
ACTING ON THE CALL

A FOCUS ON THE JOURNEY TO SELF-RELIANCE
FOR PREVENTING CHILD AND MATERNAL DEATHS

JUNE 2018



USAID
FROM THE AMERICAN PEOPLE

INTRODUCTION

The purpose of foreign assistance must be to end the need for its existence. As the U.S Agency for International Development Administrator Mark Green states, “We provide development assistance to help partner countries on their own development journey to self-reliance. We look at ways to help lift lives and build communities.” For decades, USAID has worked with country governments to meet the health needs of their women and children. As a development agency, USAID aims to build capacity and reduce disease burden while strengthening health systems to enable countries to plan, fund, and manage their own continued progress. The 2018 *Acting on the Call* report focuses on 25 countries’ journeys to self-reliance for preventing child and maternal deaths.

Investing in health benefits both the U.S. and our partner countries. For the first time ever, we have calculated a return on investment for a portion of our maternal and child survival efforts. This new analysis shows that our work to eliminate health system bottlenecks can yield an average return on investment of 6 to 1, and will make available around \$26.9 billion in public and private funds in the health sector across our 25 priority countries for preventing child and maternal deaths.

In 2012, USAID, along with the Governments of Ethiopia and India, and in collaboration with the United

Nations Children’s Fund (UNICEF), gathered country governments, academia, the private sector, and civil society to agree upon one achievable goal: ensure children everywhere have the same chance of survival. In 2014, USAID issued an ambitious roadmap, to outline how working in partnership with countries, other donors, and the private sector, we could together save 15 million children’s lives and 600,000 women’s lives by 2020. Since 2014, we have offered an annual analysis reflecting on this data. These analyses demonstrate that if we focus on high impact interventions tailored to individual countries, address inequities and strengthen health systems, this goal remains achievable through partnership and collaboration.

By meeting the 2014 targets, countries set themselves on track to achieve the relevant global target to reduce child mortality to 25 deaths per 1,000 live births and maternal mortality to a global average of seventy deaths per 100,000 live births. These targets also now appear in countries’ own strategies. This report takes stock of the paths we have travelled together – both to celebrate successes and to understand where additional efforts and innovations are needed to save women and children. Of the 25 priority countries for this effort, USAID recognizes none have reached the end of their journey to self-reliance, but we continue to progress together.

USAID’S IMPACT SINCE THE 2012 CALL TO ACTION

In 2017 alone, USAID helped 76 million women and children access essential — and often life saving — health services.



13.2M

health workers trained in maternal and child health and nutrition



8.7M

women gave birth in a health facility



7.9M

newborns reached with care after delivery



77.1M

treatments provided to children for diarrhea and pneumonia



34.7M

children vaccinated against deadly preventable diseases



12.2M

people gaining access to basic drinking water services



25M

women reached with voluntary family planning services, annually



28M

children reached with nutrition programs



ACTING ON THE CALL

A Focus on the Journey to Self-Reliance for Preventing Child and Maternal Deaths

June 2018

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USAID PARTNERS WITH COUNTRIES ON THEIR JOURNEY TO SELF-RELIANCE

Self-reliance is a country's ability to plan, finance, and implement solutions to its own development challenges.

If we are to one day end the need for foreign assistance, USAID needs to understand where countries are on their development journey and ensure the programs we implement are best supporting a country's journey to self-reliance.

In this report, we present data to better understand where the 25 priority countries for preventing child and maternal deaths are in their unique health development journeys, as well as identify opportunities for further advancement and areas that require more attention. As in past years, this analysis builds on previous efforts and continues to refine how USAID works with governments to meet their health goals. This report is also part of a larger USAID effort on measuring a country's overall level of self-reliance. As part of this effort, child health is one of the

primary metrics the Agency will use to measure a country's progress on its overall journey to self-reliance.

The journey to self-reliance in the health sector begins first by reducing the disease burden, and then by a focus on building sustainability, which is reinforced by creating virtuous cycles of improvement. This relationship is demonstrated in the 2017 *Acting on the Call* report, in which we provided examples of how the six health system building blocks are interrelated and interdependent, and how we must focus across them in order to achieve lasting gains. Each country's health journey is unique. Different interventions that aim to reduce maternal and child mortality also experience shifts at different times, and, as shown in Figure 1, countries take different paths during the course of their journey.

At the beginning of the journey, it is essential to define a standard package of interventions, generate demand

for services within the community, and identify health system barriers. An integrated service delivery platform, with a cross cutting focus on prevention, care, and treatment, provides the best foundation to prevent child and maternal deaths. Such a platform includes national coverage of maternal and child health, voluntary family planning, nutrition, water, sanitation and hygiene (WASH), and malaria services.

As a country continues along the journey, the coverage of basic services increases and the focus shifts to ensuring access for the most underserved, as well as to the establishment of quality standards. Focus and resources can also shift to more specific and targeted evidence-based interventions to address the most significant drivers of mortality. As services become more effective, better management and accountability mechanisms are needed to improve

Examples of Virtuous Cycles of Improvement in Health Development

Effective health systems deliberately identify and nurture interrelated cycles, which create exponential and constant improvement in the system.

- Quality Improvement Teams identify problems leading to poor care, they address and track progress on those issues and success emboldens them to address new problems continuously.
- Health managers review and track district level outcome data, using it to advocate for additional resources, when resources are provided, they are emboldened to improve quality and quantity of data tracked which allows them to advocate for more resources.
- Effective management of medicines and contraceptive supplies leads to better forecasting which improves management of new supplies.
- Communities hold health facilities accountable for basic standards, such as hours and staffing, which makes the health facility more responsive to community needs and then emboldens the community to provide more robust oversight.

JOURNEY TO SELF-RELIANCE FOR PREVENTING CHILD AND MATERNAL DEATHS

NEAR DESTINATION

Ensure systems are durable, accountable and responsive and can progress with reduced donor involvement

All pockets of the population are able to access needed care equitably

System delivers consistent, effective services, which communities access and hold accountable

Domestic resources fund key health functions, and expanded risk pools improve financial protection

EN ROUTE

Use data to target bottlenecks affecting management, system quality and community engagement

Consistently practice high impact interventions and equip facilities to meet quality standards

Mobilize resources to cover more public health functions and create limited risk pools

Use data to improve and deploy health staff and resources based on need

BEGINNING OF JOURNEY

Build a system that delivers a basic package of services

Countries are heavily reliant on donor resources, while starting to create risk pools and growing domestic health resources

Increase the reach of health services through outreach and community-based delivery

Equip workers to deliver a basic package of services, like vaccinations, voluntary family planning, and childbirth services

FINANCIAL PROTECTION
Making health systems efficient and minimizing financial burden on population

POPULATION COVERAGE
Ensuring equitable access to health services across diverse sectors of the population

SERVICE CAPACITY
Ensuring quality, integrated health services with available medical commodities



domestic resource mobilization and provide financial protection. When country capacity improves, key donor-supported inputs, including commodities, salary support, and data systems, should transition to national management and domestic financing.

As countries build resilient systems, the focus will also shift to more targeted attention to a limited number of gaps and challenges that aim to ensure ongoing quality and equity. Countries need to develop, lead, fund, and sustain a prioritized strategy for reproductive, maternal, newborn, and child health (RMNCH) that includes sustainable financing efforts, policies, and commitment to evidence-based interventions that improve population health.

Political prioritization, stability, and unforeseen natural or man-made disasters can all change or interrupt a country's journey to self-reliance. The following pages identify where countries are in the journey to self-reliance for preventing child and maternal deaths, according to various indications of their health status and the strength of their health system.

To assess the severity of need in each of our priority countries, we looked at the relative strengths and weaknesses as compared to all USAID assisted

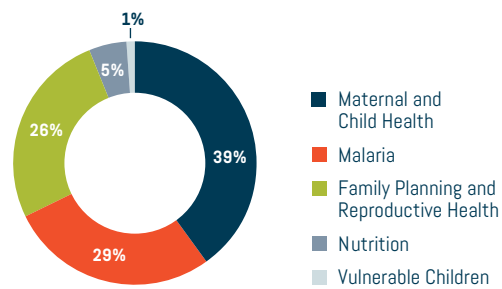
countries in the health sector. Using composite scores in maternal and child health, voluntary family planning, and nutrition, we can see the degree of progress these focus countries have made in each area from 2012 to 2017. We also look at the current capacity of the health system, in order to inform future programming and areas that need strengthening during the journey to self-reliance for health.

Finally, we have identified specific interventions that will help address gaps and build self-reliance in the health sector. We have calculated the return on USAID's investment in these areas, including the money our investment will leverage and make available in the health sector. Depending on the country, this leveraged money is realized in the form of "resources mobilized," defined as additional dollar investments made by

country governments or local actors, or as "cost savings," defined as money saved within a health system from increased efficiencies.

The 2018 *Acting on the Call* report builds on past analyses and outlines our efforts to achieve the ambitious goals set in 2014. This year's report showcases country-level progress on the journey to self-reliance for preventing child and maternal deaths, highlighting increases in country ownership since the 2012 Call to Action. It anchors the journey within the ongoing and continuous improvement process that is a cornerstone of USAID's effort to prevent child and maternal deaths and the Agency wide transition, which is further described on page 7. The following supplementary pages include country returns on investment, a Glossary of Terms, and Data Methodology.

PREVENTING CHILD AND MATERNAL DEATHS
TOTAL 2012-2017: \$14,267



DEPARTMENT OF STATE AND USAID	2012 Fiscal Year	2013 Fiscal Year	2014 Fiscal Year	2015 Fiscal Year	2016 Fiscal Year	2017 Fiscal Year	Total
(\$ MILLIONS)	8,599	8,420	8,826	9,277	8,841	8,867	52,830
PREVENTING CHILD AND MATERNAL DEATHS	2,285	2,262	2,398	2,534	2,417	2,372	14,268
CONTROLLING THE HIV/AIDS EPIDEMIC	5,893	5,773	6,000	6,000	6,000	6,000	35,666
COMBATING INFECTIOUS DISEASES	421	385	428	743*	424	495	2,896

* Includes investment for Ebola

Health and the Journey to Self-Reliance

This report is part of a larger Agency effort, beyond health, to understand where countries are on their journey to self-reliance, which, in turn, informs discussions on country strategies, policy dialogue, and when to consider countries for conversations about possible strategic transitions. We believe that two mutually reinforcing factors determine a country's self-reliance:

- **Commitment:** the degree to which a country's laws, policies, actions, and informal governance mechanisms — such as cultures and norms — support progress towards self-reliance, as measured by open and accountable government, commitment to inclusive development, and economic policy choices
- **Capacity:** how far a country has come in its journey across the dimensions of political, social, and economic development, including the ability to work across these sectors

As a country increases its commitment and capacity to plan, finance, and manage its own development, its level of self-reliance should also increase. Therefore, as self-reliance increases, our partnerships should also evolve, ensuring that the programs we implement are best supporting a country's journey to self-reliance.

After reviewing close to 200 metrics, the Agency's Transformation Task Team settled on an initial set of 17 third-party metrics to measure the core aspects of commitment and capacity. One of the metrics is the Child Health indicator, developed by the Center for International Earth Science Information Network (CIESIN). The Child Health indicator is a composite index derived from UN sources that looks at the average of scores for access to improved sanitation, access to improved water, and under-5 child mortality.

The indicators presented in this report are supplementary to, and complementary of, these broader self-reliance metrics. They will help inform where we can best target our assistance to assist countries to make their own investments to achieve self-reliance in preventing child and maternal deaths. They are one of a series of sets of secondary metrics and analyses the Agency will be using to augment our broader understanding of self-reliance, and to help guide strategic and programmatic decisions sector by sector.



A Focus on Financing

Diversifying resources for health becomes increasingly important as a county's health system and capacity matures. Such mobilization of additional resources occurs in at least three different ways: by helping countries to expand available resources at the country level, from both public and private sources, by making more of these resources specifically available in the health sector, and/or by improving the efficient use of existing resources (Figure 2).

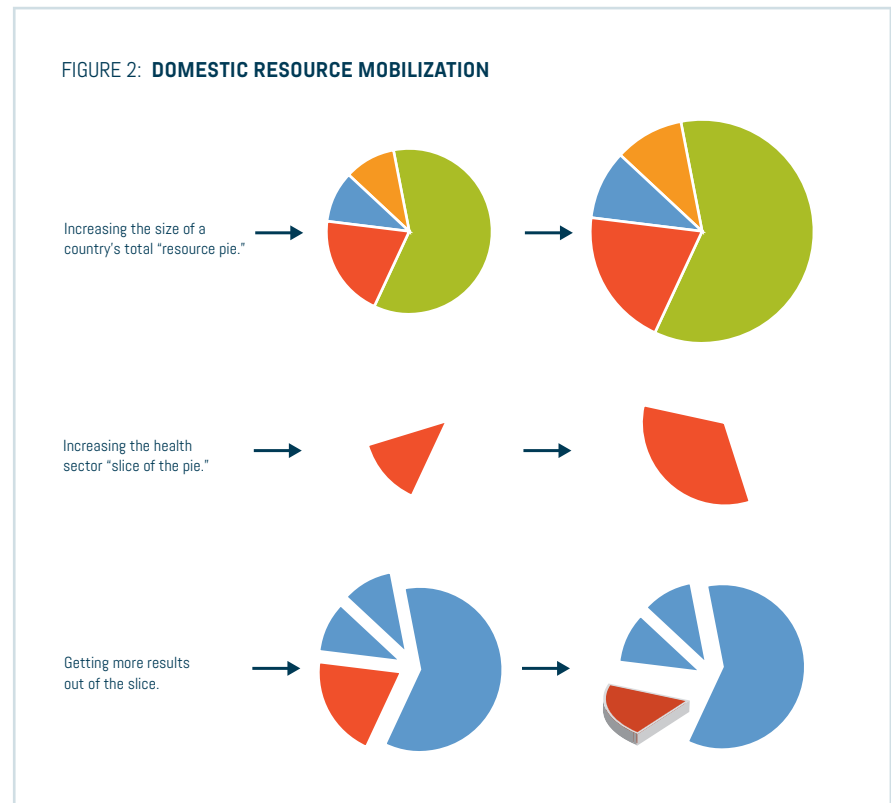
In the Democratic Republic of Congo (DRC), USAID worked with the Global Financing Facility in support of Every Woman Every Child (the GFF) to encourage the investment of domestic resources for maternal and child health services. In exchange for additional donor and private funds, the Government of the DRC has increased domestic resources for health from four to 7.5 percent of the national budget. Additionally, in the DRC other USAID investments have contributed to bringing together the two national programs that drive the country's Integrated Management of Newborn and Childhood Illness Strategy. By encouraging communication and coordination across programs, these efforts help DRC's Ministry of Public Health to track, anticipate and more efficiently manage and be accountable for the health needs across the population. They are key ingredients for resilience to potential shocks and instability, as well as for driving cost savings. Similarly, in Kenya

and other countries, work to develop the capacity of local governments in health sector planning and budgeting has resulted in increased contributions at the county level. As of June of 2017, more than 26 Kenyan counties have mobilized approximately \$7 million of domestic resources back into their health accounts.

USAID also works with countries to make health more affordable and prevent an illness from being a financial catastrophe for a family. Because it is difficult to know who will get sick when and unexpected illnesses can lead to high health costs, countries use a variety of approaches to pool resources across a population so that everyone pays a small amount and share the risk of a catastrophic expense across the pool. Risk

pooling is one way in which USAID works with partner governments to make health care affordable and accessible, and a significant step on the development journey.

USAID's efforts to assist countries along their journey to self-reliance both help countries realize cost savings and efficiencies through support to their overall health capacity development, as well as protect populations from catastrophic expenses. In this year's report, we identify examples of the return on our investments in some of the key health systems interventions identified in the 2017 *Acting on the Call* report.





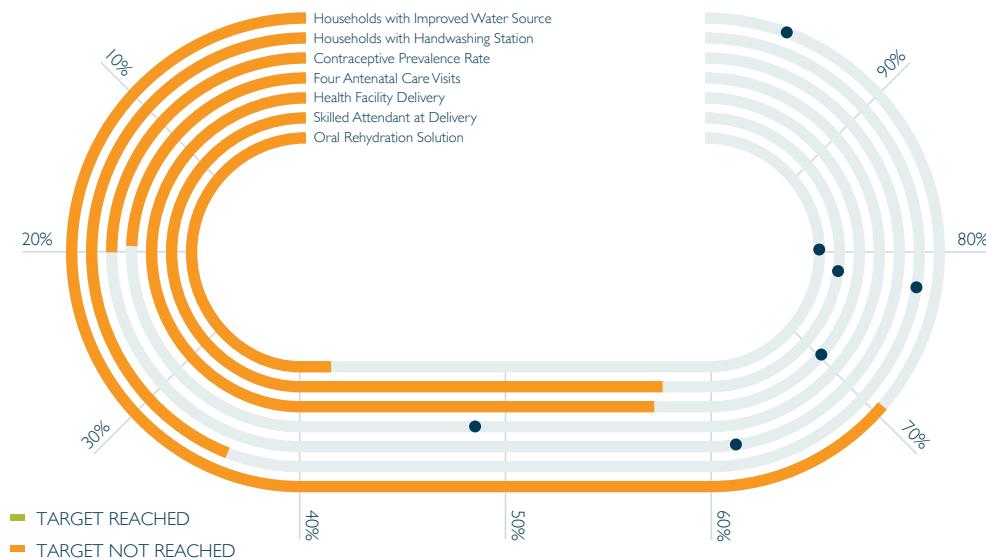


AFGHANISTAN

* Estimate from 2015 ** Estimate from 2016

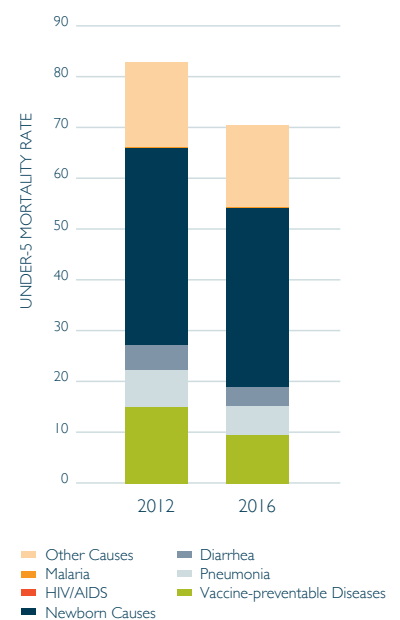
2017	34.1M ↑ Total Population	5.4M ↑ Population Under 5 Years	**80K ↓ Under-5 Deaths /Year	**70 ↓ Under-5 Mortality Rate Per 1,000 Live Births	1.3M ↑ Births	*396 ↓ Maternal Mortality Ratio Per 100,000 Live Births
1990	13.5M	2.6M	96K	176	739K	1,300

INTERVENTION COVERAGE



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

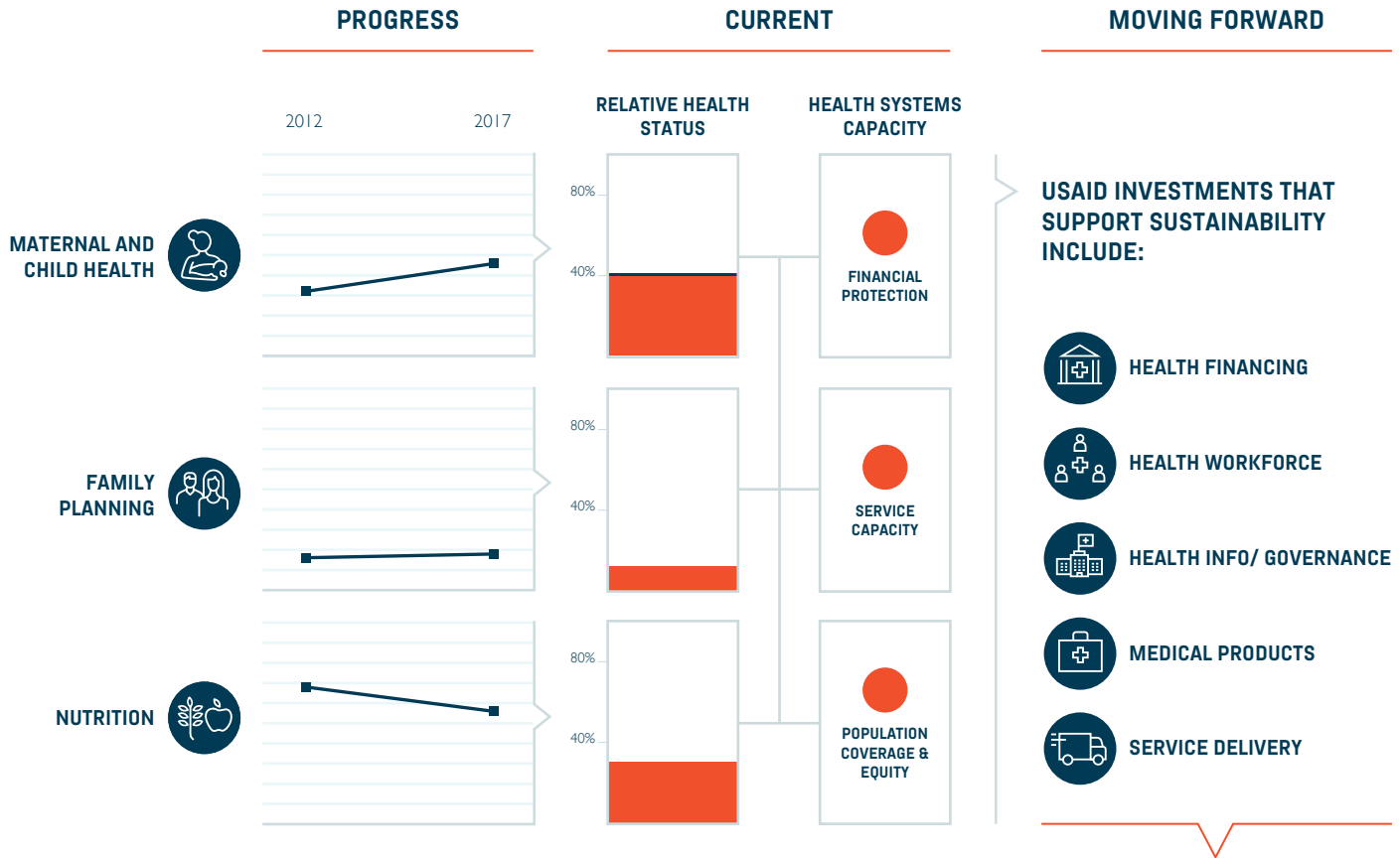
SHIFTING CAUSES OF CHILD MORTALITY



IN THE LAST YEAR, IN COLLABORATION WITH THE GOVERNMENT OF THE ISLAMIC REPUBLIC OF AFGHANISTAN (GOA) AND OTHER PARTNERS, WE HAVE ACHIEVED THE FOLLOWING:

- Added chlorhexidine gel (CHX) to the drug kit used by community health workers, following endorsement by the Ministry of Public Health (MoPH). CHX prevents neonatal sepsis: 79,000 newborns received umbilical cord care with CHX, potentially saving 14,000 lives
- Funded the delivery of basic health care in more than 2000 facilities, including equipping 94% with a female healthcare worker, which resulted in more than 860,000 deliveries with skilled birth attendants (SBAs)
- Financed efforts to include contraceptive implants and Sayana Press, both long-acting, reversible contraceptives, on the MoPH Essential Drug List, and assisted in the development of a national scale-up plan for implants, which expanded the available method mix and options for women who seek voluntary family planning
- Provided support to the MoPH to develop and endorse an overarching strategy on Reproductive, Maternal, Neonatal, Child, and Adolescent Health, which will guide future funding and prioritization by the MoPH
- Along with UNICEF, supported the first assessment of the quality of care of maternal and newborn health, the findings of which will be used to inform future governmental and donor investments to improve the quality of RMNCH services
- Trained 333 midwives to insert post-partum intrauterine devices (IUDs), resulting in 5,205 women receiving IUDs after giving birth in 2017

JOURNEY TO SELF-RELIANCE FOR PREVENTING CHILD AND MATERNAL DEATHS



USAID'S HEALTH INVESTMENTS MAY YIELD A 9 TO 1 RETURN IN ECONOMIC AND SOCIETAL BENEFITS BY 2035

GOING FORWARD, USAID WILL WORK WITH THE GOA TO FULFILL ITS COMMITMENT TO WOMEN AND CHILDREN'S HEALTH, INCLUDING THROUGH THE FOLLOWING:

- Supporting the MoPH in introducing user fees at the tertiary health care level in the capital, Kabul, which will generate approximately \$16 million annually to reinvest to improve health care
- Identifying opportunities for Indian businesses to open and improve private health services in Afghanistan
- Pre-testing and developing promotional materials – brand names and packaging – for oral rehydration solution and zinc to treat diarrhea; through social marketing, investments in this new brand of products is expected to make them self-sustainable within three years
- Supporting the application by the MoPH for resources from the GFF to improve delivery of primary health care and basic hospital services, which will help sustain health gains and improve access to, and the quality of, RMNCH care in the country
- Strengthening the GOA's ability to regulate and assure quality in the Afghan pharmaceutical system

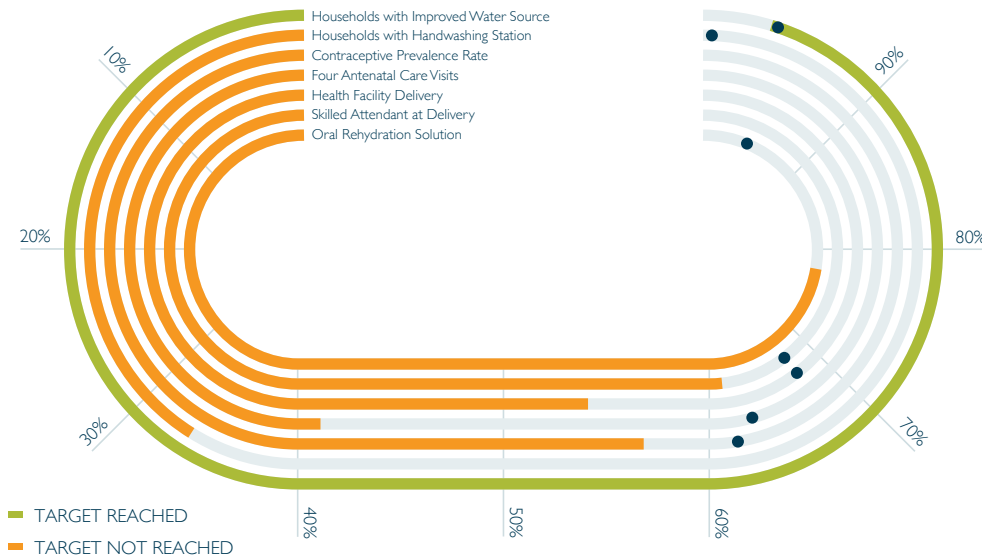


BANGLADESH

* Estimate from 2015 ** Estimate from 2016

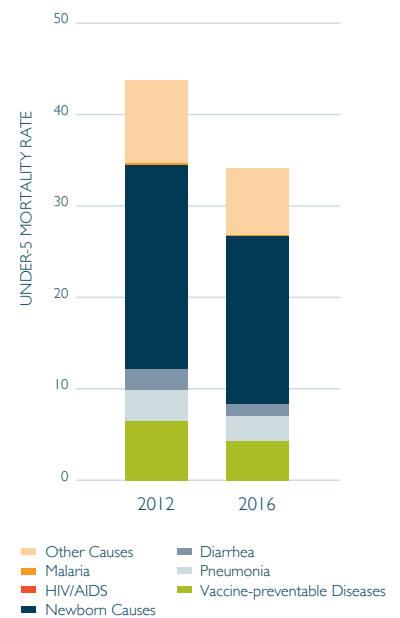
2017	157.8M ↑ Total Population	14.3M ↓ Population Under 5 Years	**106K ↓ Under-5 Deaths /Year	**34 ↓ Under-5 Mortality Rate Per 1,000 Live Births	3M ↓ Births	*176 ↓ Maternal Mortality Ratio Per 100,000 Live Births
1990	112M	17.8M	531K	143	4M	800

INTERVENTION COVERAGE



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SHIFTING CAUSES OF CHILD MORTALITY



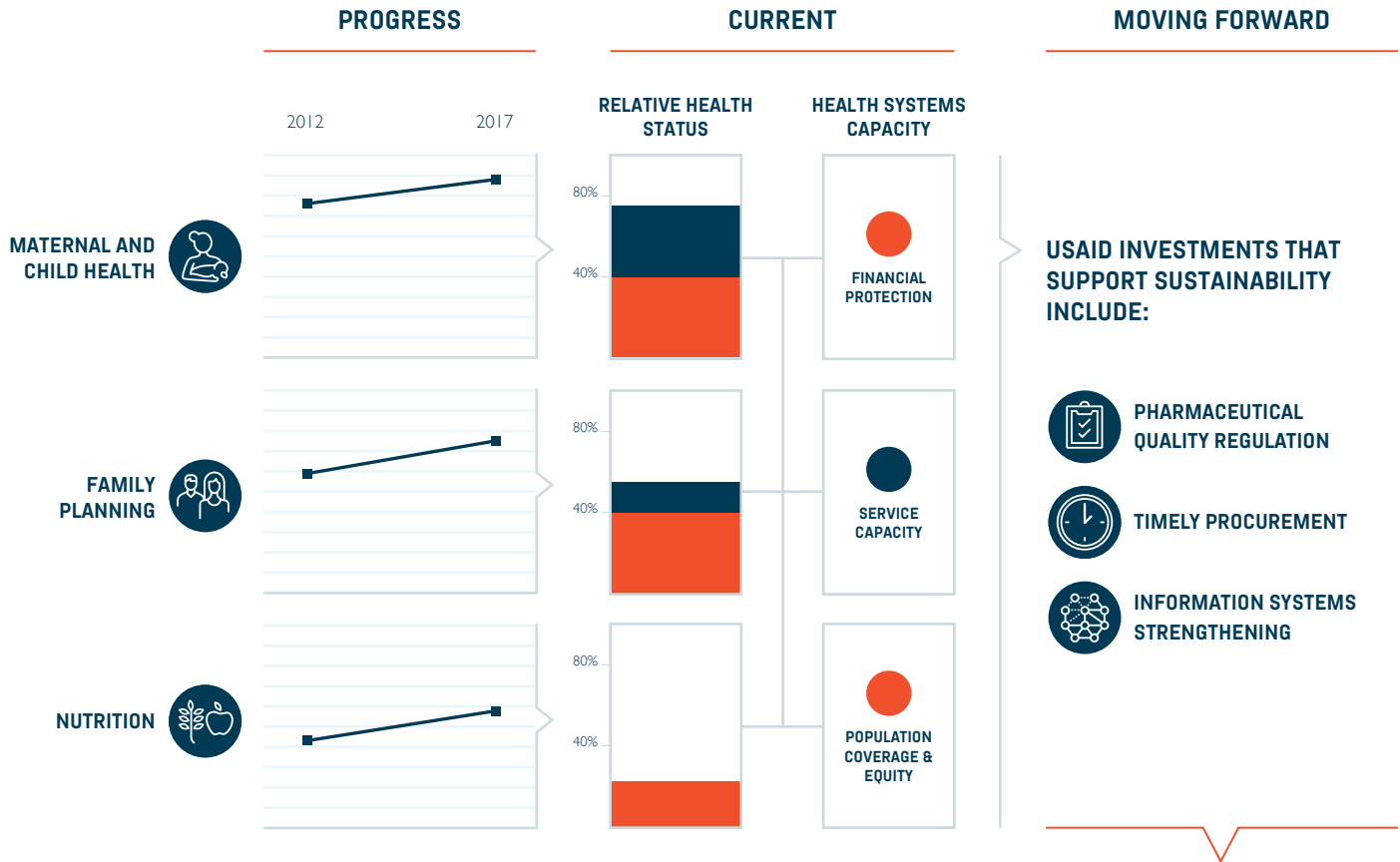
IN THE LAST YEAR, IN COLLABORATION WITH THE GOVERNMENT OF THE PEOPLE'S REPUBLIC OF BANGLADESH (GOB) AND OTHER PARTNERS, WE HAVE ACHIEVED THE FOLLOWING:

- Rolled out life-saving newborn interventions, including chlorhexidine to prevent neonatal sepsis and Helping Babies Breathe to prevent asphyxia; in 2017, the Helping Babies Breathe intervention saved the lives of 19,582 babies born not breathing
- Developed the capacity of local organizations to implement national surveys through classroom-based and on the job training, which gave five organizations the capacity to carry out data analysis and implement quality health surveys
- Trained service providers at 140 facilities in the management of pre-eclampsia and eclampsia, which resulted in a 100% survival rate for mothers presenting with pre-eclampsia/eclampsia symptoms
- Transformed access to postpartum voluntary family planning, including through the new availability of two methods and the development of a National Postpartum Family Planning Action Plan and training materials
- Developed an electronic Asset Management System to track the status of costly and life-saving medical equipment, which will ensure the readiness of health facilities for essential service delivery while reducing the misuse of resources

TRANSITION SINCE THE 2012 CALL TO ACTION

A new program will develop and implement a sustainable financial and management system to eventually bring the Smiling Sun Network of 399 clinics — funded by USAID for the past 20 years — under a newly-created private social enterprise which will gradually reduce financial dependence on USAID.

