Countdown to 2015
Maternal, Newborn & Child Survival

Accountability for Maternal, Newborn & Child Survival

The 2013 Update

Country profiles featuring core indicators selected by the Commission on Information and Accountability for Women's and Children's Health

Accountability for maternal, newborn and child survival: The 2013 Update

ISBN: 978-92-806-4690-0

Cover Photo: UN Photo/John Isaac

Accountability for Maternal, Newborn & Child Survival

The 2013 Update

www.countdown2015mnch.org

Countdown to 2015

Maternal, Newborn & Child Survival

Contributors

Countdown to 2015 developed this annual report, in support of the recommendations of the Commission on Information and Accountability for Women's and Children's Health and the ongoing work of the independent Expert Review Group (iERG), to help ensure accountability for commitments to the Global Strategy for Women's and Children's Health.

Lead writing team: Jennifer Requejo (PMNCH), Jennifer Bryce (JHSPH), Cesar Victora (Federal University of Pelotas), Adam Deixel (Family Care International)

Profile development team: Tessa Wardlaw (UNICEF), Archana Dwivedi (UNICEF), Colleen Murray (UNICEF)

Production team: Adam Deixel (FCI), Virginia Taddoni (FCI), Jennifer Requejo (PMNCH)

Design: Virginia Taddoni and Sandy Zimmerman (FCI)

Acknowledgements

Countdown to 2015 would like to thank the following:

- UNICEF Statistics and Monitoring Section for use of the global databases, preparation of country profiles and review of report text; particular recognition goes to Priscilla Idele and Tyler Andrew Porth for their help with the HIV indicators, Liliana Carvajal for her help with the child and maternal health indicators, Danzhen You for her help with the child mortality data, and Colleen Murray for her help with the databases.
- Elizabeth Hazel and Emily Wilson (JHSPH) for their help with analysis of the coverage data; Aluisio Barros, Giovanny França, Maria Clara Restrepo and Andrea Damaso (Federal University of Pelotas) for their work on the equity data and graphs.
- DevInfo for its work on developing the profiles.
- The Countdown Scientific Review Group for its inputs in shaping the report: Cesar Victora (chair, Federal University of Pelotas), Jennifer Bryce (JHSPH), Jennifer Requejo (PMNCH), Joy Lawn (LSHTM), Bernadette Daelmans (WHO), Peter Berman (HSPH), Archana Dwivedi (UNICEF), Andres de Francisco (PMNCH), Monica Fox (JHSPH).
- The Countdown Leadership Sub Group for its oversight of the report development process: Mickey Chopra (UNICEF, co-chair), Zulfiqar Bhutta (Aga Khan University, co-chair), Liz Mason (WHO), Carole Presern (PMNCH), Ann Starrs (FCI), Cesar Victora (Federal University of Pelotas), Archana Dwivedi (UNICEF), Jennifer Requejo (PMNCH).
- Joy Lawn (LSHTM) for her contributions to the newborn report text; Robert E. Black (JHSPH) for his inputs on the nutrition and child mortality report text; Justine Hsu (WHO) for her review of the report text on financial flows to reproductive health; Ties Boerma for his review of the report text.
- The Coverage Technical Working Group for its review of the report text: Jennifer Bryce (co-chair, JHSPH), Holly Newby (co-chair, UNICEF), Tessa Wardlaw (UNICEF), Doris Chou (WHO), Sennen Hounton (UNFPA), Jennifer Requejo (PMNCH), Nancy Terreri (consultant), James Tibenderana (Malaria Consortium), Allisyn Moran (USAID), Steve Hodgins (Saving Newborn Lives), Shams el Arifeen (icddr,b), Archana Dwivedi (UNICEF), Donation Beguy (APHRC), Jocelyn DeJong (AUB), Huda Zurayk (AUB).
- The PMNCH Countdown Secretariat for providing administrative, technical and logistical support, including coordinating and contributing to Countdown activities and promoting the dissemination of Countdown products. Particular recognition goes to Nacer Tarif and Nick Green for providing administrative support.
- The Bill & Melinda Gates Foundation, The World Bank, and the Governments of Australia, Canada, Norway, Sweden, and the United Kingdom for their support for Countdown to 2015.

Countdown to 2015 for Maternal, Newborn & Child Survival

Countdown to 2015 is a global movement of academics, governments, international agencies, professional organizations, donors, and non-governmental organizations, with *The Lancet* as a key partner. Countdown:

- Uses country-specific data to track, stimulate, and support country progress towards achieving the health-related Millennium Development Goals (MDGs), particularly MDGs 4 (reduce child mortality) and 5 (improve maternal health)
- Focuses on coverage levels and trends for interventions proven to improve reproductive, maternal, newborn, and child health, as well as critical determinants of coverage: health systems functionality, health policies, and financing
- Examines equity in coverage across different population groups within and across Countdown countries
- Uses these data to hold countries and their international partners accountable for progress in reproductive, maternal, newborn, and child health
- Supports country-level Countdowns to promote coverage with evidence-based interventions

Since its first set of reports and events in 2005, Countdown has achieved global impact by using available data to hold stakeholders to account for global and national action. Countdown focuses on the 75 countries where more than 95% of all maternal and child deaths occur. Information on the selection process for country inclusion in Countdown is available at **www.countdown2015mnch.org**.

UN PHOTO/MARK GARTEN

About the Accountability Agenda

In September 2010, at a United Nations General Assembly summit to assess progress on the MDGs, Secretary-General Ban Ki-moon launched the Global Strategy for Women's and Children's Health, an unprecedented plan to save the lives of 16 million women and children by 2015.[a] The Commission on Information and Accountability for Women's and Children's Health was then established to develop a framework to monitor and track commitments made to the Global Strategy. The Commission's report, *Keeping Promises, Measuring Results*, identified a set of core indicators which, taken together, enable stakeholders to track progress in reducing maternal and child mortality and increasing coverage of interventions across the continuum of care. The report also urged that all data be disaggregated by key equity dimensions.[i] An independent Expert Review Group (iERG) was appointed by the Secretary-General in September 2011 to report annually on progress in 75 priority countries regarding implementation of the Commission's recommendations regarding reporting, oversight, and accountability. The first iERG report was published in September 2012.

a. Up-to-date information on commitments to the Global Strategy is available at *www.everywomaneverychild.org*.

WHO /CHRISTOPHER BLACK

A Time for Action – 1,000 Days and Counting

Core indicators identified by the Commission on Information and Accountability

- Maternal mortality ratio
- Under-five mortality rate, with the proportion of newborn deaths
- Children under five years of age who are stunted
- Demand for family planning satisfied (met need for contraception)
- Antenatal care coverage (at least four visits during pregnancy)
- Antiretroviral prophylaxis among HIV-positive pregnant women to prevent mother-to-child transmission of HIV and antiretroviral therapy for HIV-positive pregnant women who are treatment-eligible
- Skilled attendant at birth
- Postnatal care for mothers and babies within two days of birth
- Exclusive breastfeeding for first six months of life
- Three doses of combined diphtheria-tetanus-pertussis (DTP3) immunization coverage
- Antibiotic treatment for pneumonia

Fewer than 1,000 days remain until December 31, 2015, the deadline for the Millennium Development Goals (MDGs). As this date approaches, evidence is needed urgently about country progress – and challenges preventing progress – in scaling up the health interventions that work to save women's and children's lives.

Countdown to 2015 is committed to supporting the accountability agenda by providing evidence on progress for each of the 75 countries where more than 95% of all maternal and child deaths occur. Countdown has pledged to prepare an annual report with one-page profiles – adapted from the two-page country profiles produced by Countdown on a roughly two-year cycle – showcasing progress on the 11 core indicators selected by the Commission on Information and Accountability for Women's and Children's Health *(see box at left)*. These 11 indicators encompass key elements of the reproductive, maternal, newborn, and child health (RMNCH) continuum of care.

The results in this report highlight country achievements in increasing coverage of key interventions, and identify remaining challenges many countries face in reaching all women and children with life-saving services. *The key findings include:*

- Across most of the Countdown countries, levels of maternal and child mortality have both been dropping over the past two decades. But in some countries, particularly in sub-Saharan Africa where fertility levels typically remain high, progress has been slower. **These countries must be prioritized for collective global, regional, and national action.**
- Child deaths are increasingly concentrated in the first month of life. Newborn deaths now account for 40% or more of all child deaths in 35 of the Countdown countries. **Improving newborn survival, including reducing stillbirths, must be a major focus of policies and programs.**
- Undernutrition, in a synergistic relationship with infectious diseases, contributes to almost half of all child deaths. Levels of stunting, a form of growth failure resulting from chronic undernutrition, remain unacceptably high in virtually all 75 countries. **Nutrition must continue to be emphasized as an essential ingredient of maternal, newborn, and child survival programs.**
- Wide variations in coverage for interventions addressed by the Commission indicators, both across and within Countdown countries, show the importance of equity as a core component of all health strategies. **Global and national efforts must focus on reaching the poorest and other vulnerable sub-groups of the population.**
- High levels of fertility and unmet need for family planning in many Countdown countries highlight the need to broaden access to contraception. **The global community has woken up to this need, and the growing political momentum must be translated into substantially increased resources.**

Significant challenges remain before us. High population growth remains a looming obstacle to progress in countries where health systems are least equipped to respond to escalations in demand, and pervasive inequities must be addressed if we are to fulfill the promise of MDGs 4 and 5 for millions of women and children.

But, ultimately, this report is about hope. The country profiles contain many success stories which show that commitment, investment, and coordinated action can result in concrete achievements that will save countless lives.

Now is the time to learn from these success stories, and to act based on the evidence. Generations of women and children are counting on us.

UN PHOTO/MARK GARTEN

A snapshot of progress on the Commission indicators

This section summarizes the data presented in the 2013 country profiles, providing an overview of progress and challenges ahead across the 75 priority countries.

IMPACT INDICATORS

The Countdown profiles show promising news of reductions in maternal and child mortality.

