Determinants of coverage and equity—policies, systems and financing

An understanding of intervention coverage is incomplete without attention to legislative frameworks and critical features of health systems, including health financing, human resources, supply chain and referral networks, the quality of service delivery, the acceptability of available services to the population and other factors driving service demand. *Countdown* works closely with those conducting research and programme evaluation in these areas. This section provides updates on country progress in improving determinants of coverage, including service quality (box 6). *Countdown’s* conceptual model (shown in annex A) illustrates how these key determinants of coverage can lead to improvements in health and nutrition outcomes.

**Supportive policies and a strong health system**

A well functioning health system and a set of enabling policies provide a foundation for reaching all women and children with the interventions they need. Box 7 describes country progress in family planning to show how these factors influence coverage change and ultimately fertility and mortality outcomes.

*Countdown* tracks adoption of 10 tracer policies that ensure access to family planning, provide protection for pregnant women from harmful environmental and labour conditions, authorize midwives to perform life-saving tasks, foster women’s ability to breastfeed immediately after birth and up to age 2, boost the delivery of key newborn interventions and stimulate increased uptake of treatment interventions for leading killers of children. *Countdown* also tracks a policy indicator on the legal status of abortion (see box 1). Some policies—such as low-osmolarity oral rehydration salts and zinc for management of diarrhoea, postnatal home visits in the first week of life and specific notification of maternal deaths—have high adoption rates (figure 8). But critical gaps remain, and fewer than half of *Countdown* countries report having policies that allow adolescents access to contraception without parental or spousal consent, maternity protection in accordance with Convention 183 and regulation of the marketing of breastmilk substitutes.

These tracer policies are of relevance to virtually all *Countdown* countries, yet no country has endorsed all 10 tracer indicators, and 22 have adopted five or fewer (figure 9).

Understanding country progress in adopting key policy measures requires assessing changes in the number of countries that have endorsed policies over time. Over 2012–2014 the number of *Countdown* countries that have adopted five of the six key policies for which trend data are available has increased (figure 10). The number of *Countdown* countries that have adopted tracer policies related to maternal death notification and to postnatal home visits in the first week of life, for example, more than doubled between the two reporting years. These positive changes reflect important improvements in government prioritization of women’s and children’s health in recent years. The stagnation at a very low level in the number of countries that have adopted policies related to maternity protection is an alarm bell that should remind countries to focus more attention on this issue.

However, policy adoption is not sufficient per se in the absence of ample resources and political will for ensuring successful policy and programme implementation. For example, the high adoption of policies on low-osmolarity oral rehydration salts and zinc treatment for diarrhoea (see figure 8) are in sharp contrast to the lack of improvement in oral rehydration salts coverage rates (see box 3).

A major milestone on the pathway to sustainable programme and policy implementation is country development of costed plans for maternal, newborn and child health. Of the 57 *Countdown* countries with available data, 46 have costed plans for maternal health, 42 for newborn health and 36 for child health.
Increases in intervention coverage will translate into reduced maternal, newborn and child mortality only if health care providers are able to deliver services at a high level of quality. Measuring and monitoring the quality of care is a complex process that ranges from time-consuming observations of the actual services provided during regular health care contacts to simpler, routine checks on the availability of equipment and supplies needed to deliver the standard of care.

For example, Countdown tracks coverage of the presence of a skilled attendant at birth, which is an important measure of how well countries are doing in reaching women with skilled delivery care. But this indicator does not capture information on the specific life-saving services actually provided during and immediately after delivery. Quality assessments of the care around the time of birth conducted in Egypt showed that although 65% of births occurred in facilities, only 8% of babies were born with the assistance of a midwife trained in resuscitation techniques and only 17% were born in facilities with equipment for newborn respiratory support. These findings show the importance of combining estimates of coverage with estimates of service quality (sometimes referred to as “effective coverage”) to best monitor health system performance.

An increasing number of Countdown countries are conducting assessments of quality and readiness for reproductive, maternal, newborn and child health services. Countries adapt standard tools to their own context, so cross-national interpretations must be made with care. The figures below show selected results collected since 2010 using one of these tools—the World Health Organization Service Availability Readiness Assessments—in eight Countdown countries in Sub-Saharan Africa with available data.

