



10th
ANNIVERSARY
EDITION

Preventing Child and Maternal Deaths

A Framework for Action in a Changing World

2023-2030



USAID
FROM THE AMERICAN PEOPLE



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FRAMEWORK SUMMARY

VISION

A world where all women, newborns, and children survive, are healthy, and are able to develop and reach their full potential, contributing to the development of their communities and countries.



GOALS

To save lives, decrease disease, and increase the potential of women, newborns, children, families, and communities to thrive.



OBJECTIVES

- 1 Reduce preventable child and maternal mortality in 25 priority countries** to 12 percent or lower of total deaths by 2030.
- 2 Increase coverage levels of lifesaving interventions** across priority countries to a level of 68 by 2030, as measured by the reproductive, maternal, newborn, and child health (RMNCH) service coverage subindex.



FOCUS AREAS

- 1 Strengthen Quality**
- 2 Enhance Equity**



STRATEGIC APPROACHES

- 1 Primary Health Care**
- 2 Reach the Hardest to Reach**
- 3 Local Partnership**
- 4 Human Resources for Health**
- 5 Commitment and Accountability**
- 6 Data for Decision-Making**





MESSAGE FROM THE BUREAU FOR GLOBAL HEALTH LEADERSHIP

The United States government's commitment to preventing child and maternal deaths has long helped ensure that lifesaving health services are delivered to women and children. Together with our country and global partners, and with the steadfast support of the U.S. Congress and the American people, USAID helped more than 91 million women and children access essential—often lifesaving—care in 2021.

The COVID-19 pandemic resulted in the largest global reduction in life expectancy in a century. The pandemic not only exposed systemic weaknesses in the health systems around the world, but also disrupted access to these essential services and widened equity gaps, threatening decades of global progress on health and development. With our shared success in jeopardy, the global health community has reached a critical moment, and country baselines, priorities, and strategies must reset to reflect this new programmatic landscape.

USAID sees stronger, more integrated primary health care systems as the way forward for delivering health services that are responsive, people centered, well financed, affordable, accessible, and reliable. Integrating health programs more effectively through primary health

care systems will result in stronger, more resilient health systems that produce improved and sustainable health and nutrition outcomes for women and children around the world.

Imagine what health systems could look like—and could achieve—by shifting more leadership, ownership, decision-making, and implementation to local community stakeholders and institutions. Empowering those who possess the capability, connectedness, and credibility to drive change in their own countries and communities is the most effective means for generating contextually tailored solutions that can address deeply rooted barriers to maternal and child survival.

Every woman and child, in every country, deserves access to high-quality health services that meet their needs throughout their life. A renewed focus on primary health care is an opportunity for USAID and partner countries to reclaim lost ground from the COVID-19 pandemic and align approaches to advance our shared commitments and foster resilience and preparedness against future health threats. Improving the health and well-being of women and children is a development imperative that cannot go unrealized.



DR. ATUL GAWANDE
ASSISTANT ADMINISTRATOR,
BUREAU FOR GLOBAL HEALTH, USAID



INTRODUCTION

For the last 60 years, USAID leadership has been pivotal in advancing maternal and child survival. Since the 2012 Child Survival Call to Action, USAID's 25 priority partner countries for preventing child and maternal deaths have made significant progress toward the Sustainable Development Goal (SDG) targets for Good Health and Well-Being. Several countries – including Bangladesh, India, Indonesia, Malawi, Nepal, Senegal, Rwanda, and Uganda – are on track to achieve or have already achieved one or more of the SDG targets for child, newborn, and maternal survival. Across all countries, the political will, investments, and learning of this past decade have saved millions of women's and children's lives.

Yet, many countries are not on track to achieve their SDG targets. Recurring conflict and political strife, poor governance, infectious disease outbreaks, natural disasters, countries' inability to increase domestic budgets for health, and the reverberating impacts of the global COVID-19 pandemic all impeded progress.

Additionally, as we look ahead to the 2030 deadline for the SDG goals, and in the context of a world altered by the COVID-19 pandemic, we need a new framework to

guide and prioritize USAID's maternal and child survival programming toward the investments that will best save lives and promote equity in maternal and child health. Regaining the ground lost during the pandemic and progressing forward to achieve the 2030 SDG targets will benefit from an enhanced focus on delivering primary health care. Primary health care is a central component of all high-performing health systems because it is a vehicle for delivering essential and cost-effective health interventions, including maternal and newborn care; family planning; malaria; nutrition; routine immunizations; and treatment for common childhood illnesses—which can reduce preventable child and maternal deaths.

Over the next seven years, USAID will focus on shaping and supporting policies, practices, and country-led programs that improve the quality of care, promote equity, and improve coverage of lifesaving care to reach optimal levels across local communities and regions. USAID's new strategic framework for preventing child and maternal deaths harnesses the learning and progress of the last decade in six strategic approaches that will yield programmatic improvements and, in turn, save lives.

Together with country and global partners, **the U.S. government is working to significantly reduce child and maternal deaths**, with the goal of all countries having fewer than 20 deaths per 1,000 live births and fewer than 50 maternal deaths per 100,000 live births by 2035.¹

A Call to Action 2012-2022

In 2012, USAID, in partnership with the United Nations Children's Fund (UNICEF) and the governments of India and Ethiopia, convened the Child Survival Call to Action to catalyze global commitments to child survival. More than 175 countries and over 400 civil society and faith organizations pledged to sharpen national plans for child survival, monitor results, and focus greater attention on the most disadvantaged and vulnerable children. The same year, complementary efforts in family planning (now known as Family Planning 2030) and nutrition (Nutrition for Growth Compact) launched, generating expanded commitment and collaboration around critical reproductive, maternal, and child health programming.

In 2014, USAID unveiled a bold framework, Acting on the Call, to save the lives of 15 million children and 600,000 women by 2020. USAID presented country-specific plans for scaling up interventions, including for maternal and child health, nutrition, family planning, and malaria, that would have the greatest impact on child and maternal mortality rates in priority countries. This integrated, systems-based approach was designed to produce

improved and sustainable public health outcomes for women and children. Extensive consultations with bilateral partners, experts, and country leadership informed the 2014 Acting on the Call framework. These global consultations informed the subsequent Sustainable Development Goal targets under goal #3, adopted globally by the United Nations member states in 2015.

The 2014 framework placed great emphasis on envisioning a world in which it was possible to accelerate the scale-up of high-impact interventions in maternal and child survival at rates equal to those previously achieved by "best performers." These projections and targets were set with the optimal conditions for progress in mind. Annual reports tracked progress and explored key challenges and solutions for accelerating progress, including new evidence-based approaches, components of strong health systems, and different dimensions of equity and access. These reports offered an introspective look at opportunities for program design and adaptation. Many of these thematic deep dives are reflected in the new strategic framework for 2023-2030.



Sustainable Development Goals

The United Nations Sustainable Development Goals are the blueprint to achieve a better and more sustainable future for all. Sustainable Development Goal: Good Health and Well-Being includes two specific global targets for maternal and child survival:

- **3.1: Reduce the global maternal mortality ratio to less than 70 per 100,000 live births**
- **3.2: End preventable deaths of newborns and children under 5 years of age**, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births, and under-5 mortality to at least as low as 25 per 1,000 live births²



A DECADE OF SAVING LIVES

PREVENTING CHILD AND MATERNAL DEATHS

Since the 2012 Call to Action, USAID has:



ENABLED
44 MILLION WOMEN
TO GIVE BIRTH IN
A HEALTH FACILITY



REACHED
**33 MILLION
NEWBORNS**
WITH CARE
AFTER DELIVERY



PROVIDED
**115 MILLION
TREATMENTS**
TO CHILDREN FOR
DIARRHEA AND
PNEUMONIA



DELIVERED
**327 MILLION PREVENTIVE
TREATMENTS**
TO PROTECT WOMEN AND
CHILDREN FROM MALARIA IN
PRESIDENT'S MALARIA INITIATIVE
PARTNER COUNTRIES



HELPED
23 MILLION PEOPLE
GAIN ACCESS TO BASIC
DRINKING WATER



TRAINED
**14 MILLION HEALTH
WORKERS**
IN MATERNAL AND
CHILD HEALTH
AND NUTRITION

In 2021, USAID:



REACHED
**27 MILLION WOMEN
AND COUPLES**
WITH VOLUNTARY FAMILY
PLANNING



REACHED
**11 MILLION
PREGNANT WOMEN**
WITH BREASTFEEDING
COUNSELING AND SUPPORT



REACHED
12 MILLION NEWBORNS
WITH POSTNATAL CARE
WITHIN TWO DAYS OF BIRTH



REACHED
31 MILLION CHILDREN
WITH NUTRITION PROGRAMS



PROCURED NETS
TO PROTECT
91 MILLION PEOPLE
FROM MALARIA-CARRYING
MOSQUITOES IN PMI
PARTNER COUNTRIES



In 2021 alone, USAID helped more than **91 million women and children** access essential, often lifesaving, care.

SCALED UP PROVEN, COST-EFFECTIVE INTERVENTIONS

Fig. 1: **LIFESAVING INTERVENTIONS BY THE NUMBERS**

Percent increase in coverage among 25 priority countries, 2012 to 2020

 <p>Four Antenatal Care Visits</p> <p>36%</p>	 <p>Contraceptive Prevalence Rate</p> <p>15%</p>	 <p>Health Facility Delivery</p> <p>58%</p>
 <p>Households with Improved Water Source</p> <p>7%</p>	 <p>Insecticide-Treated-Net Ownership</p> <p>57%</p>	 <p>Measles-Containing Vaccine First Dose</p> <p>12%</p>
 <p>Oral Rehydration Solution</p> <p>25%</p>	 <p>Skilled Attendant at Delivery</p> <p>52%</p>	 <p>Households with Handwashing Station</p> <p>38%</p>

These figures represent the estimated percent change in intervention coverage from 2012 to 2020 based on available data combined with linear projections to 2020 for cases in which 2020 data are not available. The values are weighted by population size.

Sources: Demographic and Health Survey (DHS), Multiple Indicator Cluster Survey (MICS), and/or HIV/AIDS and Malaria Indicator Surveys, WHO-UNICEF Estimates of Vaccine Coverage, UN Population Division for population data.

Since 2001, USAID has contributed approximately \$3.36 billion to Gavi, the Vaccine Alliance, to help **immunize more than 981 million children** and **save more than 23 million lives.**

DEMONSTRATED FINANCIAL COMMITMENT

United States Government’s Investment in Preventing Child and Maternal Deaths

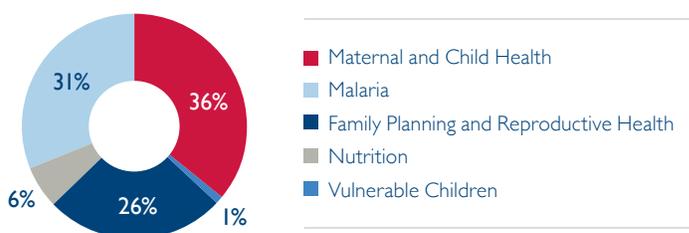
With the support of Congress and the American people, the U.S. government invested more than \$23 billion from 2012 to 2021 in global health programming to prevent child and maternal deaths. Recent research has shown that in countries where USAID has made considerable investments, the Agency has helped countries to reduce preventable child deaths to significantly lower rates than would have occurred without those investments.³

Fig. 2: PRIORITY GLOBAL HEALTH INVESTMENTS, 2012-2021

Department of State and USAID Fiscal Year:	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	TOTAL
(\$ Millions)	8,599	8,420	8,826	9,277	8,841	8,867	8,801	8,939	9,210	9,297	89,077
Preventing Child & Maternal Deaths:	2,285	2,262	2,398	2,534	2,417	2,372	2,363	2,381	2,430	2,399	23,840
Controlling the HIV/AIDS Epidemic:	5,893	5,773	6,000	6,000	6,000	6,000	6,000	6,050	6,260	6,235	60,211
Combating Infectious Diseases:	421	385	428	743	424	495	439	508	520	663	5,026

OUR INVESTMENTS IN PREVENTING CHILD AND MATERNAL DEATHS

Total Fiscal Year 2012-2021 Budget:
\$23,840,000,000

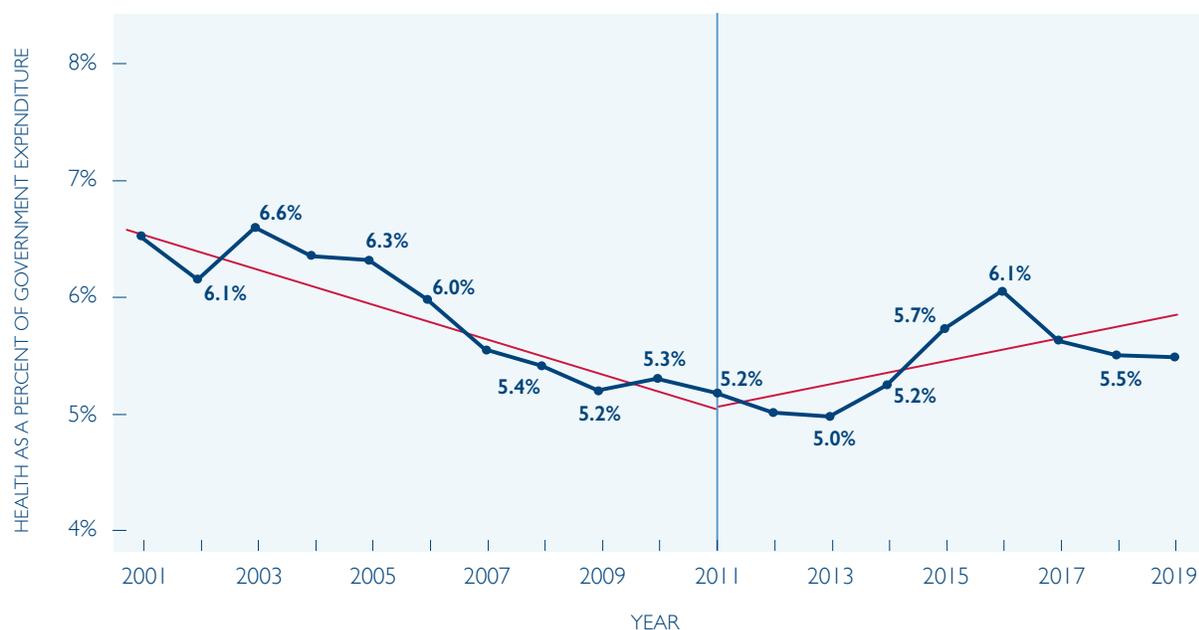


Domestic Resource Mobilization for Health

In USAID's priority countries, governments increased their own investments in health, on average, between 2012 and 2019, reversing the downward trend from prior years. Over the past decade of Acting on the Call, 15⁴ of the 23 priority countries for which government spending data are available to demonstrate the prioritization of health measured by general domestic government spending on health as a percentage of total government spending (Figure 3).⁵ This trend is generally consistent with that observed across all low- and lower-middle-income countries, where the share of government spending on health declined and stagnated, respectively, before rebounding in recent years.⁶