Maternal mortality

The number of women who die each year from causes related to pregnancy or childbirth has dropped substantially – from 543,000 deaths in 1990 to around 287,000 deaths in 2010.[ii] Thirty Countdown countries achieved reductions of 50% or more in the maternal mortality ratio[b] between 1990 and 2010, and three countries (Equatorial Guinea, Nepal, and Vietnam) achieved reductions of at least 75%. Over fifty countries reduced maternal mortality during 2000-2010 at a faster rate than during the previous decade, showing that the pace of progress is improving. However, the news is not all positive. Nine Countdown countries in sub-Saharan Africa – all of which have struggled with high HIV prevalence or, in the case of Somalia, with protracted civil war and instability – experienced increases in maternal mortality in the past two decades. All Countdown countries need to continue efforts to increase coverage of high-quality services, including family planning, antenatal and postnatal care, and skilled delivery and emergency obstetric care. *See Table 1 on page 8.*

Child mortality

The global number of deaths in children under five years of age has dropped from nearly 12 million in 1990 to approximately 6.9 million in 2011.[iii] Eight Countdown countries (Bangladesh, Brazil, China, Egypt, Lao People's Democratic Republic, Liberia, Mexico, and Peru) achieved reductions of at least two-thirds in their under-five mortality rate during this time period, and 22 others achieved reductions of at least half. In more than 50 Countdown countries, the decline in child mortality has been accelerating, with a greater annual rate of reduction in 2000-2011 than in 1990-2000. However, some Countdown countries are lagging behind. In 24 countries – all of them, except Afghanistan, in sub-Saharan Africa – the under-five mortality rate in 2011 remained above 100 deaths per 1,000 live births. It is projected that, by 2050, one in three of the world's children will be born in sub-Saharan Africa.[iv] Efforts to improve child survival in sub-Saharan Africa must not only continue – they must be intensified. *See Table 2 on page 10.*

Almost two-thirds of all child deaths are the result of infectious diseases (malaria, pneumonia, diarrhea, sepsis, measles, and AIDS) that could be prevented through cost-effective, available interventions.[v]

As the global under-five mortality rate has fallen, the proportion of child deaths that occur in the neonatal period has increased. Neonatal deaths now account for 40% or more of all child deaths in 35 Countdown countries, and this percentage reached 50% or higher in 12 countries. Greater investment and attention to the newborn period, including the prevention of preterm births and stillbirths and the scale-up of effective, low-cost interventions such as antenatal corticosteroids, cord care, and kangaroo mother care, is needed if the world is to achieve MDG 4.

b. Because very few low- and middle-income countries have accurate civil registration of maternal deaths, and because household survey data sets with sample sizes adequate to measure maternal deaths – a relatively rare event – are not available for most countries, maternal mortality ratios are estimated on the basis of regression models such as the Maternal Mortality Estimation Inter-agency Group model, which includes country-level variables such as gross domestic product per capita, general fertility rate, and coverage of skilled attendant at birth.

TABLE 1

Reducing maternal mortality: Most countries are accelerating progress

Countdown countries, sorted by average annual rate of reduction 2000-2010[†,‡]

Country or territory	Maternal mortality ratio, modelled					
	Deaths per 100,000 live births			Average annual rate of reduction (%)		
	1990	2000	2010	1990-2010	1990-2000	**2000-2010**
Rwanda	910	840	340	4.9	0.9	**8.7**
Afghanistan	1300	1000	460	5.1	2.2	**7.9**
Botswana	140	350	160	-0.7	-9.5	**7.5**
Nepal	770	360	170	7.3	7.2	**7.4**
Cambodia	830	510	250	5.8	4.7	**6.9**
Ethiopia	950	700	350	4.9	2.9	**6.9**
Angola	1200	890	450	4.7	2.7	**6.7**
India	600	390	200	5.2	4.1	**6.3**
Equatorial Guinea	1200	450	240	7.9	9.6	**6.2**
Yemen	610	380	200	5.3	4.6	**6.0**
Malawi	1100	840	460	4.4	2.8	**5.9**
Lao People's Democratic Republic	1600	870	470	5.9	5.9	**5.9**
Tajikistan	94	120	65	1.8	-2.4	**5.8**
Peru	200	120	67	5.2	4.9	**5.6**
Vietnam	240	100	59	6.9	8.2	**5.5**
Bangladesh	800	400	240	5.9	6.6	**5.2**
Liberia	1200	1300	770	2.4	-0.5	**5.2**
Uganda	600	530	310	3.2	1.2	**5.1**
Morocco	300	170	100	5.1	5.3	**4.9**
Madagascar	640	400	240	4.7	4.5	**4.9**
China	120	61	37	5.9	6.8	**4.9**
Mexico	92	82	50	3.0	1.1	**4.8**
Eritrea	880	390	240	6.3	7.9	**4.6**
Tanzania, United Republic of	870	730	460	3.2	1.7	**4.6**
Ghana	580	550	350	2.6	0.5	**4.5**
Guinea	1200	970	610	3.4	2.4	**4.5**
Indonesia	600	340	220	4.9	5.4	**4.4**
Nigeria	1100	970	630	2.6	0.9	**4.3**
Benin	770	530	350	3.9	3.5	**4.3**
São Tomé and Príncipe	150	110	70	3.8	3.6	**4.1**
Egypt	230	100	66	6.0	7.9	**4.1**
Azerbaijan	56	65	43	1.3	-1.5	**4.0**
Myanmar	520	300	200	4.8	5.5	**4.0**
Burkina Faso	700	450	300	4.1	4.3	**4.0**
Niger	1200	870	590	3.6	3.3	**3.9**
Togo	620	440	300	3.5	3.2	**3.9**
Gambia	700	520	360	3.4	3.0	**3.8**
Korea, Democratic People's Republic of	97	120	81	0.9	-2.1	**3.8**
Bolivia	450	280	190	4.1	4.5	**3.7**
Mozambique	910	710	490	3.1	2.4	**3.7**
Côte d'Ivoire	710	590	400	2.8	1.9	**3.7**
Pakistan	490	380	260	3.0	2.4	**3.6**
Djibouti	290	290	200	1.9	0.1	**3.6**

TABLE 1 (CONTINUED)

Country or territory	Maternal mortality ratio, modelled					
	Deaths per 100,000 live births			Average annual rate of reduction (%)		
	1990	2000	2010	1990-2010	1990-2000	**2000-2010**
Congo, Democratic Republic of the	930	770	540	2.7	1.8	**3.6**
Brazil	120	81	56	3.5	3.5	**3.5**
Sierra Leone	1300	1300	890	1.8	0.2	**3.3**
Mali	1100	740	540	3.5	3.9	**3.2**
Turkmenistan	82	91	67	1.0	-1.1	**3.0**
Papua New Guinea	390	310	230	2.6	2.3	**2.9**
Senegal	670	500	370	3.0	3.0	**2.9**
Kenya	400	490	360	0.5	-2.0	**2.9**
Haiti	620	460	350	2.7	2.8	**2.7**
Burundi	1100	1000	800	1.5	0.4	**2.6**
Solomon Islands	150	120	93	2.2	2.3	**2.2**
Mauritania	760	630	510	2.0	1.9	**2.1**
Guinea-Bissau	1100	970	790	1.7	1.3	**2.1**
Iraq	89	78	63	1.7	1.3	**2.1**
Zambia	470	540	440	0.4	-1.3	**2.0**
Comoros	440	340	280	2.2	2.5	**1.9**
Gabon	270	270	230	0.8	-0.1	**1.7**
Sudan	1000	870	730	1.6	1.5	**1.7**
Philippines	170	120	99	2.8	3.8	**1.7**
Uzbekistan	59	33	28	3.7	5.7	**1.6**
Kyrgyzstan	73	82	71	0.2	-1.2	**1.5**
Central African Republic	930	1000	890	0.2	-0.9	**1.3**
South Africa	250	330	300	-0.9	-3.0	**1.1**
Zimbabwe	450	640	570	-1.2	-3.7	**1.1**
Swaziland	300	360	320	-0.3	-1.7	**1.1**
Lesotho	520	690	620	-0.9	-2.8	**1.0**
Chad	920	1100	1100	-0.7	-2.0	**0.6**
Guatemala	160	130	120	1.5	2.5	**0.6**
Cameroon	670	730	690	-0.2	-0.8	**0.5**
Somalia	890	1000	1000	-0.7	-1.4	**0.0**
Congo	420	540	560	-1.5	-2.5	**-0.4**

Source: Maternal Mortality Estimation Inter-agency Group (MMEIG) - WHO, UNICEF, UNFPA and World Bank, 2012

† Includes 74 countries. Disaggregated data for Sudan and South Sudan was not available for 2010.
‡ Negative value indicates an increase in the maternal mortality ratio.

