# ACTING ON THE CALL

## ending preventable child and maternal deaths

June 2014

Cover Photo:AFP / Adriane Ohanesian

# FOREWORD

By Dr. Rajiv Shah
Administrator, USAID

This June, we mark the second anniversary of the Child Survival Call to Action, when the world came together to craft a global goal to end preventable child deaths by 2035. In the last two years, we pioneered a new approach that has empowered partner countries to achieve this aspiration by leading with robust business plans and evidence-based report cards. With a strong foundation in place, now is the time for the global community to mobilize around results-oriented country action plans to realize a world where every child everywhere lives to celebrate his or her 5th birthday.

Since the beginning of the Obama Administration, the U.S. has invested $13 billion in global child and maternal survival. Emblematic of the strong bipartisan legacy of American leadership in global health, this commitment represents a 56% increase in annual funding since 2008. Most importantly, we have aligned our resources in priority countries and toward life-saving interventions that have the greatest impact on mortality. We have focused on the 24 countries — primarily in sub-Saharan Africa and South Asia — that account for 70% of child and maternal deaths and half of the unmet need for family planning.

Over the last 18 months, we have undertaken an ambitious review of every dollar USAID spends preventing child and maternal mortality in these 24 countries to identify inefficiencies and accelerate reductions in child and maternal mortality. This report outlines the results of this review. It demonstrates how we are advancing President Obama's commitment with a smart, strategic, and cost-effective approach that will bend the curve of progress, even in a time of global fiscal rest aint.

Ending preventable child and maternal deaths will require more than resources. It requires a new model of development that harnesses the power of science and business to push the boundaries of possibility. In South Asia, for example, we supported randomized control trials and feasibility studies demonstrating that chlorhexidine could cut newborn mortality by 23%. We partnered with a local Nepali pharmaceutical company and community health workers to deliver the life-saving antiseptic to expectant mothers. Today, efforts to introduce it are underway in 15 other countries.

Through Saving Lives at Birth: A Grand Challenge for Development, we are investing in 59 global health innovations just like chlorhexidine that are already having an impact on the ground — from stopping the transmission of HIV/AIDS to infants to helping newborns take their fi st breath.

The results worldwide have been extraordinary. In two years alone, we have helped achieve an eight percent reduction in under-fi e mortality in the 24 focus countries, saving 500,000 lives. Maternal mortality has fallen by half in these same countries over two decades. Global donor funding for child and maternal survival has increased at an annualized rate of 14% over the past decade, while more than two-thirds of the 24 priority countries spent a greater proportion of general government expenditure on health in 2012 than they did 10 years prior.

We are proud of this progress, but more must be done to ensure every child survives and thrives and no mother dies from preventable causes as a consequence of pregnancy and childbirth. We need our partners to join with us and align their investments with country-owned plans that focus on delivering results for the most vulnerable families in the most vulnerable communities. By accelerating our rate of progress together, we can save the lives of 15 million children and nearly 600,000 women by 2020.

Reaching this goal is only possible if we increase access to voluntary family planning, enabling couples to act on the choice to have smaller families and invest more in the health and well-being of each child. When couples have smaller families, children grow up healthier and economies flou ish.

Two years in a row, President Obama has called upon us in his State of the Union address to join the world in ending extreme poverty and its most devastating consequences — child hunger and child death — in the next two decades. It is an ambitious but achievable vision. With a clear path for action, we can deliver on this fundamental human aspiration and usher in one of the greatest contributions to progress in history.

# ACTING ON THE CALL:

## Ending Preventable Child and Maternal Deaths Report June 2014

CONTENTS


I. List of Acronyms . . . 5

II. Introduction: Issuing the Call
Child Survival: Call to Action and *A Promise Renewed* . . . 6

III. Acting on the Call: 24 Country Action Plans . . . 14
- Afghanistan . . . 18
- Bangladesh . . . 20
- Democratic Republic of Congo . . . 22
- Ethiopia . . . 24
- Ghana . . . 26
- Haiti . . . 28
- India . . . 30
- Indonesia . . . 32
- Kenya . . . 34
- Liberia . . . 36
- Madagascar . . . 38
- Malawi . . . 40
- Mali . . . 42
- Mozambique . . . 44
- Nepal . . . 46
- Nigeria . . . 48
- Pakistan . . . 50
- Rwanda . . . 52
- Senegal . . . 54
- South Sudan . . . 56
- Tanzania . . . 58
- Uganda . . . 60
- Yemen . . . 62
- Zambia . . . 64

IV. Acting on the Call: Sharpening the Focus on Bottlenecks by UNICEF . . . 66

V. Acting on the Call: Technical Approaches to Proven Interventions by USAID . . . 80
- Newborn . . . 82
- Immunization . . . 86
- Prevention and Treatment of Childhood Illness . . . 89
- Nutrition . . . 93
- Maternal Health . . . 97
- Family Planning . . . 101
- Ensuring Healthy Behaviors . . . 107
- Water, Sanitation, and Hygiene . . . 111

VI. Conclusion . . . 114

Acknowledgements . . . 116

VII. Annex A: Data Sources and Methodology . . . 117

VIII. Annex B: Award Data:
Tables on Principal USAID Awards by Country . . . 123

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# ACRONYMS

**APR** A Promised Renewed

**ARV** Antiretroviral

**CATS** Community Approaches to Total Sanitation

**CDC** Centers for Disease Control and Prevention

**CHWs** Community health workers

**CPR** Contraceptive prevalence rate

**DHS** Demographic and Health Surveys

**DTP3** Diphtheria, tetanus, pertussis

**EPCMD** Ending preventable child and maternal deaths

**FTF** Feed the Future

**iCCM** Integrated community case management

**IDA** International Development Association

**IDB** United States Census Bureau's International Database

**IGME** Interagency Group for Child Mortality Estimation

**IHME** Institute for Health Metrics and Evaluation

**LiST** Lives Saved Tool

**MDGs** Millennium Development Goals

**MMR** Maternal mortality ratio

**MNCH** Maternal, newborn, and child health

**MOH** Ministry of Health

**NGOs** Non-governmental organizations

**ORS** Oral rehydration solution

**ORT** Oral rehydration therapy

**PEPFAR** President's Emergency Plan for AIDS Relief

**PMI** President's Malaria Initiative

**PMTCT** Prevention of mother-to-child-transmission [of HIV]

**RMNCH** Reproductive, maternal, newborn, and child health

**SUN** Scaling up nutrition

**TB** Tuberculosis

**UNAIDS** The Joint United Nations Programme on HIV and AIDs

**UNFPA** United Nations Population Fund

**UNICEF** United Nations Children's Fund

**USAID** United States Agency for International Development

**WASH** Water, Sanitation, and Hygiene

**WHO** World Health Organization

# INTRODUCTION: ISSUING THE CALL

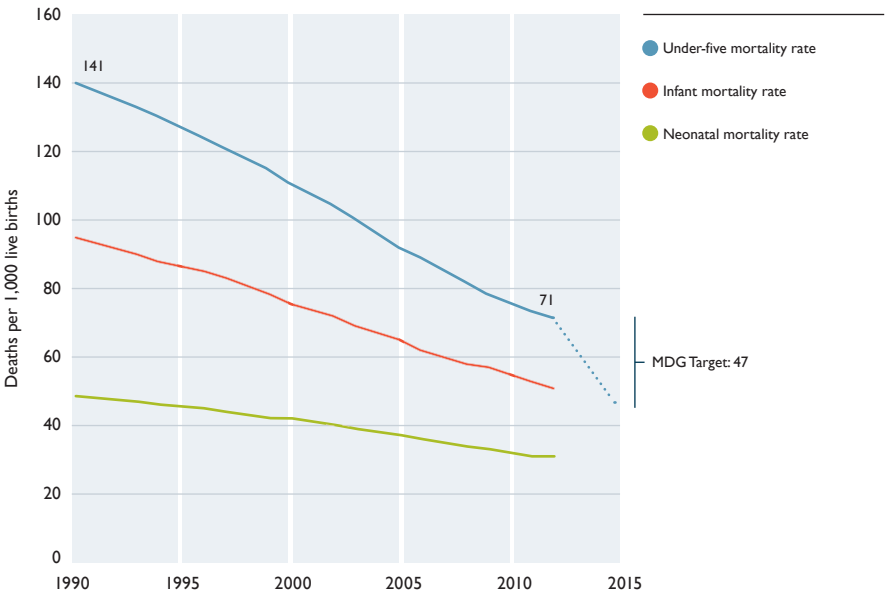
## A Child Survival Revolution

All women deserve to give birth safely, and all children — no matter where they are born — deserve the same chance to survive and thrive. Over the last 30 years, the global community has responded to the urgency of this mission, raising child and maternal survival to the top of the international development agenda. Just as the Green Revolution transformed agricultural production and prevented widespread famine, the child survival revolution is saving millions of lives and unleashing a virtuous cycle of progress and opportunity.

Working together over the last three decades, we have expanded coverage of voluntary family planning, dramatically improved access to new vaccines, integrated nutrition and hygiene into global health, and launched innovative public-private partnerships to extend our reach. Since 2010, the Helping Babies Breathe partnership has trained and equipped 130,000 health workers in 60 countries to provide life-saving resuscitation for newborns with asphyxia, with results in Tanzania showing a 47% reduction in early newborn mortality. From 1990 to 2012, the world achieved a 72% reduction in the risk of a child dying from pneumonia or diarrhea, thanks in part to the introduction of vaccines against rotavirus and pneumococcus and improvements in treatment — both advances supported by diverse public and private organizations, including USAID. Together with its partners, the President's Malaria Initiative contributed to the significant reduction n malaria mortality rates in children under ve in Africa by an estimated 54% between 2000 and 2012.

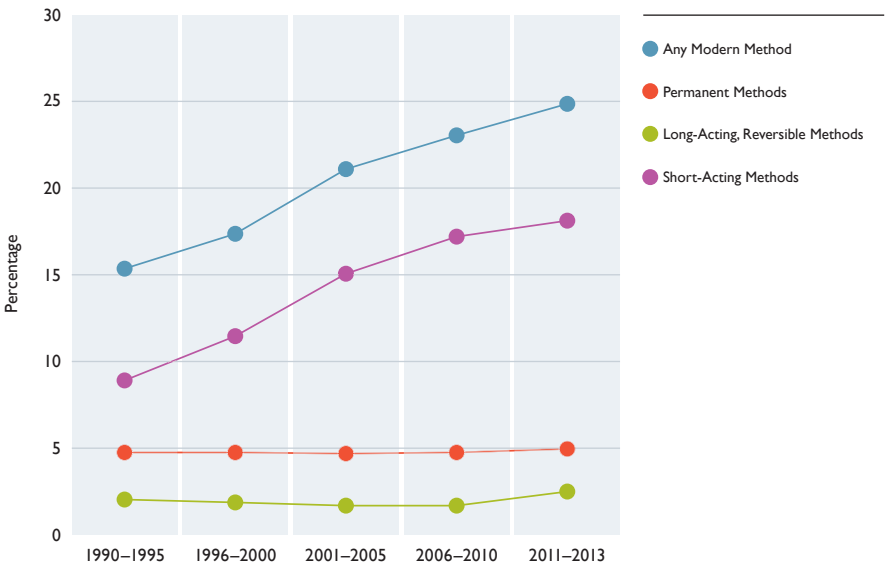
### TARGET: UNDER-FIVE MORTALITY RATE

24 Priority Countries




### USE OF MODERN METHODS OF CONTRACEPTION

24 Priority Countries




Source: UNFPA

Photo:AFP / Aref Karim

**All told, from 1990 to 2012, the total number of child deaths fell by 48% from 12.6 million to 6.6 million.** In the last 20 years, nearly 100 million child lives have been spared, and the rate at which mortality is declining continues to accelerate. The total number of maternal deaths also decreased globally by 45% from 523,000 in 1990 to 289,000 in 2013.

By the time the Millennium Development Goals (MDGs) were adopted in 2000, the global community had recognized the fundamental connection between health and development, and the momentum surrounding the overall efforts to reduce child and maternal mortality only accelerated. In 2010, UN Secretary-General Ban Ki-moon launched *Every Woman Every Child* to present a roadmap for enhanced financing strengthened policy, and improved service to address the major health challenges facing vulnerable women and children. As progress has advanced, so too has our definition of child survival, which has evolved over the last 30 years to include a more integrated picture of health, development, and well-being.

**Despite this extraordinary progress, rates of child and maternal death remain unacceptably high.** Hundreds of thousands of mothers continue to die during what should be a joyous moment in their lives, and millions of children die from causes we know how to prevent. Today, a woman's risk of dying from childbirth in sub-Saharan Africa is more than 47 times greater than in the United States.

## THE CALL TO ACTION'S FIVE STRATEGIC SHIFTS:

- Increase efforts in the countries that account for the largest share of under-fi e deaths
- Reach the most underserved populations
- Target priority causes of mortality with innovation efforts and interventions poised to go to scale
- Invest beyond health programs to include empowering women and supporting an enabling environment
- Create transparency and mutual accountability at all levels, with strengthened commitment to common metrics for tracking progress

### A New Approach at the Call to Action

That is why, in June 2012, the Governments of Ethiopia, India, and the United States, in collaboration with UNICEF, hosted the "Child Survival: Call to Action." **Designed to focus the disparate priorities of the global health community, the Call to Action set a single, comprehensive, and achievable goal: ending preventable child deaths by 2035.** More than 175 countries and over 400 civil society and faith organizations signed a pledge in support. This global commitment became known as *A Promise Renewed* (APR).

Reenergizing the child survival movement, *A Promise Renewed* set a global goal of fewer than 20 deaths per thousand live births in all countries by the year 2035.[i] It kicked off an effort to find agreement on a similar goal of fewer than 50 maternal deaths per 100,000 live births by 2035.[ii] Recently, the global community came together at the World Health Assembly to endorse a global newborn action plan and set a target to reduce preventable newborn deaths to a global average of 7 deaths per 1,000 live births by 2035, and a national target of fewer than 10 deaths per 1,000 live births by 2035. Progress is underway for a related measure and benchmark for family planning.

Perhaps most importantly, APR outlined a modern new approach to child survival through fi e strategic shifts (see text box) and encouraged countries themselves to take the lead. Complementary efforts in family planning (London Summit on Family

# LEADING BY EXAMPLE: PROGRESS SINCE A CALL TO ACTION

**Nigeria: October 2012:** President Goodluck Jonathan launched *Saving One Million Lives,* a comprehensive initiative to scale up access to essential primary health services and commodities for Nigeria's women and children.

**WHO Eastern Mediterranean Region: January 2013:** After extensive consultation, Eastern Mediterranean Region member states identified greatest needs, created action plans, and selected priority countries. Ministers of Health meeting in Dubai committed to accelerate progress toward MDGs 4 and 5 in the region.

**Ethiopia: January 2013:** The Government of Ethiopia convened Ministers of Health, global health policy analysts, and technical experts from 20 African countries to review regional progress on child survival, take stock of lessons learned, call for greater accountability, and reaffi m commitment to reducing under-fi e mortality rates to fewer than 20 deaths per 1,000 live births.

**India: February 2013:** The Government of India held a high-level Child Survival forum with state policymakers, technical advisers, civil society organizations and private sector actors to launch the Reproductive Maternal Neonatal Child and Adolescent Health Strategy.

**Zambia: April 2013:** The First Lady of Zambia hosted a national launch of *A Promise Renewed* and unveiled a four-year road map that aims to save an average of 27,000 maternal and child lives per year.

**Sierra Leone: May 2013:** The government launched a national effort to accelerate a decline in maternal and child deaths and developed a scorecard with stakeholders to symbolize a commitment to tracking reproductive, maternal, newborn, and child health (RMNCH) interventions at subnational levels.

**Democratic Republic of Congo: May 2013:** Under *A Promise Renewed,* the DRC Ministry of Health launched the national acceleration framework to reduce infant and maternal mortality. The strategy sets out targets to reduce child mortality by 48% and maternal mortality by 31%, saving the lives of 430,000 children and 7,900 mothers over the next three years.

**Senegal: July 2013:** Senegal's Minister of Health launched *A Promise Renewed* in Dakar. The Ministry of Health aims to work with partners to save 10,000 children by the end of 2015.

**Bangladesh: July 2013:** The Government of Bangladesh pledged to end preventable child deaths by scaling-up interventions proven to address preventable causes of child mortality, with a special emphasis on newborn survival.

**Liberia: July 2013:** President Ellen Johnson Sirleaf launched *A Promise Renewed: Committing to Child Survival in Liberia* at a gathering of community leaders, health workers, government officials and de elopment partners.

**African Union Conference: August 2013:** The Campaign for Accelerated Reduction of Maternal Mortality in Africa targeted cross-sectoral leadership to mobilize actions and build greater accountability and transparency for both child and maternal survival.

**Latin America Regional Launch: September 2013:** The Government of Panama hosted *A Promise Renewed for the Americas.* The regional forum convened 26 Ministers of Health from the Latin America and Caribbean region joining seven international partners in signing the Declaration of Panama, reaffi ming their commitment to end all preventable child and maternal deaths by 2035.

**Benin: November 2013:** The government launched a national effort in support of maternal and child survival.

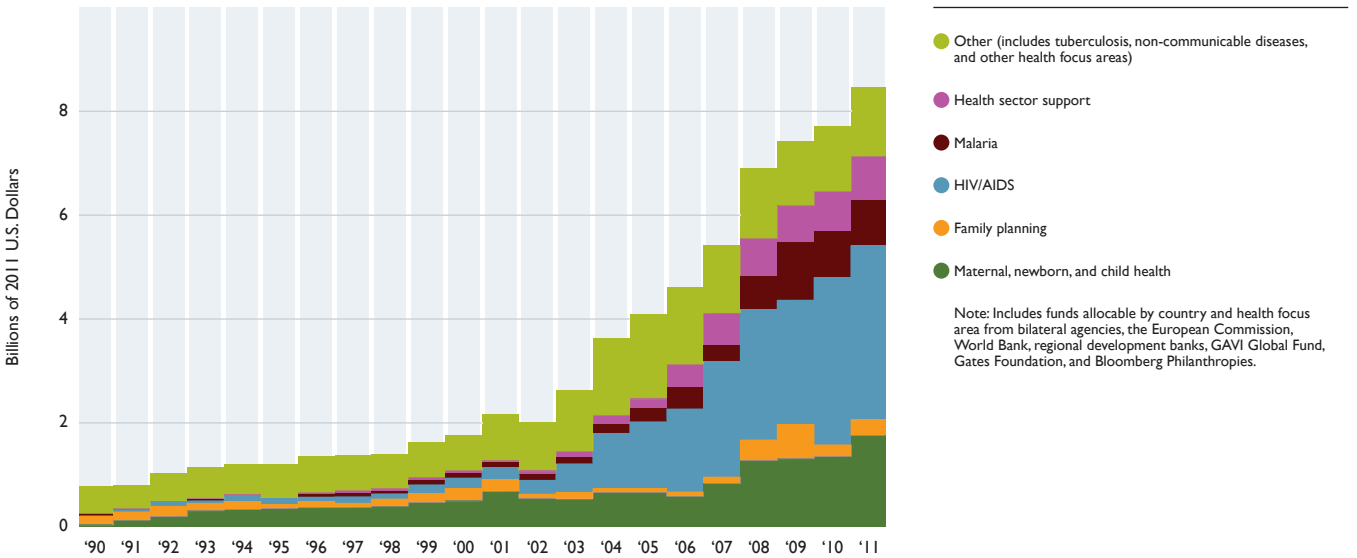
**Malawi: November 2013:** In support of maternal, newborn, and child health, Vice President Khimbo Kachali launched Malawi's scorecard and highlighted the nation's sharpened plan, emphasizing newborn health.

**Uganda: November 2013:** Honorable Edward Kiwanuka Sekandi, Vice President of Uganda, unveiled a sharpened reproductive, maternal, newborn, and child health plan that aims to prevent an additional 40% of under-fi e deaths and 26% of maternal deaths by 2017.

Every African and Asian country listed here has also made a commitment to the FP2020 goal of enabling an additional 120 million women and girls to use contraceptives by 2020. Many other countries have held APR launches (Philippines, Peru, Côte d'Ivoire, Tanzania, and Yemen) or are considering launches later in 2014 (Afghanistan, Cameroon, Ghana, Indonesia, Kenya, Mali, Mozambique, Namibia, Nepal, and Pakistan).

## DEVELOPMENT ASSISTANCE FOR HEALTH, BY HEALTH FOCUS AREA

### 24 Priority Countries (Figure A)




Source: IHME

Planning and Family Planning 2020[1]) and nutrition (Nutrition for Growth Compact) have signi cantly expanded the level of collaboration around critical child and maternal heath programming.

## Country Ownership

**At the Call to Action, partner countries stepped forward to lead with energy and focus.** Representatives from ve countries that contribute to more than 50 percent of child deaths worldwide (India, Nigeria, Democratic Republic of the Congo, Pakistan, and Ethiopia) made public commitments to change their practices to accelerate progress and bend the curve on reducing under- ve deaths. To date, 16 countries have launched national efforts to improve maternal, newborn, and child survival and accelerate declines in preventable maternal, newborn, and child deaths. More are planning launches in their countries.

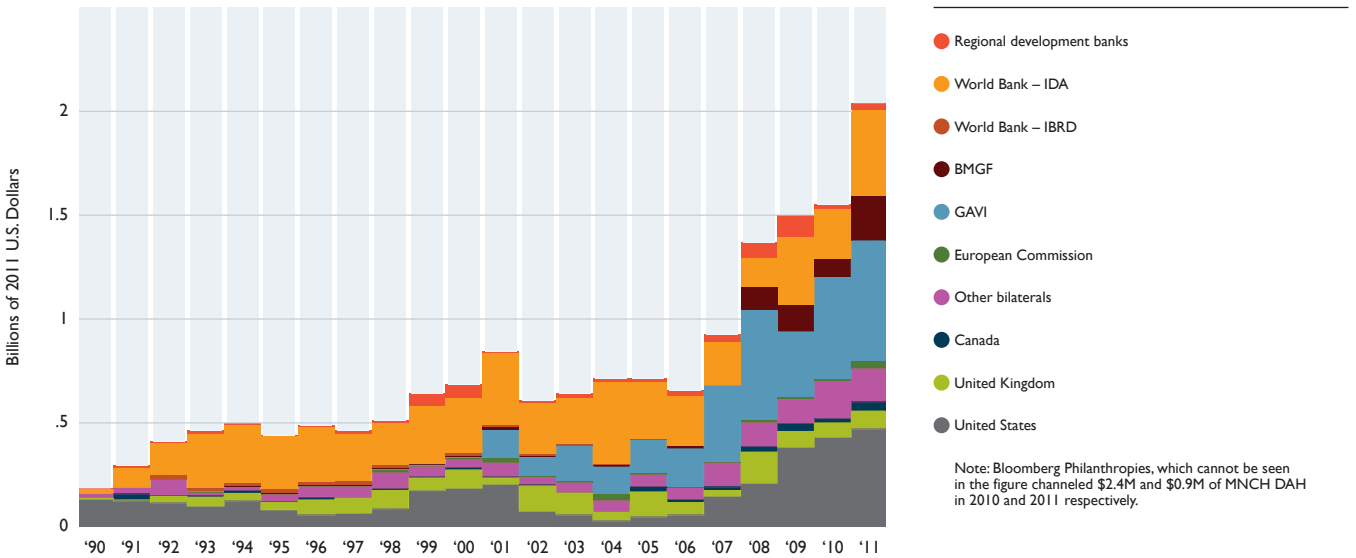
These countries have also sharpened national strategies, set national targets, and developed scorecards to track progress. They have identi ed target districts and communities where the highest rates of child and maternal deaths occur, and focused resources and energy on reducing those rates. Country scorecards are based on national priorities and planning processes, with appropriate indicators, including indicators developed by the U.N. Commission on Information and Accountability for Women's and Children's Health, the Global Vaccine Action Plan, and the Countdown to 2015.

In Bangladesh, for instance, the government developed a ve-year strategy and a results framework with indicators that have been fully agreed to by eight donors — guiding their efforts through a highly functional Donor Coordination Committee. Donors pool their resources through the World Bank and participate in annual program reviews and evaluations that are coordinated, transparent, and consistent with a shared vision based on the ve-year plan.

[1] At the London *Summit on Family Planning*, more than 20 governments made commitments to address the policy, nancing, delivery, and socio-cultural barriers to women accessing contraceptive information, services, and supplies. Donors also pledged an additional US$2.6 billion in funding in support of the Summit goal of enabling an additional 120 million women and girls to use contraceptives by 2020. This global commitment became known as FP2020.

## RECENT GROWTH IN DAH FOR MNCH COMES FROM INCREASES IN MULTIPLE CHANNELS

**24 Priority Countries (Figure B)**




Source: IHME

## Investing More in Health

Child and maternal survival is increasingly being recognized as a  scal priority both globally and within countries themselves. Thanks to this momentum, government health expenditures have seen meaningful growth. Of the 24 countries examined in depth in the following sections of this report, 17 spent a greater proportion of general government expenditure on health in 2012 than they did ten years prior.[iii]

Meanwhile, donor health funding for maternal, newborn, and child heath grew at an annualized rate of 14% over the past decade. Combined family planning and maternal, newborn, and child health (MNCH) funding averaged approximately $1.8 billion annually during the period 2008–2011, which was 2.4 times greater than the annual average during the previous four years.

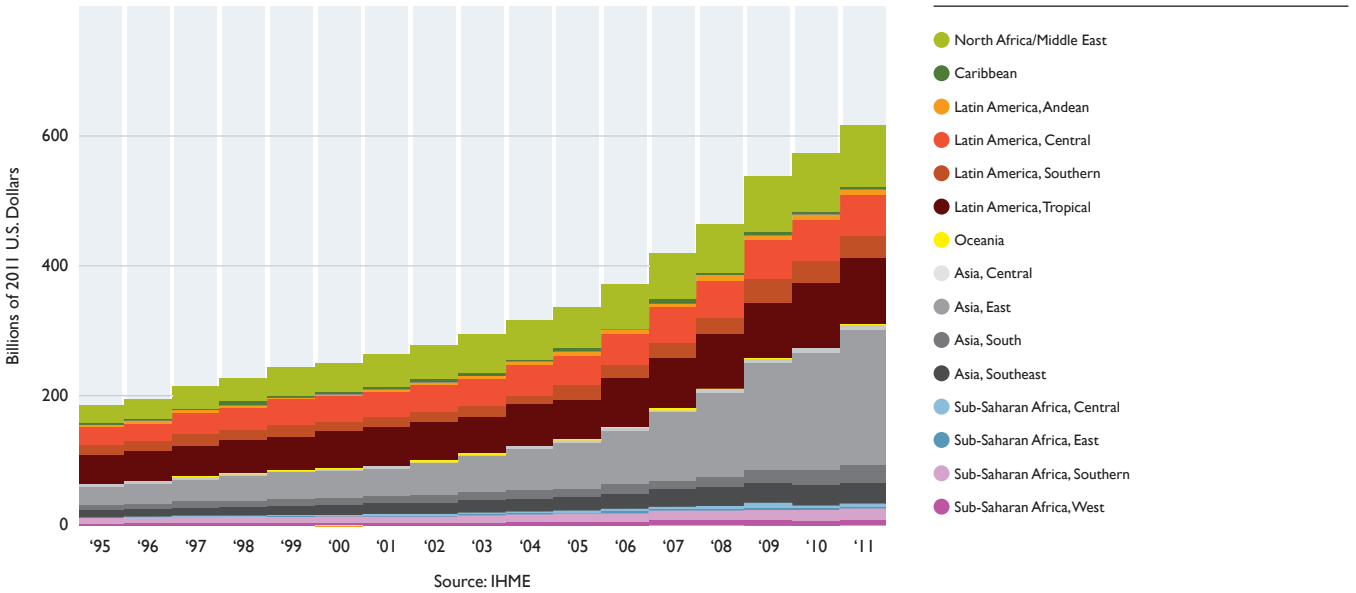
An overview of global health funding representing donor expenditures in health or development assistance for health for the 24 countries is presented in Figure A, by health area. The global health funding disbursed for MNCH includes spending on vaccinations, antenatal, postnatal, and maternal care, and other expenditures vital to maintaining the health of children and mothers. Sources of MNCH funding are shown in Figure B for the 24 countries[2]. MNCH spending totaled $2.0 billion in these countries in 2011 — up from $1.6 billion in 2010.

[2] Data exclude funds from WHO, UNAIDS, UNFPA, and NGOs because these data could not be broken out by recipient country.

The growth throughout the period from 2006 to 2011 was driven by increases in spending by development partners, such as the United States, the GAVI Alliance, the Bill & Melinda Gates Foundation, and most recently by increases in the International Development Association (IDA) funding through the World Bank.

As reported by the Institute for Health Metrics and Evaluation (IHME) in *Financing Global Health 2013*, government health expenditure as a source has grown over time in all regions of the world. Levels of government health expenditure for all health focus areas are presented in Figure C. Governments in the Asia region spend the most on health, driven largely by spending by the Chinese government.

## VARIED GOVERNMENT SPENDING ON HEALTH ACROSS REGIONS
(Figure C)




Latin America follows, and government spending on health in sub-Saharan Africa trails signi cantly.

The U.S. Government remains a world leader in global health, focusing on delivering meaningful results in three key areas: ending preventable child and maternal deaths, creating an AIDS-free generation, and protecting communities from infectious diseases. Since the beginning of the Obama Administration, the U.S. Department of State and the U.S. Agency for International Development have invested $13 billion in global child and maternal survival, family planning, nutrition, and malaria — all contributing to ending preventable child and maternal deaths. Emblematic of the strong bipartisan legacy of American leadership in global health, this commitment represents a 56% increase in annual funding since 2008.

In addition, the U.S. Government makes signi cant investments in related health activities that contribute to reducing child and maternal mortality. Some funding to end preventable child and maternal deaths also is part of other U.S. Government-wide initiatives, including (PEPFAR; www.pepfar.gov), the **President's Malaria Initiative** (PMI; www.pmi.gov), and **Feed the Future** (FTF; www.feedthefuture.gov). Many other U.S. Government agencies contribute to global health goals, including the Department of State, the Centers for Disease Control and Prevention, the Department of Health and Human Services, the Peace Corps, and the Millennium Challenge Corporation. The United States remains steadfast in its commitment to funding quality interventions along with country partners, multilateral organizations, and other donors. Responding to global health challenges is a shared responsibility that cannot be met by one nation alone.

Photo: AFP / Mohammed Huwais

| | 2009 Fiscal Year | 2010 Fiscal Year | 2011 Fiscal Year | 2012 Fiscal Year | 2013 Fiscal Year | 2014 Fiscal Year | TOTAL |
|---|---|---|---|---|---|---|---|
| DOS AND USAID ($ MILLIONS) | 7,741 | 8,477 | 8,279 | 8,608 | 8,420 | 8,826 | 50,352 |
| ENDING PREVENTABLE CHILD AND MATERNAL DEATHS | 1,736 | 2,206 | 2,183 | 2,285 | 2,262 | 2,398 | 13,070 |
| CREATING AN AIDS FREE GENERATION | 5,609 | 5,713 | 5,684 | 5,893 | 5,773 | 6,000 | 34,672 |
| PROTECTING COMMUNITIES FROM INFECTIOUS DISEASES | 396 | 558 | 413 | 430 | 385 | 428 | 2,610 |

# ACTING ON THE CALL: CHANGING THE WAY WE WORK AT USAID

As a result of sustained global commitment and growing country ownership, we stand within reach of achieving goals once unimaginable: ending preventable child and maternal deaths by 2035, and bringing about a grand convergence in life expectancy between poor and rich nations. The global and national mobilizations of the last two years have made a meaningful difference. By analyzing the causes of child and maternal death and the current coverage of life-saving interventions, we have identified the investments that will have the greatest impact, and enable us to work together to save the lives of 15 million children and nearly 600,000 women by 2020 in 24 focus countries. If we continue to accelerate this rate of reduction through to 2035, we can realize a world where children survive and thrive and no mother dies from preventable causes as a consequence of childbirth.

These investments not only represent a great moral achievement, but also a down payment on a more peaceful and prosperous planet. In country after country, we have seen population growth slow and economic growth take off as families choose to have fewer children, those children survive and thrive, and social and economic policies support their education and employment. Today, we know that investments in global health deliver a payoff 9 to 20 times in economic and social dividends.

In order to succeed, however, progress must be driven by domestic resources and supported by targeted international contributions. We must all step forward and align our investments with country-owned plans that focus on delivering results for the most vulnerable families in the most vulnerable communities. Whether we represent a small civil society organization or a large multinational company, all of us must work together to achieve this goal — ensuring we support local change agents across society, from the community health worker who travels to a remote mountain village to the Minister of Health who builds her nation's health budget.

## Changing the Way We Work at USAID

The Call to Action galvanized response in the United States, as USAID has aligned its resources in priority countries and toward the life-saving interventions that have the greatest impact. Over the last 18 months, USAID has undertaken a rigorous review of maternal and child health funding to identify inefficiencie and accelerate progress.

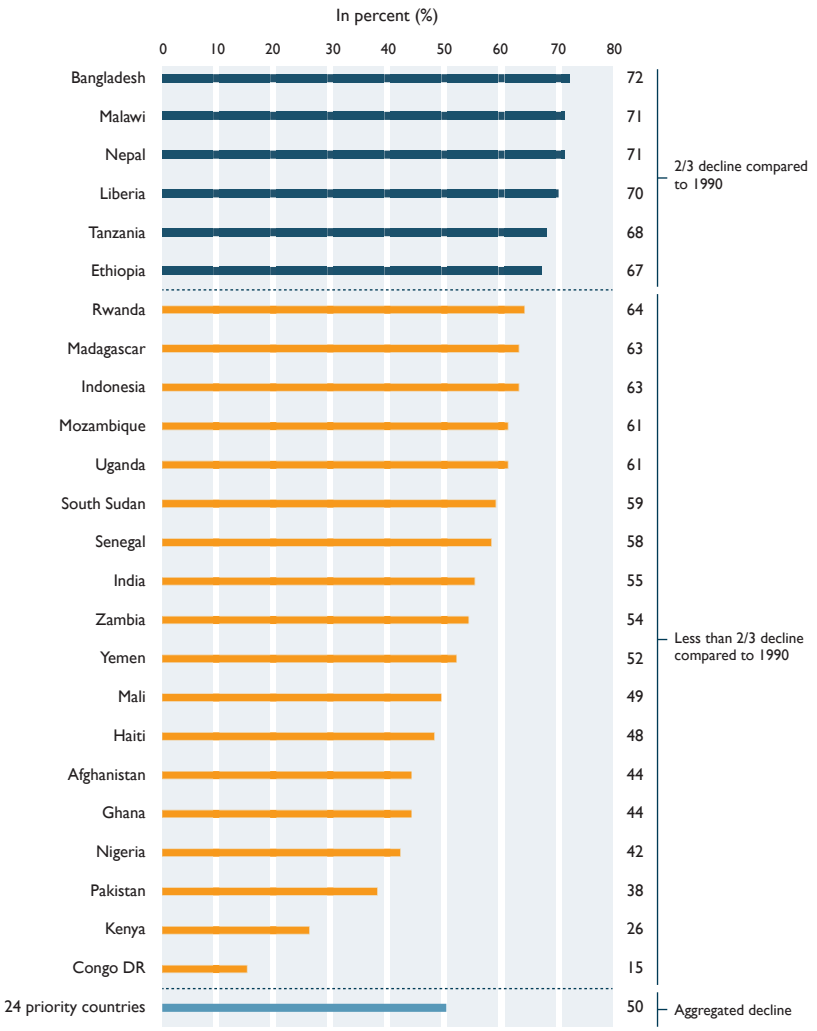
To achieve these results, USAID has shifted its focus to 24 countries, primarily in sub-Saharan Africa and South Asia, that account for 70% of maternal and child deaths and half of the unmet need for family planning. They are: Afghanistan, Bangladesh, the Democratic Republic of the Congo, Ethiopia, Ghana, Haiti, India, Indonesia, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Nepal, Nigeria, Pakistan, Rwanda, Senegal, South Sudan, Tanzania, Uganda, Zambia, and Yemen. These countries are characterized by high magnitude (numbers) and/or severity (rates) of maternal and child deaths and also meet the following criteria:

- Governments have demonstrated a commitment to working with partners and civil society to achieve accelerated reductions in maternal and under-fi e mortality;
- Opportunities exist to integrate and leverage broader U.S. Government resources, such as the President's Malaria Initiative; the President's Emergency Plan for AIDS Relief; family planning; basic education; nutrition; and Feed the Future, President Obama's global food security initiative; and
- Opportunities exist for effective leveraging of USAID resources against those of the host country as well as other international partners, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the GAVI Alliance.