**BOX 6**

**Coverage + Service Quality/Readiness = Impact**

**Share of facilities surveyed with tracer commodities available on the day of the assessment visit**

**Legend**

- Benin (2013)
- Burkina Faso (2012)
- Kenya (2013)
- Mauritania (2013)
- Sierra Leone (2012)
- Libya (2012)
- Togo (2012)
- Uganda (2012)

**Commodities for basic obstetric care**

- Oxytocin
- Magnesium sulphate
- Antibiotics injectable

**Commodities for child health services**

- Oral rehydration salts
- Zinc
- Amoxicillin
An adequate and well trained health workforce and functioning referral and supply chain mechanisms are essential building blocks of a health system that can effectively and efficiently deliver services to all women and children. Many Countdown countries face severe health workforce shortages, including for midwives (box 8). These shortages negatively impact their ability to provide high-quality care. Only 7 of the 56 Countdown countries with available data (Botswana, Egypt, Gabon, India, the Philippines, the Solomon Islands and Viet Nam) meet or exceed the threshold of 23 skilled health professionals (doctors, nurses, midwives) per 10,000 population needed to achieve high coverage of essential interventions. The good news is that most Countdown countries with available data are reporting increases in the absolute numbers of doctors, nurses and midwives. However, in some countries these net gains are not enough to keep pace with increased service demands resulting from population growth. Many countries are introducing various strategies to ameliorate their health workforce crises, such as delegating and sharing tasks across various categories of health care professionals and factoring in population dynamics when planning for human resource needs.25

The low availability of many of the commodities in the highlighted countries should be a red flag to decisionmakers. Targeted efforts are needed to strengthen supply chain management systems, so that providers are equipped with the supplies needed to deliver lifesaving reproductive, maternal, newborn and child health services.

Tools enabling the regular collection of rigorous quality of care data need further development. In December 2013 the World Health Organization and the Partnership for Maternal, Newborn and Child Health convened a technical consultation to reach consensus on a core set of tracer indicators to monitor the quality of reproductive, maternal, newborn and child health services at the facility level. The next steps will focus on developing standardized definitions and data collection processes so that these indicators can be used to populate country and subnational scorecards that inform routine programme planning and monitoring.

Note
1. Wall and others 2009.
Family planning is a cost-effective strategy for reducing maternal and newborn mortality by reducing the number of unintended and high-risk pregnancies and averting unsafe abortions (see box 1). Family planning services can also help delay women’s age at first pregnancy and lengthen the time interval between pregnancies, both of which improve maternal, newborn and child health and reduce the risk of low birth weight and stillbirth.1

Increasing access to and use of family planning services requires sustained political and financial support, accompanied by community-based approaches to improve awareness of and demand for modern contraceptive methods. Legislative frameworks are needed that support the availability of a full range of family planning services, including for adolescents, a rapidly expanding population group in many Countdown countries.

The median annual birth rate among adolescent women in Countdown countries with available data is 89 births per 1,000 women ages 15–19, with a low of 0.7 in the Democratic People’s Republic of Korea and a high of 229 in the Central African Republic. In the 45 Countdown countries with data for 2008–2012, the median proportion of women ages 20–24 that had given birth before the age of 18 was 23%, with a low of 3% in Viet Nam and a high of 47% in Chad.

It is important that laws and regulations to reduce adolescent pregnancy and prohibit child marriage are put into place and enforced to expand young women’s opportunities and improve their control over their own fertility. But only 15 of the 57 Countdown countries with policy data for 2013 have laws or regulations that allow adolescents to access contraception without parental or spousal consent.

Family planning in Bangladesh: Community outreach as a pathway to success!

Bangladesh identified family planning as a health priority more than five decades ago, even before the country’s independence from Pakistan. Early programmes in the 1970s–1990s involved recruiting thousands of married women as family welfare assistants to deliver basic family planning services—including oral pills, condoms, counselling and referrals for longer term methods on request—to the doorstep.

This intense community-based effort contributed to the steady increase in the country’s contraceptive prevalence rate, from 8% in the mid-1970s to around 50% by 1999, and to the drop in the total fertility rate, from around 7 children per woman to 3.3 over the same period.

The rising expense of maintaining an extensive family welfare assistants programme due to a tripling in the population of women of childbearing age led to a new approach, adopted at the end of the 1990s, to delivering family planning services through community clinics and the private sector. This helped the country maintain its positive trends in contraceptive prevalence rate and total fertility rate, which continued through 2011 (see figure).

The fertility decline in Bangladesh has also been attributed in part to the expansion of microcredit financing, girls’ improved access to education and growing employment opportunities in the textile sector, all of which increased legitimate alternatives to early motherhood.