TABLE 2

Reducing child mortality: Progress accelerating, but newborn deaths need action

Countdown countries, sorted by average annual rate of reduction 2000-2011†

Country or territory	Under-five mortality rate						% of under-5 deaths occurring in neonatal period (2011)
	Deaths per 1,000 live births			Average annual rate of reduction (%)			
	1990	2000	2011	1990-2011	1990-2000	**2000-2011**	
Rwanda	156	183	54	5.1	-1.6	**11.1**	42%
Botswana	53	81	26	3.4	-4.3	**10.4**	43%
China	49	35	15	5.8	3.3	**7.9**	58%
Cambodia	117	102	43	4.8	1.4	**7.9**	46%
Brazil	58	36	16	6.3	4.9	**7.5**	66%
Peru	75	39	18	6.8	6.6	**7.0**	51%
Egypt	86	44	21	6.7	6.6	**6.8**	35%
Liberia	241	164	78	5.4	3.9	**6.7**	36%
Senegal	136	130	65	3.5	0.4	**6.4**	41%
Malawi	227	164	83	4.8	3.2	**6.2**	35%
Lao People's Democratic Republic	148	81	42	6.0	6.0	**6.0**	42%
Tanzania, United Republic of	158	126	68	4.0	2.2	**5.7**	40%
Zambia	193	154	83	4.0	2.3	**5.6**	37%
Mexico	49	29	16	5.4	5.2	**5.6**	46%
Bangladesh	139	84	46	5.3	5.0	**5.5**	60%
Ethiopia	198	139	77	4.5	3.6	**5.3**	42%
Korea, Democratic People's Republic of	45	58	33	1.4	-2.5	**5.0**	52%
Niger	314	216	125	4.4	3.8	**5.0**	28%
Nepal	135	83	48	4.9	4.8	**5.0**	58%
Madagascar	161	104	62	4.6	4.4	**4.8**	38%
Mozambique	226	172	103	3.7	2.7	**4.7**	35%
Indonesia	82	53	32	4.5	4.4	**4.6**	49%
Morocco	81	53	33	4.3	4.3	**4.3**	56%
Bolivia	120	81	51	4.1	3.9	**4.3**	45%
South Africa	62	74	47	1.4	-1.7	**4.2**	43%
Guatemala	78	48	30	4.5	4.8	**4.2**	49%
Zimbabwe	79	106	67	0.8	-2.9	**4.1**	46%
Uganda	178	141	90	3.3	2.4	**4.1**	33%
Vietnam	50	34	22	4.0	3.9	**4.1**	55%
Kenya	98	113	73	1.4	-1.5	**4.0**	39%
Kyrgyzstan	70	47	31	4.0	3.9	**4.0**	48%
Azerbaijan	95	69	45	3.6	3.2	**3.9**	42%
Philippines	57	39	25	3.8	3.8	**3.9**	50%
Nigeria	214	188	124	2.6	1.3	**3.8**	34%
Tajikistan	114	95	63	2.8	1.9	**3.7**	40%
Haiti	143	102	70	3.4	3.4	**3.4**	36%
Eritrea	138	98	68	3.4	3.4	**3.4**	33%
India	114	88	61	3.0	2.6	**3.3**	53%
Solomon Islands	42	31	22	3.1	3.2	**3.1**	50%
Guinea	228	175	126	2.8	2.7	**3.0**	33%
South Sudan	217	165	121	2.8	2.8	**2.8**	29%
Lesotho	88	117	86	0.1	-2.9	**2.8**	46%
Turkmenistan	94	71	53	2.8	2.8	**2.8**	44%
Afghanistan	192	136	101	3.1	3.4	**2.7**	40%
Myanmar	107	84	62	2.6	2.5	**2.6**	47%

TABLE 2 (CONTINUED)

Country or territory	Under-five mortality rate						% of under-5 deaths occurring in neonatal period (2011)
	Deaths per 1,000 live births			Average annual rate of reduction (%)			
	1990	2000	2011	1990-2011	1990-2000	**2000-2011**	
Pakistan	122	95	72	2.5	2.5	**2.5**	48%
Benin	177	140	106	2.4	2.4	**2.5**	30%
Sierra Leone	267	241	185	1.7	1.0	**2.4**	27%
Yemen	126	99	77	2.4	2.4	**2.4**	43%
Gambia	165	130	101	2.3	2.3	**2.4**	36%
Equatorial Guinea	190	152	118	2.3	2.2	**2.3**	33%
Ghana	121	99	78	2.1	2.0	**2.2**	38%
Angola	243	199	158	2.1	2.0	**2.1**	29%
Gabon	94	82	66	1.7	1.4	**2.1**	39%
Comoros	122	100	79	2.0	2.0	**2.1**	41%
Uzbekistan	75	61	49	2.1	2.1	**2.1**	30%
Papua New Guinea	88	72	58	2.0	2.0	**2.0**	39%
Burkina Faso	208	182	146	1.7	1.4	**2.0**	25%
Mali	257	214	176	1.8	1.8	**1.8**	29%
Côte d'Ivoire	151	139	115	1.3	0.9	**1.7**	37%
Sudan	123	104	86	1.7	1.7	**1.7**	37%
Burundi	183	165	139	1.3	1.0	**1.5**	32%
Djibouti	122	106	90	1.5	1.4	**1.5**	38%
Togo	147	128	110	1.4	1.4	**1.4**	33%
Guinea-Bissau	210	186	161	1.3	1.2	**1.3**	29%
Iraq	46	43	38	0.9	0.7	**1.1**	54%
Chad	208	189	169	1.0	1.0	**1.0**	27%
Swaziland	83	114	104	-1.0	-3.2	**0.9**	34%
Congo	119	109	99	0.9	0.9	**0.9**	33%
Cameroon	145	140	127	0.6	0.4	**0.8**	27%
Congo, Democratic Republic of the	181	181	168	0.4	0.0	**0.7**	29%
Central African Republic	169	172	164	0.2	-0.2	**0.5**	29%
Mauritania	125	118	112	0.5	0.6	**0.5**	37%
São Tomé and Príncipe	96	93	89	0.4	0.4	**0.4**	34%
Somalia	180	180	180	0.0	0.0	**0.0**	29%

Source: Inter-agency Group for Child Mortality Estimation (IGME) – UNICEF, WHO, World Bank and UN Population Division, 2012

† Negative value indicates an increase in the child mortality rate.

Nutrition

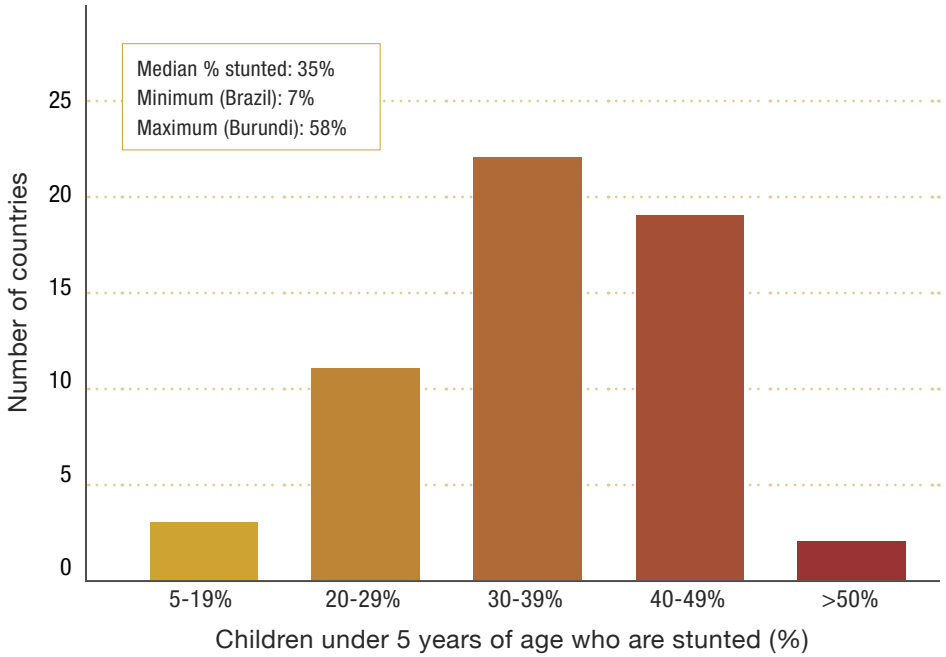
Undernutrition, in a synergistic relationship with infectious diseases, accounts for almost half of all child deaths.[vi] Poor nutrition increases a child's susceptibility to death from diseases such as pneumonia, diarrhea, and measles. It can also result in long-lasting, negative cognitive and physical consequences, including intellectual impairment and elevated risk of adult-onset cardiovascular disease and diabetes. In recent years, stunting has been singled out as the key indicator for assessing child undernutrition and its harmful immediate and long-term consequences. Stunting reflects chronic exposure to inadequate diets and infections, especially in the first two years of life. Although stunting levels have been declining globally, Africa is the only major world region where the absolute number of stunted children increased in the last decade because of continued high population growth.[vii] Eighty percent of the world's stunted children now live in 14 Countdown countries;[viii] in 43 Countdown countries, approximately one-third or more of all children are stunted. Virtually all of the 57 Countdown countries with recent data show stunting levels that require urgent remedial action. *See Figure 1.*

There is increased understanding of the crucial importance of the 1,000-day window encompassing pregnancy and the first two years of life, when rapid physical and mental development occurs. Improving the nutritional status of women prior to and throughout pregnancy can reduce the incidence of low birth weight and other poor obstetrical outcomes. Providing optimal nutrition to children during the first two years of life can help prevent stunting. In 20 Countdown countries with data for a range of infant feeding indicators during the time period 2007-2012,[c] the median coverage for early initiation of breastfeeding is 53%, and the median coverage for exclusive breastfeeding up to six months of age is 48%. These low figures indicate the urgency of strengthening infant

FIGURE 1

Stunting prevalence indicates widespread undernutrition

Children under 5 years of age who are stunted (%), 57 Countdown countries, 2007-2012†



Source: UNICEF global databases, January 2013, based on Demographic and Health Surveys, Multiple Indicator Cluster Surveys, and other household surveys

† Includes data from India, 2005-2006

c. Countdown analysis of Demographic and Health Surveys and Multiple Indicator Cluster Surveys

and young child feeding programs and other community-based programs in many Countdown countries, to promote optimal breastfeeding and complementary feeding practices and appropriate micro-nutrient supplementation (e.g., vitamin A and zinc) up to and beyond two years of age. Antenatal, delivery, and postnatal care services also offer opportunities to counsel women, including women living with HIV, on breastfeeding and other nutritional practices.

Stunting is a condition often rooted in poverty. It reflects the harsh challenges many women face in accessing income-earning opportunities, education, and health care for themselves and their children. Children of mothers with less education, for example, are at higher risk of stunting *(see Figure 2 on page 14)*.[ix] In all 32 Countdown countries with available data, stunting prevalence is lowest among children of mothers with at least some secondary education and highest among children of mothers with no education.