While useful as a foundation for dialogue between health and finance ministries, general domestic government expenditure on health as a proportion of general government expenditure has not kept pace with population dynamics. Over the past decade, per capita health spending increased in 19 of the 24 countries for which data are available.⁷ However, in all but one of the priority countries (Indonesia), per capita health spending in 2019 remained below the recommended \$86 to cover an essential package of services.⁸

Fig. 3: GOVERNMENT SPENDING ON HEALTH REBOUNDS AFTER 2012



Indicator: Domestic general government health expenditure (GGHE-D) as a percentage of general government expenditures (GGE).
 Blue Line: Priority countries average for 2000-2019; Red Line: trend line for periods (a) 2001-2011 and (b) 2012-2019.

Source: World Health Organization (WHO), Global Health Expenditure Database

ADDRESSED COVERAGE BOTTLENECKS

The 2014 framework included an extensive analysis of coverage bottlenecks for maternal and child survival interventions. This analysis helped to guide governments, donors, and partners to review and sharpen national plans to increase coverage of services and care over the last decade. The following examples offer snapshots of how countries are implementing evidence-based programs that address these bottlenecks to deliver results.

HUMAN RESOURCES, QUALITY, MANAGEMENT, AND COORDINATION



ETHIOPIA

In Ethiopia, USAID activities in agrarian and pastoralist regions strengthened capacity for over 11,000 health care providers between 2017 and 2021 to improve quality of basic and emergency obstetric and newborn care, supplemented with clinical mentoring, clinical skills labs, and supportive supervision.



HAITI

Through local organizations, USAID programs in Haiti are supporting the Ministry of Health to manage their financial and human resources for health, growing the health workforce by nearly one-third to a ratio of one health provider for every 1,000 people.



INDIA

USAID provided strategic support for over 250 health facilities in India to achieve state or national quality certification for labor and postpartum care.



GEOGRAPHICAL ACCESS, SERVICE USE, AND CONTINUITY



DEMOCRATIC REPUBLIC OF THE CONGO

USAID programs in the Democratic Republic of the Congo expanded the number of health facilities implementing basic and comprehensive emergency obstetric and newborn care across nine provinces from 410 to 697 during the last two years.



MALAWI

USAID supported an integrated maternal and child health program in 16 of Malawi's districts over the last decade, allowing more than 2 million people to access essential services for immunization, maternal and newborn care, family planning, HIV testing and counseling, nutrition, and malaria, through more than 10,000 clinics.



MALI

The USAID-led U.S. President's Malaria Initiative supported Mali to spray homes with insecticide, protecting more than 270,000 people in 2022 from malaria-carrying mosquitoes, including 50,000 children under age 5. Malaria services like these have contributed to a 25 percent drop in Mali's under-5 mortality rate from 2012 to 2020.



SOCIAL NORMS AND THE AVAILABILITY OF COMMODITIES



MOZAMBIQUE

With USAID support, government of Mozambique programs for community-based management of acute malnutrition and maternal iron/folate supplementation and deworming contributed to a decrease in stunting from 43 percent in 2012 to 38 percent in 2021.



NEPAL

USAID programs in Nepal promoted sanitation and hygiene behaviors, particularly handwashing and water treatment, through home visits to 113,853 households in 2021.



PAKISTAN

In Pakistan, USAID worked with private-sector partners to adopt the use of chlorhexidine gel for umbilical cord care and to produce chlorhexidine in the country using local manufacturers.



SOUTH SUDAN

In the last three years, USAID-supported programs in South Sudan have increased the number of women receiving uterotonic medications in the third stage of labor by more than 60 percent.

POLICIES AND LEGISLATION



NIGERIA

In 2020, USAID programs succeeded in adding gender-based violence (GBV) indicators to Nigeria's National Health Management Information System so that GBV clients can be identified through routine services for antenatal care, labor and delivery, and child welfare.



RWANDA

In Rwanda, USAID programs worked with the Ministry of Health, an association of private pharmacists, and other stakeholders to allow pharmacists to administer injectable contraceptives, significantly improving access to this family planning method.



ZAMBIA

In Zambia, USAID supported the development of COVID-specific guidelines for reproductive, maternal, newborn, child, and adolescent health and nutrition to ensure continuity of services during the pandemic.

ACCELERATING MATERNAL AND CHILD SURVIVAL THROUGH PRIMARY HEALTH CARE

With integrated primary health care services, every health care touch point is an opportunity to identify and deliver care that promotes good health for women, children, and families, at every stage in life.

Pregnancy and Childbirth

Through primary health care, women receive at least 8 antenatal contacts, skilled attendance at birth, and postnatal monitoring. These services are proven to improve outcomes for women and infants.

Newborn

Primary health care supports a healthy start for newborns through breastfeeding counseling, routine immunization, and timely and accurate monitoring for complications, illness, and hygienic care practices.



Childhood

Primary health care promotes child health through routine immunizations, nutrition counseling, and the prevention and treatment of common childhood illnesses—including malaria, pneumonia, and diarrhea.

Adolescents and Youth

As children progress into adolescence, primary health care services deliver routine immunization and help to prevent and treat illness and infectious disease. Nutrition along with water, sanitation, and hygiene programs, keeps adolescents in good health for academic success, while family planning programs equip them with the knowledge and means to delay childbearing.

Adulthood

In adulthood, primary health care delivers family planning and reproductive health services, allowing women and couples to plan and space their pregnancies, reduce high-risk pregnancies, and achieve their desired family size.



- ▶ Primary health care referrals connect women, newborns, and children to specialized care such as managing high-risk pregnancies and births, care for small and sick newborns, and treatment for malnutrition or severe illness in children.



BENCHMARKING PERFORMANCE

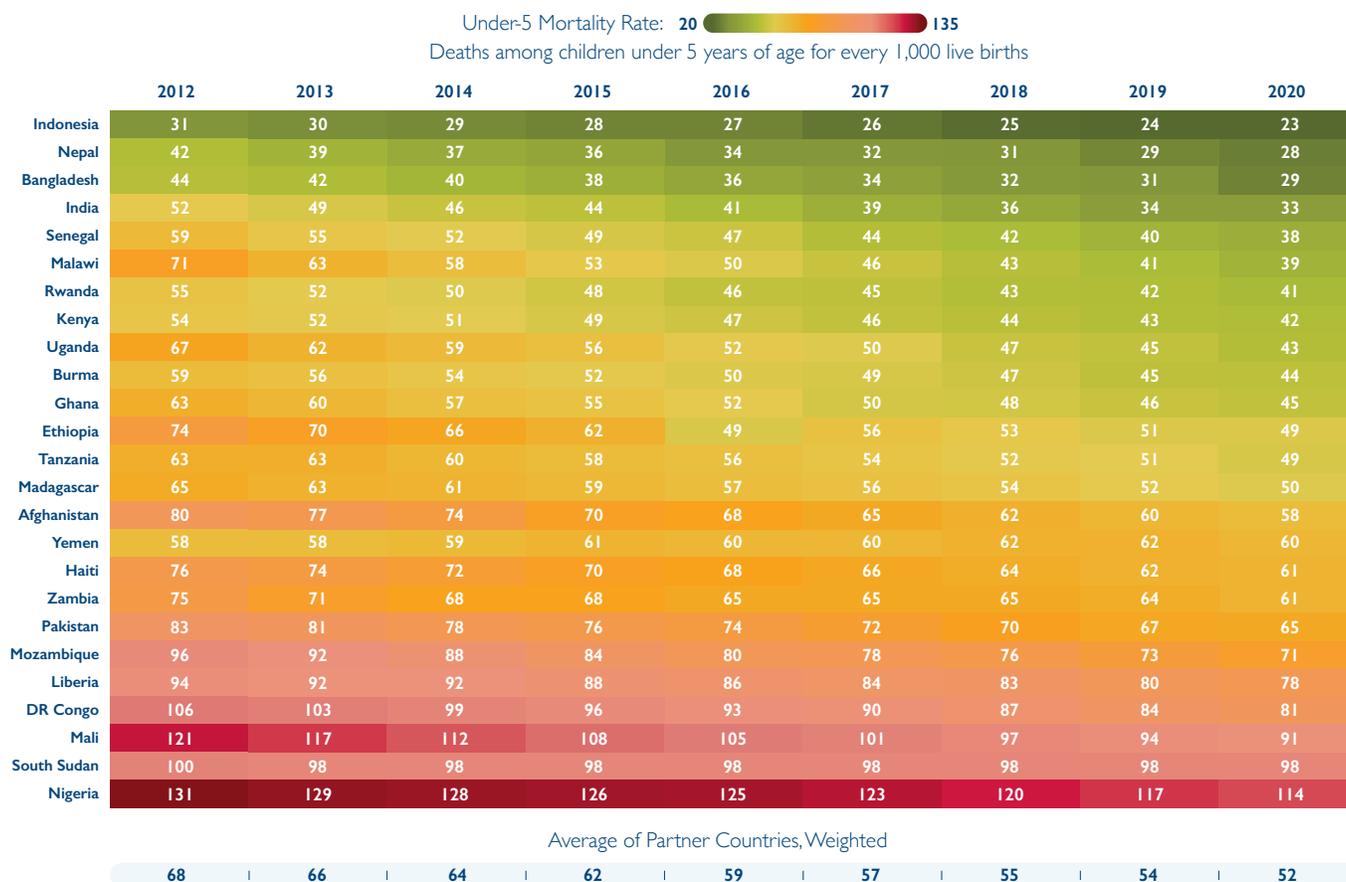
Nearly all of USAID's 25 priority countries have made progress toward their SDG targets for reducing child and maternal mortality. As shown in Figure 4, this progress was steady but incremental. Countries did not achieve the "best performer" levels of reduced mortality targeted in the 2014 Acting on the Call framework, yet the data illustrate meaningful gains in survival.

In many places, progress towards the targets has slowed or even stagnated and is at risk of backsliding due to the impact of COVID-19, conflict, climate change, and other emerging diseases on health systems, economies, livelihoods, and rates of sexual and gender-based

violence. The following analyses compare data by country for child, newborn, and maternal mortality from 2012, the most recent year available, and a projection to 2030. They also note where the SDG target falls, illustrating which countries are on track to achieve their SDG targets. These data also show that most of these countries are not on track to achieve the SDG targets for child and maternal survival. In many cases, the most recent data available was collected prior to the COVID-19 pandemic. These will provide the baselines for country action in the years to come.



Fig. 4: **UNDER-FIVE MORTALITY HAS DECLINED IN PARTNER COUNTRIES**
 Countries show incremental yet steady progress over the last decade in reducing child mortality



Source: UN IGME 2021: United Nations Inter-agency Group for Child Mortality Estimation (UN IGME), "Levels & Trends in Child Mortality: Report 2021, Estimates Developed by the United Nations Inter-agency Group for Child Mortality Estimation," United Nations Children's Fund, New York, 2021. UN Population Division for population data used to weight the average across countries.