JOURNEY TO SELF-RELIANCE FOR PREVENTING CHILD AND MATERNAL DEATHS



**\$7.5M IN COST SAVINGS AND RESOURCES MOBILIZED BY 2025
WHICH IS A 6 TO 1 RETURN ON USAID'S INVESTMENT**

GOING FORWARD, USAID WILL WORK WITH THE GOB TO FULFILL ITS COMMITMENT TO WOMEN AND CHILDREN'S HEALTH, INCLUDING THROUGH THE FOLLOWING:

- Continuing to support the Social Marketing Company (SMC) which provides 55% of all oral rehydration solution and 62% of oral contraceptives nationally, to be a self-sustaining company; SMC currently covers 91% of its expenses and will be sustainable by 2021
- Implementing a costed plan for the nationwide scale up of public health centers to provide normal delivery care 24 hours per day, seven days per week (24/7) with only local resources
- Conducted rapid assessments to review the institutional and managerial capacity of the National Institute of Population Research and Training, responsible for the training of primary health care providers, and the results will inform future trainings for supervisors and managers
- Developing a harmonized job description for community health workers and a community health strategy, which will ensure health workers are providing the same type and level of care, thereby strengthening primary health care and the referral network to higher level facilities

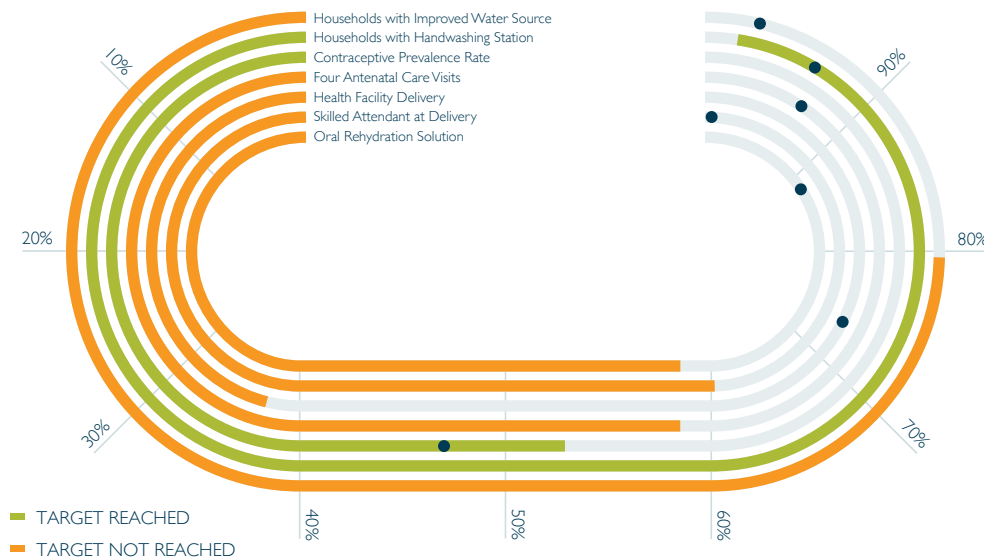


BURMA

* Estimate from 2015 ** Estimate from 2016

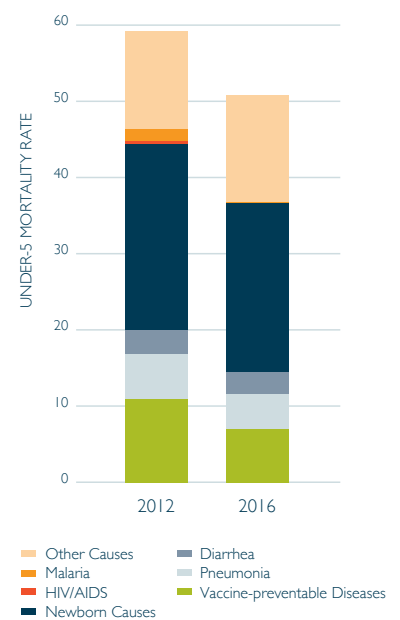
2017	55.1M ↑ Total Population	4.9M ↓ Population Under 5 Years	** 48K ↓ Under-5 Deaths /Year	** 51 ↓ Under-5 Mortality Rate Per 1,000 Live Births	996K ↓ Births	* 178 ↓ Maternal Mortality Ratio Per 100,000 Live Births
1990	40.5M	5.5M	121K	110	1.2M	520

INTERVENTION COVERAGE



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

SHIFTING CAUSES OF CHILD MORTALITY



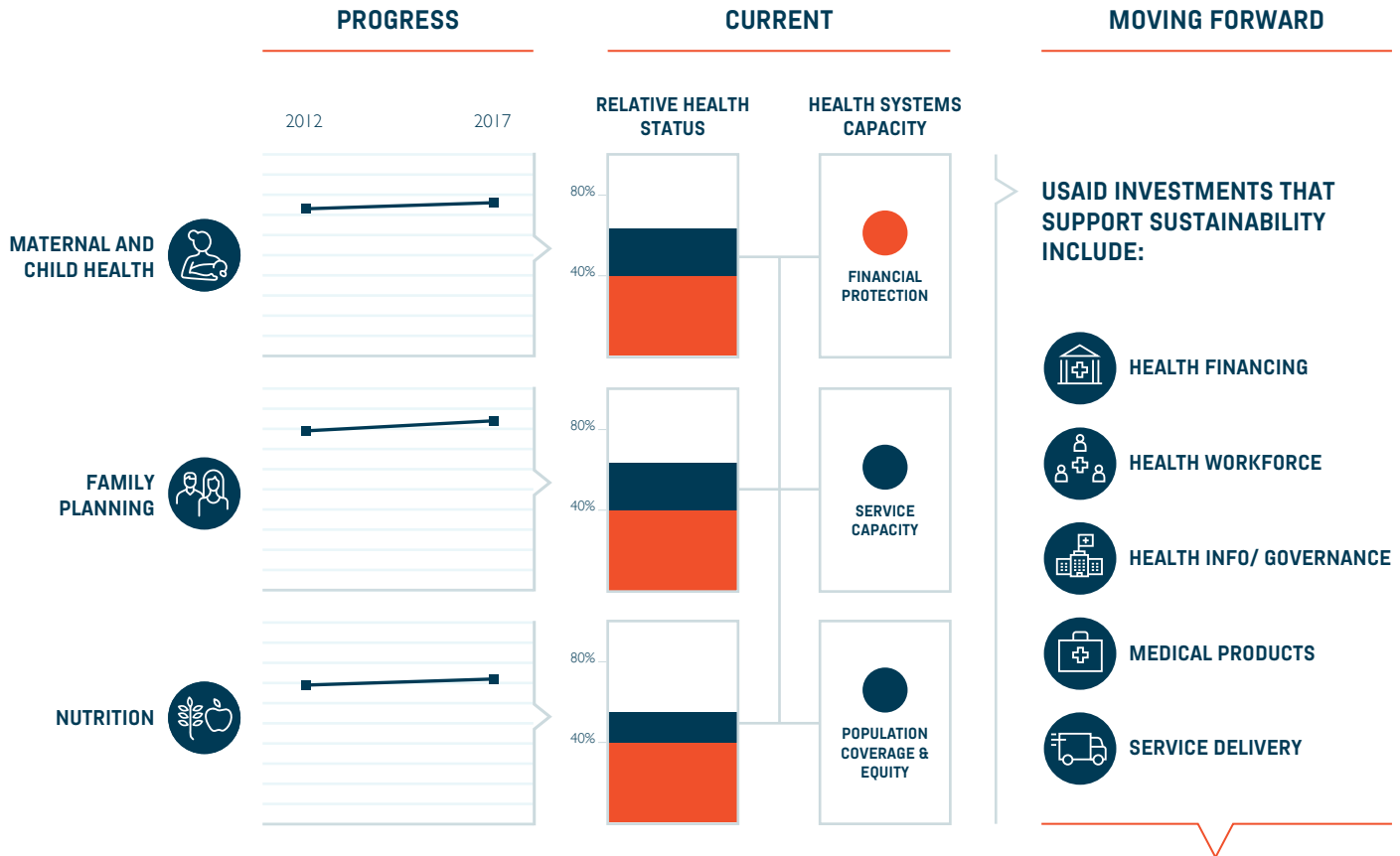
IN THE LAST YEAR, IN COLLABORATION WITH THE GOVERNMENT OF BURMA (GOB) AND OTHER PARTNERS, WE HAVE ACCOMPLISHED THE FOLLOWING:

- Financed the training and certification of 53 ethnic health providers as Basic Emergency Obstetric and Newborn Care trainers, which is the first time the Ministry of Health and Sport (MoHS) has certified health workers from minority communities
- Supported training of 841 health workers across five states, including in six newly established skills-based learning labs, which allowed the MoHS to train an additional 354 workers with this approach
- Supported a mentorship program through which the American College of Nurse Midwives provides targeted organizational capacity and technical skills-building to the Myanmar Nurse Midwives Association (MNMA)
- Established a new skills training lab at MNMA, which increased organizational capacity assessment scores by nearly 30% since USAID assistance began
- Supported the dissemination and use of Burma's first Demographic and Health Survey (DHS) data for decision-making through more than 15 workshops, the training of 50 MoHS staff in data analysis, and the training of 12 journalists on how to use data for reporting
- Helped 10,736 pregnant women to receive emergency referrals to skilled and equipped providers, and as a result skilled health personnel attended 34,148 births across 43 townships

TRANSITION SINCE THE 2012 CALL TO ACTION

Since 2012, USAID has expanded support from ensuring the delivery of basic services at the community level to engaging the GOB, private sector and civil society stakeholders on ways to improve policy and build a more inclusive and sustainable health system.

JOURNEY TO SELF-RELIANCE FOR PREVENTING CHILD AND MATERNAL DEATHS



USAID'S HEALTH INVESTMENTS MAY YIELD A 9 TO 1 RETURN IN ECONOMIC AND SOCIETAL BENEFITS BY 2035

GOING FORWARD, USAID WILL WORK WITH THE GOB TO FULFILL ITS COMMITMENT TO WOMEN AND CHILDREN'S HEALTH, INCLUDING THROUGH THE FOLLOWING:

- Strengthening Township Health Departments to be more effective managers and identify and address gaps in service coverage, which will ensure domestic investments in health yield increased coverage and improved health
- Supporting the development of costed plans and a cadre of master trainers for Comprehensive Emergency Obstetric and Neonatal Care
- Providing continued support to improve the quality of maternal and neonatal care services in Rakhine State at Sittwe General Hospital
- Developing quality improvement tools, including dashboards and governance structures to monitor quality improvement across health institutions



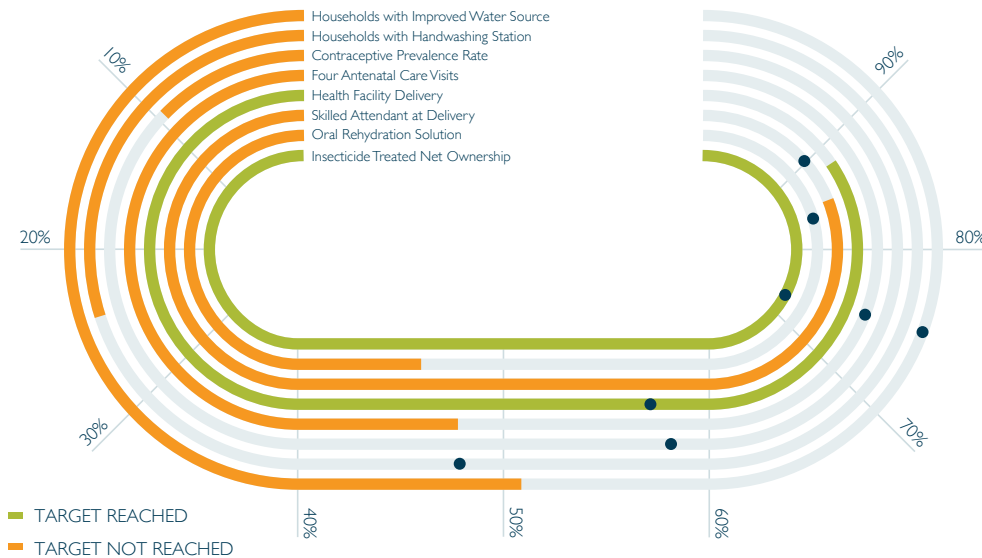
DEMOCRATIC REPUBLIC OF CONGO

* Estimate from 2015 ** Estimate from 2016

2017	83.3M ↑ Total Population	12.6M ↑ Population Under 5 Years	** 304K ↑ Under-5 Deaths /Year	** 94 ↓ Under-5 Mortality Rate Per 1,000 Live Births	2.8M ↑ Births	* 693 ↓ Maternal Mortality Ratio Per 100,000 Live Births
1990	39M	7.4M	266K	171	1.8M	930

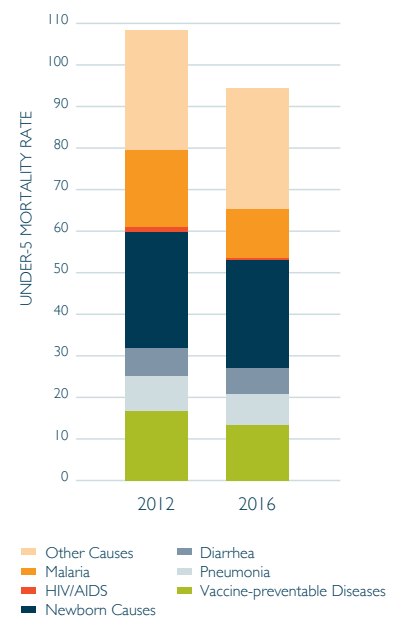
INTERVENTION COVERAGE

● = PREDICTED COVERAGE RATE
BASED ON 2014 AOTC ANALYSIS



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

SHIFTING CAUSES OF CHILD MORTALITY



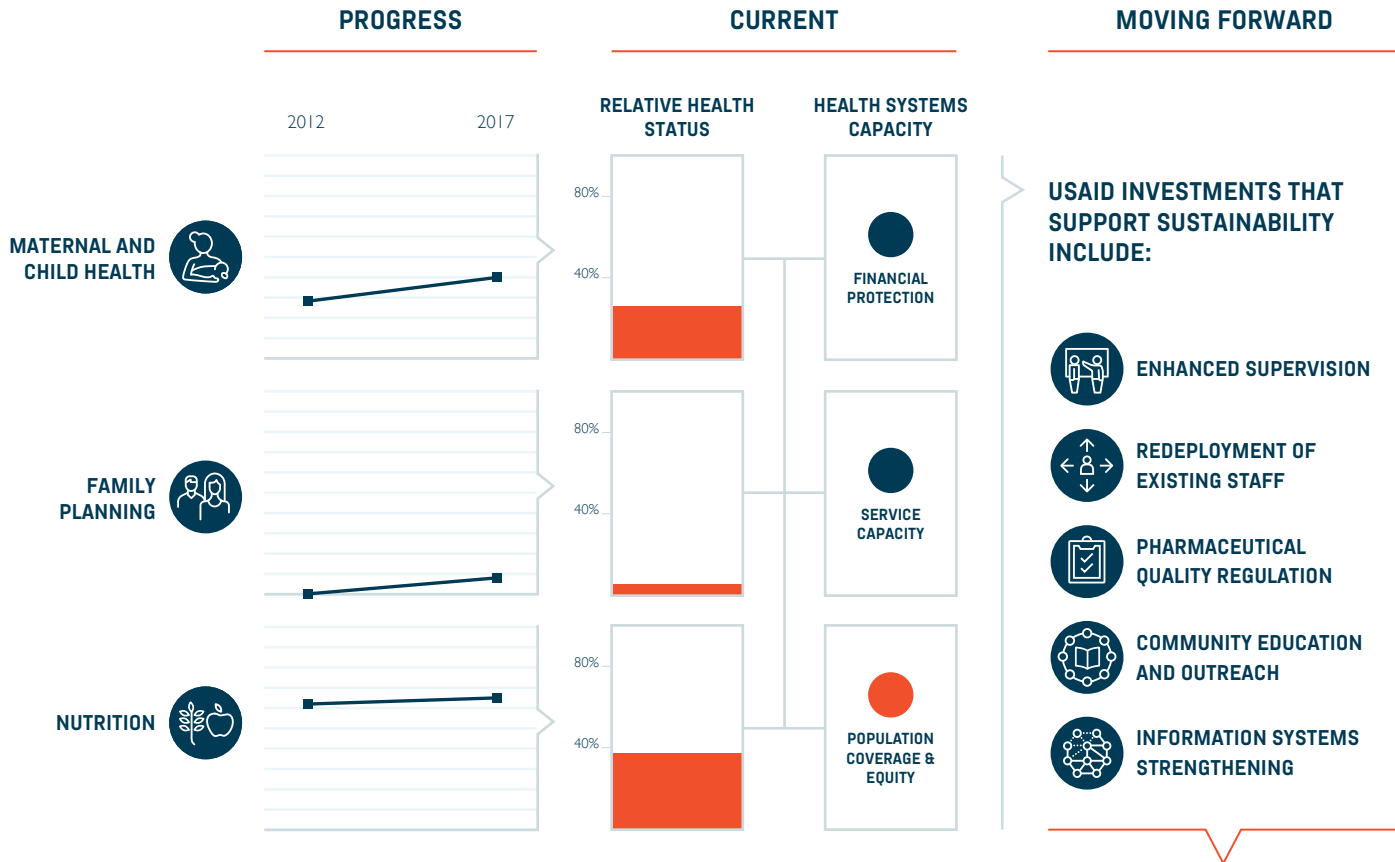
IN THE LAST YEAR, IN COLLABORATION WITH THE GOVERNMENT OF THE DEMOCRATIC REPUBLIC OF CONGO (GDRC) AND OTHER PARTNERS, WE HAVE ACHIEVED THE FOLLOWING:

- Advocated at the provincial level for the creation of budget lines for contraceptives, which resulted in a \$480,000 investment by local governments
- Trained 70 senior Ministry of Health (MoH) staff on decentralization in the health sector, which will help improve health by bringing decision-making closer to recipients
- Created national support for health: following the 2017 *Acting on the Call* event, the Government of the DRC held a two-day workshop on RMNCH, during which the Prime Minister announced his Government will subsidize access to health care for pregnant women and children under-five in Kinshasa, the capital city
- Mobilized \$120,000 from private companies to support the provision of voluntary family planning in the Provinces of Lualaba and Haut Katanga.
- Provided coaching that led the Kinshasa School of Public Health to organize a course to assist senior MoH staff in mobilizing domestic resources to achieve health objectives
- Scaled-up performance-based financing at the county level, including by expanding the program geographically and coordinating with other donors across three provinces in 730 health facilities

TRANSITION SINCE THE 2012 CALL TO ACTION

Because of the humanitarian situation in the Kasai Region, USAID shifted programs from a development approach to a humanitarian response to meet the needs of 1.4 million displaced persons, by training community health workers on humanitarian health care and preventive services in camps of internally displaced populations, often using mobile clinics. USAID also participates in a working group to plan for the eventual transition back to development programs in the Kasai.

JOURNEY TO SELF-RELIANCE FOR PREVENTING CHILD AND MATERNAL DEATHS



\$81M IN RESOURCES MOBILIZED BY 2025
WHICH IS A **31%** RETURN ON USAID'S INVESTMENT

GOING FORWARD, USAID WILL WORK WITH THE GDRC TO FULFILL ITS COMMITMENT TO WOMEN AND CHILDREN'S HEALTH, INCLUDING THROUGH THE FOLLOWING:

- Sponsoring the Community Leadership Development Program and the new Community Health National Strategic Plan, which will emphasize local ownership, resources, and knowledge in community health
- Strengthening the management of the Kinshasa School of Public Health to move from a manual financial reporting system to an automated report generated with financial software to help predict future expenses



ETHIOPIA

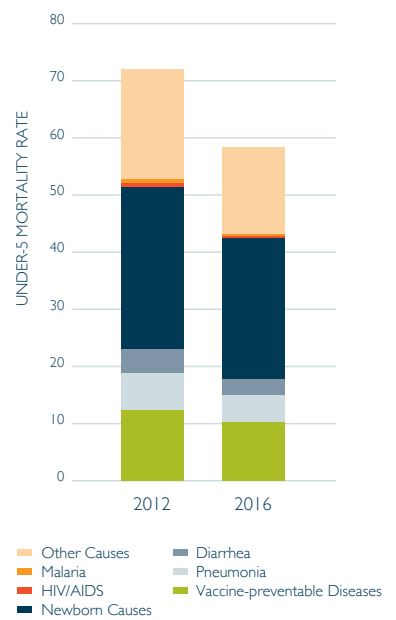
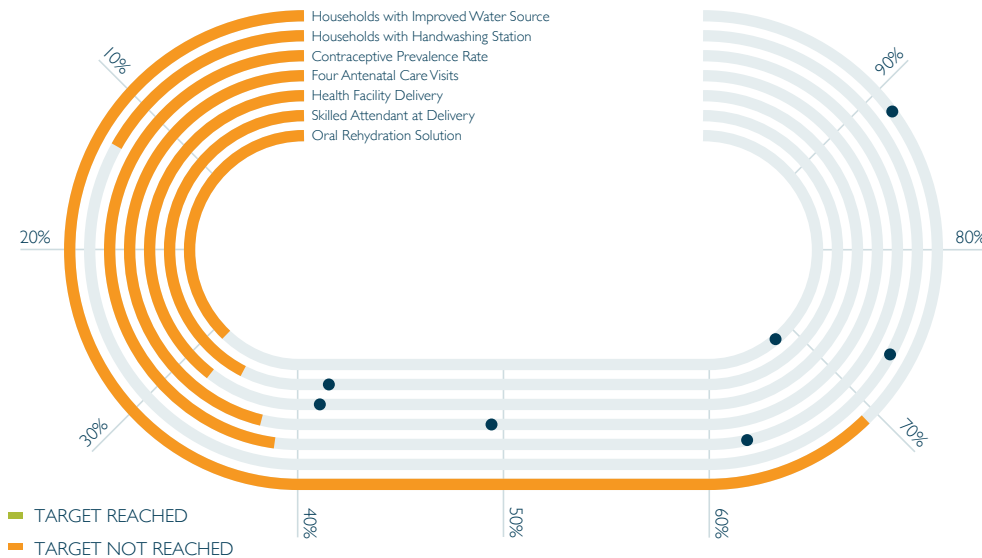
* Estimate from 2015 ** Estimate from 2016

2017	105.4M ↑ Total Population	17.2M ↑ Population Under 5 Years	**187K ↓ Under-5 Deaths /Year	**58 ↓ Under-5 Mortality Rate Per 1,000 Live Births	3.8M ↑ Births	*353 ↓ Maternal Mortality Ratio Per 100,000 Live Births
1990	47.5M	8.5M	444K	204	2.2M	950

INTERVENTION COVERAGE

● = PREDICTED COVERAGE RATE
BASED ON 2014 AOTC ANALYSIS

SHIFTING CAUSES OF CHILD MORTALITY



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

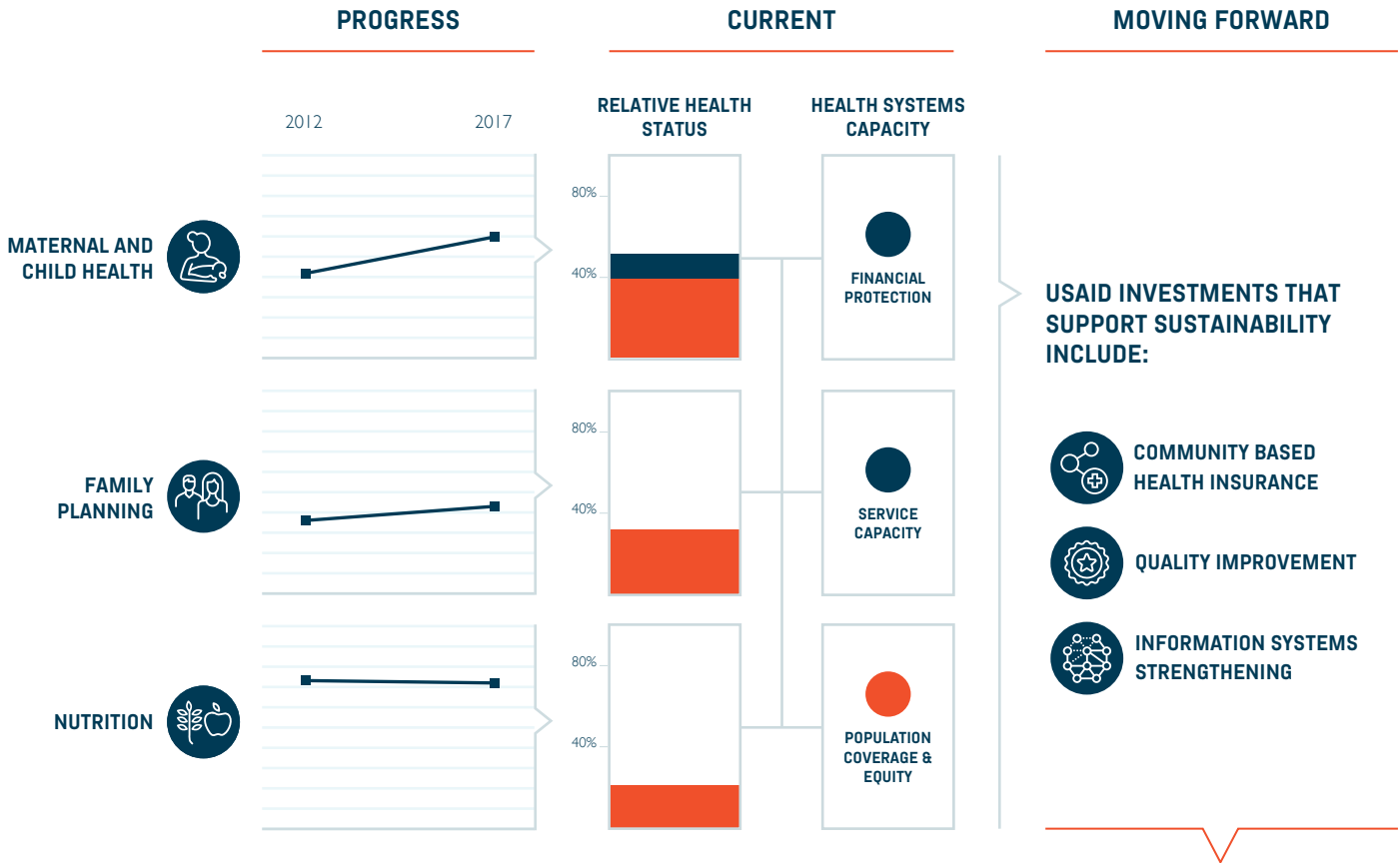
IN THE LAST YEAR, IN COLLABORATION WITH THE GOVERNMENT OF THE FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPIA (GOE) AND OTHER PARTNERS, WE HAVE ACCOMPLISHED THE FOLLOWING:

- Advocated for the creation and filling of more than 1,500 Human Resource Manager positions within host-government institutions to improve the timely recruitment, motivation, retention, and transfer of health workers
- Increased financial sustainability in 90% of public facilities, by allowing primary health centers to retain the revenue they generate through user fees and reinvest it to improve the quality of care
- Conducted training on the cold chain for vaccines, which saved over \$10,000 in repair costs and ensured the viability of over 136,000 doses of vaccines
- Vaccinated 927,012 children under-five against polio and improved laboratory capacity to ensure the rapid identification of polio cases, which improved the quality of surveillance for all vaccine preventable diseases
- Supported 54 pre-service institutions to train and graduate 2,060 midwives, 215 anesthetists, and 4,500 Health Extension Workers with job-appropriate skills
- Trained 1,039 sub-district and facility managers to implement a local-language community scorecard to collect feedback from clients on the quality of services

TRANSITION SINCE THE 2012 CALL TO ACTION

Many of the 300 woredas, or districts, that received prior USAID support have graduated to technical assistance or are now functioning on their own, with 13 high-performing districts even serving as mentors to 13 lower performing districts.

