underfive deaths reported in the survey that occur in the poorest quintile. If fertility and mortality were the same in all quintiles, this proportion should be 20%. Only two of the 64 countries have fewer than 20% of deaths in the poorest quintile: Niger (19.3%) and Chad (15.5%). The latter result may be a consequence of sampling error or imprecise classification of families according to wealth.

It is important to note that because information on mortality by quintile is based on deaths occurring in the 10 years prior to the survey, some of the estimates in Table 3 are quite outdated.

Based on the ranking according to the proportion of underfive deaths that occur in the poorest quintile,

the least equitable countries are Brazil (47.5%), Guatemala (45.9%), Philippines (45.7%), Turkey (41.9%), Viet Nam (41.8%), and Bolivia (40.4%). It should be noted that estimates for Turkey and Viet Nam refer to the late 1990s and those for Brazil to 2001, because more recent surveys are not available.

The most equitable countries are Kyrgyzstan, Zambia, Ukraine, Niger, and Chad, all with less than 22% of all deaths in the poorest quintile.

Appendix III also presents four additional approaches for ranking countries according to mortality inequalities: (a) the ratio of number of deaths in the poorest over the richest quintile; (b) the ratio of U5MR in poorest/richest quintile; (c) the concentration index for U5MR (expressing relative inequality); and (d) the slope index for U5MR (expressing absolute inequality). Except for the last approach, the resulting country rankings are relatively similar.

Table 4. Ranking of 64 countries by proportion of underfive deaths occurring in the poorest quintile (least to most equitable)

Rank	Country	Underfive deaths in the poorest quintile	Survey year	Reference year
1	Brazil	47.5%	2006	2001
2	Guatemala	45.9%	2008	2003
3	Philippines	45.7%	2013	2008
4	Turkey	41.9%	2003	1998
5	Viet Nam	41.8%	2002	1997
6	Bolivia	40.4%	2008	2003
7	Nicaragua	39.0%	2001	1996
8	Indonesia	37.1%	2012	2007
9	Albania	36.2%	2008	2003
10	India	36.0%	2005	2000
11	Cambodia	35.7%	2010	2005
12	Cameroon	35.3%	2011	2006
13	South Africa	35.2%	1998	1993
14	Morocco	35.1%	2003	1998
15	Colombia	34.0%	2010	2005
16	Dominican Republic	33.9%	2007	2002
17	Peru	33.5%	2012	2007
18	Honduras	33.2%	2011	2006
19	Nigeria	32.5%	2013	2008
20	Madagascar	32.1%	2008	2003
21	Jordan	31.6%	2012	2007
22	Egypt	31.6%	2008	2003
23	Nepal	31.2%	2011	2006
24	Ghana	30.5%	2008	2003
25	Guinea	30.2%	2012	2007
26	Bangladesh	30.1%	2011	2006
27	Pakistan	30.0%	2012	2007
28	Senegal	29.5%	2012	2007
29	Ethiopia	28.4%	2011	2006
30	Namibia	28.3%	2006	2001
31	Liberia	27.9%	2013	2008
32	Mozambique	27.9%	2011	2006
33	Kenya	27.6%	2008	2003
34	Azerbaijan	27.4%	2006	2001
35	Sao Tome and Principe	26.6%	2008	2003
36	Tajikistan	26.5%	2012	2007
37	Haiti	26.4%	2012	2007
38	Uganda	26.4%	2011	2006
39	Comoros	26.3%	2012	2007
40	Benin	25.9%	2011	2006
41	Rwanda	25.9%	2010	2005
42	Congo	25.9%	2011	2006