CHILD MORTALITY

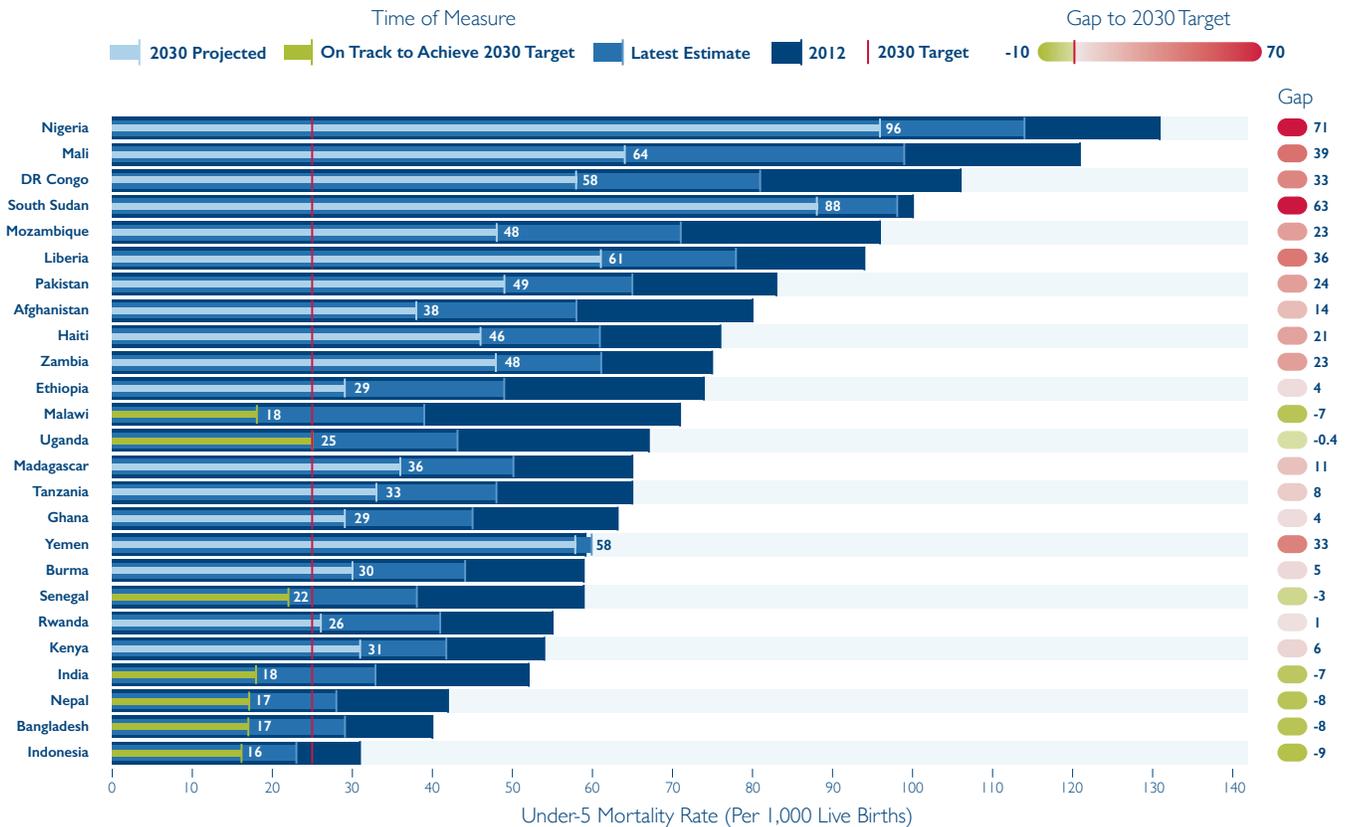
Pneumonia, diarrhea, and malaria continue to be the leading causes of child mortality. Additionally, around 45 percent of deaths among children under 5 years of age are linked to undernutrition. These deaths are largely preventable. USAID programming has focused on childhood vaccination, dietary counseling, micronutrient supplementation in pregnancy and childhood, breastfeeding, and the prevention and treatment of diarrheal illness, malaria,⁹ and malnutrition. Many of these interventions are part of the integrated management of childhood illness (IMCI) that USAID helped countries to adopt as the standard of care to prevent childhood deaths. These gains, however, are at risk of backsliding, particularly due to pandemic-related disruptions. In 2021, 25 million children missed

out on basic childhood vaccines through routine health services—6 million more than in 2019, with coverage levels declining to the lowest in three decades.¹⁰ Experts predict that by the end of 2022, an additional 13.6 million children will have suffered from wasting and 3.6 million more children will be stunted due to pandemic-related disruptions to food and health systems.¹¹

Since 2021, Malawi has made the most significant progress in reducing under-5 mortality. It has reduced mortality for this age group by 45 percent since 2012 and is projected to achieve the SDG target of fewer than 25 deaths per 1,000 live births. Bangladesh, India, Indonesia, Nepal, Senegal, and Uganda also are projected to meet or exceed the SDG target.



Fig. 5: UNDER-FIVE MORTALITY: PROGRESS AND PROJECTIONS



Estimates for children under five years of age and newborns are produced by the UN Inter-agency Group for Child Mortality Estimation (IGME). IGME, established by the United Nations, 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 fits a smoothed trend curve to a set of observations and uses that to predict a trend line that is extrapolated to a common reference year; in this case 2020. The under-five mortality rate 2030 target for all countries is 25 per 1,000 live births or lower. The ovals to the right of the graph show the gap between the 2030 target of 25 and the expected USMR value in 2030 given current trends, where red indicates a value farther from the target and green indicates achieving the target.

Source: UN Inter-agency Group for Child Mortality Estimation (IGME)

In 2021, five million children died before their fifth birthday.

Adequate nutrition, vaccinations, and the prevention and treatment of common childhood diseases could save countless child lives.

NEWBORN MORTALITY

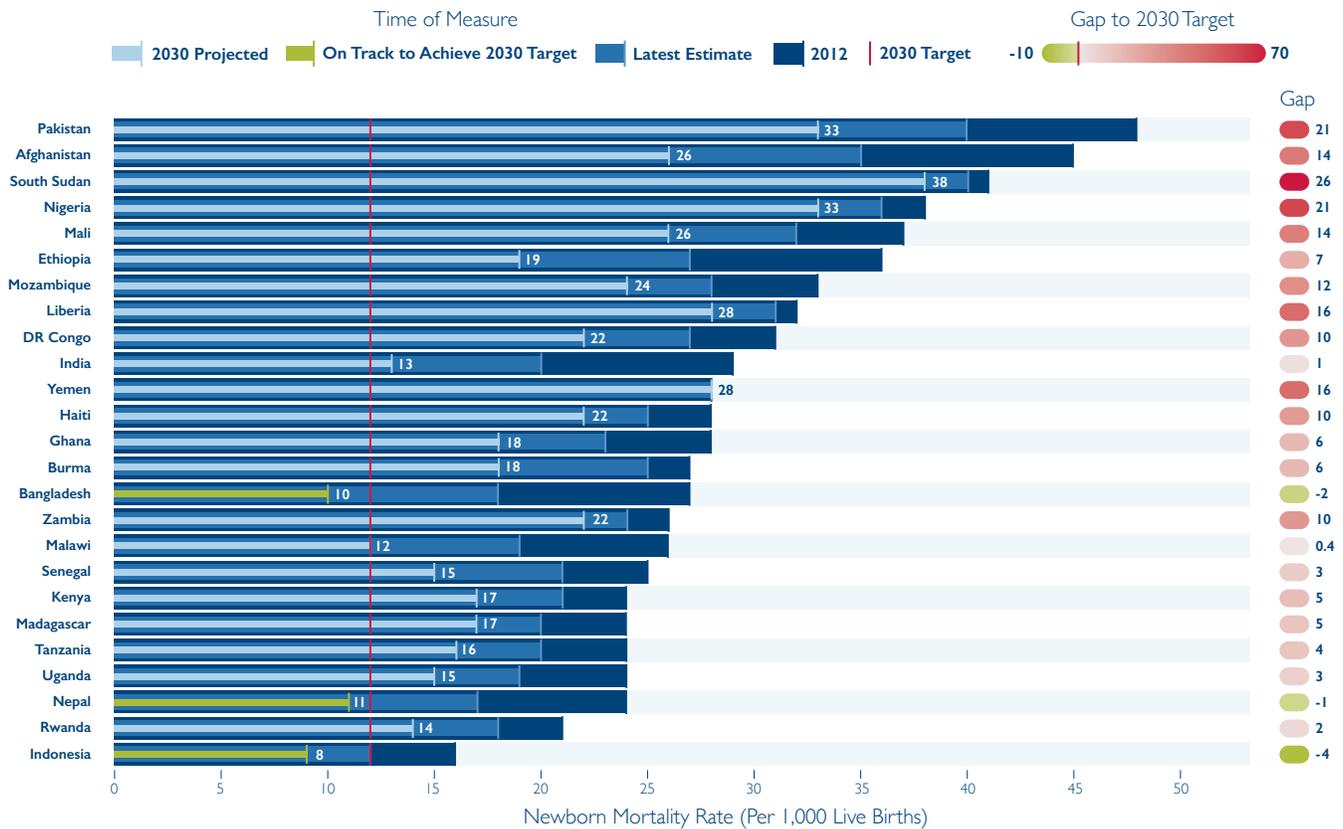
In 2012, three causes accounted for more than 80 percent of neonatal mortality: complications of prematurity, intrapartum complications such as birth asphyxia, and neonatal infections. Care around the time of birth could avert about a third of neonatal deaths. Over the last decade, USAID supported key interventions to save newborn lives, including skilled attendance at birth, emergency obstetric care, immediate care for every newborn baby (including breastfeeding support and clean birth practices such as cord and thermal care), newborn resuscitation, and management of possible serious bacterial infections, even where referrals are not feasible. In many countries,

USAID helped create “newborn corners” in health facilities, stocked with essential newborn care and resuscitation equipment, medicines, and job aids.

Since 2012, Bangladesh and India have made the greatest progress in reducing neonatal mortality, though India is projected to be just short of the SDG target of 12 newborn deaths per 1,000 live births under the current rate of reduction. Indonesia has already met the SDG target, and Nepal is on track to achieve the target by 2030. All other countries, except Yemen, have made significant progress over the last decade, but are not expected to meet the target.



Fig. 6: NEWBORN MORTALITY: PROGRESS AND PROJECTIONS



Estimates for newborns are produced by the UN Inter-agency Group for Child Mortality Estimation (IGME). IGME, established by the United Nations, 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 neonatal mortality. To do so, IGME fits a smoothed trend curve to a set of observations and uses that to predict a trend line that is extrapolated to a common reference year; in this case 2020. The under-five mortality rate 2030 target for all countries is 25 per 1,000 live births or lower. The ovals to the right of the graph show the gap between the 2030 target of 12 and the expected NMR value in 2030 given current trends, where red indicates a value farther from the target and green indicates achieving the target.

Source: UN Inter-agency Group for Child Mortality Estimation (IGME)

Newborns represent nearly half of deaths among children under five years of age. Access to basic lifesaving interventions such as skilled delivery at birth, postnatal care, and breastfeeding could save many of these young lives.

MATERNAL MORTALITY

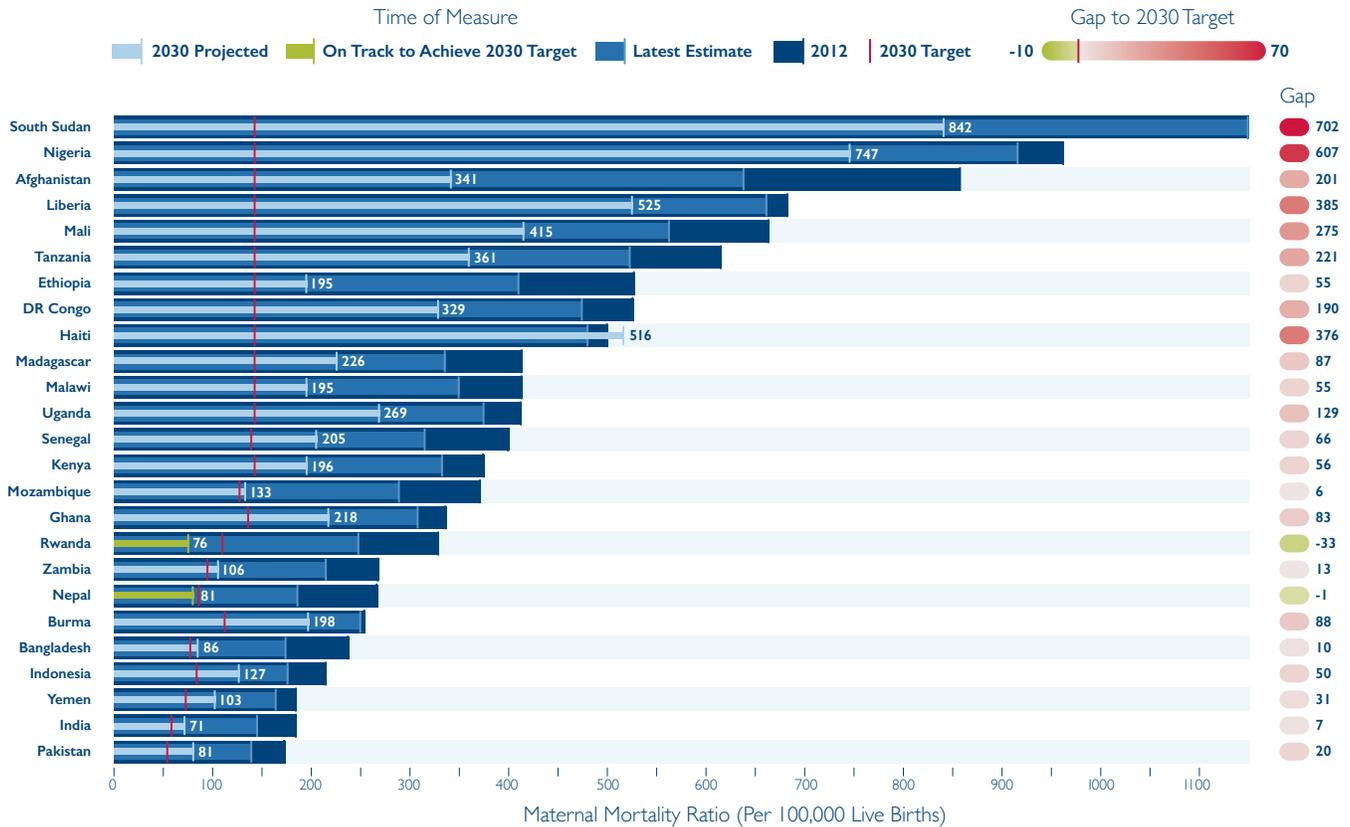
Postpartum hemorrhage, the leading cause of maternal mortality, accounts for 27 percent of all deaths. Preexisting medical conditions aggravated by pregnancy cause another quarter of maternal deaths. Hypertensive disorders of pregnancy, sepsis, embolism, and complications of unsafe abortion also claim a substantial number of maternal lives. Nearly all maternal deaths can be prevented by skilled health personnel—doctors, nurses, or midwives—who have training, support, equipment, and supplies, and can refer women to emergency obstetric care where and when necessary. USAID investments

have expanded the active management of the third stage of labor to prevent postpartum hemorrhage, delivering training and medicines and strengthening supply chains to save lives. USAID programs have increased antenatal care, facility delivery, and skilled birth attendance, while also strengthening provider skills to deliver quality and respectful maternal care.