Within these countries, USAID has committed to geographically align around priority districts and shift resources toward newborn health, immunization, and treatment of childhood illness, including expanding access to a broader range of contraceptive methods and essential commodities for reproductive health (e.g., implants), maternal health (e.g., oxytocin, magnesium sulfate), newborn health (e.g. chlorhexidine, antenatal corticosteroid, injectable antibiotics, and resuscitation equipment), and child health (e.g., amoxicillin, ORS/zinc). In addition, USAID will continue to seek greater cost ef ciency through its procurement processes, including exploring co-location, cost-sharing, and collaboration with local rms and NGOs.

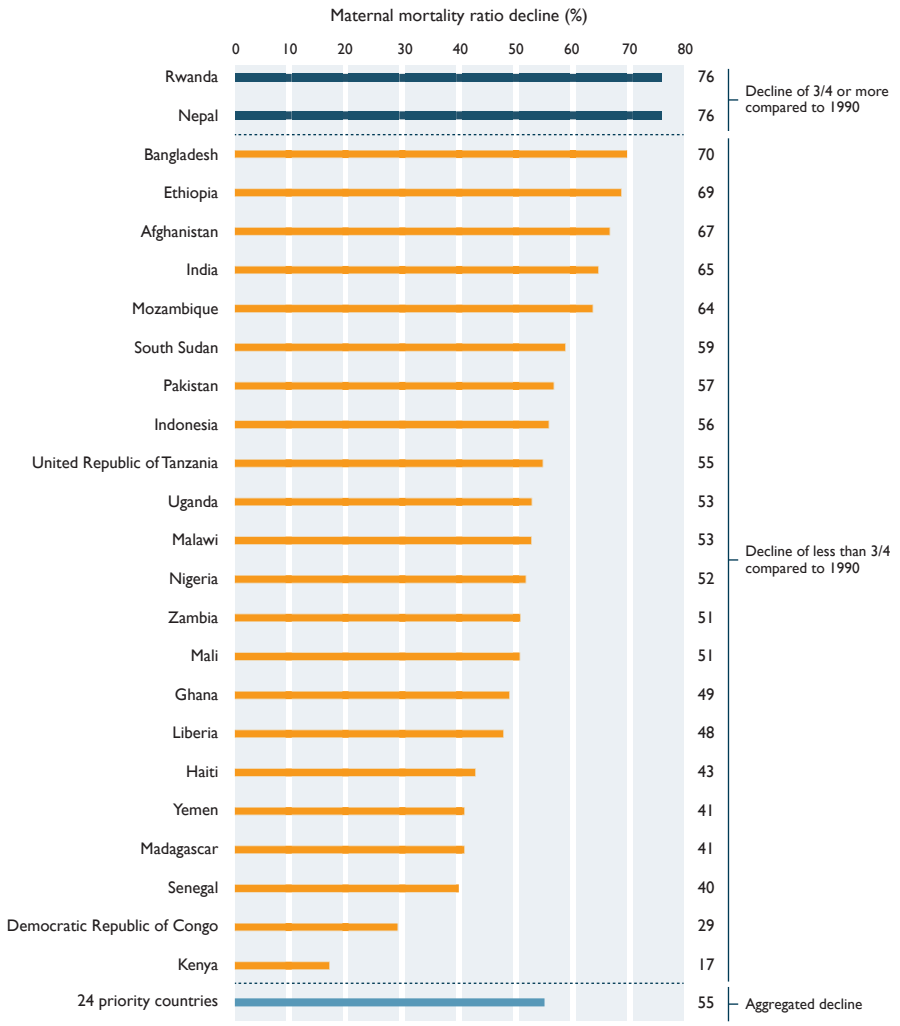
There have been dramatic reductions in deaths of children and mothers since 1990 in these 24 countries. Despite this, not every country is on track to reach Millennium Development Goals 4 (a two-thirds reduction in under- ve mortality), 5a (a three-quarters reduction in maternal mortality by 2015), and 5b (universal access to reproductive health). Even in those countries with dramatic progress, there remains signi cant work to reach every woman and child and usher in sustainable new advances in newborn, child, and maternal health.

## PERCENTAGE DECLINE IN UNDER-FIVE MORTALITY RATE (1990 TO 2012)




Source: UNICEF analysis based on UN IGME 2013

## PERCENT DECLINE IN MATERNAL MORTALITY RATIO, 24 PRIORITY COUNTRIES (1990 TO 2013)




Source: UNICEF analysis based on MMEIG 2014

The following sections represent strategic, results-oriented country action plans for the 24 priority countries. Each plan includes:

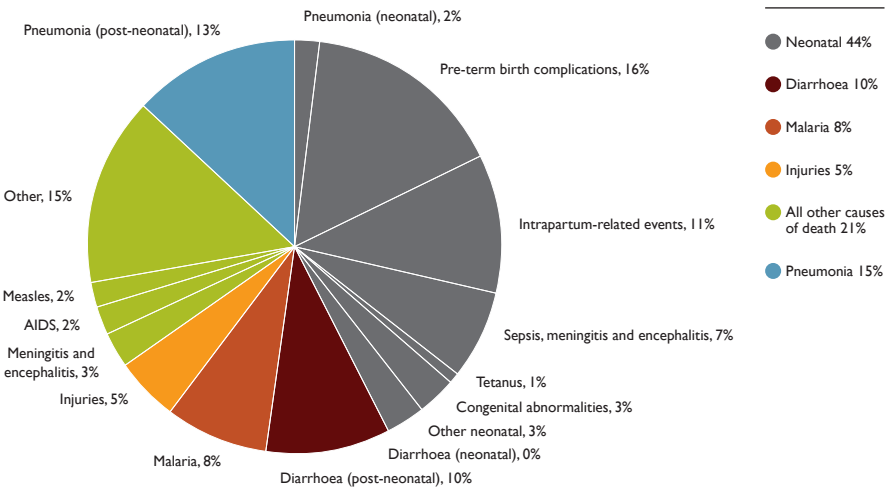
- USAID's Ending Preventable Child and Maternal Deaths (EPCMD) investments, scal years 2009 through 2014;
- Identi ed priorities toward which USAID is aligning its leadership and programs;
- Additional actions to drive EPCMD; and
- Cumulative modeling of all potential lives saved by 2020.

## Modeling and Data Sources

The information presented on the following pages comes from common, publicly available sources outlined further in Annex A. 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 of cial numbers used within countries.

The Lives Saved Tool (LiST) has been used in a number of countries to analyze the impact that priority interventions can have on accelerating reductions in child and maternal mortality. Using this tool, one can measure how many lives will be saved by scaling up interventions. In this

## 24 PRIORITY COUNTRIES: DISTRIBUTION OF DEATHS AMONG CHILDREN UNDER AGE 5, BY CAUSE

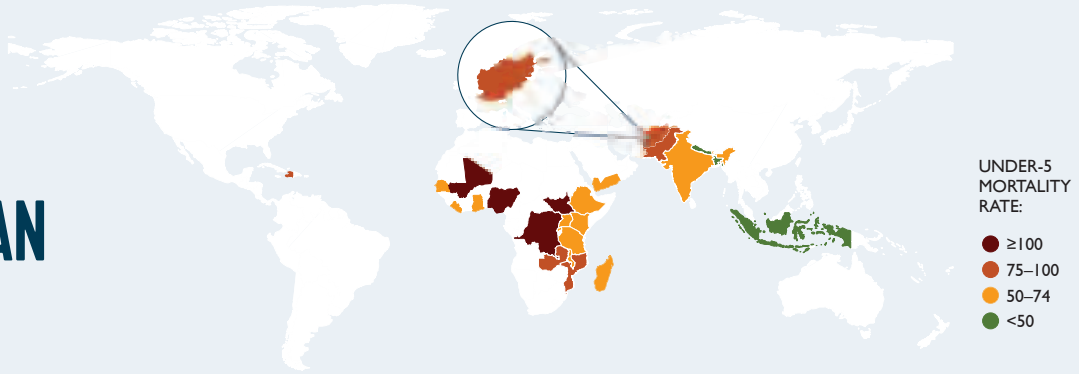



Source: UNICEF

document, the modeled results presented assume scale up of high-impact interventions to achievable rates of coverage by 2020 (see annex A for methodology).

In order to project the child and maternal lives that could be saved, projected coverage rates of effective interventions between 2012 and 2020 are reviewed against current rates of coverage. The "best performer" scenario changes coverage for each intervention based on the rate of progress achieved by the best performing country within categories. The "best performer" values were developed based on analyses of the full set of 75 countdown countries, but stratified according to similar interventions type and level of baseline coverage to arrive at a "best performer" rate of change for each intervention within each country. This projection of coverage change is used to estimate under-fi e mortality reduction between 2012 and 2020, based on the changes in both coverage in both coverage and contraceptive prevalence rate. Bangladesh, Nepal, and Indonesia were used as the reference countries for the demographic impact best performer model. For this reason, there will be no additional lives saved due to demographic impact in these countries.

# AFGHANISTAN




| ENDING PREVENTABLE CHILD AND MATERNAL DEATHS | 2009 Fiscal Year | 2010 Fiscal Year | 2011 Fiscal Year | 2012 Fiscal Year | 2013 Fiscal Year | 2014 Fiscal Year | TOTAL |
|---|---|---|---|---|---|---|---|
| USAID $ IN MILLIONS | 87 | 141 | 136 | 113 | 125 | 116 | 718 |

## USAID HAS COMMITTED TO:

*Support the joint U.S. Government and Government of the Islamic Republic of Afghanistan goals:*

- **Contribute to donor pooled resources through the Afghanistan Reconstruction Trust Fund** to support delivery of the Basic Package of Health Services to increase access to, quality of, and use of primary health care services with a focus on high-impact interventions, such as antenatal services, skilled attendance at delivery, postpartum and newborn care, routine immunization, malnutrition, diarrhea, and pneumonia.
- **Support maternal nutrition during pregnancy** and use of complementary foods for children being weaned and develop a regional strategy for food forti cation under the Almaty consensus.
- **Support expansion and address retention of Afghanistan's cadre** of 22,000 community health workers, including supporting community midwifery and community nursing programs to address shortage of female workers.
- **Increase access to, quality of, and use** of family planning services through direct support to community and faith-based organizations.
- **Strengthen sanitation and hygiene approaches** in the basic package of health services
- **Identify and pilot strategies, including private sector partnerships, social protection** of families, and risk-pooling to strengthen long-term nancial sustainability of the health system.
- **Strengthen governance and management capabilities within the health sector** to support quality health service delivery.
- **Strengthen disease-surveillance systems,** such as the Disease Early Warning System, as well as improved use of data to inform policies and decision-making.

## WORKING TOGETHER, WE CAN DO MORE:

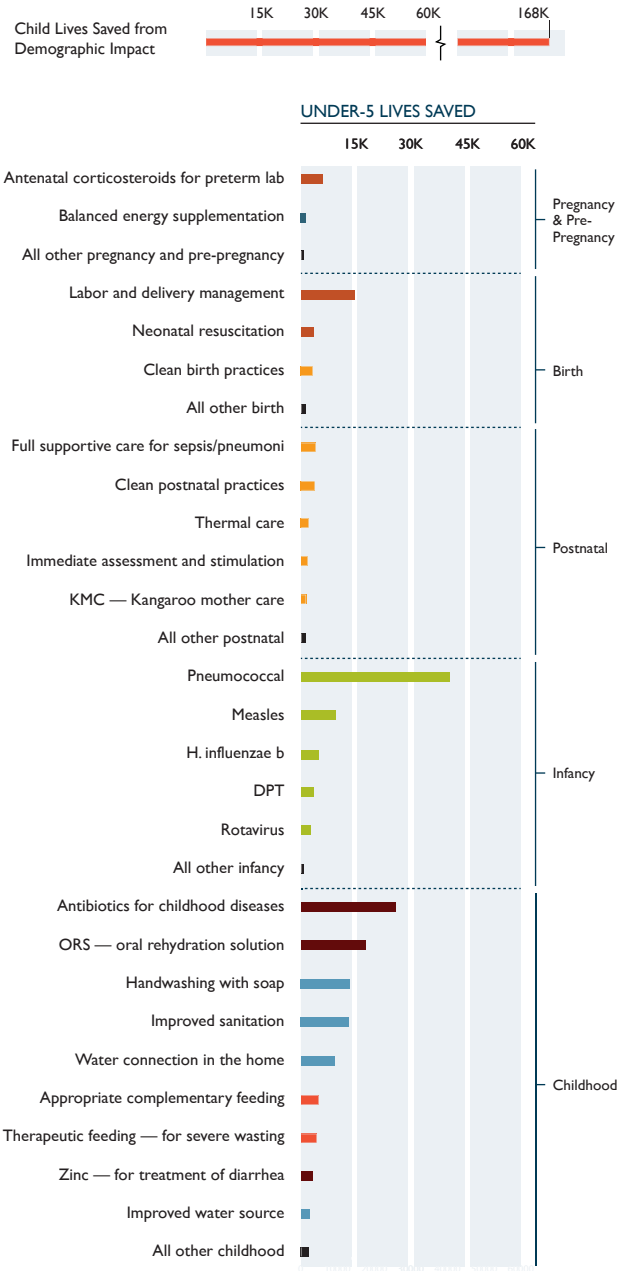
- **Strengthen the government's resilience** to ensure that health sector gains are sustained as donor resources decline.
- **Maintain donor coordination and combination of resources** to enhance the provision of the Basic Package of Health Services.
- **Improve the quality of and con dence** of the hospital sector through the Essential Package of Hospital Services.
- **Increase multi-sectoral integration, especially the inclusion** of health education into the existing education and agricultural systems to reach the household level.
- **Strengthen capacity of national authorities** in emergency preparedness and response, especially for recurrent natural disasters.
- **Address inequality in access to healthcare and expand service provision** through restored and upgraded health care facilities, including expanded provision of services to rural areas still unreachable.
- **Strengthen capacity of the Ministry of Public Health** to ensure availability of high quality essential medicines and commodities.

## COUNTRY DATA: POPULATION AND CHILD & MATERNAL MORTALITY

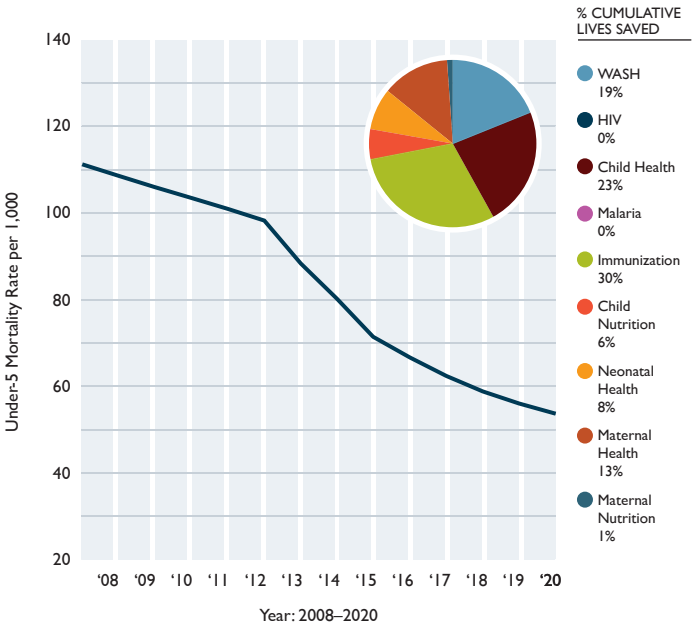
| | Total Population ↑ | Population Under 5 Years ↑ | Under-5 Deaths / Year ↑ | Under-5 Mortality Rate Per 1,000 Live Births ↓ | Births ↑ | Maternal Mortality Ratio Per 100,000 Live Births ↓ |
|---|---|---|---|---|---|---|
| 1990 | 13.5M | 2.6M | 96K | 176 | 739K | 1,300 |
| 2012 | 30.4M | 4.8M | 103K | 98 | 1.2M | 400* |

*2013

## PROJECTED INTERVENTION IMPACTS OVER FIRST 5 YEARS OF LIFE: 2012–2020




## BENDING THE CURVE: REDUCING CHILD MORTALITY




## WORKING TOGETHER, WE CAN REACH THESE GOALS

| | Under-5 Mortality Rate per 1,000 | Maternal Mortality Ratio per 100,000 |
|---|---|---|
| 2012 | 98 | 400* |
| 2020 | 54 | 293 |
| 2035 | 20 | 50 |

*2013

### BY 2020

**470,000 CHILD LIVES SAVED**

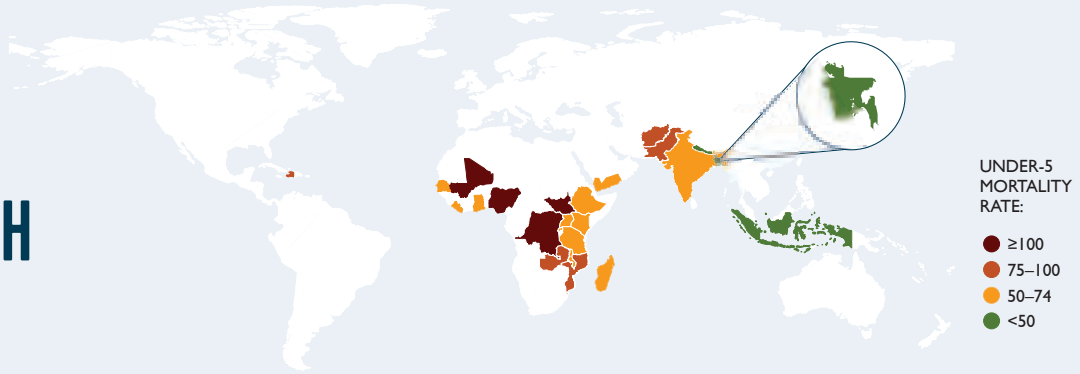
OF WHICH 170,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

**19,000 WOMEN'S LIVES SAVED**

OF WHICH 13,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

Demographic impact is the projected impact of family planning interventions on reducing the number of deaths due to fewer unintended pregnancies.

# BANGLADESH




| ENDING PREVENTABLE CHILD AND MATERNAL DEATHS | 2009 Fiscal Year | 2010 Fiscal Year | 2011 Fiscal Year | 2012 Fiscal Year | 2013 Fiscal Year | 2014 Fiscal Year | TOTAL |
|---|---|---|---|---|---|---|---|
| USAID $ IN MILLIONS | 34 | 41 | 49 | 57 | 60 | 66 | 306 |

## USAID HAS COMMITTED TO:

*Scale up proven solutions in maternal newborn and child health:*

- **Expand the reach of prioritized newborn interventions** through the National Newborn Health Strategy, focusing on the introduction of antenatal corticosteroids for preterm babies, chlorhexidine for umbilical cord care, newborn resuscitation, and antibiotics for treatment of newborn infection.
- **Support the introduction of rotavirus and pneumococcal vaccines** through the Expanded Program on Immunization.
- **Build on successful public and private child health platforms** to manage diarrhea and pneumonia through the national integrated plan for the Management of Childhood Illnesses.
- **Increase equitable access to and utilization of safe delivery services,** including comprehensive emergency obstetric care. Work through NGOs, the private sector, and the public sector to roll out life-saving treatments, including magnesium sulfate for preeclampsia/eclampsia and active management of the third stage of labor, in addition to safe delivery kits for women who deliver at home.
- **Provide technical assistance to the Government of Bangladesh** to strengthen key health systems functions, including commodity procurement and distribution channels and routine health information systems.

*Improve nutrition:*

- **Collaborate with the Feed the Future initiative** to reduce stunting and wasting among children through improved infant and young child feeding practices, and improved household dietary diversity through homestead food production.
- **Assist the government's efforts under the National Nutrition Strategy** to scale up prioritized nutrition interventions nationally, including exclusive breastfeeding, appropriate complementary feeding, and iron-folate supplementation during pregnancy.
- **Support the development of a national strategy** to manage moderate and acute malnutrition, and assist the government to implement the strategy nationwide.

*Sustain focus on reducing unmet need for family planning:*

- **Increase access** to long-acting, reversible contraceptives and permanent methods of family planning nationwide.
- **Expand investment adolescent health services** to reduce early childbearing and closely spaced pregnancies.

## WORKING TOGETHER, WE CAN DO MORE:

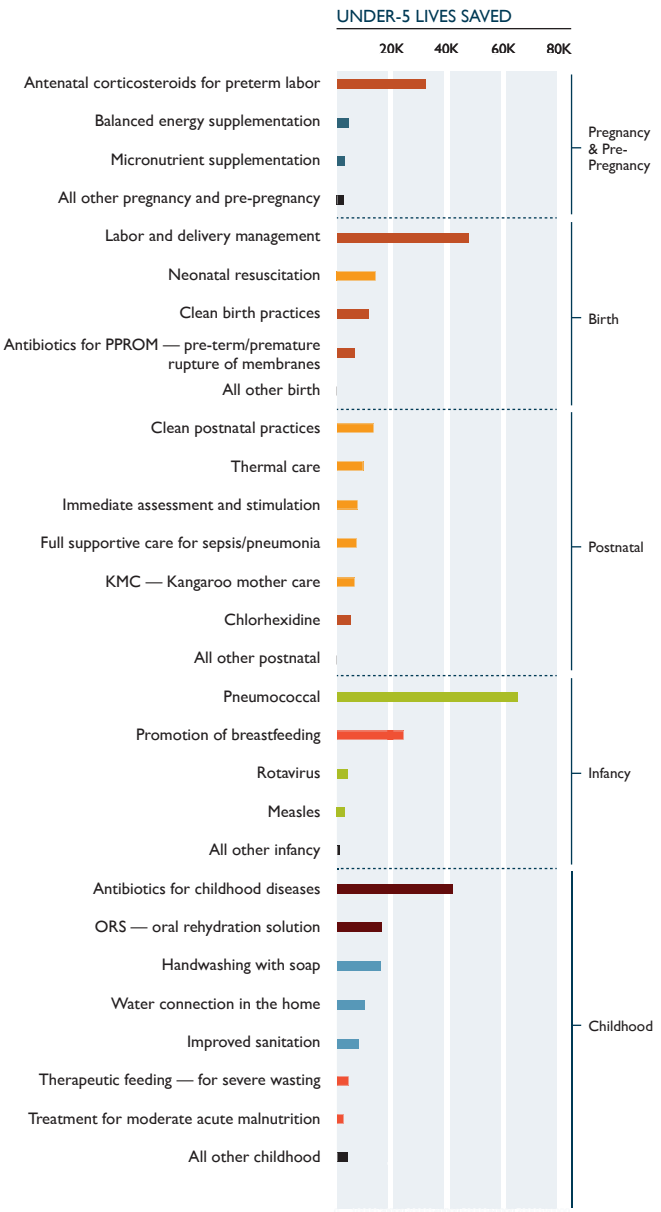
- **Share lessons learned** from the Government of Bangladesh's highly innovative approach to donor coordination that pools the resources of eight health donors through the World Bank.
- **Address inequities through a focus** on reaching marginalized populations with essential services, especially among the urban poor and those living in geographically isolated areas, including urban centers and wards that have no government presence under the NGO Health Service Delivery Project.
- **Ensure uninterrupted supply of essential commodities** — especially commodities that require cold chain — through investments in the supply chain and supply chain management

## COUNTRY DATA: POPULATION AND CHILD & MATERNAL MORTALITY

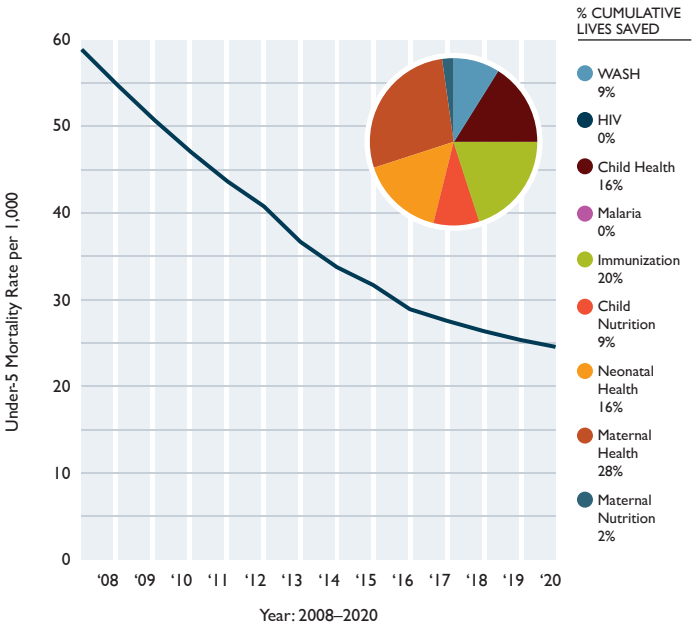
| | Total Population ↑ | Population Under 5 Years ↓ | Under-5 Deaths / Year ↓ | Under-5 Mortality Rate Per 1,000 Live Births ↓ | Births ↓ | Maternal Mortality Ratio Per 100,000 Live Births ↓ |
|---|---|---|---|---|---|---|
| 1990 | 112M | 17.8M | 531K | 143 | 4M | 800 |
| 2012 | 161M | 17.5M | 126K | 41 | 3.6M | 170* |

*2013

## PROJECTED INTERVENTION IMPACTS OVER FIRST 5 YEARS OF LIFE: 2012–2020




## BENDING THE CURVE: REDUCING CHILD MORTALITY




## WORKING TOGETHER, WE CAN REACH THESE GOALS

| | Under-5 Mortality Rate per 1,000 | Maternal Mortality Ratio per 100,000 |
|---|---|---|
| 2012 | 41 | 170* |
| 2020 | 24 | 108 |
| 2035 | <20 | <50 |

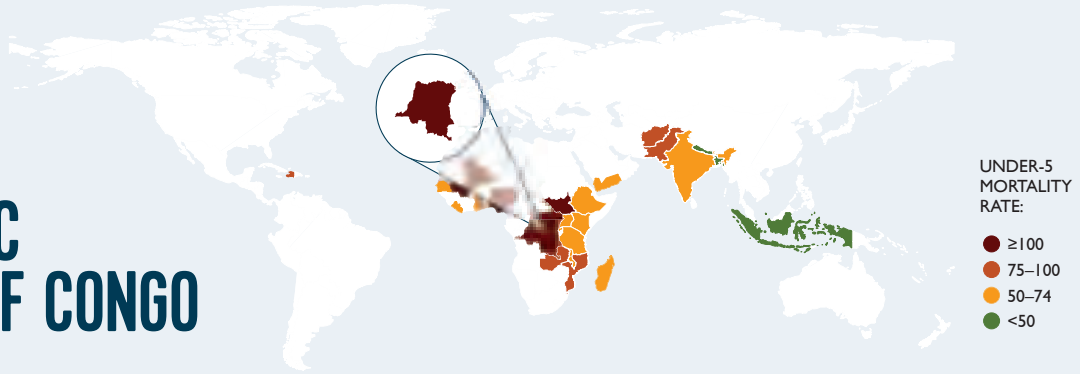
*2013

BY 2020

**366,000 CHILD LIVES SAVED**

**15,600 WOMEN'S LIVES SAVED**

# DEMOCRATIC REPUBLIC OF CONGO




| ENDING PREVENTABLE CHILD AND MATERNAL DEATHS | 2009 Fiscal Year | 2010 Fiscal Year | 2011 Fiscal Year | 2012 Fiscal Year | 2013 Fiscal Year | 2014 Fiscal Year | TOTAL |
|---|---|---|---|---|---|---|---|
| USAID $ IN MILLIONS | 38 | 47 | 67 | 76 | 92 | 104 | 423 |

## USAID HAS COMMITTED TO:

*Deliver high-impact maternal and child survival interventions:*

- **Expand coverage — from 100 iCCM sites to 185** — of an integrated maternal and child health service package that includes: essential newborn care; promotion of early and exclusive breastfeeding; and integrated treatment of childhood illnesses for malaria, pneumonia, and diarrhea in 25 priority health zones in East Kasai, West Kasai, South Kivu, and Katanga Provinces.
- **Expand integrated treatment of malaria and diarrhea** at the community level building on the President's Malaria Initiative platform. Currently, PMI reaches approximately one-third of the country's population.
- **Support for immunization coverage improvements,** including scaling up the newly introduced pneumococcal vaccine and planning for introduction of the rotavirus vaccine.
- **Strengthen collaboration with democracy and governance and education sectors** to address signi cant system bottlenecks to service delivery.

*Reduce malnutrition in high-risk children:*

- **Integrate best practice nutrition interventions** into integrated service delivery packages.
- **Expand promotion of exclusive breastfeeding** and appropriate complementary feeding.
- **Collaborate with Food for Peace programs** to improve capacity for community-based management of malnutrition in targeted health zones.

*Expand access to voluntary family planning:*

- **Expand access to a wide range of culturally acceptable methods of family planning,** including implants, fertility awareness methods, and community-based distribution of Depo-Provera.
- **Increase focus on** postpartum family planning.
- **Leverage the PEPFAR platform and support the expansion** of integrated family planning and prevention of mother-to-child transmission of HIV sites to include 256 sites in Kinshasa, Orientale, and Katanga Provinces.

*Ensure commodities reach all levels of the health system, from the central level down to the community:*

- **Build the capacity of the central procurement entity, FEDECAME,** to effectively manage the national supply chain system.
- **Expand accessibility of high-priority commodities,** such as long-acting, reversible contraceptives, antibiotics, malaria rapid diagnostic tests and treatment, chlorhexidine, misoprostol, Vitamin A, and newborn resuscitation devices.
- **Strengthen information systems and human resource capacity** to ensure commodities reach all service delivery points with minimal stock-outs.

## WORKING TOGETHER, WE CAN DO MORE:

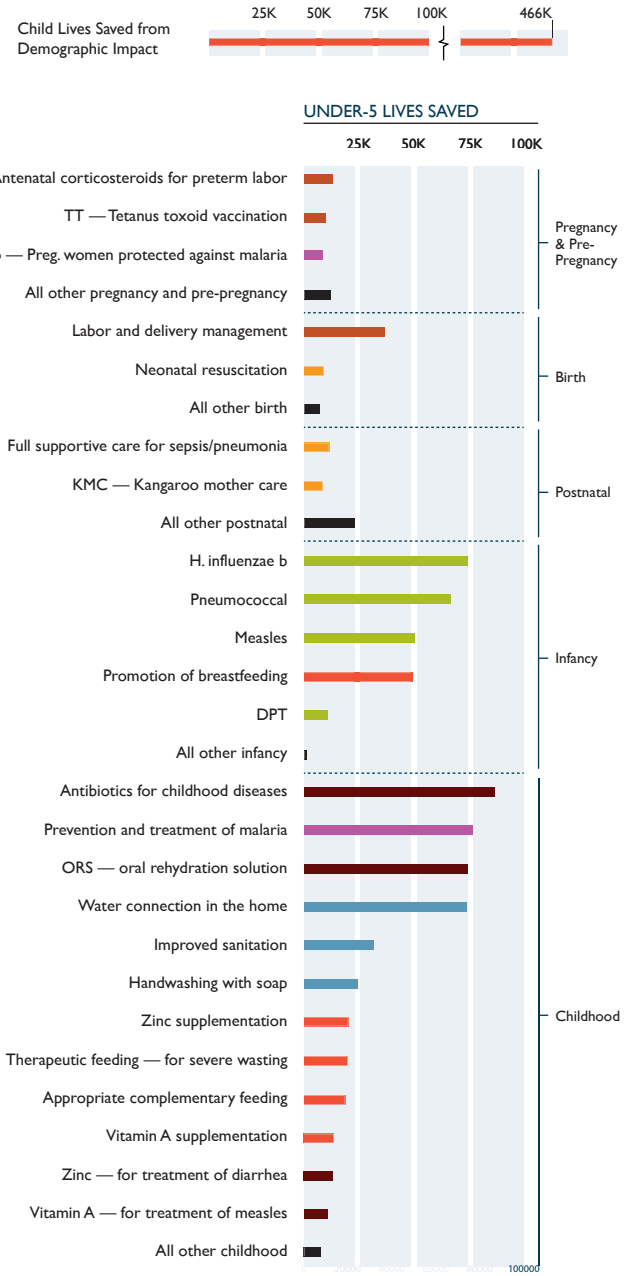
- **Support the government's supply chain system** and procurement partners, FEDECAME, and harmonize supply chain strengthening efforts.
- **Expand use of voluntary family planning,** given continued high fertility.
- **Align efforts to ensure effective prevention and treatment** of childhood pneumonia and diarrhea, ensuring correct use of available, low-cost treatments, such as antibiotics for pneumonia case management, ORS and zinc, as well as integration with malaria treatment at both the facility and community levels.
- **Collaborate with in-country civil society organizations and private sector** to leverage their ability to expand the reach and coverage of life-saving interventions and essential commodities.

## COUNTRY DATA: POPULATION AND CHILD & MATERNAL MORTALITY

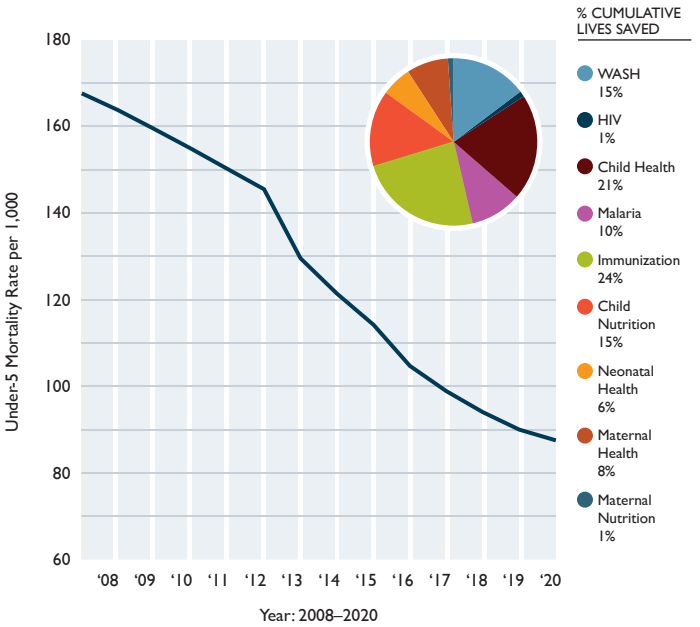
| | Total Population ↑ | Population Under 5 Years ↑ | Under-5 Deaths / Year ↑ | Under-5 Mortality Rate Per 1,000 Live Births ↓ | Births ↑ | Maternal Mortality Ratio Per 100,000 Live Births ↓ |
|---|---|---|---|---|---|---|
| 1990 | 39M | 7.4M | 266K | 171 | 1.8M | 930 |
| 2012 | 73.6M | 11.9M | 391K | 146 | 2.7M | 730* |

*2013

## PROJECTED INTERVENTION IMPACTS OVER FIRST 5 YEARS OF LIFE: 2012–2020




## BENDING THE CURVE: REDUCING CHILD MORTALITY




## WORKING TOGETHER, WE CAN REACH THESE GOALS

| | Under-5 Mortality Rate per 1,000 | Maternal Mortality Ratio per 100,000 |
|---|---|---|
| 2012 | 146 | 730* |
| 2020 | 88 | 370 |
| 2035 | 20 | 50 |

*2013

### BY 2020

**1.5 MILLION CHILD LIVES SAVED**

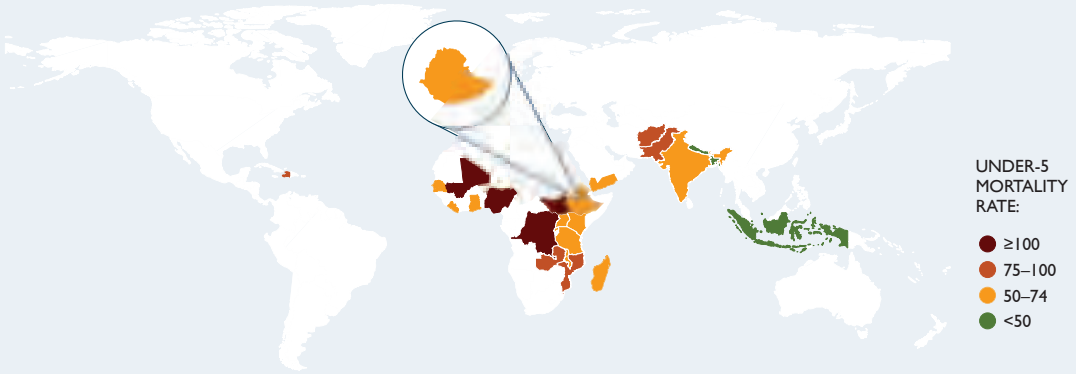
OF WHICH 466,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

**38,000 WOMEN'S LIVES SAVED**

OF WHICH 27,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

Demographic impact is the projected impact of family planning interventions on reducing the number of deaths due to fewer unintended pregnancies.