Delivering family planning services through community clinics and the private sector has helped Bangladesh maintain its positive trends in contraceptive prevalence rate and total fertility rate

Contraceptive prevalence rate (modern and traditional) (%)
Fertility has declined mostly among women older than age 30, which has been linked to increases in birth spacing intervals through the use of contraception.\(^3\)

Geographic differences in fertility patterns that parallel economic development also persist, with higher fertility in the least developed eastern regions than in the west.

The current national family planning programme targets adolescents and regions of the country where higher than average total fertility rates persist and aims to make a greater diversity of contraceptive methods (including long-term methods) more widely available.

**Notes**

1. Ahmed and others 2012; Cleland and others 2012; UNICEF, UNFPA and UN Women 2012.
2. CPD 2003; Bangladesh Demographic and Health Survey 2011.
3. Arifeen and others forthcoming.
Almost all Countdown countries are facing major workforce challenges in delivering midwifery services, particularly in areas where the burden of maternal mortality and morbidity is highest. Although midwives can perform almost 90% of essential care for women and newborns if adequately trained on the latest evidence-based guidelines, countries have been slow to adopt policies enabling midwives to provide this care. There has been no increase among the 33 Countdown countries with available trend data since 2012 in adopting a policy authorizing midwives to administer a core set of life-saving interventions.
**Countdown** tracks essential commodities across the continuum of care. The UN Commission on Life-Saving Commodities was established in 2012 to promote the availability and effective use of 13 life-saving commodities for women’s and children’s health. Including these commodities on the essential medicines list is a steppingstone to ensuring that these commodities are procured and widely distributed. Most **Countdown** countries with available data include the majority of these 13 commodities on their list, with the notable exception of the three prioritized reproductive health commodities, which are included on the list of fewer than half of countries with available data (figure 11).

**Financing women’s and children’s health**

Countdown tracks information on key indicators of domestic and external spending patterns for reproductive, maternal, newborn and child health. There is evidence of very modest positive trends in these indicators. Across the **Countdown** countries, the per capita total expenditure on health (in current purchasing power parity terms) increased from $200 in 2010 to $222 in 2012. Over the same period there was also a very slight increase in government expenditure on health as a share of total government expenditure, from 9.9% to 10%. Similarly, countries made marginal improvements in reducing the reliance on out-of-pocket payments to finance health, from 43% of total expenditure on health in 2010 to 42% in 2012 (box 9). Increasing government expenditure on health is an important measure for improving access to health care and reducing poverty.

Tracking development partner disbursements to reproductive, maternal, newborn and child health is important for holding partners to account for commitments made and helps identify resource gaps or areas where further investment may be required.

---

**FIGURE 11**

Most **Countdown** countries with available data include the majority of the 13 essential commodities on their essential medicines list

<table>
<thead>
<tr>
<th>Number of <strong>Countdown</strong> countries with selected commodity, 2013 (n = 57)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pregnancy and birth</strong></td>
</tr>
<tr>
<td><strong>Postnatal</strong></td>
</tr>
<tr>
<td><strong>Infancy and childhood</strong></td>
</tr>
<tr>
<td><strong>Pre-pregnancy</strong></td>
</tr>
<tr>
<td>60</td>
</tr>
</tbody>
</table>

- **Female condoms**
- **Implants**
- **Emergency contraception**
- **Oxytocin**
- **Misoprostol tablets**
- **Magnesium sulphate**
- **Misoprostol tablets**
- **Gentamycin injection**
- **Dexamethasone injection**
- **71% chlorhexidine digluconate**
- **Self-inflating bag and mask**
- **Paediatric formulation of amoxicillin**
- **Oral rehydration salts**
- **Zinc**

a. Refers mainly to other uses (such as for response to allergic reaction). Antenatal corticosteroids in preterm labour are recommended for use in all countries but were not added to the World Health Organization essential medicines list for preterm indication until 2013.

b. Chlorhexidine has been recommended only since 2013, and World Health Organization guidelines suggest use only in high-mortality countries (with a neonatal mortality rate greater than 30 deaths per live births) and home births.

Trend data on official development assistance (ODA) to the Countdown countries is available from 2003 for maternal, newborn and child health and from 2009 for reproductive health. This report presents ODA data up to 2011. Countdown expects to release ODA data for 2012 later in 2014.