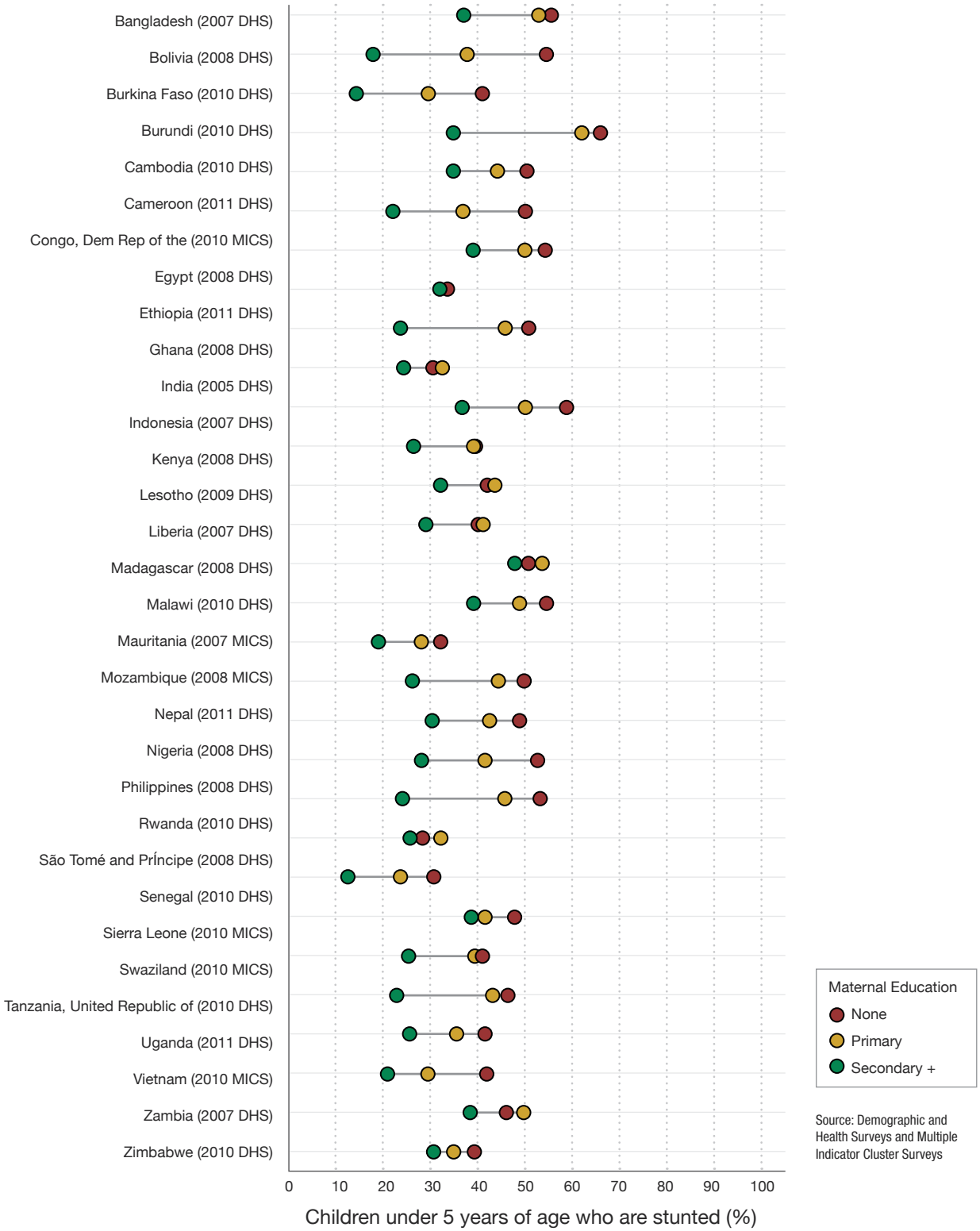
Movements to integrate nutrition initiatives, such as the *Road Map for Scaling-Up Nutrition*, into national reproductive, maternal, newborn, and child health programs must continue to be prioritized in the Countdown countries. Addressing undernutrition and increasing the impact of nutrition-specific interventions also requires multi-sectoral efforts including social protection and women's empowerment initiatives, agricultural and food fortification programs, food subsidies for the poor, and water and sanitation programs. In light of rapidly rising food prices and volatile markets in recent years, the global community has a responsibility to help countries meet the growing costs of feeding their populations.

WHO /CHRISTOPHER BLACK

FIGURE 2

Stunting is lower when mothers have been educated

Stunting prevalence by maternal education, Countdown countries with recent data



Source: Demographic and Health Surveys and Multiple Indicator Cluster Surveys

INDICATORS OF INTERVENTION COVERAGE

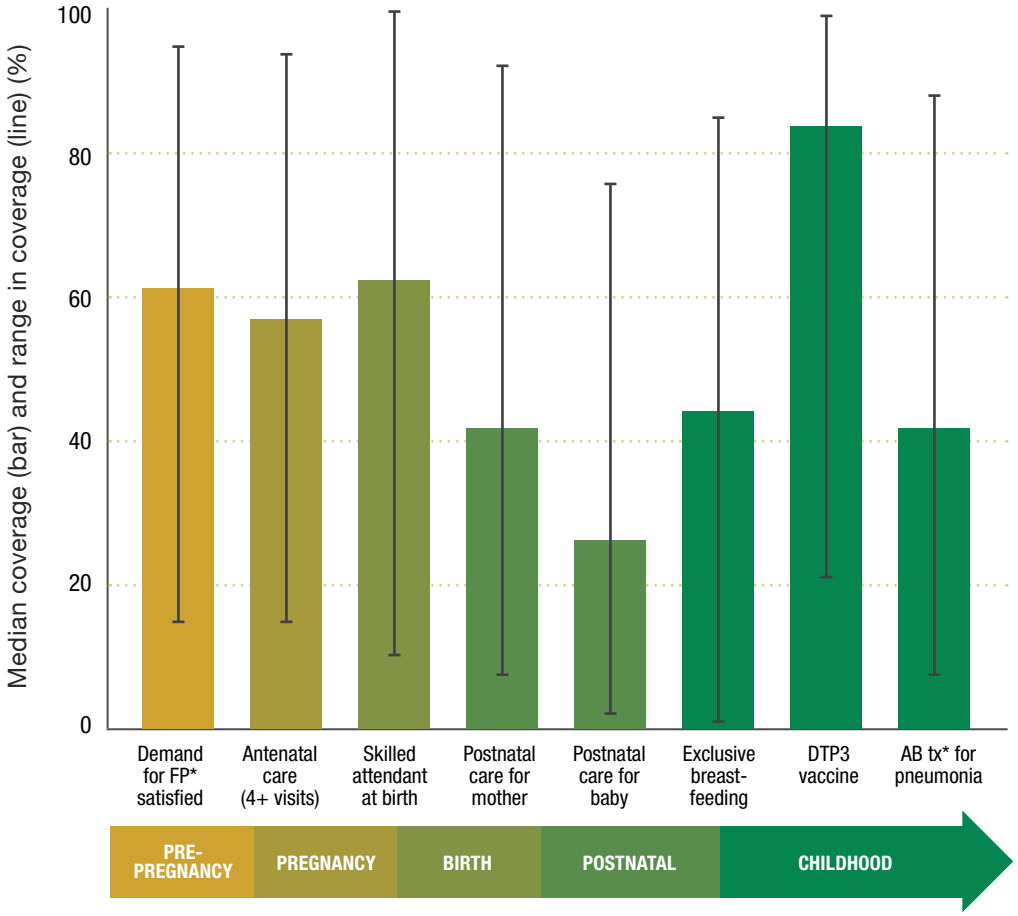
The Commission selected a set of core coverage indicators that reflect the continuum of care and have strong political and public health significance across the 75 priority countries (*see box on page 4*). These represent a sub-set of the indicators that Countdown tracks and uses to assess progress towards achieving the health MDGs.

Figure 3 and Table 3 show median coverage levels and the range in coverage of these indicators for Countdown countries with available data (2007-2012). Although not selected by the Commission, data on careseeking for pneumonia is included in Table 3 to complement the information provided on antibiotic treatment, because both are needed to interpret progress in coverage of correct treatment for pneumonia.[ix] The two HIV indicators selected by the Commission are presented separately in order to highlight the latest coverage estimates in the 21 Countdown countries considered priority countries for the prevention of mother-to-child transmission of HIV (PMTCT).

FIGURE 3

Coverage varies across the continuum of care

Coverage levels for selected Commission indicators of intervention coverage,† median and range for priority countries with data available, 2007-2012‡



Sources: DTP3: WHO and UNICEF; postnatal care for mother and postnatal care for baby: Saving Newborn Lives analysis of Demographic and Health Surveys; all other indicators: UNICEF global databases, January 2013, based on Demographic and Health Surveys, Multiple Indicator Cluster Surveys, and other national surveys

* FP = Family planning; AB tx = antibiotic treatment for pneumonia

† Definitions of these and other Countdown indicators are available at *www.countdown2015mnch.org/about-countdown/country-selection-and-data.*

‡ Includes the 2005-2006 India NHFS/DHS where applicable

These results highlight noteworthy models of success – for each of the interventions, at least one country has achieved a coverage level exceeding 75%; and for five interventions, at least one country has reached over 90% coverage. The results also show wide variation in coverage across the countries, and for every intervention, there is at least one country with unacceptably low coverage. Comparison of median coverage levels similarly shows a mixed picture, with medians of above 80% for DTP3 immunization but less than 45% for postnatal care for mothers, postnatal care for babies, exclusive breastfeeding, and antibiotic treatment for pneumonia. More intensive efforts are needed to achieve universal coverage for all of these critical interventions.