# ETHIOPIA




| ENDING PREVENTABLE CHILD AND MATERNAL DEATHS | 2009 Fiscal Year | 2010 Fiscal Year | 2011 Fiscal Year | 2012 Fiscal Year | 2013 Fiscal Year | 2014 Fiscal Year | TOTAL |
|---|---|---|---|---|---|---|---|
| USAID $ IN MILLIONS | 58 | 77 | 97 | 108 | 119 | 125 | 583 |

## USAID HAS COMMITTED TO:

*Improve maternal, newborn, and child health:*

- **Address anemia in pregnant women** through iron and folic acid supplementation and nutrition counseling.
- **Scale up of Active Management of Third Stage of Labor** in Ethiopia's four largest regions: Amhara, Oromia, Tigray, SNNPR (Southern Nations, Nationalities, and Peoples' Region).
- **Roll-out of magnesium sulfate** for women presenting with severe pre-eclampsia and eclampsia.
- **Expand primary health care service availability** in line with the Government of Ethiopia's National Integrated Community Case Management initiative.
- **Support routine immunization system strengthening** with an emphasis on improving data quality and strong linkages between health centers and health extension workers.
- **Extend services through the health extension worker,** particularly for measles and the introduction of pneumococcal and rotavirus vaccines, as well as indoor residual spraying to help prevent malaria.
- **Support scale-up and evaluation of the Essential Care** for Every Ethiopian Newborn program in Amhara, Oromia, SNNPR, and Tigray regions and sharing lessons learned with additional health centers and hospitals, emphasizing essential newborn care to address premature births, asphyxia, and sepsis. With malaria prevalence low and decreasing in some places, PMI supports improved data and information management in Ethiopia, including an epidemic detection system to promptly identify and respond to malaria outbreaks.
- **Focus on community-based management and prevention** of acute malnutrition in Feed the Future Zones of In uence.

*Strengthen capacity of national cadre of 38,000 community health workers:*

- **Improve training** for midwives, integrated emergency surgical of cers, nurse anesthetists, and health extension workers to improve birth preparedness/complication readiness training.
- **Empower local health, water and education authorities** to undertake WASH programs in line with USAID's Water and Development Strategy and the National Hygiene and Sanitation Protocol.

*Increased demand, quality, and availability of family planning methods:*

- **Focus on long-acting, permanent and postpartum methods,** including implants, and the consumable products that support such methods.
- **Strengthen social and behavior change communication interventions** on contraceptives misconceptions and harmful traditional practices, including female genital mutilation.

## WORKING TOGETHER, WE CAN DO MORE:

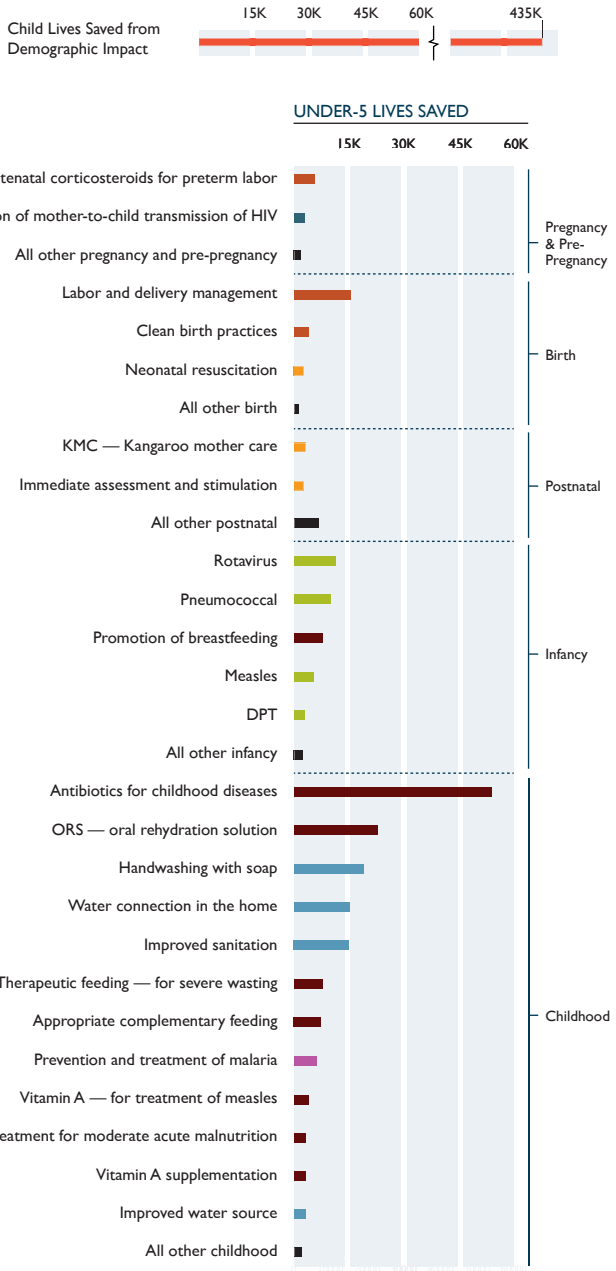
- **Improve maternal health services, including increased facility births and access** to comprehensive emergency obstetric care, as maternal mortality has remained constant.
- **Invest in human resources particularly at primary health care level and** in rural Ethiopia where staff retention is lowest.
- **Improve communications through a renewed partnership with the Ethiopian National Drug Store** to address the current lack of availability of and access to drugs and other health commodities.

## COUNTRY DATA: POPULATION AND CHILD & MATERNAL MORTALITY

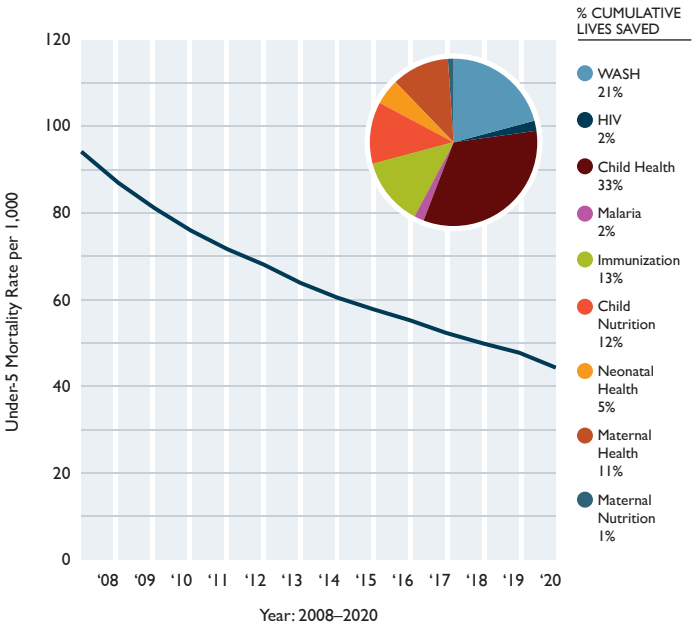
| | Total Population ↑ | Population Under 5 Years ↑ | Under-5 Deaths / Year ↓ | Under-5 Mortality Rate Per 1,000 Live Births ↓ | Births ↑ | Maternal Mortality Ratio Per 100,000 Live Births ↓ |
|---|---|---|---|---|---|---|
| 1990 | 47.5M | 8.5M | 444K | 204 | 2.2M | 950 |
| 2012 | 91.2M | 15.5M | 205K | 68 | 3.5M | 420* |

*2013

## PROJECTED INTERVENTION IMPACTS OVER FIRST 5 YEARS OF LIFE: 2012–2020




## BENDING THE CURVE: REDUCING CHILD MORTALITY




## WORKING TOGETHER, WE CAN REACH THESE GOALS

| | Under-5 Mortality Rate per 1,000 | Maternal Mortality Ratio per 100,000 |
|---|---|---|
| 2012 | 68 | 420* |
| 2020 | 45 | 267 |
| 2035 | 20 | 50 |

*2013

### BY 2020

**815,000 CHILD LIVES SAVED**

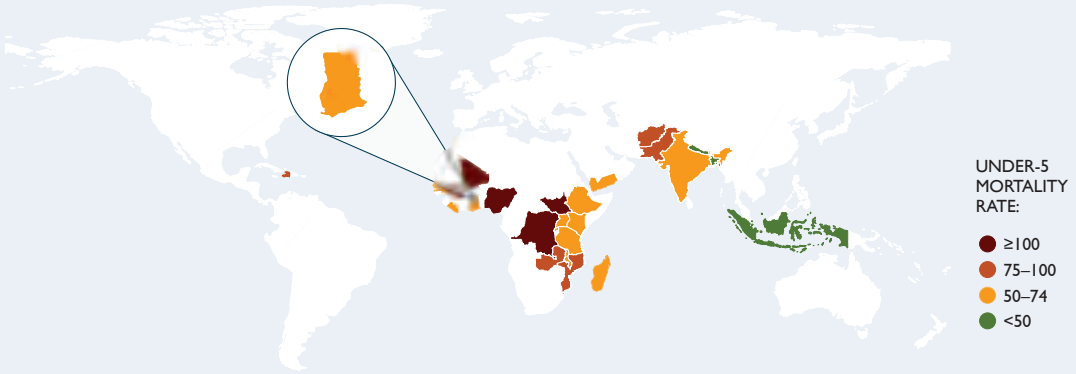
OF WHICH 435,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

**40,000 WOMEN'S LIVES SAVED**

OF WHICH 34,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

Demographic impact is the projected impact of family planning interventions on reducing the number of deaths due to fewer unintended pregnancies.

# GHANA




| ENDING PREVENTABLE CHILD AND MATERNAL DEATHS | 2009 Fiscal Year | 2010 Fiscal Year | 2011 Fiscal Year | 2012 Fiscal Year | 2013 Fiscal Year | 2014 Fiscal Year | TOTAL |
|---|---|---|---|---|---|---|---|
| USAID $ IN MILLIONS | 32 | 53 | 56 | 60 | 56 | 56 | 313 |

## USAID HAS COMMITTED TO:

*Strengthen universal health coverage:*

- **Support Ghana's National Health Insurance Agency** through government-to-government assistance, focusing on the following priority areas of intervention: expanding clinical audits and support for the inclusion of family planning services into the bene ts package; enhancing claims management to generate evidence for ef cient health purchasing; and support to the development of a sustainability strategy.

*Invest in proven child and maternal health solutions:*

- **Support contraceptive supply and logistics and service delivery,** in coordination with Ghana's Supply Chain Master Plan, including improving method mix and access within the private sector.
- **Prevent postpartum hemorrhage through use** of uterotonics and increased skilled attendance at birth.
- **Support the essential newborn care package and implementation** of the Accelerated Newborn Action Plan.
- **Support the Expanded Program on Immunization** to strengthen delivery of immunizations, including polio, pneumococcal, and rotavirus vaccines, and improve the availability of cold chain equipment and logistics for hard-to-reach health facilities in rural communities.
- **Work with licensed chemical sellers** to promote and train on the use of ORS and zinc.
- **Expand equitable access** to an additional 55 high-quality Community Health Planning and Services (CHPS) facilities to vulnerable and impoverished communities, with a focus on Northern and Volta regions.
- **Provide technical assistance** in the CHPS policy revision, dissemination of the new policy, and support to strengthening CHPS with a particular focus on the regions in which the National Health Insurance Authority will be rolling out the capitated payment system.
- **Improve childhood nutrition in coordination with Feed the Future** through support to 20 high-impact nutrition interventions, including provision of Vitamin A supplements as well as community and facility based management of under-nutrition.
- **Reinforce malaria prevention and case management efforts** with support from the President's Malaria Initiative through the implementation of integrated community case management in at least 27 districts in four regions (Brong Ahafo, Ashanti, Volta, and Eastern) in coordination with UNICEF, which focuses on Northern, Central, Upper East, and Upper West regions.
- **Support local sanitation interventions,** particularly those that address environmental enteropathy in agricultural zones.

## WORKING TOGETHER, WE CAN DO MORE:

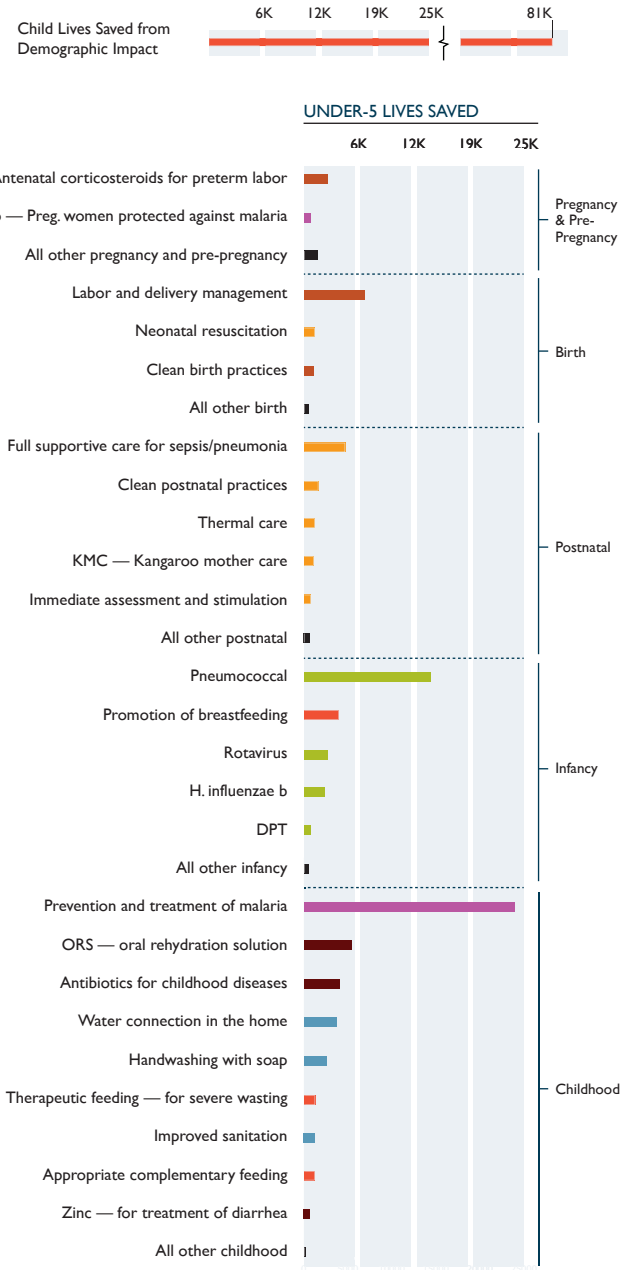
- **Work with local private providers such as Licensed Chemical Sellers** to improve the quality of their services and improve access and choice for Ghanaians.
- **Support supply chain management and explore private sector participation** in supply chain management.
- **Build the capacity of local non-governmental and civil society organizations** to monitor and advocate for improved ef ciencies in the government's health care provision performance at the national, regional, district, and community levels.
- **Ensure the District Health Information Management Systems** re ects community-based services, and that systems are digitized to allow for real time data use.

## COUNTRY DATA: POPULATION AND CHILD & MATERNAL MORTALITY

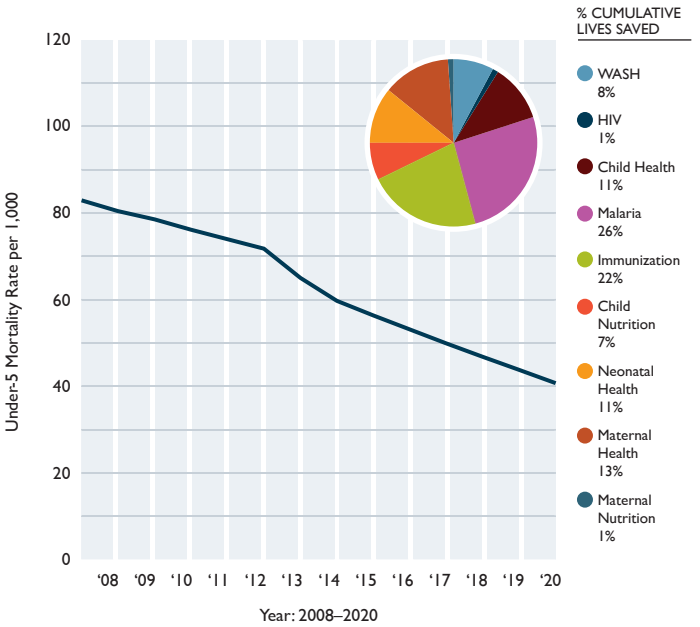
| | Total Population ↑ | Population Under 5 Years ↑ | Under-5 Deaths / Year ↓ | Under-5 Mortality Rate Per 1,000 Live Births ↓ | Births ↑ | Maternal Mortality Ratio Per 100,000 Live Births ↓ |
|---|---|---|---|---|---|---|
| 1990 | 15.5M | 2.7M | 70K | 128 | 603K | 580 |
| 2012 | 24.6M | 3.6M | 60K | 72 | 789K | 380* |

*2013

## PROJECTED INTERVENTION IMPACTS OVER FIRST 5 YEARS OF LIFE: 2012–2020




## BENDING THE CURVE: REDUCING CHILD MORTALITY




## WORKING TOGETHER, WE CAN REACH THESE GOALS

| | Under-5 Mortality Rate per 1,000 | Maternal Mortality Ratio per 100,000 |
|---|---|---|
| 2012 | 72 | 380* |
| 2020 | 41 | 242 |
| 2035 | 20 | 50 |

*2013

### BY 2020

**215,000 CHILD LIVES SAVED**

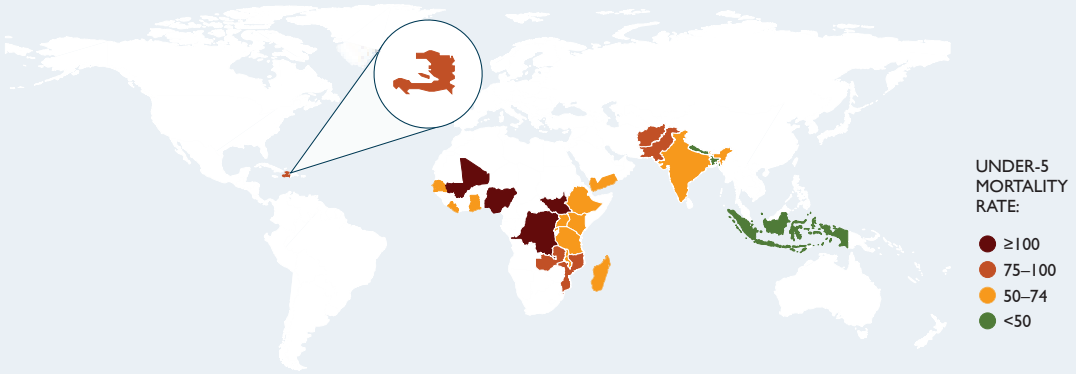
OF WHICH 81,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

**8,000 WOMEN'S LIVES SAVED**

OF WHICH 6,400 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

Demographic impact is the projected impact of family planning interventions on reducing the number of deaths due to fewer unintended pregnancies.

# HAITI




| ENDING PREVENTABLE CHILD AND MATERNAL DEATHS | 2009 Fiscal Year | 2010 Fiscal Year | 2011 Fiscal Year | 2012 Fiscal Year | 2013 Fiscal Year | 2014 Fiscal Year | TOTAL |
|---|---|---|---|---|---|---|---|
| USAID $ IN MILLIONS | 17 | 113 | 25 | 27 | 25 | 25 | 233 |

## USAID HAS COMMITTED TO:

*Improve maternal, newborn and reproductive health:*

- **Increase capacity for skilled birth attendance and referrals** between community and facilities systems to manage delivery complications and newborn care.
- **Expand access to community-based interventions** such as antenatal care, post-natal kangaroo mother care, and family planning through community health workers and mobile services.
- **Expand family planning services** that provide a wide range of methods, including long-acting reversible contraception, and integrate family planning into other health platforms such as immunization and HIV services.
- **Increase treatment of sexually transmitted infections,** including HIV in collaboration with PEPFAR, as part of integrated services.

*Improve child health and nutrition in collaboration with Feed the Future:*

- **Increase community child growth monitoring** to include promotion of Vitamin A supplementation.
- **Expand access to routine immunization services** including introduction of new pneumococcal and rotavirus vaccines.
- **Screen and treat neglected tropical diseases,** including gastro-intestinal worms/parasites.
- **Increase access to health promotion materials** to raise awareness about family planning, maternal health, and nutrition for HIV-positive people in the health and non-health sectors.

*Strengthen health system capacity:*

- **Support the inclusion of contraceptives** as part of essential medicines in the National Budget.
- **Increase effort** to construct eight new health facilities and/or improve existing health facilities and staff skills.
- **Work with the World Bank to expand results-based nancing,** which pays for actual health outcomes rather than service delivery. Currently covers 43% of the population.
- **Support the Ministry of Health** to cost the National Health Strategic Plan.
- **Strengthen the integrated vaccination delivery system** to expand routine immunization services in addition to existing vaccination campaigns.

## WORKING TOGETHER, WE CAN DO MORE:

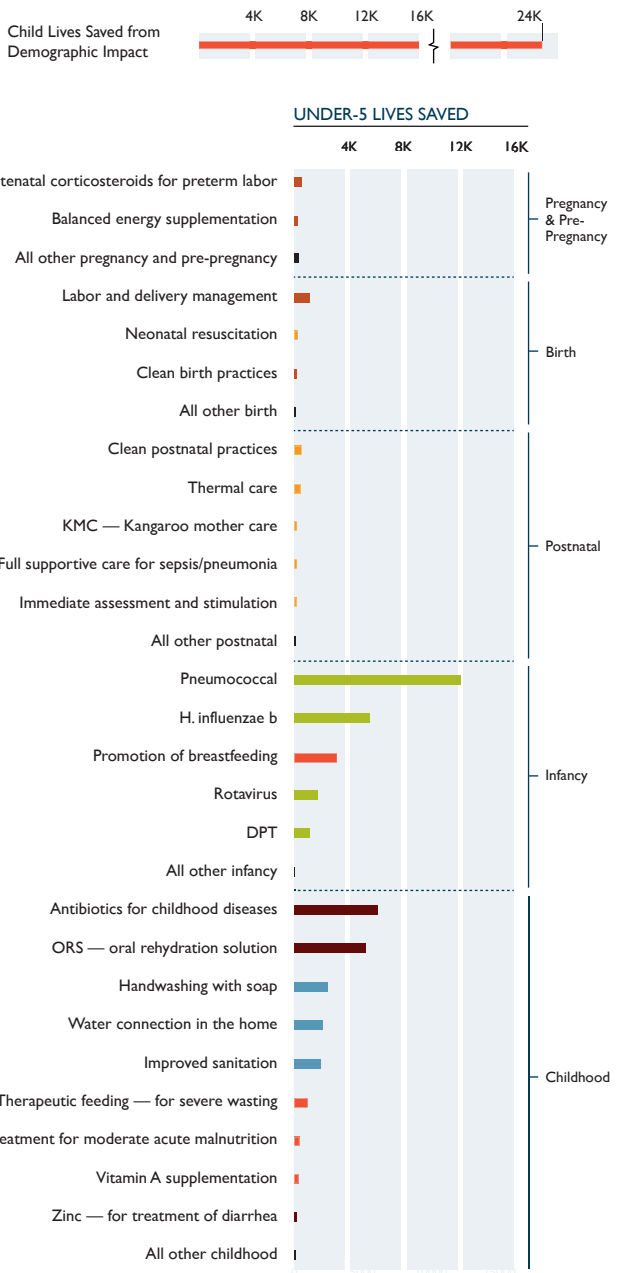
- **Expand efforts to engage with local and faith based organizations** to reach the poorest, most vulnerable populations.
- **Increase and strategically focus greater resources** for access to safe water, sanitation, and improved hygiene behaviors to prevent and control waterborne diseases, including cholera.
- **Improve infrastructure, including road construction, to reduce barriers** to reaching health facilities, especially in hard-to-reach and remote areas of the country.

## COUNTRY DATA: POPULATION AND CHILD & MATERNAL MORTALITY

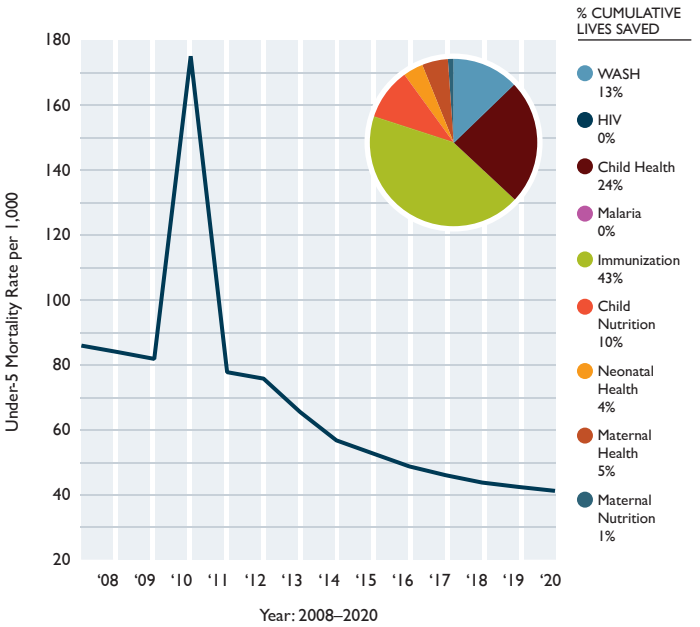
| | Total Population ↑ | Population Under 5 Years ↑ | Under-5 Deaths / Year ↓ | Under-5 Mortality Rate Per 1,000 Live Births ↓ | Births ↓ | Maternal Mortality Ratio Per 100,000 Live Births ↓ |
|---|---|---|---|---|---|---|
| 1990 | 6.8M | 1M | 36K | 144 | 260K | 620 |
| 2012 | 9.8M | 1.1M | 20K | 75 | 234K | 380* |

*2013

## PROJECTED INTERVENTION IMPACTS OVER FIRST 5 YEARS OF LIFE: 2012–2020




## BENDING THE CURVE: REDUCING CHILD MORTALITY




## WORKING TOGETHER, WE CAN REACH THESE GOALS

| | Under-5 Mortality Rate per 1,000 | Maternal Mortality Ratio per 100,000 |
|---|---|---|
| 2012 | 75 | 380* |
| 2020 | 41 | 242 |
| 2035 | 20 | 50 |

*2013

### BY 2020

**85,000 CHILD LIVES SAVED**

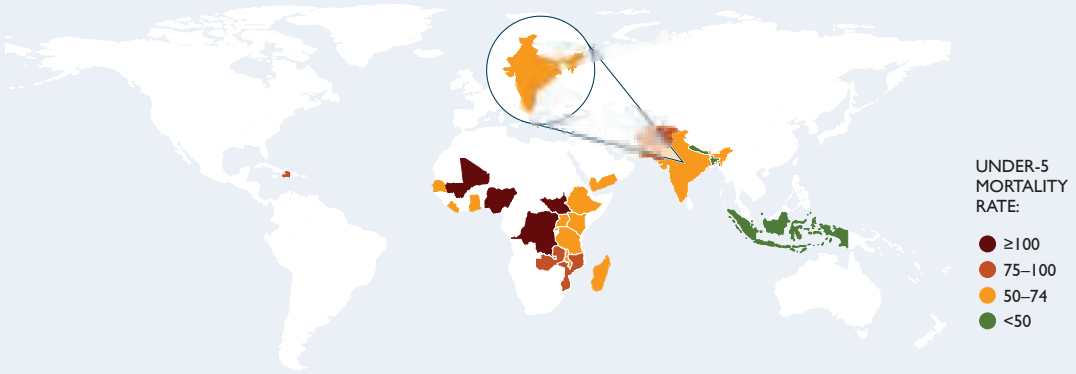
OF WHICH 24,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

**3,000 WOMEN'S LIVES SAVED**

OF WHICH 1,800 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

Demographic impact is the projected impact of family planning interventions on reducing the number of deaths due to fewer unintended pregnancies.

# INDIA




| ENDING PREVENTABLE CHILD AND MATERNAL DEATHS | 2009 Fiscal Year | 2010 Fiscal Year | 2011 Fiscal Year | 2012 Fiscal Year | 2013 Fiscal Year | 2014 Fiscal Year | TOTAL |
|---|---|---|---|---|---|---|---|
| USAID $ IN MILLIONS | 39 | 44 | 43 | 45 | 41 | 38 | 249 |

## USAID HAS COMMITTED TO:

*Serve as the lead development partner in six states (Uttarakhand, Jharkhand, Punjab, Haryana, Himachal Pradesh, and Delhi), supporting work in 30 high-priority areas and numerous other districts:*

- **Scale up Priority Interventions** de ned in the Government of India's Reproductive, Maternal, Newborn, Child, and Adolescent Health strategy.
- **Support routine immunization systems** and address challenges in cold chain and in vaccine and logistics management.
- **Utilize tools and interventions for managing labor,** including partograms to record progress and quickly detect complications.
- **Expand choice for contraception, including IUDs, and strengthen doorstep delivery** of contraceptives through frontline health workers, smart integration of family planning with care after delivery, and promotion of behavior change through messages on healthy timing and spacing of pregnancies.

*Catalyze innovative public-private partnerships:*

- **Leverage the multi-billion dollar national health programs** of the Government of India and private sector nancial resources, skills, and expertise.
- **Expand upon the 2013 USAID, Kiawah Trust of the United Kingdom, Piramal Foundation, and Dasra partnership** to provide priority interventions to address the healthcare needs of adolescent girls, mothers, newborns, and children.
- **Strengthen government stewardship** of public-private partnerships.

## WORKING TOGETHER, WE CAN DO MORE:

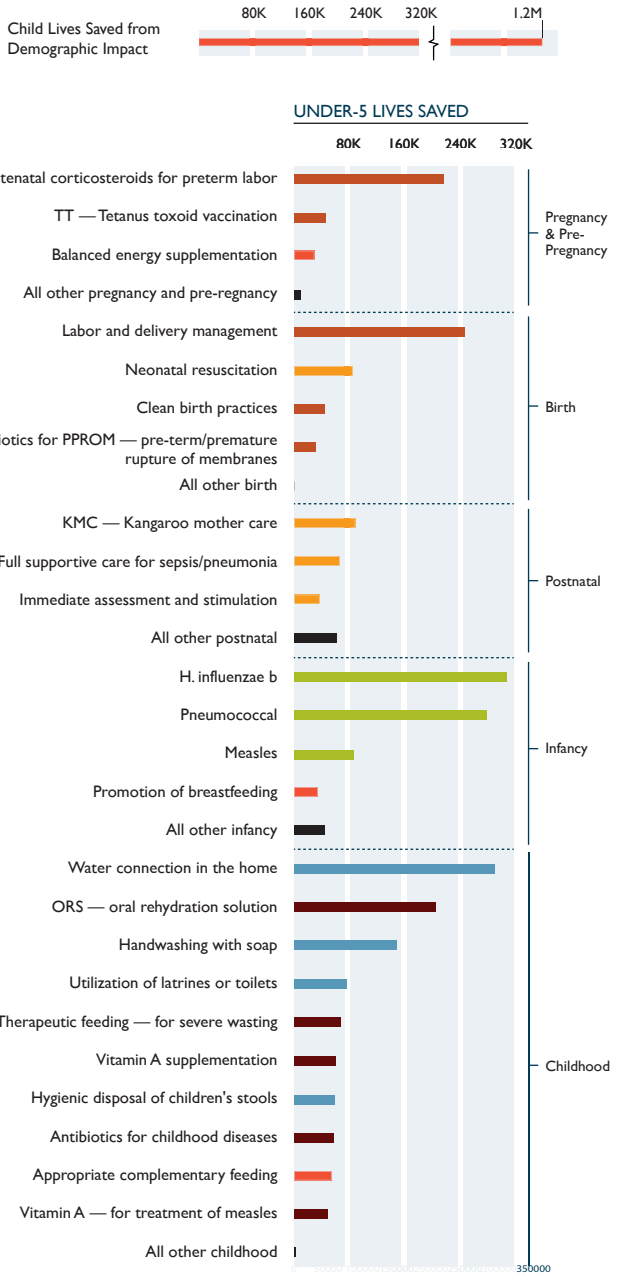
- **Galvanize private sector engagement** and seize the unprecedented opportunity provided by the recent Indian law mandating companies that meet certain criteria to invest in Corporate Social Responsibility activities.
- **Invest in adolescents with a holistic approach** to delay early marriage and child-bearing, address gender, health, and education related barriers, and enhance life skills development.
- **Use existing regional cooperation platforms,** such as the Almaty Consensus, to identify regional resources, experience and expertise to address intractable nutrition challenges in South and Central Asia.
- **Address under nutrition among mothers, children, and adolescents,** which contributes to more deaths and disability than any other factor.
- **Reduce out-of-pocket health expenditure** as government social insurance schemes cover only 25% of the population, and expand programs aimed at providing nancial risk protection.
- **Improve the health workforce by promoting skill development, appropriate placement, and incentives** to health personnel in collaboration with PEPFAR, particularly in disadvantaged, rural, and slum areas, where India's health disparities are most prominent.