Rank	Country	Underfive deaths in the poorest quintile	Survey year	Reference year
43	Burkina Faso	25.7%	2010	2005
44	Zimbabwe	25.4%	2010	2005
45	Gabon	25.3%	2012	2007
46	Côte d'Ivoire	25.0%	2011	2006
47	Sierra Leone	24.7%	2013	2008
48	Burundi	24.2%	2010	2005
49	United Rep. of Tanzania	24.2%	2010	2005
50	Armenia	23.8%	2010	2005
51	Guyana	23.2%	2009	2004
52	Lesotho	23.1%	2009	2004
53	Moldova	22.9%	2005	2000
54	Timor-Leste	22.8%	2009	2004
55	Mali	22.7%	2012	2007
56	Democratic Republic of the Congo	22.6%	2013	2008
57	Swaziland	22.3%	2006	2001
58	Maldives	22.1%	2009	2004
59	Malawi	22.0%	2010	2005
60	Kyrgyzstan	21.2%	2012	2007
61	Zambia	21.1%	2007	2002
62	Ukraine	20.0%	2007	2002
63	Niger	19.3%	2012	2007
64	Chad	15.5%	2004	1999

Note: Reference year is approximately 5 years before date of survey.

SUMMARY OF PART 6.

When countries were ranked according to the proportion of all underfive deaths that occur in the poorest quintile, the least equitable countries were Brazil, Guatemala, Philippines, Turkey, Viet Nam, and Bolivia. The most equitable countries were Kyrgyzstan, Zambia, Ukraine, Niger, and Chad.

Part 7. Analyses on family planning needs satisfied for adolescents

These analyses provide information on the indicator “demand for family planning needs satisfied” (FPS) according to 3 categories of maternal age: 15–17 years, 18–19 years, and 20–49 years. Only adolescents and women who reported being sexually active were included in the analyses.

The FPS variable is defined as the “proportion of all women aged 15-49 using contraception among those who are fecund, in union, and in need of contraception.” Women who are willing to get pregnant are excluded from the denominator.

We were able to analyse data for 48 countries, out of the 98 with available surveys. We could not include 24 countries with a MICS and 18 with a DHS because information was lacking on maternal age, on sexual

activity, or on use of contraceptives. Eight of the 56 countries with the required information included fewer than 25 women in one of the age groups; these are not included in the figure because of poor precision of the FPS estimate. Thus, Figure 38 shows 48 countries with surveys since 2001, ordered by family planning needs satisfied among adolescents aged 15-17, from lowest to highest.

The figure shows that, in virtually all countries, adolescents have lower coverage of family planning needs satisfied than women aged 20 years or older. In several countries, the differences are substantial. In addition, younger adolescents (aged under 18 years) tend to have lower coverage than those aged 18-19 years.

