In this publication, Countdown to 2015 provides profiles for the countries where more than 95% of all maternal and child deaths occur. The profiles highlight how well each country is doing in increasing coverage of high-impact interventions that can save the lives of millions of women and children. The core indicators included in these profiles, selected in 2011 by the Commission on Information and Accountability for Women’s and Children’s Health, encompass key elements of the reproductive, maternal, newborn, and child health (RMNCH) continuum of care. A snapshot of progress on these core indicators, across the priority countries, reveals promising news as well as challenges that still remain to be addressed.

COUNTDOWN TO 2015 IS A GLOBAL MOVEMENT OF ACADEMICS, GOVERNMENTS, INTERNATIONAL AGENCIES, HEALTH CARE 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 RMNCH, 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 RMNCH
- Supports country-level Countdowns to promote evidence-based accountability

Since its first set of reports and events in 2005, Countdown has achieved global impact with its focus on accountability and use of available data to hold stakeholders to account for global and national action.
Countdown and the Accountability Agenda

In September 2010, at a UN 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. This was followed by the establishment of the Commission on Information and Accountability for Women’s and Children’s Health, charged with developing an accountability framework to monitor and track commitments made to the Global Strategy. In May 2011, the Commission released its report, Keeping Promises, Measuring Results. Drawing on advice from Countdown members and other technical experts, the report identified a set of core indicators which, taken together, enable stakeholders to track progress in improving coverage of interventions across the continuum of care. The report also urged that all coverage data be disaggregated by key equity considerations. An independent Expert Review Group (iERG) was appointed by the Secretary-General in September 2011 to report annually on progress in implementing the Commission’s recommendations regarding reporting, oversight, and accountability in 75 priority countries.

Countdown is contributing significantly to this global accountability agenda, through the preparation of:

- Countdown profiles focused on the Commission indicators, updated every year with new data and results
- Special analyses to address accountability questions, and to inform the iERG
- Country-level Countdown processes that include national consultations, workshops, or publications, and utilize Countdown data and methodological approaches

The country profiles in this publication, customized to showcase the Commission indicators, are adapted from the full, two-page Countdown country profile, which Countdown produces on a roughly two-year cycle. Full country profiles will be included in Countdown’s 2012 Report, to be published later in the year.

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1. Up-to-date information on commitments to the Global Strategy is available at www.everywomaneverychild.org.
3. Profiles are provided for 73 of the 75 high-burden countries. Profiles are not provided for South Sudan and post-ceSSION Sudan because of lack of data availability at the time of publication.
The Countdown country profile, highlighting the Commission indicators

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. Most of the data for the Commission indicators come from household surveys: the two main surveys used to collect nationally-representative data for RMNCH are the USAID-supported Demographic and Health Surveys (DHS) and the UNICEF-supported Multiple Indicator Cluster Surveys (MICS).4

These country profiles reflect the data that are available for each country. Missing values for certain indicators, or estimates that are more than five years old, indicate an urgent need for concerted action to increase data collection efforts so that evidence is available for policy and program development.

Countdown addresses multiple Millennium Development Goals

- MDG 4 to reduce child mortality
- MDG 5 to improve maternal health
- MDG 1 to eradicate extreme poverty and hunger, specifically by addressing nutrition with a focus on infant and young child feeding
- MDG 6 to combat HIV/AIDS, malaria, and other diseases
- MDG 7 to ensure environmental sustainability, through tracking improved access to safe water and improved sanitation

More information on the MDGs is available at: www.un.org/millenniumgoals

How to use the country profile

**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?

**Example Profile: Ghana**

**Demographics**

- School enrollment rates: 96%
- Infant and childhood mortality rates: 12%
- Maternal mortality rate: 130 per 100,000 births
- Under-five mortality rate: 110 per 1,000 live births
- Female literacy rate: 57%
- Male literacy rate: 82%

**Maternal and Newborn Health**

- Contraceptive prevalence: 50%
- Maternal mortality ratio: 210 per 100,000 live births
- Under-five mortality rate: 48 per 1,000 live births

**Equity**

- Socio-economic inequities in health services: 30%
- Infant and childhood deaths: 20%

**Child Health**

- Prevalence of underweight among children under 5: 15%
- Prevalence of anemia among pregnant women: 50%

**Nutrition**

- Prevalence of undernutrition among children under 5: 30%
- Prevalence of stunting among children under 5: 40%

**Continuum of Care**

- Coverage along the continuum of care: 80%
- Maternal and newborn care: 70%
- Family planning services: 60%

**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 contributes to at least 1/3 of all under-5 deaths, globally.
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 infant feeding indicators? Would a focus on early initiation of breastfeeding and exclusive breastfeeding 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?
A snapshot of progress on the Commission indicators

This section summarizes the data presented in the country profiles included in this publication, providing an overall picture of progress and remaining challenges. Such summaries must be interpreted with care, because aggregate statistics can mask important information about progress or problems in individual countries.