ODA for health was an estimated $19 billion in 2011, an increase of only 1% in real terms over 2010. This amount represents 12.4% of total ODA. In the 75 Countdown countries an estimated $8.7 billion went to reproductive, maternal, newborn and child health in 2011, a 1% increase over 2010, and accounted for 44% of ODA to health and 5% of total ODA. Of this amount, $3.9 billion (45%) went to child health, $3.1 billion (36%) went to reproductive health (which includes funding for family planning, sexual health and sexually transmitted infections including HIV) and $1.7 billion (19%) went to maternal and newborn health. ODA to maternal, newborn and child health in the 75 Countdown countries decreased by 1% in real terms from 2010, due to a 3% reduction in funding to child health. Funding to maternal and newborn health increased 4% over 2010, and funding to reproductive health increased 5%. The noted reduction in ODA to maternal, newborn and child health in Countdown countries in 2011 continues a slowdown detected between 2009 and 2010 relative to previous years.

Assessing who benefits from ODA and whether resources are being allocated according to country need can improve resource allocation and efficiency (box 10).
From whom?

In 2011 ODA from bilateral agencies accounted for more than half of ODA for maternal, newborn and child health in the 75 Countdown countries, just under a quarter came from multilateral agencies and another quarter from global health initiatives and foundations (comparable to proportions in 2009 and 2010) (box figure 1). A higher proportion of ODA for reproductive health comes from bilateral donors (76% of all ODA; box figure 2).

Box figure 1. Official development assistance for maternal, newborn and child health in the 75 Countdown countries was $5.6 billion in 2011 (in 2012 dollars)

The United States continues to be the largest source of funding to reproductive, maternal, newborn and child health in the Countdown countries, followed by the Global Fund to Fight AIDS, Tuberculosis and Malaria (box figure 3). U.S. contributions to reproductive health including HIV exceeded $1.8 billion, nearly four times more than the next largest donor and nearly twice as much as U.S. contributions to maternal, newborn and child health. Across all donors, on average, higher amounts were disbursed to child health ($76 million) than to reproductive health ($60 million) and to maternal and newborn health ($32 million). This pattern is similar to previous years.

Box figure 3. In 2011 the United States continued to be the largest source of funding to reproductive, maternal, newborn and child health in the Countdown countries

To whom?

In 2011 approximately 79% of official development assistance for maternal, newborn and child health went to the 75 Countdown countries, with India and Ethiopia receiving the most (box figure 4). India also received the highest share of ODA for maternal, newborn and child health in 2009 and 2010. The
amount varies widely across countries and is not always in proportion to need.

Seven Countdown countries received more than half of ODA to reproductive health, with the highest shares going to South Africa and Kenya (box figure 5). Nigeria, Ethiopia, Tanzania and Kenya received high shares of both ODA to maternal, newborn and child health and to reproductive health.

Box figure 4. Ten Countdown countries received just under half of total official development assistance for maternal, newborn and child health in 2011

Box figure 5. Seven Countdown countries received just over half of official development assistance to reproductive health in 2011

Box figure 6. In 2011 median official development assistance to child health per child ages 0–5 was $1.89 for the 10 countries receiving the least official development assistance and $47.58 for the 10 countries receiving the most

Official development assistance to maternal, newborn and child health in the context of target population size

ODA for child and maternal and newborn health varies widely across Countdown countries, even after adjusting for the size of the target population. For example, in 2011 median ODA to child health per child ages 0–5 was $1.89 for the 10 countries receiving the least ODA and $47.58 for the 10 countries receiving the most (figure 6). Similarly, for maternal and newborn health, the median was $5.23 per live birth for the 10 countries receiving the least ODA and $115.92 per live birth for the 10 countries receiving the most (figure 7).

Source: Organisation for Economic Co-operation and Development’s Development Assistance Committee’s Creditor Reporting System Aid Activities Database.
More-populous Countdown countries receive more ODA for maternal, newborn and child health than less-populous ones. But adjusting for the size of the target population shows a different picture of aid flows to women’s and children’s health in the Countdown countries. For example, in 2011 Nigeria received the most ODA per country for child health in absolute terms, but the amount received per child ages 0–5 was $8.59 (the 51st highest). In contrast, Solomon Islands received the highest amount per child, $143.45, but much lower total funds (the 54th highest). For maternal and newborn health India received the most ODA overall, but only $6.05 per live birth, compared with $32.58 in Ethiopia, which received the second highest total ODA for maternal and newborn health, and $90.89 in Afghanistan, which received the third highest total ODA.

**Funding allocation by focus area**

The slight reduction in funding to child health is driven by a reduction in funding to immunization, earmarked malaria funding and basket funding, 40% of which is assumed to go to child health.