Only two countries, Nepal and Rwanda, are projected to achieve their country-specific targets for the maternal mortality ratio (MMR). South Sudan has seen an increase in MMR since 2012, while maternal deaths in Haiti are projected to rise again after a drop since 2012.



Fig. 7: MATERNAL MORTALITY: PROGRESS AND PROJECTIONS



Maternal Mortality
Historic Trends
and Global
2030 Targets

Historic Trends: The numbers and ratios of maternal deaths to live births were obtained from the United Nations Maternal Mortality Estimation Inter-agency Group (MMEIG); this works in a similar way to IGME estimates described above. The MMEIG shares and harmonizes data on maternal mortality in order to provide internationally comparable maternal mortality ratio estimates, up to 2017 in the latest report.

Global 2030 Targets: The 2030 global maternal mortality target is a reduction in the global average for the maternal mortality ratio to less than 70 deaths per 100,000 live births, with no individual country exceeding a maternal mortality ratio of 140 maternal deaths per 100,000 live births. A 2030 maternal mortality ratio target calculator has been provided by the World Health Organization (WHO) to help countries calculate their 2030 target. A reduction of 7.6 percent per year is required to bring the 2015 global average of 219 per 100,000 live births down to a global average of 70 by 2030. The 2015 maternal mortality ratio estimates for each country, which are used to calculate the 2030 target, come from the Maternal Mortality: Levels and Trends 2000 to 2017 Report. Each country should apply its 2015 maternal mortality ratio value along with a 7.6 percent annual rate of reduction to identify its maternal mortality ratio target. If the calculated MMR target is greater than 140, then 140 per 100,000 live births should be substituted for the target value.

Source: United Nations Maternal Mortality Estimation Inter-agency Group (MMEIG)

A maternal death occurred almost every two minutes in 2020.

Care before, during, and after childbirth by a skilled health professional could prevent nearly all these deaths.

COVERAGE OF INTERVENTIONS

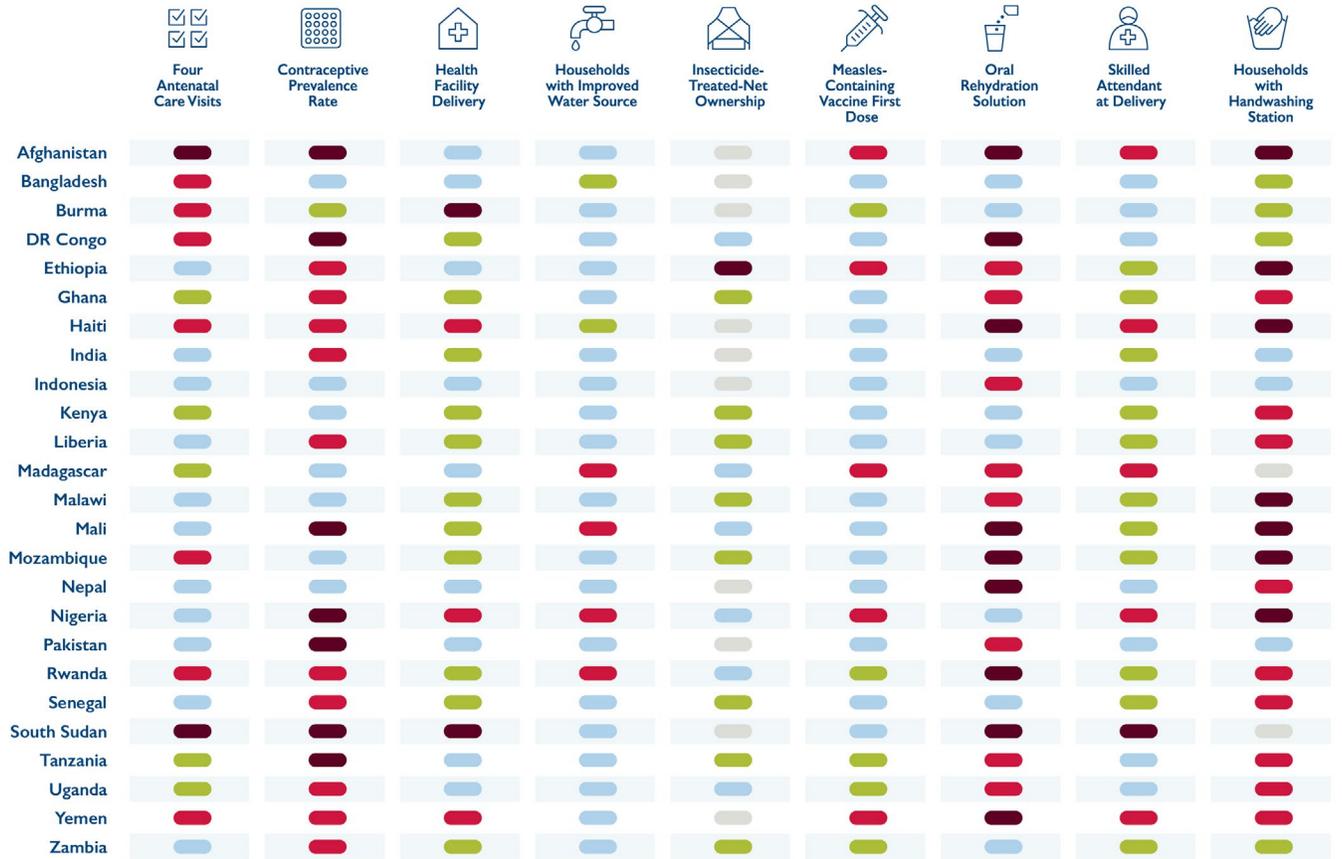
The 2014 Acting on the Call framework set targets for 2020 for a range of health interventions. These targets were identified using the Lives Saved Tool to model “best performer” scenarios, creating ambitious goals for what countries could achieve by scaling up performance to the best theoretically possible level, defined by the best-performing comparable country sustained over time. The dashboard on the following page presents an “at-a-glance” overview of country achievement for priority interventions as of the latest available data. USAID’s 25 priority countries range from high performers in need of specialized

institution-building technical support to countries in crisis that depend on lifesaving basic service support. Some priority countries have achieved notable results, while others have made little headway or seen setbacks.

Most countries did not achieve their targets for intervention coverage. Health facility delivery, ownership of insecticide-treated mosquito nets, and skilled birth attendance are the three interventions for which more than a handful of countries achieved their targets. No countries achieved their targets for the use of oral rehydration salts for diarrhea – nearly half were less than 50 percent.



Fig. 8: PERCENTAGE OF COVERAGE TARGET ACHIEVED FOR PRIORITY INTERVENTIONS



Target-achieved measures are based on comparing individual 2020 country targets for intervention coverage set under the 2014 Act on the Call framework with 2020 estimates, combined with linear projections to 2020 using most recent data available up to 2020 in the case that 2020 data are not available.

Sources: Demographic and Health Survey (DHS), Multiple Indicator Cluster Survey (MICS), and/or HIV/AIDS and Malaria Indicator Surveys, WHO-UNICEF Estimates of Vaccine Coverage, UN Population Division for population data.



UNPACKING INEQUITIES IN COVERAGE

Focusing on the national averages obscures the inequities that exist for these interventions in many countries. Income, geographic location, education, ethnic or religious group, age, and/or disability can all lead to inequities in use of health services and in health outcomes. Evidence suggests that the COVID-19 pandemic exacerbated inequities such as these between and within countries.

Wealth inequities exist across countries and across programmatic areas. For maternal and child health, skilled birth attendance is the most inequitable intervention, with the wealthiest 20 percent of the population approaching universal coverage in many countries. In Nigeria and Madagascar the disparity in skilled birth attendants (SBA) between the wealthiest and poorest is upwards of 70 percentage points. Malawi, on the other hand, offers a rare example of a country approaching equity in SBA, with a disparity of only 13 percentage points between the wealthiest and poorest populations.

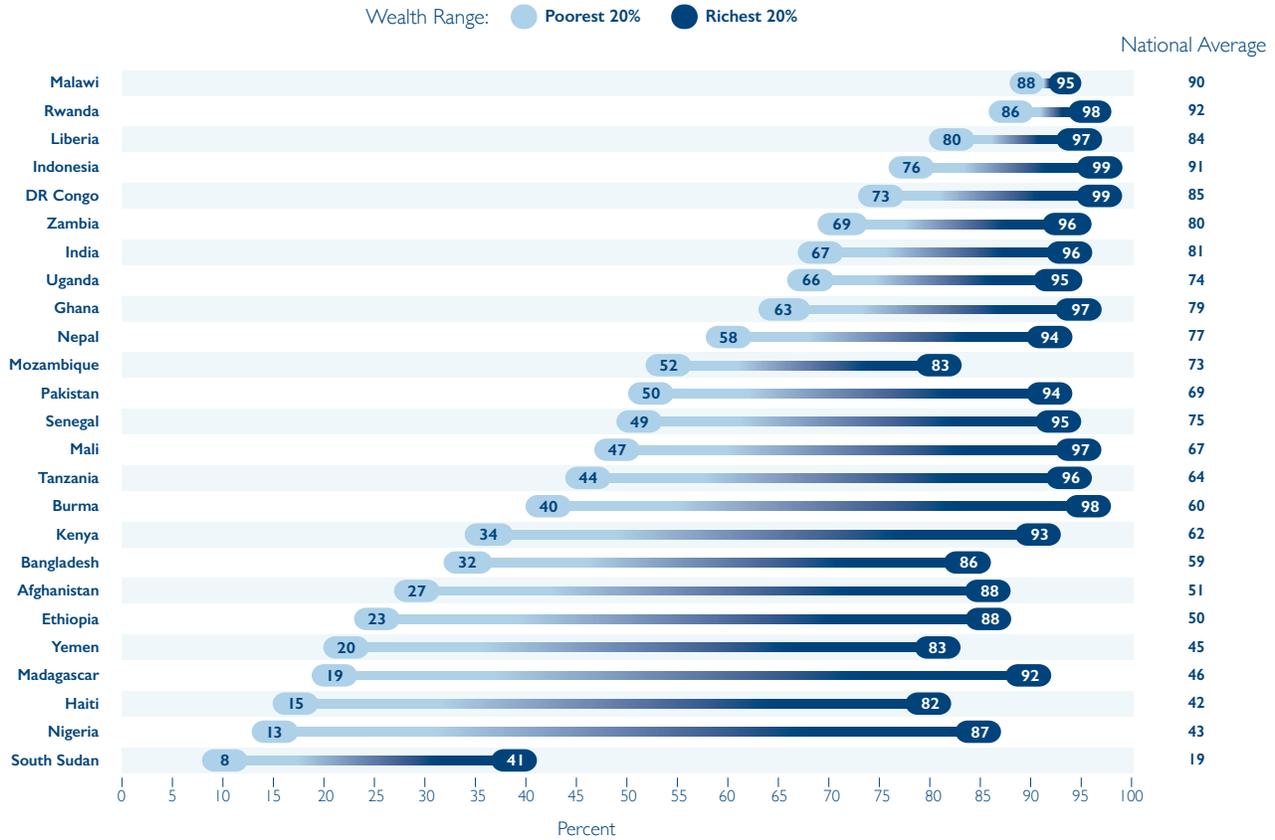


“Primary health care is the essential scaffolding for achieving equity in how long people can hope to live and how much burden of disease they must endure.

— DR. ATUL GAWANDE,
ASSISTANT ADMINISTRATOR,
BUREAU FOR
GLOBAL HEALTH, USAID



Fig. 9: **INEQUITY IN SKILLED BIRTH ATTENDANCE**
 Skilled birth attendance is inequitable across countries



Countdown to 2030 has prepared equity profiles that show disparities in coverage levels of effective interventions across the continuum of care for reproductive, maternal, newborn, child and adolescent health and nutrition—here disaggregated by poorest and richest wealth quintiles, a simple measure of wealth inequality—in USAID priority countries with a recent DHS or MICS survey.

Source: Countdown to 2030 equity profiles that compile publicly available data from Demographic and Health Survey (DHS), Multiple Indicator Cluster Survey (MICS), HIV/AIDS and Malaria Indicator Surveys and/or other national surveys.