## COUNTRY DATA: POPULATION AND CHILD & MATERNAL MORTALITY

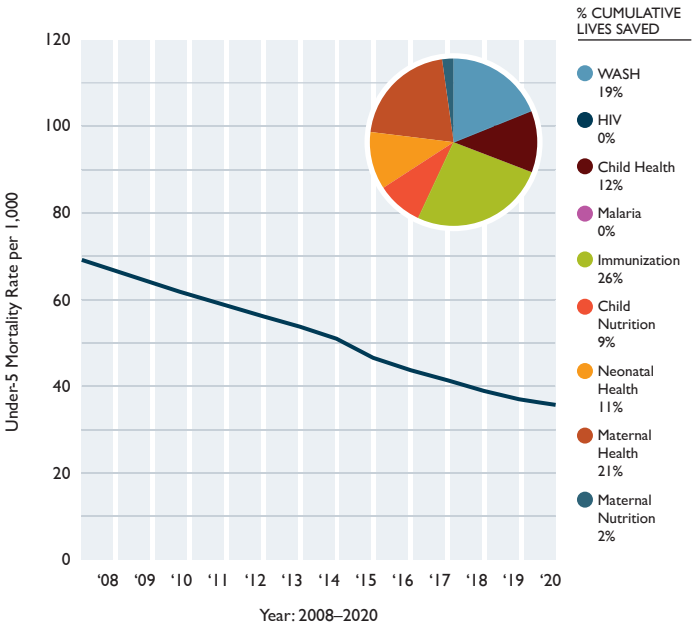
| | Total Population ↑ | Population Under 5 Years ↓ | Under-5 Deaths / Year ↓ | Under-5 Mortality Rate Per 1,000 Live Births ↓ | Births ↓ | Maternal Mortality Ratio Per 100,000 Live Births ↓ |
|---|---|---|---|---|---|---|
| 1990 | 869M | 119M | 3.3M | 126 | 26.5M | 600 |
| 2012 | 1.2B | 118M | 1.4M | 56 | 24.8M | 190* |

*2013

## PROJECTED INTERVENTION IMPACTS OVER FIRST 5 YEARS OF LIFE: 2012–2020




## BENDING THE CURVE: REDUCING CHILD MORTALITY




## WORKING TOGETHER, WE CAN REACH THESE GOALS

| | Under-5 Mortality Rate per 1,000 | Maternal Mortality Ratio per 100,000 |
|---|---|---|
| 2012 | 56 | 190* |
| 2020 | 36 | 121 |
| 2035 | 20 | <50 |

*2013

### BY 2020

## 4.3 MILLION CHILD LIVES SAVED

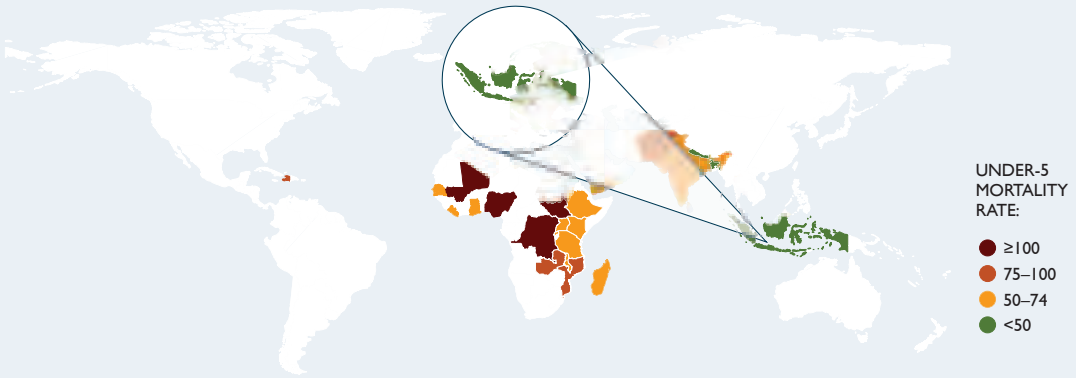
OF WHICH 1,200,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

## 128,000 WOMEN'S LIVES SAVED

OF WHICH 60,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

Demographic impact is the projected impact of family planning interventions on reducing the number of deaths due to fewer unintended pregnancies.

# INDONESIA




| ENDING PREVENTABLE CHILD AND MATERNAL DEATHS | 2009 Fiscal Year | 2010 Fiscal Year | 2011 Fiscal Year | 2012 Fiscal Year | 2013 Fiscal Year | 2014 Fiscal Year | TOTAL |
|---|---|---|---|---|---|---|---|
| USAID $ IN MILLIONS | 13 | 16 | 15 | 20 | 20 | 20 | 104 |

## USAID HAS COMMITTED TO:

*Contribute to a 25% reduction in maternal and newborn mortality in the next  ve years:*

- **Support improvements in quality of care** for both public and private health services in 23 districts with a target to reach 30 districts, 150 hospitals, and 300 health centers in the six provinces responsible for 50% of maternal and newborn deaths. In hospitals in these districts, improve the quality of services in emergency room, obstetric, neonatal, and surgical wards.
- **Support the Ministry of Health at all levels** to scale up high-impact MNCH interventions through in  uential regional teaching hospitals, and by strengthening provincial public and private facilities to function as regional experts in essential obstetric and neonatal care.
- **Improve the impact of maternal and perinatal audits** on decision-making and operations.
- **Support the national integrated quality of care strategy,** including improved hospital accreditation practices and BPJS (the Indonesian social security agency) credentialing to primary care and hospitals.
- **Utilize a cell phone-based system** to improve the ef  ciency and effectiveness of the referral system
- **Advance equitable implementation** of universal health coverage.
- **Address non-  nancial barriers,** including disrespectful care, that limit the poor and vulnerable populations from accessing quality health services.
- **Provide technical assistance** to collect, analyze, and use MNCH data, including maternal and perinatal death audits.

*Apply evidence and innovation:*

- **Help Indonesian scientists to be published** in international journals, generate new evidence, and translate scienti  c evidence to inform MNCH policy and program priorities.
- **Enable civil society organizations and the media** to assess and use evidence in advocating for MNCH issues.

## WORKING TOGETHER, WE CAN DO MORE:

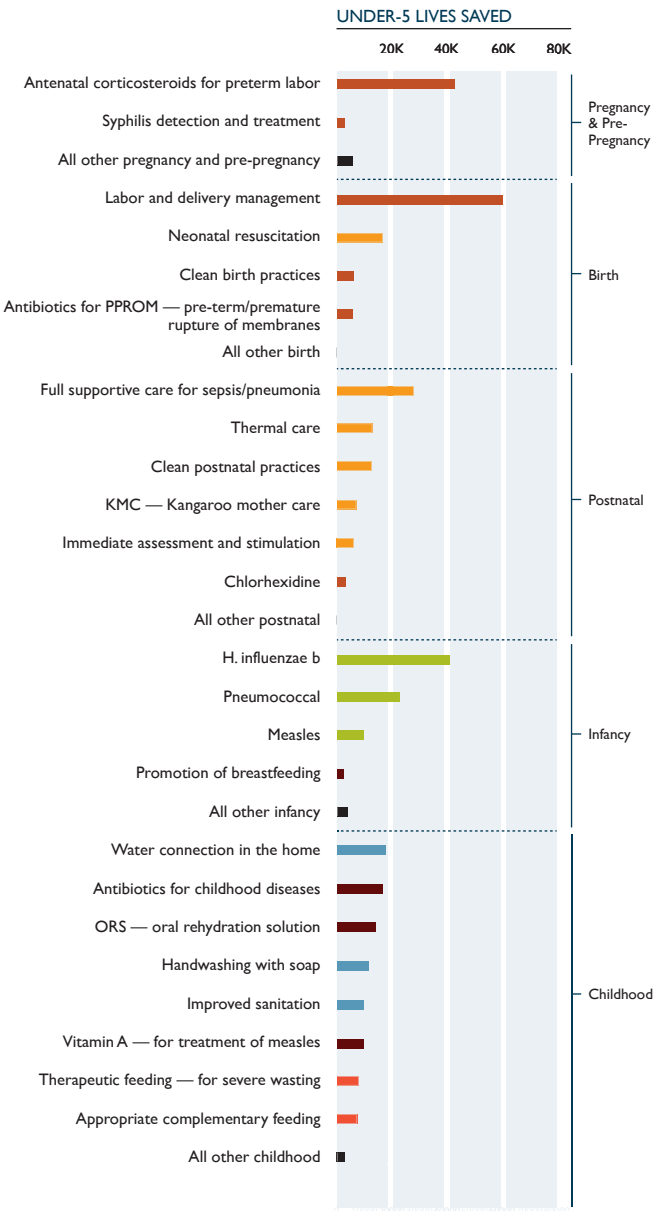
- **Strengthen engagement around nutrition** to prevent stunting as part of the Scaling Up Nutrition initiative through increased support and collaboration with the private sector, government, and the Millennium Challenge Corporation.
- **Advocate for and unlock local resources** to build the capacity of local civil society partners.
- **Address issues of decentralization** with huge variability in local health care services.
- **Improve human resources** for health, addressing inadequate training of midwives, the scarcity of doctors, and over-reliance on village-level care instead of facility-level care.
- **Support routine immunization strengthening and customize approaches** to achieve high and equitable coverage.

## COUNTRY DATA: POPULATION AND CHILD & MATERNAL MORTALITY

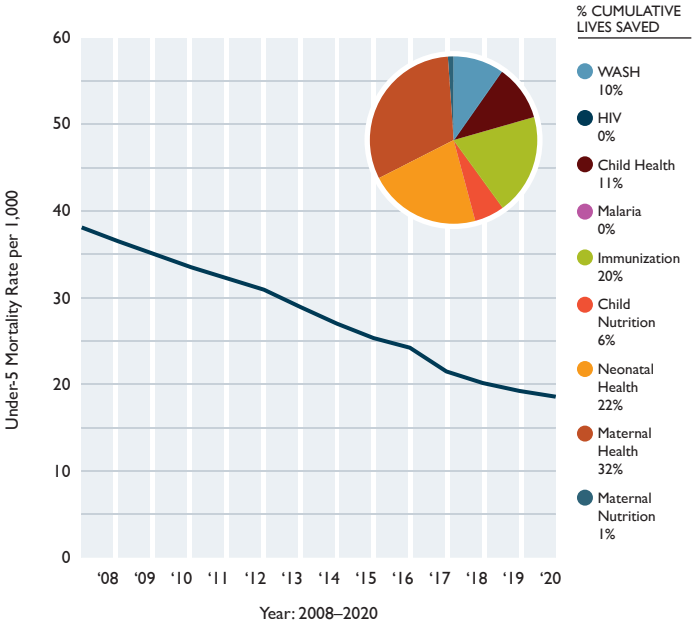
| | Total Population ↑ | Population Under 5 Years ↑ | Under-5 Deaths / Year ↓ | Under-5 Mortality Rate Per 1,000 Live Births ↓ | Births ↓ | Maternal Mortality Ratio Per 100,000 Live Births ↓ |
|---|---|---|---|---|---|---|
| 1990 | 182M | 21.5M | 384.7K | 83 | 4.6M | 600 |
| 2012 | 249M | 21.8M | 151.6K | 31 | 4.4M | 190* |

*2013

## PROJECTED INTERVENTION IMPACTS OVER FIRST 5 YEARS OF LIFE: 2012–2020




## BENDING THE CURVE: REDUCING CHILD MORTALITY




## WORKING TOGETHER, WE CAN REACH THESE GOALS

| | Under-5 Mortality Rate per 1,000 | Maternal Mortality Ratio per 100,000 |
|---|---|---|
| 2012 | 31 | 190* |
| 2020 | 19 | 121 |
| 2035 | <19 | <50 |

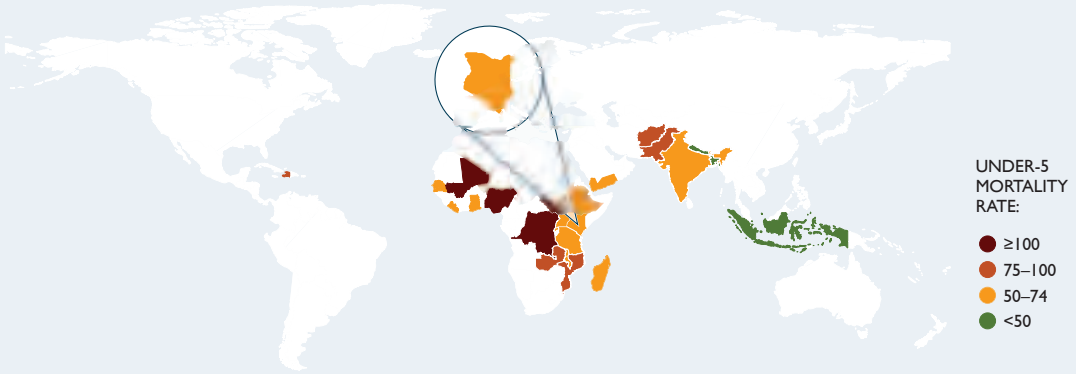
*2013

BY 2020

**382,000 CHILD LIVES SAVED**

**31,000 WOMEN'S LIVES SAVED**

# KENYA




| ENDING PREVENTABLE CHILD AND MATERNAL DEATHS | 2009 Fiscal Year | 2010 Fiscal Year | 2011 Fiscal Year | 2012 Fiscal Year | 2013 Fiscal Year | 2014 Fiscal Year | TOTAL |
|---|---|---|---|---|---|---|---|
| USAID $ IN MILLIONS | 43 | 68 | 71 | 74 | 74 | 78 | 407 |

## USAID HAS COMMITTED TO:

*Improve demand, quality, and access to maternal and newborn health:*

- **Improve providers' skills in basic emergency obstetric care and essential newborn care,** including active management of the third stage of labor, neonatal resuscitation, early initiation and exclusive breastfeeding, and prevention and optimal management of neonatal infection and preterm complications.
- **Increase community health workers' home visits and provision** of up-to-date information.
- **Work closely with medical training institutions, regulatory bodies, and the private sector** to increase the number of health workers graduating every year.

*Identify and improve services for most vulnerable:*

- **Target 400,000 children in 2014 for the scale up of ORS and zinc** for management of diarrhea, including availability of an ORS/zinc co-pack in the private sector, through training of retailers and small-scale health clinics and the development of marketing materials for Licensed Chemists Shops, of which there are approximately 10,000.
- **Procure and distribute insecticide-treated mosquito nets with PMI support** through multiple distribution strategies, including antenatal care and child health clinics to help Kenya achieve universal coverage, de ned as one net per two people.
- **Support the introduction** of rotavirus vaccine.
- **Train 9,000 facility and community health workers** in comprehensive nutrition assessment for early detection of acute malnutrition, as well as counseling and demonstration on appropriate infant and young child feeding, in coordination with Feed the Future.
- **Strengthen collection and use of immunization data** to improve human resource management and commodity procurement.
- **Promote Community-Led Total Sanitation and household hygiene practices,** including through social marketing of point-of-use water treatment and storage.

*Increase supply and demand of family planning methods:*

- **Reach the underserved, particularly youth and the poor,** by developing and disseminating behavior change communication messages nationwide that address common misconceptions, such as the myth that the use of contraception might cause infertility.
- **Increase access to a broad range of modern contraceptives, including implants and injectables,** through a variety of service delivery channels, such as community health workers, mobile services, and HIV comprehensive care centers.
- **Expand coverage of integrated family planning, HIV and MNCH services** in Coast, Nyanza, and Western Regions; procure contraceptives; and improve commodity distribution and reporting.

## WORKING TOGETHER, WE CAN DO MORE:

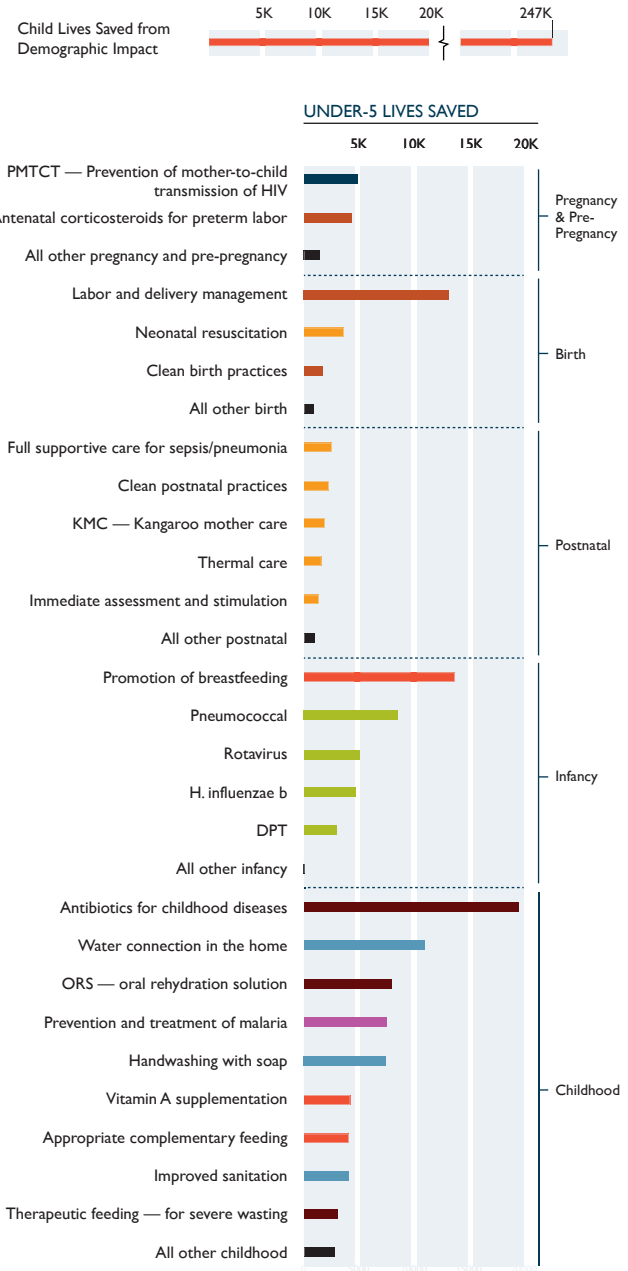
- **Build capacity of Kenya's new 47-county governments** to better plan, budget, and manage health workforce and service delivery.
- **Help address human resource constraints, supply and equipment needs, and quality-of-care issues** as the new county health management structure rolls out.
- **Work to transition contract health workers** to the government payroll once county governments have the minimum capacity and systems to absorb these staff.
- **Support Kenya in addressing high out-of-pocket expenditures,** from reducing out-of-pocket payments at the point of service to extending social health insurance, paving the way toward universal health coverage.

## COUNTRY DATA: POPULATION AND CHILD & MATERNAL MORTALITY

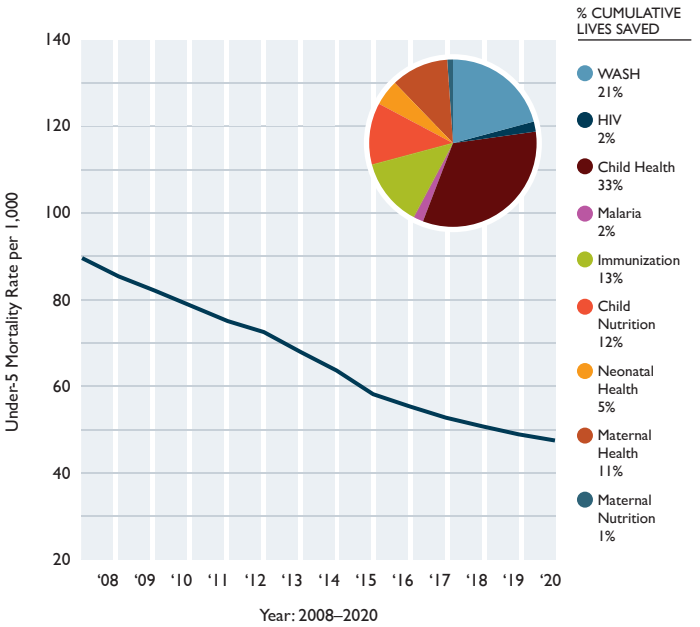
| | Total Population ↑ | Population Under 5 Years ↑ | Under-5 Deaths / Year ↑ | Under-5 Mortality Rate Per 1,000 Live Births ↓ | Births ↑ | Maternal Mortality Ratio Per 100,000 Live Births ↓ |
|---|---|---|---|---|---|---|
| 1990 | 23M | 4.2M | 95K | 98 | 927K | 490 |
| 2012 | 43M | 6.8M | 108K | 73 | 1.4M | 400* |

*2013

## PROJECTED INTERVENTION IMPACTS OVER FIRST 5 YEARS OF LIFE: 2012–2020




## BENDING THE CURVE: REDUCING CHILD MORTALITY




## WORKING TOGETHER, WE CAN REACH THESE GOALS

| | Under-5 Mortality Rate per 1,000 | Maternal Mortality Ratio per 100,000 |
|---|---|---|
| 2012 | 73 | 400* |
| 2020 | 48 | 254 |
| 2035 | 20 | 50 |

*2013

### BY 2020

**472,000 CHILD LIVES SAVED**

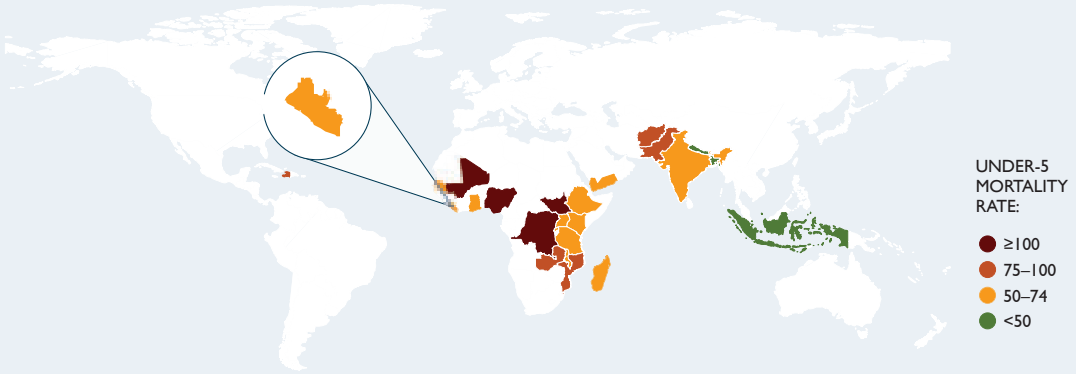
OF WHICH 247,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

**22,000 WOMEN'S LIVES SAVED**

OF WHICH 17,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

Demographic impact is the projected impact of family planning interventions on reducing the number of deaths due to fewer unintended pregnancies.

# LIBERIA




| ENDING PREVENTABLE CHILD AND MATERNAL DEATHS | 2009 Fiscal Year | 2010 Fiscal Year | 2011 Fiscal Year | 2012 Fiscal Year | 2013 Fiscal Year | 2014 Fiscal Year | TOTAL |
|---|---|---|---|---|---|---|---|
| USAID $ IN MILLIONS | 29 | 32 | 29 | 28 | 30 | 30 | 179 |

## USAID HAS COMMITTED TO:

*Advance integrated community case management with a focus on neonatal and childhood illnesses:*

- **Implement a forward-leaning government-to-government approach,** reimbursing the government for costs it has incurred in managing health clinics in three of the country's 15 counties after pre-de ned milestones have been met.
- **Strengthen antenatal care including iron folate,** as well as intermittent preventive treatment for malaria to pregnant women and distribution of insecticide-treated mosquito nets with support from the President's Malaria Initiative.
- **Expand essential newborn care** — including the use of chlorhexidine for cord care, antenatal corticosteroids, and kangaroo mother care — and emergency obstetric care and community distribution of misoprostol.
- **Operationalize the Government of Liberia's Reaching Every District strategy,** which emphasizes capacity building for improved district management, in order to broaden coverage of the Expanded Program on Immunization to hard-to-reach and marginalized populations.

*Strengthen service delivery of family planning methods in targeted counties of Nimba, Bong, and Lofa:*

- **Scale up of pilot approach for family planning service provision** at urban markets to six additional counties.
- **Scale up a pilot program integrating family planning** with immunization services.
- **Support the MOH Supply Chain Master Plan** to strengthen management, including forecasting and distribution of family planning and health commodities at the facility and community level.

*Advance a comprehensive nutrition approach:*

- **Focus on the promotion of essential nutrition actions** in coordination with Feed the Future Zones of In uence.

*Apply Community-Led Total Sanitation approach:*

- **Apply the innovative Community-Led Total Sanitation approach to improve sanitation** by mobilizing at least 350 communities to develop action plans to eliminate open defecation, promote proper hand washing, and proper treatment of drinking water.

## WORKING TOGETHER, WE CAN DO MORE:

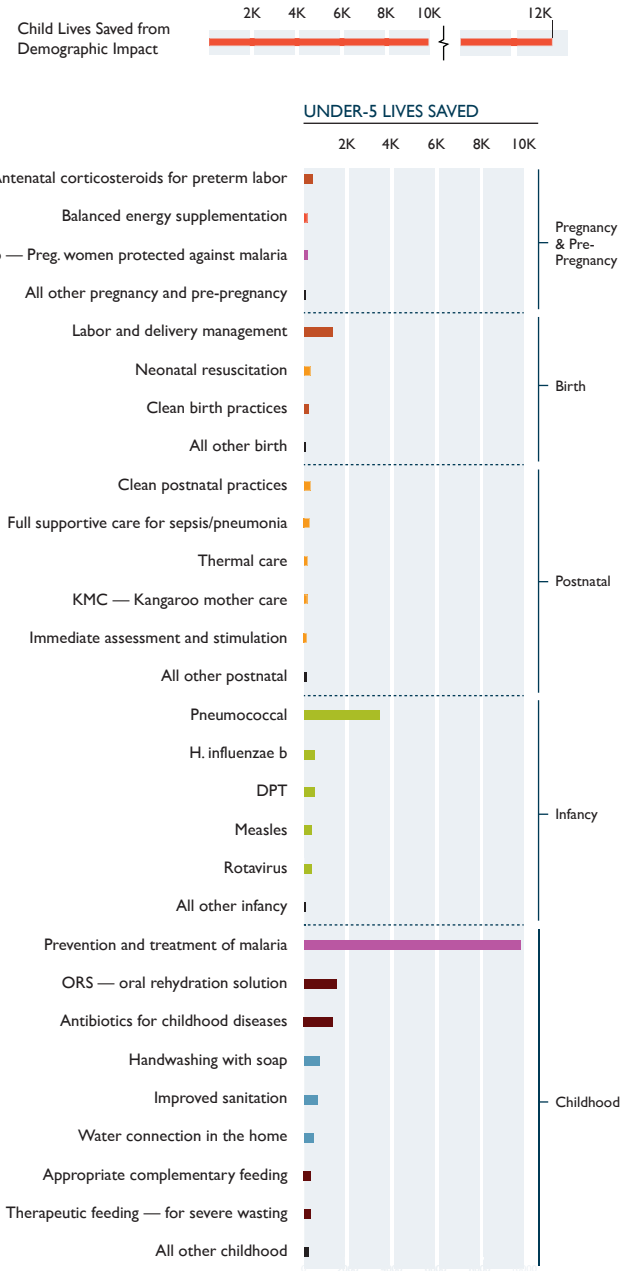
- **Support the implementation of the Government of Liberia's Supply Chain Master Plan,** which addresses commodity storage, forecasting, procurement, and distribution of health commodities to service delivery sites.
- **Provide assistance and support to the Government of Liberia's National Capacity Development Strategy** in reforming its human resources for health with a focus on recruitment, deployment, motivation, capacity, and management, while continuing to urge the Government to migrate more health workers to government payroll.
- **Overcome challenges in nancing the health system in Liberia.** Approximately eight percent of the government's overall budget is allocated to health; however, the overall health sector expenses far exceed this allocation, which covers roughly 20% of the overall health costs.

## COUNTRY DATA: POPULATION AND CHILD & MATERNAL MORTALITY

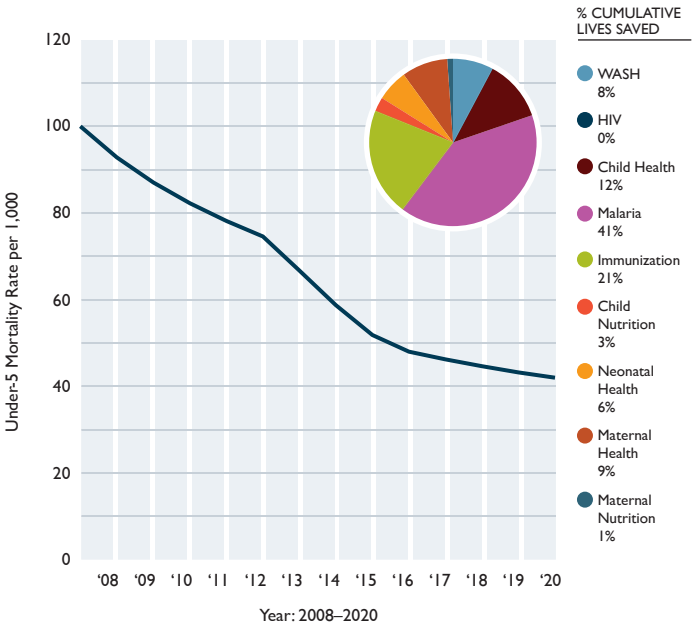
| | Total Population ↑ | Population Under 5 Years ↑ | Under-5 Deaths / Year ↓ | Under-5 Mortality Rate Per 1,000 Live Births ↓ | Births ↑ | Maternal Mortality Ratio Per 100,000 Live Births ↓ |
|---|---|---|---|---|---|---|
| 1990 | 2.1M | 386K | 22.5K | 247 | 102K | 1,200 |
| 2012 | 3.9M | 634K | 10.9K | 67 | 142K | 640* |

*2013

## PROJECTED INTERVENTION IMPACTS OVER FIRST 5 YEARS OF LIFE: 2012–2020




## BENDING THE CURVE: REDUCING CHILD MORTALITY




## WORKING TOGETHER, WE CAN REACH THESE GOALS

| | Under-5 Mortality Rate per 1,000 | Maternal Mortality Ratio per 100,000 |
|---|---|---|
| 2012 | 67 | 640* |
| 2020 | 42 | 342 |
| 2035 | 20 | 50 |

*2013

### BY 2020

**43,000 CHILD LIVES SAVED**

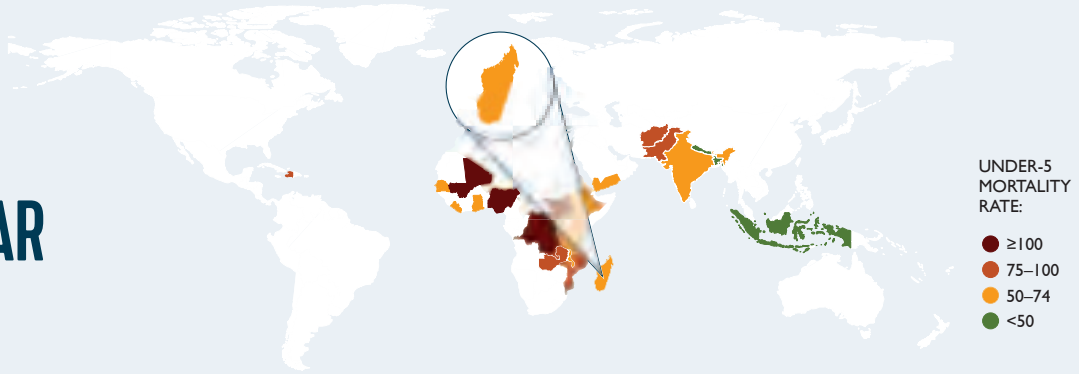
OF WHICH 12,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

**3,200 WOMEN'S LIVES SAVED**

OF WHICH 2,200 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

Demographic impact is the projected impact of family planning interventions on reducing the number of deaths due to fewer unintended pregnancies.

# MADAGASCAR




| ENDING PREVENTABLE CHILD AND MATERNAL DEATHS | 2009 Fiscal Year | 2010 Fiscal Year | 2011 Fiscal Year | 2012 Fiscal Year | 2013 Fiscal Year | 2014 Fiscal Year | TOTAL |
|---|---|---|---|---|---|---|---|
| USAID $ IN MILLIONS | 37 | 57 | 51 | 50 | 48 | 49 | 293 |

## USAID HAS COMMITTED TO:

*Expand reach of high-impact interventions:*

- **Scale up integrated community case management** for simple pneumonia, diarrhea, and malaria through training and support of more than 17,500 community health volunteers in 8,000 villages, leveraging resources from the President's Malaria Initiative.
- **Pilot and scale the delivery of chlorhexidine** for infection prevention, pregnancy test kits to increase family planning uptake, misoprostol to prevent postpartum hemorrhage, and pre-eclampsia case management through community health volunteers.
- **Advance Community-Led Total Sanitation, an innovative hygiene behavior change methodology** that mobilizes communities to eliminate open defecation.
- **Improve emergency transport systems,** including motorized cyclopousse ambulances, bicycle ambulances, wheeled stretchers, and canoe ambulances.
- **Expand mobile phone health tools, like the The Village Phone Project,** which enables community supply points to more ef ciently report stock levels, and place orders for socially marketed products
- **Improve immunization outreach and links** between communities and services.

*Strengthen quality family planning services:*

- **Improve access and demand for quality family planning services** through private sector social franchising, social marketing, mobile outreach, and community health volunteers.
- **Provide vouchers and e-vouchers for family planning services** through mobile phones for lowest wealth quintile population.

## WORKING TOGETHER, WE CAN DO MORE:

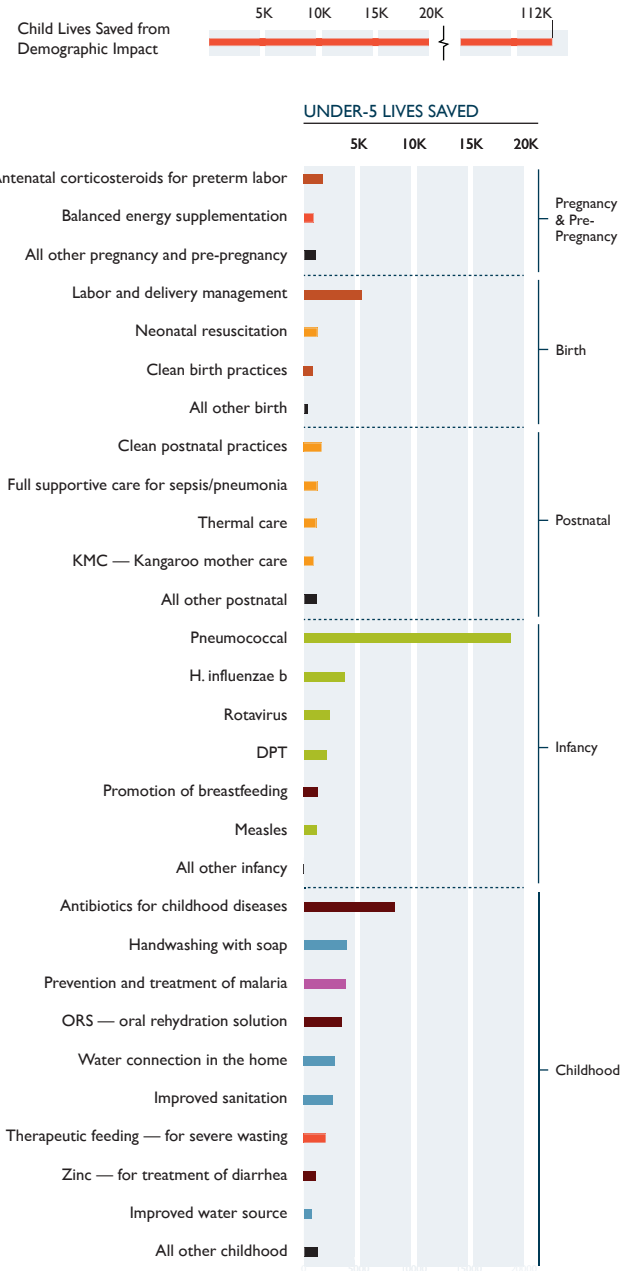
- **Strengthen critical health system functions,** including human resources, supply chain, health information, and health nancing, which will improve the sustainability and quality of and access to RMNCH services.
- **Increase focus to reduce under-nutrition in children,** improve primary healthcare services, increase facility-based delivery and safe caesarian delivery, and increase contraceptive coverage.
- **Strengthen the integration of health and environment programs** and promote resilience to support prevention, mitigation, adaptation, and recovery during shocks.
- **Advocate ensuring maternal and child health programs are well reflected** in the Ministry of Health's budget levels.
- **Build capacity in the Ministry of Health** and incorporate evidence-based monitoring and governance.
- **Strengthen the national commodity distribution system** to prevent frequent stock-outs of essential commodities.
- **Improve access to services,** including through effective referral and emergency transportation systems, as more than 65% of the population lives more than ve kilometers or a one-hour walk from a clinic.