The percentage of funding allocated to reproductive health remains driven by response to the HIV epidemic (78%). However, family planning accounts for a growing proportion (14%), a 42% increase over 2010 in real terms, compared with a 2% increase in funding related to HIV (which does not include prevention of mother-to-child transmission or childhood AIDS, which are captured in maternal, newborn and child health totals).

**Box figure 7. In 2011 median official development assistance to maternal and newborn health per live birth was $5.23 for the 10 countries receiving the least official development assistance and $115.92 for the 10 countries receiving the most**

![Bar chart showing official development assistance to maternal and newborn health per live birth, 2012 ($) for selected countries.](chart)

Source: Organisation for Economic Co-operation and Development’s Development Assistance Committee’s Creditor Reporting System Aid Activities Database.
Data revolution and evolution: the foundation for accountability and progress

Without data there can be no accountability. Without accountability we risk making no progress for women and children. **Countdown** therefore puts a special focus on data availability, quality and use. Working closely with the independent Expert Review Group of the Commission on Information and Accountability for Women’s and Children’s Health, **Countdown** advocates for efforts to ensure that all countries have adequate data to make informed decisions about programme priorities for women and children and to monitor the implementation of those programmes. These data include but are not limited to high-quality household surveys. Continued efforts are needed to strengthen civil registration and vital statistics, health management information systems and institutional capacity at the country level to conduct independent evaluations of reproductive, maternal, newborn and child health programmes.

Of the 75 **Countdown** countries, 28 (37%) conducted a nationally representative survey in 2011 or 2012, providing high-quality, recent data to support assessments of progress towards the Millennium Development Goals (map 1). Another 29 countries (39%) conducted such a survey between 2008 and 2010. This represents a major achievement, probably linked to the emphasis on global monitoring of the Millennium Development Goals. Prior to 2000 few of the 75 countries had nationally representative survey data on coverage of interventions for maternal, newborn and child health.

Accurate and consistent data are crucial for governments and their partners to manage health

---

**Map 1**

Of the 75 **Countdown** countries, 28 (37%) conducted a nationally representative survey in 2011 or 2012, providing high-quality, recent data to support assessments of progress towards the Millennium Development Goals

---

Note: Based on country reporting on the antenatal care (at least one visit) indicator.

Source: United Nations Children’s Fund global databases, April 2014, based on Demographic and Health Surveys, Multiple Indicator Cluster Surveys and other national surveys.
systems effectively, allocate resources according to need, and make and deliver on commitments where the impact will likely be greatest. These data must be:

- **Fit for purpose**, designed to measure a set of standardized indicators that respond to accountability requirements. As new effective interventions are identified and consensus indicators agreed on, further work will be required to develop, validate and incorporate appropriate questions into the core surveys used by countries. The process through which indicators for postnatal care were defined and tested provides a good example of how this process can work (box 11). Similar efforts are needed to define standard coverage measures for other newborn-specific interventions and nutrition interventions that have been scaled up rapidly in the past decade but that lack standard methods for measurement.

- **Reliable**, at least, and ideally also valid, so that they can be used over time and across countries to assess progress. There is an important research agenda on improving coverage measurement for reproductive, maternal, newborn and child health that has already shown that at least one of the core indicators recommended by the commission—antibiotic treatment for childhood pneumonia—cannot be measured accurately through household surveys. Countdown has therefore added an indicator on careseeking for symptoms of childhood pneumonia to its reporting on commission indicators. This work on improving coverage measurement is continuing and is closely coordinated with Countdown. A particular focus is on unpacking service contact indicators such as antenatal care visits and skilled attendant at delivery to determine how best to generate valid measures of coverage for individual interventions provided through these service delivery platforms.

- **Timely**, providing information on coverage that reflects recent progress and can be used in the short term to improve the performance of reproductive, maternal, newborn and child health programmes.

- **Able to be disaggregated**, to assess inequity and to determine which women and children are not being reached, as a basis for action.