JOURNEY TO SELF-RELIANCE FOR PREVENTING CHILD AND MATERNAL DEATHS



\$600M IN RESOURCES MOBILIZED BY 2025
WHICH IS A **22 TO 1** RETURN ON USAID'S INVESTMENT

GOING FORWARD, USAID WILL WORK WITH THE GOE TO FULFILL ITS COMMITMENT TO WOMEN AND CHILDREN'S HEALTH, INCLUDING THROUGH THE FOLLOWING:

- Using a market-based approach to improve the quality and quantity of sanitation commodities available through the private sector, which complements public health outreach to expand access to and uptake of sanitation facilities
- Supporting the Global Polio Legacy Plan, which includes timelines for transferring responsibility and surveillance to the GOE and identifies gaps as donor support for polio eradication winds down
- Collaborating with the Data Use Partnership, funded by the Bill and Melinda Gates Foundation, to reform the Ethiopian Health Information Systems architecture and build local capacity in governance, data management and use of information, which will drive efficiency, and cost-savings
- Under the GFF, engage the World Bank and other donors to mobilize a very low interest loan of \$150 million to leverage domestic health financing
- Applying and adapting management and governance training, strengthening surveillance, and creating mentoring and coaching opportunities for district-level officials
- Guiding the expansion of the Ethiopian community-based health insurance program to help identify links between insurance and improvements in the quality of care, and increase availability of supplies, and customer satisfaction and enrollment

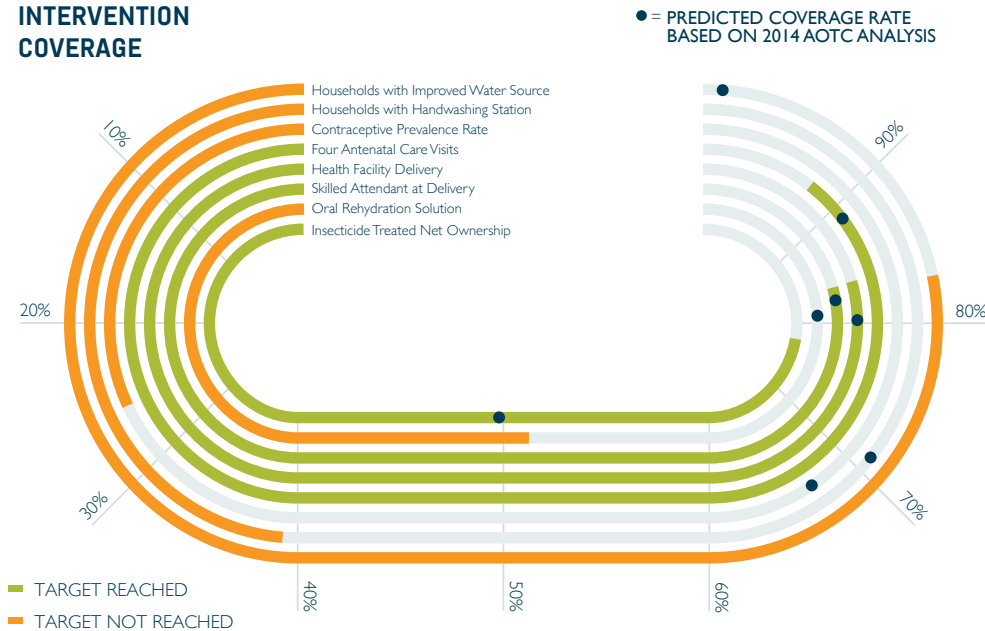


GHANA

* Estimate from 2015 ** Estimate from 2016

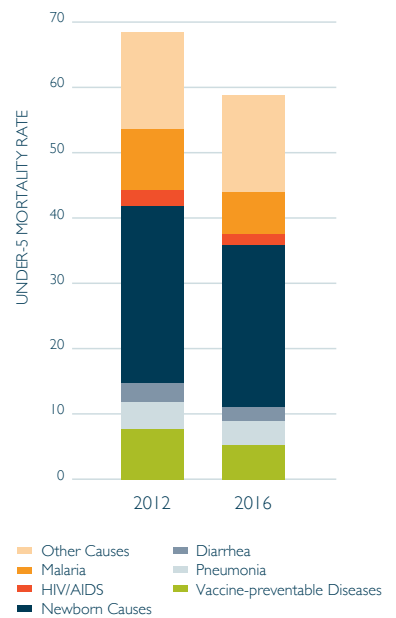
2017	27.5M ↑ Total Population	3.9M ↑ Population Under 5 Years	**51K ↓ Under-5 Deaths /Year	**59 ↓ Under-5 Mortality Rate Per 1,000 Live Births	838K ↑ Births	*319 ↓ Maternal Mortality Ratio Per 100,000 Live Births
1990	15.5M	2.7M	70K	128	603K	580

INTERVENTION COVERAGE



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

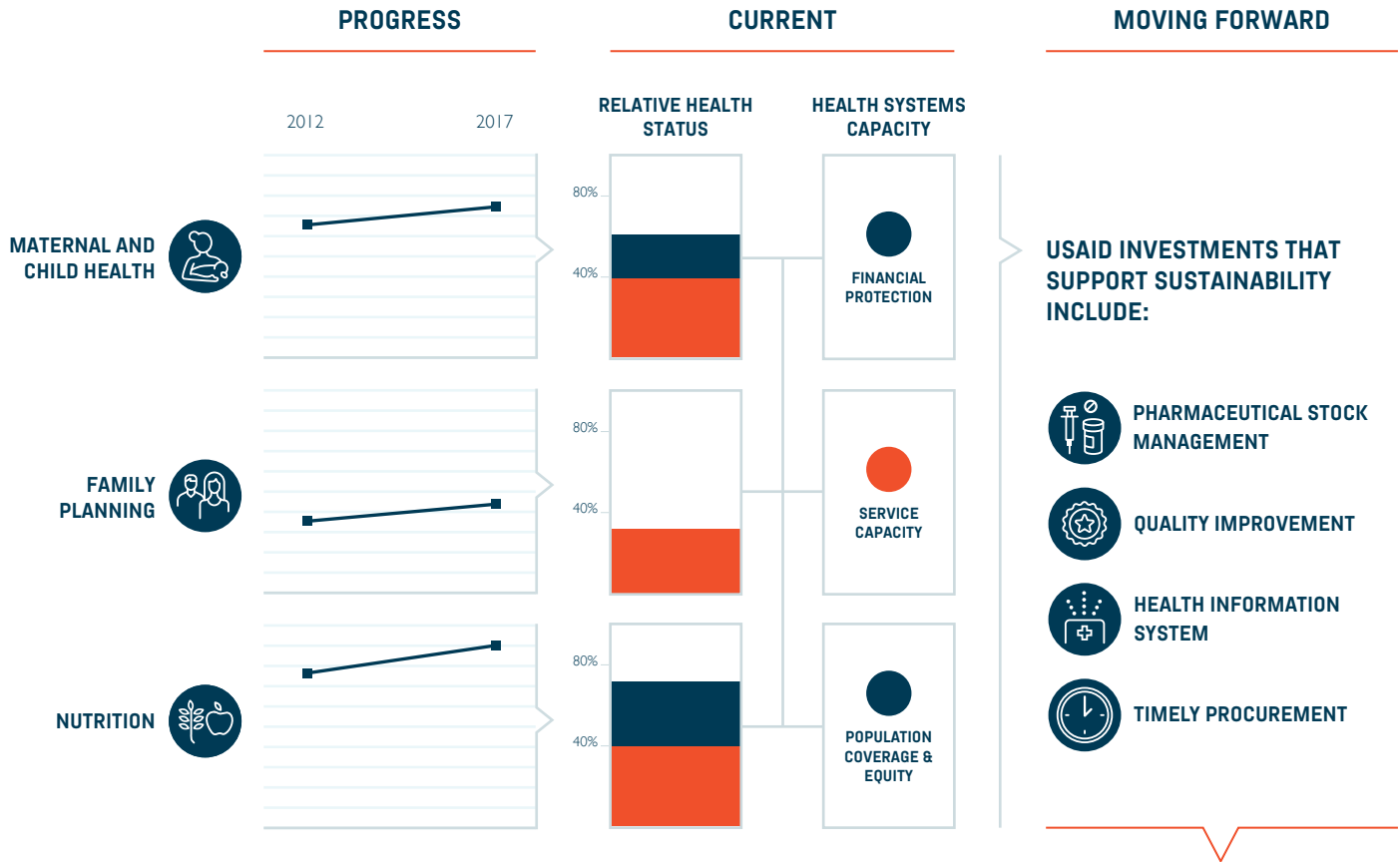
SHIFTING CAUSES OF CHILD MORTALITY



IN THE LAST YEAR, IN COLLABORATION WITH THE GOVERNMENT OF THE REPUBLIC OF GHANA (GOG) AND OTHER PARTNERS, WE HAVE ACCOMPLISHED THE FOLLOWING:

- Achieved a 16.5 percent increase in new users of long-acting reversible contraceptives through training and on-site coaching for over 1,000 midwives
- Supported the development and launch of Digni-Loo, an innovative latrine that is locally manufactured, affordable, easy to install, durable, hygienic, sustainable, and being scaled up with over \$800,000 in anticipated investments from the World Bank and World Vision International
- Funded efforts to reduce chronic malnutrition in 6,200 vulnerable households with pregnant women and children under-two, a model the GOG is now expanding with its own resources to 37,000 more households
- Funded a study to identify the constraints and opportunities for mobilizing domestic resources for health and education, which is now guiding conversations on raising revenue and allocating resources for health
- Procured and distributed models, training equipment, and skills laboratory materials to 17 medical training schools
- Distributed 1.4 million long lasting insecticide treated nets to 23,000 schools using a third party logistic provider, which increased efficiencies from prior distribution through educational workers
- Supported nutrition activities through integrated nutrition-sensitive health, WASH, agricultural, social protection, and governance interventions; reaching 1,195,219 children under five with nutrition-specific interventions across five focus regions

JOURNEY TO SELF-RELIANCE FOR PREVENTING CHILD AND MATERNAL DEATHS



\$88M IN COST SAVINGS BY 2025
WHICH IS A **21 TO 1** RETURN ON USAID'S INVESTMENT

GOING FORWARD, USAID WILL WORK WITH THE GOG TO FULFILL ITS COMMITMENT TO WOMEN AND CHILDREN'S HEALTH, INCLUDING THROUGH THE FOLLOWING:

- Scaling-up Village Savings and Loans Associations nationally, which to date have helped 81,000 women save \$2.25 million, and borrow an additional \$1.22 million, which they invest in small businesses, increasing their income and improving food security for their households
- Support to Ghana Health Service (GHS) for the transition from pen and paper to a digital health record system; enabling GHS to better manage patient cases and promote efficiency in data management
- Finance a mapping exercise to determine key districts or health facilities that are contributing to gaps in service delivery and quality of care, which will help direct future efforts to improve services
- Fund the expansion of a clinical audit, which helps track providers' compliance with national guidelines and the claims requirements of national health insurance claims requirements

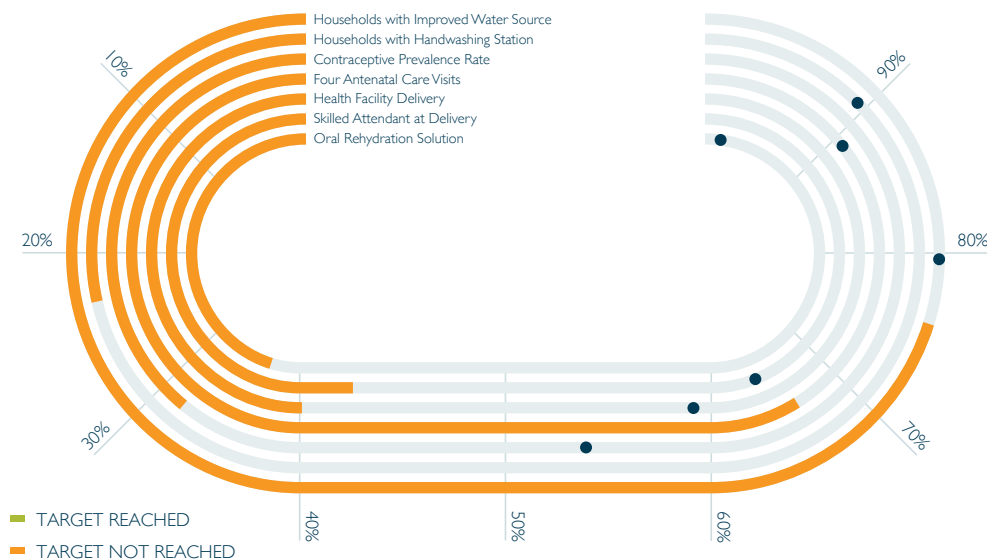


HAITI

* Estimate from 2015 ** Estimate from 2016

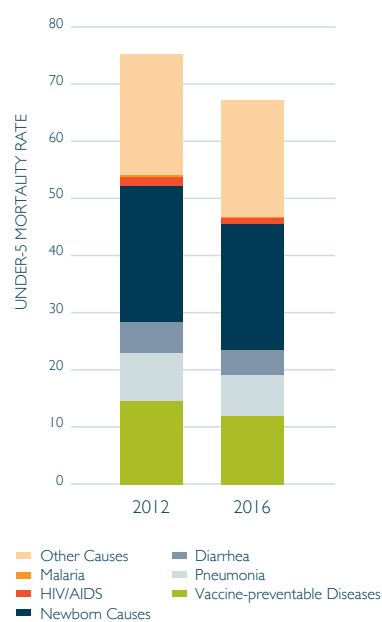
2017	10.6M ↑ Total Population	1.2M ↑ Population Under 5 Years	** 17K ↓ Under-5 Deaths /Year	** 67 ↓ Under-5 Mortality Rate Per 1,000 Live Births	244K ↓ Births	* 359 ↓ Maternal Mortality Ratio Per 100,000 Live Births
1990	6.8M	1M	36K	144	260K	620

INTERVENTION COVERAGE



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

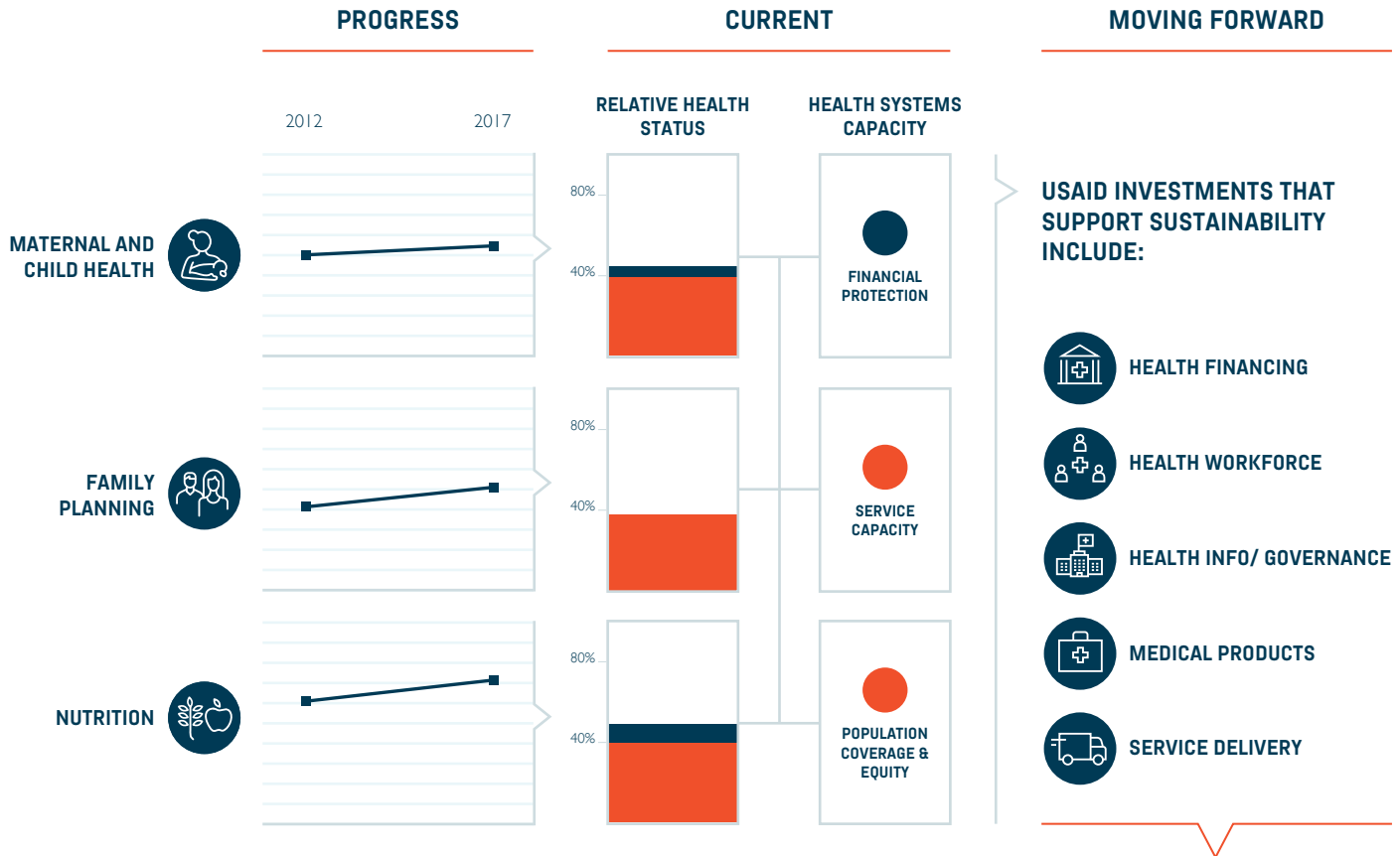
SHIFTING CAUSES OF CHILD MORTALITY



IN THE LAST YEAR, IN COLLABORATION WITH THE GOVERNMENT OF THE REPUBLIC OF HAITI (GOH) AND OTHER PARTNERS, WE HAVE ACCOMPLISHED THE FOLLOWING:

- Supported two faith-based organizations (FBOs) to serve as National Training Centers to train health providers across the country on high impact interventions such as newborn resuscitation, the management of postpartum bleeding, and the insertion and removal of an IUD
- Trained 5,714 health workers to ensure competency in the prevention of Zika virus infection, the provision of voluntary family planning, the management of child illness, and the improvement of WASH
- Reached 51,422 women with quality antenatal care and immunized 72,339 children under-one year with a full course of vaccinations
- Launched a Participatory Hygiene and Sanitation Transformation approach around 69 Clean Clinic facilities, which will encourage community solutions to poor WASH practices
- Reached 49,832 newborns with a postnatal check within three days of birth

JOURNEY TO SELF-RELIANCE FOR PREVENTING CHILD AND MATERNAL DEATHS



USAID'S HEALTH INVESTMENTS MAY YIELD A 9 TO 1 RETURN IN ECONOMIC AND SOCIETAL BENEFITS BY 2035

GOING FORWARD, USAID WILL WORK WITH THE GOH TO FULFILL ITS COMMITMENT TO WOMEN AND CHILDREN'S HEALTH, INCLUDING THROUGH THE FOLLOWING:

- Developing a national Human Resources for Health Strategy, which includes cost estimates and a financing strategy, to align the Haitian domestic budget with the needs of the Ministry of Health
- Supporting the development of a health financing framework, including mapping available donor and domestic resources against strategic priorities to inform efforts to increase domestic resources for health
- Helping select hospitals to develop business plans to track expenses and leverage additional resources from the Haitian domestic budget, the private sector, and private donations to ensure future sustainability
- Rolling out a Community Tracker to capture data on health care delivered by community health workers, which will help align the workforce and budgets around need

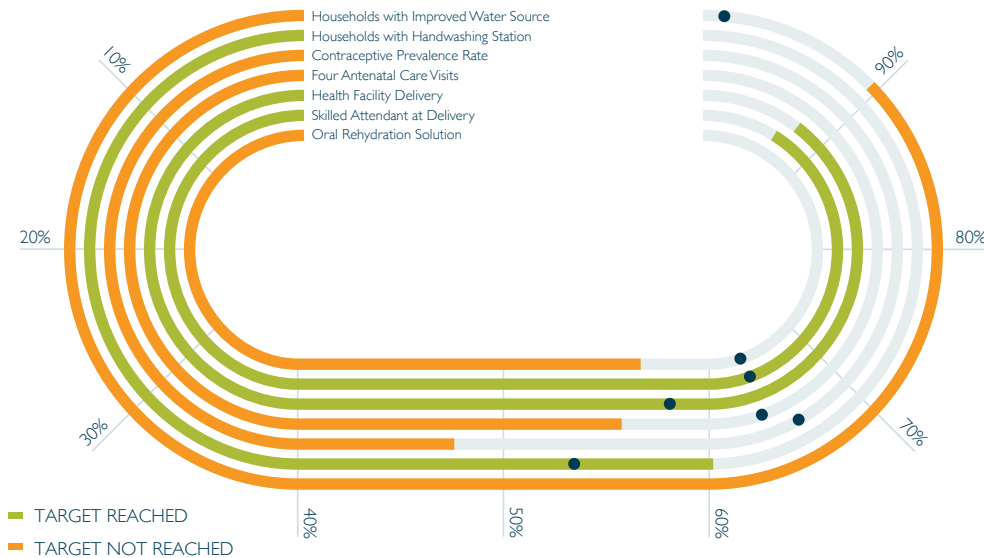


INDIA

* Estimate from 2015 ** Estimate from 2016

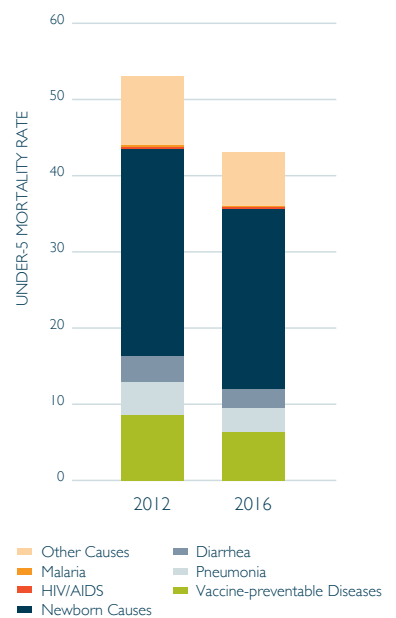
2017	1.3B ↑ Total Population	116.9M ↓ Population Under 5 Years	** 1.1M ↓ Under-5 Deaths /Year	** 43 ↓ Under-5 Mortality Rate Per 1,000 Live Births	24.4M ↓ Births	* 174 ↓ Maternal Mortality Ratio Per 100,000 Live Births
1990	869M	119M	3.3M	126	26.5M	600

INTERVENTION COVERAGE



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

SHIFTING CAUSES OF CHILD MORTALITY



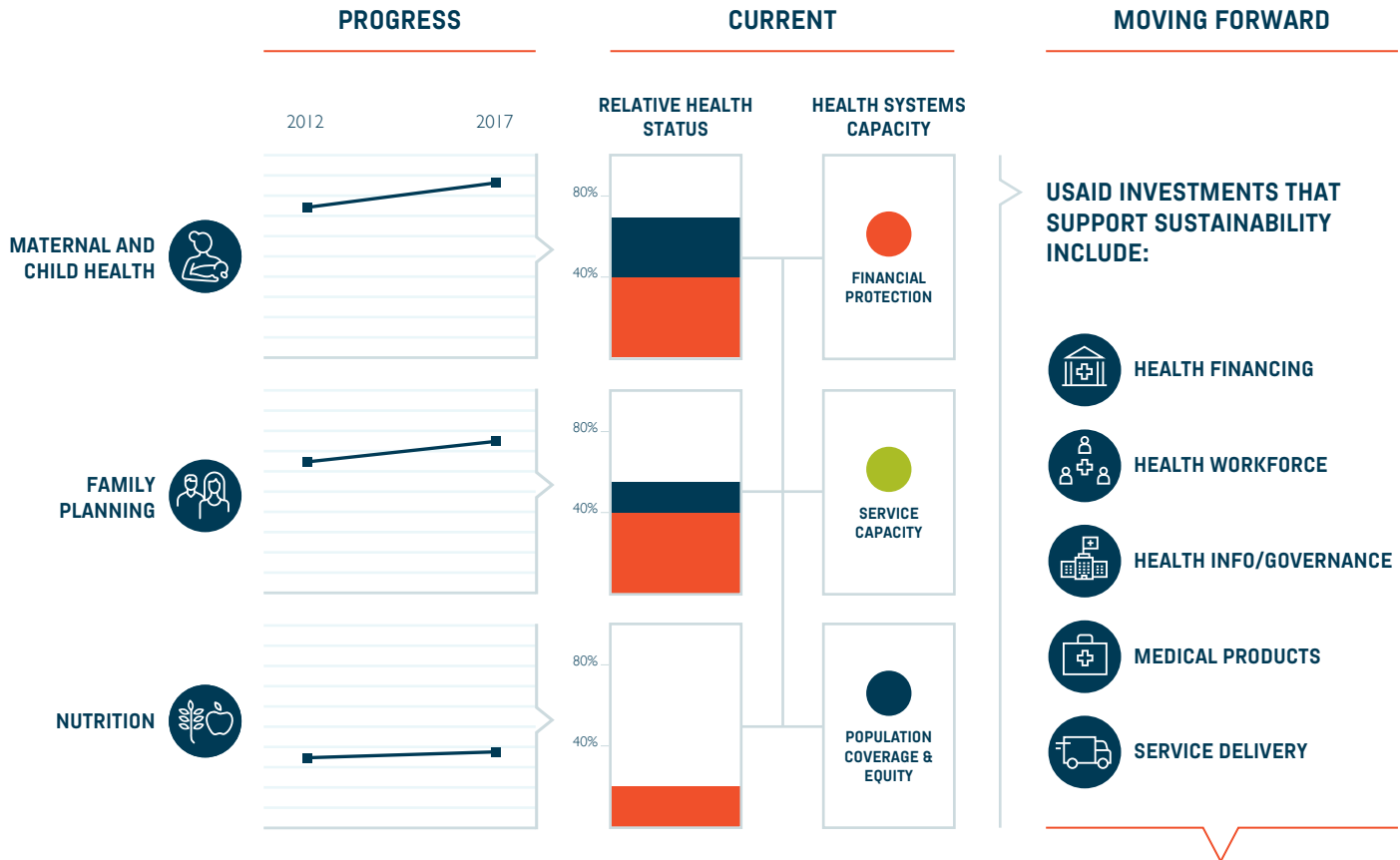
IN THE LAST YEAR, IN COLLABORATION WITH THE GOVERNMENT OF THE REPUBLIC OF INDIA (GOI) AND OTHER PARTNERS, WE HAVE ACHIEVED THE FOLLOWING:

- Generated over \$82 million in funding from national and state governments to scale-up successful high impact interventions proven effective by USAID's initial \$14 million investment
- Proved a new model of antenatal care and caring for women around birth in pilot districts, which compelled the State Government of Uttarakhand to incorporate this method into its annual program implementation plan and scale it up statewide with its own resources
- Supported the roll-out of the nationwide survey Swachh Survekshan, which ranks progress on WASH indicators and resulted in 37% of 4,041 cities becoming open-defecation free in 2017
- Supported a private sector medical college in Indore to adopt all 14 health centers in the city, and to provide doctors, nurses, and other paramedical staff to make the centers fully operational, and reach 590,000 slum dwellers with health care
- Reach 131 million people annually with health services, saving the lives of an estimated 4,686 women and 5,619 newborns every year
- Incorporated lessons from polio eradication efforts into the Indian routine immunization program, which resulted in a 7% increase in immunization coverage in two years

TRANSITION SINCE THE 2012 CALL TO ACTION

From 2012 to 2016, nearly 41% of USAID-supported districts transitioned from poor performing to good performing, four times the national rate of improvement, and now at the request of the GOI, USAID is transitioning our financial and technical support to other poor performing districts.

JOURNEY TO SELF-RELIANCE FOR PREVENTING CHILD AND MATERNAL DEATHS



\$25.5B IN RESOURCES MOBILIZED BY 2025
WHICH IS A **2,928 TO 1** RETURN ON USAID'S INVESTMENT

GOING FORWARD, USAID WILL WORK WITH THE GOI TO FULFILL ITS COMMITMENT TO WOMEN AND CHILDREN'S HEALTH, INCLUDING THROUGH THE FOLLOWING:

- Support for the *Utkrishi* ("Excellence") Development Impact Bond, which uses private funds to improve maternal health care in the private sector in Rajasthan, which will reduce the burden on the public sector
- Using a \$1 million investment from the Bill and Melinda Gates Foundation to build nutrition programs into USAID's existing RMNCH programs in Jharkhand
- Providing technical assistance at the request of the GOI to support a national initiative to improve quality of care around birth across India
- Making a \$7 million investment as an anchor partner in the 10 to 19: Dasra Adolescents Collaborative to leverage up to \$20 million from foundations and philanthropists to improve adolescent health and well-being nationally

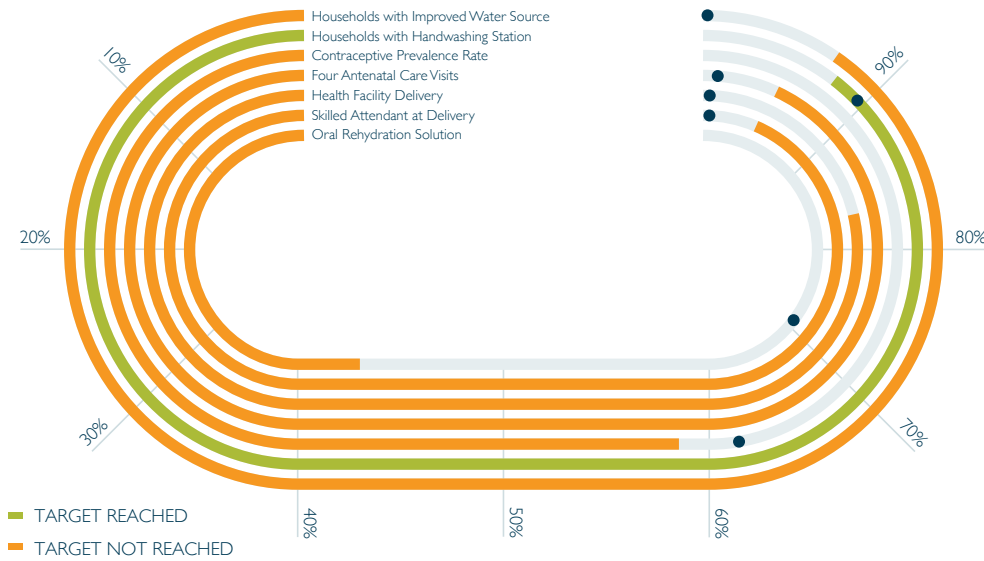


INDONESIA

* Estimate from 2015 ** Estimate from 2016

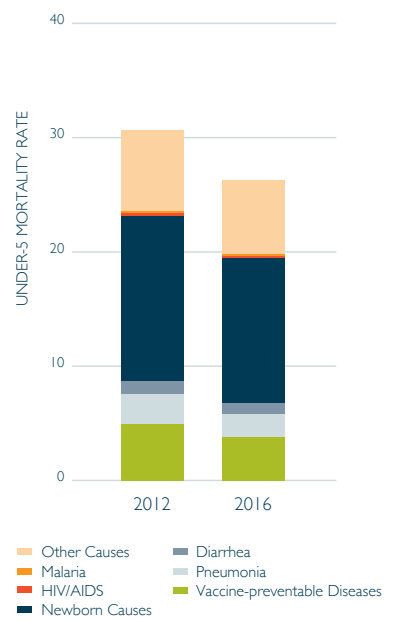
2017	260.6M ↑ Total Population	20.9M ↓ Population Under 5 Years	** 131K ↓ Under-5 Deaths /Year	** 26 ↓ Under-5 Mortality Rate Per 1,000 Live Births	4.2M ↓ Births	* 126 ↓ Maternal Mortality Ratio Per 100,000 Live Births
1990	182M	21.5M	385K	83	4.6M	600

INTERVENTION COVERAGE



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

SHIFTING CAUSES OF CHILD MORTALITY



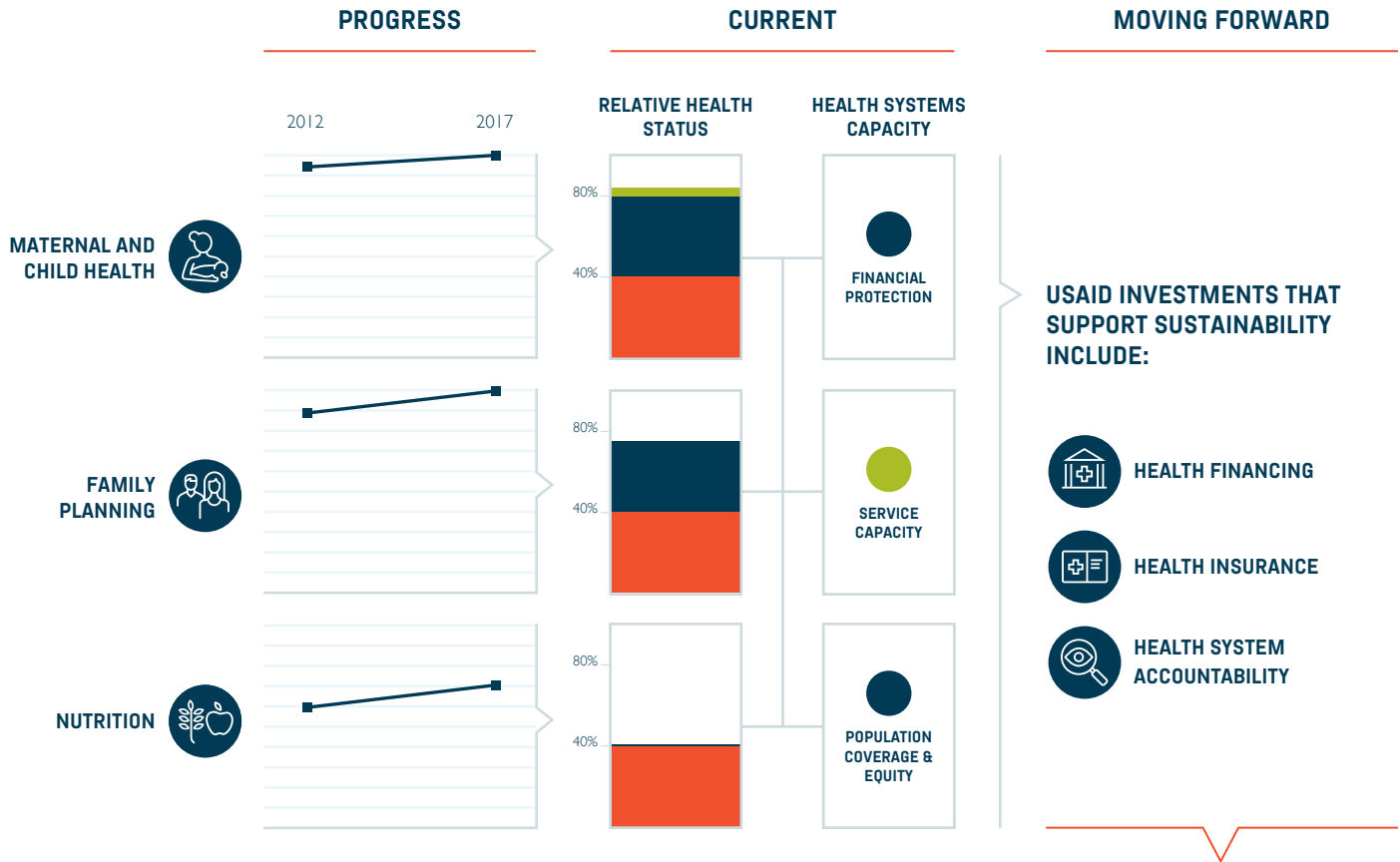
IN THE LAST YEAR, IN COLLABORATION WITH THE GOVERNMENT OF THE REPUBLIC OF INDONESIA (GORI) AND OTHER PARTNERS, WE HAVE ACCOMPLISHED THE FOLLOWING:

- Decreased maternal deaths by 50%, and early newborn deaths by 23%, over a five-year period in supported facilities
- Linked more than 1,400 facilities and 40,000 providers through a USAID-initiated referral network, which improved mothers' access to efficient and effective emergency referrals
- Developed capacity for the Ministry of Health (MoH) to apply health-expenditure tracking processes and systems, which resulted in the creation of a domestic budget line to conduct National Health Accounts annually
- Decreased stillbirths during delivery by 25% over a five-year period, in supported facilities
- Launched an electronic emergency referral system – SijariEMAS – which has transitioned to a new private social enterprise from which more than 20 districts now purchase services

TRANSITION SINCE THE 2012 CALL TO ACTION

After improvements in maternal and child health indicators in USAID districts, the MoH directed maternal and child health priority districts nationally to use domestic resources to replicate USAID's approaches. USAID developed standard operating procedures and budget implications to facilitate this scale-up.