## COUNTRY DATA: POPULATION AND CHILD & MATERNAL MORTALITY

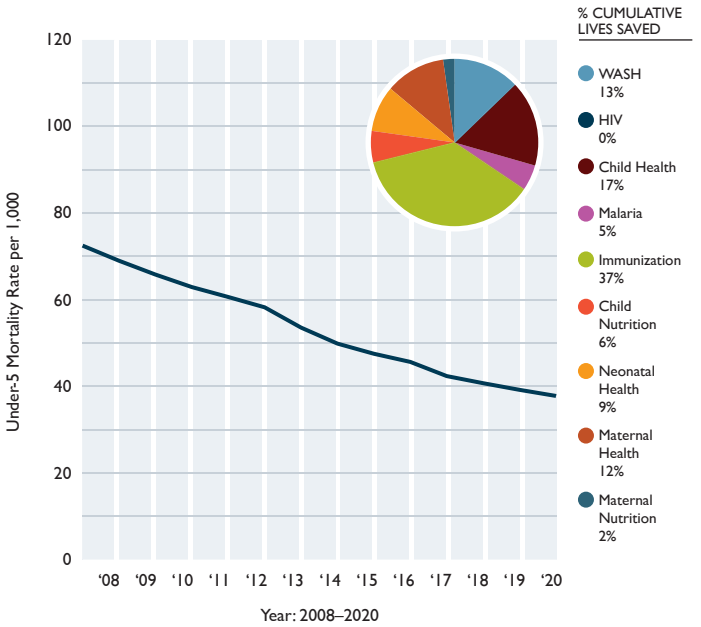
| | Total Population ↑ | Population Under 5 Years ↑ | Under-5 Deaths / Year ↓ | Under-5 Mortality Rate Per 1,000 Live Births ↓ | Births ↑ | Maternal Mortality Ratio Per 100,000 Live Births ↓ |
|---|---|---|---|---|---|---|
| 1990 | 11.6M | 2.1M | 80.4K | 158 | 530K | 640 |
| 2012 | 22M | 3.4M | 44K | 58 | 749K | 440* |

*2013

## PROJECTED INTERVENTION IMPACTS OVER FIRST 5 YEARS OF LIFE: 2012–2020




## BENDING THE CURVE: REDUCING CHILD MORTALITY




## WORKING TOGETHER, WE CAN REACH THESE GOALS

| | Under-5 Mortality Rate per 1,000 | Maternal Mortality Ratio per 100,000 |
|---|---|---|
| 2012 | 58 | 440* |
| 2020 | 38 | 275 |
| 2035 | 20 | 50 |

*2013

### BY 2020

**230,000 CHILD LIVES SAVED**

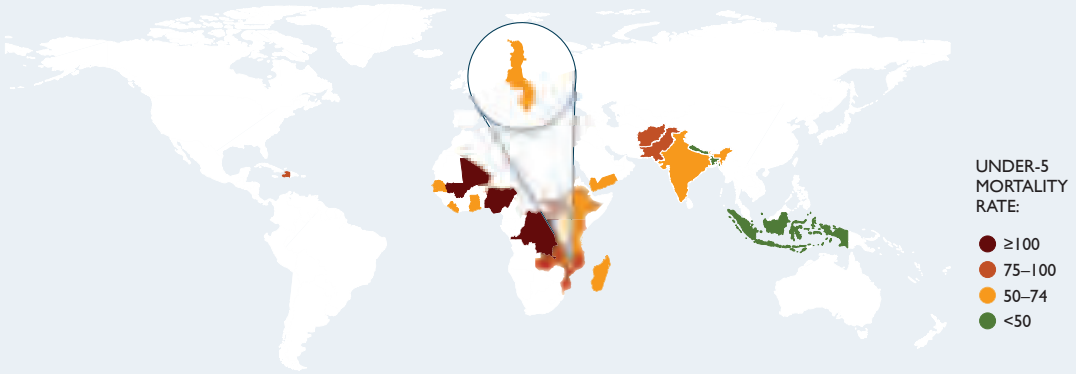
OF WHICH 112,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

**8,000 WOMEN'S LIVES SAVED**

OF WHICH 6,600 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

Demographic impact is the projected impact of family planning interventions on reducing the number of deaths due to fewer unintended pregnancies.

# MALAWI




| ENDING PREVENTABLE CHILD AND MATERNAL DEATHS | 2009 Fiscal Year | 2010 Fiscal Year | 2011 Fiscal Year | 2012 Fiscal Year | 2013 Fiscal Year | 2014 Fiscal Year | TOTAL |
|---|---|---|---|---|---|---|---|
| USAID $ IN MILLIONS | 34 | 47 | 51 | 53 | 53 | 54 | 291 |

## USAID HAS COMMITTED TO:

*Scale up high-impact maternal and child health interventions to reach full coverage in 15 districts:*

- **Expand basic and comprehensive emergency obstetric and neonatal care,** kangaroo mother care, Helping Babies Breathe resuscitation activities, the use of chlorhexidine for cord care, and the use of antenatal corticosteroids to help premature infants survive.
- **Improve demand for and access to high-quality primary health care** through community integrated community case management, provided through Malawi's cadre community health workers, each of whom covers a population of 1,000 people.
- **Strengthen malaria case management at the facility level** to reach national coverage. The President's Malaria Initiative continues to procure rapid diagnostic tests and artemisinin-based combination therapy to provide prompt and effective treatment of malaria.
- **Extend reach of nutrition investments** to achieve full coverage through Scaling Up Nutrition and in coordination with Feed the Future.
- **Support sustainable and equitable immunization coverage improvements,** improving data quality, and introduce a second dose of measles vaccine.
- **Increase commodity distribution interventions** through community health workers and/or drug shops, in part by utilizing a text messaging-based information system called C-stock to monitor health facility data.
- **Support implementation of the Malawi's Essential Health Package,** including prevention and treatment of acute respiratory infections, malaria, diarrhea, maternal and newborn health, malnutrition, vaccines, and family planning.

*Strengthen family planning services:*

- **Expand access to family planning methods,** including intrauterine contraceptive devices and immunization integration, to reach postpartum women with family planning services through Community Based Distribution Agents and integration with PEPFAR platforms.
- **Promote long-acting and permanent family planning methods;** integrate postpartum family planning with immunization; and improve family planning method mix.

## WORKING TOGETHER, WE CAN DO MORE:

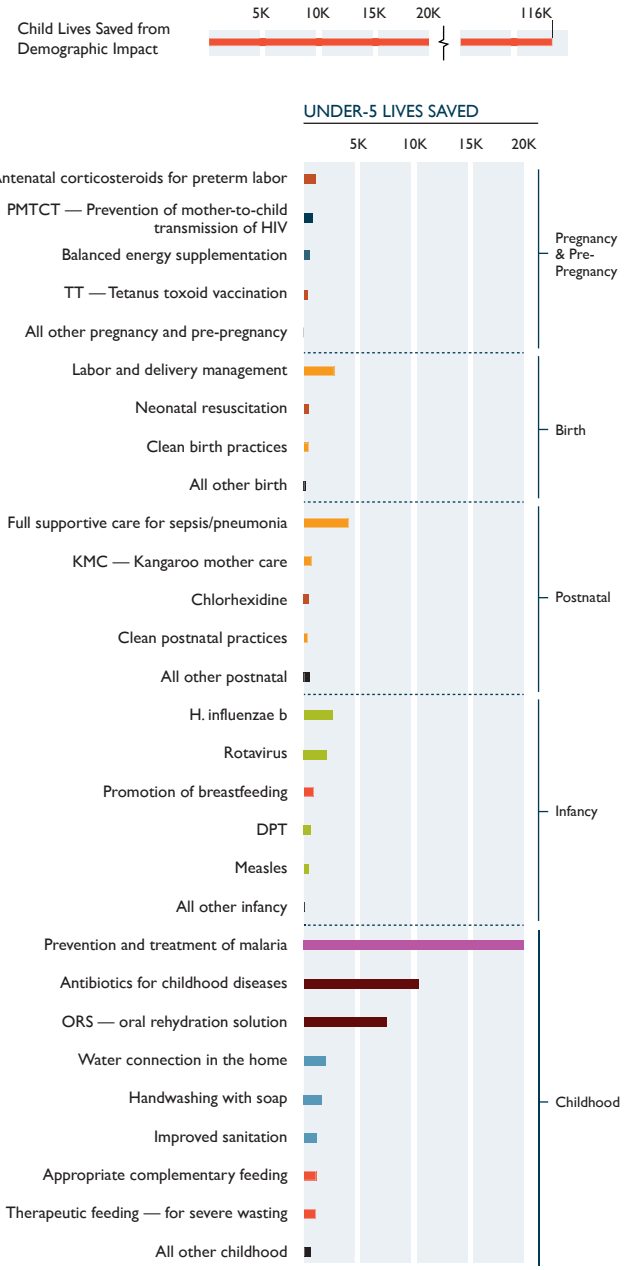
- **Support the government of Malawi in nancing its Essential Health Package.** Combined government and donor resources in the Sector Wide Approach remain below the estimated cost of the Malawi Essential Health Package. Financial insecurity has resulted in donors withdrawing budget support to the Ministry — creating gaps in the provision and delivery of essential medicines and family planning commodities.
- **Address the ongoing shortage in human resources for health** by increasing the number of quali ed personnel, including training more nurse midwife technicians.

## COUNTRY DATA: POPULATION AND CHILD & MATERNAL MORTALITY

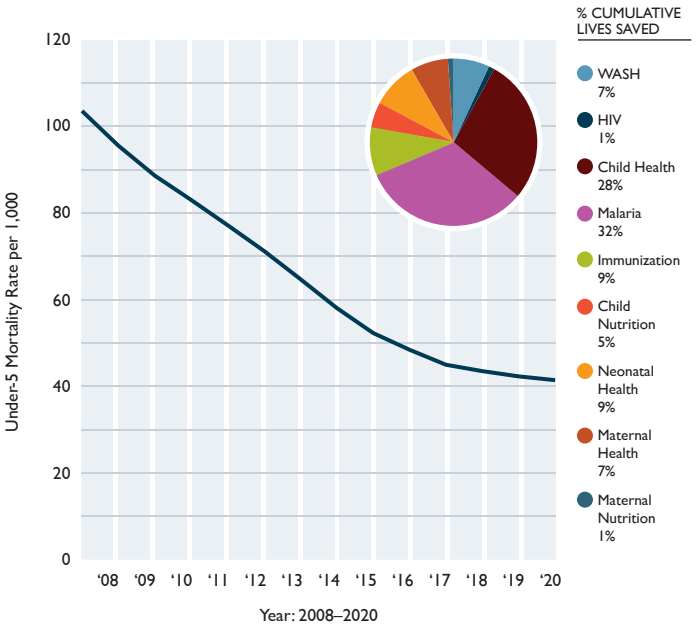
| | Total Population ↑ | Population Under 5 Years ↑ | Under-5 Deaths / Year ↓ | Under-5 Mortality Rate Per 1,000 Live Births ↓ | Births ↑ | Maternal Mortality Ratio Per 100,000 Live Births ↓ |
|---|---|---|---|---|---|---|
| 1990 | 9.5M | 1.8M | 102.5K | 244 | 459K | 1,100 |
| 2012 | 16.3M | 2.8M | 43.4K | 71 | 660K | 510* |

*2013

## PROJECTED INTERVENTION IMPACTS OVER FIRST 5 YEARS OF LIFE: 2012–2020




## BENDING THE CURVE: REDUCING CHILD MORTALITY




## WORKING TOGETHER, WE CAN REACH THESE GOALS

| | Under-5 Mortality Rate per 1,000 | Maternal Mortality Ratio per 100,000 |
|---|---|---|
| 2012 | 71 | 510* |
| 2020 | 41 | 299 |
| 2035 | 20 | 50 |

*2013

### BY 2020

**230,000 CHILD LIVES SAVED**

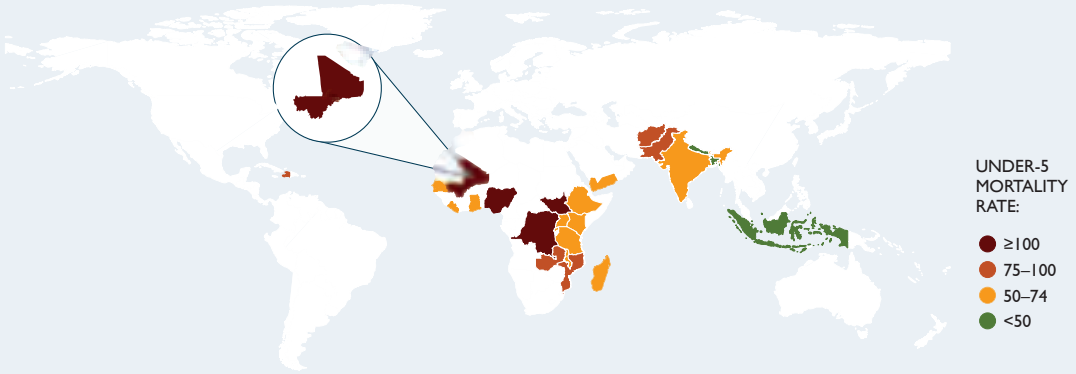
OF WHICH 116,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

**14,000 WOMEN'S LIVES SAVED**

OF WHICH 12,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

Demographic impact is the projected impact of family planning interventions on reducing the number of deaths due to fewer unintended pregnancies.

# MALI




| ENDING PREVENTABLE CHILD AND MATERNAL DEATHS | 2009 Fiscal Year | 2010 Fiscal Year | 2011 Fiscal Year | 2012 Fiscal Year | 2013 Fiscal Year | 2014 Fiscal Year | TOTAL |
|---|---|---|---|---|---|---|---|
| USAID $ IN MILLIONS | 31 | 47 | 52 | 57 | 54 | 55 | 294 |

## USAID HAS COMMITTED TO:

*Focus on high-impact interventions to reach full coverage in ve out of eight regions, in addition to the District of Bamako:*

- **Scale up focused antenatal care,** active management of the third stage of labor, essential newborn care, resuscitation, kangaroo mother care, postnatal care, and stula care.
- **Promote integrated management of childhood illnesses** and use of ORS and zinc for 250,000 children.
- **Realign family planning programs to be consistent with the Ouagadougou Partnership** and advance a speci c emphasis on expanding voluntary access to long acting, reversible contraception and postpartum family planning.
- **Improve community-based service delivery** in coordination with USAID-supported cadre of 750,000 community health volunteers, as well as increased support to religious leaders for community health promotion.
- **Support immunization of children** — particularly to reduce dropout rates — and ensure high levels of measles vaccination coverage in all parts of the country.
- **Support introduction** for rotavirus vaccine.
- **Build a franchise of private clinics and pharmacies** to expand access to high-impact health services.

*Accelerate ght against malaria:*

- **Sustain the current gains against malaria,** especially in the north, and reach the President Malaria Initiative's target of 85% coverage with interventions, including insecticide treated bed nets, indoor residual spraying, seasonal malaria
- **Scale up seasonal malaria chemoprevention** to two additional districts in 2015.

*Promote nutrition and water, sanitation, and hygiene:*

- **Target** 313,000 women of reproductive age, 160,000 children under two years old, 26,000 smallholder farmers, and 6,815 community health volunteers and agricultural extension agents.
- **Establish package of essential nutrition actions,** in coordination with Feed the Future.
- **Support the implementation of the essential nutrition actions,** including deworming, micronutrient supplementation and integrated community-based management of acute malnutrition.
- **Advocate hand washing with soap,** Community-Led Total Sanitation, and water treatment with aquatabs.
- **Build and renovate water point-of-use** in 1,810 villages in target regions.

## WORKING TOGETHER, WE CAN DO MORE:

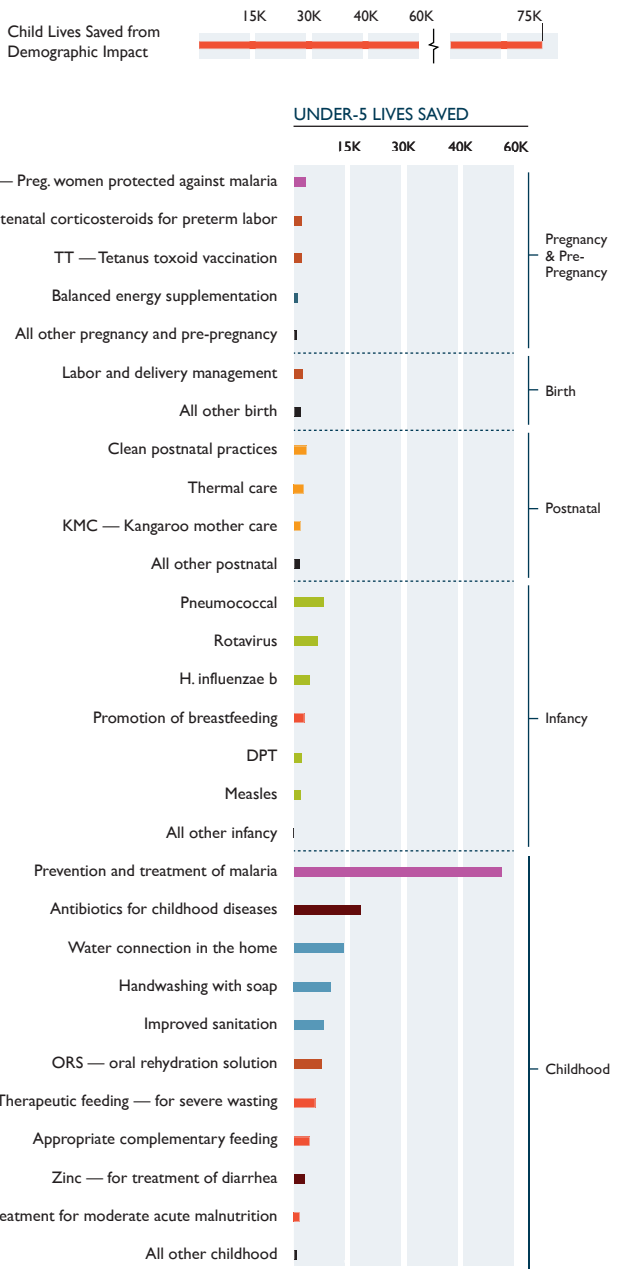
- **Address health system de ciencies and gaps identi ed in the Ministry's ve-year Health Sector Development Program evaluation,** including geographic inaccessibility of health services, quality of services, and logistics and management of pharmaceuticals and other commodities.
- **Strengthen local government and community health associations** in health management, governance, accountability, and transparency.
- **Advocate for health nancing** at the national level and local levels to address health priority issues.

## COUNTRY DATA: POPULATION AND CHILD & MATERNAL MORTALITY

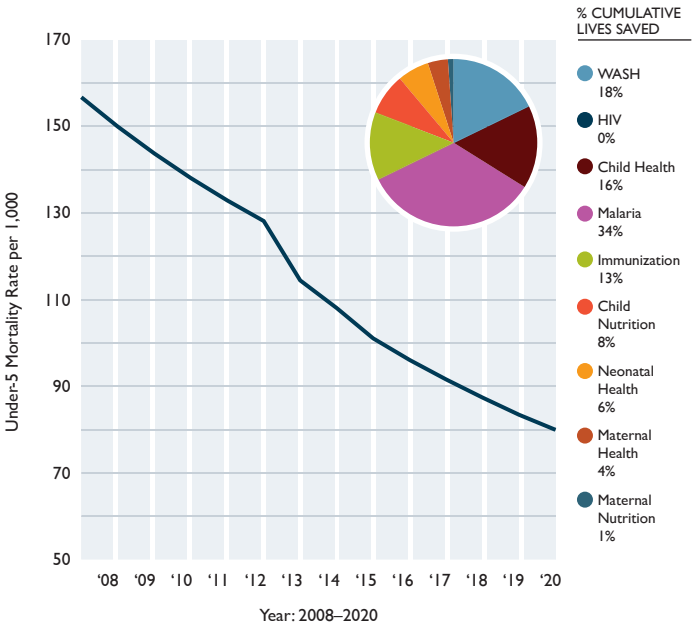
| | Total Population ↑ | Population Under 5 Years ↑ | Under-5 Deaths / Year ↓ | Under-5 Mortality Rate Per 1,000 Live Births ↓ | Births ↑ | Maternal Mortality Ratio Per 100,000 Live Births ↓ |
|---|---|---|---|---|---|---|
| 1990 | 8.5M | 1.6M | 90.7K | 253 | 440K | 1,100 |
| 2012 | 15.5M | 2.9M | 83.5K | 128 | 722K | 550* |

*2013

## PROJECTED INTERVENTION IMPACTS OVER FIRST 5 YEARS OF LIFE: 2012–2020




## BENDING THE CURVE: REDUCING CHILD MORTALITY




## WORKING TOGETHER, WE CAN REACH THESE GOALS

| | Under-5 Mortality Rate per 1,000 | Maternal Mortality Ratio per 100,000 |
|---|---|---|
| 2012 | 128 | 550* |
| 2020 | 80 | 313 |
| 2035 | 20 | 50 |

*2013

### BY 2020

**280,000 CHILD LIVES SAVED**

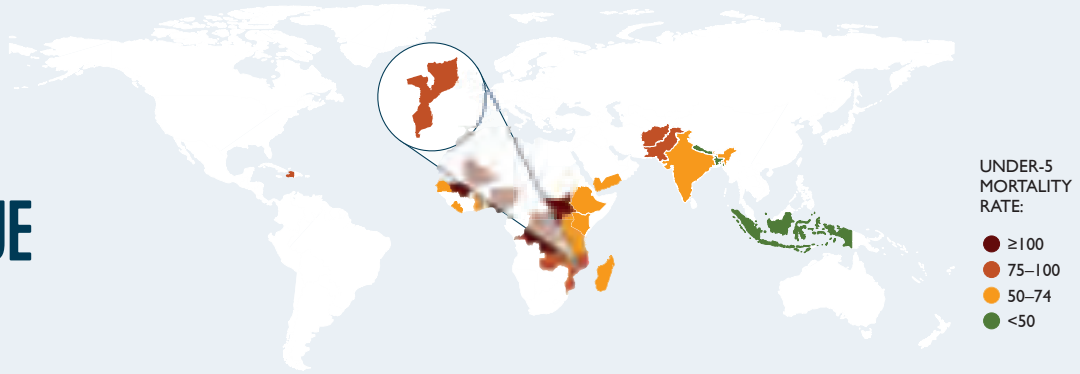
OF WHICH 75,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

**8,300 WOMEN'S LIVES SAVED**

OF WHICH 6,600 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

Demographic impact is the projected impact of family planning interventions on reducing the number of deaths due to fewer unintended pregnancies.

# MOZAMBIQUE




| ENDING PREVENTABLE CHILD AND MATERNAL DEATHS | 2009 Fiscal Year | 2010 Fiscal Year | 2011 Fiscal Year | 2012 Fiscal Year | 2013 Fiscal Year | 2014 Fiscal Year | TOTAL |
|---|---|---|---|---|---|---|---|
| USAID $ IN MILLIONS | 36 | 59 | 58 | 59 | 59 | 64 | 335 |

## USAID HAS COMMITTED TO:

*Strengthen targeted outreach to communities in Mozambique's two most populous districts:*

- **Support Mobile Brigades to rural areas** to provide long-acting and reversible contraceptive methods, including implants.
- **Support sustainable roll-out of community-based distribution** of misoprostol in partnership with the United Nations Population Fund.
- **Pilot and then roll-out sustainable community-based provision** of injectable contraceptives, such as Depo Provera.
- **Scale up of the number of community health workers** from a base of one health worker for every 12,000 people in collaboration with UNICEF and the government.
- **Support community-based screening and referral** for acute malnutrition in Feed the Future Zones of In uence.
- **Support the introduction** of new pneumococcal and rotavirus vaccines.

*Promote behavior change:*

- **Prioritize the delivery of key family planning messages** through mHealth technologies.
- **Expand nutrition and water, sanitation, and hygiene messaging** using the Feed the Future platform.

*Improve quality of care:*

- **Deepen focus on select number of Model Maternities** to improve quality of prenatal and neonatal care.
- **Expand postpartum family planning,** including IUDs and fertility awareness methods (e.g., lactational amenorrhea) to prevent rapid, repeat pregnancy.
- **Expand access to rapid diagnostic tests** for malaria, and promote correct diagnosis and treatment of childhood fever at community and facility levels, with support from the President's Malaria Initiative
- **Prioritize, align, and focus programs geographically** based on magnitude and severity of maternal and child deaths, further concentrating and integrating high priority interventions, in part through PEPFAR platforms, for greater impact.

*Strengthen commodity availability and supply chain management:*

- **Develop supply and re-supply linkages across levels** — from central, to provincial, to district, to community health worker and Mobile Brigades.

## WORKING TOGETHER, WE CAN DO MORE:

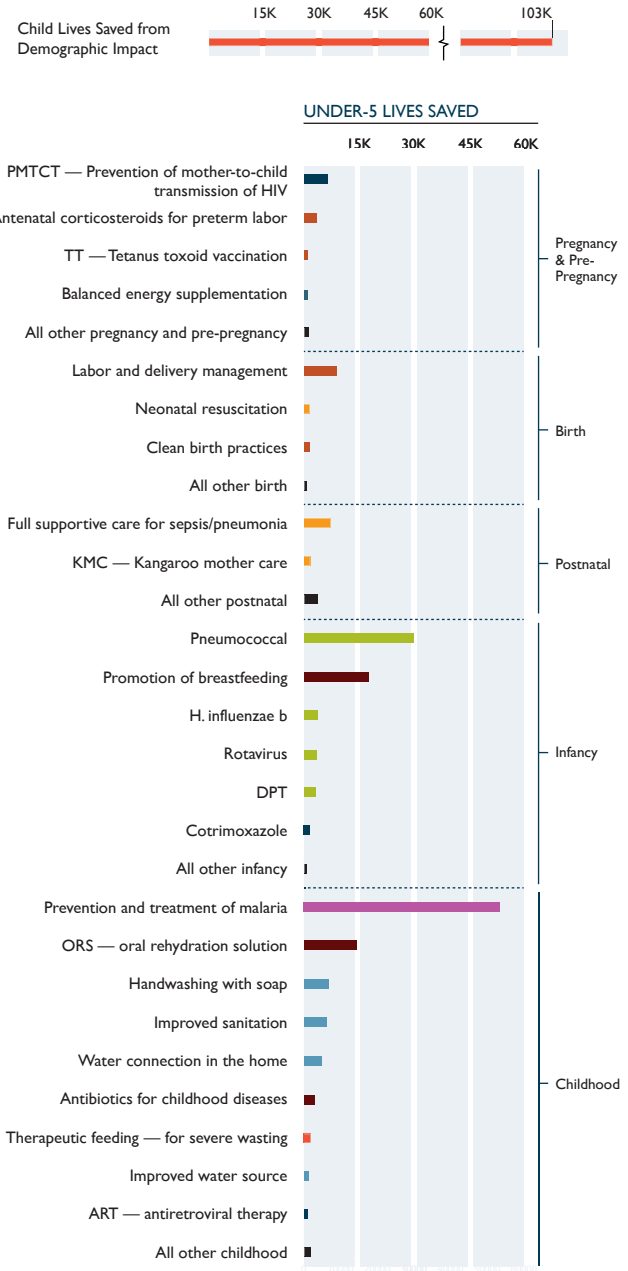
- **Support the new, integrated, and costed National Strategic Plan** for Health, which identi es priority interventions across all health areas and coordinate to ll funding gaps.
- **Support the expansion of partnerships** between health facilities and communities, with global entities (GAVI, Global Fund), and with the private sector and NGOs in line with the National Health Plan (Plano Estratégico do Sector Saúde or PESS).
- **Build innovative partnerships to support the roll-out** of the community health worker program, expanding the package of RMNCH interventions to include long-acting family planning methods and other high-impact interventions.Strengthen the supply chain system to ensure that maternal and child health and contraceptive commodities move from the provincial to the district and facility levels.
- **Strengthen the supply chain system** to ensure that essential maternal and child health and contraceptive commodities move from the provincial to the district and facility levels.

## COUNTRY DATA: POPULATION AND CHILD & MATERNAL MORTALITY

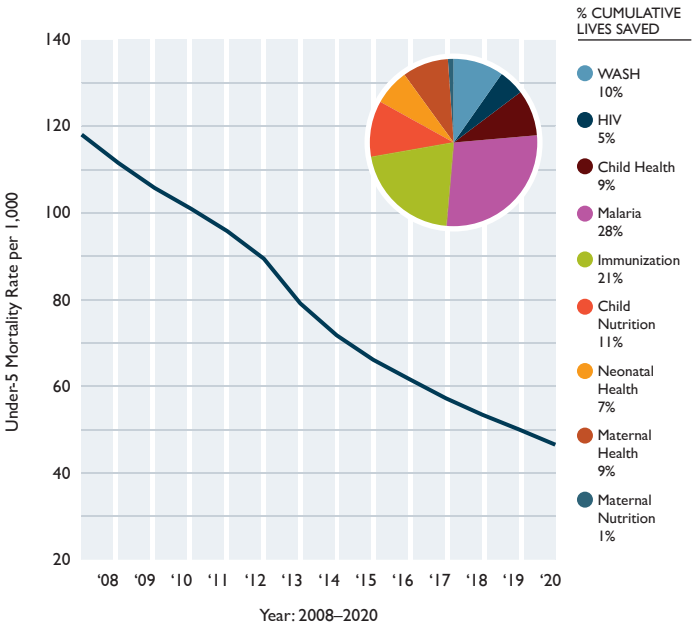
| | Total Population ↓ | Population Under 5 Years ↑ | Under-5 Deaths / Year ↓ | Under-5 Mortality Rate Per 1,000 Live Births ↓ | Births ↑ | Maternal Mortality Ratio Per 100,000 Live Births ↓ |
|---|---|---|---|---|---|---|
| 1990 | 13M | 2M | 132K | 233 | 611K | 910 |
| 2012 | 123.5M | 4M | 84K | 90 | 925K | 480* |

*2013

## PROJECTED INTERVENTION IMPACTS OVER FIRST 5 YEARS OF LIFE: 2012–2020




## BENDING THE CURVE: REDUCING CHILD MORTALITY




## WORKING TOGETHER, WE CAN REACH THESE GOALS

| | Under-5 Mortality Rate per 1,000 | Maternal Mortality Ratio per 100,000 |
|---|---|---|
| 2012 | 90 | 480* |
| 2020 | 47 | 289 |
| 2035 | 20 | 50 |

*2013

### BY 2020

**338,000 CHILD LIVES SAVED**

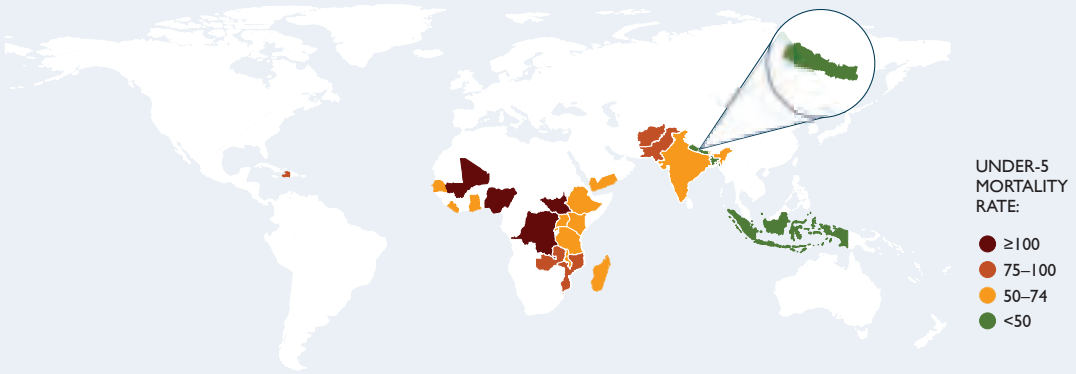
OF WHICH 103,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

**15,000 WOMEN'S LIVES SAVED**

OF WHICH 10,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

Demographic impact is the projected impact of family planning interventions on reducing the number of deaths due to fewer unintended pregnancies.

# NEPAL




| ENDING PREVENTABLE CHILD AND MATERNAL DEATHS | 2009 Fiscal Year | 2010 Fiscal Year | 2011 Fiscal Year | 2012 Fiscal Year | 2013 Fiscal Year | 2014 Fiscal Year | TOTAL |
|---|---|---|---|---|---|---|---|
| USAID $ IN MILLIONS | 17 | 20 | 28 | 36 | 36 | 38 | 174 |

## USAID HAS COMMITTED TO:

*Roll out revised Newborn Care Program:*

- **Support the Ministry** through a government-to-government agreement to roll out the evidence-based newborn care and Integrated Management of Childhood Illness program to all 75 districts, which includes promotion of institutional delivery, postnatal care, the use of chlorhexidine for umbilical cord care, community case management of pneumonia, and care for low birth weight infants.
- **Train 50,000 female community health volunteers** on essential newborn care services, including identi cation, management, and referral of sick newborns.
- **Reduce stock-outs by assisting the Ministry** to create detailed and accurate procurement forecasts.
- **Preserve Nepal as polio-free** and help eliminate measles and rubella.

*Improve supply and demand of family planning and reproductive health:*

- **Disseminate health promotion messages o**n birth timing and spacing, counseling services and contraceptive options, particularly among groups with high unmet need, including migrants.
- **Strengthen the national logistics management system** to ensure that facilities offer at least ve contraceptive options based on proper forecasting, timely procurement, routine market segmentation analyses, and commodity tracking surveys.
- **Support the Ministry's national program** to train 7,050 health workers as counselors or clinical practitioners for family planning and more than 50,000 female community health workers as educators who can refer people for services.

*Carry out comprehensive, household-level nutrition interventions in 25 prioritized districts in coordination with Feed the Future:*

- **Reach the families of 600,000 children under ve years old** with messages on essential nutrition and hygiene actions through interpersonal communication and small group activities.
- **Strengthen the capacity of Ministry service providers** to increase coverage of nutrition services, including growth monitoring, vitamin A supplementation, and deworming.
- **Support social and behavior change communication activities at critical service delivery points,** including farmers' groups, schools, and mothers group meetings.