**BOX 11**

**Keeping coverage measurement current: an example from postnatal care**

Postnatal care visits for mothers and newborns offer an important opportunity to provide proven interventions that can save the lives of women and children. Despite the sparse and inconsistent data available at the time, Countdown began including postnatal care indicators for newborns in its reporting in 2005. This gap in data spurred efforts led by the Newborn Indicators Technical Working Group to refine the indicators and develop standard tools to measure coverage of key newborn interventions. These efforts informed the technical review process of Countdown, resulting in the addition over time of three newborn-related policy indicators on postnatal home visits in the first week of life on the Countdown 2012 country profiles and antenatal corticosteroids for preterm birth and kangaroo mother care on the Countdown 2014 country profiles. The visibility raised by including postnatal care indicators in Countdown reporting also sparked the two international household survey programmes that produce the majority of coverage data used in global monitoring, Demographic and Health Surveys and Multiple Indicator Cluster Surveys, to review their data collection efforts on postnatal care. The United Nations Children’s Fund, for example, developed a new module on postnatal care visits that was incorporated into the current round of Multiple Indicator Cluster Surveys and has increased the availability of country data on coverage of this service contact. This process has resulted in the development of global consensus on the definition of postnatal care visits and a surge of new data—the number of Countdown countries with recent available data on postnatal visit for the baby increased from zero in the 2005 report to six in the 2010 report to 17 in the 2014 report.

Countdown currently tracks a systems indicator on emergency obstetric care and is actively working with partners on revising the list of signal functions that emergency obstetric care facilities must provide in order to include a comprehensive set of signal functions for newborn care.

**Notes**

1. Moran and others 2013.
The Demographic and Health Surveys and Multiple Indicator Cluster Survey programmes remain the primary source of coverage data for most low- and middle-income countries and have worked hard to coordinate their protocols and target their support to the 75 Countdown countries. An important development is that a small but growing number of countries are fielding their own surveys, often using adaptations of the standard protocols, and this increase in national capacity must be supported and expanded while ensuring that indicator definitions reflect international consensus to enable comparisons across countries and over time.

Success must be measured not only through the availability of high-quality, timely data, but also by the extent to which the process is implemented from start to finish by country-based research institutions, including special analyses to respond to questions from policymakers.

Well designed and well implemented household surveys must remain a central pillar of government systems for programme monitoring and evaluation. But they alone are not enough. Measures of coverage for interventions needed by subsets of women and children, including women with obstetric complications and newborns or children who are ill, are also likely to benefit from efforts to link household surveys to assessments of service providers. Surveys can tell us about coverage, or the proportion of those who need an intervention who have actually received it. Health facility-based data, whether from information systems or facility surveys, can tell us about the quality of care received by those who accessed services. Efforts are under way to meet these challenges and to ensure that standard, fit for purpose indicators are defined, subjected to validation assessments and measured with adequate technical and financial support and institutional capacity building at the country level. Good examples of interdisciplinary groups that engage independent technical experts to address these issues include the Roll Back Malaria Monitoring and Evaluation Reference Group, the Newborn Indicators Technical Working Group and the various interagency working groups tackling measurement issues related to women and children. Countdown collaborates closely with these groups.

Those who set global goals must be mindful of the technical demands of coverage measurement when defining indicators that will be used to track progress and assess accountability. Preliminary versions of the post-2015 sustainable development goals documentation included more than 20 targets for the health goal alone. Setting a target implies measurement, and over the years Countdown has repeatedly pointed to the unfair demand that countries report on numerous indicators for which no measurement strategy is in place or supported. This message was echoed by the Commission on Information and Accountability for Women’s and Children’s Health, which defined 11 priority indicators—including 8 coverage measures—and recommended that countries report on them. However, uptake of this recommendation has been limited by the availability of data at the country level. Only 8 of the 75 Countdown countries had recent data on all of these coverage indicators in 2011–2012, and 37—half the Countdown countries—had data for only one of them (figure 12). The paltry number

![Figure 12](image-url)

**Half of Countdown countries had data for only 1 of 9 recommended coverage measures in 2011–2012**

<table>
<thead>
<tr>
<th>Number of coverage indicators</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 indicators</td>
<td>10</td>
</tr>
<tr>
<td>8 indicators</td>
<td>14</td>
</tr>
<tr>
<td>7 indicators</td>
<td>21</td>
</tr>
<tr>
<td>6 indicators</td>
<td>32</td>
</tr>
<tr>
<td>5 indicators</td>
<td>38</td>
</tr>
<tr>
<td>4 indicators</td>
<td>46</td>
</tr>
<tr>
<td>3 indicators</td>
<td>50</td>
</tr>
<tr>
<td>2 indicators</td>
<td>54</td>
</tr>
<tr>
<td>1 indicator</td>
<td>55</td>
</tr>
</tbody>
</table>

Note: Indicators include demand for family planning satisfied (including 2013 data for Ghana and Pakistan), antenatal care (four or more visits), skilled attendant at birth, postnatal care for mother, postnatal care for baby, exclusive breastfeeding, DTP3 vaccine coverage, careseeking for pneumonia and antibiotic treatment for pneumonia. This list does not include two indicators related to HIV, counts postnatal care for mother and baby separately and includes careseeking as well as treatment for pneumonia, so it differs from the list of 11 priority indicators (8 coverage and 3 impact) from the Commission on Information and Accountability for Women’s and Children’s Health.