Equity matters

Recognizing that progress in maternal, newborn, and child survival requires reaching all population sub-groups with essential health services, the Commission recommended monitoring its selected indicators according to key equity dimensions such as wealth, gender, age, maternal education, ethnicity, and urban/rural residence. Each Countdown country profile includes a graph presenting coverage for a set of interventions among the poorest and richest households. Analysis of the Countdown data shows pronounced inequities in coverage for many essential interventions, with women and children from richer households much more likely to receive care than those from poorer households. This pattern is particularly evident for interventions that require a functional health system, such as skilled attendant at birth.[xi] Figure 4 shows coverage of skilled attendant at birth by level of maternal education in the 32 Countdown countries with available data. In all countries, coverage is substantially higher among women with secondary or higher education than for women with no education. The median absolute difference in coverage between these two groups of women across the Countdown countries is 43 percentage points, ranging from a low of 15 percentage points in São Tomé and PrÍncipe to a high of 70 percentage points in Cameroon. *See page 18.*

Countdown trend analyses have found that countries achieving rapid progress in intervention coverage have accomplished this primarily by

TABLE 3

A snapshot of coverage levels for select Commission indicators, priority countries with data available (2007-2012)†

Commission indicator‡	Number of countries with data	Median (%)	Range (%)
Demand for family planning satisfied (met need for contraception)	37	61	15-95
Antenatal care (four or more visits)	44	57	15-94
Skilled attendant at birth	57	62	10-100
Postnatal care (within two days):			
for mother	31	42	7-92
for baby	11	26	5-77
Exclusive breastfeeding (< 6 months)	49	44	3-85
DTP3 vaccine coverage	75	84	22-99
Careseeking for pneumonia	51	55	26-80
Antibiotic treatment for pneumonia	36	42	7-88

Source: UNICEF global databases, January 2013, based on Demographic and Health Surveys, Multiple Indicator Cluster Surveys, and other national surveys

† Includes the 2005-2006 India NHFS/DHS where applicable

‡ Includes data on careseeking for pneumonia to complement the information provided on antibiotic treatment, because both are needed to interpret progress in coverage of correct treatment for pneumonia

improving coverage in the poorest wealth quintiles.[xii] This suggests that countries should consider equity and target vulnerable population sub-groups when they are developing strategies for scaling-up interventions and reaching national health goals. Initiatives aimed at improving the status of women, including girls' and women's access to education, should also be emphasized.

HIV indicators

The Commission selected two related HIV indicators to promote the provision of antiretroviral therapy to HIV-positive pregnant women, both for their own health and to reduce the risk of HIV transmission to their babies. These indicators are important measures of progress towards MDG 6, and the global goals of reducing AIDS-related maternal mortality by half by 2015[xiii] and achieving an AIDS-free generation. Table 4 shows coverage levels of the most efficacious regimens[d] for the prevention of mother-to-child transmission of HIV (PMTCT) in the Countdown countries considered priority countries for the elimination of vertical transmission (excluding India and the Democratic Republic of Congo, where data are not available for 2011). The table shows wide variations in coverage levels across the countries, with five countries reaching 75% or more of those in need and four reaching less than 25% of the target population.

Global coverage of antiretroviral therapy for HIV-positive pregnant women who are treatment-eligible, for their own health, was 30% in 2011.[xiii, e]

TABLE 4

PMTCT coverage varies widely between countries

Estimated antiretroviral coverage for preventing mother-to-child transmission for HIV-positive pregnant women who are treatment-eligible, in 19 of the 21 Countdown countries considered priority countries for eliminating mother-to-child transmission (2011)

Country	Prevention of mother-to child transmission, most efficacious regimens,† 2011 (%)	Prevention of mother-to-child transmission, range, 2011 (%)
South Africa	>95	>95->95
Swaziland	>95	86->95
Botswana	94	83->95
Zambia	86	74->95
Ghana	75	61-90
Tanzania, United Republic of	74	65-85
Côte d'Ivoire	68	56-81
Kenya	67	59-75
Lesotho	62	55-70
Zimbabwe	54	48-62
Cameroon	53	45-62
Malawi	53	46-61
Burundi	52	43-62
Mozambique	51	43-61
Uganda	50	43-57
Ethiopia	24	20-28
Nigeria	18	15-21
Angola	16	10-24
Chad	11	8-14

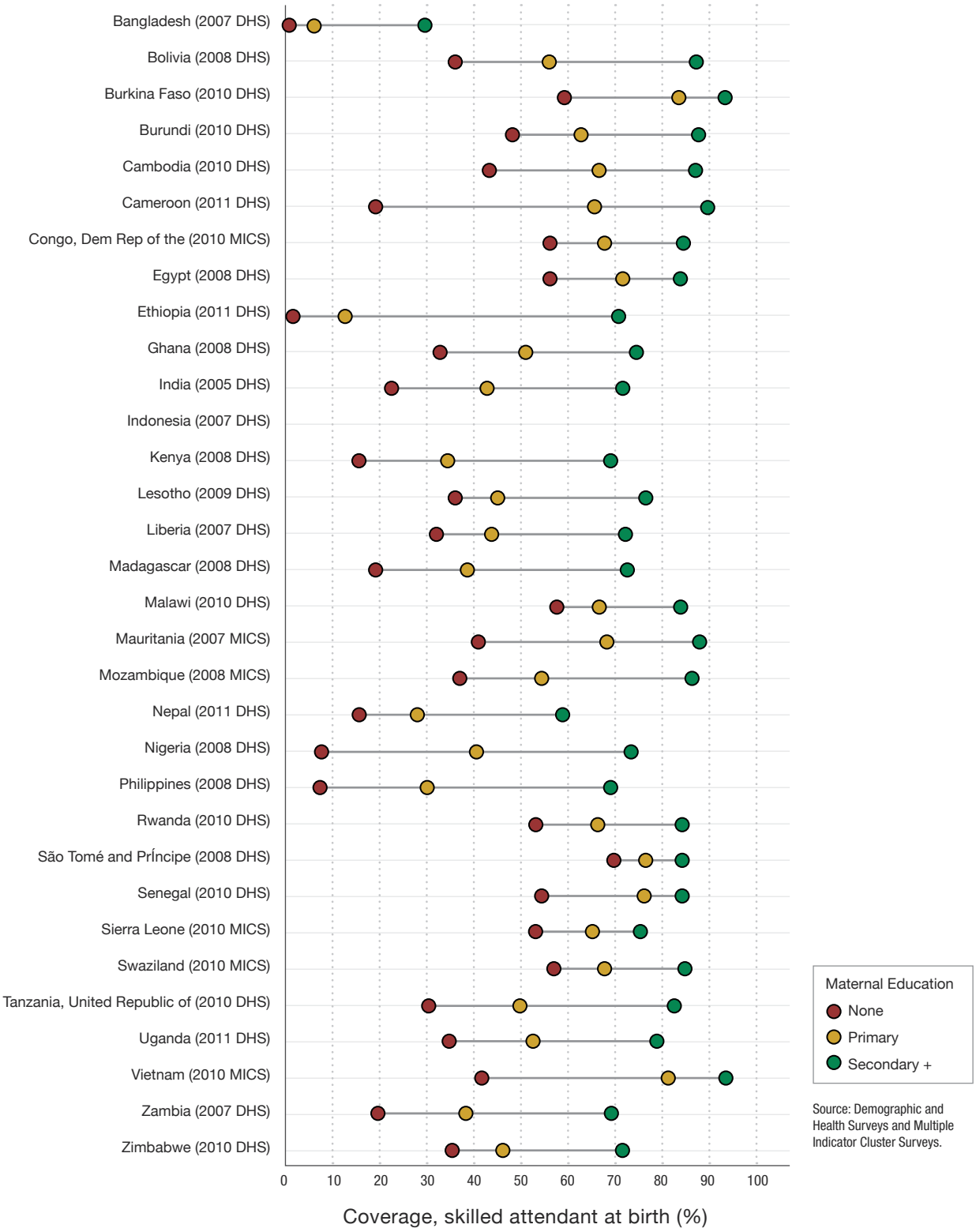
Source: UNAIDS, Report on the Global AIDS Epidemic, 2012, published via AIDSinfo

d,† Coverage data on PMTCT from 2010 and 2011 includes all regimens minus single-dose nevirapine. Data from 2005-2009 includes all regimens, including single-dose nevirapine.
e. Data are currently unavailable for the Countdown countries on antiretroviral therapy for HIV-positive pregnant women who are treatment-eligible, for their own health.

FIGURE 4

Educated women are more likely to give birth with a skilled attendant

Skilled attendant at birth, by maternal education, Countdown countries with recent data



Source: Demographic and Health Surveys and Multiple Indicator Cluster Surveys.

WHO /CHRISTOPHER BLACK

Lessons Learned: Taking Action Today and Tomorrow

Replicating the success of HIV interventions: *Advocacy, commitment, investment*

Figure 5 compares the annual percentage-point change in coverage for PMTCT and careseeking for pneumonia from around 2005 to around 2010, for all countries with available data.[f] Although most countries began this approximately five-year period with low coverage levels for both interventions, gains in coverage for PMTCT were considerably greater in every country than for careseeking for pneumonia, for which some countries even experienced drops in coverage. The message is clear: coordinated advocacy plus political commitment and financial investment can bring rapid increases in coverage. The same level of attention that has been devoted to HIV-related services must be extended to other leading killers of women and children, including pneumonia and diarrhea which together account for 2 million child deaths each year (nearly 15 times the number of child deaths caused by AIDS).[xv, xvi] The April 2013 launch of the Global Action Plan for Pneumonia and Diarrhea, in the context of the "A Promise Renewed" initiative to end preventable child deaths, is a significant step in this direction,[xvii, xviii] as are rapidly expanding efforts to provide coordinated services at the community level for mothers and children without access to health facilities.[xix]

Meeting the demand for family planning: *addressing population growth and saving lives*

Reproductive health has gained political visibility in recent years, starting with the adoption of universal access to reproductive health as a second MDG 5 target in 2007 and followed by the launch in 2010 of the Global Strategy for Women's and Children's Health, which included commitments for reproductive health services. In 2012, the Bill & Melinda Gates Foundation and the Government of the United Kingdom co-convened the Family Planning Summit in London, to catalyze political and financial commitment to address the vast unmet need for family planning in the 69 poorest countries[g] (of which 62 are also Countdown countries). At the summit, 24 Countdown countries made commitments to improve access to family planning.