JOURNEY TO SELF-RELIANCE FOR PREVENTING CHILD AND MATERNAL DEATHS



\$1.2M IN RESOURCES MOBILIZED BY 2025

GOING FORWARD, USAID WILL WORK WITH THE GORI TO FULFILL ITS COMMITMENT TO WOMEN AND CHILDREN'S HEALTH, INCLUDING THROUGH THE FOLLOWING:

- Conducting, through a partnership with the Office of the Indonesian Vice President, a financial visibility analysis of the Indonesian National Health Insurance body, which shows promising opportunities for achieving universal access to health insurance and will be helpful to encourage continued domestic investment
- Supported a systematic review of how health care services are purchased under the Indonesian National Health Insurance system, which provided evidence around the need for clarity around health insurance legislation and accountability, and will set the direction for the implementation of the National Health Insurance program

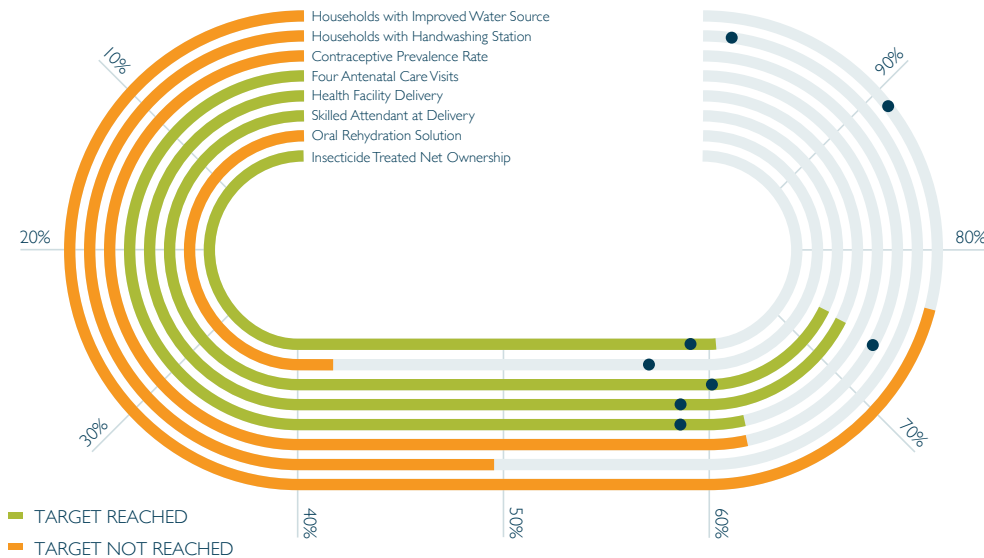


KENYA

* Estimate from 2015 ** Estimate from 2016

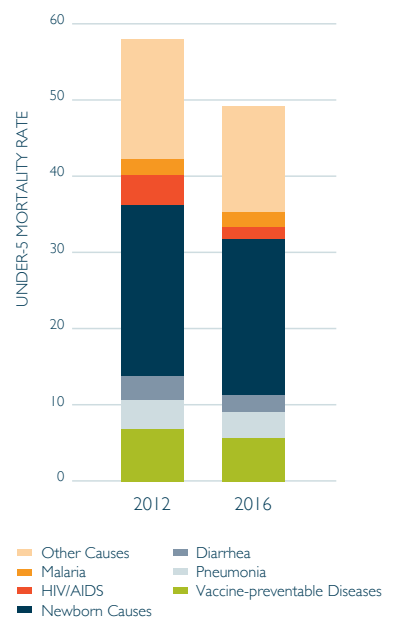
2017	47.6M ↑ Total Population	5.9M ↑ Population Under 5 Years	**74K ↓ Under-5 Deaths /Year	**49 ↓ Under-5 Mortality Rate Per 1,000 Live Births	1.1M ↑ Births	*510 ↑ Maternal Mortality Ratio Per 100,000 Live Births
1990	23M	4.2M	95K	98	927K	400

INTERVENTION COVERAGE



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SHIFTING CAUSES OF CHILD MORTALITY



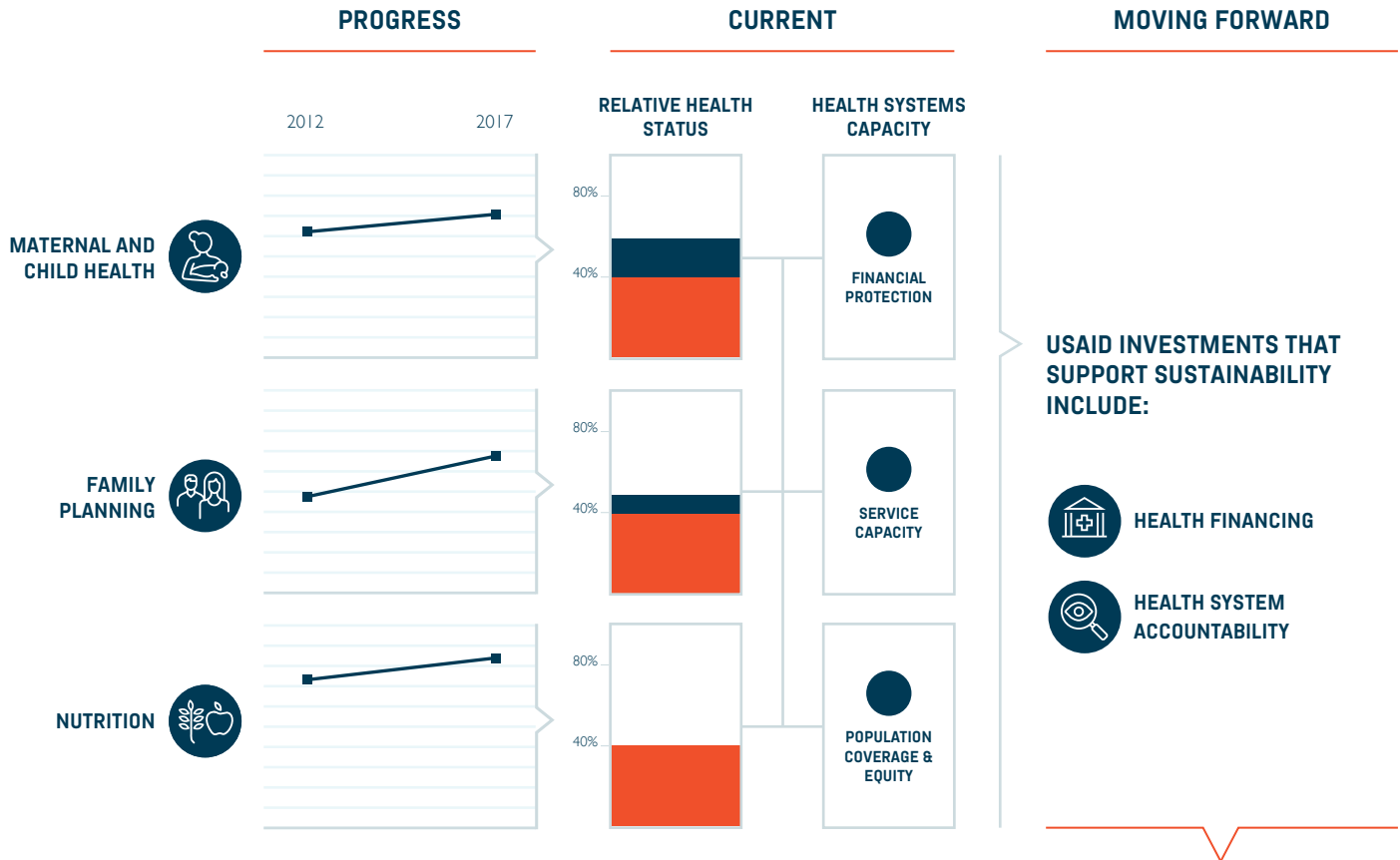
IN THE LAST YEAR, IN COLLABORATION WITH THE GOVERNMENT OF THE REPUBLIC OF KENYA (GOK) AND OTHER PARTNERS, WE HAVE ACCOMPLISHED THE FOLLOWING:

- Supported the development of program-based budgets to help expand the available resources for health, increasing county budget allocation for health by 13% from 2016 to 2017
- Contributed to a student loan fund, which resulted in public and private contributions that doubled USAID's, and which has trained over 12,500 health staff, the majority of whom now fill staffing shortages in rural areas
- Standardized the process of health worker training before delivering care, which has contributed to a 30% cost savings because of increased skills and efficiencies
- Increased the number of communities certified as open-defecation free by 31% in one year in 16 target sub-counties, allowing for a shift in geographical focus to other areas with higher needs
- Reached 322,389 pregnant women with nutrition interventions
- Established human-resource units with appropriate manpower in 20 counties, which helps to maintain consistent and appropriate staffing and mitigate workforce strikes

TRANSITION SINCE THE 2012 CALL TO ACTION

USAID transitioned management of multiple supply chains to the Kenya Medical Supplies Authority, which now manages procurement and distribution of commodities to support key national health programs. This shift has resulted in increased efficiency.

JOURNEY TO SELF-RELIANCE FOR PREVENTING CHILD AND MATERNAL DEATHS



\$86M IN RESOURCES MOBILIZED BY 2025
WHICH IS A **45 TO 1** RETURN ON USAID'S INVESTMENT

GOING FORWARD, USAID WILL WORK WITH THE GOK TO FULFILL ITS COMMITMENT TO WOMEN AND CHILDREN'S HEALTH, INCLUDING THROUGH THE FOLLOWING:

- Promoting quality health care beyond the public sector, including by identifying opportunities to work with the private sector to improve quality and information systems
- Helping to institutionalize quality-of-care standards in high volume facilities
- Supporting planning around transition from financing from Gavi, the Vaccine Alliance, including a focus on universal health access, domestic resource mobilization, and commercial and private sector partnerships
- Aligning with other U. S. Government efforts, including Feed the Future, to leverage resources and identify effective strategies for creating food security and resilience



LIBERIA

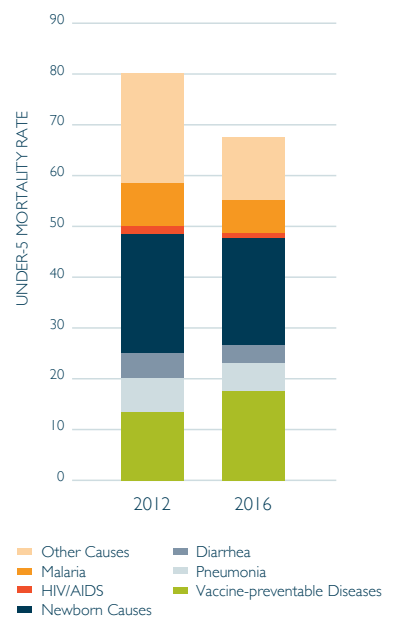
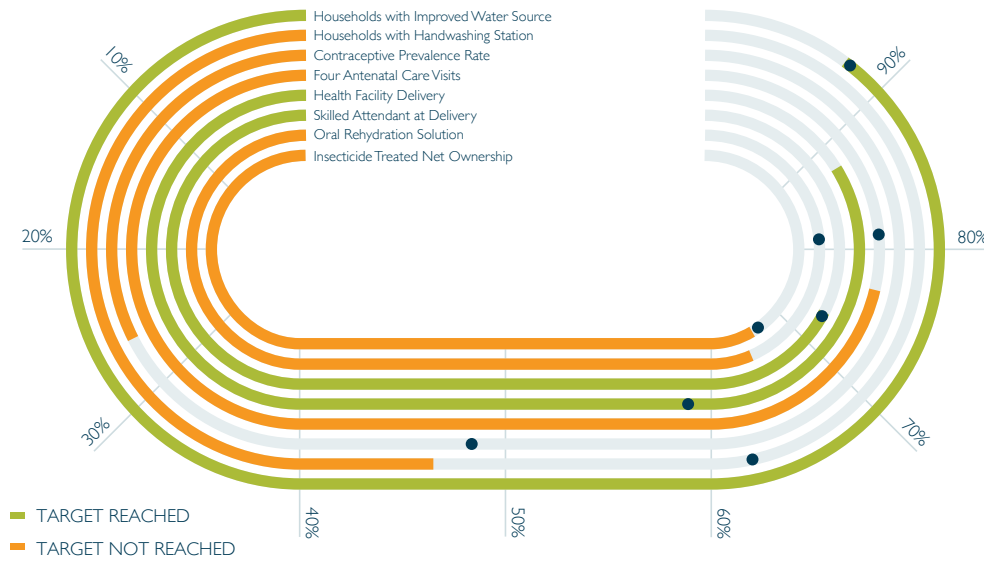
* Estimate from 2015 ** Estimate from 2016

2017	4.7M ↑ Total Population	783.9K ↓ Population Under 5 Years	**10K ↓ Under-5 Deaths /Year	**67 ↓ Under-5 Mortality Rate Per 1,000 Live Births	179K ↑ Births	*725 ↓ Maternal Mortality Ratio Per 100,000 Live Births
1990	2.1M	386M	22.5K	247	102K	1,200

INTERVENTION COVERAGE

● = PREDICTED COVERAGE RATE
BASED ON 2014 AOTC ANALYSIS

SHIFTING CAUSES OF CHILD MORTALITY

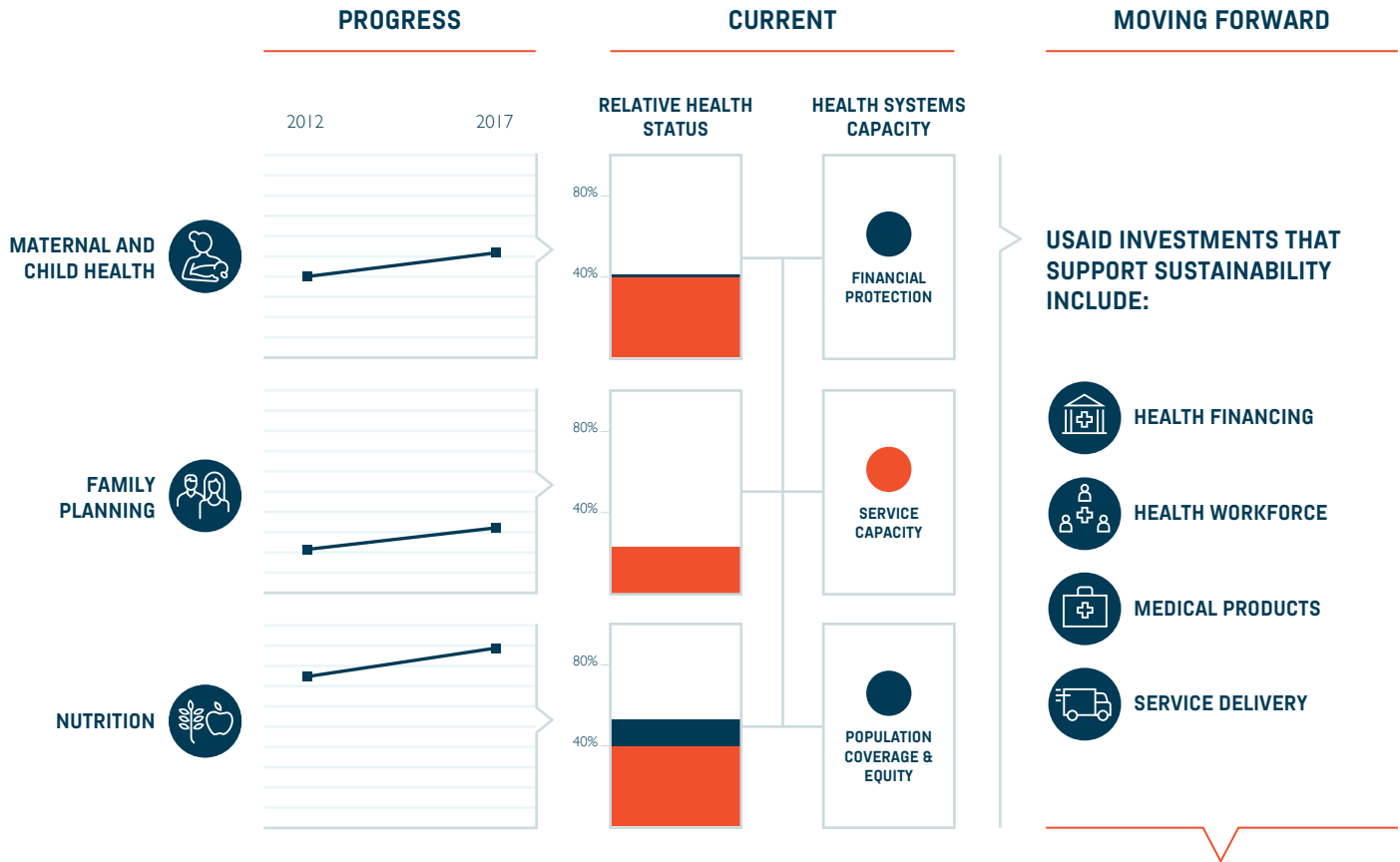


Estimates are based on trends from most recently available surveys and therefore may not reflect acceleration due to *Acting on the Call* efforts

IN THE LAST YEAR, IN COLLABORATION WITH THE GOVERNMENT OF THE REPUBLIC OF LIBERIA (GOL) AND OTHER PARTNERS, WE HAVE ACCOMPLISHED THE FOLLOWING:

- Increased the percentage of households with at least one insecticide-treated bed net from 50% to 62% and the proportion of children sleeping under a net from 37% to 44% under the President's Malaria Initiative (PMI)
- Assisted 58,000 people in rural areas to gain access to basic sanitation services and nearly 20,000 people to gain access to improved drinking water
- Trained 1,101 community health workers to provide voluntary family planning information, referrals, and services, which resulted in 245,981 women counseled in one year
- Finalized a new Community Health Strategy, which introduced community health agents who increase access to health care in remote and hard to reach communities
- Treated 102,267 children for pneumonia and 49,545 for diarrhea
- Rolled out the quarterly monitoring standards for nursing and midwifery schools, which will help improve the quality of training and therefore health care

JOURNEY TO SELF-RELIANCE FOR PREVENTING CHILD AND MATERNAL DEATHS



USAID'S HEALTH INVESTMENTS MAY YIELD A 9 TO 1 RETURN IN ECONOMIC AND SOCIETAL BENEFITS BY 2035

GOING FORWARD, USAID WILL WORK WITH THE GOL TO FULFILL ITS COMMITMENT TO WOMEN AND CHILDREN'S HEALTH, INCLUDING THROUGH THE FOLLOWING:

- Helping to institutionalize performance standards and codes of conduct for the health workforce, and to train human resource managers to lead the roll out
- Funding scholarships for over 200 midwifery and laboratory technicians to address gaps in the health workforce
- Supporting the roll out of the electronic Logistics Management Information System (e-LMIS), which will provide more real time data to improve supply-chains, and will be transitioned to the Ministry of Health by January 2019
- Providing technical assistance to support management capacity at central and county levels, particularly around annual planning and performance management
- Strengthening quality-assurance systems at the national level, and scaling up quality-improvement approaches at the facility level for institutionalization
- Supporting national and local government teams to improve the quality, availability, and use of data, including increased integration and interoperability across different health information systems

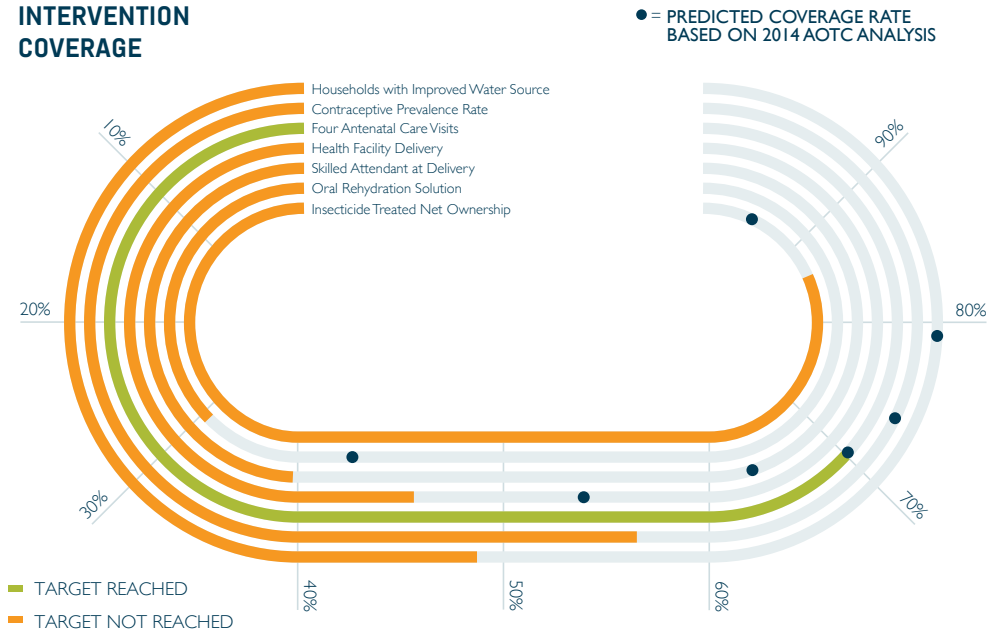


MADAGASCAR

* Estimate from 2015 ** Estimate from 2016

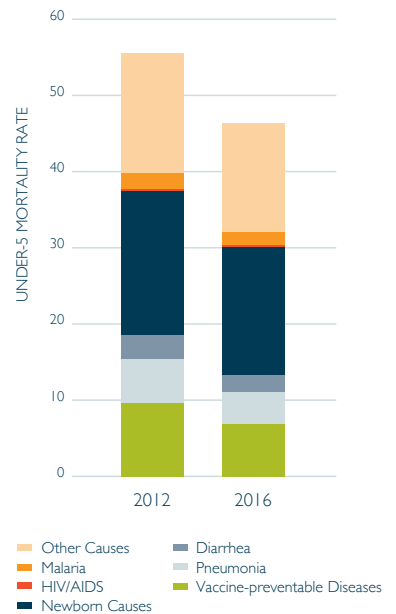
2017	25.1M ↑ Total Population	3.7M ↑ Population Under 5 Years	**37K ↓ Under-5 Deaths /Year	**46 ↓ Under-5 Mortality Rate Per 1,000 Live Births	790K ↑ Births	*353 ↓ Maternal Mortality Ratio Per 100,000 Live Births
1990	11.6M	2.1M	80K	158	530K	640

INTERVENTION COVERAGE



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

SHIFTING CAUSES OF CHILD MORTALITY



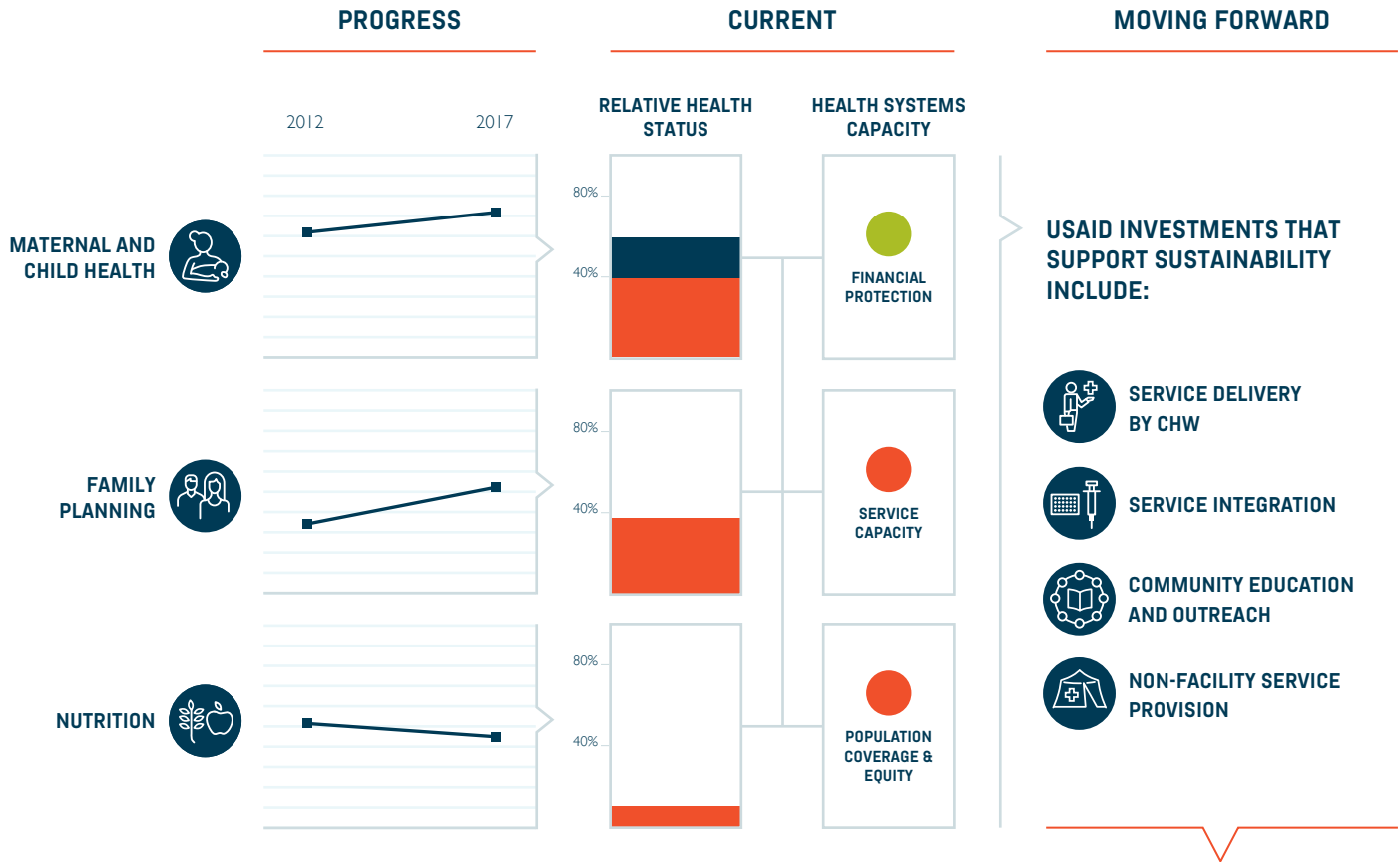
IN THE LAST YEAR, IN COLLABORATION WITH THE GOVERNMENT OF THE MALAGASY REPUBLIC (GMR) AND OTHER PARTNERS, WE HAVE ACCOMPLISHED THE FOLLOWING:

- Saved the lives of 5,761 babies who were not breathing after birth, and helped 84,940 babies receive essential newborn care within two days of birth
- Trained 139 clinical trainers, who then trained 1,344 service providers in maternal and newborn health and voluntary family planning, and will continue to strengthen workforce skills by training new and existing health workers
- Supported a Development Credit Authority deal that resulted in over 100 loans to private health sector personnel, 34 of whom were newly graduated health workers who used the loans to help them enter the health workforce
- Supported the drafting and passing of the new Family Planning/ Reproductive Health Law, which allows for universal access to voluntary family planning and permits community health volunteers to provide short-acting methods to clients in their communities
- Leveraged \$350,000 in World Bank funding to complement USAID's efforts to improve the GMR's analytical capacity, which allowed Madagascar to qualify for GFF funding
- Partnered with Coca-Cola to leverage \$2.5 million from a \$500,000 USAID investment to build WASH infrastructure in urban and rural areas

TRANSITION SINCE THE 2012 CALL TO ACTION

Transitioned from partial support in 15 regions to 100% coverage of 10 regions, in order to focus on sustainable change at the health system level.