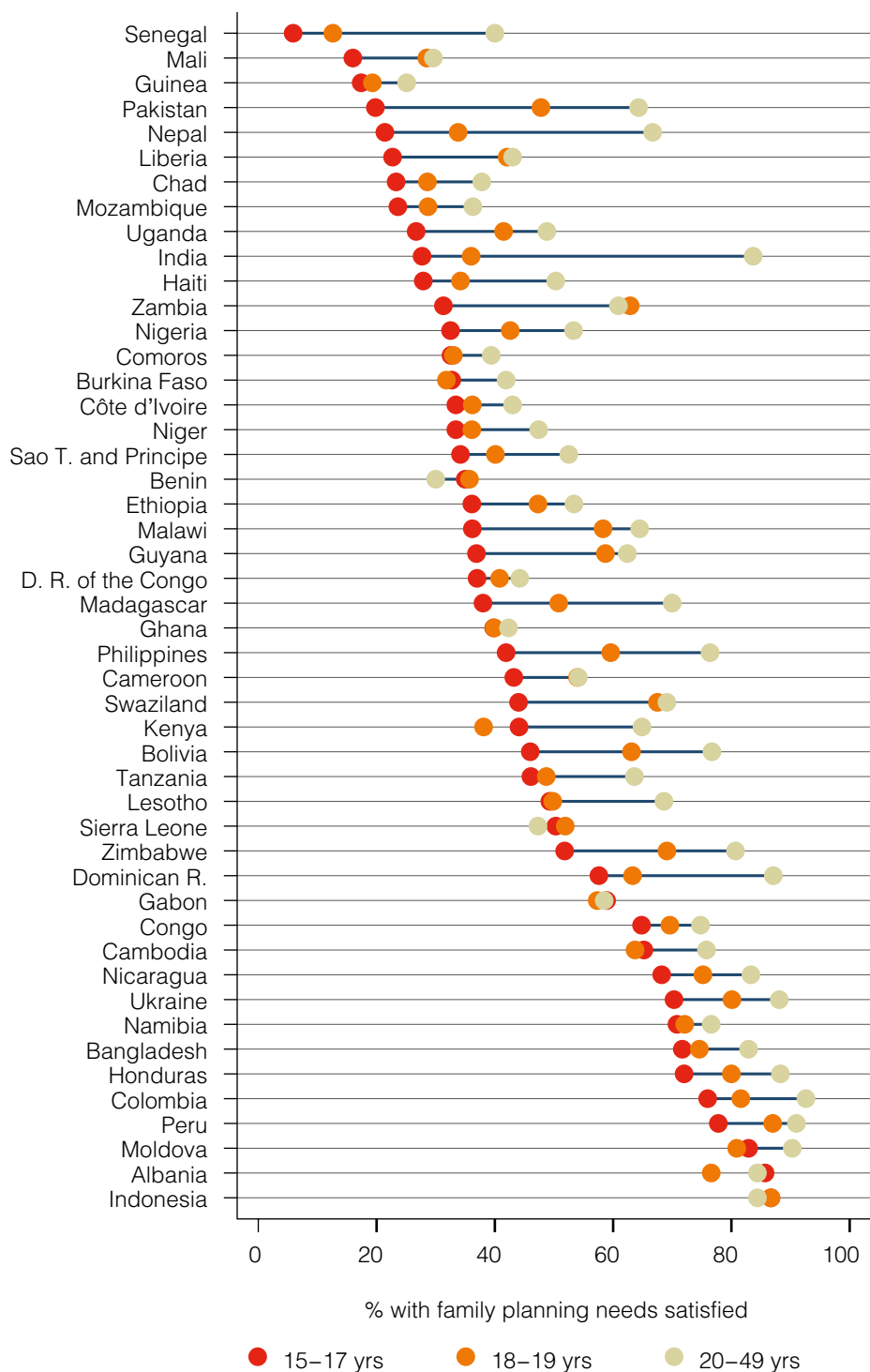


Figure 38. Family planning needs satisfied in adolescents and women aged 15-49

Appendices

- Appendix I. Definitions of the indicators used in the analyses
- Appendix II. Results for the most recent survey in 98 countries
- Appendix III. Results for time trends in 10 countries
- Appendix IV. Ranking of countries according to mortality inequalities

Appendices can be found on the iERG website, at www.who.int/woman_child_accountability/iERG/en/.

ANNEX 4. CORE INDICATORS FOR MONITORING COUNTRY PROGRESS IN IMPLEMENTING THE COIA RECOMMENDATIONS

Recommendation	Indicator	Proposed target	Comments
1. Vital events and HIS	Birth registration	At least 75% of births are registered	Actual birth registration coverage rate will be available for each country
	Death registration	At least 60% of deaths are registered	Actual death registration coverage rate will be available for each country
	Maternal death reviews	At least 90% of maternal deaths are notified and reviewed	Additional indicator could be % of countries in which maternal death is a notifiable event
	CRVS improvement	CRVS improvement plan, approved by country government, is in place	This involves a systematic CRVS assessment and the development of a comprehensive multi-sectoral plan
2. Health indicators	Coverage indicators	Statistics for 8 coverage indicators are available for at least one of the two preceding years, disaggregated by equity stratifiers	The data may be derived from surveys or facility data, and are disaggregated by sex, wealth, and district where possible; information will be gathered by indicator; reliability will be assessed; facility data will be available annually, and survey data 2-3 times every 5 years
	Impact indicators	Data for the 3 impact indicators are available based on data collected in the preceding three years, disaggregated by equity stratifiers	The data may be derived from surveys, census or registration systems, and are disaggregated by sex, wealth, and district where possible; mortality data are usually collected in retrospective surveys
3. Innovation and eHealth	eHealth strategy	National eHealth strategy and plan are in place	These plans need to be comprehensive and cover all relevant health data sources
	Web-based reporting	All districts are part of a national web-based system to report health data and receive feedback	Single country-led system should be operational, reporting facility and administrative data, forming the basis for good and rapid analysis and transparency
4. Resource tracking	Total health expenditure	Total health expenditure per capita was tracked during the two preceding years, by financing source	To track, data on both preceding years are required
	RMNCH expenditure	RMNCH expenditure per capita was tracked during the two preceding years, by financing source	To track, data on both preceding years are required; the indicator refers to government and external sources