Family planning services can improve maternal mortality by reducing unintended and high-risk pregnancies and unsafe abortions. These services can also help improve newborn and child survival by lengthening inter-pregnancy intervals.[xx]

New Countdown analyses show that the total volume of official development assistance to reproductive health (broadly defined as inclusive of maternal and newborn health services, family planning, sexual health, the treatment and prevention of sexually transmitted diseases, and the treatment and prevention of HIV) was approximately $5579 million in 2009 and $5637 million in 2010, a slight increase of 1%.[xxi] On average across the two years, more than half of this aid was directed to HIV services, and only around 7% was allocated to family planning.

The Countdown countries received approximately three-quarters of all official development assistance to reproductive health in both 2009 and 2010. Aid to the Countdown countries increased at a rate of 5.3%, from $4066 million in 2009 to $4284 million in 2010.

Significant additional investment in comprehensive family planning services is urgently needed, given

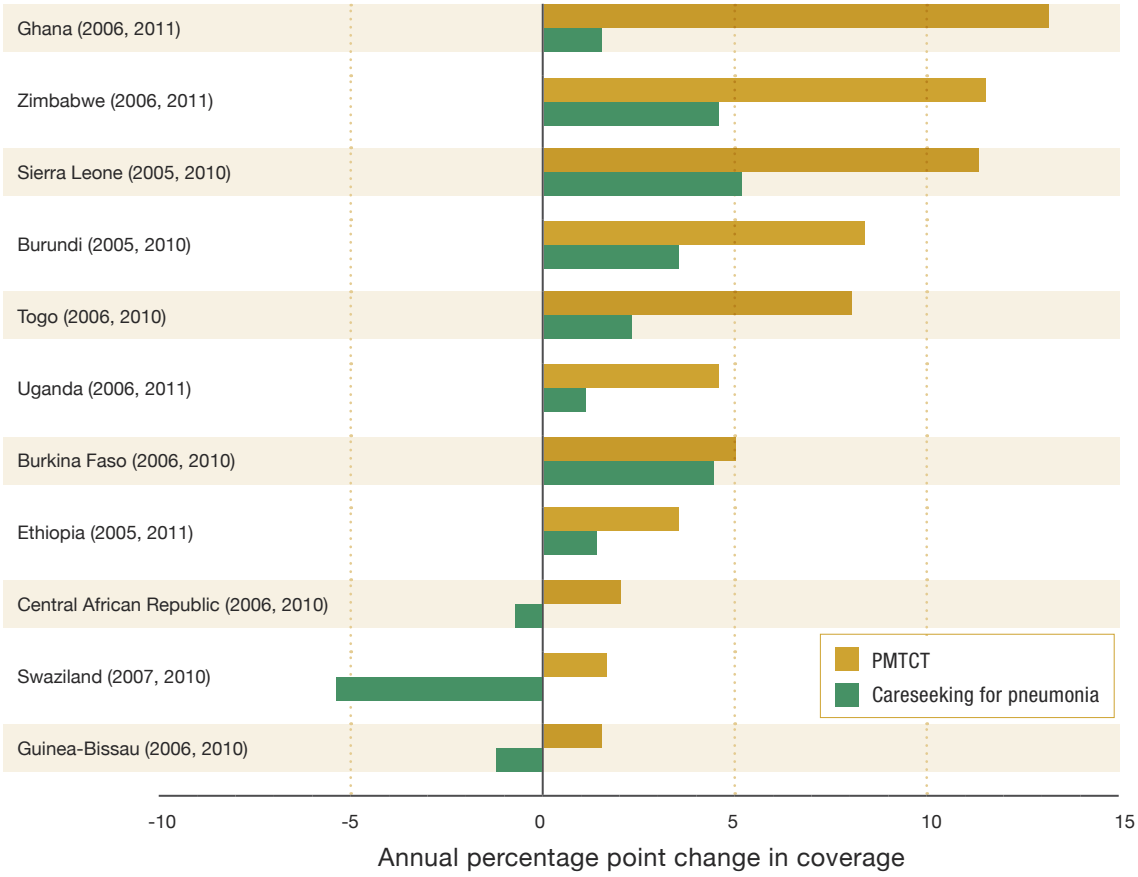
f. The data sources for the two indicators are different. Annual estimates for PMTCT are derived from a joint reporting process by the World Health Organization, UNICEF, and the Joint United Nations Programme on HIV/AIDS. Data for careseeking for pneumonia are from UNICEF global databases based on Demographic and Health Surveys, Multiple Indicator Cluster Surveys, and other national surveys, which for some countries were not performed during the years immediately around 2005 and 2010.

g. The poorest countries are defined as those with a Gross National Income (GNI) of $2,500 per year or less (based on the World Bank 2010 classification using the Atlas Method) – a group of 69 countries.

FIGURE 5

Rapid gains for PMTCT: Why can't we do the same for other interventions?

Annual percentage point change in coverage for careseeking for childhood pneumonia and PMTCT over about 5 years; all Countdown countries with sufficient data (around 2005 and around 2010)



Sources: ARVs for PMTCT: UNAIDS, Report on the Global AIDS Epidemic, 2012, published via AIDSinfo; Careseeking for pneumonia: UNICEF global databases, January 2013, based on Demographic and Health Surveys, Multiple Indicator Cluster Surveys, and other national surveys

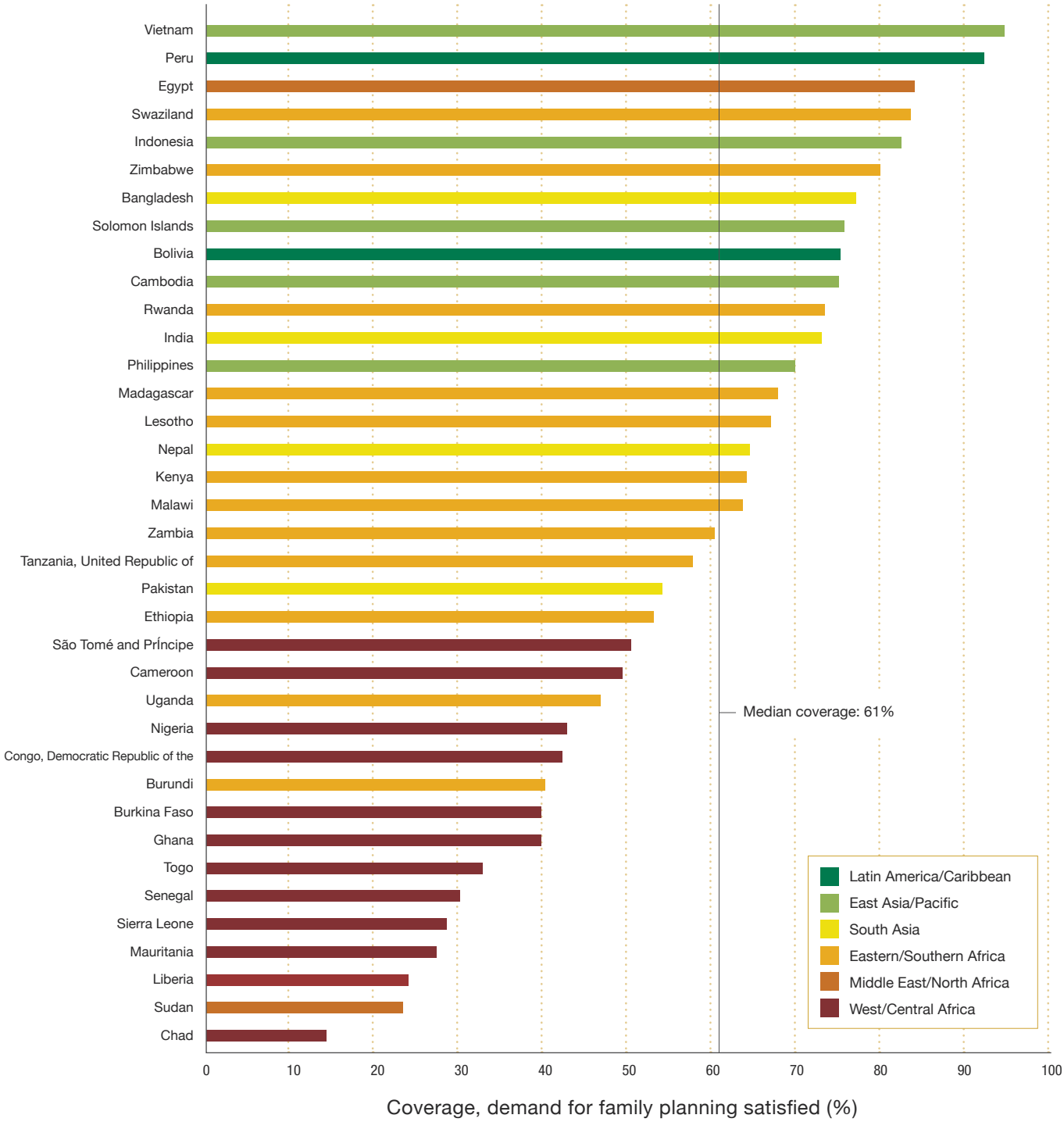
continued high fertility rates and high levels of unmet need in many Countdown countries. More than half of all Countdown countries have a total fertility rate of 4.0 children per woman or higher; 35 of these countries are in sub-Saharan Africa, with 21 in West and Central Africa and 14 in Eastern and Southern Africa.[h] This concentration of high fertility is matched by generally low levels of contraceptive use in countries in sub-Saharan Africa. As shown in Figure 6, Countdown countries with the lowest coverage levels of the Commission indicator 'demand for family planning satisfied' are clustered in West and Central Africa, while the best-performing countries tend to be in the East Asia and Pacific region and the Latin America and Caribbean region, where fertility levels have been dropping in nearly all countries. The median coverage for the 37 Countdown countries with data is 61% with a range of 15% (Chad) to 95% (Vietnam). *See Figure 6 on page 22.*

h. Countdown categorizes countries according to UNICEF world regions.