JOURNEY TO SELF-RELIANCE FOR PREVENTING CHILD AND MATERNAL DEATHS



 **\$2.9M IN RESOURCES MOBILIZED BY 2025**

GOING FORWARD, USAID WILL WORK WITH THE GMR TO FULFILL ITS COMMITMENT TO WOMEN AND CHILDREN'S HEALTH, INCLUDING THROUGH THE FOLLOWING:

- Focusing on a total market approach, including with public and private pharmaceutical and medical stores, to eliminate parallel supply chains and increase efficiency, which will strengthen resilience to future shocks like the 2017 bubonic plague outbreak
- Leveraging additional domestic resources to strengthen the private sector, which typically will serve a higher socioeconomic class, while reserving public-sector funds and care for the poorest of the poor
- Using sentinel surveillance to help track climatic and environmental factors that affect mosquito density, which will help focus and accelerate malaria elimination efforts
- Scaling up the use of the CommCare phone application, which allows community health volunteers to collect data and improve service delivery

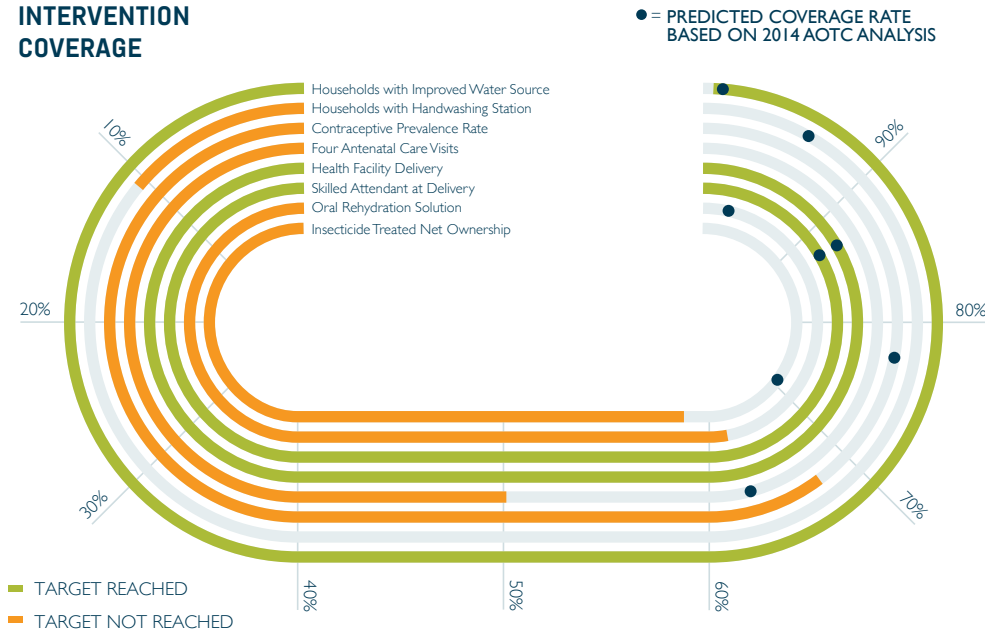


MALAWI

* Estimate from 2015 ** Estimate from 2016

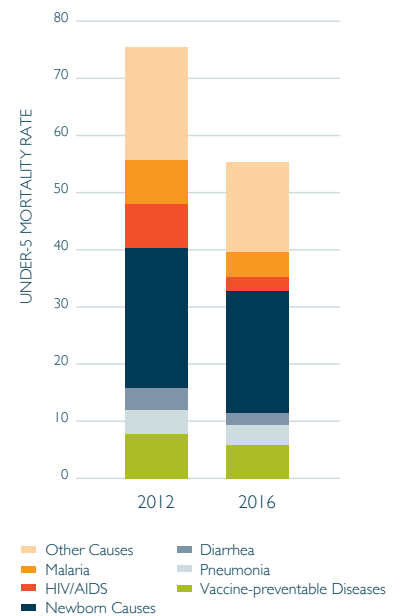
2017	19.2M ↑ Total Population	3.5M ↑ Population Under 5 Years	** 36K ↓ Under-5 Deaths /Year	** 55 ↓ Under-5 Mortality Rate Per 1,000 Live Births	788K ↑ Births	* 634 ↓ Maternal Mortality Ratio Per 100,000 Live Births
1990	9.5M	1.8M	102.5K	244	459K	1,100

INTERVENTION COVERAGE



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

SHIFTING CAUSES OF CHILD MORTALITY



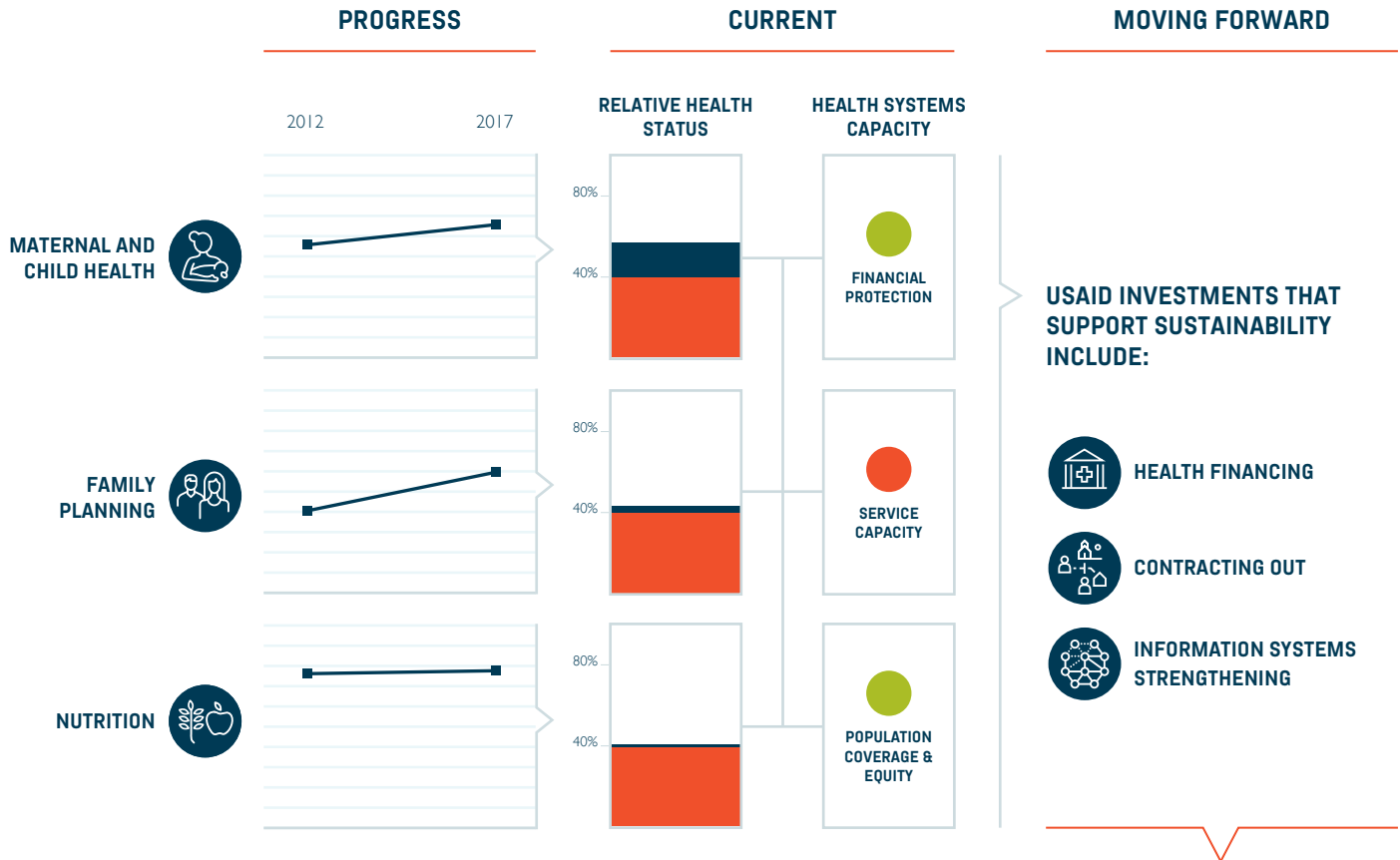
IN THE LAST YEAR, IN COLLABORATION WITH THE GOVERNMENT OF THE REPUBLIC OF MALAWI (GRM) AND OTHER PARTNERS, WE HAVE ACCOMPLISHED THE FOLLOWING:

- Provided secure pharmacy storage space to health facilities across the country to reduce theft of malaria drugs with leveraged funds from the Department for International Development, of the United Kingdom, and prosecuted 70 drug theft suspects
- Supported 250 kangaroo mother care sites to save low birth weight babies, which resulted in an increase in coverage from 56% to 93% in one year
- Supported 5,302 calls to Chipatala Cha Pa Foni, a local language call-in health hotline for health providers with questions
- Integrated nutrition services into a planned vaccination campaign, which gave 8.1 million children access to the measles rubella vaccine and 2.9 million children Vitamin A supplements
- Expanded the use of the Saving Lives at Birth-supported bubble Continuous Positive Airway Pressure (bCPAP), to help premature infants breathe, to Christian Health Association of Malawi hospitals and integrated the bCPAP into the curriculum for nursing and clinical officers in training colleges, using leveraged funds from Elma Philanthropies

TRANSITION SINCE THE 2012 CALL TO ACTION

USAID supported the GRM in a major decentralization process, moving Ministry of Health staff to local councils, which will result in improved supply chain management, ensure quality service delivery at local levels, increase emergency referrals, and improve data management.

JOURNEY TO SELF-RELIANCE FOR PREVENTING CHILD AND MATERNAL DEATHS



**\$2.1M IN COST SAVINGS AND RESOURCES MOBILIZED BY 2025
WHICH IS AN 11 TO 1 RETURN ON USAID'S INVESTMENT**

GOING FORWARD, USAID WILL WORK WITH THE GRM TO FULFILL ITS COMMITMENT TO WOMEN AND CHILDREN'S HEALTH, INCLUDING THROUGH THE FOLLOWING:

- Supporting a Senior Health Economist in the MoH to improve domestic financing, efficiency, service availability, and equity
- Strengthening collaboration with UNICEF and other partners on social accountability, including through citizens' hearings, community scorecards, and a Maternal Death Surveillance and Response survey
- Rolling out a new logistics information management system to over 600 public health facilities in Malawi, which will allow facilities to generate and report medical commodity supply chain data
- Develop a national Adolescent Girls and Young Women Strategy to facilitate effective coordination among the four key ministries responsible for youth programming
- Supporting the Quality Management Department at the MoH to improve healthcare quality in line with the goals of the newly launched Quality, Equity, and Dignity Network



MALI

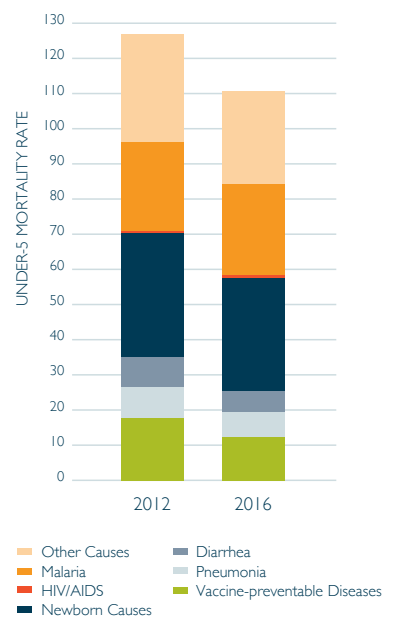
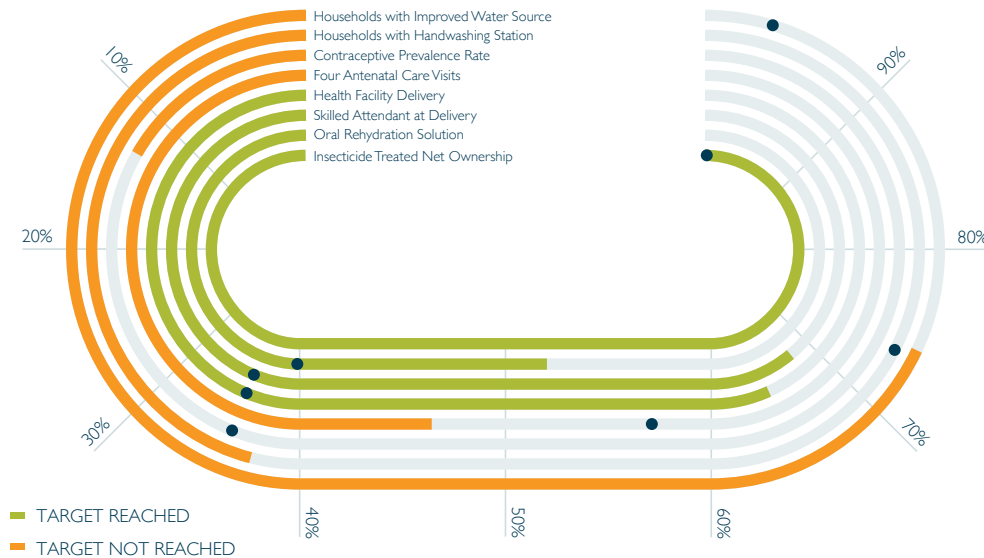
* Estimate from 2015 ** Estimate from 2016

2017	17.9M ↑ Total Population	3.4M ↑ Population Under 5 Years	**82K ↓ Under-5 Deaths /Year	**111 ↓ Under-5 Mortality Rate Per 1,000 Live Births	785K ↑ Births	*587 ↓ Maternal Mortality Ratio Per 100,000 Live Births
1990	8.5M	1.6M	90.7K	253	440K	1.1K

INTERVENTION COVERAGE

● = PREDICTED COVERAGE RATE
BASED ON 2014 AOTC ANALYSIS

SHIFTING CAUSES OF CHILD MORTALITY



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

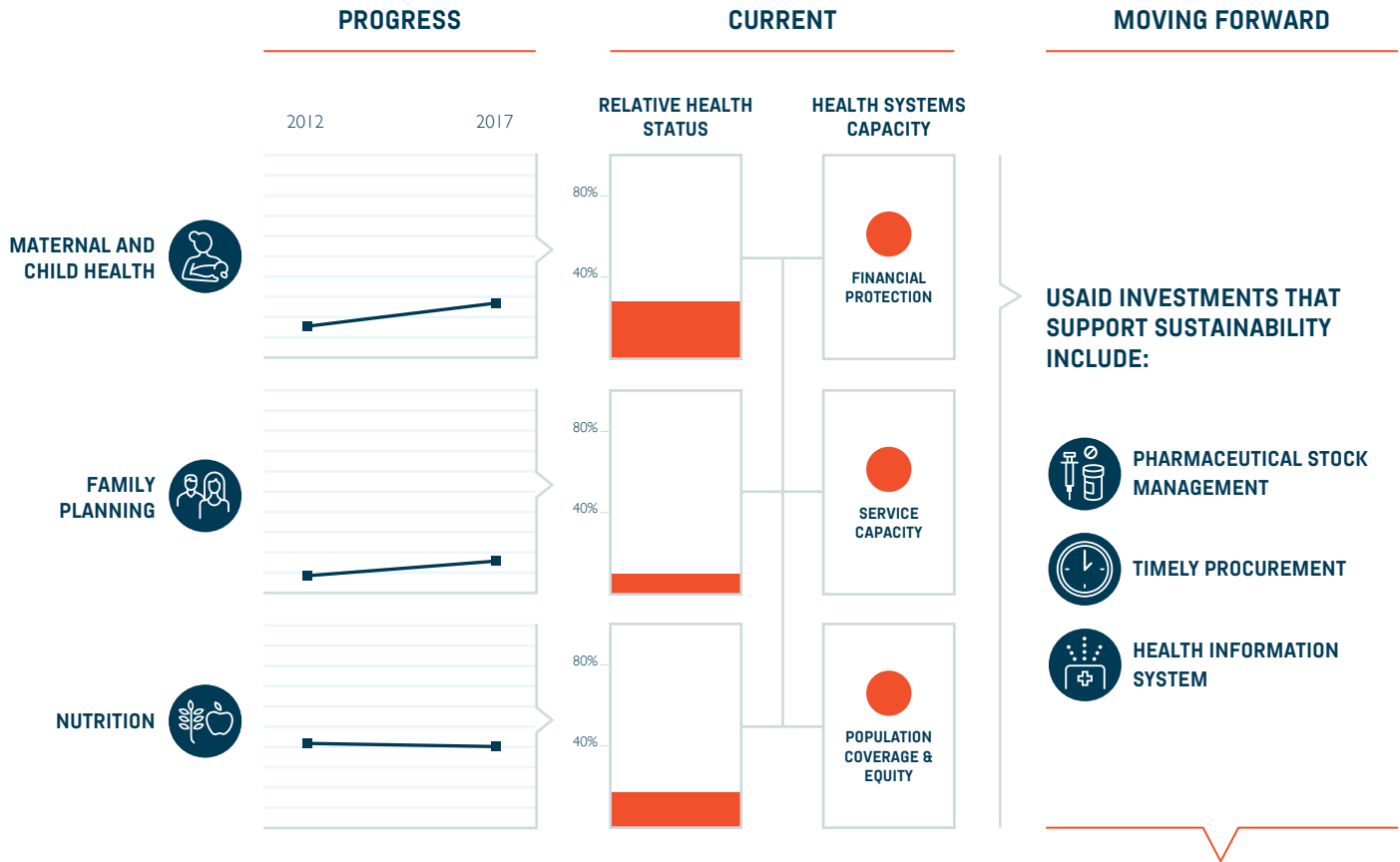
IN THE LAST YEAR, IN COLLABORATION WITH THE GOVERNMENT OF THE REPUBLIC OF MALI (GOM) AND OTHER PARTNERS, WE HAVE ACCOMPLISHED THE FOLLOWING:

- Worked with 212 Christian and Muslim religious leaders to advocate for the healthy timing and spacing of pregnancy, stigma reduction among people living with HIV, and the prevention of gender-based violence
- Reached nearly 2.5 million children under-5 and 700,000 pregnant women with community-based nutrition interventions, including nutrition counseling and Vitamin A distribution
- Saved the lives of 16,215 newborns born not breathing using the Helping Babies Breathe approach
- Supported the GOM's ability to target low performing districts with immunization coverage, resulting in a 7% increase in coverage in one year and 363,233 children receiving a Penta 3 immunization to protect them against Haemophilus Influenzae type B (a bacterium that causes meningitis, pneumonia and otitis), whooping cough, tetanus, hepatitis B, and diphtheria
- Established WASH management communities in 497 villages, which resulted in 100% of them being declared open-defecation free
- Funded two polio immunization campaigns, which covered 6.4 million children

TRANSITION SINCE THE 2012 CALL TO ACTION

USAID investments in strengthening the supply chain management system have resulted in dramatic and sustained reductions of health commodity stock-out rates from 65% to 27% from 2011 to 2017.

JOURNEY TO SELF-RELIANCE FOR PREVENTING CHILD AND MATERNAL DEATHS



\$0.7M IN COST SAVINGS BY 2025

GOING FORWARD, USAID WILL WORK WITH THE GOM TO FULFILL ITS COMMITMENT TO WOMEN AND CHILDREN'S HEALTH, INCLUDING THROUGH THE FOLLOWING:

- Support the passing of a law for the government to incorporate community health workers into the formal health system, including to pay salaries, and in five years, to support 40% of the community health workforce
- Reinforce the capacity of health planners and budget managers at community, district, and regional levels to develop a disbursement plan for timely implementation of planned health activities
- Build the capacity of the Ministry of Health and Public Hygiene at all levels to use a free, open-source software to reduce workforce shortages and improve workforce planning, education, deployment, management, and retention
- Support the interoperability of a logistics monitoring tool and a patient data tool, resulting in 70% of health facilities submitting timely reports by 2020



MOZAMBIQUE

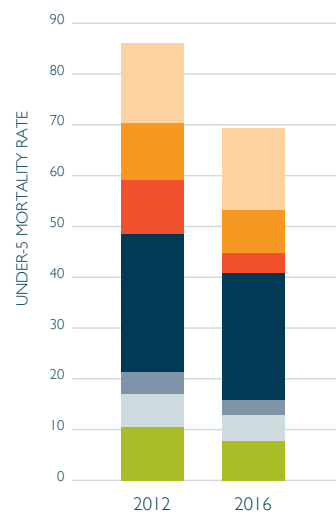
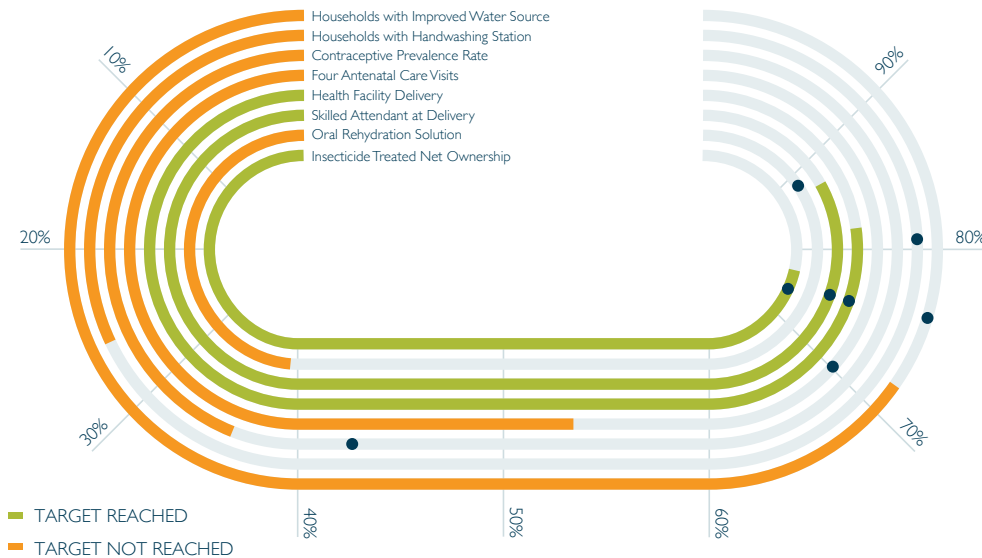
* Estimate from 2015 ** Estimate from 2016

2017	28.9M ↑ Total Population	5.3M ↑ Population Under 5 Years	** 78K ↓ Under-5 Deaths /Year	** 71 ↓ Under-5 Mortality Rate Per 1,000 Live Births	1M ↑ Births	* 489 ↓ Maternal Mortality Ratio Per 100,000 Live Births
1990	13M	2M	132K	233	611K	910

INTERVENTION COVERAGE

● = PREDICTED COVERAGE RATE
BASED ON 2014 AOTC ANALYSIS

SHIFTING CAUSES OF CHILD MORTALITY



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

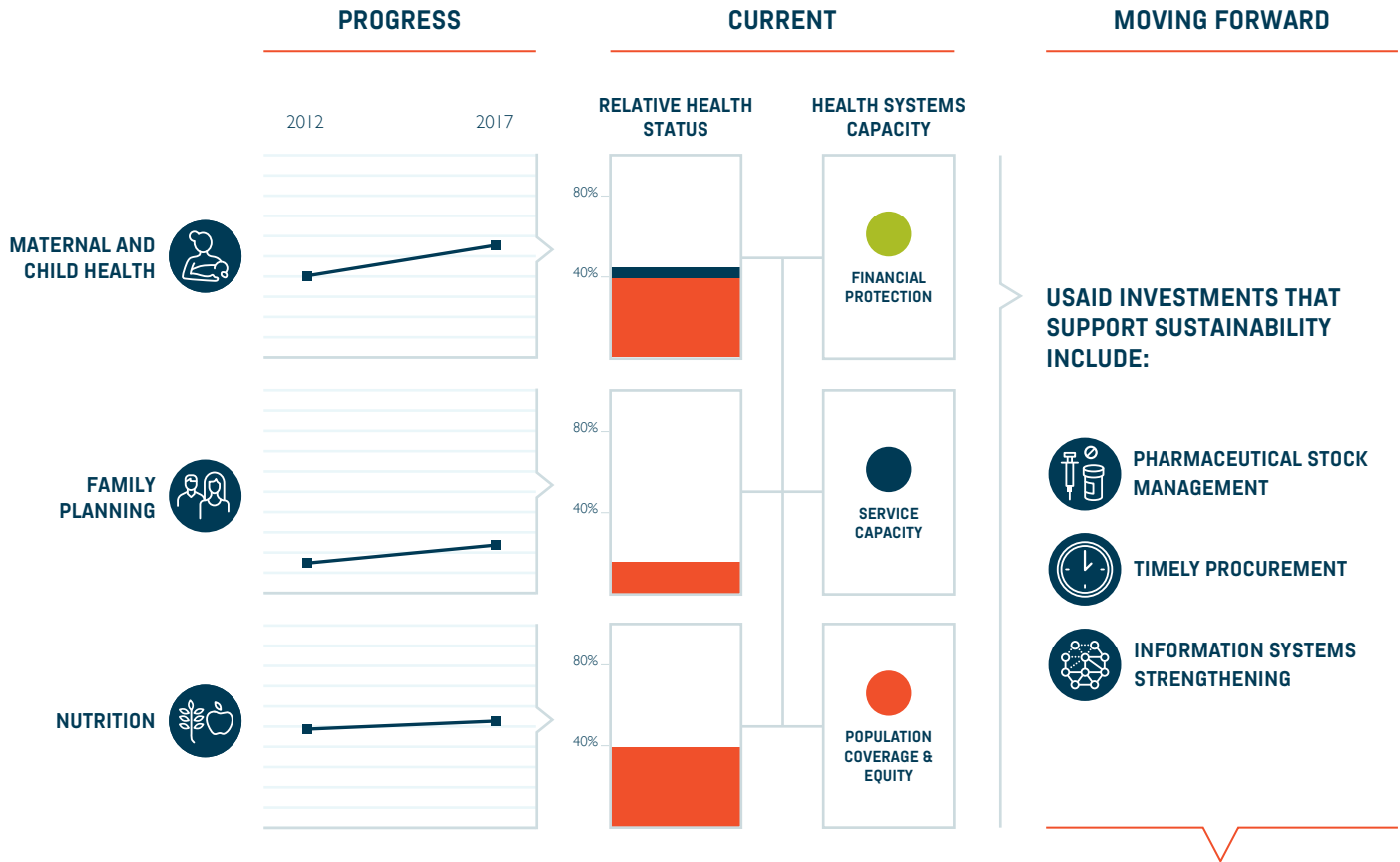
IN THE LAST YEAR, IN COLLABORATION WITH THE GOVERNMENT OF THE REPUBLIC OF MOZAMBIQUE (GRMZ) AND OTHER PARTNERS, WE HAVE ACCOMPLISHED THE FOLLOWING:

- Promoted the ability of community health workers to provide voluntary family planning, which enabled over 47,000 women to opt for a modern contraceptive method
- Reached 1.2 million people with health education and promotion activities
- Distributed more than 50,000 copies of malaria prevention materials through religious leaders and lay people, and funded the broadcast of over 250 community radio programs, which combined reached 2.7 million people with malaria prevention messages
- Increased the percentage of men who participated in at least one antenatal care visit from 70% to 81% in one province
- Financed the establishment of 1,231 WASH demonstration centers to promote the wider use of key hygiene behaviors in communities, which resulted in the construction of over 41,000 new latrines with materials previously available in the community
- Developed manuals, training materials, and job aids to help diagnose and treat malnutrition, including training more than 1,300 health officials, facility staff, and community members

TRANSITION SINCE THE 2012 CALL TO ACTION

After USAID support to improve national warehouse infrastructure, GRMZ's contribution for the warehousing of medical commodities has increased from 20% to 30%, which has reduced reliance on external funding. Mozambique is on track to finance 50% of its national warehousing needs by 2020

JOURNEY TO SELF-RELIANCE FOR PREVENTING CHILD AND MATERNAL DEATHS



 **\$1.3M IN COST SAVINGS BY 2025**
WHICH IS A **64%** RETURN ON USAID'S INVESTMENT

GOING FORWARD, USAID WILL WORK WITH THE GRMZ TO FULFILL ITS COMMITMENT TO WOMEN AND CHILDREN'S HEALTH, INCLUDING THROUGH THE FOLLOWING:

- Support the National Food Fortification Decree, which will increase the availability of fortified staple foods, in particular for the 30% of Mozambicans who live in urban areas
- Fund a cost-effectiveness analysis of potential interventions to strengthen nutrition and food security to inform the GRMZ's spending and programming



NEPAL

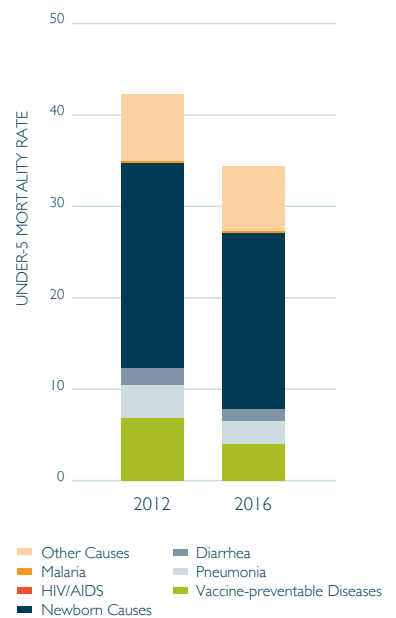
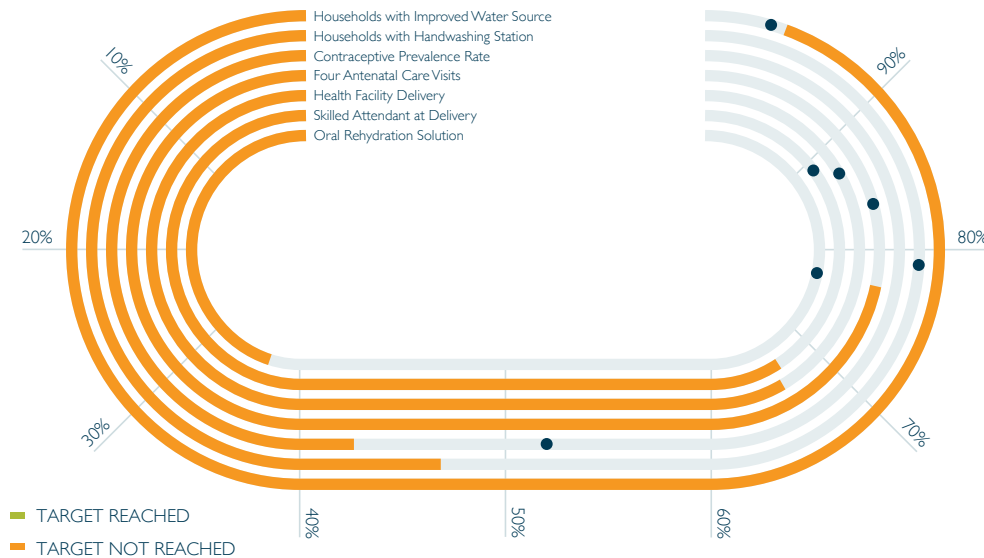
* Estimate from 2015 ** Estimate from 2016

2017	29.4M ↑ Total Population	2.8M ↓ Population Under 5 Years	**20K ↓ Under-5 Deaths /Year	**35 ↓ Under-5 Mortality Rate Per 1,000 Live Births	573K ↓ Births	*258 ↓ Maternal Mortality Ratio Per 100,000 Live Births
1990	19M	3.2M	95K	142	768K	770

INTERVENTION COVERAGE

● = PREDICTED COVERAGE RATE
BASED ON 2014 AOTC ANALYSIS

SHIFTING CAUSES OF CHILD MORTALITY



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

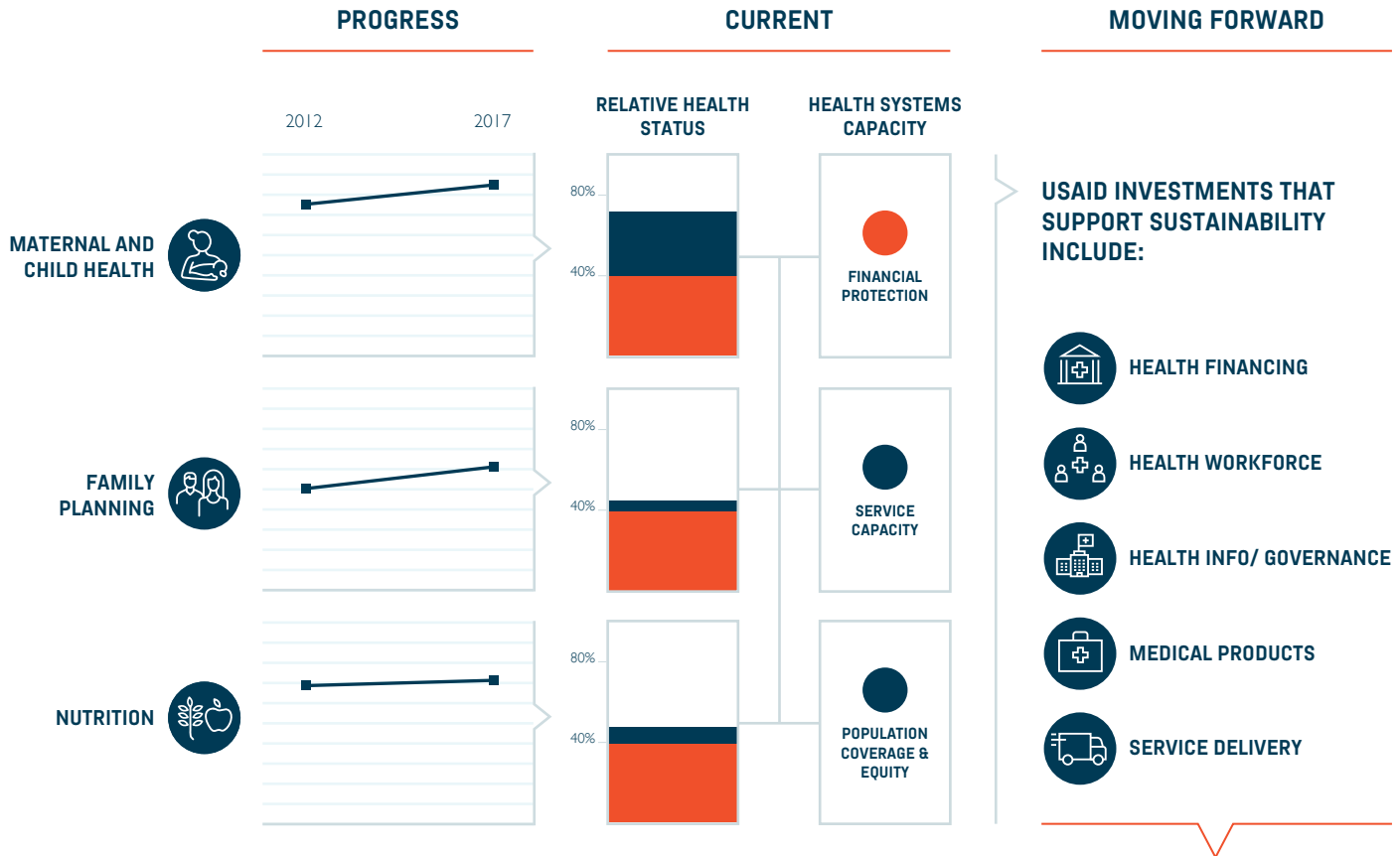
IN THE LAST YEAR, IN COLLABORATION WITH THE GOVERNMENT OF THE REPUBLIC OF NEPAL (GON) AND OTHER PARTNERS, WE HAVE ACCOMPLISHED THE FOLLOWING:

- Supported the Ministry of Health and Population (MoHP) in the national scale up of chlorhexidine gel to prevent newborn umbilical sepsis, resulting in the direct MoHP procurement of 600,000 tubes of gel, with a commitment to procure an additional 700,000 tubes in 2018
- Saved an estimated total of 9,600 neonatal lives between 2012 and 2017 as a result of USAID support to roll out chlorhexidine for newborn umbilical care
- Trained 10,462 local government and civil society staff to implement multi-sectoral nutrition approaches, including a through focus on technical, management, and operational capacity
- Trained 1,527 health service providers on voluntary family planning, which led to an increase in the availability of services from 15% to 39% in supported health facilities
- Helped 106 administrative units to be declared open-defecation free (ODF), and trained 9,970 community and local government members to apply improved sanitation methods and sustain ODF status
- Oriented 152 newly elected municipal government officials on evidence-based planning and budgeting, which will help ensure the transition of responsibility from national to municipal level goes smoothly

TRANSITION SINCE THE 2012 CALL TO ACTION

In a rapid decentralization of the government, USAID supported all levels of the health system to ensure the services were not disrupted as responsibilities for budget, human resources, accountability, and governance shifted from the national to local governments.