**IMPACT INDICATORS**

These profiles show promising news on maternal mortality, though global progress is insufficient to achieve MDG 5. Thirty-five Countdown countries experienced a decline of 40% or more in maternal mortality between 1990 and 2008. Six countries are now on track to achieve MDG 5, and another 33 are making progress. However, progress is insufficient in 19 countries, and there has been no progress towards MDG 5 in another eight countries. Although maternal mortality has dropped in the majority of Countdown countries, 60% still have very high or high maternal mortality levels, indicating the need for continued focus on the provision of high-quality family planning, antenatal, delivery, and postnatal services.

Under-5 mortality is declining! Among the Countdown countries, 24 are now on track to achieve MDG 4, up from 19

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5. Because of the cession in July 2011 of the Republic of South Sudan by the Republic of the Sudan, and its subsequent admission to the United Nations on 14 July 2011, disaggregated data for the Sudan and South Sudan as separate States are not yet available for most indicators. Aggregated data presented are for the Sudan pre-cession. Indicators for which Sudan (pre-cession) had available data during the time period 2006-2010 include: Demand for family planning satisfied, DTP3, Exclusive breastfeeding (<6 months), Skilled attendant at birth. This follows the convention used in UNICEF’s State of the World’s Children 2012 Report. The mortality and stunting data also include Sudan (pre-cession).

6. Key: Countries with MMR greater than or equal to 100 are categorized as “on track” = 5.5% decline or more annually; “making progress” = declined between 2% and 5.5%; “insufficient progress” = less than 2% annually; “no progress” = an annual increase in MMR. Countries with MMR less than 100 in 1990 are not categorized. Source: WHO, UNICEF, UNFPA, World Bank. 2010. Trends in Maternal Mortality: 1990 to 2008. WHO.

at the time of the 2010 Countdown Report. The news is not all good, however, and about half of all under-5 deaths occur in only five Countdown countries: India, Nigeria, Democratic Republic of Congo, Pakistan, and China.

As under-5 mortality declines, the percentage of child deaths that are newborn deaths increases. The latest global estimates, as well as results from the 74 Countdown countries with data available, indicate that approximately 40% of under-5 deaths occur in the neonatal period. Countries must continue to prioritize child survival activities as well as concentrate on reducing newborn mortality.

Stunting is a critical indicator of progress in child survival, reflecting long-term exposure to poor health and nutrition, especially in the first two years of life. Children under the age of five around the world have the same growth potential, and prevalence of stunting above the 3% level expected in a well-nourished population indicates the need for remedial actions. All 61 Countdown countries with data available since 2006 have levels of stunting that require urgent attention. In the majority of these countries, more than one in three children is stunted. Addressing undernutrition through multi-sectoral programs must continue to be a major priority in these countries.

**FIGURE 3**

**STUNTING PREVALENCE**

Percentage of children under five who are stunted, Countdown countries with data available, 2006-2010

- Median % stunted: 35%
- Minimum (Brazil): 7%
- Maximum (Burundi): 58%

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**Key:** “On track” indicates that the under-5 mortality rate for 2010 is less than 40 per 1,000 or that it is 40 or more with an average annual rate of reduction of 4% or higher for 2000-2010; “insufficient progress” indicates that the under-5 mortality rate for 2010 is 40 or more with an average annual rate of reduction of 1% - 3.9% for 1990-2010; “no progress” indicates that the under-5 mortality rate for 2010 is 40 or more with an average annual rate of reduction of less than 1% for 1990 to 2010. Source: UNICEF, WHO, World Bank, United Nations Population Division/DESA, 2011. Levels & Trends in Child Mortality: Report 2011. Estimates developed by the UN inter-agency group for child mortality estimation. UNICEF.

INDICATORS OF INTERVENTION COVERAGE
The Commission selected eight coverage indicators from among those already in use by Countdown and for tracking progress toward achieving the MDGs. Their choice was strategic, selecting a limited number of interventions along the continuum of care that are likely to be supported by the collection of consistent and timely data.