Source: United Nations Children’s Fund global databases, April 2014, based on Demographic and Health Surveys, Multiple Indicator Cluster Surveys and other national surveys.
of countries able to report recent data on the full set of recommended coverage indicators is a distressing testament to data gaps in the countries where the burden of preventable maternal, newborn and child deaths is highest. Responsibility for filling those gaps, and for defining indicators based on what it is feasible to measure well, is shared by countries and the global reproductive, maternal, newborn and child health community.

Gaps in data on the policy and health systems determinants of coverage also need to be addressed. *Countdown* reporting has drawn attention to some of these gaps and helped stimulate an effort led by the World Health Organization to work at the country level to obtain standardized reports on selected indicators in each area. Intensive efforts are also under way to generate evidence and develop guidance on policies and health systems factors that affect access to essential reproductive, maternal, newborn and child health interventions. 39

There are critical gaps in resource tracking (see box 9). For the first time in 2014 *Countdown* country profiles include the Commission on Information and Accountability for Women’s and Children’s Health—recommended resource indicator on reproductive, maternal, newborn and child health expenditures by source of funding, intended to track both domestic and external financial commitments to achieving the goals of the Global Strategy on Women’s and Children’s Health. More than two years have passed since the 2011 launch of the commission’s action agenda, and progress has been slow. According to the World Health Organization, only 4 of the 75 *Countdown* countries can report completely on the recommended financing indicator for recent years, and 2 countries can report partially. However, it is encouraging to note that 18 countries report that development of these indicators is in process and that 25 countries report being in the planning phase. 40

Robust civil registration systems are still lacking in most *Countdown* countries, requiring the use of modelling to develop mortality and cause of death estimates (see annexes A and H). Most newborns and nearly all stillborn babies are born and die without ever being recorded, a situation that must be corrected in order to improve country capacity to plan for needed services and to monitor progress.
In 2014, as Countdown’s original time horizon approaches, we must look both backwards and forwards to draw lessons that may inform the future landscape for women’s and children’s health. Many of the same challenges remain. Some—including the broadening of the goals to encompass a more holistic agenda and the explosion of tools and initiatives for monitoring—will be new.

Countdown is fundamentally about accountability. It was conceived in a 2003 meeting at the Rockefeller Foundation’s Bellagio Center, resulting in the publication of a series on child survival in The Lancet in 2003.41 The original call was specific to child survival, but was later extended to include the full continuum of reproductive, maternal, newborn and child health:

... we commit ourselves to ensuring that there is an overall mechanism for improving accountability, re-energising commitment, and recognising accomplishments...

Participants will be those who support child survival, who monitor interventions and delivery strategies, and other concerned individuals and organisations.

... regular opportunities for the world to take stock of progress ... and to hold countries and their partners accountable.

Countdown has grown in different dimensions since the first report in 2005. In addition to the shift from child survival to a broader reproductive, maternal, newborn and child health agenda, the number of countries has expanded from 60 to 75, and the number of interventions being monitored from 35 to 73. The 2005 report had 11 institutions’ logos on the back cover; the 2014 report has 43. Countdown now produces annual reports, with the full report (containing two-page country profiles) in even years and a shorter version (containing one-page country profiles focused on the 11 commission indicators) in odd years. Countdown has become a key resource for the global health community.

What are the strengths of Countdown that merit special consideration as the accountability and oversight structures are framed for the post-2015 period? First on the list is Countdown’s reliance on recent, replicable, relevant data on coverage and its determinants at the country level as the driving force, providing an unfiltered lens on progress and results. Second is the essential focus on disaggregating data to reveal inequities. Third, Countdown has maintained its commitment to bringing to the table scientists, policymakers, program leaders and advocates from both country and international institutions to review and act on these data. Finally, Countdown continues to search for more user-friendly ways to present country-specific data to promote the translation of scientific findings into actions that will prolong and improve the lives of women and children.