## WORKING TOGETHER, WE CAN DO MORE:

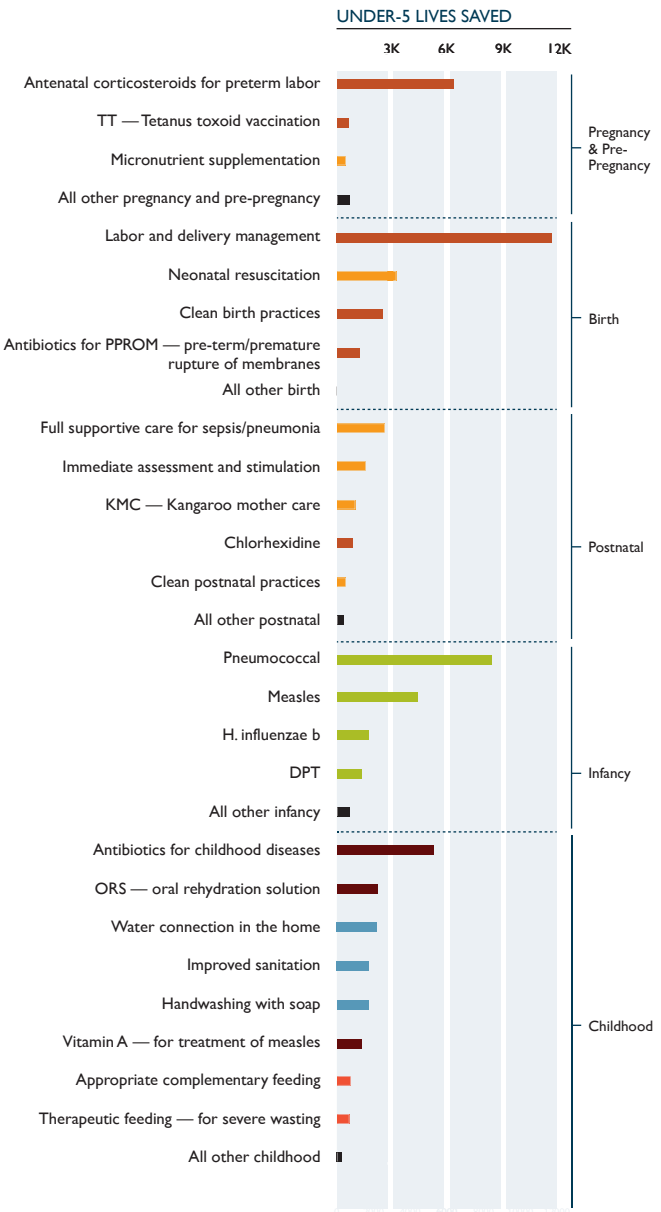
- **Improve the speed and effectiveness of commodity procurement services** and reduce stock-outs of essential commodities and drugs.
- **Realign programs** to better target marginalized and hard-to-reach groups with the highest unmet need for family planning.
- **Ensure gender equity and social inclusion** in accessing and utilizing services.
- **Invest in decentralized management and funding systems** so district health of ces get the authority and management support to allocate adequate resources.

## COUNTRY DATA: POPULATION AND CHILD & MATERNAL MORTALITY

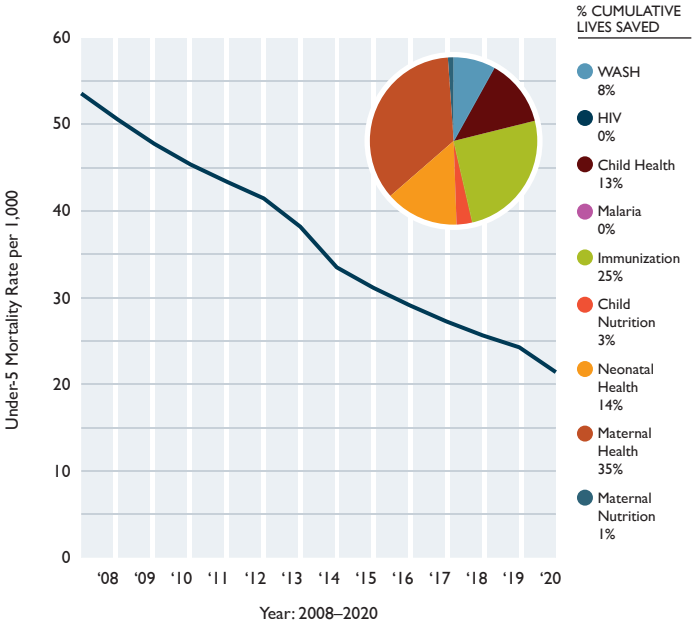
| | Total Population ↑ | Population Under 5 Years ↓ | Under-5 Deaths / Year ↓ | Under-5 Mortality Rate Per 1,000 Live Births ↓ | Births ↓ | Maternal Mortality Ratio Per 100,000 Live Births ↓ |
|---|---|---|---|---|---|---|
| 1990 | 19M | 3.2M | 95K | 142 | 142K | 770 |
| 2012 | 30M | 3.1M | 24K | 42 | 42K | 190* |

*2013

## PROJECTED INTERVENTION IMPACTS OVER FIRST 5 YEARS OF LIFE: 2012–2020




## BENDING THE CURVE: REDUCING CHILD MORTALITY




## WORKING TOGETHER, WE CAN REACH THESE GOALS

| | Under-5 Mortality Rate per 1,000 | Maternal Mortality Ratio per 100,000 |
|---|---|---|
| 2012 | 42 | 190* |
| 2020 | 22 | 121 |
| 2035 | <20 | <50 |

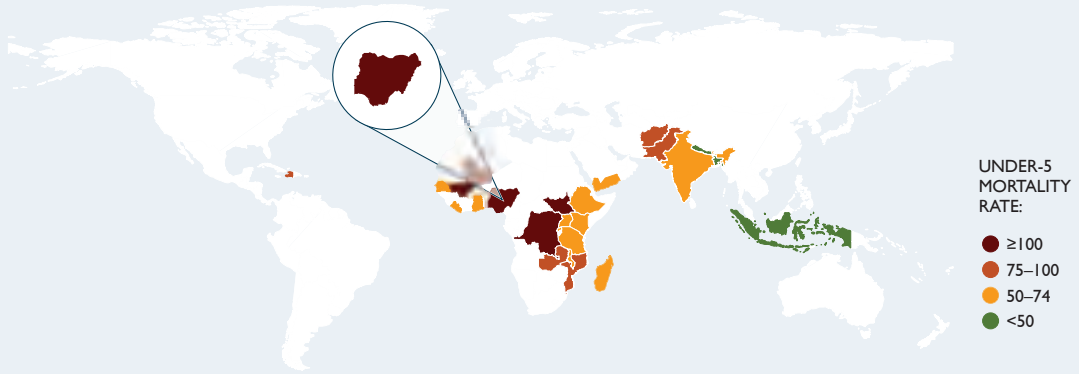
*2013

BY 2020

**65,000 CHILD LIVES SAVED**

**2,400 WOMEN'S LIVES SAVED**

# NIGERIA




| ENDING PREVENTABLE CHILD AND MATERNAL DEATHS | 2009 Fiscal Year | 2010 Fiscal Year | 2011 Fiscal Year | 2012 Fiscal Year | 2013 Fiscal Year | 2014 Fiscal Year | TOTAL |
|---|---|---|---|---|---|---|---|
| USAID $ IN MILLIONS | 52 | 60 | 92 | 121 | 152 | 160 | 636 |

## USAID HAS COMMITTED TO:

*Expand focus on maternal newborn child health:*

- **Implement community-based distribution of misoprostol and chlorhexidine** in the north, and integrate maternal and newborn health and family planning interventions into prevention of mother-to-child transmission of HIV platforms in the south.
- **Improve capacity of primary care providers at community health facilities** to provide essential high quality newborn care, resuscitation, care of preterm and low birth weight babies, and infection management.
- **Improve the quality and availability of MNCH commodities** — including antibiotics, ORS, and zinc — through supply chain investments at the national level and in select states.
- **Promote behavior change and use of insecticide-treated mosquito nets,** as well as diagnosis and treatment of malaria nationally and in select state, with support from the President's Malaria Initiative.

*Reach children through private sector approaches:*

- **Expand the availability and increase the quality of zinc and ORS therapy in the private sector,** including private providers and patented drug vendors.
- **Pilot the delivery of integrated community case management of childhood illness** by drug shop staff.

*Strengthen family planning services:*

- **Expand access to long-acting, reversible contraceptive methods** by focusing on demand creation and capacity to provide services at high-volume public sector facilities in the north.
- **Analyze the impact on contraceptive prevalence rate** of using Interpersonal Communication Agents to carry out door-to-door demand generation activities for family planning in targeted districts in the north.

## WORKING TOGETHER, WE CAN DO MORE:

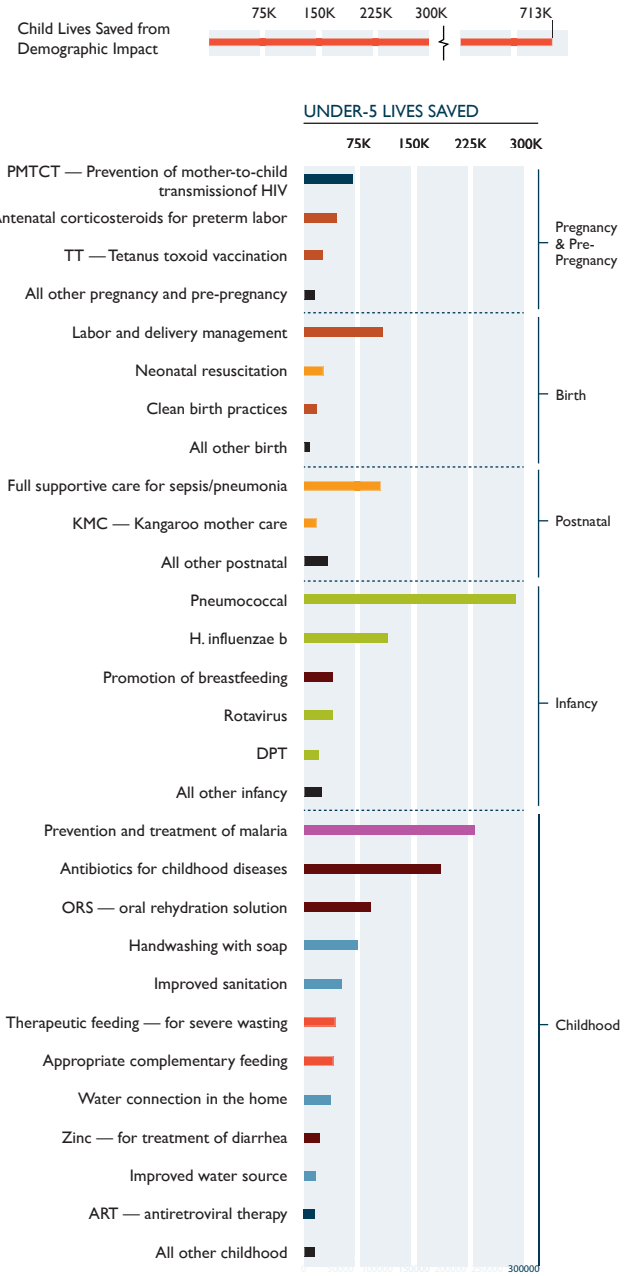
- **Improve the capacity of state and local government authorities** to release health funds in a timely manner, while encouraging state leadership to invest in core health interventions and both public and private sector solutions.
- **Address persistent challenges to routine immunization systems strengthening** by implementing the recently endorsed 2013–2015 National Routine Immunization Strategic Plan.
- **Focus on** household- and community-based primary health care in the north.
- **Expand access to long-acting reversible contraception** for populations with less ability to access facility-based services, using mobile outreach activities that are currently implemented on a limited scale.
- **Strengthen critical health system functions,** including health governance and  nancing, human resources, supply chain, and health information, at local, state, and national level.
- **Scale up integrated community case management** by drug shops, based on analysis of USAID pilot.

## COUNTRY DATA: POPULATION AND CHILD & MATERNAL MORTALITY

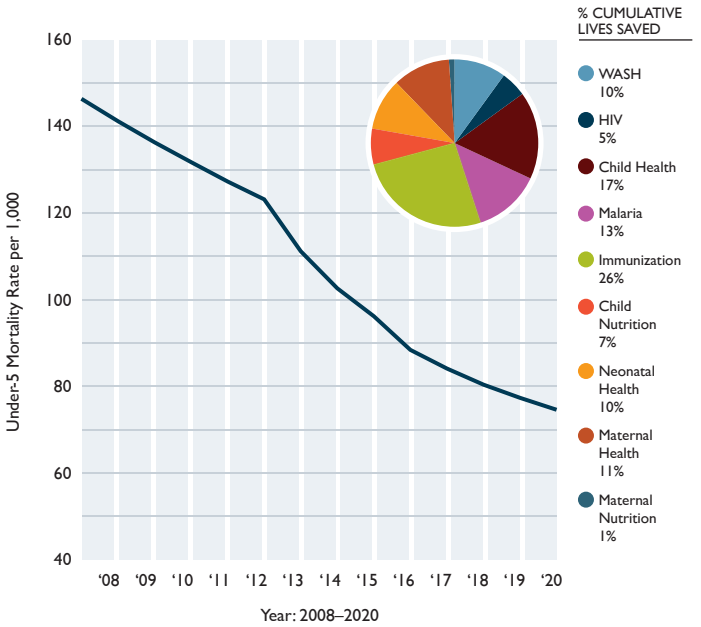
| | Total Population ↑ | Population Under 5 Years ↑ | Under-5 Deaths / Year ↓ | Under-5 Mortality Rate Per 1,000 Live Births ↓ | Births ↑ | Maternal Mortality Ratio Per 100,000 Live Births ↓ |
|---|---|---|---|---|---|---|
| 1990 | 97M | 17M | 848K | 213 | 4.3M | 1,110 |
| 2012 | 169M | 28M | 826K | 124 | 6.5M | 560* |

*2013

## PROJECTED INTERVENTION IMPACTS OVER FIRST 5 YEARS OF LIFE: 2012–2020




## BENDING THE CURVE: REDUCING CHILD MORTALITY




## WORKING TOGETHER, WE CAN REACH THESE GOALS

| | Under-5 Mortality Rate per 1,000 | Maternal Mortality Ratio per 100,000 |
|---|---|---|
| 2012 | 124 | 560* |
| 2020 | 75 | 339 |
| 2035 | 20 | 50 |

*2013

### BY 2020

**2.7 MILLION CHILD LIVES SAVED**

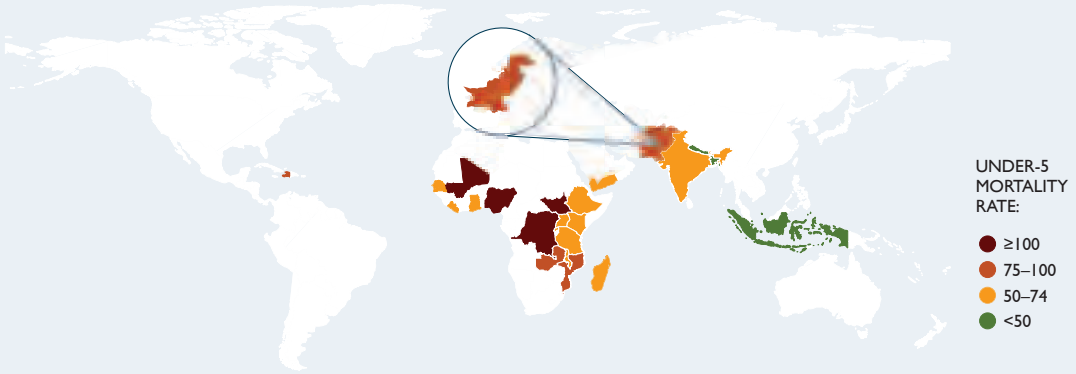
OF WHICH 713,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

**107,000 WOMEN'S LIVES SAVED**

OF WHICH 64,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

Demographic impact is the projected impact of family planning interventions on reducing the number of deaths due to fewer unintended pregnancies.

# PAKISTAN




| ENDING PREVENTABLE CHILD AND MATERNAL DEATHS | 2009 Fiscal Year | 2010 Fiscal Year | 2011 Fiscal Year | 2012 Fiscal Year | 2013 Fiscal Year | 2014 Fiscal Year | TOTAL |
|---|---|---|---|---|---|---|---|
| USAID $ IN MILLIONS | 97 | 122 | 86 | 75 | 30 | 49 | 459 |

## USAID HAS COMMITTED TO:

*Elevate maternal and child health across 1,000 maternal, newborn, and child health centers:*

- **Support 1,000 midwives to establish their practices** in the community through maternal, newborn, and child health centers and strengthen their capacity in emergency obstetric and newborn care.
- **Promote early initiation of and exclusive breastfeeding** for the  rst six months.
- **Introduce use of misoprostol** for home-based births to prevent postpartum hemorrhage.
- **Reduce birth asphyxia by training skilled attendants** on Helping Babies Breathe and neonatal resuscitation.
- **Introduce chlorhexidine use** to prevent newborn sepsis.
- **Strengthen case management** of diarrhea and pneumonia.
- **Support the operational integration** of family planning and maternal, newborn, and child health services.

*Expand access to immunization:*

- **Support the Government in the establishment of a vaccine logistics management information system** for effective management including reduction of wastage, utilization, forecasting, and accountability of vaccines for enhanced routine immunization coverage.

*Advance family planning and reproductive health:*

- **Build private and public sector capacity** through 320 social franchises and 20 outreach teams providing a range of family planning services.
- **Advocate for host government procurement and distribution** of contraceptives for improved commodity security.

*Support health systems strengthening:*

- **Strengthen critical health system functions,** including human resources, supply chain, health information, and health  nancing — all of which will improve the sustainability and quality of and access to RMNCH services in Pakistan.

## WORKING TOGETHER, WE CAN DO MORE:

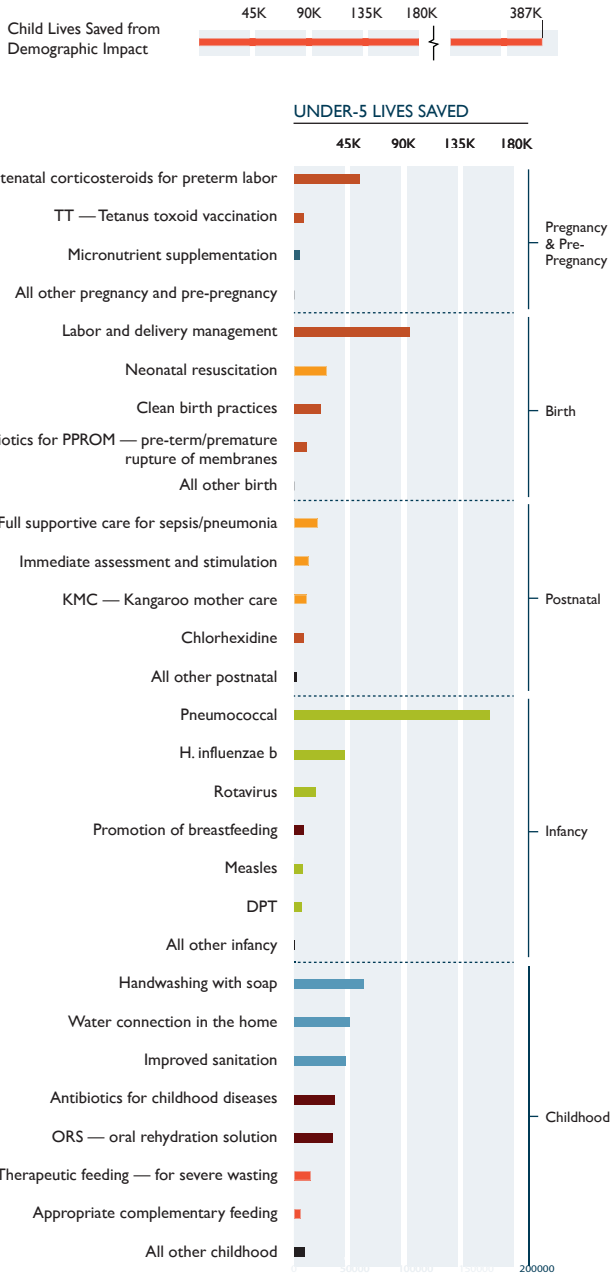
- **Strengthen health  nancing and advocate** for increased host government investments, allocation, and utilization of resources in primary healthcare, family planning, WASH, and nutrition.
- **Engage the private sector** on WASH and nutrition, as 44% of children are stunted and 15% are wasted.

## COUNTRY DATA: POPULATION AND CHILD & MATERNAL MORTALITY

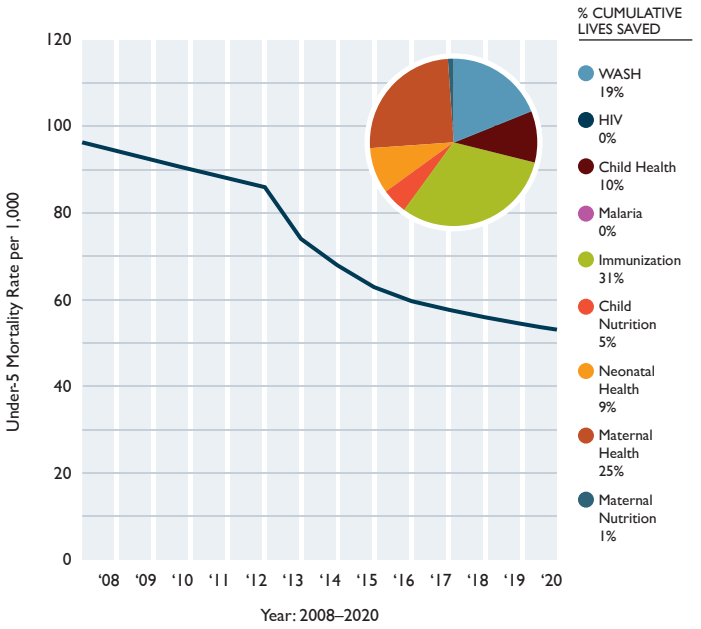
| | Total Population ↑ | Population Under 5 Years ↑ | Under-5 Deaths / Year ↓ | Under-5 Mortality Rate Per 1,000 Live Births ↓ | Births ↓ | Maternal Mortality Ratio Per 100,000 Live Births ↓ |
|---|---|---|---|---|---|---|
| 1990 | 119M | 20.9M | 619K | 138 | 5M | 490 |
| 2012 | 190M | 21.7M | 409K | 86 | 4.6M | 170* |

*2013

## PROJECTED INTERVENTION IMPACTS OVER FIRST 5 YEARS OF LIFE: 2012–2020




## BENDING THE CURVE: REDUCING CHILD MORTALITY




## WORKING TOGETHER, WE CAN REACH THESE GOALS

| | Under-5 Mortality Rate per 1,000 | Maternal Mortality Ratio per 100,000 |
|---|---|---|
| 2012 | 86 | 170* |
| 2020 | 53 | 108 |
| 2035 | 20 | <50 |

*2013

### BY 2020

**1.3 MILLION CHILD LIVES SAVED**

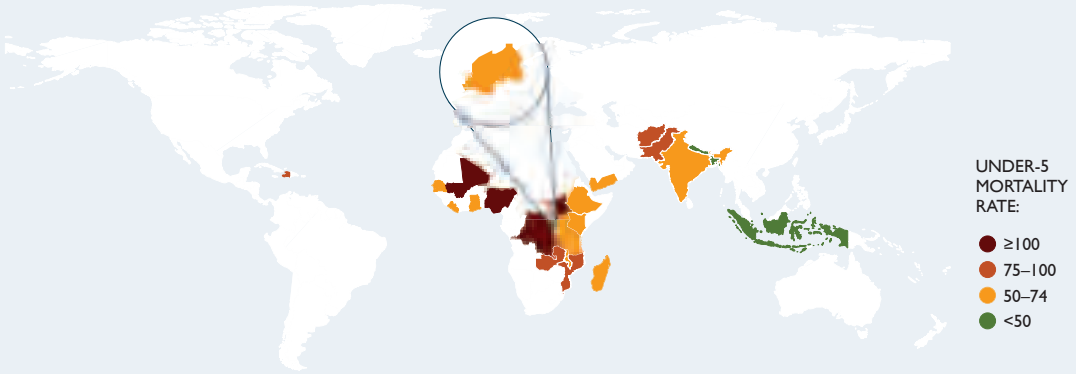
OF WHICH 387,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

**34,000 WOMEN'S LIVES SAVED**

OF WHICH 16,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

Demographic impact is the projected impact of family planning interventions on reducing the number of deaths due to fewer unintended pregnancies.

# RWANDA




| ENDING PREVENTABLE CHILD AND MATERNAL DEATHS | 2009 Fiscal Year | 2010 Fiscal Year | 2011 Fiscal Year | 2012 Fiscal Year | 2013 Fiscal Year | 2014 Fiscal Year | TOTAL |
|---|---|---|---|---|---|---|---|
| USAID $ IN MILLIONS | 32 | 38 | 42 | 42 | 42 | 44 | 240 |

## USAID HAS COMMITTED TO:

*Support the Government of Rwanda's Health Sector Strategy Plan to improve the provision of an integrated package of quality health services in 20 of the country's 30 districts:*

- **Improve access** to primary health care facilities, emergency obstetric and newborn care and post-birth services for mother and newborn, stula prevention and care, and community case management of malaria, pneumonia and diarrhea.
- **Support monitoring to protect gains achieved** in immunizations, including pentavalent, rotavirus, and pneumococcal vaccines and the second dose of measles within the standard expanded program on immunization.
- **Implement a comprehensive approach to prevent and treat malaria** through indoor spraying of homes with insecticides, insecticide-treated mosquito nets, essential antimalarial drugs, and malaria case management, with support from the President's Malaria Initiative.

*Scale up family planning:*

- **Strengthen demand for and access** to a full range of quality family planning services, including vasectomy and tubal ligation.
- **Improve behavior change communication** to promote healthy behaviors, notably delaying rst pregnancies.
- **Encourage male involvement** in family planning services and promote culturally sensitive programming.
- **Increase the currently very limited role** of the private sector, especially pharmacies and private clinics.

*Elevate nutrition:*

- **Scale up community based nutrition interventions,** with a focus on the rst 1,000 days, to prevent and manage chronic malnutrition.
- **Promote breastfeeding** and appropriate infant and young child feeding.
- **Strengthen identi cation and management** of under-nutrition and itsunderlying causes.
- **Integrate nutrition, WASH, and agricultural activities** in the Feed the Future Zones of In uence.

## WORKING TOGETHER, WE CAN DO MORE:

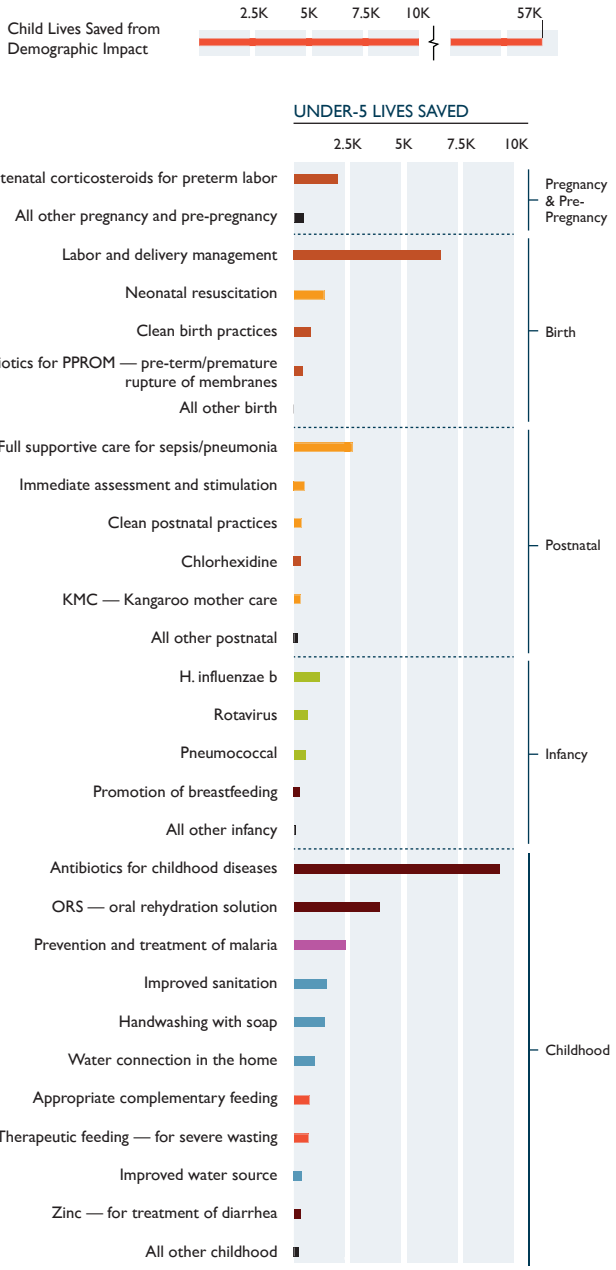
- **Support the Government's commitment to ensure and sustain universal access** to quality health services.
- **Reduce Rwanda's reliance on external nancing to fund its health** by focusing on resource mobilization, strengthening nancial planning and management, and facilitating private sector engagement in the overall health sector.
- **Maximize ef ciencies in the health system and make calculated investments** in innovative solutions in the health sector.
- **Strengthen the commodity logistics system nationwide** to prevent stock-outs and waste at the service delivery point, notably for family planning and malaria commodities.
- **Improve collection, analysis, and use of data** for decision-making.
- **Strengthen the leadership and governance of the health sector** at the central and district levels, and improve coordination between the two.

## COUNTRY DATA: POPULATION AND CHILD & MATERNAL MORTALITY

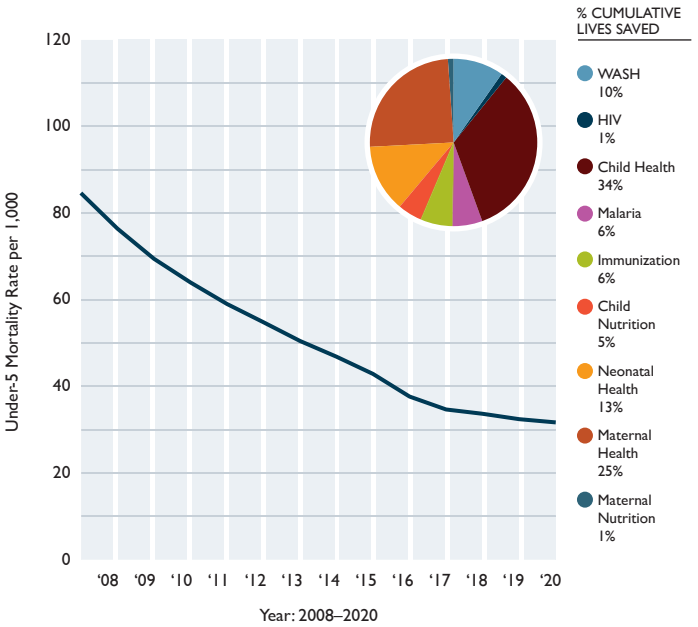
| | Total Population ↑ | Population Under 5 Years ↑ | Under-5 Deaths / Year ↓ | Under-5 Mortality Rate Per 1,000 Live Births ↓ | Births ↑ | Maternal Mortality Ratio Per 100,000 Live Births ↓ |
|---|---|---|---|---|---|---|
| 1990 | 7M | 1.3M | 49.3K | 151 | 304K | 910 |
| 2012 | 11.7M | 1.9M | 23.6K | 55 | 422K | 320* |

*2013

## PROJECTED INTERVENTION IMPACTS OVER FIRST 5 YEARS OF LIFE: 2012–2020




## BENDING THE CURVE: REDUCING CHILD MORTALITY




## WORKING TOGETHER, WE CAN REACH THESE GOALS

| | Under-5 Mortality Rate per 1,000 | Maternal Mortality Ratio per 100,000 |
|---|---|---|
| 2012 | 55 | 320* |
| 2020 | 32 | 204 |
| 2035 | 20 | 50 |

*2013

### BY 2020

**123,000 CHILD LIVES SAVED**

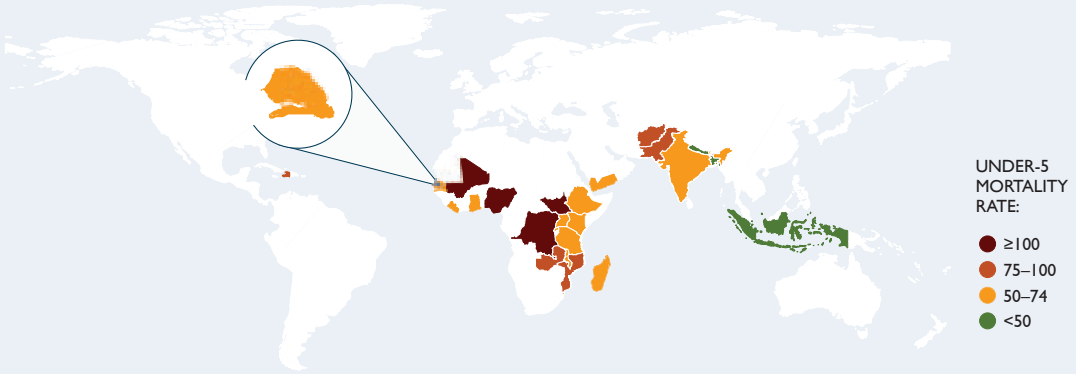
OF WHICH 57,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

**6,800 WOMEN'S LIVES SAVED**

OF WHICH 3,900 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

Demographic impact is the projected impact of family planning interventions on reducing the number of deaths due to fewer unintended pregnancies.

# SENEGAL




| ENDING PREVENTABLE CHILD AND MATERNAL DEATHS | 2009 Fiscal Year | 2010 Fiscal Year | 2011 Fiscal Year | 2012 Fiscal Year | 2013 Fiscal Year | 2014 Fiscal Year | TOTAL |
|---|---|---|---|---|---|---|---|
| USAID $ IN MILLIONS | 28 | 45 | 47 | 51 | 52 | 54 | 277 |

## USAID HAS COMMITTED TO:

*Apply high-impact RMNCH interventions:*

- **Support the introduction of new interventions:** pneumococcal vaccine, chlorhexidine for umbilical cord care, seasonal malaria chemoprevention, and Sayana Press (Depo-Provera in uniject).
- **Scale up proven interventions: misoprostol** to prevent postpartum hemorrhage, mobile outreach services, and emergency transport systems.
- **Support the development** of watchdog support groups for women.
- **Collaborate with the Feed the Future Initiative** in areas with high malnutrition to reduce stunting.
- **Help prevent malaria through the procurement and distribution of insecticide-treated mosquito nets** through routine systems as well as mass campaigns, with support from the President's Malaria Initiative.

*Promote innovative vendor coordination model:*

- **Design, integrate, and implement** ve bilateral health projects simultaneously to maximize cost ef ciencies.
- **Support** an annual integrated and budgeted work plan among partners.
- **Co-locate USAID implementing partners** in three eld of ces to ensure effective coordination and alignment with the health sector's planning and budgeting processes.

*Advance health sector reforms:*

- **Ensure access to quality health services under Senegal's new Universal Health Coverage policy** by expanding community-based mutual health insurance models to reach the country's target of 65% insurance coverage by 2017.
- **Support scale up of performance-based nancing,** working closely with the World Bank to scale up USAID's pilot.