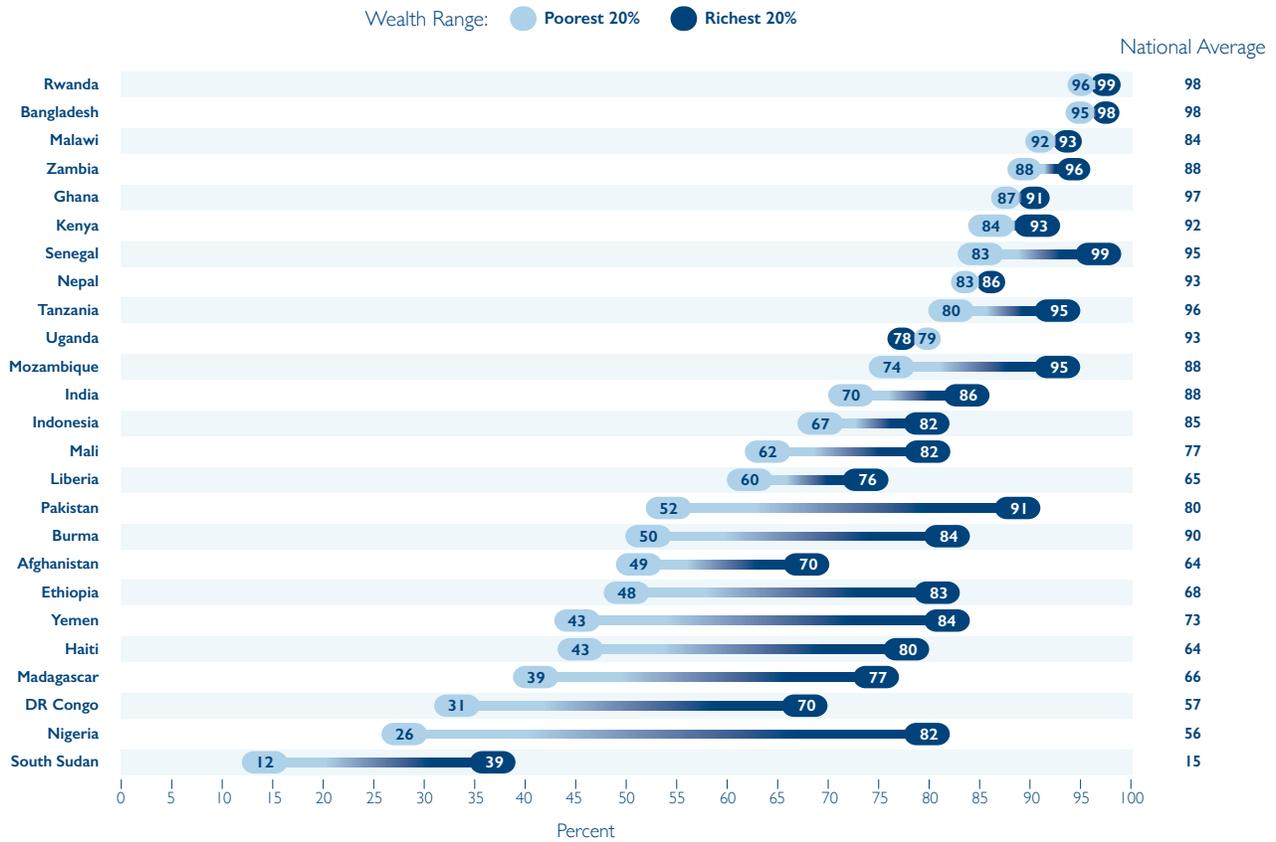
“An equitable health system affords every individual a fair opportunity to attain their highest level of health regardless of social or demographic factors, with particular emphasis on underserved, socially excluded, and vulnerable populations.

— USAID VISION FOR HEALTH SYSTEM STRENGTHENING 2030

The child immunization indicator for DTP3 (diphtheria, tetanus, and pertussis) at age one year illustrates that similar inequities hold true for child health interventions. Most countries see a significant divide between the proportion of the wealthiest and poorest one-year-olds vaccinated against DTP3. In the Democratic Republic of the Congo, Madagascar, Nigeria, and Yemen, upwards of 70 percent of the wealthiest children are vaccinated, while less than 40 percent of the poorest are. National averages between 56 and 73 percent in these countries mask the severity of need among the poorest communities to protect children. On the other hand, Bangladesh, Rwanda, Ghana, and Uganda all have immunization rates that differ by less than five percentage points between the poorest and wealthiest groups, illustrating that equity is a realistic goal when countries make it a priority.



Fig.10: **INEQUITY FOR DTP3 IMMUNIZATION**
 Inequity for DTP3 immunization varies across countries



Countdown to 2030 has prepared equity profiles that show disparities in coverage levels of effective interventions across the continuum of care for reproductive, maternal, newborn, child and adolescent health and nutrition—here disaggregated by poorest and richest wealth quintiles, a simple measure of wealth inequality—in USAID priority countries with a recent DHS or MICS survey.

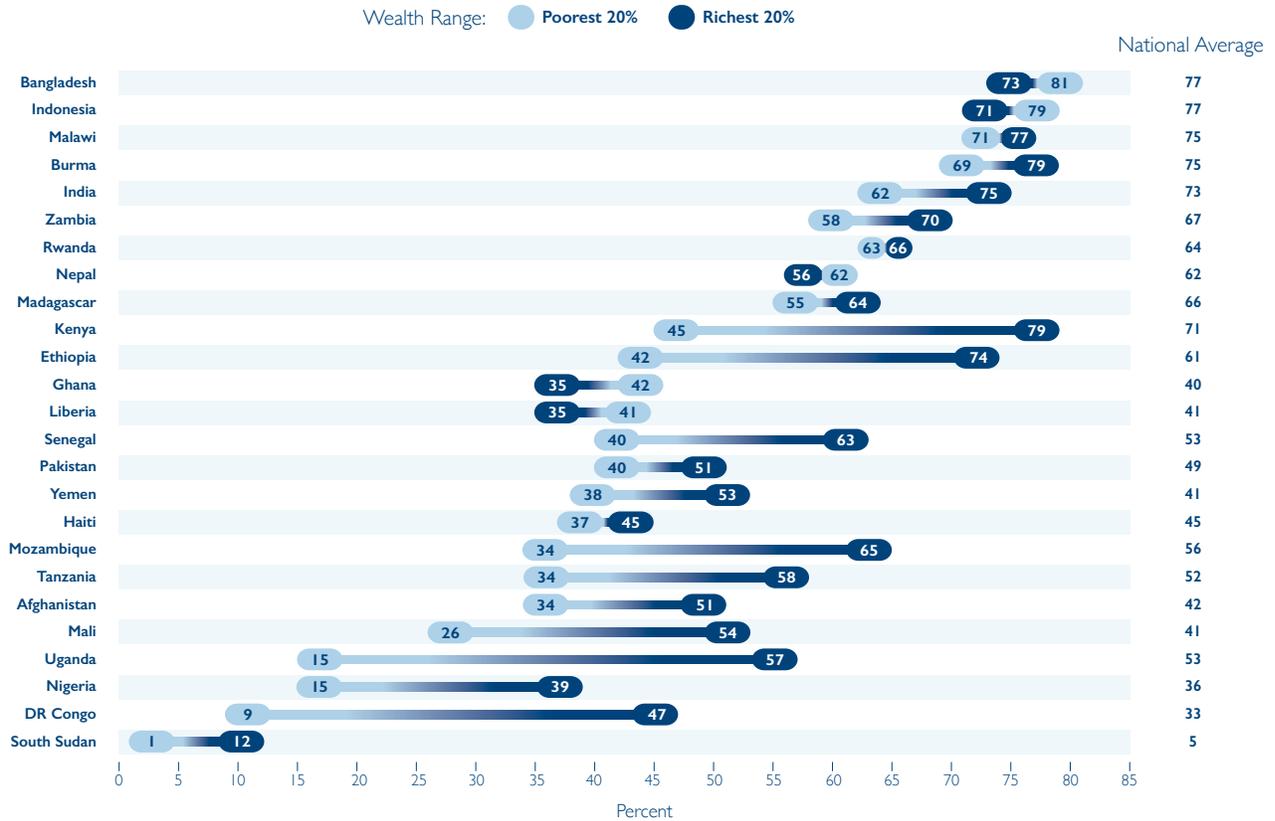
Source: Countdown to 2030 equity profiles that compile publicly available data from Demographic and Health Survey (DHS), Multiple Indicator Cluster Survey (MICS), HIV/AIDS and Malaria Indicator Surveys and/or other national surveys.

Equity within reach is also illustrated by measuring the demand for family planning satisfied by modern methods of contraception (demand satisfied). Over the last decade, family planning programs have made concerted efforts to overcome the barriers posed by poverty and to reach the poorest, most hard-to-reach populations. Comparing the poorest and wealthiest 20 percent of populations highlights countries (Bangladesh, Ghana, Indonesia, Liberia, and Nepal) in which the demand-satisfied rate is higher among the poorest 20 percent than the wealthiest 20 percent, illustrating that reducing inequity is possible when programs focus on that outcome. This pattern is not consistent, however, as illustrated by DRC, Ethiopia, Kenya, Mozambique, and Yemen, where there is a gap of 30 percentage points or more between the demand satisfied for the poorest 20 percent and the wealthiest 20 percent.

These examples illustrate the importance of continuing to examine data fully, looking beyond national averages to identify populations not being reached or at risk of being left behind. Wealth is just one measure of inequality, among others, that impacts access to preventing child and maternal deaths services and must be effectively addressed through a concerted and expanded focus on equity going forward. Geographic considerations are critical and can present a paradox in terms of equity. Women and children living in urban areas usually fare better when compared to those living in rural communities. However, country-level data can mask inequities within higher-density areas. For example, the urban poor often face challenges in accessing or affording health care, particularly in places where the infrastructure and services cannot keep pace with rapid population growth. Quality and timely data at national and subnational levels are crucial for countries to identify the populations most in need of services and explore adaptations or interventions that will most effectively reach those groups.



Fig. 11: **INEQUITY IN DEMAND FOR FAMILY PLANNING SATISFIED WITH MODERN METHODS**
 Demand satisfied is higher among the poorest than the wealthiest in some countries



Countdown to 2030 has prepared equity profiles that show disparities in coverage levels of effective interventions across the continuum of care for reproductive, maternal, newborn, child and adolescent health and nutrition—here disaggregated by poorest and richest wealth quintiles, a simple measure of wealth inequality—in USAID priority countries with a recent DHS or MICS survey.

Source: Countdown to 2030 equity profiles that compile publicly available data from Demographic and Health Survey (DHS), Multiple Indicator Cluster Survey (MICS), HIV/AIDS and Malaria Indicator Surveys and/or other national surveys.

DENSITY OF HEALTH WORKERS

In all of USAID's priority countries, there is a shortage of skilled health workers, including clinicians, community health and care workers, and public health professionals. Population growth, coupled with longer life expectancy and changes in the patterns of disease, has increased the global demand for skilled providers. The COVID-19 pandemic introduced additional challenges for health workers faced with the increased burden of disease, the secondary effects of diverting health care resources and overburdening health workers, and the mental and emotional stress of providing care in uncertain times or with limited personal protective equipment. Insufficient coverage of health workers continues to hinder equitable access to, and quality of, essential, lifesaving interventions such as safe pregnancy and delivery packages, counseling and support for breastfeeding, childhood immunization, voluntary family planning, and prevention of and treatment for HIV/AIDS and malaria.

Only one of USAID's partner countries, Indonesia, even approaches the global median of 48.6 skilled health workers per 10,000 people,¹² while the majority fall well below half of that recommendation. Sustained improvement in maternal and child survival is not achievable without increasing the number and equitable distribution of health workers with the critical skills needed to provide quality, respectful care. Increasing the number of health workers at the community level is essential to reach rural and "last mile" communities to expand equitable access to lifesaving interventions.



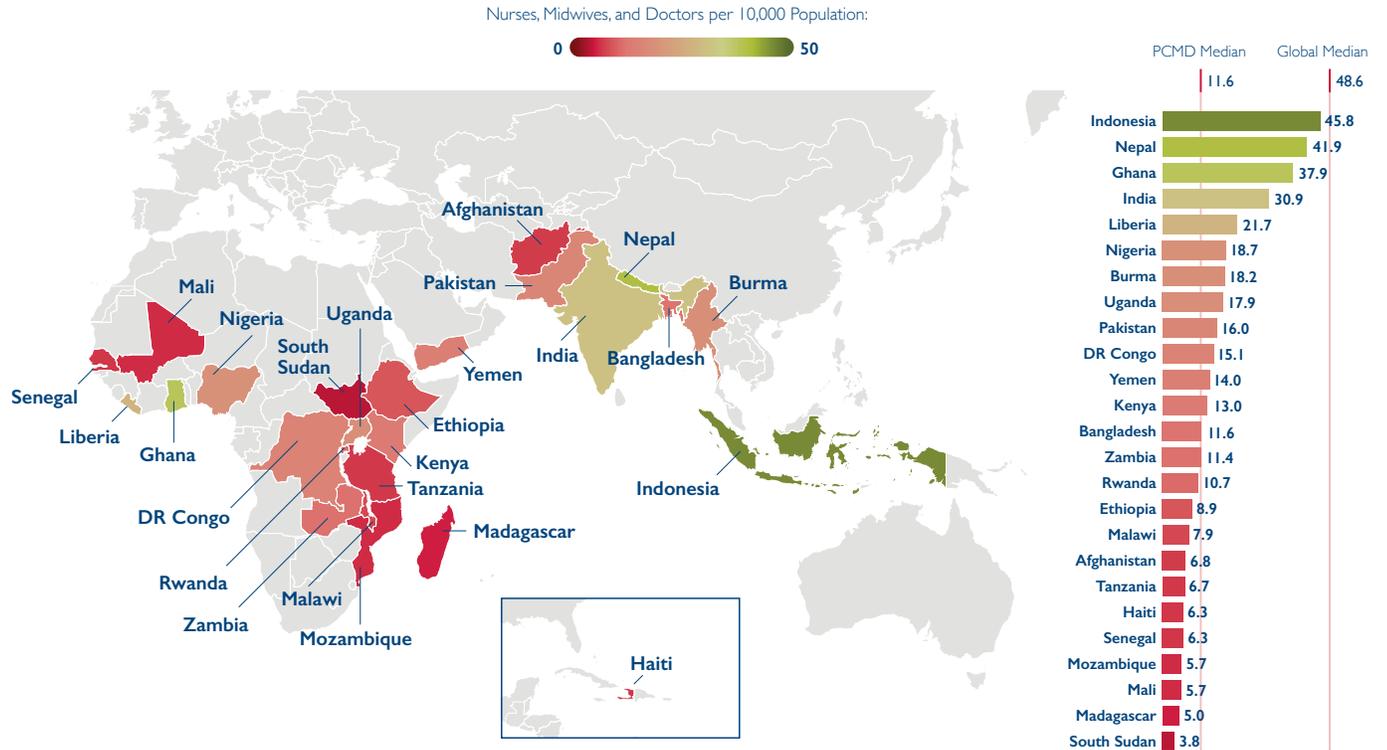
“A comprehensive, trained, protected, well-equipped, and supported workforce is foundational to expanding equitable access to public health services and health care across the globe.