Figure 4 and Table 1 show the current coverage levels for the Commission indicators based on available data from the Countdown country profiles included in this publication. The HIV indicators selected by the Commission are presented separately below.

These coverage results demonstrate what is possible – for six of the interventions, at least one country has achieved a coverage level above 80%, and for the remaining two interventions, at least one country has achieved a coverage level of over 70%. The results also show, however, that substantial progress is still needed. The median coverage levels hover around 50%, with higher levels for DTP3 vaccine and lower levels for postnatal care for mothers, exclusive breastfeeding, and antibiotic treatment for pneumonia.

**FIGURE 4**
**COVERAGE ACROSS THE CONTINUUM OF CARE**
Coverage levels for selected Commission indicators of intervention coverage, median and range for Countdown countries with data available, 2006-2010.

*FP = Family planning; AB bx = antibiotic treatment for pneumonia
TABLE 1: A snapshot of coverage levels for select Commission indicators, Countdown countries with data available, 2006-2010.10

<table>
<thead>
<tr>
<th>COMMISSION INDICATOR</th>
<th>NO. OF COUNTRIES WITH DATA</th>
<th>MEDIAN (%)</th>
<th>RANGE (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demand for family planning satisfied (met need for contraception)</td>
<td>46</td>
<td>56</td>
<td>17 - 97</td>
</tr>
<tr>
<td>Antenatal care (four or more visits)</td>
<td>42</td>
<td>56</td>
<td>6 - 97</td>
</tr>
<tr>
<td>Skilled attendant at birth</td>
<td>65</td>
<td>57</td>
<td>18 - 100</td>
</tr>
<tr>
<td>Postnatal care (within two days)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>for mother</td>
<td>22</td>
<td>41</td>
<td>22 - 87</td>
</tr>
<tr>
<td>for baby</td>
<td>4</td>
<td>50</td>
<td>8 - 77</td>
</tr>
<tr>
<td>Exclusive breastfeeding (&lt; 6 months)</td>
<td>57</td>
<td>37</td>
<td>1 - 74</td>
</tr>
<tr>
<td>DTP3 vaccine</td>
<td>74</td>
<td>85</td>
<td>33 - 99</td>
</tr>
<tr>
<td>Antibiotic treatment for pneumonia</td>
<td>41</td>
<td>38</td>
<td>3 - 88</td>
</tr>
</tbody>
</table>

Each country profile provides a summary graph showing whether coverage for a set of interventions is equitable across poorer and richer households. Analysis of the Countdown data shows that intervention coverage is substantially higher among women and children from richer households, but that inequalities in coverage vary by intervention. Interventions such as presence of a skilled attendant at birth are particularly inequitable, while interventions that do not require a functional health system, such as vaccines, are more equitable.11

The Commission selected two HIV indicators, encouraging countries to increase provision of antiretroviral medicines to HIV-infected pregnant women in order to reduce the risk of transmission of HIV to their babies, and for their own health. These indicators are important measures of progress towards MDG 6. New reporting on coverage for the most effective antiretroviral drug regimens, as recommended by WHO, will now enable monitoring of country progress in scaling up these regimens. Table 2 shows coverage levels for the most effective regimens for the prevention of mother-to-child transmission (PMTCT) in the Countdown countries that are considered priority countries for the elimination of mother-to-child transmission. (Ethiopia, India, and Malawi are also priority countries, but they do not have disaggregated data for 2010, and are therefore not included.) The table shows a wide range in coverage levels, with three countries reporting coverage levels of 10% or less and six countries reaching over 75% of the eligible population in need.12

10. Source: UNICEF Global Databases, November 2011, based on Demographic and Health Surveys, Multiple Indicator Cluster Surveys and other national surveys.
Coverage levels of antiretroviral therapy for HIV+ pregnant women who are treatment-eligible also vary substantially across the Countdown countries that are considered priorities for the elimination of mother-to-child transmission. Of the 17 priority countries with data for 2010, coverage values range from zero in Ghana to a high of 39% in Botswana and Chad.