Conversely, it is precisely these strengths that have produced some of Countdown’s biggest challenges. One challenge has been maintaining the plurality of Countdown and its supra-institutional governance, while remaining true to the evidence. Achieving evidence-based consensus across 43 institutions has transaction costs, particularly around issues related to selecting the subset of proven interventions to be tracked and upholding an appropriate balance across the reproductive, maternal, newborn and child health continuum of care. A related challenge is maintaining flexibility so that Countdown can change in response to new evidence and country needs while adhering to its core principles and processes of work. Another major challenge has been preserving the focus of Countdown. As Countdown has grown in visibility and influence, there has been continuous pressure to expand the areas of concern. For example, should Countdown also...
be reporting on child and maternal overweight or obesity? How much emphasis should be given to adolescent health, child development and human capital, maternal morbidity or stillbirths as elements of the continuum of care? How much collaboration is needed with other Millennium Development Goal and topic-specific monitoring initiatives so that each retains its added value yet is an integral part of the whole? Should Countdown retain its main focus on intervention coverage, or should it move more into social and environmental determinants of health or put a greater focus on health impact beyond mortality and nutrition? These debates are ongoing and are an important dialogue for ensuring that Countdown is responsive to the evidence and integrated into other accountability processes while maintaining a manageable, well defined scope of work so that its messages are clear and actionable.

Protecting the strengths of the Countdown process while addressing these challenges is the work of the future. We believe that there is no one optimal structural arrangement to protect the scientific integrity, programme relevance and independence of Countdown and that instead it represents a process of dedication, commitment, compromise and trust. One absolute necessity is to generate and sustain interest and commitment among young epidemiologists, program evaluators, health economists, communications specialists and programme leaders at the global level—particularly those living and working in Countdown countries.
Countdown speaks: priorities for the next 500 days and beyond

What do the 2014 findings mean for women and children, both immediately for the 500 days that remain until the end of the Millennium Development Goal era and for the process of defining the post-2015 framework? What actions must be taken? The 2014 Countdown results continue to point to the agenda-setting role of the Millennium Development Goals. This power must be harnessed for women and children in the next set of goals as well.

Looking forward to the post-2015 era, the Countdown experience and findings point to four absolute necessities related to accountability.

• First, this is the time to be building a foundation of baseline data that can be used to track progress. This was a critical omission in the Millennium Development Goal framework.

• Second, we must work to define an accountability mechanism that will serve women and children going forward. Countdown has tried to contribute to that conversation in this report.

• Third, we must back up our accountability rhetoric with real resources that can be used by countries to generate the data they need to participate meaningfully in the process. Too many Countdown countries still cannot report annually on key indicators, even after more than a decade of Millennium Development Goal monitoring and more recent efforts around the Commission on Information and Accountability for Women’s and Children’s Health initiative. Addressing this gap means increasing support for and strengthening country institutional capacity to conduct high-quality household surveys at regular intervals of no more than three years, while working to strengthen vital statistics, tracking of financial resources and assessments of service provision.

• Fourth, these data systems must be designed intentionally to permit disaggregation and examination of equity trends, to identify the women and children who are being missed and to support effective programming to reach them.

Our mandate is to use the coming 18 months to maintain and move forward on achieving high, sustained and equitable coverage with proven interventions that can save women’s and children’s lives and to strengthen country data systems so that they are able to respond to the future accountability agenda and build better programmes. There are opportunities to save lives now that must not be missed in the process of final assessments related to the Millennium Development Goals and in the current scrambling for places in the sun in the next set of goals. Experience from the Millennium Development Goals reflected in our results show that it took a long while for international agencies and country leaders to translate their global commitments into concrete action and for countries to accelerate coverage gains and mortality reduction. This must not happen on our watch over the coming two to three years. The essential foundation and processes for achieving the next set of goals begins today, with reinvigorated efforts to address the unfinished business of maternal, newborn and child survival. This includes continued recognition of the deep links between women’s and children’s health and the importance of improving service integration across the reproductive, maternal, newborn and child health continuum of care to maximize the impact, quality and efficiency of care provided.

We, as Countdown, challenge ourselves and the global reproductive, maternal, newborn and child health community to make the remaining days in the Millennium Development Goal era and the years beyond 2015 count for women and children. There must be continued, and even increased, accelerations in coverage for life-saving interventions. There must be improvements in the equitable delivery of these interventions,
providing essential services for all. There must be progress in ensuring that the necessary policy, health system and financial supports for these services are in place. And there must be greater commitment to data evolution that results in more and better data and data use for improving programmes. In addition, this transition period must see measureable progress in improving nutrition and in making family planning universally available. These targets do not need to wait for validation through the language of the sustainable development goals—they are a necessary part of any global agenda, and delays are unconscionable. *Countdown* will continue to track progress towards these immutable targets at the country level, and we will hold fast to the principle of accountability by all for the health and development of women and children.