— WHITE HOUSE FACT SHEET,
GLOBAL HEALTH WORKER
INITIATIVE, MAY 11, 2022



Fig. 12: HEALTH WORKFORCE DENSITY

Partner countries all fall below the global median of 48.6 health workers per 10,000 people



Definition of health workforce density: The total number of physicians, nursing and midwifery personnel per 10,000 population. The indicator is calculated by dividing the aggregate numbers of physicians, nursing and midwifery personnel by the country population estimate. For each country the latest available year data was used.

Source: WHO Global Health Workforce Statistics database || <https://www.who.int/data/gho/data/themes/topics/health-workforce>.

UNDERSTANDING HOW THE COVID-19 PANDEMIC HAS CHANGED THE GLOBAL HEALTH LANDSCAPE

The COVID-19 pandemic reshaped lives, health systems, and economies around the globe in ways that are still being revealed. The pandemic not only increased excess deaths but disrupted health services and health behaviors, deepening inequalities that already existed. A recent *Lancet* paper indicates that there may have been up to 18 million excess deaths during the pandemic.¹³ A large share of these deaths were attributed to disruptions of essential services, including those for women, newborns, and children. The majority of USAID partner countries lack quality vital registration data that are timely and nationally representative, limiting our ability to track pandemic-related impacts on mortality, yet we expect that continued disruptions in the use of essential services will negatively impact mortality. The pandemic has undeniably underscored the need for more resilient health systems as we continue to see widespread service and supply chain disruptions, the redeployment of staff despite workforce shortages, and dampened community demand for care due to fear or misinformation.

Sustaining and advancing health systems in light of COVID-19 requires an approach that strengthens the current capacity of the health system to respond to novel threats while continuing to deliver essential functions and services. USAID is supporting countries to strengthen integrated health system functions, especially around primary health care as the foundation of a strong health system, supporting system resilience and capacity to respond to the critical needs posed by COVID-19 and future pandemics. USAID investments balance and support both the urgent needs of the COVID-19 response and the needs of the overall health system to improve long-term population health outcomes.







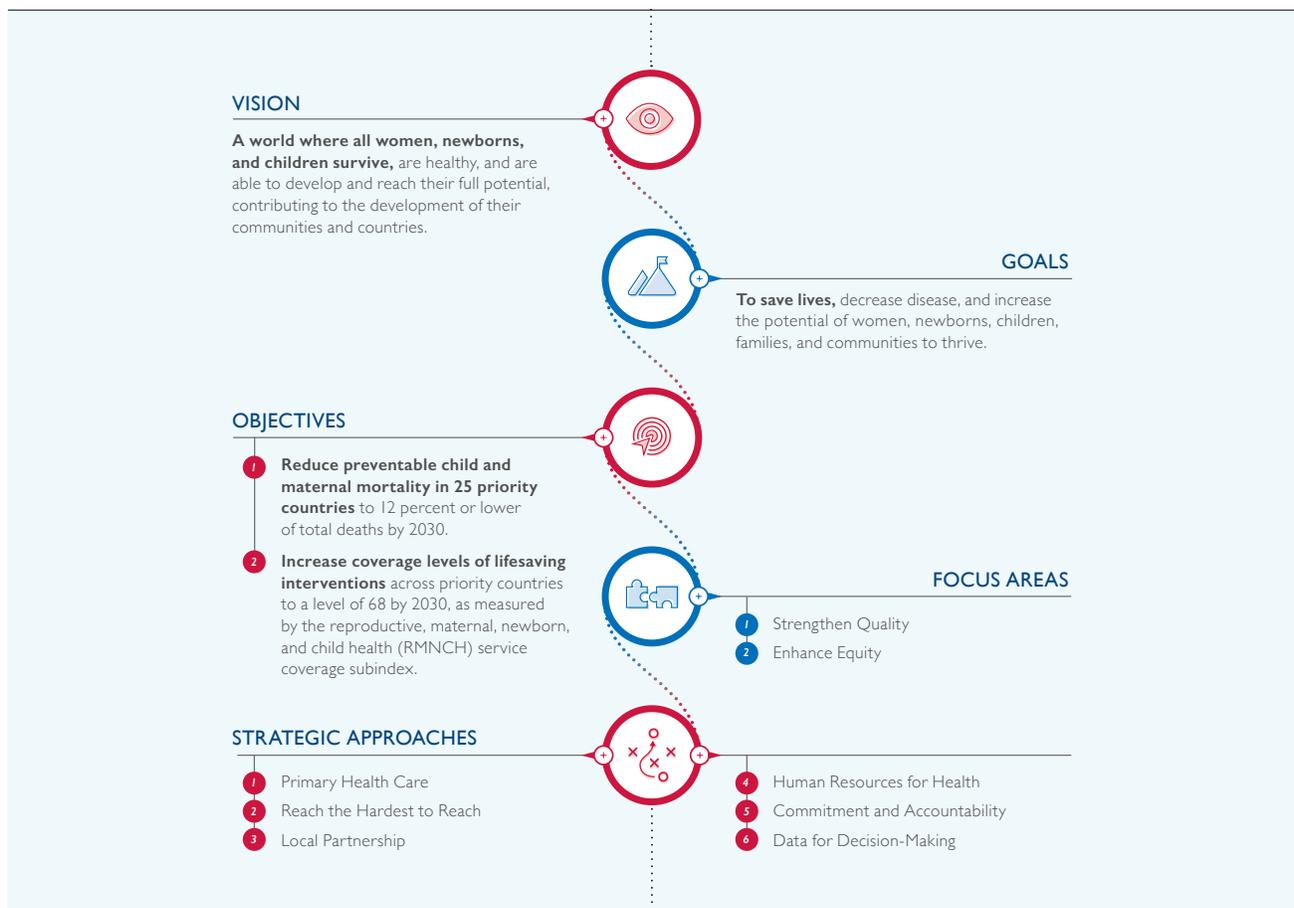
A STRATEGIC FRAMEWORK: 2023-2030

The Preventing Child and Maternal Deaths framework for 2023-2030 builds on the achievements and lessons learned under the 2014 framework. This strategic framework will guide the collaborative efforts of USAID’s Bureau for Global Health across the Office of Maternal and Child Health and Nutrition, the Office of Population and Reproductive Health, and the Office of Health Systems. Consistent with the U.S. President’s Malaria Initiative U.S. Government Malaria Strategy 2021-2026, PMI will also contribute in joint-partner countries to provide continued integrated support to countries to achieve the SDGs.

When USAID launched the 2014 Acting on the Call framework for accelerating progress on preventing child and maternal deaths, we set ambitious country-level targets for progress. These targets were based on projections with the optimal conditions for progress in

mind. Yet over the last decade, many partner countries have experienced far from optimal conditions—recurring conflict and political strife, poor governance, infectious disease outbreaks, natural disasters, and devastation from the global COVID-19 pandemic all impeded progress.

Now more than ever before, USAID recognizes the need to meet communities in our partner countries where they are on the development continuum. The objectives included in our new strategic framework are designed to better capture the Agency’s overall efforts, with less emphasis on country-by-country measures. We believe these objectives are still ambitious but are also feasible and realistic given the complexity of challenges our partner countries will likely continue to face in the coming years.





VISION

USAID envisions a world where all women, newborns, and children survive, are healthy, and are able to develop and reach their full potential, contributing to the development of their communities and countries.



Perhaps most importantly, we have to focus on driving development progress, not simply development programs, building on past efforts to spur catalytic investments and bring in new partners to our work.

— USAID ADMINISTRATOR SAMANTHA POWER



GOALS

To save lives, decrease disease, and increase the potential of women, newborns, children, and communities to thrive.

OBJECTIVES

The following objectives were selected as proxy measures based on the availability of data across the 25 priority countries for preventing child and maternal deaths and the fact that these measures capture the strength of a country's health system to deliver maternal and child health services even in the face of shocks and stressors.

To achieve the objectives defined below, countries will need to make significant progress in expanding coverage of lifesaving, maternal, newborn, and child health, nutrition, malaria, and reproductive services to reduce child and maternal mortality. The investments and improvements that will drive countries toward achieving their country-level SDGs will also generate progress toward achieving these two objectives, as measured across USAID priority countries.

I.

REDUCE PREVENTABLE CHILD AND MATERNAL MORTALITY IN 25 PRIORITY COUNTRIES TO 12 PERCENT OR LOWER OF TOTAL DEATHS BY 2030

To achieve our vision and goals, USAID and our partner countries must continue to prioritize investments that will save child and maternal lives. We believe that reaching a child and maternal mortality level of 12 percent of total deaths, or below, in USAID priority countries is a challenging yet feasible objective. Measuring mortality in this way captures the combined effects of USAID efforts to prevent child and maternal deaths. In countries where progress lags on this indicator, further investigation is needed of the underlying mortality rates along with the progress of the coverage, equity, and quality of key high-impact interventions and insight into health system challenges.

USAID will track progress towards this objective on a biannual basis using population estimates produced by the United Nations Population Division in the World

Population Prospects, which are used by the United Nations mortality estimation groups for child mortality and for maternal mortality. Each of these groups comprises leading academic scholars and independent experts in demography and biostatistics who review mortality data and publish country-level estimates of under-five and maternal deaths, respectively. To do so, all available national-level data on child and maternal mortality are compiled, including data from vital registration systems, population censuses, household surveys, and sample registration systems, and weights of these data are based on data-quality measures. Under-five mortality estimates are produced annually. Maternal mortality estimates are produced every two years.

2.

INCREASE COVERAGE OF LIFESAVING INTERVENTIONS ACROSS USAID'S MATERNAL AND CHILD HEALTH PRIORITY COUNTRIES TO A LEVEL OF 68 BY 2030, AS MEASURED BY THE RMNCH HEALTH SERVICE COVERAGE SUBINDEX.

To achieve our vision, goal, and objective of reduced child and maternal mortality, we must scale up coverage of the lifesaving interventions that are proven to reduce mortality. The RMNCH health service coverage is measured by an internationally recognized subindex, which captures priority interventions scientifically proven to reduce mortality among mothers, newborns, or children and regarded as approaches that are feasible for universal implementation in low-income countries. Globally, countries have signed on to improve health service coverage as monitored by the Health Service Coverage index and sub-indices. Working with our partners to reach a priority country average of 68 on the RMNCH subindex, an increase of nine points from our current estimate, is a challenging yet feasible goal to achieve by 2030.

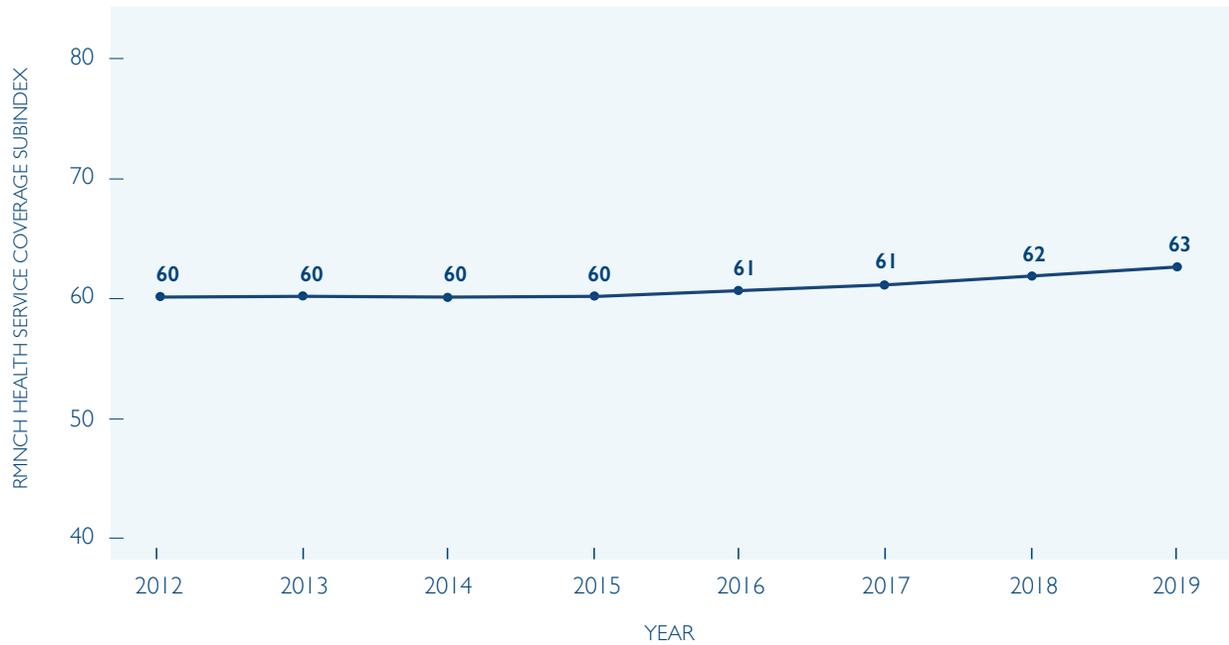
USAID will track progress towards this objective biannually using the RMNCH health service coverage subindex of the broader Health Service Coverage Index and, annually, by tracking individual coverage indicators that make up the index. The index and

subindex are calculated by WHO and partners on a biennial basis. The component indicators of these indices come primarily from household surveys, including the USAID-funded Demographic and Health Surveys, among others. USAID will review progress against the following high-impact interventions, most of which are included in these indices: (a) demand for family planning satisfied by modern methods of family planning; (b) four or more antenatal care visits during last pregnancy; (c) immunization with three doses of a DTP-containing vaccine; (d) care-seeking for suspected pneumonia; (e) at least basic sanitation; (f) proportion of infants 0–5 months of age who are fed exclusively with breast milk; and, if indicated, (g) population use of insecticide-treated bednets (in relevant countries). These interventions are associated with a valid coverage indicator that is reliable, comparable across countries and time, nationally representative, clear and comprehensible by policy makers and program managers, and available regularly in most priority countries. The coverage of an intervention is defined as the proportion of the population in need of the intervention that receives it.