## WORKING TOGETHER, WE CAN DO MORE:

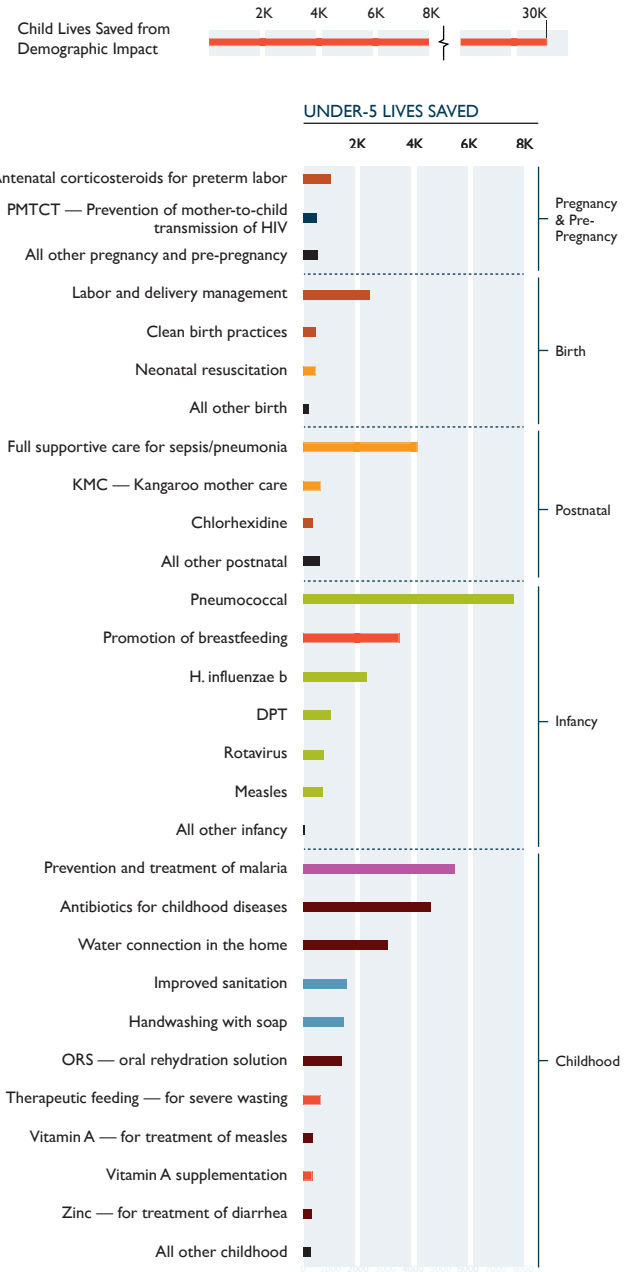
- **Sustain the current gains in reducing malaria burden** and achieve pre-elimination as planned by 2018.
- **Support health system strengthening efforts,** particularly health nancing through scaling up the performance-based nancing experiment in collaboration with the World Bank and other interested partners.
- **Sustain the current momentum in establishing a metrics system** that ensures production of data for timely decision-making.
- **Pursue and expand public-private partnerships** at all levels of the health system.
- **Improve governance of the health sector** to ensure ownership and sustainability.
- **Build a more effective supply chain management system** to avoid recurrent commodities stock-outs at the regional and district levels.

## COUNTRY DATA: POPULATION AND CHILD & MATERNAL MORTALITY

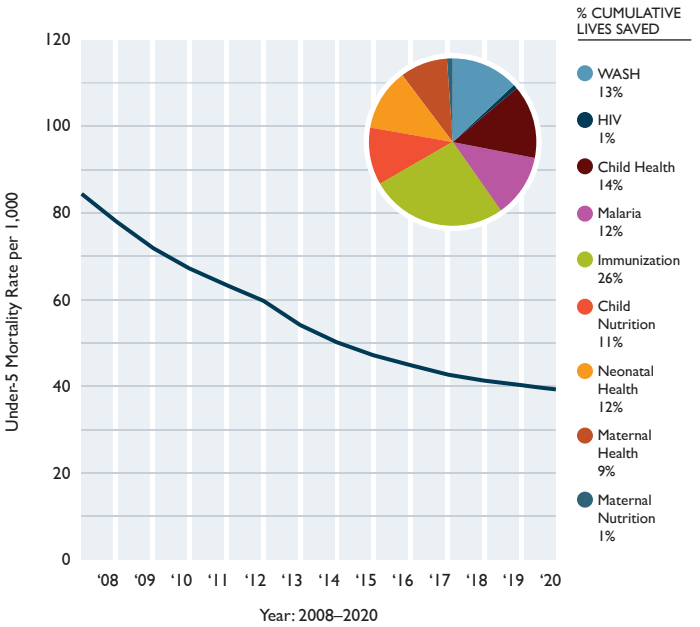
| | Total Population ↑ | Population Under 5 Years ↑ | Under-5 Deaths / Year ↓ | Under-5 Mortality Rate Per 1,000 Live Births ↓ | Births ↑ | Maternal Mortality Ratio Per 100,000 Live Births ↓ |
|---|---|---|---|---|---|---|
| 1990 | 7.3M | 1.4M | 44K | 142 | 342K | 670 |
| 2012 | 12.9M | 2.1M | 30K | 60 | 469K | 320* |

*2013

## PROJECTED INTERVENTION IMPACTS OVER FIRST 5 YEARS OF LIFE: 2012–2020




## BENDING THE CURVE: REDUCING CHILD MORTALITY




## WORKING TOGETHER, WE CAN REACH THESE GOALS

| | Under-5 Mortality Rate per 1,000 | Maternal Mortality Ratio per 100,000 |
|---|---|---|
| 2012 | 60 | 320* |
| 2020 | 39 | 204 |
| 2035 | 20 | 50 |

*2013

### BY 2020

**88,000 CHILD LIVES SAVED**

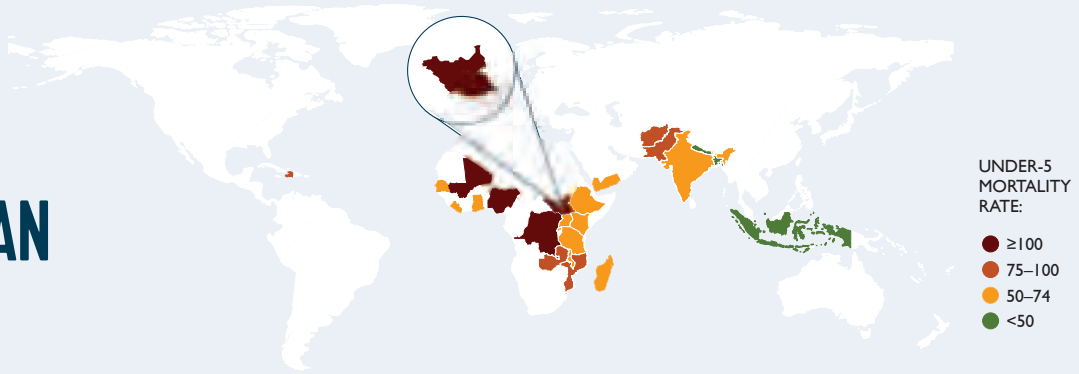
OF WHICH 30,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

**4,300 WOMEN'S LIVES SAVED**

OF WHICH 3,100 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

Demographic impact is the projected impact of family planning interventions on reducing the number of deaths due to fewer unintended pregnancies.

# SOUTH SUDAN




| ENDING PREVENTABLE CHILD AND MATERNAL DEATHS | 2009* Fiscal Year | 2010* Fiscal Year | 2011 Fiscal Year | 2012 Fiscal Year | 2013 Fiscal Year | 2014 Fiscal Year | TOTAL |
|---|---|---|---|---|---|---|---|
| USAID $ IN MILLIONS | 27 | 27 | 31 | 39 | 35 | 32 | 191 |

*All funding for these programs prior to FY 2011 was implemented in the southern region of Sudan, as the nation of South Sudan did not gain independence until 2011.

## USAID HAS COMMITTED TO:

*Advance primary health care services in the states of Central and Western Equatoria:*

- **Improve the delivery of the minimum package of health services** through county implementing partners in all 16 counties in both states, focusing on creating demand for all services, quality improvement, maternal and newborn care (especially antenatal care, assisted deliveries), family planning information and services, HIV testing and PMTCT in collaboration with PEPFAR, community mobilization through village health committees, child health (integrated management of childhood illnesses; Vitamin A; routine immunizations), and WASH activities (social marketing of Water Guard).
- **Scale up a Prevention of Postpartum Hemorrhage Program** — which identi es and trains volunteer "home health promoters" who visit women in the last month of pregnancy — from two counties to four additional counties with plans for eventual national scale up.
- **Support basic and comprehensive emergency obstetric and site assessments** and training in facilities in both states.

*Support improved routine immunization services in all 10 states of South Sudan in collaboration with the World Health Organization:*

- **Intensify active surveillance** of vaccine-preventable disease and eradicate polio.
- **Strengthen weak health infrastructure** at the national and state levels and increase resources to strengthen the routine immunization system.

*Expand access to essential pharmaceuticals:*

- **Support the procurement, storage, and delivery** of an emergency $48 million one-year supply of essential medicines and other health commodities to all counties nationwide with additional technical assistance to strengthen pharmaceutical management and logistics.

## WORKING TOGETHER, WE CAN DO MORE:

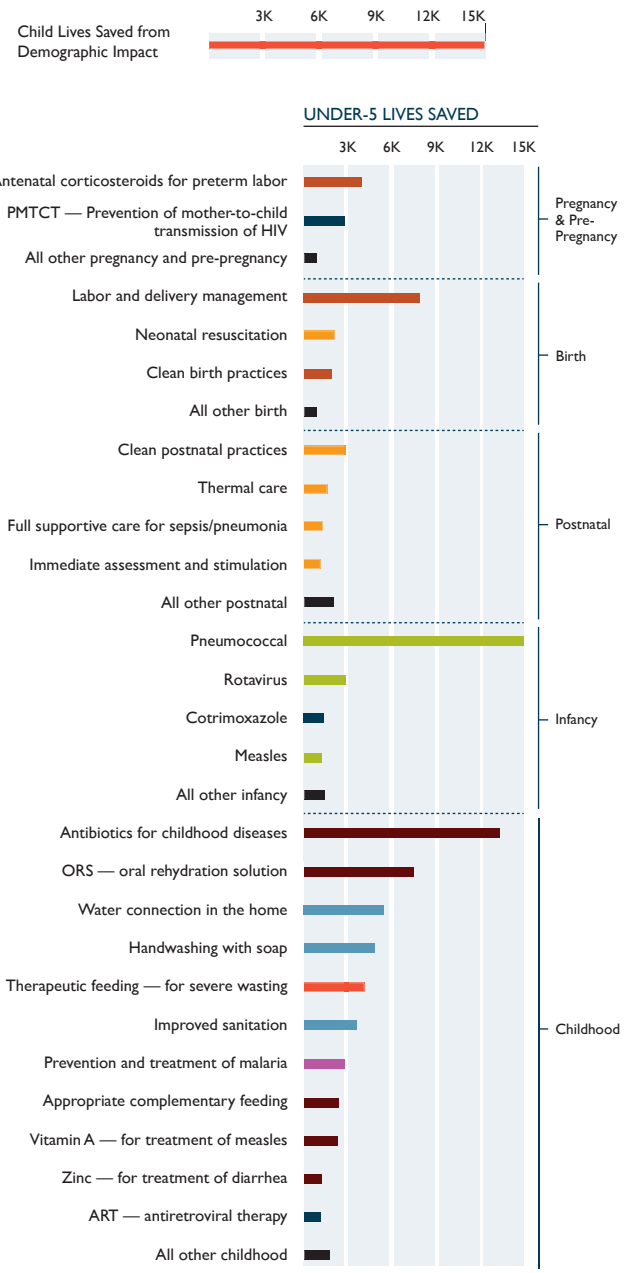
- **Provide the minimum package of health services across the country** to complement humanitarian response.
- **Support South Sudan in addressing its health funding shortages** and instability in light of the ongoing crisis, and alleviate uncertainty regarding future procurement and distribution of pharmaceutical and health commodities.
- **Address the extreme health workforce shortage in South Sudan** in all categories of trained health professionals, including physicians and midwives, which led to substantial inequity of health workers among the states and between urban and rural areas, where the majority of the population lives. Overall, 20% of health facilities at the primary level are not operative, mainly due to lack of staff.

## COUNTRY DATA: POPULATION AND CHILD & MATERNAL MORTALITY

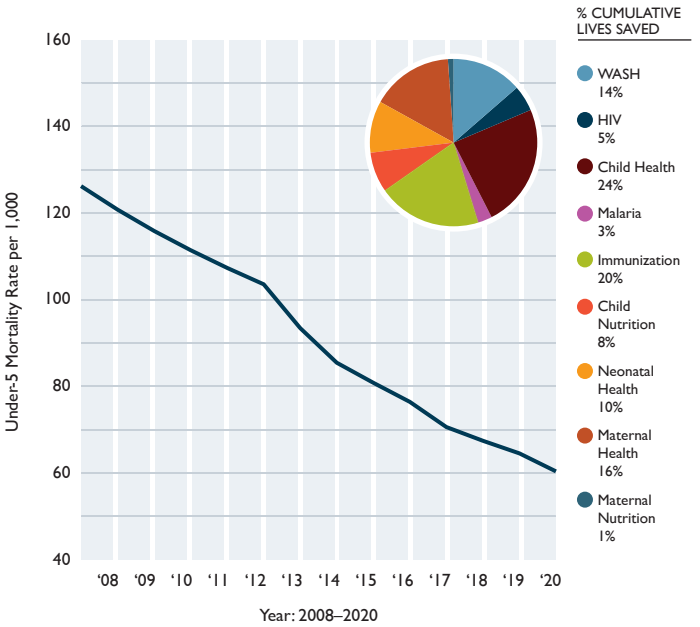
| | Total Population ↑ | Population Under 5 Years ↑ | Under-5 Deaths / Year ↓ | Under-5 Mortality Rate Per 1,000 Live Births ↓ | Births ↑ | Maternal Mortality Ratio Per 100,000 Live Births ↓ |
|---|---|---|---|---|---|---|
| 1990 | 5.8M | 1.1M | 66.2K | 251 | 263K | 1,800 |
| 2012 | 10.6M | 1.8M | 39.5K | 104 | 418K | 703* |

*2013

## PROJECTED INTERVENTION IMPACTS OVER FIRST 5 YEARS OF LIFE: 2012–2020




## BENDING THE CURVE: REDUCING CHILD MORTALITY




## WORKING TOGETHER, WE CAN REACH THESE GOALS

| | Under-5 Mortality Rate per 1,000 | Maternal Mortality Ratio per 100,000 |
|---|---|---|
| 2012 | 104 | 730* |
| 2020 | 61 | 370 |
| 2035 | 20 | 50 |

*2013

### BY 2020

**116,000 CHILD LIVES SAVED**

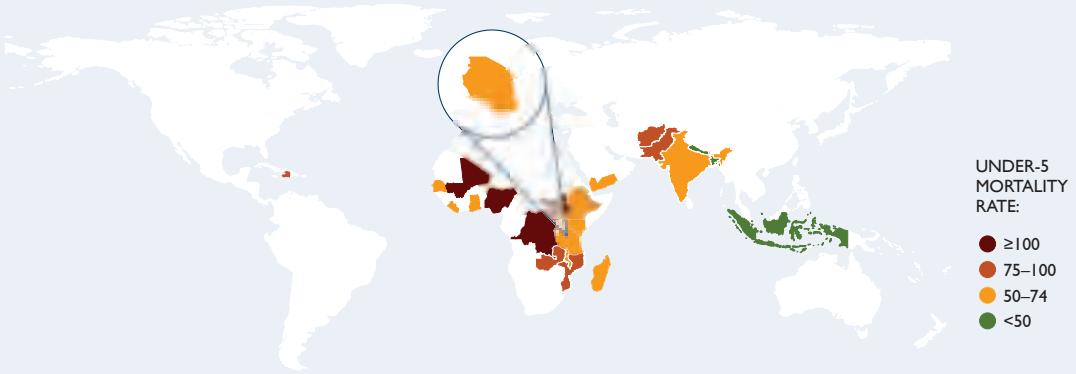
OF WHICH 15,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

**6,000 WOMEN'S LIVES SAVED**

OF WHICH 1,800 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

Demographic impact is the projected impact of family planning interventions on reducing the number of deaths due to fewer unintended pregnancies.

# TANZANIA




| ENDING PREVENTABLE CHILD AND MATERNAL DEATHS | 2009 Fiscal Year | 2010 Fiscal Year | 2011 Fiscal Year | 2012 Fiscal Year | 2013 Fiscal Year | 2014 Fiscal Year | TOTAL |
|---|---|---|---|---|---|---|---|
| USAID $ IN MILLIONS | 59 | 80 | 85 | 94 | 92 | 93 | 502 |

## USAID HAS COMMITTED TO:

*Promote integrated access to health services, supporting Tanzania's "One Plan" for maternal, newborn, and child health:*

- **Improve demand for and delivery of high quality RMNCH services** in highest-need regions from skilled birth attendance, to essential newborn care, to the case management of childhood illness.
- **Provide support — through the President's Malaria Initiative —** for the integrated commodity logistics system as well as technical assistance to quantify annual rapid diagnostic test and artemisinin-based combination therapy needs to ensure availability of malaria and other health commodities in facilities.
- **Support the adoption of a national standardized Community Health Worker cadre** to encourage women to seek antenatal care and delivery services from trained medical providers.
- **Update health care facilities in seven regions** to ensure 24 hours/seven days a week delivery and availability of emergency obstetric care.
- **Promote early initiation and exclusive breastfeeding** during the  rst six months of life, followed by complementary feeding, through a range of activities, including developing and disseminating a national Social and Behavior Change Communication strategy.
- **Strengthen the routine immunization platform,** including the vaccine disease surveillance system.
- **Expand access to new rotavirus and pneumococcal vaccines,** which were launched in 2013, and support the new introduction of measles2 and rubella vaccines.
- **Create demand for RMNCH services and key practices,** including point-of-use water treatment, hygiene and sanitation, and other healthy practices through television, mobile phones, radio, and print and folk media.
- **Integrate care through high-impact interventions,** including family planning service provision at HIV care and treatment sites in collaboration with PEPFAR.
- **Integrate nutrition and agricultural activities** in the Feed the Future Zones of In  uence.

*Strengthen critical health system functions:*

- **Improve the availability of commodities at facility level** by strengthening the Integrated Logistics Management System, converting from paper to an electronic system, and enabling mobile reporting.
- **Support the Government of Tanzania's National Family Planning Costed Implemented Plan,** focusing on improving contraceptive security, local capacity building, service delivery, advocacy and demand creation, and management, monitoring and evaluation. For example, expand task-shifting efforts to allow Clinical Of  cers to provide female sterilization in selected regions in the Lake Zone.
- **Support a platform to allow data sharing across different health information systems** and identify approaches to subsidize the poor without penalizing the health providers who serve them.

## WORKING TOGETHER, WE CAN DO MORE:

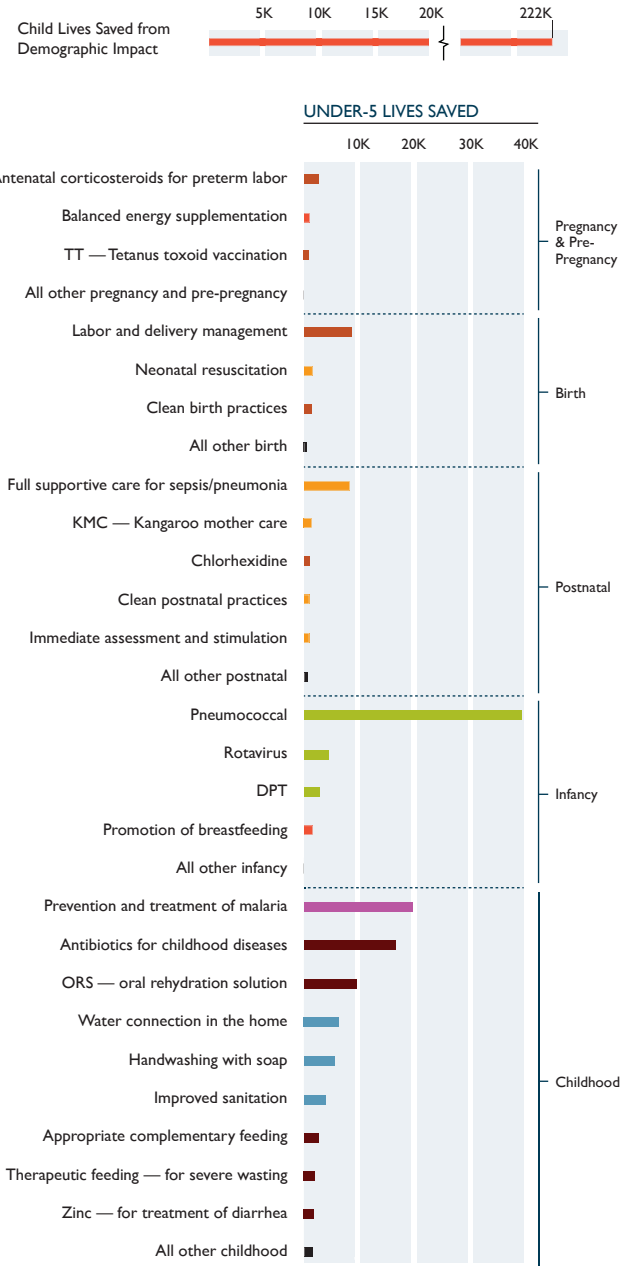
- **Address severe shortage and inequitable distribution of health care workers** by assisting with strengthening pre- and in-service training curricula — improving coordination of community health worker programs across different geographic and technical areas, and strengthening the capacity of district health management teams.
- **Engage communities as active participants** in their own health — promoting key preventive behaviors and health interventions, as well as improving knowledge of when and where to seek care.
- **Target resources to geographic areas** of highest maternal, newborn, and child mortality to accelerate the pace of interventions, such as frequency of mobile outreach services in highest-need areas.

## COUNTRY DATA: POPULATION AND CHILD & MATERNAL MORTALITY

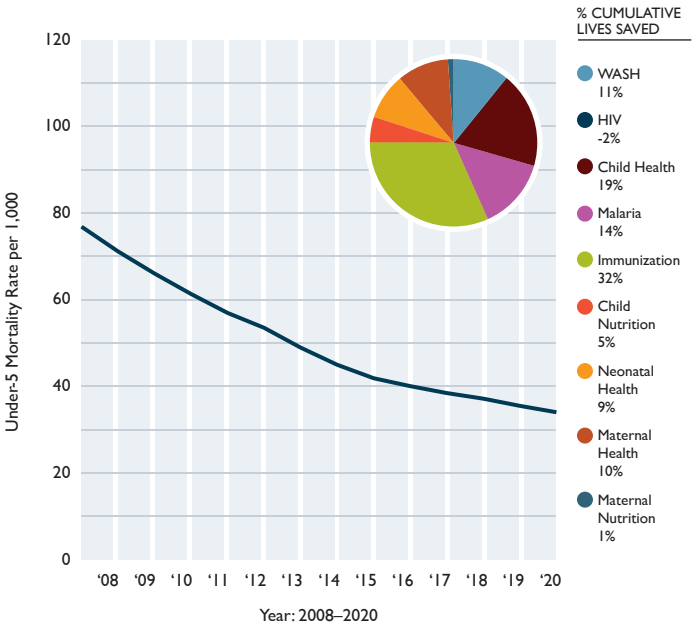
| | Total Population ↑ | Population Under 5 Years ↑ | Under-5 Deaths / Year ↓ | Under-5 Mortality Rate Per 1,000 Live Births ↓ | Births ↑ | Maternal Mortality Ratio Per 100,000 Live Births ↓ |
|---|---|---|---|---|---|---|
| 1990 | 25M | 4.4M | 179K | 166 | 1M | 870 |
| 2012 | 47M | 8M | 98K | 54 | 1.8M | 410* |

*2013

## PROJECTED INTERVENTION IMPACTS OVER FIRST 5 YEARS OF LIFE: 2012–2020




## BENDING THE CURVE: REDUCING CHILD MORTALITY




## WORKING TOGETHER, WE CAN REACH THESE GOALS

| | Under-5 Mortality Rate per 1,000 | Maternal Mortality Ratio per 100,000 |
|---|---|---|
| 2012 | 54 | 410* |
| 2020 | 34 | 261 |
| 2035 | 20 | 50 |

*2013

### BY 2020

**460,000 CHILD LIVES SAVED**

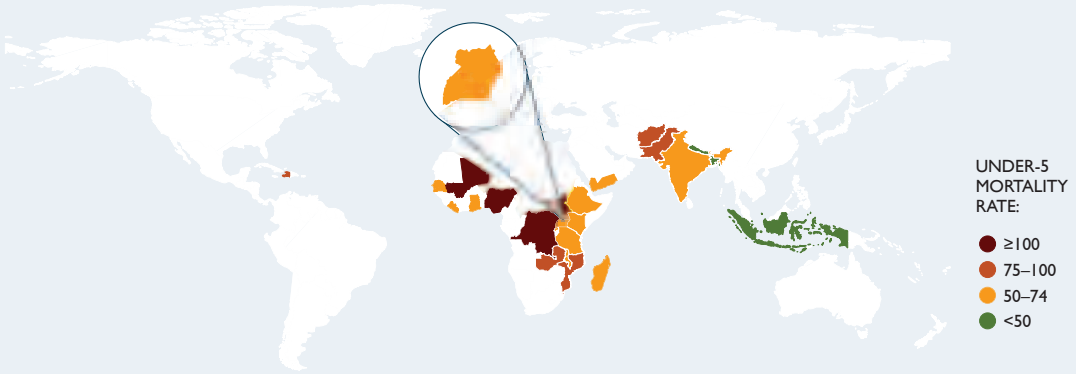
OF WHICH 222,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

**35,000 WOMEN'S LIVES SAVED**

OF WHICH 30,00 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

Demographic impact is the projected impact of family planning interventions on reducing the number of deaths due to fewer unintended pregnancies.

# UGANDA




| ENDING PREVENTABLE CHILD AND MATERNAL DEATHS | 2009 Fiscal Year | 2010 Fiscal Year | 2011 Fiscal Year | 2012 Fiscal Year | 2013 Fiscal Year | 2014 Fiscal Year | TOTAL |
|---|---|---|---|---|---|---|---|
| USAID $ IN MILLIONS | 43 | 62 | 71 | 75 | 80 | 86 | 417 |

## USAID HAS COMMITTED TO:

*Shift our approach to focus on regional integrated projects in four regions (North, Southwest, East, and East-Central), covering 61 of Uganda's 112 districts and accounting for 47% of the population.*

*Improve health service delivery:*

- **Provide on-the-job training and mentoring** for birth attendants to improve the active management of the third stage of labor.
- **Expand the Saving Mothers, Giving Life initiative from four to six additional districts** to deliver high quality interventions focused on the critical period around labor, delivery, and the  rst 48 hours postpartum.
- **Ensure poor women have access to subsidized vouchers** for safe delivery services in collaboration with the World Bank in 70 of the nation's 112 districts.
- **Train health workers in emergency obstetric care** and newborn resuscitation through Helping Babies Breathe-Plus curriculum.
- **Conduct post-introduction evaluation** of roll-out of pneumococcal vaccine and strengthen routine immunization systems in low-performing districts.
- **Expand coverage of four highly effective malaria prevention and treatment measures,** with support from the President's Malaria Initiative. These measures include: indoor residual spraying, insecticide-treated mosquito nets, intermittent preventive treatment for pregnant women, and malaria diagnosis and treatment.
- **Support the provision of a broad family planning method mix,** including implants, injectables, and long-acting reversible and permanent methods through community and mobile outreach services.
- **Expand access to family planning vouchers** redeemable at accredited private provider networks targeted to the poorest 40% of the population.
- **Integrate nutrition and agricultural activities** in the Feed the Future Zones of In  uence.

*Strengthening health systems:*

- **Provide technical assistance to the Government of Uganda** to improve the ef  ciency of recruitment, deployment, and placement of health workers, including advocacy for an increased wage bill allocation that resulted in recruitment of more than 7,000 new health workers.
- **Strengthen national supply chain systems** with improved policy and regulatory measures, accreditation of dispensing outlets, and  nancing, procurement planning, warehousing, distribution, and monitoring.
- **Roll out a web-based Health Management Information System at the district level** to support decentralized data collection, data quality improvement and program evaluation.

## WORKING TOGETHER, WE CAN DO MORE:

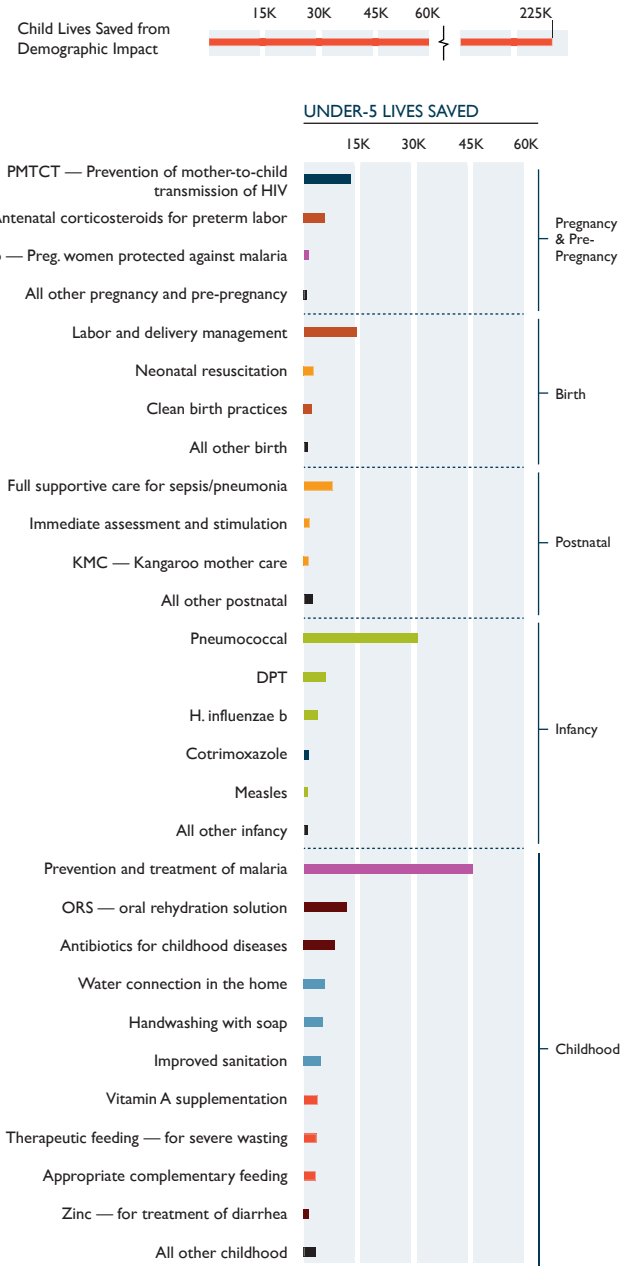
- **Develop an effective public system** to enable citizens to see exactly where their resources are spent.
- **Address challenges of decentralized health service delivery** and support local governments to improve resource mobilization.
- **Address funding shortages** by better engaging with private non-pro  t organizations and the private sector.
- **Address rapid growth in population,** which is expected to double within 20 years.

## COUNTRY DATA: POPULATION AND CHILD & MATERNAL MORTALITY

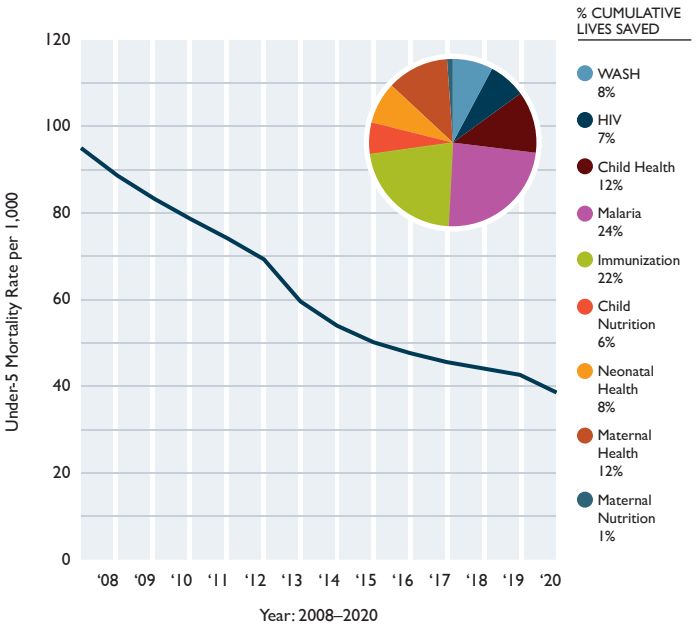
| | Total Population ↑ | Population Under 5 Years ↑ | Under-5 Deaths / Year ↓ | Under-5 Mortality Rate Per 1,000 Live Births ↓ | Births ↑ | Maternal Mortality Ratio Per 100,000 Live Births ↓ |
|---|---|---|---|---|---|---|
| 1990 | 16.5M | 3.5M | 145K | 178 | 875K | 600 |
| 2012 | 33.6M | 6.5M | 103K | 69 | 1.5M | 360* |

*2013

## PROJECTED INTERVENTION IMPACTS OVER FIRST 5 YEARS OF LIFE: 2012–2020




## BENDING THE CURVE: REDUCING CHILD MORTALITY




## WORKING TOGETHER, WE CAN REACH THESE GOALS

| | Under-5 Mortality Rate per 1,000 | Maternal Mortality Ratio per 100,000 |
|---|---|---|
| 2012 | 69 | 360* |
| 2020 | 39 | 229 |
| 2035 | 20 | 50 |

*2013

### BY 2020

**509,000 CHILD LIVES SAVED**

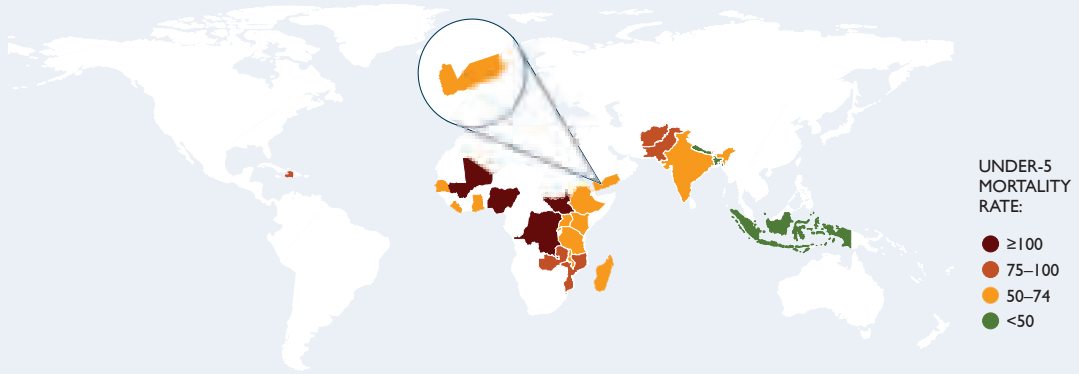
OF WHICH 225,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

**21,000 WOMEN'S LIVES SAVED**

OF WHICH 15,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

Demographic impact is the projected impact of family planning interventions on reducing the number of deaths due to fewer unintended pregnancies.

# YEMEN




| ENDING PREVENTABLE CHILD AND MATERNAL DEATHS | 2009 Fiscal Year | 2010 Fiscal Year | 2011 Fiscal Year | 2012 Fiscal Year | 2013 Fiscal Year | 2014 Fiscal Year | TOTAL |
|---|---|---|---|---|---|---|---|
| USAID $ IN MILLIONS | 11 | 10 | 9 | 8 | 8 | 9 | 55 |

## USAID HAS COMMITTED TO:

- **Improve maternal and child outcomes in four focus governorates** with a package of 10 key high-impact interventions called "Best Practices for Day of Birth," including development of birth preparedness plans and skilled attendance at home deliveries.
- **Support the development of a checklist** for the Best Practice Package and program tools for Respectful Maternity Care, as well as establish a core group of 40 family planning trainers.
- **Improve workforce preparedness** by strengthening midwifery pre-service institutes, scaling up to cover 10 of the 22 institutes within the next year.
- **Strengthen routine immunization offered through services at xed posts** in four focus governances, using all components of the Reach Every District approach.
- **Update national policies, clinical guidance, and competency-based training and job aids** to include the 10 high-impact practices included in the package.
- **Support governorate and district level health teams in four focus governorates** to strengthen their skills in planning, supportive supervision, and data collection and analysis.
- **Strengthen national capacity** to improve and manage the national supply chain system and commodity security for family planning and MNCH commodities.