Recommendation	Indicator	Proposed target	Comments
5. Country “compacts”	Financial reporting system	A country-led reporting system is in place for externally funded expenditures and predictable commitments	These include “compacts” and similar mechanisms, which should be part of broader compacts between external partners and recipient countries in the health sector
6. Capacity to review health spending	Reviews of health spending	Annual reviews are conducted of health spending from all financial sources, including spending on RMNCH, as part of broader health sector reviews	This indicator focuses on the country capacity to conduct these analytical reviews
7. National oversight	Reviews of performance	The country has conducted a comprehensive review of health progress and performance in the last year	Implementation requires: the involvement of civil society, parliamentarians, development partners, and other sectors; that a report of the review is public; and that the review includes review of resources/ expenditures and results
8. Transparency	Public performance report	A health sector performance report for the preceding year is available in the public domain	The report should meet quality standards: data quality assessment, access to underlying data, equity, includes MNCH resources and results
	Global partners transparency	% of global partners that are publicly sharing information on commitments, resources provided, and results achieved	Assessment of progress on this indicator is based on a web-based review of main international agencies, bilateral donors, partnerships, foundations, etc.
9. Reporting Aid for MNCH	OECD Creditor Reporting System (CRS)	External partners report annually to OECD-DAC their commitments and disbursements on health, with the components on RMNCH clearly identified	
10. Global oversight	iERG – Global Strategy	iERG has reported to the UNSG on results and resources related to the Global Strategy	Requires iERG review of country and partner commitments to the Global Strategy
	iERG – accountability	iERG has reported to the UNSG on progress in implementing the Commission’s recommendations	

ANNEX 5. EVIDENCE SUBMITTED TO, AND COMMISSIONED BY, THE iERG

Evidence submitted to the iERG

1. *Business Case for Female Condoms*
Global Health Visions, May 2014
Submitted by Universal Access to Female Condoms Joint Programme
2. *From facility scorecards to budget advocacy: Working up the chain of accountability to improve the quality of maternal and newborn care in Sierra Leone*
Submitted by Evidence for Action-MamaYe
3. *Local accountability mechanisms using evidence to influence progress on maternal, newborn and child health in Nigeria*
Submitted by Evidence for Action-MamaYe
4. *Accountability and action at the facility level: A case study on improving maternal and newborn health services in Ghana*
Submitted by Evidence for Action-MamaYe
5. *Maternal Death Surveillance and Response Action Network*
Submitted by Evidence for Action-MamaYe
6. *Building and sustaining momentum for maternal and newborn survival: The Mara strategy cocktail of ownership, evidence, and accountability*
Submitted by Evidence for Action-MamaYe
7. *Comparison of two approaches to monitoring quality of care in Sierra Leone: the comprehensive, face-to-face "FIT" assessment and rapid, telephone-based "QuIC FIT" approach*
Submitted by Evidence for Action-MamaYe
8. *Using evidence to drive action: A "revolution in accountability" to implement quality care for better maternal and newborn health in Africa*
International Journal of Gynecology and Obstetrics (2015), 127:1, 96–101
Submitted by Evidence for Action-MamaYe
9. *The Nigeria Independent Accountability Mechanism for maternal, newborn, and child health*
International Journal of Gynecology and Obstetrics (2015), 127:1, 113–116
Submitted by Evidence for Action-MamaYe
10. *Establishing a baseline to measure change in political will and the use of data for decision-making in maternal and newborn health in six African countries*
International Journal of Gynecology and Obstetrics (2015), 127:1, 102–107
Submitted by Evidence for Action-MamaYe
11. *Using scorecards to achieve facility improvements for maternal and newborn health*
International Journal of Gynecology and Obstetrics (2015), 127:1, 108–112
Submitted by Evidence for Action-MamaYe
12. *Effective accountability for disrespect and abuse experienced by women during maternity care*
Submitted by White Ribbon Alliance, on behalf of the Global Respectful Maternity Care Community of Concern
13. *Case Study: Citizens' Hearings*
Submitted by White Ribbon Alliance
14. *Case Study: Uganda Citizens' Hearings*
Submitted by White Ribbon Alliance
15. *Case Study: Family Planning in Senegal*
Submitted by Rabin Martin, on behalf of Merck for Mothers, the Bill & Melinda Gates Foundation, and IntraHealth International
16. *Saving Mothers, Giving Life*
Submitted by Rabin Martin