Affirming and Advancing Agency Priorities

The new Preventing Child and Maternal Deaths Framework (2023-2030) relies on and advances the commitments and priorities outlined in the U.S. Department of State and the U.S. Agency for International Development Joint Strategic Plan FY 2022-2026, the U.S. Government Global Nutrition Coordination Plan, the U.S. Government Global Food Security Strategy, the U.S. Global Water Strategy 2022-2027, the Global Child Thrive Act of 2020, the White House Health Worker Initiative, and USAID's localization vision and Local Capacity Strengthening Policy. In addition, this framework affirms the U.S. President's Malaria Initiative Strategy 2021-2026 and USAID's programmatic priorities from the Vision for Health System Strengthening 2030, the Maternal and Child Health and Nutrition Technical Roadmap, and the Office of Population and Reproductive Health Results Framework.

Fig. 13: **REPRODUCTIVE, MATERNAL, NEWBORN, AND CHILD HEALTH SERVICE COVERAGE SUBINDEX**



The RMNCH service coverage subindex captures priority interventions scientifically proven to reduce mortality among mothers, newborns, or children and regarded as approaches that are feasible for universal implementation in low-income countries. It is a subindex of the broader Health Services Coverage Index, calculated by the Global Health Observatory at WHO on a biennial basis. The subindex is reported on a scale of 0 to 100 based on the following four tracer indicators of RMNCH service coverage: (1) family planning demand satisfied with modern methods; (2) four or more antenatal care visits; (3) immunization with at least three DTP-containing vaccines; and (4) care-seeking for suspected pneumonia. The tracer indicators of these indices come primarily from household surveys, including the USAID-funded Demographic and Health Surveys, as well as administrative data and special facility surveys.

Source: WHO Global Health Observatory RMNCH Service Coverage Subindex
<https://www.who.int/data/gho/data/indicators/indicator-details/GHO/uhc-sci-components-reproductive-maternal-newborn-and-child-health>

FOCUS AREAS

Effective primary health care systems are able to identify the number and causes of maternal and child deaths and to take specific actions in response to prevent future mortality. The last decade of maternal and child survival programs has shown that progress in increasing survival is challenging—but incremental and steady progress is feasible and realistic. By expanding coverage of lifesaving interventions, countries will be able to accelerate maternal and child survival to achieve the objective of reducing preventable mortality to 12 percent of total deaths or below. To expand coverage of these interventions, USAID will focus on strengthening the quality of care and enhancing equity to accelerate the pace of progress in saving child and maternal lives by implementing the strategic shifts outlined below. USAID will support countries to bring critical promotive, preventive, and curative health services—in both public and private sectors—closer to the communities that need them.

Strengthen Quality. Enhancing the quality of health care is a cornerstone of USAID’s approach to improving measurable health outcomes for women and children. High-quality care is safe, effective, timely, respectful, coordinated, and equitable. According to a 2018 *Lancet* Series on High Quality Health Systems, five million global deaths occur when health care is accessed but is of poor quality. An analysis of data from USAID-supported service provision assessments (SPA) conducted between 2013 and 2019 showed dramatic gaps in protecting children despite appropriate care-seeking. Regardless of whether care was delivered by public or private health facilities, just three percent of children were assessed for danger signs, immunization status was checked for only 57 percent of cases, and nutritional status was assessed for only two percent of children. Respectful, quality care delivered through integrated, primary health care can reduce mortality and promote timely access to lifesaving services. USAID will support countries to ensure that high-quality services are delivered in facilities for both preventive and therapeutic care for women and children in public and private sectors.

Enhance Equity. Unpacking the progress in preventing child and maternal deaths over the last decade has shown that, in many cases, the wealthiest populations are approaching universal coverage while the poorest are being left behind. Across the 25 priority countries, the poorest 20 percent of the population experience between 10 and 240 more child deaths per 1,000 live births than the wealthiest 20 percent. Beyond income inequality, social determinants including residence, ethnic or religious group, age, or disability can also lead to inequities in use of health services and in health outcomes. Evidence suggests that the COVID-19 pandemic exacerbated inequities such as these between and within countries. In order to make the progress necessary to achieve the SDG targets for 2030 and the longer-term U.S. government goal for 2035, there must be a concerted focus on interventions and strategies that reach poor, marginalized, or vulnerable women and children. USAID will support countries to reach these target populations and increase demand for and utilization of essential health services to close gaps in care seeking.



STRATEGIC APPROACHES

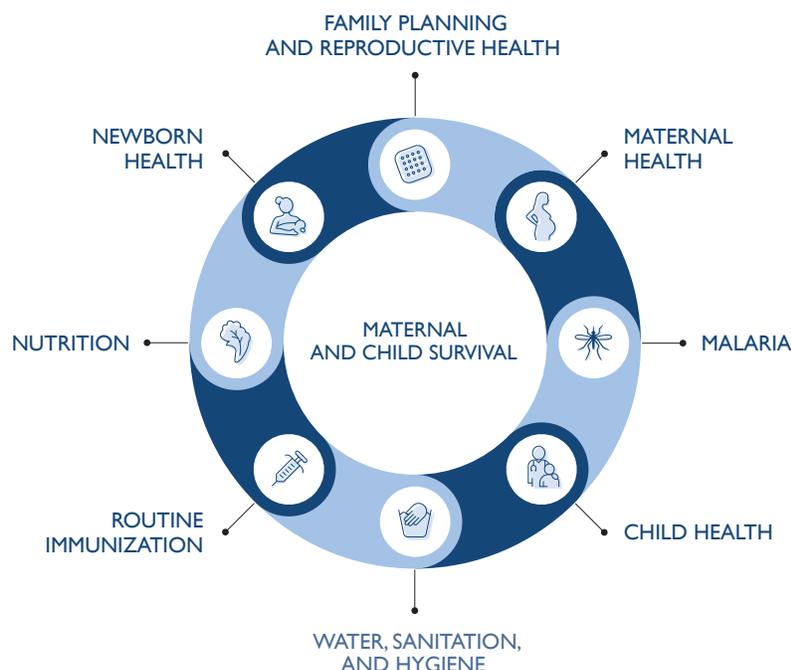
We believe that the following strategic approaches for maternal and child survival programming will increase the quality and equity of services, leading to achieving our objectives for reduced mortality and increased coverage of lifesaving interventions. These strategic approaches build and expand on key lessons learned from the last decade.

I.

ANCHOR OUR RESPONSE IN PRIMARY HEALTH CARE SYSTEMS TO OPTIMIZE HEALTH OUTCOMES.

Health systems anchored in primary health care are associated with better health outcomes, improved equity, and better cost efficiency. Despite improvements over the last decade in specific services and outcomes, health outcomes improved slowly, often because emphasis remained on scaling up specific health interventions instead of integrated health system strengthening. When integrated programs deliver comprehensive care, every health care touchpoint opens an opportunity to fill a gap in care. Delivering integrated health services needs to be supported and sustained by a strong primary health system, yet primary health care remains inadequately incorporated into policies, actions, and services, particularly for those most in need. USAID will work to align and coordinate resources for greater impact and will support country partners to deliver integrated services to achieve optimal health and well-being outcomes. To connect points of service supported across global health programs to deliver whole-of-person care will require further integration and coordination across health sectors within USAID, and with global, national, and subnational partners.

Fig.14: AN INTEGRATED SYSTEMS APPROACH IS CRITICAL TO MATERNAL AND CHILD SURVIVAL





2.

REACH THE HARDEST-TO-REACH MOTHERS AND CHILDREN.

An equitable health system affords every individual a fair opportunity to attain their highest level of health regardless of social or demographic factors, with particular emphasis on underserved, socially excluded, and vulnerable populations. Reaching these populations with timely, quality and respectful care delivered in culturally sensitive ways is the only way to generate the increases in coverage of interventions and corresponding reductions in mortality that are needed. USAID will support countries to reach the hardest-to-reach people and communities, particularly the poorest and most vulnerable. Populations at highest risk include women and adolescent girls, preterm, low-birth-weight, and sick newborns, children who have never been vaccinated and those vulnerable to wasting and malnutrition or exposed to conflict or environmental risk factors, and the urban poor.



3.

CATALYZE COUNTRY COMMITMENT AND MUTUAL ACCOUNTABILITY.

Commitment from government leaders, the private sector, civil society, and communities and accountability mechanisms must be in place at all levels. The landmark commitments made at the 2012 Call to Action and the subsequent commitments by governments around the world created meaningful openings in the policy landscape for programmatic changes that saved lives. In the first two years after the Call to Action, 12 countries launched policies, increased financial commitment, or held convenings under the highest levels of government. Regional convenings engaged the leadership of even more countries. In these two years alone, these efforts contributed to an eight percent reduction in under-five mortality in the original 24 focus countries. However, after the initial outpouring of political support and energy, many country commitments for national budget allocations to health were not realized. To regain the ground lost as a result of the COVID-19 pandemic and accelerate progress to achieve 2030 targets, USAID will focus on motivating strong, committed country leadership, complementary domestic resource allocation, private sector investment, and community accountability for progress towards intermediate milestones and advancing towards maternal and child survival targets.

4.

INVEST IN THE HEALTH WORKFORCE AS THE FOUNDATION OF HEALTH SYSTEMS.

Sustained investments in the health workforce are the foundations of effective, equitable, and resilient health systems. The COVID-19 pandemic highlighted the essential role that nurses, midwives, community health workers, and other members of the health workforce play in providing vital health care and services to women and children, both routinely and during times of crisis. The challenges brought by the pandemic were due not only to the increased burden of disease from COVID-19, but to the secondary effects of diverting health care resources and the overburdening of health workers. Resilient, equitable health systems need trained professionals who are supported to deliver sustained, high-quality, respectful care and adapt to changing circumstances. Without increased priority and investments to recruit, support, and retain a high-quality health workforce, health systems cannot strengthen and expand to support accelerated progress on maternal and child survival. Addressing barriers, including gender, ethnic/racial, geographic, and age barriers, particularly among the community health workforce, will help to build a more diverse cohort of health worker graduates and leaders that is better equipped to serve local populations and provide patient-centered care, especially at the primary health care level.

5.

IDENTIFY BOTTLENECKS AND TAILOR SOLUTIONS THROUGH LOCALLY LED DEVELOPMENT.

Locally led solutions that are tailored to a country's unique context are required to overcome systemic barriers and to generate locally sustained change. Access to and use of many health services continue to be shaped by social determinants of health, including but not limited to socio-economic status, with the poorest populations generally faring worst. New challenges continue to emerge—results of a changing climate, political conflict, or the unforeseen disruption of the COVID-19 global pandemic. These challenges have played out uniquely in each country, underscoring the importance of local leadership and innovation for nimble and adaptive solutions to reach the most vulnerable populations. In response, USAID will support our country partners to adapt evidence-based solutions and policies in a way that reflects the context, health system, and changing world. Civil-society, community, faith-based and private-sector organizations should be included as partners with country governments in the direction of, participation in and oversight of the health system to help ensure accountability—for quality care, healthy behaviors, consumer choice, and efficient and integrated services. USAID's approach aims to empower local actors, particularly women and girls, to ensure efforts are responsive to local priorities, draw upon and strengthen local capacities and resources, and remain accountable to local communities so that results are more likely to be effective and sustained.



6.

GENERATE AND USE DATA, EVIDENCE, AND LEARNING FOR DECISION-MAKING.

Quality, reliable, real-time data are necessary to track progress and prioritize interventions. The 2014 Acting on the Call framework included extensive analysis of proven interventions and bottlenecks in service delivery to guide programming and resources. This information, and more, helped USAID to better target guidance and country support to generate progress. Annual progress reports, including spotlight analyses on equity, health systems, self-reliance, and the health workforce, helped USAID and partners to track progress, adapt, and course-correct while focusing attention on priority issues. Investments in health information systems increased the flow of routine and real-time health service data, allowing for more evidence-based decision-making. However, improved use of monitoring, evaluation, research, and learning is needed to better understand what contributes to and the impact of maternal and child survival efforts. Further, better data is essential to ensuring that programming can appropriately adapt or rapidly respond to contextual changes and circumstances. In response, USAID will focus on strengthening data quality and transparency of reporting, including monitoring primary health care outputs and outcomes as a key component of understanding health system performance. This increased focus on metrics is needed to track progress, monitor equity and quality of service provision, adapt programs to better achieve results, and hold all partners accountable for progress.





REALIZING OUR SHARED GOALS

Every woman and every child, in every country, deserves access to high-quality health care services that respond to their current and future needs in this changing world. USAID remains committed to preventing child and maternal deaths, and our new strategic framework will guide us toward our vision. By building on decades of evidence-based programs and with an enhanced focus on increasing the quality and equity of health services delivered through integrated and effective primary health care, USAID and our partners can increase the coverage of lifesaving interventions that will in turn increase survival

for women and children. The connections between development challenges today are woven more tightly than ever, and as the COVID-19 pandemic has shown us, countries with strong, well-equipped health care systems are more resilient and better able to respond to pandemics, climate change, conflict, and other emergencies. Collectively, the global health community has the opportunity to rebuild and strengthen health systems in ways that better reach the women, children, and families who are most vulnerable and drive the lifesaving results needed to achieve the SDGs.