FIGURE 6

Action is needed to meet family planning needs, especially in Africa

Demand for family planning satisfied, 2007-2012



Source: United Nations Population Fund global database, January 2013, based on Demographic and Health Surveys, Multiple Indicator Cluster Surveys, Reproductive Health Surveys, and other national surveys

Scaling up services to save more mothers and newborns

Through several major initiatives and resolutions – such as "A Promise Renewed," "Every Woman Every Child," and the UN Commission on the Status of Women's resolution on eliminating preventable maternal mortality – countries around the world have committed to reducing preventable deaths of mothers and of children under five years of age. The global percentage of child deaths occurring during the newborn period is now 43%,[xxii] making a focus on saving newborn lives essential to reaching this goal and achieving MDG 4. Proven, cost-effective interventions can reduce newborn deaths by three-quarters without the need for intensive care. Many of these interventions can be delivered through antenatal care, skilled delivery, and postnatal care visits, which represent major opportunities to reach mothers and their babies with lifesaving services that often bring long-lasting health and developmental benefits. Improved care at birth is also the most important strategy for reducing stillbirths.[xxiii]

Many Countdown countries are experiencing severe shortages of health workers, drugs, and medical supplies, and many families living in remote and disadvantaged areas continue to face barriers to accessing health care facilities. To address these issues and to increase the availability of postnatal care services for mothers and their babies, WHO and UNICEF in 2009 issued a Joint Statement[xxiv] recommending home visits during pregnancy and in the first week of life as a complementary strategy to facility-based services. Interventions recommended during these home visits include promotion of exclusive breastfeeding and family planning, appropriate cord and thermal care, counseling on danger signs, and treatment and referral when needed.

A recent WHO study found that over half of the 68 African and Asian countries surveyed now have a policy on home visits for newborns, and 30 countries are now implementing community-based home visit packages for newborn care.[xxv] Reported national coverage of postnatal care for babies ranged from 6% to 100%, but only four countries surveyed reported coverage levels exceeding 50% for home visits within two days of birth. Improvements in the coverage and quality of postnatal care are clearly needed. This will require greater financial commitment to newborn health, more research on the optimal timing and content of services during the postnatal period, continued integration of newborn care interventions into facility-based maternity care and frontline health worker delivery platforms, strengthening linkages between frontline workers and health facilities, and monitoring of postnatal services.[xxvi]

The lack of available coverage data on newborn interventions makes it difficult to evaluate scale-up efforts. Only 11 Countdown countries, for example, have recent data on postnatal care for babies. An inter-agency technical working group on newborn indicators, convened by Saving Newborn Lives/ Save the Children, is actively advocating for stronger health information systems, including vital registration, to better track newborn mortality, preterm births, and stillbirths. It is also developing metrics for consistent assessment of coverage of proven interventions provided around the time of birth and in the early postnatal period. These key interventions include antenatal corticosteroids, neonatal resuscitation, drying and thermal care for the newborn, cord care, kangaroo mother care, and care-seeking and treatment for newborn sepsis.[xxvii] Several of these interventions are priorities for the United Nations Commission on Life-Saving Commodities, and collaborative work is underway to identify and address bottlenecks to their scale-up.

Accountability: Now is the time

Accountability requires each of us to take action. Countdown is committed to making the evidence on progress accessible to decision makers, stimulating action where it is needed by producing regular reports and country profiles. Because success depends upon country ownership and participation, Countdown is now engaging in country-level activities to catalyze change through better information.

Understanding the determinants of success: *In-depth country case studies*

In a small number of countries, Countdown is supporting intensive analysis of the determinants of progress in RMNCH and nutrition. Independent scientists, working closely with Ministries of Health, review existing data on financial inputs, policies and systems factors, program implementation, broader contextual factors, intervention coverage, and equity patterns. They examine not only the extent of progress in reducing maternal, newborn, and child mortality, but also why and how this progress was or was not achieved. Niger was the first country to undertake such a case study analysis, focusing on the dramatic reductions in under-five mortality that were documented over the past decade.[xxviii] Bangladesh is completing a similar effort now, focusing on maternal mortality. These and future case studies will contribute to a more refined understanding of the interplay of factors that lead to progress, identifying potential lessons that can be applied in other contexts and building national capacity for such analyses.

Using evidence to guide decision making: *Country Countdowns*

Countdown is also supporting a country-led process, the Country Countdown, which offers countries a set of methods and tools for making data an effective instrument of change. At the heart of the Country Countdown is the development and dissemination of sub-national profiles through a consultative process involving all key stakeholders. The Country Countdown helps countries ensure that policy follows evidence, and that investments of health resources support interventions proven to save lives. It empowers decision makers with the information they need to set priorities, and to strengthen evidence-based programs that focus on efficiency, effectiveness, and equity. It aligns with the international and regional frameworks that have been put in place to support and monitor countries' fulfillment of their RMNCH commitments, and provides a template for objectively and consistently tracking progress and ensuring accountability.

The aim of all Countdown country-level activities is to:

- Increase public and policy attention to RMNCH, and to achievement of MDGs 4 and 5
- Focus national health strategies, investments, and programming to achieve high and equitable coverage of high-impact interventions, with emphasis on reaching the underserved
- Increase and more efficiently allocate financial resources for RMNCH
- Strengthen capacity to assess and analyze data, and to use data for evidence-based action
- Improve the quantity and quality of data, as national leaders become more aware of its importance and of current data gaps
- Foster accountability, both for committed actions and for outcomes

The global Countdown team is committed to supporting and facilitating these country-led activities by developing and disseminating tools, providing technical support as needed, and sharing relevant experiences from both the global and country levels. More information is available at **www.countdown2015mnch.org/country-countdown**.

WHO /CHRISTOPHER BLACK

The Countdown country profile: A tool for action

The Countdown country profile presents in one place the best and latest evidence to enable an assessment of a country's progress in improving RMNCH and nutrition. It provides a snapshot across the continuum of care on where success has been achieved and where gaps remain, which can inform national reviews and other prioritization processes. Above all, the country profile is a tool for ***action***. It helps decision makers to identify where progress has been too slow, and where resources should be directed. It yields information on achievements that can guide policy and program development, and strengthen scale-up efforts.

Exploring the country profile is just a first step. Only our actions, informed by the evidence, can save the lives of the millions of women and children who still face the risk of preventable death. The time for action is ***now***.

How to use the country profile

STEP 1: REVIEW THE DIFFERENT TYPES OF INFORMATION

The first step is to explore the range of data presented in the profile: demographic factors, mortality measures, coverage of evidence-based interventions, nutritional status measures, and measures of socioeconomic equity in coverage. Key questions to ask in reviewing the data include the following:

- Are trends in mortality and nutritional status moving in the right direction? Is the country on track to achieve the health MDGs?
- How high is coverage for the various interventions? Are trends moving in the right direction towards universal coverage? Are there gaps in coverage for specific interventions?
- How equitable is coverage? Are certain interventions particularly inaccessible for the poorest segment of the population?

Key population characteristics

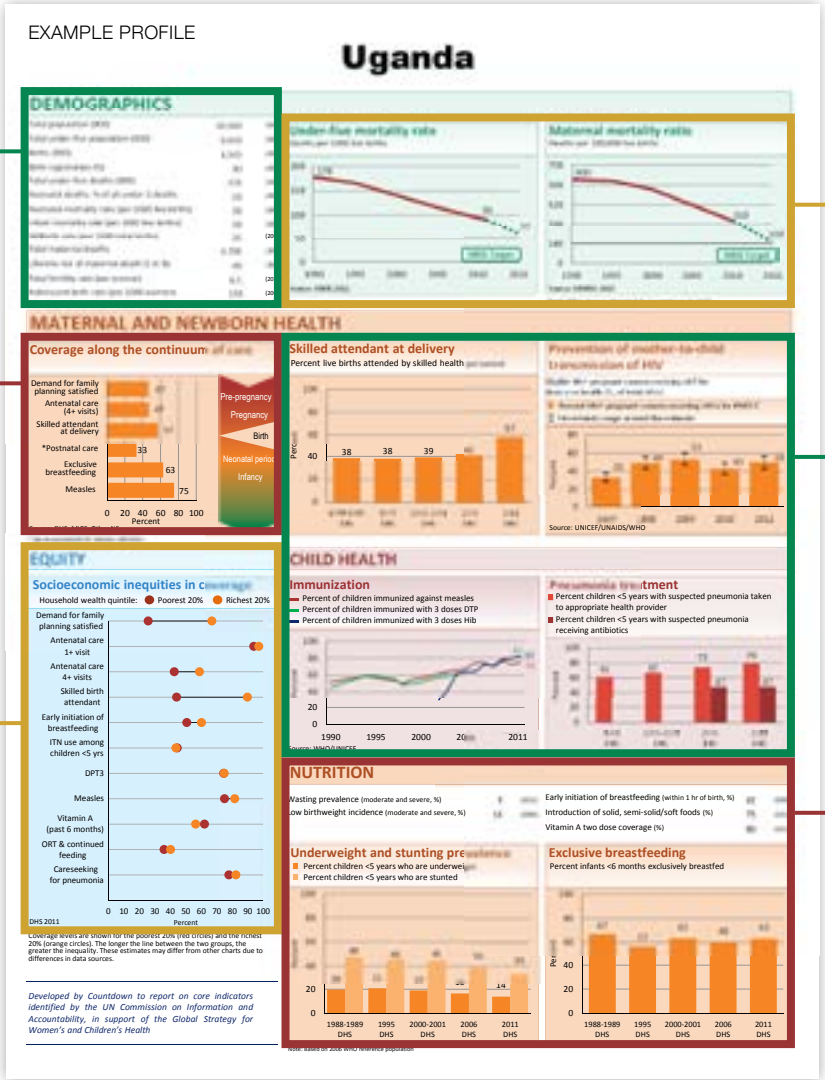
These demographic indicators include proportion of newborn deaths among all under-5 mortality, a Commission indicator.