Evidence commissioned by the iERG

1. *A Promise Renewed*
A progress report on the implementation of A Promise Renewed commitments in the 75 priority countries, including both under-five mortality and maternal mortality targets, highlighting both positive developments and challenges.
Note: no submission received
2. *Action Aid*
A report with information on how Action Aid supports the CoIA recommendations and how it is engaged in the national accountability mechanisms in the 75 priority countries, highlighting both positive developments and challenges.
Note: no submission received
3. *Countdown to 2015*
(1) A progress report on CoIA's 12 health indicators to inform and complement the iERG's review and analysis;
(2) A report on progress in rates of coverage over the last decade by interventions and equity analysis, including in particular under-five mortality rates and maternal mortality rates presented by asset quintile and gender equity considerations.
Note: submission received
4. *Family Care International (FCI)*
A progress report with information on how FCI work supports the CoIA recommendations and how it is engaged in the national accountability mechanisms in the 75 priority countries, highlighting both positive developments and challenges.
Note: submission received
5. *Family Planning 2020 (FP2020)*
A report on progress in monitoring the implementation of FP commitments in the 75 priority countries, highlighting both positive developments and challenges.
Note: submission received
6. *Gavi, the Vaccine Alliance*
A progress report on the vaccination agenda in the 75 priority countries, including the plans to scale up and strengthen routine immunization systems in these countries, highlighting both positive developments and challenges.
Note: submission received
7. *Global Fund*
Evidence or case studies about the progress in implementation of health programmes supported by the Global Fund that cover a range of interventions for women and children across the continuum of pre-pregnancy, pregnancy, birth and infant and child care, including adolescent health metrics, worldwide and in particular in the 75 priority countries, highlighting both positive developments and challenges.
Note: submission received
8. *Guttmacher Institute*
A report with data reflecting progress in addressing unsafe abortion worldwide and in particular in the 75 priority countries, especially among adolescents, highlighting both positive developments and challenges.
Note: submission received
9. *H4+*
A progress report on monitoring the implementation of commitments made to the Global Strategy in the 75 priority countries, highlighting both positive developments and challenges.
Note: submission received
10. *International Planned Parenthood Federation (IPPF)*
A report with information on how the work of IPPF supports the CoIA recommendations and how it is engaged in the national accountability mechanisms in the 75 priority countries, highlighting both positive developments and challenges.
Note: submission received
11. *Inter-Parliamentary Union (IPU)*
A report on the progress achieved in parliamentary engagement and oversight for reproductive, maternal, newborn, and child health in the 75 priority countries, highlighting both positive developments and challenges in this area, in particular with regard to the IPU's own Resolution on Women's and Children's Health.
Note: submission received
12. *International Telecommunication Union (ITU)*
Evidence on how information and communication technologies support the UN Secretary-General's Global Strategy.
Note: no submission received
13. *Office of the UN High Commissioner for Human Rights (OHCHR)*
A report with evidence regarding the contribution of human rights instruments to women's and children's health.
Note: no submission received