JOURNEY TO SELF-RELIANCE FOR PREVENTING CHILD AND MATERNAL DEATHS



USAID'S HEALTH INVESTMENTS MAY YIELD A 9 TO 1 RETURN IN ECONOMIC AND SOCIETAL BENEFITS BY 2035

GOING FORWARD, USAID WILL WORK WITH THE GON TO FULFILL ITS COMMITMENT TO WOMEN AND CHILDREN'S HEALTH, INCLUDING THROUGH THE FOLLOWING:

- Implementing a new approach to improve the quality of care for newborns with possible severe bacterial infection, with the intention of showing the private sector can play a key role in addressing this issue, affordably and at a large scale
- Supporting the GON to improve access to diverse and nutrient-rich foods, including by providing food production training for 7,500 households with pregnant women or children under-two
- Increasing access to and the utilization of quality, respectful health care, through community engagement, supported by strengthened systems, and governed by a skilled, responsive workforce
- Exploring the possibility of an autonomous supply-chain procurement agency to handle all national procurements at a reduced cost
- Building institutional capacity of the GON in the design, implementation, and coordination of social behavior change communication programs

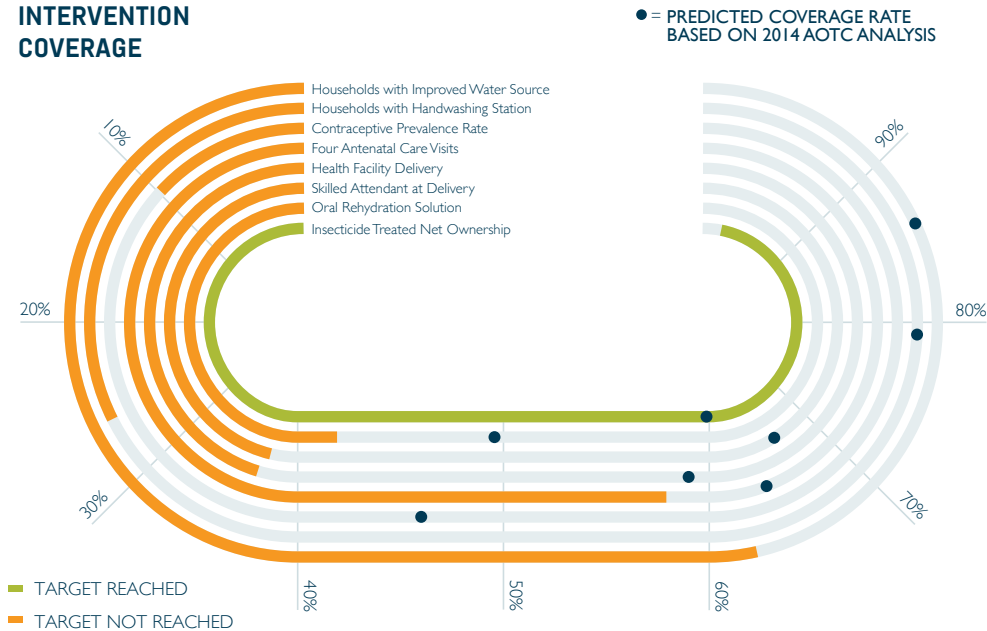


NIGERIA

* Estimate from 2015 ** Estimate from 2016

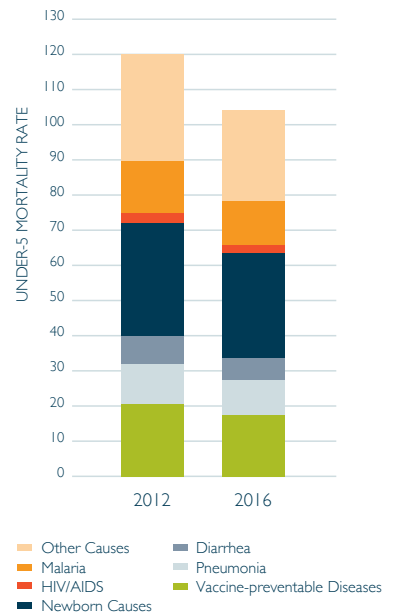
2017	190.6M ↑ Total Population	30.6M ↑ Population Under 5 Years	**733K ↓ Under-5 Deaths /Year	**104 ↓ Under-5 Mortality Rate Per 1,000 Live Births	7M ↑ Births	*814 ↓ Maternal Mortality Ratio Per 100,000 Live Births
1990	97M	17M	848K	213	4.3M	1110

INTERVENTION COVERAGE



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

SHIFTING CAUSES OF CHILD MORTALITY



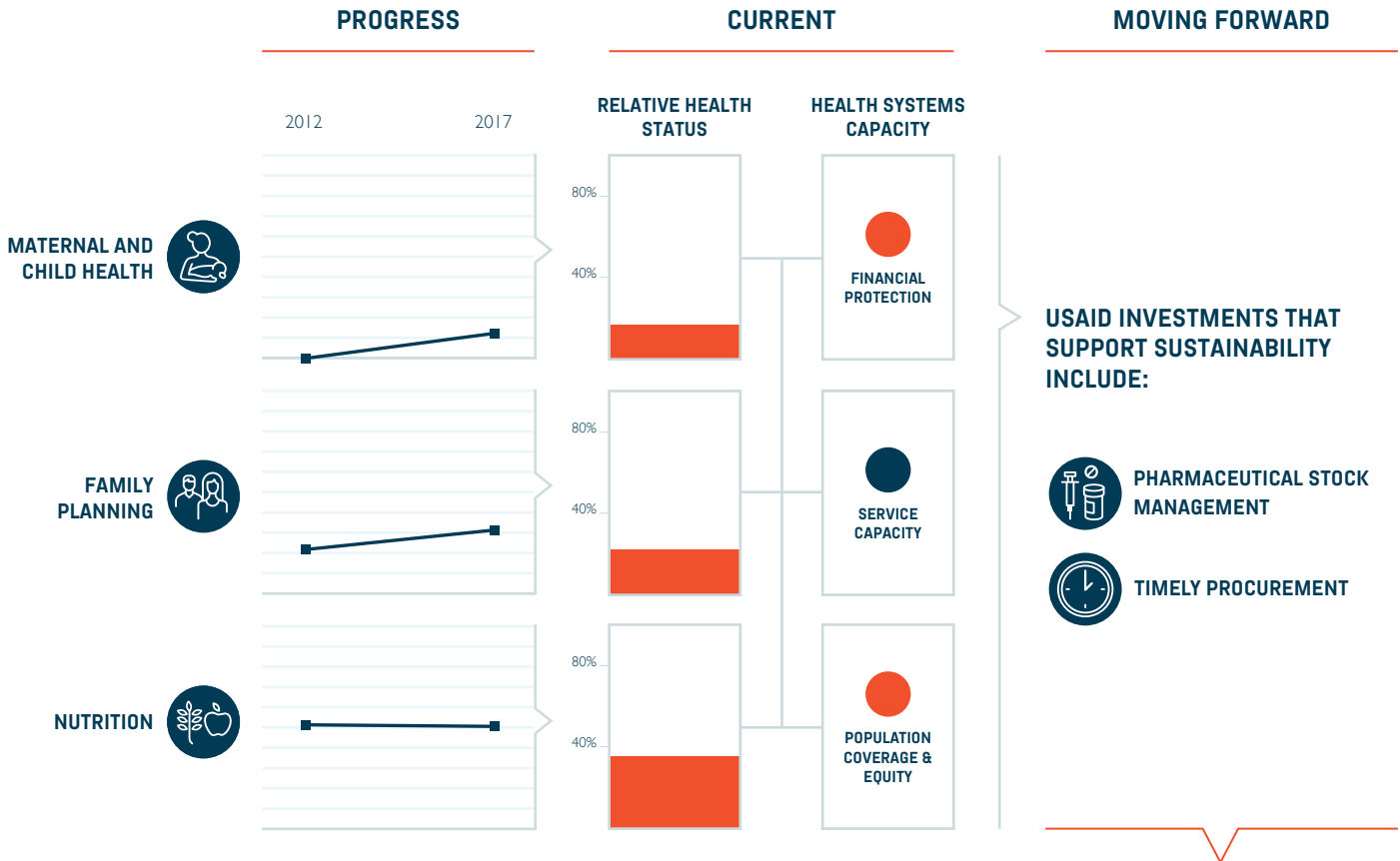
IN THE LAST YEAR, IN COLLABORATION WITH THE GOVERNMENT OF THE FEDERAL REPUBLIC OF NIGERIA (GFRN) AND OTHER PARTNERS, WE HAVE ACCOMPLISHED THE FOLLOWING:

- Supported local manufacturers to produce quality-assured chlorhexidine to prevent newborn sepsis; more than 4 million tubes of gel were sold in 2017, and exports began to five additional countries
- Promoted antenatal care visits through community-level behavior change activities, which allowed 30,900 pregnant women in Cross River State to attend least one antenatal care visit, while 19,500 delivered in a USAID-supported health facility
- Trained 106 members of the National Union of Road Transport Workers as volunteer drivers to help address barriers in women's ability to travel to a health facility for delivery
- Supported local manufacturers to produce oral rehydration solution with zinc, a cost-effective treatment for diarrhea: exports now account for nearly half of sales and four million packets were sold in the Nigerian market in one year
- Assisted four laboratories in achieving international accreditation to conduct quality assurance testing of medicines, which means many maternal and child health drugs no longer need to be sent abroad for testing
- Supported the distribution of 11.6 million insecticide-treated nets to provide protection to pregnant women and children under PMI

TRANSITION SINCE THE 2012 CALL TO ACTION

Developed a new operational strategy to increase sustainable state funding and management, by requiring them to commit more resources to primary health care activities as well as sign Memoranda of Understanding (MOUs) with clearly defined roles and responsibilities for state governments

JOURNEY TO SELF-RELIANCE FOR PREVENTING CHILD AND MATERNAL DEATHS



\$52M IN COST SAVINGS BY 2025
WHICH IS A 3 TO 1 RETURN ON USAID'S INVESTMENT

GOING FORWARD, USAID WILL WORK WITH THE GFRN TO FULFILL ITS COMMITMENT TO WOMEN AND CHILDREN'S HEALTH, INCLUDING THROUGH THE FOLLOWING:

- Conducting an assessment of the availability and readiness of services to provide new information about the distribution and preparedness of health workers, as well as information about private sector facilities and infrastructure limitations
- Supporting analysis and training to better enable states to reform health financing and significantly reduce out-of-pocket spending on health care
- Supporting the creation of fistula in-patient wards in six teaching hospitals and the institutionalization of rotations for fistula within medical school residency programs, which will improve access to treatment for women with fistula and improve the ability of the federal and state governments to deal with the existing fistula burden

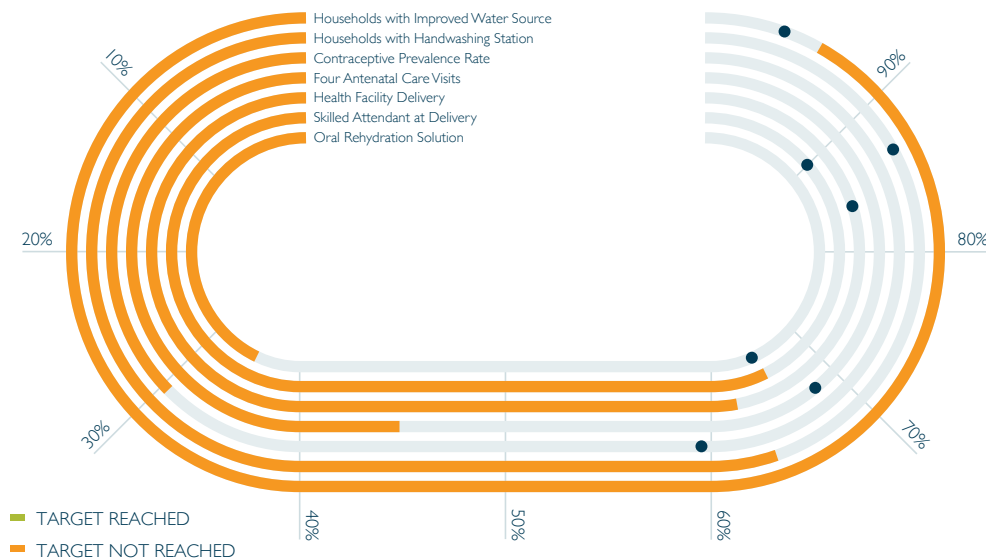


PAKISTAN

* Estimate from 2015 ** Estimate from 2016

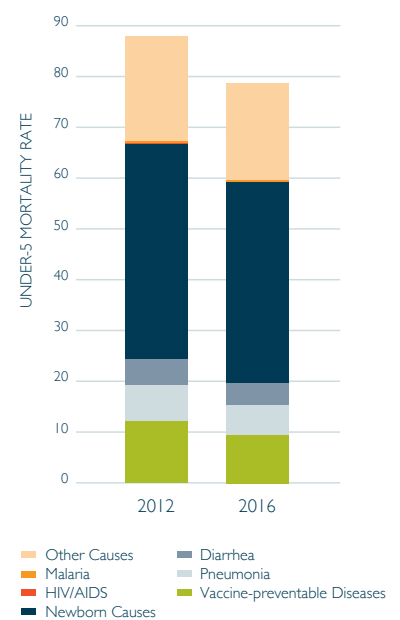
2017	204.9M ↑ Total Population	21.2M ↑ Population Under 5 Years	**424K ↓ Under-5 Deaths /Year	**79 ↓ Under-5 Mortality Rate Per 1,000 Live Births	4.5M ↓ Births	*178 ↓ Maternal Mortality Ratio Per 100,000 Live Births
1990	119M	20.9M	619K	138	5M	490

INTERVENTION COVERAGE



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

SHIFTING CAUSES OF CHILD MORTALITY



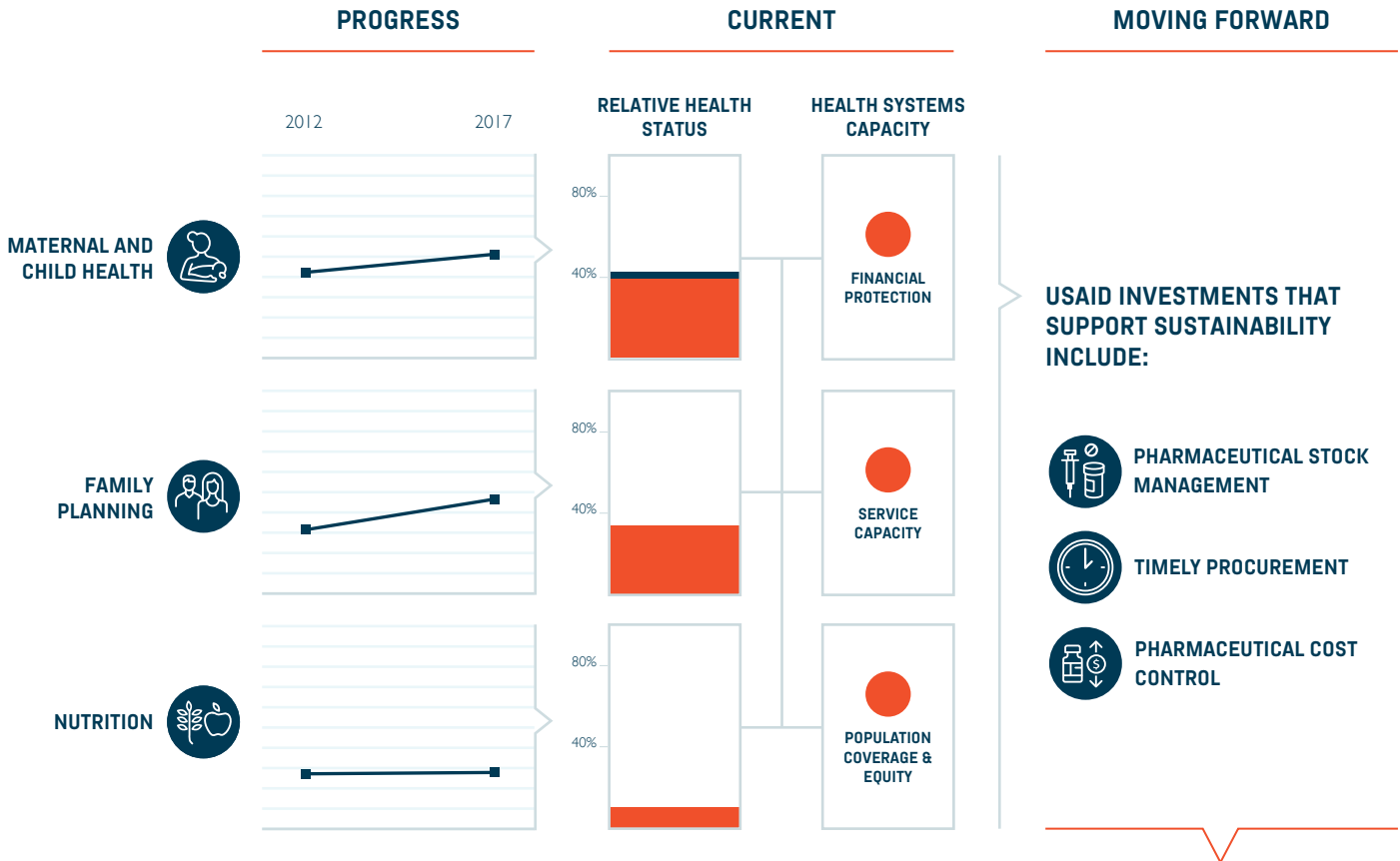
IN THE LAST YEAR, IN COLLABORATION WITH THE GOVERNMENT OF THE ISLAMIC REPUBLIC OF PAKISTAN (GOP) AND OTHER PARTNERS, WE HAVE ACCOMPLISHED THE FOLLOWING:

- Included chlorhexidine to prevent newborn sepsis on the national Essential Medicine List, and worked with local manufacturers to produce it, so the GOP now procures affordable tubes of gel from local manufacturers to stock all health facilities, and will soon export the life-saving commodity
- Conducted a comprehensive assessment of 916 health facilities to identify critical gaps in infrastructure and human resources, which has helped the GOP to recruit and hire 6,000 medical officers, para-medical staff, and specialists
- Worked with 1,000 public and private health facilities to train healthcare personnel and institutionalize quality of care best practices
- Launched a mass media campaign that reached 10.7 million viewers with messages on voluntary family planning and maternal health
- Saved the lives of 9,000 newborns who were born not breathing

TRANSITION SINCE THE 2012 CALL TO ACTION

Since 2014, USAID supported provincial governments to allocate \$110 million more in health funding from their own budgets for the procurement and transportation of contraceptives from domestic resources, compared to a historical budget of \$5 million per year nationwide prior to USAID's engagement.

JOURNEY TO SELF-RELIANCE FOR PREVENTING CHILD AND MATERNAL DEATHS



 **\$60M IN COST SAVINGS BY 2025**
WHICH IS A **165%** RETURN ON USAID'S INVESTMENT

GOING FORWARD, USAID WILL WORK WITH THE GOP TO FULFILL ITS COMMITMENT TO WOMEN AND CHILDREN'S HEALTH, INCLUDING THROUGH THE FOLLOWING:

- Supporting a health information system dashboard and health and population management committees in the Sindh province, which has already resulted in an additional \$140 million in provincial government resources for primary health care in 2017

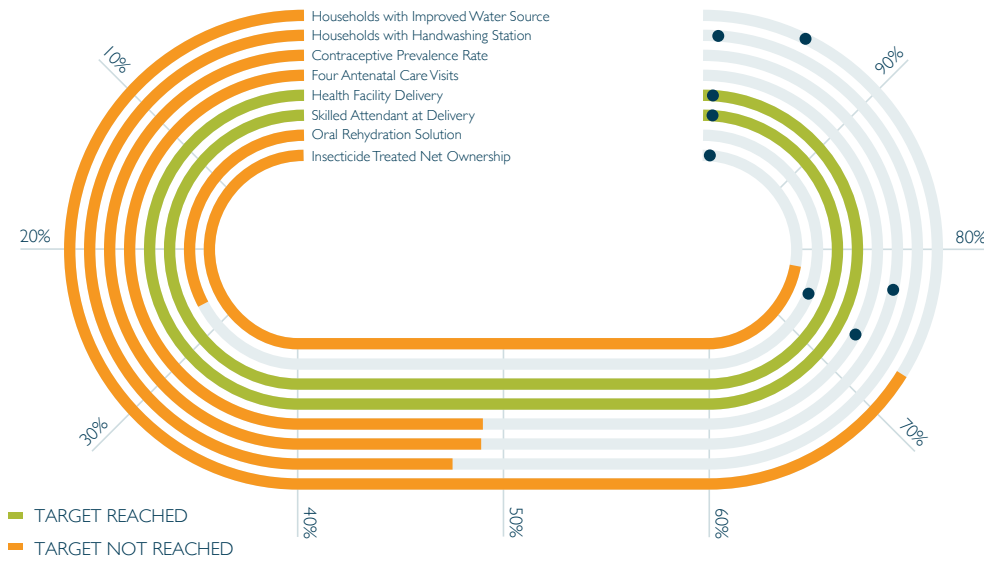


RWANDA

* Estimate from 2015 ** Estimate from 2016

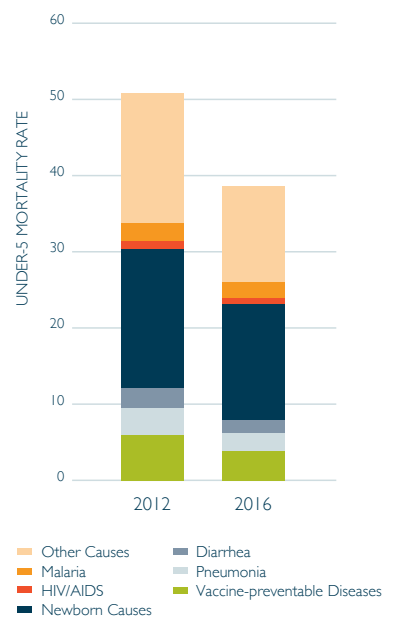
2017	11.9M ↑ Total Population	1.8M ↑ Population Under 5 Years	** 14K ↓ Under-5 Deaths /Year	** 39 ↓ Under-5 Mortality Rate Per 1,000 Live Births	365K ↑ Births	* 290 ↓ Maternal Mortality Ratio Per 100,000 Live Births
1990	7M	1.3M	49.3K	151	304K	910

INTERVENTION COVERAGE



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

SHIFTING CAUSES OF CHILD MORTALITY



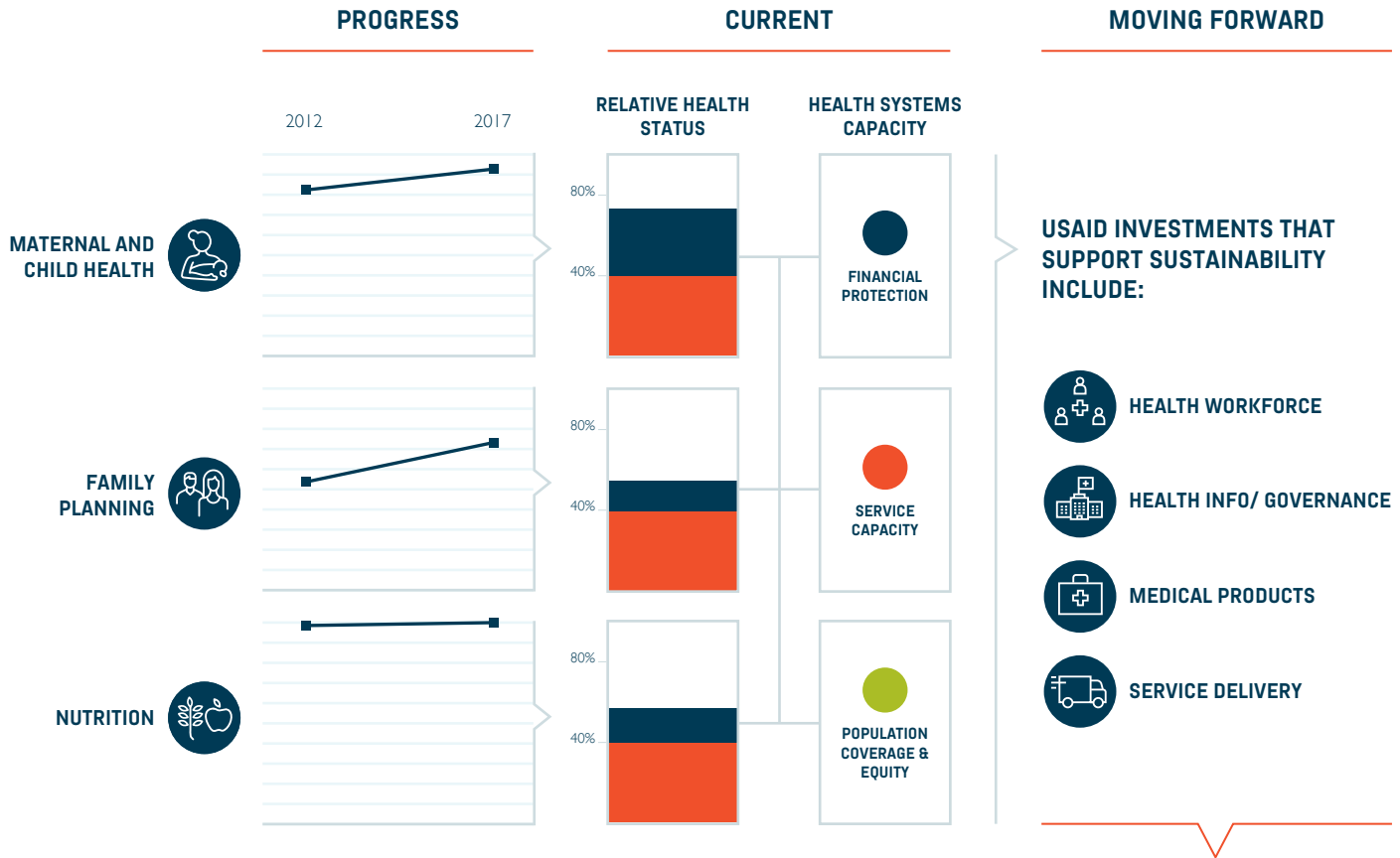
IN THE LAST YEAR, IN COLLABORATION WITH THE GOVERNMENT OF THE REPUBLIC OF RWANDA (GOR) AND OTHER PARTNERS, WE HAVE ACCOMPLISHED THE FOLLOWING:

- Trained 308 providers and 320 clinicians to provide postpartum family planning counseling and care, which increased the number of women who adopted a voluntary family planning method after they gave birth from 0% to 45% by discharge, and the Ministry of Health has committed to scaling up the training to all remaining districts
- Launched a Financial Management Information System in all primary referral hospitals nationally and trained administrators and accountants, which will improve the management and accountability for funds at the health facility level
- Partnered with Rwandan professional organizations to create a mentorship program to improve the skills of health professionals in midwifery, pediatrics, obstetrics, and gynecology
- Enhanced the functionality of the District Health Units and the District Health Management Tools to empower district leaders, which has resulted in 75% adherence to a set work plan

TRANSITION SINCE THE 2012 CALL TO ACTION

Transitioned from substantial financial and technical support for the community-based health insurance to targeted technical assistance only, as the insurance program has been transitioned to the Rwanda Social Security Board (RSSB) for ongoing management.