ANNEX

DATA AND METHODOLOGY

The analyses and the information presented in this report come from globally recognized, publicly available sources as described below. Sources were chosen to maximize the ability to compare across countries, and standardized methodologies for estimation were used to allow for visualizing data in specific time periods across countries. Therefore, the numbers presented may vary from recently released data and/or from the official numbers used within countries.

UNDER-FIVE AND NEONATAL MORTALITY HISTORIC TRENDS AND GLOBAL 2030 TARGETS

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

Estimates for children under five years of age and newborns are produced by the Interagency Group for Child Mortality Estimation (IGME). IGME, established by the United Nations, 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 uses that to predict a trend line that is extrapolated to a common reference year, in this case 2021. The under-five mortality rate target for all countries is 25 per 1,000 live births or lower. The neonatal mortality rate target is 12 per 1,000 live births.

MATERNAL MORTALITY HISTORIC TRENDS AND GLOBAL 2030 TARGETS

Historic Trends

<https://www.who.int/reproductivehealth/publications/maternal-mortality-2000-2017/en/>

The numbers and ratios of maternal deaths to live births were obtained from the United Nations Maternal Mortality Estimation Inter-agency Group (MMEIG) that works in a similar way to IGME estimates described above. The MMEIG shares and harmonizes data on maternal mortality in order to provide internationally comparable maternal mortality ratio estimates, up to 2017 in the latest report.

Global 2030 Targets

The 2030 global maternal mortality target is a reduction in the global average for the maternal mortality ratio to less than 70 deaths per 100,000 live births, with no individual country exceeding a maternal mortality ratio of 140 maternal deaths per 100,000 live births. A 2030 maternal mortality ratio target calculator has been provided by the World Health Organization (WHO) to help countries calculate their 2030 target. A reduction of 7.6 percent per year is required to bring the 2015 global average of 219 per 100,000 live births down to a global average of 70 by 2030. The 2015 maternal mortality ratio estimates for each country, which are used to calculate the 2030 target, come from the Maternal Mortality: Levels and Trends 2000 to 2017 Report. Each country should apply its 2015 maternal mortality ratio value along with a 7.6 percent annual rate of reduction to identify its maternal mortality ratio target. If the calculated MMR target is greater than 140, then 140 per 100,000 live births should be substituted for the target value.



INTERVENTION COVERAGE ESTIMATES AND INEQUITY

Intervention coverage rates were extracted from the most recently available Demographic and Health Survey (DHS), Multiple Indicator Cluster Survey (MICS), and/or HIV/AIDS and Malaria Indicator Surveys. In addition, the WHO-UNICEF Estimates of Vaccine Coverage: 1980-2021 (https://data.unicef.org/wp-content/uploads/2016/07/wuenic2021rev_web-update.xlsx) were used for measles immunization coverage rates. Where recent data points were unavailable, coverage estimates were based on an application of the annual rate of change from the two closest available survey data points.

Recent data points may not be available for countries affected by conflict, internal displacement, and migration, or disruptions in data collection due to COVID-19; thus, coverage rates may overestimate or underestimate current access. Additionally, if there was disagreement between two recent data points, the data source more commonly used across countries was ultimately used, for comparability. New data are always forthcoming, so these estimates may slightly differ from year to year based on newly available data.

Comparisons of intervention coverage based on wealth quintiles were drawn from [Countdown to 2030](#) equity profiles. These profiles show disparities in coverage levels of effective interventions across the continuum of care for reproductive, maternal, newborn, child and adolescent health and nutrition—here disaggregated by poorest and richest wealth quintiles, a simple measure of wealth inequality. [Countdown to 2030](#) equity profiles compile publicly available data from Demographic and Health Survey (DHS), Multiple Indicator Cluster Survey (MICS), HIV/AIDS and Malaria Indicator Surveys and/or other national surveys.

UNIVERSAL HEALTH CARE (UHC) AND RMNCH COVERAGE INDICES

Health service coverage indicators reflect the extent to which people in need of essential health services actually receive them. Essential services relevant for the prevention of child and maternal deaths include the following: care of women during pregnancy and childbirth, reproductive health services, immunization to prevent common childhood infections, vitamin A supplementation in children, and treatment for common childhood diseases. The main sources of data for these indicators are respondents' answers to questions about service use from household surveys such as the Expanded Programme on Immunization 30-cluster Survey, the UNICEF Multiple Indicator Cluster Survey, and the Demographic and Health Survey funded by USAID.

[The Universal Health Coverage \(UHC\) index](#) of essential services coverage is a component of a group of indicators used to assess progress towards the Sustainable Development Goal Target 3.8: Achieve universal health coverage, including financial risk protection. A subset of the Universal Health Coverage index of essential services coverage is the [RMNCH subindex](#) of specific reproductive, maternal, newborn and child health components.



MODERN CONTRACEPTIVE PREVALENCE, UNMET NEED FOR MODERN CONTRACEPTION, AND DEMAND SATISFIED BY A MODERN METHOD

Data on modern contraceptive prevalence among married women, unmet need for modern contraception, and demand satisfied by a modern contraceptive method were obtained from the 2020 Family Planning 2020 Progress Report, Full Estimate Table.

The indicators are defined as follows: The modern contraceptive prevalence among married women is the percentage of married women (or women in union) who were using (or whose partners were using) a modern contraceptive method. The unmet need for modern contraception was estimated as the percentage of fecund women of reproductive age who wanted no more children or wanted to postpone having the next child but who (and whose partners) were not using a modern method. Women who were using a traditional method were assumed to have an unmet need for modern contraception. The demand satisfied by a modern method was estimated as the percentage of women who desired either to have no additional children or postpone the next child and who (or whose partners) were using a modern contraceptive method. A demand satisfied rate of 75 percent or above is considered good.

GOVERNMENT HEALTH SPENDING

Data on government health spending come from the WHO's Global Health Expenditure Database (<https://apps.who.int/nha/database>). WHO works collaboratively with member states to update the database annually, using available information such as health accounts data, government expenditure records and official statistics. Where necessary, modifications and estimates are made to ensure the comprehensiveness and consistency of the data across countries and years.

HEALTH WORKFORCE DENSITY

Data on health workforce density are drawn from the WHO's National Health Workforce Accounts Data Portal (<https://apps.who.int/nhwportal/>). The data presented in the WHO NHWA data portal are processed data extracts of the national reporting in the National Health Workforce Accounts data platform. Complementing the national reporting, additional sources such as the National Census, Labour Force Surveys and key administrative national and regional sources are also employed.



ENDNOTES

1. This framework contributes to the U.S. government's broader goal to reduce child mortality to 20 or fewer deaths per 1,000 live births in every country and fewer than 50 maternal deaths per 100,000 live births by 2035 as outlined in the U.S. Department of State and U.S. Agency for International Development Joint Strategic Plan FY 2022-2026 (March 2022). https://www.state.gov/wp-content/uploads/2022/03/Final-State-USAID-FY-2022-2026-Joint-Strategic-Plan_29MAR2022.pdf
2. SDG 3 has nine targets, of which two targets, 3.1 and 3.2, directly link to improving the survival of mothers and children under five and are reported through this framework. Several of these other targets contribute to preventing child and maternal deaths but do not directly report on mortality outcomes.
3. William Weiss, et al. "Estimating the impact of donor programs on child mortality in low- and middle-income countries: a synthetic control analysis of child health programs funded by the United States Agency for International Development," *Population Health Metrics* 20, no. 2 (2022), <https://doi.org/10.1186/s12963-021-00278-9>.
4. The 15 countries are: Afghanistan, Burma (Myanmar), Congo (Kinshasa), Haiti, Indonesia, Kenya, Liberia, Malawi, Mali, Mozambique, Nigeria, Pakistan, Rwanda, Tanzania, and Zambia. Bangladesh and South Sudan do not publicly report this data.
5. WHO, "Global Health Expenditure Database," accessed November 15, 2022, <https://apps.who.int/nha/database>.
6. WHO, "Global expenditure on health: public spending on the rise?" Geneva: World Health Organization; 2021. License: CC BY-NC-SA 3.0 IGO.
7. WHO, "Global expenditure on health: public spending on the rise?"
8. Karin Stenberg, et al. "Financing transformative health systems towards achievement of the health Sustainable Development Goals: a model for projected resource needs in 67 low-income and middle-income countries." *Lancet Global Health* 5, no. 9 (Sept 2017) e875-e887. [https://doi.org/10.1016/S2214-109X\(17\)30263-2](https://doi.org/10.1016/S2214-109X(17)30263-2).
9. USAID malaria investments are made possible through the USAID-led U.S. President's Malaria Initiative.
10. UNICEF, "COVID-19 pandemic fuels largest continued backslide in childhood vaccinations in three decades," July 14, 2022, <https://www.unicef.org/press-releases/WUENIC2022release>.
11. Standing Together for Nutrition, "A Resilient Future: Investing today to safeguard tomorrow." https://static1.squarespace.com/static/5fc228ec616251320838493c/t/60f1d92d3686e8630bb69801/1626462510497/ST4N+Investor+Brief_Short.pdf.
12. WHO, "Health Workforce Support and Safeguards List, 2020" (WHO: Geneva 2021), <https://www.who.int/publications/m/item/health-workforce-support-and-safeguards-list>.
13. COVID-19 Excess Mortality Collaborators, "Estimating excess mortality due to the COVID-19 pandemic: a systematic analysis of COVID-19-related mortality, 2020–21," *The Lancet* 399, no. 10334 (2022) 1513–36: [https://doi.org/10.1016/S0140-6736\(21\)02796-3](https://doi.org/10.1016/S0140-6736(21)02796-3).

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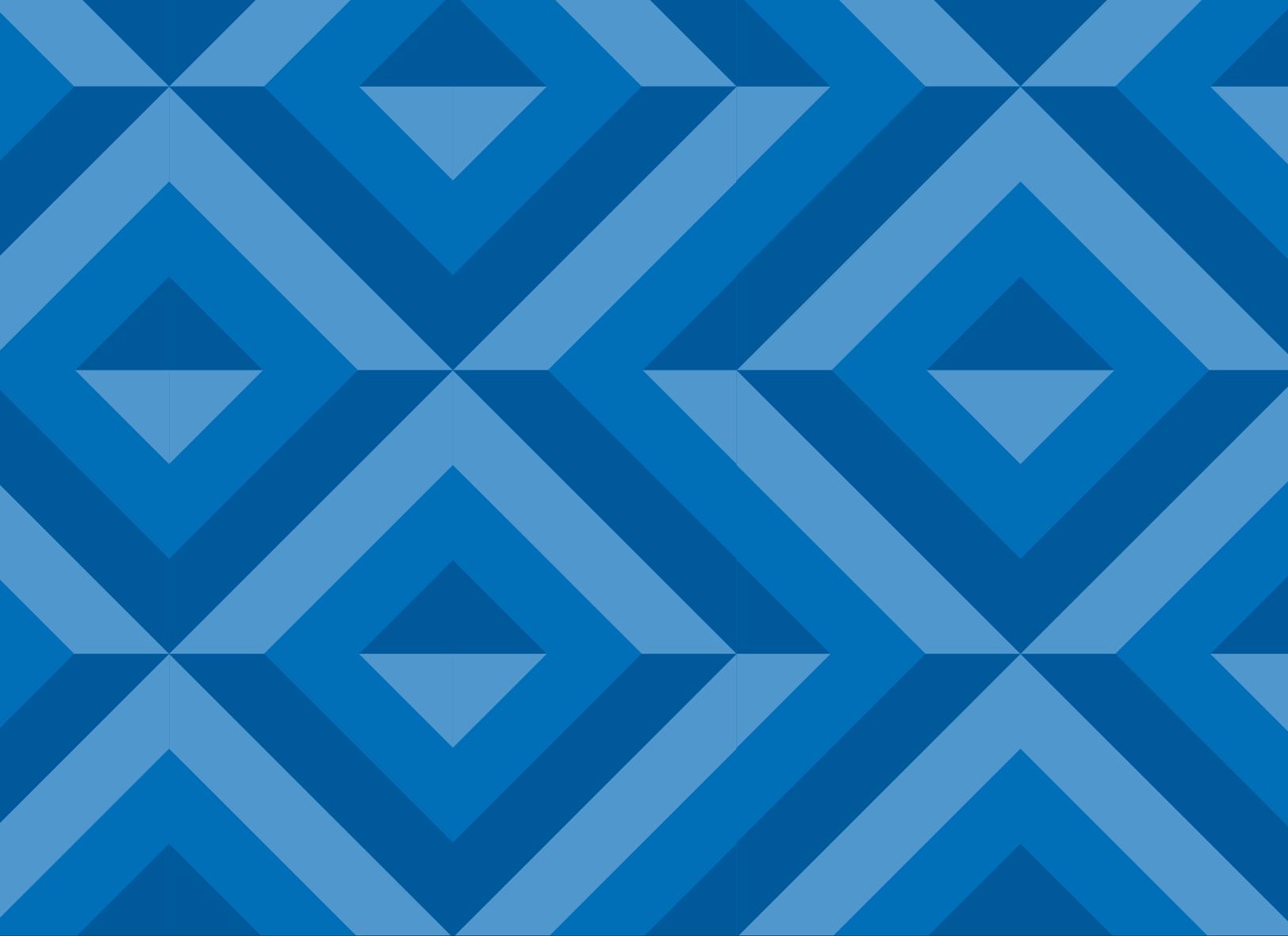
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