14. *Oxfam*
A report regarding Oxfam's contribution to the UN Secretary-General's Global Strategy and implementation of the CoIA recommendations, highlighting both positive developments and challenges.
Note: no submission received
15. *PEPFAR*
A progress report on how PEPFAR's programmes are advancing women's and children's health worldwide and in particular in the 75 priority countries, highlighting both positive developments and challenges.
Note: no submission received
16. *PMNCH*
A report on the impact and implementation of the Global Strategy commitments by stakeholders, with a particular focus on the 75 priority countries. The report should pay particular attention to both donor and country commitments, as well as to how the countries have performed and how they were financed.
Note: submission received
17. *RMNCH Steering Committee*
A report on 2014/2015 progress related to the work of the RMNCH Steering Committee in the 75 priority countries, as well as an overview of the Committee's future strategy and plans after 2015.
Note: no submission received
18. *Save the Children*
A report with information on how the work of Save the Children supports the CoIA recommendations and how it is engaged in the national accountability mechanisms in the 75 priority countries, highlighting both positive developments and challenges.
Note: submission received
19. *Strategic Advisory Group of Experts (SAGE) on Immunization*
A progress report as well as any relevant updates or information on immunization and the contribution it makes to children's and women's health worldwide and in particular in the 75 priority countries.
Note: submission received
20. *UNAIDS*
A report regarding the contribution of UNAIDS (and AIDS programmes more generally) to women's and children's health.
Note: submission received
21. *UN Commission on Life-Saving Commodities*
A report on progress towards implementation of the CoIA recommendations.
Note: submission received
22. *UN Secretary-General*
A summary of contributions the UN Secretary-General's Global Strategy has made to the MDGs for women's and children's health.
Note: submission received
23. *UN Statistics – UNECA*
A report with information on the progress in strengthening health information systems in the African countries.
Note: submission received
24. *WHO, including HQ and Regional Offices (AFRO, EMRO, EURO, PAHO, SEARO, WPRO)*
(1) Information on the progress made in implementing the first nine CoIA recommendations in the 75 priority countries;
(2) Information on specific actions that were taken by WHO and the partners to address the iERG 2012, 2013, and 2014 recommendations, and their outcomes;
(3) WHO assessment of achievements of, and remaining challenges facing, the UN Secretary-General's Global Strategy for Women's and Children's Health.
Note: submission received, including separate submissions from WHO AFRO, EURO, SEARO, and WPRO
25. *World Bank*
Evidence or case studies about how the WB has supported the Global Strategy in the 75 priority countries, highlighting both positive developments and challenges.
Note: reporting through WHO
26. *World Vision International*
A report regarding World Vision's contribution to *Every Woman Every Child* and CoIA.
Note: submission received

ANNEX 6. THE iERG'S INPUT ON THE BACKGROUND PAPER ON ACCOUNTABILITY FOR THE UPDATED GLOBAL STRATEGY FOR WOMEN'S, CHILDREN'S, AND ADOLESCENTS' HEALTH

The iERG met in London in April to discuss the latest draft of the Background Paper on Accountability (dated 24 March, 2015), prepared by the Accountability Substream as part of the preparation for the updated Global Strategy for Women's, Children's, and Adolescents' Health. On 13 April, 2015, the iERG submitted its input to the coordinators and to PMNCH, summarizing their discussions and outlining their position on independent accountability with regard to the updated Global Strategy.

1. The iERG very much welcomes the positive references to existing work, reports, and recommendations regarding progress towards strengthening independent accountability mechanisms to accelerate advances in women's, children's, and adolescents' health. We are extremely pleased that the drafting team endorses the tripartite CoIA framework for independent accountability, which we have been using for 4 years now—to monitor, review, and act/remedy. We also support the operating principles for post-2015 accountability (page 10), many of which we set out in our 2014 report.
2. We agree that while much progress has been made in strengthening independent accountability since 2010, serious challenges remain in countries and globally. We therefore strongly support the renewed attention to countries—a consistent theme in each of our three annual reports. We urge you to consider carefully, and make specific recommendations for, ways in which national mechanisms that are robust and fully participatory, including the most marginalized populations, can become a major force for independent accountability in countries and can feed into global accountability mechanisms.
3. We welcome the recommendation that a broader set of harmonized and SDG-aligned indicators needs to be defined urgently, including indicators for human rights.
4. We also agree that a revised Global Strategy 2.0 independent accountability system must take greater note of equity considerations (which will be extensively covered in the iERG's 2015 report),

adolescent health (see the iERG's 2013 Report), social determinants of health (our 2014 report), sexual and reproductive health (reports passim), humanitarian settings, and the private sector.