JOURNEY TO SELF-RELIANCE FOR PREVENTING CHILD AND MATERNAL DEATHS



USAID'S HEALTH INVESTMENTS MAY YIELD A 9 TO 1 RETURN IN ECONOMIC AND SOCIETAL BENEFITS BY 2035

GOING FORWARD, USAID WILL WORK WITH THE GOR TO FULFILL ITS COMMITMENT TO WOMEN AND CHILDREN'S HEALTH, INCLUDING THROUGH THE FOLLOWING:

- Continuing to strengthen community based health insurance, including by helping the RSSB to determine premiums and facilitate online payments, which makes subscriptions easier for consumers and lessens bureaucratic barriers to enrollment
- Supporting the establishment of, and equipping, a fistula repair site at Kibungo Referral Hospital, which will enable gynecologists with fistula repair skills to travel to nearby hospitals and train local doctors
- Increasing private sector engagement, including by providing loan guarantees for private clinics to improve health care at the community level

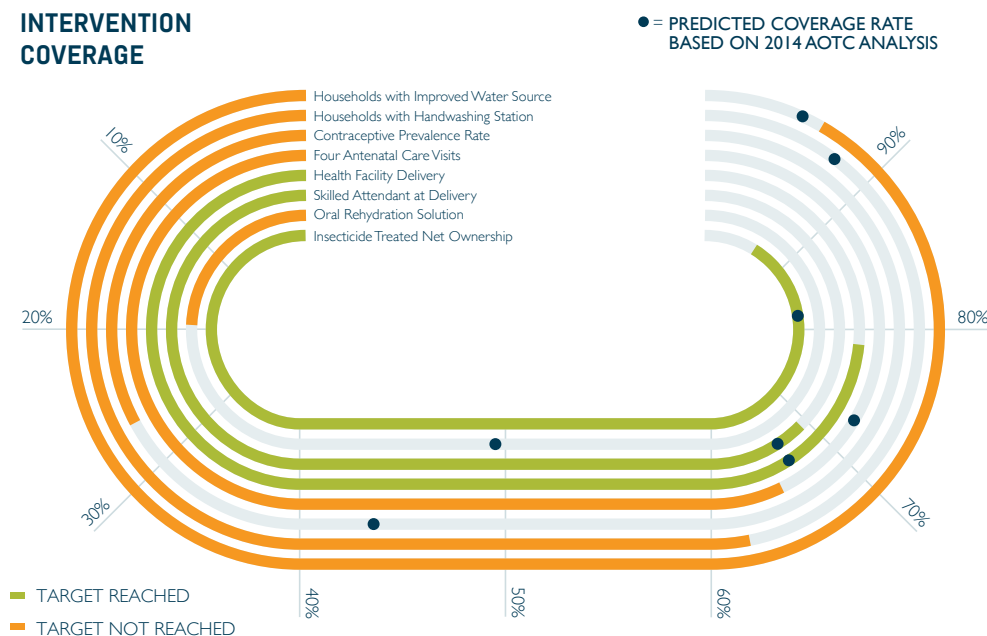


SENEGAL

* Estimate from 2015 ** Estimate from 2016

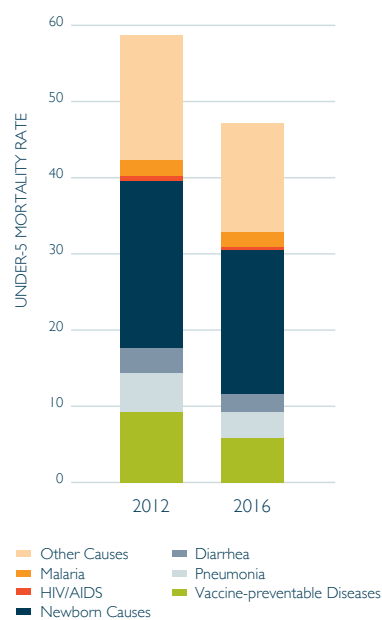
2017	14.7M ↑ Total Population	2.2M ↑ Population Under 5 Years	** 25K ↓ Under-5 Deaths /Year	** 47 ↓ Under-5 Mortality Rate Per 1,000 Live Births	491K ↑ Births	* 315 ↓ Maternal Mortality Ratio Per 100,000 Live Births
1990	7.3M	1.4M	44K	142	342K	670

INTERVENTION COVERAGE



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

SHIFTING CAUSES OF CHILD MORTALITY



IN THE LAST YEAR, IN COLLABORATION WITH THE GOVERNMENT OF THE REPUBLIC OF SENEGAL (GOS) AND OTHER PARTNERS, WE HAVE ACCOMPLISHED THE FOLLOWING:

- Conducted a mapping of the Senegalese private sector, which will provide the Ministry of Health and Social Action with an accurate and comprehensive database of 2,754 private facilities
- Created 265 community "watchdog" committees, which help identify and refer pregnant women for antenatal care and facility delivery, and resulted in a 15% increase in the percentage of births that take place in health clinics
- Strengthened the capacity of community organizations and local governments, to improve advocacy for and awareness of health issues and care, and to increase local funding, management, and sustainability of care
- Strengthened health providers' capacity through an on-site training and mentoring program, including a service delivery point assessment and a resolution plan developed with community and local government officials
- Developed a health financing strategy that will increase the efficient use of health sector resources, through a GOS commitment to revise criteria for free care to target vulnerable populations

TRANSITION SINCE THE 2012 CALL TO ACTION

Transitioned from supporting a full package of health services nationally to tailoring investments based on regional need. Today, USAID concentrates its investments in lower performing regions to significantly impact the key drivers of child and maternal mortality, while providing targeted investments to maintain gains in higher performing regions.

JOURNEY TO SELF-RELIANCE FOR PREVENTING CHILD AND MATERNAL DEATHS



\$204M IN RESOURCES MOBILIZED BY 2025
WHICH IS A **656 TO 1** RETURN ON USAID'S INVESTMENT

GOING FORWARD, USAID WILL WORK WITH THE GOS TO FULFILL ITS COMMITMENT TO WOMEN AND CHILDREN'S HEALTH, INCLUDING THROUGH THE FOLLOWING:

- Providing funds directly to the GOS to support activities in Kaffrine, which has already resulted in a doubling of contributions from local health committees over two years, because of increased engagement of the community
- Providing direct financing to high performing regions, accompanied by technical assistance, which will allow local governments to directly manage resources for health service delivery. In a single year, this approach resulted in an increase from 68% to 77% of health facilities that offer the full range of RMNCH care
- Expanding support for the private health sector, including private facilities and providers
- Supporting implementation of the GOS Health Financing Strategy, including analytics, to allocate domestic resources in the health sector to improve health outcomes
- Continuing to support the Senegalese National Malaria Control Program, under PMI, including by strengthening its capacity both technically and in planning and implementation

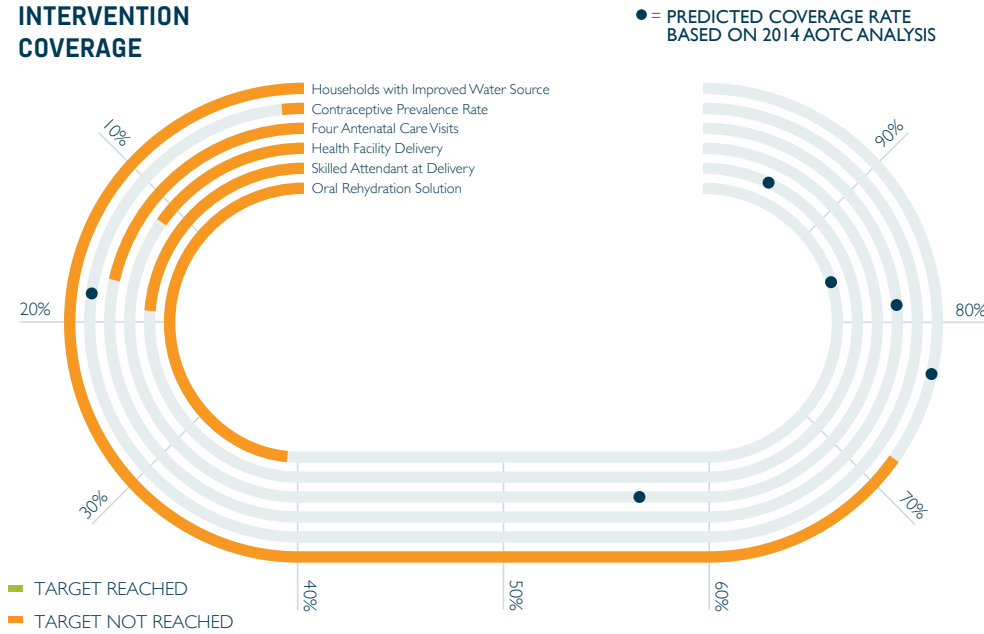


SOUTH SUDAN

* Estimate from 2015 ** Estimate from 2016

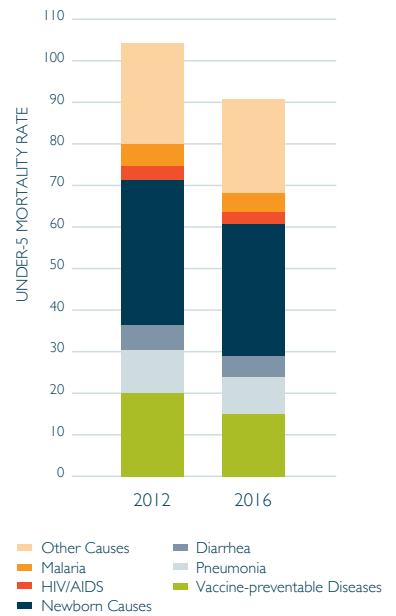
2017	13M ↑ Total Population	2.1M ↑ Population Under 5 Years	**38K ↓ Under-5 Deaths /Year	**91 ↓ Under-5 Mortality Rate Per 1,000 Live Births	462K ↑ Births	*789 ↓ Maternal Mortality Ratio Per 100,000 Live Births
1990	5.8M	1.1M	66.2K	252	263K	1,800

INTERVENTION COVERAGE



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

SHIFTING CAUSES OF CHILD MORTALITY



IN THE LAST YEAR, IN COLLABORATION WITH THE GOVERNMENT OF THE REPUBLIC OF SOUTH SUDAN (GRSS) AND OTHER PARTNERS, WE HAVE ACCOMPLISHED THE FOLLOWING:

- Designed an effective contraceptive distribution system that, for the first time, enables the routine delivery of contraceptives to health facilities outside of the capital, Juba
- Supported the delivery of critical health care to 8.5 million people, or 70% of the population
- Provided 1,321 health facilities with essential medicines to combat the major killers of women and children

TRANSITION SINCE THE 2012 CALL TO ACTION

Since December 2013, USAID has transitioned to targeting care toward the population, rather than supporting the central government's programs.

JOURNEY TO SELF-RELIANCE FOR PREVENTING CHILD AND MATERNAL DEATHS



USAID'S HEALTH INVESTMENTS MAY YIELD A 9 TO 1 RETURN IN ECONOMIC AND SOCIETAL BENEFITS BY 2035

GOING FORWARD, USAID WILL WORK WITH THE GRSS TO FULFILL ITS COMMITMENT TO WOMEN AND CHILDREN'S HEALTH, INCLUDING THROUGH THE FOLLOWING:

- Supporting the training of 205 home health promoters, who provide lifesaving medication and care free of charge to children under-five for malaria, pneumonia, and diarrhea, and are often the only form of care accessible to rural populations
- Expanding the use of misoprostol to prevent postpartum bleeding after delivery, through a shipment of commodities, expanded distribution, and training for at-home births

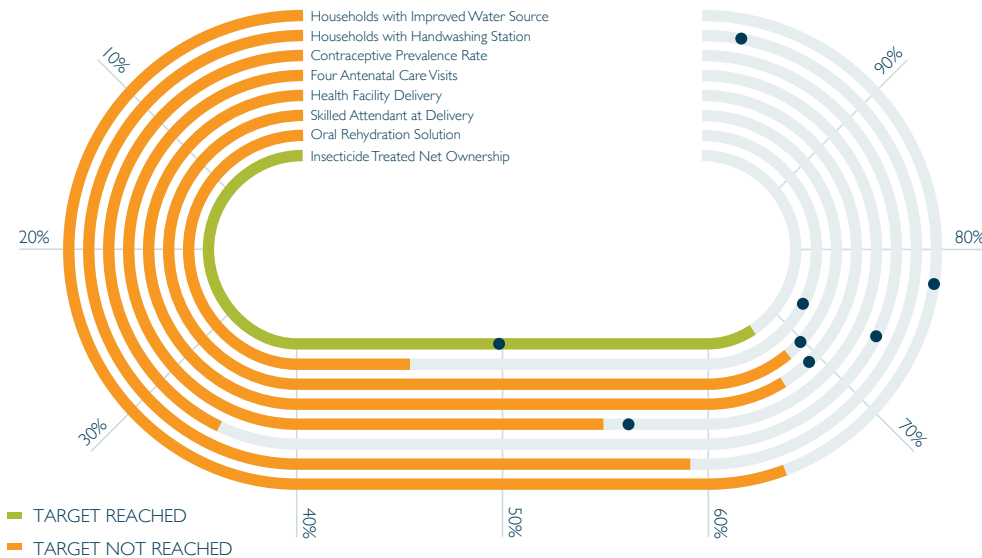


TANZANIA

* Estimate from 2015 ** Estimate from 2016

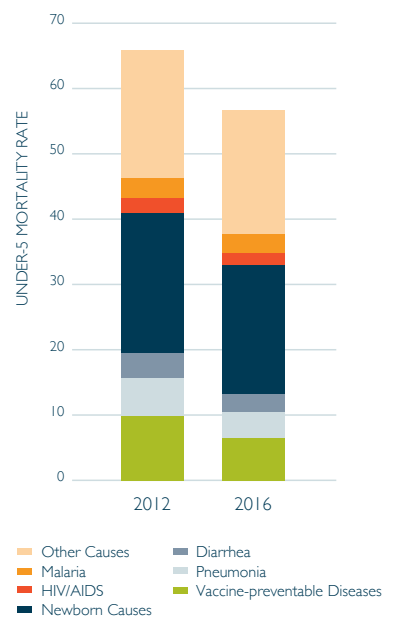
2017	54M ↑ Total Population	8.7M ↑ Population Under 5 Years	** 117K ↓ Under-5 Deaths /Year	** 57 ↓ Under-5 Mortality Rate Per 1,000 Live Births	1.9M ↑ Births	* 398 ↓ Maternal Mortality Ratio Per 100,000 Live Births
1990	25M	4.4M	179K	166	1M	870

INTERVENTION COVERAGE



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

SHIFTING CAUSES OF CHILD MORTALITY



IN THE LAST YEAR, IN COLLABORATION WITH THE GOVERNMENT OF THE UNITED REPUBLIC OF TANZANIA (GOT) AND OTHER PARTNERS, WE HAVE ACCOMPLISHED THE FOLLOWING:

- Established an emergency transport system using rural taxis to assist women who are facing difficult births to travel to a health facility, which has contributed to a 27% reduction in maternal mortality over three years
- Decreased the number of unvaccinated children by 93% from 2013 to 2017 in the Lake Zone, an area with a high number of unvaccinated children, by using the Reaching Every Child strategy
- Established surveillance and response teams in 131 public, private, and faith-based health facilities to examine the causes of maternal and facility newborn deaths, which has resulted in a 20% reduction in deaths in one year
- Supported 1,291,331 women of reproductive age to opt for long acting and permanent contraceptives, while preventing 1.5 million unintended pregnancies and 3,300 maternal deaths, and saving the GOT nearly \$32 million in health care costs
- Empowered women-owned private health facilities by assisting them to apply for loans; 24 borrowers received \$1 million in loans within 12 months
- Supported the GOT to relocate 2,038 health care workers to distribute workload and address existing gaps

TRANSITION SINCE THE 2012 CALL TO ACTION

Following a USAID investment in maternal health, local government authorities and partners are committing \$6 million of their own funds to scale-up this approach from one district to five.

JOURNEY TO SELF-RELIANCE FOR PREVENTING CHILD AND MATERNAL DEATHS



 **\$32.5M IN RESOURCES MOBILIZED BY 2025**

GOING FORWARD, USAID WILL WORK WITH THE GOT TO FULFILL ITS COMMITMENT TO WOMEN AND CHILDREN'S HEALTH, INCLUDING THROUGH THE FOLLOWING:

- Supporting the development of skilled health workers who graduate from pre-service public, faith-based and private health training institutions for midwifery and medicine
- Supporting planning to allocate the public sector health workforce focused both at the local governance level and central level
- Providing strategic and technical support around the GOT's Health Financing Strategy, including efforts in domestic resource mobilization and a path to national health insurance
- Coordinating the national response to the exit strategy of the Global Polio Eradication Initiative, which will strengthen national laboratory capacity to improve surveillance and real time confirmation of polio cases
- Undertaking a study to better understand what is required to harness the demographic dividend, to realize the economic growth associated with well-timed reductions in fertility and mortality
- Strengthening the supply chain, particularly at the local level, to avoid contraceptive stock-outs

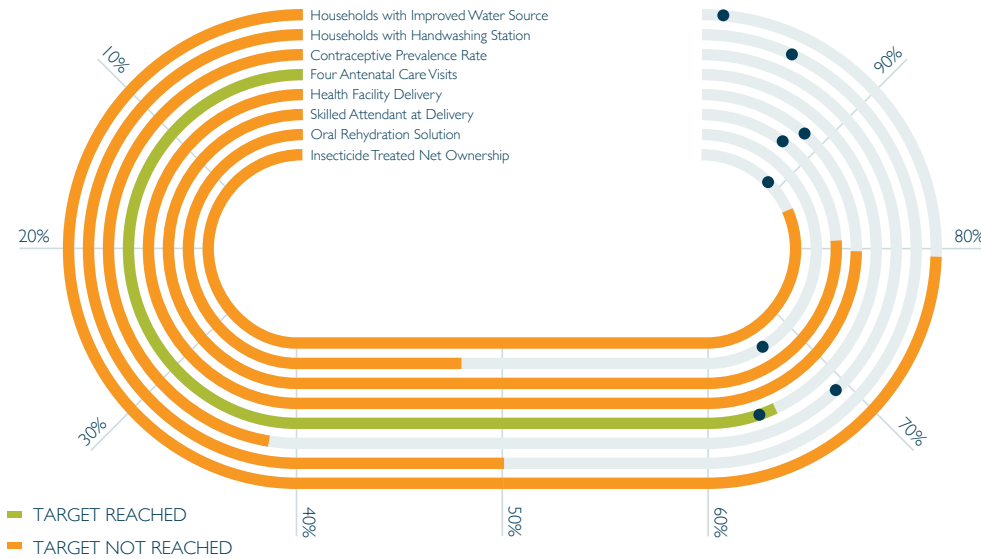


UGANDA

* Estimate from 2015 ** Estimate from 2016

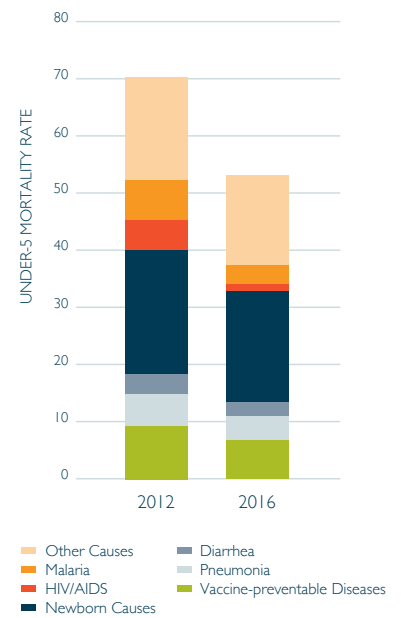
2017	40M ↑ Total Population	7.4M ↑ Population Under 5 Years	**90K ↓ Under-5 Deaths /Year	**53 ↓ Under-5 Mortality Rate Per 1,000 Live Births	1.7M ↑ Births	*343 ↓ Maternal Mortality Ratio Per 100,000 Live Births
1990	16.5M	3.5M	145K	178	875K	600

INTERVENTION COVERAGE



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

SHIFTING CAUSES OF CHILD MORTALITY



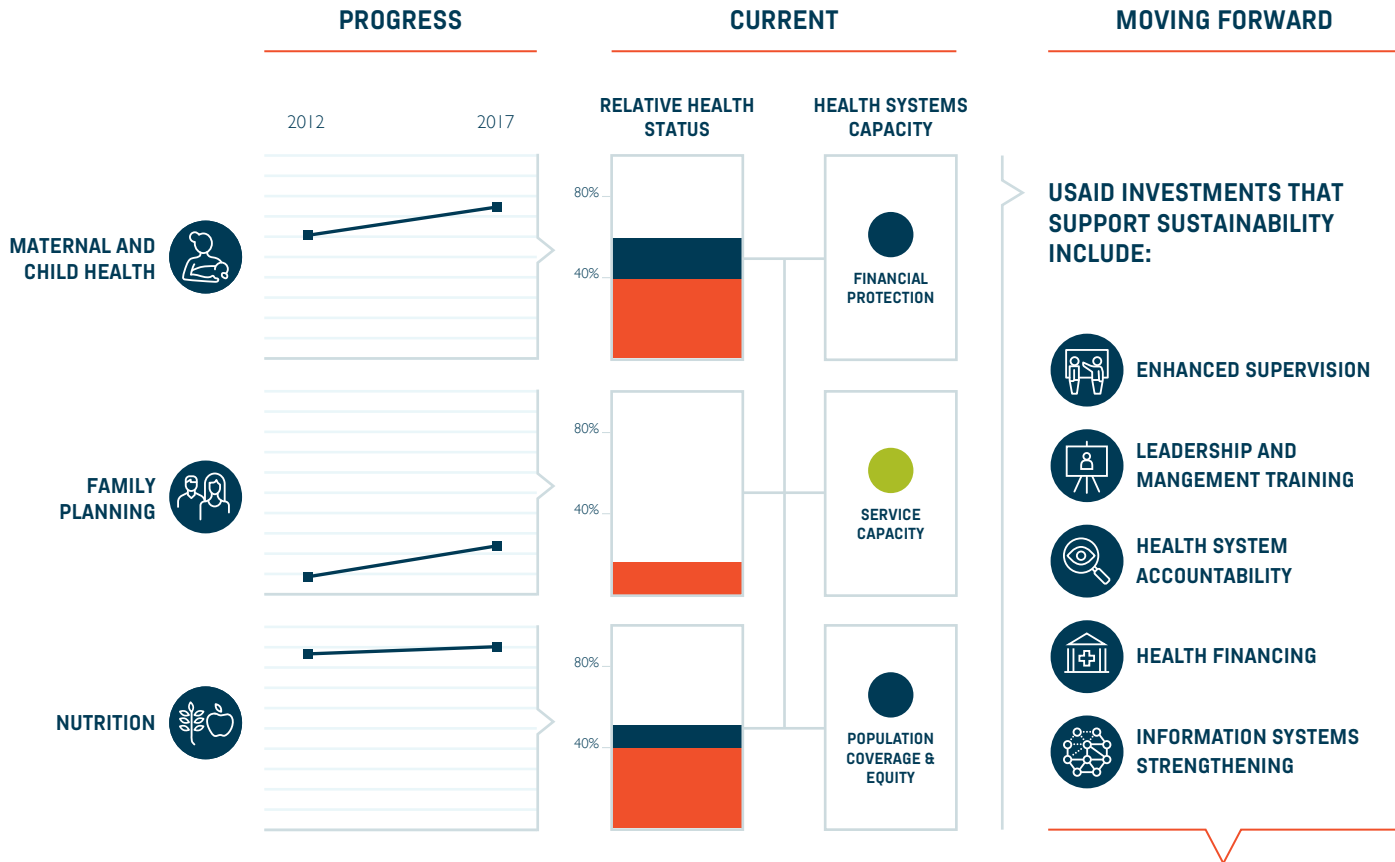
IN THE LAST YEAR, IN COLLABORATION WITH THE GOVERNMENT OF THE REPUBLIC OF UGANDA (GOU) AND OTHER PARTNERS, WE HAVE ACCOMPLISHED THE FOLLOWING:

- Supported local councils to assess financial performance at the district level, which increased locally raised funds for health by 52% from 2012 to 2017
- Influenced the national scale up of injectable contraceptives, including by expanding the distribution of injectables to private sector drug shops
- Trained 2,349 new community health workers while 556 health workers received additional training in long-acting reversible contraception
- Finalized the multi-sectoral Ugandan National Food Fortification Strategy and costed implementation plan, which will enable the GOU to train, streamline, and enforce food fortification standards
- Funded a "training of trainers" to develop a cadre to help roll out the Immunization in Practice Manual, which will improve and expand immunization coverage, particularly in hard to reach areas

TRANSITION SINCE THE 2012 CALL TO ACTION

At the end of the Saving Mothers, Giving Life partnership, the the GOU has incorporated the model into the national health strategy, which will be implemented nationally in part through financing from the Global Financing Facility and a World Bank grant

JOURNEY TO SELF-RELIANCE FOR PREVENTING CHILD AND MATERNAL DEATHS



\$27M IN RESOURCES MOBILIZED BY 2025
WHICH IS A **16 TO 1** RETURN ON USAID'S INVESTMENT

GOING FORWARD, USAID WILL WORK WITH THE GOU TO FULFILL ITS COMMITMENT TO WOMEN AND CHILDREN'S HEALTH, INCLUDING THROUGH THE FOLLOWING:

- Supporting the budgeting process, including a bottleneck analysis, to inform the development of a health program based on expected financial needs
- Supporting the development of a private sector guide to direct and coordinate private funding more effectively and efficiently
- Expanding the Ugandan human resource information system (HRIS) to central level agencies, district planning teams, and facility level teams, which will allow these institutions to make informed decisions regarding distribution of the health workforce

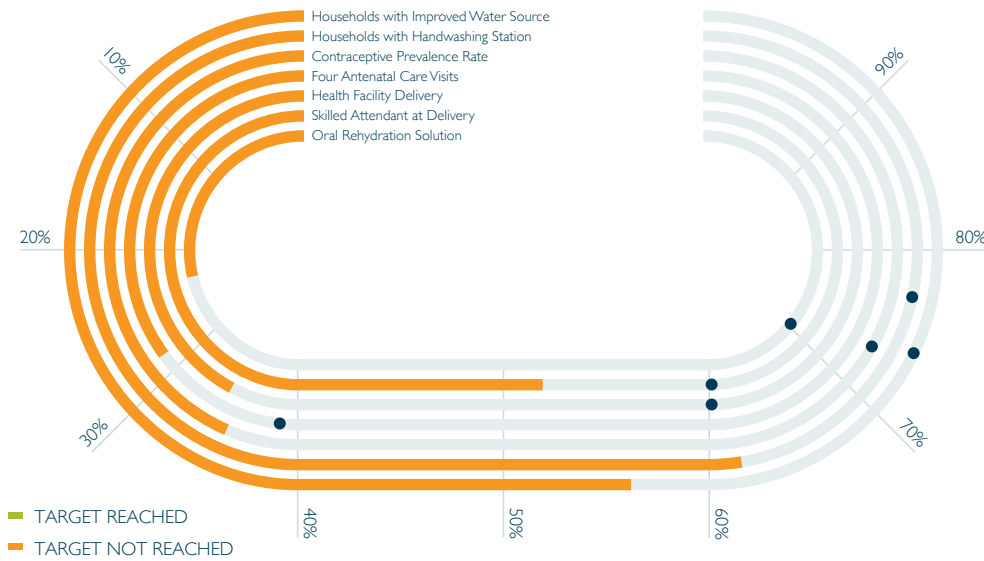


YEMEN

* Estimate from 2015 ** Estimate from 2016

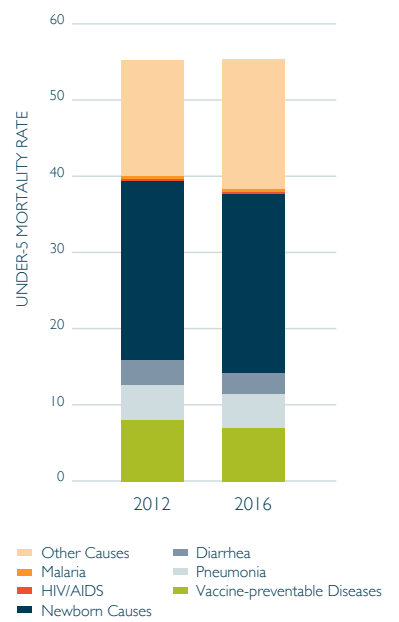
2017	28M ↑ Total Population	3.8M ↑ Population Under 5 Years	** 48K ↓ Under-5 Deaths /Year	** 55 ↓ Under-5 Mortality Rate Per 1,000 Live Births	796K ↑ Births	* 385 ↓ Maternal Mortality Ratio Per 100,000 Live Births
1990	11.8M	2.5M	71K	125	570K	610

INTERVENTION COVERAGE



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

SHIFTING CAUSES OF CHILD MORTALITY



In March 2015, USAID/Yemen fully evacuated our staff and suspended all development activities. In the Fall of 2016, USAID/Yemen initiated pilot early recovery assistance activities that are helping prevent the total collapse of key social service institutions and helping households cope with the effects of the conflict.

JOURNEY TO SELF-RELIANCE FOR PREVENTING CHILD AND MATERNAL DEATHS



**USAID'S HEALTH INVESTMENTS MAY YIELD A 9 TO 1 RETURN
IN ECONOMIC AND SOCIETAL BENEFITS BY 2035**

In the current security environment, USAID cannot make any investments in maternal and child health and family planning/reproductive health. Following post-conflict assessments, USAID will assess possible improvements in the access to and the quality of basic healthcare to target Yemen's vulnerable women and children.

This approach will slowly transition to a normalized development strategy once the country's violence stops and basic health infrastructure, systems and workforce can stabilize.