**TABLE 2: Estimated antiretroviral coverage for the prevention of mother-to-child transmission using the most effective regimen, priority countries, 2010.**

<table>
<thead>
<tr>
<th>PRIORITY COUNTRY</th>
<th>PERCENT</th>
<th>UNCERTAINTY*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congo, Democratic Republic of</td>
<td>1</td>
<td>(&lt;1-1)</td>
</tr>
<tr>
<td>Chad</td>
<td>7</td>
<td>(5-9)</td>
</tr>
<tr>
<td>Nigeria</td>
<td>9</td>
<td>(7-10)</td>
</tr>
<tr>
<td>Angola</td>
<td>20</td>
<td>(15-28)</td>
</tr>
<tr>
<td>Burundi</td>
<td>36</td>
<td>(32-49)</td>
</tr>
<tr>
<td>Uganda</td>
<td>42</td>
<td>(36-51)</td>
</tr>
<tr>
<td>Kenya</td>
<td>43</td>
<td>(37-49)</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>46</td>
<td>(40-52)</td>
</tr>
<tr>
<td>Ghana</td>
<td>48</td>
<td>(40-57)</td>
</tr>
<tr>
<td>Mozambique</td>
<td>52</td>
<td>(44-62)</td>
</tr>
<tr>
<td>Cameroon</td>
<td>53</td>
<td>(43-65)</td>
</tr>
<tr>
<td>Tanzania, United Republic of</td>
<td>59</td>
<td>(52-68)</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>66</td>
<td>(54-79)</td>
</tr>
<tr>
<td>Zambia</td>
<td>75</td>
<td>(67-85)</td>
</tr>
<tr>
<td>Lesotho</td>
<td>89</td>
<td>(77-&gt;95)</td>
</tr>
<tr>
<td>Botswana</td>
<td>&gt;95</td>
<td>(&gt;95-&gt;95)</td>
</tr>
<tr>
<td>South Africa</td>
<td>&gt;95</td>
<td>(85-&gt;95)</td>
</tr>
<tr>
<td>Swaziland</td>
<td>&gt;95</td>
<td>(88-&gt;95)</td>
</tr>
</tbody>
</table>

*The ranges around the levels of coverage are based on the uncertainty ranges around the estimates of need. Point estimates and ranges are given for countries with a generalized epidemic.
WHAT DO THE 2012 COUNTDOWN DATA TELL US?

• There is important progress in reducing deaths among mothers and children, but efforts must be maintained and accelerated to achieve our goals in 2015 and beyond. Maternal and child survival gains must be protected and accelerated. Countries that are flagging must redouble their efforts; within countries—even those that are on track—population groups that are lagging behind must be identified and reached. Efforts targeted at reducing newborn deaths are urgent.

• Undernutrition is a crisis that must be addressed now. Stunting prevalence is unacceptably high, even in countries that are making progress in reducing child mortality. Addressing child undernutrition should be a priority for all governments and their partners, especially among children under two years of age.

• We must achieve universal coverage with proven RMNCH interventions. Only DTP3 coverage, with a median of 85% based on data from 74 countries, approaches an acceptable level of coverage. All other interventions are reaching fewer than 60% of women and children who need them. Inequities in intervention coverage must be corrected.

• We can and must learn from country successes. The ranges in coverage are wide, indicating that for each intervention there are countries that are reaching much higher and much lower proportions of the population than the median. For example, although a median of 56% of women reported four or more antenatal care visits during their last pregnancy, this was true for only 6% of women in Somalia and for 97% of women in Swaziland. Countdown is analyzing the factors associated with differences in levels and trends of coverage in the priority countries as a basis for providing better guidance for governments and their partners.
Countdown country profiles: A basis for action

Information is a powerful force for change. Policies and programs must be developed based on evidence about what works and where improvements are needed. Governments, donors, and other stakeholders must be held accountable for fulfilling their commitments to improving RMNCH.

ACTIONS AT COUNTRY LEVEL
Countries can use the Countdown country profiles as a tool for action. Governments and their partners can conduct a “country Countdown” process, potentially involving conferences, reports, and the production of provincial or state-level Countdown profiles. These country Countdowns can:

• Stimulate policy and program improvements targeted at remedying coverage gaps and inequalities in coverage at national, provincial, district, and local levels

• Use evidence to advocate for more resources and greater political prioritization of the health of women and children

ACTIONS AT GLOBAL LEVEL
There is a role for each individual and every organization in increasing accountability for women’s and children’s health. The Countdown profiles offer a concise summary of the burden of maternal, newborn, and child mortality, and evidence on progress in efforts to scale-up proven interventions. Where the evidence shows that the level or focus of effort does not match the needs, decision makers and citizens have a responsibility to stand up and demand change.

Political will, combined with sound evidence, can change the world. Countdown stands ready to help.