5. We wish to draw attention to the importance of donor accountability, notably missing from the current draft. Donor accountability was core to the original vision of CoIA, and is increasingly becoming a strong demand from countries. Unless donor accountability is fully addressed, we will likely find that independent accountability in countries will be resisted or seen as inequitable.
6. We support the conclusion by the drafting team that stronger processes are needed to facilitate follow-up actions. Despite several attempts, the iERG has not been able to secure strong enough follow-up by partners outside of a stakeholders' forum held after publication of iERG, PMNCH, and Countdown reports.
7. While we agree that existing independent accountability arrangements are fragmented, we do not fully share the solution for global accountability proposed by the drafting team. Here are some reasons for our concern.
 - The nature and extent of fragmentation is both misdiagnosed and insufficiently acknowledged. The division in global accountability is not primarily between iERG, Countdown, and PMNCH. In fact, these three entities have worked closely together these past 4 years to ensure the maximum possible coordination and coherence. The major fragmentation has been between vertical programmes—with separate accountability arrangements for A Promise Renewed, FP2020, Gavi, nutrition, Global Fund, and so on.
 - While we agree that PMNCH has many advantages as an organisation to support administratively and logistically global accountability, we do not agree that PMNCH itself should carry out the independent accountability function for GS 2.0. It is not sufficiently independent to do so, and nor does

it currently have the diversity and depth of experience necessary for this role.

- While we support the creation of an Independent Advisory panel, we do not agree that its function should be to “guide” and “peer review” an accountability process that is primarily the responsibility of PMNCH.
 - We do not agree that the Independent Advisory Panel (IAP) should report to the Chair of the PMNCH Board. The Chair of the PMNCH Board is not responsible for implementation of GS 2.0. The locus of that responsibility—and so the reporting line for the IAP—rests with the Executive Office of the Secretary-General, through WHO.
8. We have an alternative proposal to make to secure appropriately independent global accountability for women’s, children’s, and adolescents’ health.
- A 7-9 member IAP should be established through a widely disseminated call for nominations to all stakeholders, overseen by the PMNCH Board. The Board, or a sub-committee of the Board, would review candidates and make the final selection for IAP membership. That final shortlist would be sent to the UNSG for approval.
 - The core task of the IAP would be to gather and commission evidence from multiple sources and write an annual State of Women’s, Children’s, and Adolescents’ Health Report. PMNCH itself would not be given the primary responsibility for writing this report.
- To assist the IAP, a small technical team would be established (total 2 FTEs, appointed by the IAP in collaboration with PMNCH) to gather, analyse, and help interpret the data being considered by the IAP.
 - The IAP would report to the UNSG, through the DG of WHO.
 - PMNCH would not only act as the appointee organisation, through its Board, for the IAP—it would also be the locus of full administrative and logistical support for the IAP.
 - We would also encourage country-based IAPs to be created, set up by national governments, with the support of the H4+.
9. Regarding dissemination and action, we endorse your proposal that “a key lesson from GS1 is to ensure that the accountability process is linked/embedded in inter-governmental mechanisms. In this regard, key intergovernmental and regional bodies include the UNGA and the World Health Assembly, the African Union and the PPD.”
10. Finally, we would like to inform you that we are submitting a request to the EWEC Technical Content Working Group on Financing to add a sixth recommendation—namely, that a portion of financing be devoted to independent accountability at both global and national levels.

independent Expert Review Group (iERG)

Members

Mrs Joy Phumaphi **iERG Co-Chair**



Joy Phumaphi is the Executive Secretary of the African Leaders Malaria Alliance, a member of the UNSG's High-Level Panel on the Global Response to Health Crises, and the Chair of the Global Leaders Council for Reproductive Health. She served as Member of Parliament in Botswana, holding portfolio responsibility in the cabinet, first for Lands and Housing (1995–1999), and then for Health (1999–2003). She later joined the WHO as Assistant Director General for Family and Community Health (2003–2007). She has served as Vice President for Human Development at the World Bank (2007–2009) and has held positions on a number of commissions and expert groups. She currently sits on the Board of several international non-profit organizations working on global health.