ZAMBIA

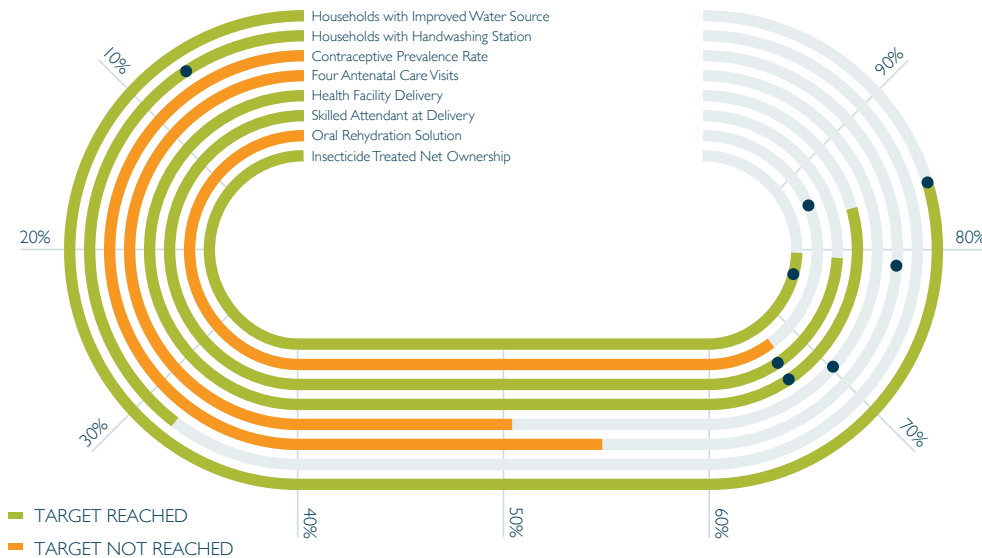
* Estimate from 2015 ** Estimate from 2016

2017	16M ↑ Total Population	2.9M ↑ Population Under 5 Years	**39K ↓ Under-5 Deaths /Year	**63 ↓ Under-5 Mortality Rate Per 1,000 Live Births	662K ↑ Births	*224 ↓ Maternal Mortality Ratio Per 100,000 Live Births
1990	7.6M	1.4M	63K	192	339K	470

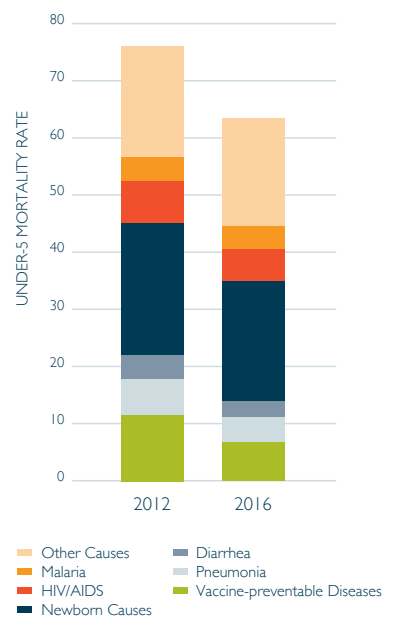
INTERVENTION COVERAGE

● = PREDICTED COVERAGE RATE
BASED ON 2014 AOTC ANALYSIS

SHIFTING CAUSES OF CHILD MORTALITY



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



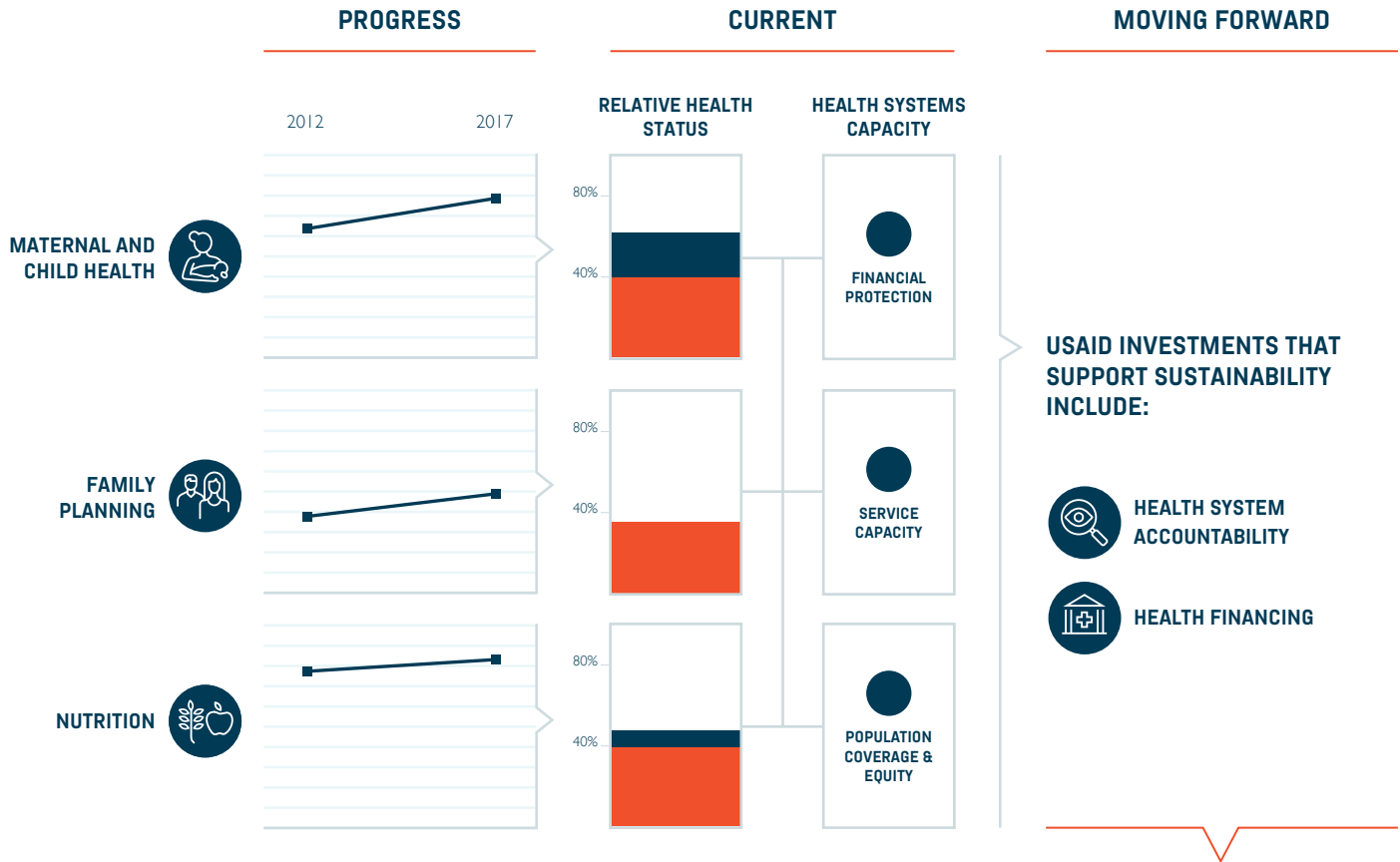
IN THE LAST YEAR, IN COLLABORATION WITH THE GOVERNMENT OF THE REPUBLIC OF ZAMBIA (GOZ) AND OTHER PARTNERS, WE HAVE ACCOMPLISHED THE FOLLOWING:

- Trained over 1,800 Safe Motherhood Action Group members who contributed to an 80% increase in women who delivered in a facility
- Trained a total of 53 traditional leaders as change champions who improve health seeking behaviors in their communities
- Supported the Ministry of Health to draft an induction package for new health workers and launch a framework to standardize expectations of employees and improve the quality of care
- Partnered with Stanbic Bank of Zambia, through Saving Mothers, Giving Life, to fund the construction of five maternity waiting homes to help women deliver in a facility
- Trained over 300 community health workers to provide integrated, community-based voluntary family planning, which reached more than 30,000 users
- Supported 31 students who graduated from the Zambia Management and Leadership Academy, and are now working in districts to improve quality and results

TRANSITION SINCE THE 2012 CALL TO ACTION

The GOZ is incorporating the lessons and best practices from *Saving Mothers, Giving Life* into a national plan to provide RMNCH services. This effort will be funded jointly between the Government and other partners

JOURNEY TO SELF-RELIANCE FOR PREVENTING CHILD AND MATERNAL DEATHS



\$44M IN COST SAVINGS BY 2025
WHICH IS A **43 TO 1** RETURN ON USAID'S INVESTMENT

GOING FORWARD, USAID WILL WORK WITH THE GOZ TO FULFILL ITS COMMITMENT TO WOMEN AND CHILDREN'S HEALTH, INCLUDING THROUGH THE FOLLOWING:

- Strengthening monitoring and evaluation systems to ensure the generation of quality data to inform decision making and maximize efficiencies, based on lessons learned from Saving Mothers, Giving Life
- Partner with the private sector to co-finance programs to target healthy behaviors across maternal and child health, voluntary family planning, nutrition, and malaria
- Providing technical assistance to support the newly created District Health Promotion Officer role, tasked with leading the promotion of health behaviors and care seeking practices at the community level
- Exploring alternative service delivery mechanisms, like leveraging resident retired nurses, to reach underserved communities
- Supporting the scale-up of an injectable contraceptive in the private sector, which will influence future policy on self-injections and could expand commercial participation in this market

ACRONYMS

AOTC *Acting on the Call*

bCPAP bubble Continuous Positive Airway Pressure

CIESIN Center for International Earth Science Information Network

CHX Chlorhexidine

DHS Demographic and Health Surveys

DRM Domestic Resource Mobilization

e-LMIS electronic Logistics Management Information System

FBO Faith-Based Organization

GFF The Global Financing Facility in support of Every Woman Every Child

GHS Ghana Health Service

HRIS Human Resource Information System

IUD Intrauterine device

MCH Maternal and Child Health

mCPR Modern Contraceptive Prevalence Rate

MNCH Maternal, Newborn, and Child Health

MNMA Myanmar Nurse Midwives Association

ODF Open Defecation Free

ORS Oral Rehydration Solution

PMI President's Malaria Initiative

RMNCH Reproductive, Maternal, Newborn, and Child Health

RSSB Rwanda Social Security Board

SBA Skilled Birth Attendant

SMC Social Marketing Company

UNICEF United Nations Children's Fund

USAID U.S. Agency for International Development

USG United States Government

WASH Water, Sanitation and Hygiene

WHO World Health Organization



GLOSSARY OF TERMS

USAID partners with countries throughout their journey to self-reliance:

Beginning of Journey refers to countries with relatively weak health systems, and/or that require significant additional progress to achieve maternal and child survival goals. At this stage, the focus of assistance is to increase national coverage of essential evidence based and life saving interventions.

En Route refers to countries with relatively stronger health systems and/or that still need moderate progress to achieve maternal and child survival goals. Global health assistance shifts from primarily targeting the drivers of mortality to building health system capacities and ensuring sustainability for continued programs.

Near Destination refers to countries with moderately strong health systems and/or who have made substantial progress toward achieving maternal and child survival goals. The focus of global health assistance is to ensure systems are in place to make health care sustainable. Prioritized national strategies, financial protection, and data systems enable countries to maintain and fund quality health care.

USAID has reviewed country status relative to other countries and presents the results of that review.

Progress is an indication of relative progress in voluntary family planning, maternal and child health, and nutrition outcomes across the 25 priority countries.

Relative Health Status is the level of disease, morbidity, and mortality burdens countries experience relative to a set of 55 countries receiving USAID health assistance over the period from 2012 to 2017. This is based on a number of indicators related, respectively, to voluntary family planning, maternal and child health, and nutrition.

For both Progress and Relative Health Status:

- a. **Family planning** values are based on the total fertility rate, modern contraceptive prevalence for married women, unmet need for family planning, percentage of closely spaced births, and age of first birth.
- b. **Maternal and child health** values are based on maternal mortality, neonatal mortality, under-five mortality, and intervention coverage.
- c. **Nutrition** values are based on stunting and wasting rates, exclusive breastfeeding, minimum acceptable diet, low birth weight, and anemia in women of reproductive age.

Health Systems Capacity is an index that measures countries' ability across three dimensions for which a health system should be responsive to its population. This measure is relative to the same set of 55 countries used to determine Relative Health Status.

- a. **Financial Protection** refers to the health system's ability to ensure that those seeking care do not experience catastrophic spending for services or treatment.
- b. **Service Capacity** refers to a health system's ability to deliver quality care and respond to public health threats.
- c. **Population Coverage/Equity** refers to the ability of a health system to reach the entire population it serves in an equitable manner.

Resources Mobilized are additional dollar investments made by national and sub-national governments or the private sector, or funds pooled together to reduce risk, as a result of USAID's investments to date in the specific interventions identified under "Moving Forward".

Cost Savings refers to the dollar investments saved as a result of increased efficiencies resulting from USAID's investments to date in the specific interventions identified under "Moving Forward".

USAID support for the following interventions, as identified on each country page, will fill gaps and drive progress toward self-reliance:

Health Financing helps countries mobilize sufficient resources to pay for health needs and aim to reduce catastrophic health costs to individuals, thereby improving access to and availability of services that improve and save lives. Health financing interventions include:

- Conditional cash transfers are cash payments made to individuals or households for medical spending and are contingent upon certain behaviors (i.e. school attendance) or use of particular services (i.e. immunization).
- Contracting out refers to governments establishing contracts with health care providers to offer publicly-funded health care services to a specified population.
- Health insurance collects regular and predictable payments from large numbers of people to “pool” resources and disburse payments to eligible individuals for health care when it is needed.
- Supply-side financial incentive programs—including performance based financing, performance-based incentives, and pay-for-performance programs—provide rewards to providers or facilities that are based on the achievement of specific health outcomes, increased service use and/or improved service quality.
- User fees are point-of-service charges patients pay to receive care. User fee exemption policies aim to reduce the financial burden on vulnerable patients and increase access to health care services by reducing or eliminating fees for certain services (i.e., delivery care) or certain groups (i.e., pregnant women or under-five children).
- Vouchers provide coupons to individuals, based on eligibility criteria, to receive free or reduced-price access to care.



Photo: Mubeen Siddiqui/MCSP

Health Workforce interventions aim to improve the availability and accessibility of qualified health care providers to a population in order to save lives through adequate and appropriate service delivery. Health Workforce interventions include:

- Enhanced Supervision is a broad set of supervisory interventions that improve provider performance through team based, learning approaches, including supportive supervision, the use of checklists and in-person visits.
- Leadership and Management Training is the provision of training of health workers and facility managers in management and leadership skills to improve care delivery.
- Relocation of Existing Staff is the process of redistributing the existing health workforce to optimize population access to health care services, especially in rural and underserved areas.
- Task sharing / Task shifting is the redistribution of duties for health care workers as a way to increase patient access to service delivery.
- Training and Recruitment of New Staff is the action of increasing the supply of qualified health workers.

Health Information interventions aim to improve the collection, analysis, dissemination, and timely use of health data in evidence-based decision making at all levels of the health system in order to save lives. Health Information interventions include:

- Health Info Systems Strengthening is the effort to improve the organizational, behavioral and

technical capacity of the health information system so that decision making at the national and subnational levels is informed by timely, complete and accurate data.

- Patient Reminders are electronic communications sent to patients to increase compliance with appointments and adherence to treatment.

Health Governance interventions help improve the responsiveness of health systems to their populations, thus addressing perceptions of poor quality or mistreatment which may impede populations from accessing health services. Health Governance interventions include:

- Health System Accountability is the existence of appropriate policies and strategies to promote transparency in the health system and encourage that all actors answer for their actions.

Medical Products interventions aim to ensure that people have sustained access to and make appropriate use of safe, effective, and quality medical products to improve their health status and save lives. Medical Products interventions include:

- Ensure Availability of Equipment is the procurement of all necessary equipment within the supply chain, from the central medical store to a health facility, which is necessary to safely and effectively deliver medication and supplies.
- Pharmaceutical Cost Control is the practice of managing or reducing costs for medicines and supplies required by the health system, while maintaining quality.

- Pharmaceutical Quality Regulation is the set of rules or policies that ensure the quality and integrity of pharmaceuticals.
- Pharmaceutical Stock Management is the effort to maintain a continuous and sufficient stock of appropriate drugs and supplies in facilities and other patient serving settings.
- Timely Procurement of Medical Products is the selection and purchasing of appropriate medications and supplies to prevent shortages and stock-outs.

Service Delivery interventions aim to ensure access to safe, effective, and high-quality services by individuals and populations when they need them in order to sustain health and well-being and to prevent illness and death. Service delivery interventions include:

- Building/Rehabilitation of Facilities is the constructing and renovating of health facilities in order to improve access to and/or quality of health care services.
- Community Education and Outreach encompasses all learning activities conducted collaboratively with individuals and groups in a community to raise awareness, transfer knowledge and skills and catalyze behavior change.
- Emergency Access Interventions are programs and structural interventions designed to facilitate access to medical care in emergencies, including ambulances, radio communication, accompaniment, and maternity waiting homes.

- Facility Accreditation is a process by which an independent body evaluates compliance with an established set of norms and standards that are meant to optimize the quality of services provided at the facility level.
- Quality Improvement consists of systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups.
- Service Delivery by Community Health Workers are services performed by a non-medical professional who is trusted in the community and trained to support, diagnose, and/or deliver culturally competent basic health services.
- Service Integration refers to a broad array of service delivery activities meant to enable patients to receive multiple needed health services in a coordinated and convenient fashion.
- Service Provided Outside Facility is the provision of priority services by medical practitioners to improve access to care outside of a standard fixed health facility site.



DATA AND METHODOLOGY

Data Sources:

The analyses and the information presented on the country pages comes from common, publicly available sources as described below. Sources were chosen to maximize ability to compare across countries in a single year and based on common methodologies for estimation. Therefore, the numbers presented may vary from recently released data and/or from the official numbers used within countries. These sources are used both as absolute numbers and as input into the data analyses done on the country pages.

Total Population, Population under-five, Number of Births:

The US Census Bureau's International DataBase (IDB) estimates and projections (funded by USAID) are provided for each calendar year beyond an initial or base year, through 2050. The estimation and projection process is conducted by the statisticians and demographers of the US Census Bureau's International Programs Center, and involves data collection, data evaluation, parameter estimation, making assumptions about future change, and final projection of the population for each country. The Census Bureau begins the process by collecting demographic data from censuses, surveys, vital registration, and administrative records from a variety of sources. Available data are externally evaluated, with particular attention to internal and temporal consistency. The resulting body of data in the IDB is unique because it exists for every country and the Census Bureau updates it annually; these single year estimates

reflect the demographic impact of sudden events, such as earthquakes, wars, and refugee movements. The United Nations (UN) maintains the only other similar source of estimates for all countries, but updates its data less frequently; its estimates do not yet reflect the precise timing of sudden events.

Under-five and Neonatal Mortality Rates:

<http://www.childmortality.org/>

The Interagency Group for Child Mortality Estimation (IGME), established by the UN, has a membership of leading academic scholars and independent experts in demography and biostatistics who review mortality data and publish annual country level estimates of under-five mortality. To do so, IGME compiles all available national-level data on child mortality, including data from vital registration systems, population censuses, household surveys and sample registration systems, and weights these data based on quality measures. In order to reconcile differences caused by estimation technique, error rates and overlapping confidence intervals, the Technical Advisory Group of the IGME fits a smoothed trend curve to a set of observations and then uses that to predict a trend line that is extrapolated to a common reference year, in this case 2016.

Maternal Mortality Ratio (MMR):

These data come from the report: Trends in Maternal Mortality: 1990 to

2015. Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division:

<http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2015/en/>.

The 2013 round of UN estimates (World Health Organization et al., 2013) provided an integrated evaluation of maternal mortality over the full interval from 1990 to 2013, utilizing all available data over this period. A key goal of this analysis was to create comparable estimates of the MMR and related indicators for 183 countries (or territories), with reference to 5-year time intervals centered on 1990, 1995, 2000, 2005, and 2013. The 2015 report included two key methodological refinements to enhance the quality of the data. First, the 2015 model utilizes national data from civil registrations systems, population-based surveys, specialized studies and surveillance and censuses data to estimate trends for all countries. Second, the 2015 methodology weights data from higher quality sources higher so these have a greater impact on the final estimates than data from lesser sources.

Intervention Coverage Estimates:

Intervention coverage rates were abstracted from the most recently available *Demographic and Health Survey* (DHS) and *Multiple Indicator Cluster Survey* (MICS) or *HIV/AIDS and Malaria Indicator Surveys*. Where data points for 2017 were unavailable, coverage estimates were based on an application of the annualized rate of change from the two most recently available survey data points.

Cause of Death Estimates:

Cause-specific mortality rates of children under-5 (per 1,000 live births) were downloaded from the WHO's Global Health Observatory Data Repository via USAID's IDEA database. They were grouped into the main causes of child mortality (diarrheal diseases, acute lower respiratory infections, malaria, HIV, neonatal causes, and other). This data source does not separate malnutrition as a distinct cause of child mortality, although it is highly contributory to all main causes that are listed. It should be noted for completeness that Black et al. *Lancet* 2013 estimates that malnutrition contributes to 45% of child mortality (approximately a quarter of which are newborns). Finally, vaccine-preventable diseases were calculated as follows: measles, 37% of diarrheal diseases (since rotavirus is estimated to cause 37% of global deaths from diarrhea: https://www.defeatdd.org/article/rotavirus-vaccine-advocacy-resources#deaths_rota) and 50% of acute lower respiratory infections (since approximately half of such pneumonia deaths result from vaccine-preventable bacteria: <http://www.who.int/bulletin/volumes/86/5/07-044503/en/>).

Methods for composite analyses:

The indicators used to describe the journey to self-reliance for preventing child and maternal deaths were developed as composite scores using the following methodology:

- For countries in which the most recent surveys (DHS or MICS) were conducted between 2015 and 2017, the indicator values from the most recent surveys were used.
 - For countries with two or more surveys but with the last survey conducted before 2015, the rates of change between the last two surveys were used to extrapolate the indicator values at the last survey to 2017. The estimated 2017 values were then adopted.
 - For countries with only one survey conducted several years ago or with no survey data available on the DHS STATcompiler, estimates from United Nations (usually 2015-2020) or Family Planning 2020 (2017) were used.
- ### Methods for calculating progress from 2012 to 2017 using composite scores:
- The assessment of progress on maternal and child health, nutrition and family planning between 2012 and 2017 represent the results from a 6-step process.
1. The most recent data points in the 25 USAID priority countries for maternal and child survival were gathered from the data sources described above for the composite indicators listed later in this section.
 2. A data set was arranged with both 2012 values and 2017 values for the indicators.
 3. For each indicator, the values across the priority countries for both time points, were converted to a relative score from the average (a z-score) so that indicators of different types (some rates, some percentages, some ratios) could be compared and combined.
 4. The converted, relative scores (z-scores) for each indicator were combined into an average score each for maternal and child health, nutrition, and family planning as follows:
 - a. Maternal and child health (MCH): The scores for the two MCH intervention coverage indicators were averaged. Then an average was taken from the three MCH mortality indicators and the average of the intervention coverage indicators.
 - b. Nutrition: The relative scores for each nutrition indicator were averaged.
 - c. Family Planning: The average relative score for the five population and reproductive health indicators was obtained by dividing the sum of the five relative scores (z-scores) by 5.
 5. For ease of communication, the average scores for maternal and child health, for nutrition, and for family planning were converted into percentile ranks on a scale of 0-100%, with 0% meaning the worst performance and 100% meaning the best performance.¹
 6. For each USAID priority country, the percentile rank scores for 2012 are compared to the scores for 2017 for indications of progress as follows:
 - a. The 2012 maternal and child health percentile score for country X is compared to its 2017 maternal and child health percentile score. This is repeated separately for nutrition and for family planning
 - b. If the 2017 percentile score is higher than the 2012 score, then positive (good) progress has been made. The difference in the two scores is a measure of how much progress is made in a country, the greater the difference, the greater the (good) progress.

¹ z-scores are often difficult to communicate as they have hard-to-understand values that can typically range from -3 to 3. The percentile rank scores convert the z-scores onto a scale of 0 to 100, with the lowest z-score given a value of 0% and the highest z-score given a value of 100%. Z-scores in between the highest and lowest z-scores are provided a percentile value between 0 and 100 at a relative distance from the lowest z-score.



Methods for ranking of priority countries by current stage of their journey toward self-reliance:

The methods for assessing country progress on their journey toward self-reliance relies on the development of composite scores as described above except that the values for 2017 were compared relative to a full set of 55 countries that have received some form of health assistance from USAID between 2012 and present.

Health Systems Capacity composite score indicators were combined as follows:

- The financial risk protection score represents an average of the two indicators, OOP spending and public domestic investment in health, after normalizing the data on a scale from 0-100.
- The service capacity score represents an average of the two indicators: international health regulation core capacity and skilled health provider density, after normalizing z-scores for each on a scale from 0-100.
- The population equity score is comprised of three indicators, equitable coverage of four antenatal care (ANC) visits, skilled birth attendant (SBA), and Modern Contraceptive Prevalence Rate (mCPR). The ratios between the different populations described above demonstrate inequity. The inequity ratios were transformed into z-scores and normalized on a scale from 0-100. The scores were then subtracted from 100 to ensure consistent directionality with measuring equity.

Thresholds were assigned to the composite scores for each dimension. Countries performing in the bottom 40 percent in each dimension were labeled “Beginning of Journey;” those

in the mid 40 percent, “En Route;” and those in the top 20 percent, “Near Destination.”

The Maternal and Child Health composite score indicators include the following:

Maternal mortality ratio (MMR) per 100,000 live births — The maternal mortality ratio (MMR) is defined as the annual number of female deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, per 100,000 live births, for a specified year. Complications during pregnancy, childbirth and post-partum are a leading cause of death and disability among women of reproductive age in developing countries. The maternal mortality ratio represents the risk associated with each pregnancy, i.e. the obstetric risk. The indicator monitors deaths related to pregnancy and childbirth. It reflects the capacity of the health systems to provide effective health care in preventing and addressing the complications occurring during pregnancy and childbirth.

Neonatal mortality rate per 1,000 live births — This is defined as the number of deaths during the first 28 completed days of life per 1000 live births in a given year or other period. Neonatal deaths (deaths among live births during the first 28 completed days of life) may be subdivided into early neonatal deaths, occurring during the first 7 days of life, and late neonatal deaths, occurring after the 7th day but before the 28th completed day of life.

Under-five mortality rate per 1,000 live births — This is defined as the probability of a child born in a specific year or period dying before reaching the age of five, if subject to age-specific mortality rates of that period. Under-five mortality rate as defined here is strictly speaking not a rate (i.e. the number of deaths divided by the number of population at risk during a certain period of time) but a probability of death derived from a life table and expressed as rate per 1000 live births. It also reflects the social, economic and environmental conditions in which children (and others in society) live, including their health care. Because data on the incidences and prevalence of diseases (morbidity data) frequently are unavailable, mortality rates are often used to identify vulnerable populations.

Intervention coverage for delivery in a health facility — Percentage of total deliveries that occurred in public and private hospitals, clinics and health centres, irrespective of who attended the delivery at those facilities.

Intervention coverage for surviving infants fully vaccinated against DPT — The percentage of one-year-olds who have received three doses of the combined diphtheria, tetanus toxoid and pertussis vaccine in a given year.

Intervention coverage for postnatal care of newborns — This is defined as the percentage of infants who received postnatal care within two days of childbirth, regardless of place of delivery. The majority of maternal and newborn deaths occur within a few hours after birth, mostly within the first 48 hours. Deaths in the newborn period (first 28 days) are a growing proportion of all child deaths. Postnatal care contacts, especially within the first few days following birth, are a critical opportunity for improving maternal and newborn health and survival and for provision of information about birth spacing.

The Family Planning composite score indicators include:

Total Fertility Rate (TFR) – This is defined as the average number of children a woman would have at the end of her childbearing years if she bore children at the age-specific fertility rates of women at the time of the most recent survey in 2015–17 (or as projected for 2017).

Modern Contraceptive Prevalence Rate (mCPR) for Married Women

– This is defined as the percentage of married or in union women who reported (or whose husband/partner reported) to be using modern family planning at the time of the most recent survey in 2015-17 (or as projected for 2017).

Unmet Need for Family Planning

– This is the percentage of married or in union women who were fecund and who expressed desire to prevent pregnancy or postpone childbearing, but were not using a contraceptive method at the time of the most recent survey in 2015-17 (or as projected for 2017). The total number of women with unmet need for family planning consists of two groups of women: (a) those with an unmet need for limiting, and (b) those with an unmet need for spacing. Women with an unmet need for limiting are those who desired no additional children and were not using a contraceptive method at the time of the survey. Women with an unmet need for spacing are those who desired to postpone their next birth by a specified length of time (for example, for at least two years from the date of a survey) and were not using a contraceptive method at the time of the survey.

Percentage of closely spaced births

– Percentage of all closed birth intervals (from one birth to another birth) that are less than 36 months in the five years preceding a survey in 2015-17 (or as projected for 2017).

Age of first birth – Percentage of women 18-24 who had first births before age 18 in 2015-2017.

The Nutrition composite score indicators include:

Stunting

Percent of children under 5 years of age who are stunted. Being stunted is defined as having a low length- or height-for-age (<-2 standard deviations from median height-for-age for reference population) and is an indicator of chronic malnutrition.

Wasting

Percent of children under 5 years of age who are wasted. Being wasted is defined as having a low height-for-weight (<-2 standard deviations from median weight-for-height for reference population) and is an indicator of acute undernutrition.

Exclusive Breastfeeding

Percent of infants 0 to 5 months of age who are fed exclusively with breast milk.

Minimum Acceptable Diet

Percent of children 6 to 23 months of age who received a minimum acceptable diet defined as the fraction of breastfed children 6 to 23 months of age who had at least the minimum dietary diversity and the minimum meal frequency during the previous day plus the fraction of non-breastfed children 6 to 23 months of age who received at least 2 milk feedings and had at least the minimum dietary diversity not including milk feeds and the minimum meal frequency during the previous day. Minimum dietary diversity is defined as the proportion of children 6 to 23 months of age who receive food from four or more (out of seven) food groups. Minimum meal frequency is defined as the proportion of breastfed and non-breastfed children 6 to 23 months of age who receive solid, semi-solid, or soft foods (also including milk feeds for non-breastfed children) the minimum number of times or more (minimum is defined as 2 times for breastfed infants 6 to 8 months, 3 times for breastfed children 9-23 months, 4 times for non-breastfed children 6-23 months).

Low Birth Weight

Percent of infants with a birth weight less than 2,500 grams.

Anemia among Women of Reproductive Age

Percent of women of reproductive age (15 to 49 years of age) with anemia (hemoglobin concentration below 12.0 grams/deciliter).

The Health Systems Capacity composite score indicators include:

Financial Protection

Out-of-pocket (OOP) expenditures: a five-year average of household OOP health expenditure as a percentage of a country's current expenditure for health. The data is gathered from the World Health Organization Global Health Expenditure Database for 2011-2015.

Public domestic investment in health: estimated using the five-year average of general government health expenditures as a percent of a country's current health expenditure, which does not include donor support to public institutions. The data is gathered from the World Health Organization Global Health Expenditure Database for 2011-2015.

Service Capacity

Core capacity index: taken from the International Health Regulations (IHR) core capacity index and reflects a health system's ability to detect and respond to public health problems. This index ranges from zero to 100, where a higher score indicates greater capacity. The data is collected from the World Health Organization (2016).

Skilled health professional (SHP) density: the density of physicians, nurses and midwives per 1,000 population. It reflects the availability of health professionals and the World Health Organization Global Health Observatory data was projected for 2017 based on data observed in the last ten years.

Population Equity

Equitable coverage of four antenatal care (ANC) visits: calculated using

the ratio of coverage between urban and rural populations. The data was collected from historical Demographic and Health Surveys for each country and projected to 2017.

Equitable coverage of SBA: calculated using the ratio of coverage between the highest and lowest wealth quintiles. The data was collected from historical Demographic and Health Surveys for each country and projected to 2017 estimates.

Equitable coverage of modern methods of contraceptive prevalence (mCPR): calculated using the ratio of coverage between the highest and lowest wealth quintiles. The data was collected from historical Demographic and Health Surveys for each country and projected to 2017 estimates.

Methods for return on investment calculations

USAID missions and implementing partners provided information for relevant health systems related activities on USAID investment costs, the number of years USAID made these investments, estimates of benefits in terms of the cost savings or domestic resources mobilized, and the number of years that USAID expected that these benefits would be realized. World Bank World Development Indicators was the source of real interest rates. Data from 2016 or the latest available real interest rate was used.

The return on investment is calculated based on the following formula: $(PV(\text{benefits}) - PV(\text{investments})) / PV(\text{investments})$ where PV is the present value

All benefits and costs are calculated using US dollars. The benefits accrued from a health system investment

can result from the expected cost savings of a health system based on an improvement in the efficiency of the health system or through an increase in domestic (government or private pre-paid risk pooled) resources that are raised as a result of the health systems strengthening investment. The figures were provided by the USAID mission and/or implementing partner.

The investment costs of the health system are based on USAID project records and focus only on USAID's share of the health systems investment. The present value (PV) is calculated by taking the sum of discounted future benefits accrued by the health system. The real interest rate serves as the discount rate. All investment costs provided by the mission were assumed to be already in present value terms. The maximum time period for realizing benefits is calculated to be 15 years for activities that were expected to realize benefits in perpetuity. For countries, where a time range was provided, the time period used was the max of the range.

For countries in which we were unable to calculate a country specific return on investment, due to unavailable data or other circumstances at the country level, we have cited the conclusion of the Commission on Investing in Health, which is based on overall investments in health, not just health systems investments. (<http://globalhealth2035.org/about-us/commission-investing-health>).