Continuum of care

Gaps in coverage along the continuum of care from pre-pregnancy and childbirth through childhood up to age 5 should serve as a call to action for a country to prioritize these interventions.

Equity in coverage

Socio-economic inequities in coverage highlight the need for concerted efforts to improve coverage among the poorest.



Impact: Under-5 child mortality rate and maternal mortality ratio

These charts display trends over time, reflecting progress towards reaching the MDG 4 and 5 targets.

Intervention coverage

These charts show most recent coverage levels and trends for selected RMNCH interventions.

Nutrition

Undernutrition in a synergistic relationship with infectious diseases accounts for almost half of all child deaths.

STEP 2: IDENTIFY OPPORTUNITIES TO ACCELERATE PROGRESS

The second step is to compare progress in different areas, focus on specific coverage gaps, and identify opportunities to address these gaps and accelerate progress in improving coverage and health outcomes. Questions to ask include the following:

- Are the coverage data consistent with the epidemiological situation? For example:
  - If stunting prevalence is high, are coverage levels low for the nutrition intervention indicators? Would a focus on promoting optimal breastfeeding practices help to drive progress on reducing stunting?
  - In priority countries for the elimination of mother-to-child transmission of HIV, are sufficient resources being targeted to preventing mother-to-child transmission?
  - If progress on reducing maternal mortality is lagging, and/or if newborn mortality is high, is this a reflection of low coverage of family planning, antenatal care (four or more visits), skilled attendance at birth, and postnatal care?
- Are there patterns in the coverage data that suggest clear action steps? For example, lower coverage for interventions involving treatment of an acute need (e.g., treatment of childhood diseases, childbirth services) than for interventions delivered routinely through outreach or scheduled in advance (e.g., vaccinations) suggests the need for measures to strengthen health systems, such as a greater policy focus on the training and equitable deployment of skilled health workers to increase access to care.
- Are gaps in coverage along the continuum of care suggestive of a call to action to prioritize specific interventions in future planning activities? For example, is access to labor, delivery, and immediate postnatal care being prioritized in countries with gaps in interventions delivered around the time of birth?

Country profiles

The information in the country profiles, customized to showcase the core indicators selected by the Commission on Information and Accountability for Women's and Children's Health, is intended to help policy makers and their partners assess progress and prioritize actions to save women's and children's lives. These country profiles reflect the data that are available for each country. Most of the data for the Commission indicators come from household surveys: mainly the USAID-supported Demographic and Health Surveys and the UNICEF-supported Multiple Indicator Cluster Surveys.[xxix] More information on the data sources for the Commission indicators is available in the annexes to previous Countdown reports: *www.countdown2015mnch.org/reports-and-articles*.

New survey data are available for 22 countries since the publication of Countdown's 2012 Report. Coverage estimates that are missing or that are more than five years old indicate an urgent need for concerted action to increase data collection efforts so that updated evidence is available for policy and program development.

This report contains profiles for 75 countries with high burdens of maternal and/or child mortality, including the 49 lowest-income countries covered by the Global Strategy for Women's and Children's Health. Profiles are included for the following countries:

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

References

[i] Further technical guidance on the Commission indicators is available from Countdown to 2015, Health Metrics Network, WHO. Monitoring maternal, newborn and child health: understanding key progress indicators. Geneva: WHO Document Production Services, 2011. ISBN 978 92 4 1502818 8.

[ii] Maternal Mortality Estimation Inter-agency Group (MMEIG) - WHO, UNICEF, UNFPA, the World Bank. Trends in Maternal Mortality: 1990-2010. WHO, UNICEF, UNFPA and The World Bank estimates. WHO 2012.

[iii] UN-Inter-agency Group for Child Mortality Estimation. Levels and Trends of Child Mortality. The 2012 Report. UNICEF 2012.

[iv] UN-Inter-agency Group for Child Mortality Estimation. Levels and Trends of Child Mortality. The 2012 Report. UNICEF 2012.

[v] Liu L, Johnson HL, Cousens S, Perin J, Scott S, et al. Global, regional, and national causes of child mortality: an updated systematic analysis for 2010 with time trends since 2000. *Lancet*, 2012; 379: 2151–61.

[vi] Black RE, Victora C, Walker S, Bhutta Z, Christian P, de Onis M, Ezzati M, Granthem-McGregor S, Katz J, Martorell R, Uauy R, and the Maternal and Child Nutrition Study Group. Maternal and Child undernutrition and overweight in low and middle income countries. *Lancet*, 2013, in press.

[vii] Black RE, Victora C, Walker S, Bhutta Z, Christian P, de Onis M, Ezzati M, Granthem-McGregor S, Katz J, Martorell R, Uauy R, and the Maternal and Child Nutrition Study Group. Maternal and Child undernutrition and overweight in low and middle income countries. *Lancet*, 2013, in press.

[viii] Improving Child Nutrition: The achievable imperative for global progress. UNICEF 2013.

[ix] Save the Children. Nutrition in the first 1,000 days. State of the World's Mothers. Save the Children 2012.

[x] Campbell H, el Arifeen S, Hazir T, O'Kelly J, Bryce J, Rudan I, Qazi S. Measuring Coverage in MNCH: Challenges in Monitoring the Proportion of Young Children with Pneumonia Who Receive Antibiotic Treatment. *PLoS Med,* 2013; 10(5): e1001421. doi:10.1371/journal.pmed.1001421.

[xi] Barros AJD, Ronsmans C, Axelson H, Loaiza E, Bertoli AD, Franca GV, Bryce J, Boerma T, Victora CG. Equity in maternal, newborn and child health interventions in Countdown to 2015: a retrospective review of survey data from 54 countries. *Lancet*, 2012. 379(9822), 1225-1233.

[xii] Victora C, Barros A, et al., How changes in coverage affect equity in maternal and child health interventions in 35 Countdown to 2015 countries: an analysis of national surveys. *Lancet*, 2012. DOI: 10.1016/S0140-6736(12)61427-5.

[xiii] UNAIDS strategy 2011-2015. Getting to zero. Joint United Nations Programme on HIV/AIDS (UNAIDS) 2010.

[xiv] UNAIDS, *Report on the Global AIDS Epidemic*, 2012, published estimates.

[xv] World Health Organization, UNICEF. Ending preventable child deats from pneumonia and diarrhea by 2025: the integrated Global Action Plan for Pneumonia and Diarrhoea (GAPPD). WHO 2013.

[xvi] Liu L, Johnson HL, Cousens S, Perin J, Scott S, et al. Global, regional, and national causes of child mortality: an updated systematic analysis for 2010 with time trends since 2000. *Lancet*, 2012; 379: 2151–61.

[xvii] World Health Organization, UNICEF. Ending preventable child deats from pneumonia and diarrhea by 2025: the integrated Global Action Plan for Pneumonia and Diarrhoea (GAPPD). WHO 2013.

[xviii] Bhutta Z, Das J, Walker N, Rizvi A, Campbell H, Rudan I, Black R, for The *Lancet* Diarrehoea and Pneumonia Interventions Study Group. Interventions to address deaths from childhood pneumonia and diarrhea equitably: what works and at what cost? *Lancet,* 2013. Published online April 12, 2013. http://dx.doi.org/10.1016/S0140-6736(13)60648-0.

[xix] March D, Davidson H, Pagnoni F, and Peterson S. Introduction to a special supplement: Evidence for the implementation, effects, and impact of the integrated community case management strategy to treat childhood infection. *Am J Trop M ed Hyg,* 2012 Nov; 87(2-5); doie: 10.4269/ajtmh.2012.12-0504.

[xx] Cleland J, Conde-Agudelo A, Peterson H, Ross J, Tsui A. Contraception and Health. *Lancet,* 2012 Jul 14; 380 (9837): 149-56. Doi:10.1016/S0140-6736(12)60609-6.

[xxi] Hsu, J, Berman P, Mills A. Reproductive health priorities: evidence from disbursements of official development assistance in 2009 and 2010. *Lancet*, 2013 in press.

[xxii] UN-Inter-agency Group for Child Mortality Estimation. Levels and Trends of Child Mortality. The 2012 Report. UNICEF 2012.

[xxiii] Lawn J, Blencowe H, Pattinson R, Cousens S, Kumar R, Ibiebele I, and others. Stillbirths: where? when? why? how to make the data count. *Lancet,* 2011. 377 (9775): 1448-63.

[xxiv] WHO and UNICEF. Home visits for the newborn child: A strategy to improve survival. World Health Organization. Geneva, Switzerland 2009.

[xxv] WHO, Save the Children, and UNICEF. Informal meeting on provision of home-based care to mother and child in the first week after birth: Follow-up to the Joint WHO/UNICEF Statement on home visits for the newborn child. World Health Organization. Geneva, Switzerland 2012.

[xxvi] Darmstadt G, Oot D, Lawn J. 2012. Newborn survival: changing the trajectory over the next decade. *Health Policy and Planning*. Volume 27 Supplement 3 July 2012 ISSN 0268-1080 Iii1-6. http://heapol.oxfordjournals.org/content/27/suppl_3.toc.

[xxvii] Moran A, Kerber K, Sitrin D, Guenther T, Morrissey C, Newby H, Fishel J, Yoder PS, Hill Z, Lawn J. Measuring coverage for MNCH: Indicators for global tracking of newborn care. *PLoS Med,* 2013, in press.

[xxviii] Amouzou A, Habi O, Bensaïd K, and the Niger Countdown Case Study Working Group. Reduction in child mortality in Niger: a Countdown to 2015 country case study. *Lancet*, 2012; 380: 1169-1178.

[xxix] Hancioglu A, Arnold F. Measuring coverage in MNCH: Tracking progress in health for women and children using DHS and MICS household surveys. *PLoS Med,* 2013: 10. E1001391. Doc 10.1371/journal.pmed.1001391.

www.countdown2015mnch.org