Professor Richard Horton **iERG Co-Chair**



Richard Horton is Editor-in-Chief of The Lancet. He is an honorary professor at the London School of Hygiene and Tropical Medicine, University College London, and the University of Oslo; a Foreign Associate of the US Institute of Medicine; and a Fellow of the UK's Academy of Medical Sciences.

Dr Carmen Barroso **iERG Member**



Carmen Barroso is the Regional Director of International Planned Parenthood Federation, Western Hemisphere Region (IPPF/WHR). She has been a Professor of the Sociology Faculty at the University of Sao Paulo, Brazil—her native country—and a Director of the Population and Reproductive Health Program of the MacArthur Foundation, in Chicago, US.

Professor Zulfiqar Bhutta **iERG Member**



Zulfiqar Bhutta is the Robert Harding Inaugural Chair in Global Child Health and Policy at the Centre for Global Child Health at the Hospital for Sick Children, Toronto, Canada and the Founding Director of the Center of Excellence in Women and Child Health across all campuses of the Aga Khan University, in South-Central Asia and East Africa. He also holds adjunct professorships at several leading universities globally, including the Schools of Public Health at Johns Hopkins (Baltimore), Boston University School of Public Health, Tufts University (Boston), University of Alberta, and the London School of Hygiene & Tropical Medicine. Dr Bhutta leads large research groups across Karachi and Toronto focusing on knowledge synthesis, translation for policy, and impact.



Mrs Kathleen Ferrier
iERG Member

Kathleen Ferrier is actively involved in issues relating to international relations and cooperation, with a focus on health, human rights, migration, and sustainability. Born in Suriname, she worked on grassroots health, education, and development projects in Chile and Brazil, before serving as a member of parliament in the Netherlands for ten years. She currently lives in Hong Kong, where she works as an academic professor.



Ms Sejal Hathi
iERG Member

Sejal Hathi is an MD/MBA student at Stanford University, and the Cofounder & Global Ambassador for Girtank. She is a Stanford Hospital & Clinics Innovation Fellow, a Yale University Global Health Fellow, and a Paul & Daisy Soros Fellow. Sejal is pursuing a career at the nexus of technology, policy, and global health.



Professor Dean Jamison
iERG Member

Dean Jamison is an Emeritus Professor in the Department of Global Health at the University of Washington and a Senior Fellow in Global Health Sciences at the University of California, San Francisco. An economist, he is an elected member of the U.S. National Academy of Medicine.



Professor Tarek Meguid
iERG Member

Tarek Meguid is Consultant Obstetrician and Gynaecologist in Mnazi Mmoja Hospital and Associate Professor at the State University of Zanzibar (SUZA), School of Health & Medical Sciences, in Tanzania. He is the former Associate Professor and Head of the Department of Obstetrics & Gynaecology at the University of Namibia School of Medicine. He also served as Head of the Department of Obstetrics & Gynaecology at Bwaila Hospital and Kamuzu Central Hospital in Lilongwe, Malawi.

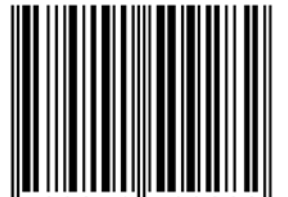


Professor Miriam Were
iERG Member

Miriam Were is currently the Chancellor of Moi University, Kenya. Professor Were's career path includes working as member of the University of Nairobi's Faculty of Medicine, with the Ministry of Health in Kenya, as UNICEF's Chief of Health and Nutrition in Ethiopia, as the WHO Representative in Ethiopia, and as Director of UNFPA's Technical Advisory Team for East, Central and Anglophone West Africa. Since retirement in 2000, she has remained professionally involved in the health sector, including as Chair of Kenya's National AIDS Control Council, Chair of the Board of the African Medical and Research Foundation (AMREF), and member of the Board of the Global Health Workforce Alliance (GHWA).



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ACHIEVEMENTS AND PROSPECTS