## WORKING TOGETHER, WE CAN DO MORE:

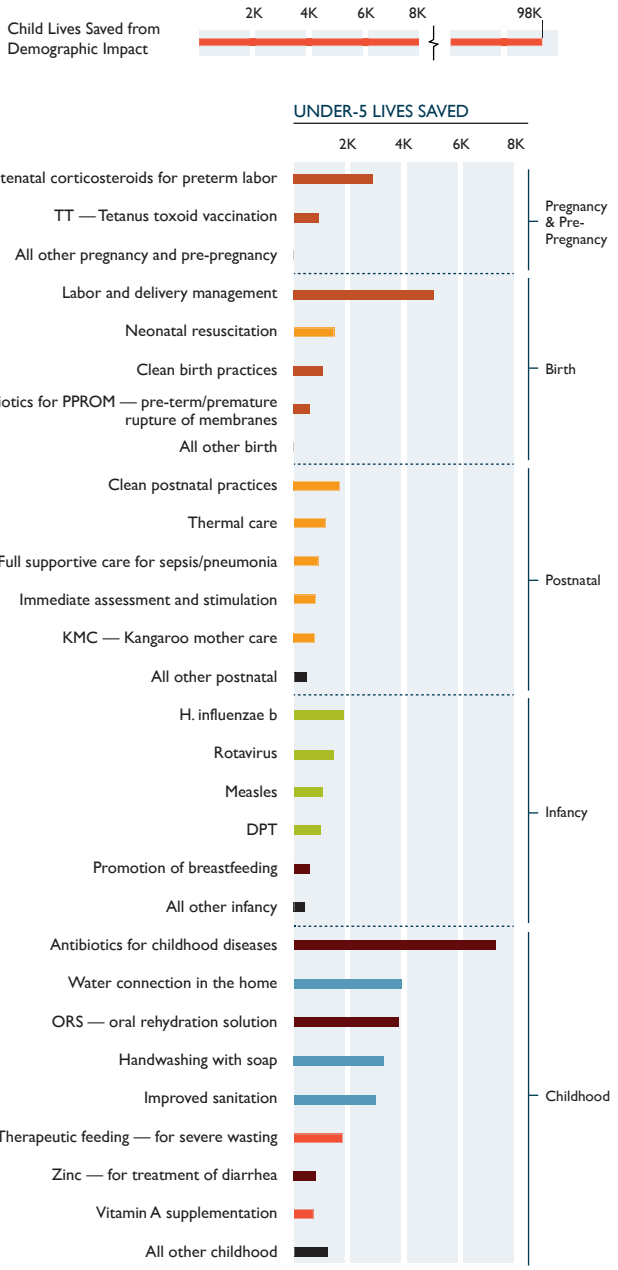
- **Leverage USAID's focus on resilience** to improve strategic coordination, reduce risk, and improve social, health, and economic conditions of vulnerable populations.
- **Integrate nutrition messages in health services, focusing on chronic malnutrition** for children under ve, in coordination with the Government of Yemen and other donors.
- **Scale up family planning programming at all levels** with emphasis on increasing demand, improving quality, expanding method mix, and reaching women who have limited access to health facilities.
- **Strengthen** facility, community, and interpersonal social behavior change communication efforts.
- **Promote gender equity** across the social, educational, and employment sectors.
- **Leverage GAVI Alliance and Government investments** to expand and sustain the gains made in routine immunization coverage, and the recent introduction of pneumococcal and rotavirus vaccines.
- **Boost immunization coverage** and ensure that high coverage with all antigens is achieved.

## COUNTRY DATA: POPULATION AND CHILD & MATERNAL MORTALITY

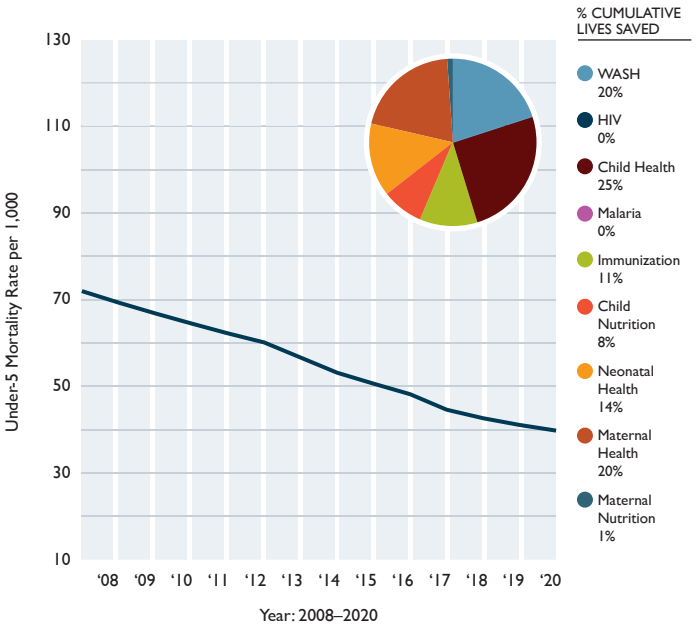
| | Total Population ↑ | Population Under 5 Years ↑ | Under-5 Deaths / Year ↓ | Under-5 Mortality Rate Per 1,000 Live Births ↓ | Births ↑ | Maternal Mortality Ratio Per 100,000 Live Births ↓ |
|---|---|---|---|---|---|---|
| 1990 | 11.8M | 2.5M | 71K | 125 | 570K | 610 |
| 2012 | 24.6M | 3.8M | 43K | 60 | 813K | 270* |

*2013

## PROJECTED INTERVENTION IMPACTS OVER FIRST 5 YEARS OF LIFE: 2012–2020




## BENDING THE CURVE: REDUCING CHILD MORTALITY




## WORKING TOGETHER, WE CAN REACH THESE GOALS

| | Under-5 Mortality Rate per 1,000 | Maternal Mortality Ratio per 100,000 |
|---|---|---|
| 2012 | 60 | 270* |
| 2020 | 40 | 172 |
| 2035 | 20 | 50 |

*2013

### BY 2020

**183,000 CHILD LIVES SAVED**

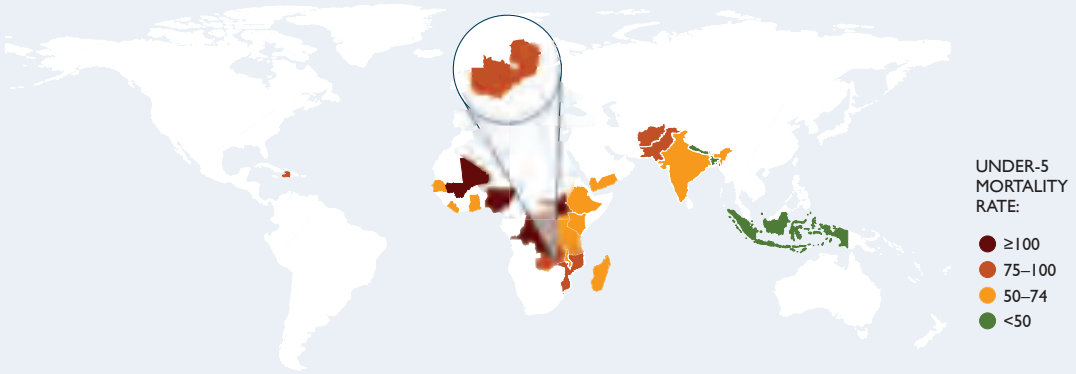
OF WHICH 98,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

**5,300 MOTHERS LIVES SAVED**

OF WHICH 4,100 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

Demographic impact is the projected impact of family planning interventions on reducing the number of deaths due to fewer unintended pregnancies.

# ZAMBIA




| ENDING PREVENTABLE CHILD AND MATERNAL DEATHS | 2009 Fiscal Year | 2010 Fiscal Year | 2011 Fiscal Year | 2012 Fiscal Year | 2013 Fiscal Year | 2014 Fiscal Year | TOTAL |
|---|---|---|---|---|---|---|---|
| USAID $ IN MILLIONS | 34 | 48 | 50 | 53 | 52 | 54 | 290 |

## USAID HAS COMMITTED TO:

*Support joint U.S. Government and Government of the Zambia's health goals:*

- **Expand Saving Mothers Giving Life (SMGL) initiative** from four districts to 16 districts in collaboration with PEPFAR.
- **Increase institutional deliveries and coverage** of emergency obstetric and neonatal care services in all districts and improve appropriate use of uterotonics to prevent postpartum hemorrhage.
- **Improve access to ARVs** for HIV+ pregnant and postnatal women.
- **Initiate early exclusive breastfeeding, use of chlorhexidine, and Helping Babies Breathe partnership** to decrease newborn complications from prematurity, sepsis, and birth asphyxia.
- **Increase number of children receiving Vitamin A supplementation,** receiving a diverse diet, ORS, and zinc, and sleeping under insecticide-treated mosquito nets.
- **Increase immunization coverage through Zambian-led Reach Every Child** in Every District Strategy.
- **Improve malaria case management** through training and supervision of facility and community-based staff as well as procurement and distribution of rapid diagnostic tests and artemisinin-based combination therapy, with support from the President's Malaria Initiative.
- **Pilot the Scaling Up Nutrition 1,000 Most Critical Days Program** in 14 districts.
- **Reduce unmet need** for contraception and adolescent pregnancy rate in 27 districts.
- **Integrate nutrition and agricultural activities in the Feed the Future Zones of Influence.**

*Improve health systems:*

- **Focus on a health system-strengthening approach** with the newly launched MOH electronic Logistics Management Information System that will enable a transition from a paper-based system of data management to an electronic format.
- **Promote the Ministry of Health's National Health Worker Retention Scheme** by supporting newly remunerated community health agents, appropriate task shifting, and use of the human resource information system/database to address human resource challenges. Promote community-based report cards to allow the communities to track progress.

## WORKING TOGETHER, WE CAN DO MORE:

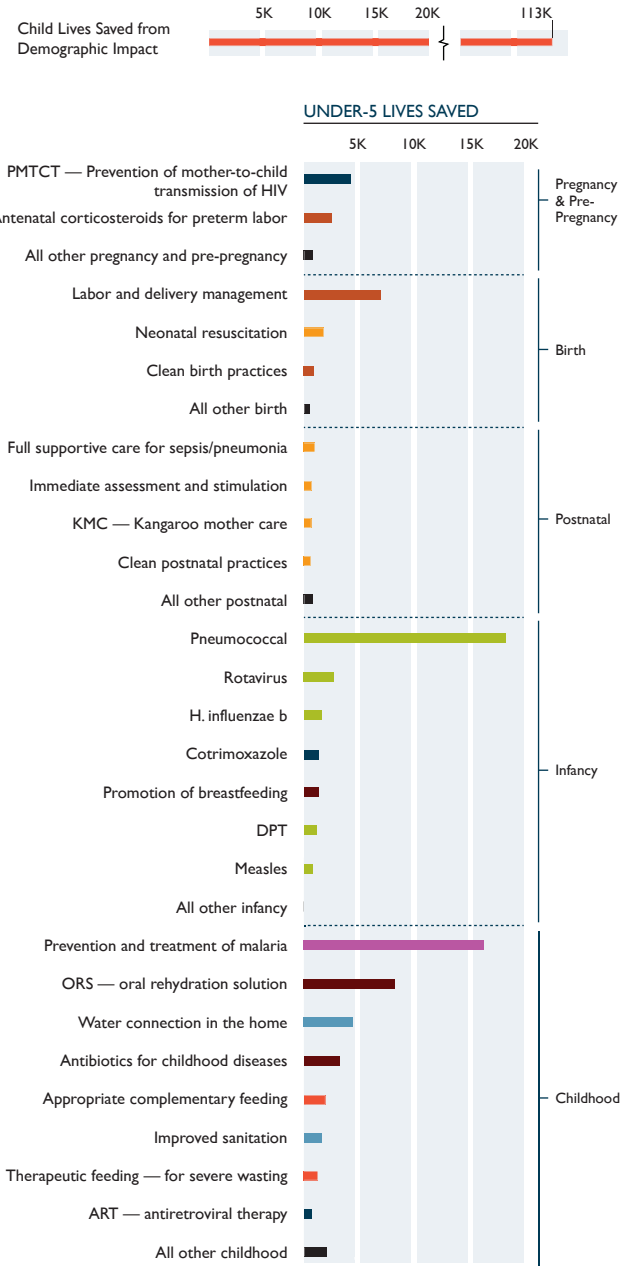
- **Foster innovative private sector and country-led solutions** by funding local organizations like CHAMP to conduct Private Sector Skills Gap Analyses.
- **Implement innovative solutions for health outcomes,** such as GeneXpert, to automate TB diagnosis and minimize the risk of TB transmission to clinical staff.
- **Strengthen the watchdog function** of civil society to minimize cases of corruption by service providers.

## COUNTRY DATA: POPULATION AND CHILD & MATERNAL MORTALITY

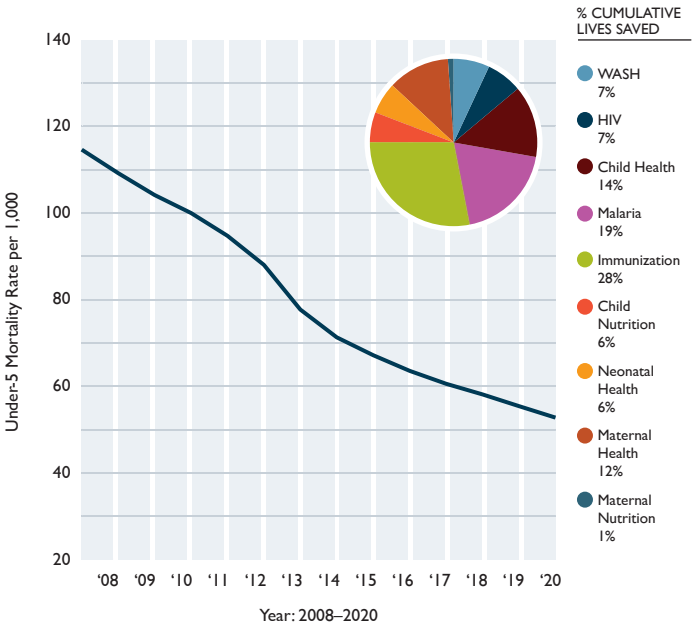
| | Total Population ↑ | Population Under 5 Years ↑ | Under-5 Deaths / Year ↓ | Under-5 Mortality Rate Per 1,000 Live Births ↓ | Births ↑ | Maternal Mortality Ratio Per 100,000 Live Births ↓ |
|---|---|---|---|---|---|---|
| 1990 | 7.6M | 1.4M | 63K | 192 | 339K | 470 |
| 2012 | 13.8M | 2.5M | 50K | 89 | 596K | 280* |

*2013

## PROJECTED INTERVENTION IMPACTS OVER FIRST 5 YEARS OF LIFE: 2012–2020




## BENDING THE CURVE: REDUCING CHILD MORTALITY




## WORKING TOGETHER, WE CAN REACH THESE GOALS

| | Under-5 Mortality Rate per 1,000 | Maternal Mortality Ratio per 100,000 |
|---|---|---|
| 2012 | 89 | 280* |
| 2020 | 53 | 178 |
| 2035 | 20 | 50 |

*2013

### BY 2020

**243,000 CHILD LIVES SAVED**

OF WHICH 113,000 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

**11,000 MOTHERS LIVES SAVED**

OF WHICH 8,400 ARE DEATHS AVERTED DUE TO FAMILY PLANNING INTERVENTIONS

Demographic impact is the projected impact of family planning interventions on reducing the number of deaths due to fewer unintended pregnancies.

# ACTING ON THE CALL

The following two sections — the first by UNICEF *(Sharpening the Focus)* and the second by USAID *(Technical Approaches to Proven Interventions)* — address the continuum of global health and guide our efforts to program effectively in support of country-led action plans. The UNICEF chapter presents an analysis of the key bottlenecks, as well as solutions to break these barriers. The USAID chapter details the proven interventions — organized in eight technical areas — that deliver the greatest results in child and maternal survival.

## UNICEF: Sharpening the Focus on Bottlenecks

As a core element of *A Promise Renewed,* governments and partners committed to review and sharpen national plans to identify the barriers to increased coverage of services and adequate care practices.

Across the 24 priority countries, analyses of key bottlenecks for many of the major interventions and their causes have been conducted with the technical support of UNICEF, primarily in the deprived districts where the burden of mortality and disease were the highest. In spite of the diversity of information sources used, the comparative analysis across countries shows systematic trends and clear findings [1]

The 24 priority countries were grouped in three categories according to their under-five mortality rates (Table 1).

[1] For the purpose of aggregation and comparability, all the available information from previous bottleneck exercises reanalyzed and synthesized using the framework described in Table 3.

### TABLE 1. COUNTRIES INCLUDED IN THE ANALYSIS

| | |
|---|---|
| **Higher Under-5 Mortality Rate (over 80)** | Democratic Republic of the Congo (COD), Mali (MLI), Nigeria (NIG), South Sudan (SSD), Afghanistan (AFG), Mozambique (MOZ), Zambia (ZMB), Pakistan (PAK) |
| **Medium Under-5 Mortality Rate (61–80)** | Haiti (HTI), Liberia (LBR), Kenya (KEN), Ghana (GHA), Malawi (MWI), Uganda (UGA), Ethiopia (ETH) |
| **Lower Under-5 Mortality Rate (60 or below)** | Yemen (YEM), Senegal (SEN), Madagascar (MDG), India (IND), Rwanda (RWA), United Republic of Tanzania (TZA), Nepal (NPL), Bangladesh (BGD), Indonesia (IDN) |

Seven important interventions were examined, from immunization to essential delivery and newborn care, and categorized according to their delivery platforms (Table 2). Clinical services, such as treatment of sick children and essential delivery and newborn care, are provided by skilled health workers in health facilities; other interventions, such as immunization or Vitamin A supplementation, are also delivered by health workers, but possibly outside of the health facility. Another set of interventions, including breastfeeding promotion, is largely delivered in the community. While not all of the technical areas covered in this report were analyzed for bottlenecks, strengthening our understanding of these interventions in detail provides an indication of the potential barriers elsewhere, including in family planning.

### TABLE 2. INTERVENTIONS AND DELIVERY PLATFORMS ANALYSIED

| DELIVERY PLATFORM | INTERVENTIONS ANALYZED |
|---|---|
| **Community-Based Interventions** | Infant and Young Child Feeding; Water, Sanitation, and Hygiene |
| **Outreach/ Schedulable Services** | Immunization; Vitamin A Supplementation |
| **Clinical Services** | Management of Diarrhea and Pneumonia; Essential Delivery and Newborn Care; Referral Maternal and Newborn Care |

Photo: Riccardo Gangale/USAID Kenya

### TABLE 3. DESCRIPTION OF COVERAGE BOTTLENECKS AND THEIR CAUSES

| | COVERAGE BOTTLENECKS | DESCRIPTION | EXAMPLES OF CAUSES IDENTIFIED |
|---|---|---|---|
| Enabling Environment | *Social Norms* | Social rules of behavior that are mainly driven by social pressure | Inadequate child feeding decisions are made by father or mother-in-law, who follow traditional practices |
| | *Policies & Legislation* | Adequacy of laws and policies at national and sub-national levels | National policy does not include use of corticosteroids for premature labor |
| | *Budget & Expenditure* | Allocation & disbursement of required resources at national and sub-national levels and efficiency of us | Erratic disbursements to lower level affect quality and frequency of outreach sessions |
| | *Management & Coordination* | Clarity of roles and accountabilities and mechanism for coordination/partnership | No institutions accountable for child nutrition, leading to uncoordinated and ineffective approach. |
| Supply | *Availability of Commodities* | Timely presence of commodities or inputs required to deliver a service or adopt a practice | Frequent stockouts of vaccines due to weak forecasting |
| | *Availability of Human Resources* | Timely presence of human resources capable of providing a service or promoting a practice/behavior | Insufficient umber of staff with skills to treat pneumonia due to limited training capacities |
| | *Geographical Access* | Physical capacity to access facilities and information | Large proportion of population without access, as facilities are more than 5 km. away. |
| Demand | *Initial Utilization* | Initial care seeking/initial adoption of practices | Low use of existing services due to financial ba riers |
| | *Continuity* | Timely initiation and completion of intervention/practice | High dropout rate in immunization due to lack of follow-up from health workers |
| Quality | *Quality* | Compliance with required standards or protocols | Inadequate diagnosis and treatment due to poor skills, job aids, and supervision |

In each of the 24 countries, bottlenecks were identified and p ioritized across the 10 categories (Table 3). Only the most critical were included in the analysis. The causes of these bottlenecks, as well as country typologies, are presented in Tables 4, 5, and 6.

*1. Community-based interventions and family practices*

**1.1. Priority bottlenecks and key causes**

Overall the most common coverage bottlenecks for community-based interventions and practices were related to detrimental social norms, low levels of utilization, and poor quality. In the high and medium-mortality countries insufficient udgets and expenditures remain a common bottleneck for this group of interventions.

For many countries — including those with low levels of mortality — there remain widespread misconceptions regarding the origins of common diseases and effectiveness of new interventions, such as use of ORS and zinc for treatment of diarrhea. The entrenched local preferences for traditional providers and methods, along with a lack of awareness of new community health workers, continue to hinder the utilization of these life-saving health providers in many countries. This barrier is also related to inadequate skills and a lack of motivation among community workers, which were identified across ma y countries as common reasons for the slow uptake of more healthy behaviors.

Underlying these causes, especially in high and medium-mortality countries, is that family and community practices — such as early initiation of breastfeeding, timely and adequate complementary feeding, use of sanitation facilities, hand washing, and drawing water from safe sources — are often not considered the government's responsibility or included as part of standard health services.

**1.2 Examples of strategies for addressing bottlenecks in community based services**

- In nine West and Central African countries key stakeholders are working to develop joint monitoring frameworks and concrete sustainability checks at the district level.
- National strategies are being developed in high priority countries in the coordination with the Scaling Up Nutrition movement; this political mobilization is complemented by other legal and institutional efforts, such as the control of marketing of breast milk substitutes in countries such as Liberia and Senegal.
- "Community Approaches to Total Sanitation" (CATS) has been developed to address entrenched beliefs regarding sanitation. The key element is the introduction of a new social norm — such as household and school latrine building and use or hand washing — by mobilizing the community to take a collective decision that leads to community-wide behavior change. CATS is already being implemented in more than 50 countries around the world and around approximately 10 million people have access to their own latrine as a result of CATS interventions.

*2. Outreach/schedulable services*

**2.1. Priority bottlenecks and key causes**

For services that are frequently given by health worker outreach, such as immunization and vitamin A supplementation, the most commonly prioritized coverage bottleneck was lack of geographic access, followed closely by problems with the availability of commodities. Second tier issues are management and coordination, human resources and policy problems, and budgets and expenditures, especially for lower-mortality countries.

The problem with geographic access is to be expected, since these services must reach remote and inaccessible populations, which are often also threatened by insecurity. Weak management of supplies, especially as vaccines require a cold chain, is another widespread cause of poor coverage. The introduction of new vaccines further increases the requirements on the cold chain and strains even relatively strong logistics systems.

Inadequate budgets make it difficult to procure additional funding for new vaccines, and to provide reliable on-time funding for vaccine purchase, cold chain operations and outreach costs. Failures and delays in funding translate very directly into disrupted services. Outreach also depends on reliable management at each level. In a number of countries either the number or skills of staff — or both — are insufficient compared to needs.

## TABLE 4. CAUSES OF BOTTLENECKS FOUND FOR COMMUNITY-BASED INTERVENTIONS AND PRACTICES

| COVERAGE BOTTLENECKS | CAUSES OF BOTTLENECKS FOUND | HIGHER UNDER-5 MORTALITY RATE (OVER 80) | MEDIUM UNDER-5 MORTALITY RATE (61–80) | LOWER UNDER-5 MORTALITY RATE (60 OR BELOW) |
|---|---|---|---|---|
| Social Norms | Misconceptions about origin of disease and effectiveness of interventions | ZMB, MOZ | KEN | SEN, TZA, YEM, MDG |
| | Limited decision power of pregnant women and mothers | MOZ, PAK | KEN | |
| | Entrenched preference for traditional methods/ practitioners | PAK, COD,NIG | KEN | NPL, BGD, SEN |
| Policies & Legislation | Inadequate/unclear policies/strategies | | UGA, KEN | YEM |
| | Policies/strategies existing, but poorly applied | MOZ | KEN | IDN, MDG |
| | Lack of policies/strategies | MOZ | LBR, KEN | TZA |
| | Ineffective regulation for private providers | | | SEN |
| Budget & Expenditure | Insufficient/inadequate allocation due to l w political priority | PAK, ZMB, MOZ | UGA, KEN,MWI | TZA |
| | Unpredictable/ insufficient fl w of funds to lower levels | ZMB, MOZ | | |
| Management & Coordination | Inadequate/lacking mechanisms for coordination of partners/stakeholders | AFG | KEN | IDN |
| | Unclear institutional leadership and accountabilities | MOZ | | TZA |
| Availability of Commodities | Inadequate policies and budgets for supplies | PAK | | |
| | Weak management of distribution of commodities | | | IND, YEM |
| | Inadequate equipment, infrastructure, and means for storage and transport | | | IND, YEM |
| Availability of Human Resources | Insufficient umber of staff | AFG, ZMB | UGA | TZA |
| | Poor distribution of staff | | | TZA |

**TABLE 4. CAUSES OF BOTTLENECKS FOUND FOR COMMUNITY-BASED INTERVENTIONS AND PRACTICES**

| COVERAGE BOTTLENECKS | CAUSES OF BOTTLENECKS FOUND | HIGHER UNDER-5 MORTALITY RATE (OVER 80) | MEDIUM UNDER-5 MORTALITY RATE (61–80) | LOWER UNDER-5 MORTALITY RATE (60 OR BELOW) |
|---|---|---|---|---|
| Availability of Human Resources *(continued)* | Staff lack capacity to do job | AFG, MOZ, ZMB, NIG, COD | LBR, KEN | MDG, TZA, RWA |
| | Insufficient y motivated/poorly managed staff | AFG | LBR | |
| Geographical Access | Insufficient functional facilities/pr viders | MOZ, COD | | IDN |
| | Inadequate geographical distribution of facilities/providers | MOZ, COD | UGA, KEN | YEM, TZA, TZA |
| | Inadequate scheduling or timing of services | | | NPL, IDN, IND, BGD |
| Initial Utilization | Families unable to pay for direct and indirect costs to use services/adopt practices | PAK | | |
| | Lack of awareness, misconceptions, traditional beliefs, and weak social support. | ZMB, NIG | KEN, MWI, UGA | NPL, SEN |
| Continuity | Poor follow-up by health workers | | | IDN |
| | Lack of/inadequate maintenance of water and sanitation facilities | | | TZA |
| | Lack of awareness of importance completion of interventions/sustenance of practice | | ETH | MDG, NPL |
| Quality | Inadequate skills and/or motivation of health providers | MOZ, PAK | ETH, KEN, MWI | IND, IDN, MDG, SEN, YEM |
| | Lack of supervision, monitoring, and accountability | MOZ, PAK, COD | KEN, MWI | BGD, IDN |
| | Inadequate management of services at the point of delivery | AFG | KEN | |
| | Poor understanding and social support for practices/ behaviors | COD, MLI, PAK | | RWA, BGD |

### TABLE 5. CAUSES OF BOTTLENECKS FOUND FOR OUTREACH/SCHEDULABLE SERVICES

| COVERAGE BOTTLENECKS | CAUSES OF BOTTLENECKS FOUND | HIGHER UNDER-5 MORTALITY RATE (OVER 80) | MEDIUM UNDER-5 MORTALITY RATE (61–80) | LOWER UNDER-5 MORTALITY RATE (60 OR BELOW) |
|---|---|---|---|---|
| Social Norms | Entrenched preference for traditional methods/practitioners | MOZ | ETH, PAK, MDG | |
| | Mistrust of modern technologies/institutions exacerbated by socio-political/religious conflict | MLI, PAK, NGA | | |
| Policies & Legislation | Outdated policies/strategies (excludes current technologies/good practices) | PAK | | BGC, |
| | Inadequate/unclear policies/strategies | AFG, COD, ZMB,MOZ | KEN | MDG, RWA,NEP |
| | Lack of policies/strategies | NGA,SSD, | KEN | |
| Budget & Expenditure | Insufficient/inadequate allocation due to l w political priority | PAK, MOZ, ZMB | UGA, KEN, ETH | IDN, RWA, TZA, MDG |
| | Unpredictable/ insufficient w of funds to lower levels | SSD, NGA | LBR, HIT,UGA | MDG |
| | Excessive dependency on donors | AFG, ZMB | | BDG, NPL,TZA, SEN, YEM |
| Management & Coordination | Weak management capacities and processes | COD, MOZ, PAK | HIT, LBR | TZA, YEM, IND |
| | Unclear institutional leadership and accountabilities | | ETH | |
| | Inadequate information systems | MLI, SSD | HIT, ETH, UGA | RWA |
| | Concurrent campaigns lead to poor planning and coordination | NGA | GHA, KEN | |
| Availability of Commodities | Inadequate policies and budgets for supplies | PAK, NIG, MOZ, | GHA, ETH | BGD |
| | Poor planning/forecasting | NIG, ZMB | | MDG, RWA, IDN |
| | Insufficient/del yed procurement/local production | PAK | ETH | IND |
| | Weak management of distribution of commodities | PAK, SSD, COD, ZMB, MOZ, NIG | UGA, MWI, HTI, LBR | YEM, MDG, SEN, TZA, IDN |

### TABLE 5. CAUSES OF BOTTLENECKS FOUND FOR OUTREACH/SCHEDULABLE SERVICES

| COVERAGE BOTTLENECKS | CAUSES OF BOTTLENECKS FOUND | HIGHER UNDER-5 MORTALITY RATE (OVER 80) | MEDIUM UNDER-5 MORTALITY RATE (61–80) | LOWER UNDER-5 MORTALITY RATE (60 OR BELOW) |
|---|---|---|---|---|
| Availability of Commodities *(continued)* | Inadequate equipment, infrastructure, and means for storage and transport | COD, PAK, MOZ, SSD, NIG | UGA, MWI, LBR | MDG, RWA |
| Availability of Human Resources | Insufficient umber of staff | AFG, ZMB, SSD | UGA | YEM, NPL, MDG, TZA |
| | Poor distribution of staff | | | YEM |
| | Staff lack capacity to do job | MOZ, SSD | HTI, UGA, ETH | |
| | Insufficient y motivated/poorly managed staff | | UGA | MDG |
| Geographical Access | Insufficient functional facilities/pr viders | ZMB, NIG | MWI, LBR, KEN, GHA | |
| | Inadequate geographical distribution of facilities/providers | ZMB, PAK, MOZ | UGA, KEN | YEM, SEN, NPL, MDG |
| | Inadequate scheduling or timing of services | NIG | MWI | TZA, IND |
| | Contextual challenges (insecurity, illegal settlements, difficult te rain, nomadism) | ZMB, SSD, PAK, MLI, COD, AFG, AFG | LBR, GHA, ETH | YEM, TZA, NPL, MDG, IND, BGD |
| Initial Utilization | Lack of awareness, misconceptions, traditional beliefs, and weak social support. | AFG | MWI, UGA | IND, IDN |
| | Poor interpersonal skills and attitudes of health workers | COD, PAK | ETH | |
| Continuity | Late referral and delays in providing care | MLI | | |
| | Poor follow up by health workers | MOZ, NIG | GHA, MWI, ETH, KEN | MDG |
| | Poor interpersonal skills and attitudes of health workers | NIG | ETH, LBR | YEM |
| Quality | Inadequate skills and/or motivation of health providers | SSD | | RWA |
| | Lack of supervision, monitoring, and accountability | | | IDN, TZA, RWA |
| | Inadequate management of services at the point of delivery | SSD | | |

Social norms remain a bottleneck in some high-mortality countries, where mistrust of modern technologies or institutions has been exacerbated by socio-political or religious conflicts

**2.2. Examples of strategies for addressing bottlenecks in outreach/ schedulable services**

- Reach Every Child is an integrated approach that aims at improving local management, defining local strategies to address problems of accessibility for deprived populations and mobilizing communities to support demand. It is implemented in 53 countries,[iv] mostly in sub-Saharan Africa and Southeast Asia.

- Complementary to Reach Every Child, the Effective Vaccine Management initiative assesses and addresses the different issues to ensure the availability of vaccines. In Mozambique, for example, the Ministry of Health has developed a specific plan to t ack progress in reducing inequities in immunization coverage.

- Vitamin A Supplementation delivery is often incorporated into planned campaigns to deliver polio and measles vaccines. Recognizing the problems that come with frequent campaigns, some countries have shifted toward enhanced routine outreach. In Ethiopia, Vitamin A supplementation delivery has shifted from biannual Enhanced Outreach Services to quarterly Community Health Days when communities are mobilized to come to fi ed sites.

- Improved micro-planning, bottom-up forecasting, and use of innovations such as mTRAC in Uganda are enabling countries to eliminate stock-outs (See Box on mTrac).

## mTRAC

Launched by the Ministry of Health in Uganda with support from UNICEF and FIND Diagnostics, mTrac is an innovation that uses mobile phones and RapidSMS to track health facility stock of essential medicines. It allows health facility workers to send real-time data to district and central level to avoid stock-outs and strengthen transparency and accountability for drugs. Using mTrac, the Ministry of Health receives up-to-date information on medicine stocks, and district health offices a e able to successfully work with the National Medical Stores for re-supply.

- Uninterrupted refrigeration of vaccines is vital. Maintaining the required cold chain from the manufacturer to the child is an enormous challenge, particularly in communities off the main grid or with intermittent electric supply. Weak links in a system can result in the loss of millions of doses of vaccines. Technological innovations have strengthened the reach and stability of supply systems through improved solar refrigerators. Affordable refrigeration systems utilize the solar array to directly drive a compressor that cools or freezes a liquid that in turn cools the vaccine — no longer relying on an electric battery to provide energy to run the compressor.

- Issues of geographic access and utilization are being addressed using context-specific st ategies, such as contracting out to NGOs, establishing additional contact points for service delivery in both urban and rural areas, mobilizing transportation to support outreach and using traditional or religious leaders to encourage communities to bring children for services. For example, the REC strategy has "linking services with communities" as one of its fi e key components, through which community volunteers are identified and gi en a role, such as following up with defaulters and holding regular meetings.

*3. Clinical Services*

**3.1 Priority bottlenecks and key causes**

The most frequent coverage bottlenecks for effective coverage of clinical services were both supply side issues — commodities, human resources, and geographical access — and demand side, such as low initial utilization. The causal analysis shows that an insufficien number of staff to provide services was the most common cause of bottlenecks in human resources, while inadequate skills and inequitable distribution, especially to rural areas, also block progress.

In high-mortality countries, the most significant bottleneck was the limited availability of commodities, due mostly to issues of insufficient or del yed procurement, poor planning and forecasting, and weak management of

## INTEGRATED COMMUNITY CASE MANAGEMENT (iCCM)

In most high-mortality countries, facility-based services alone do not provide adequate access to timely treatment of main childhood killers, especially to the most vulnerable and hard-to- reach populations. UNICEF, USAID, and other partners are supporting the iCCM strategy, which strengthens health systems through the training, equipping, and supporting of front-line community-based workers to deliver a package of essential, high-impact interventions and services for the major killers of young children (malaria, pneumonia, diarrhea, and severe malnutrition). One important result is the development of a functional community-based service delivery platform. While countries will need to continue to focus on using their large cadres of CHWs to make further gains in child health and nutrition, they can also now leverage this community-based platform to support and deliver a broader range of RMNCH and nutrition interventions. A global symposium was organized in January 2014 in an effort to consolidate evidence and improve coordination to inform further effective scale-up.

distribution. Some larger countries that aim to produce essential drugs locally find it difficult to do so at scale and wi quality. Remaining bottlenecks are found in the actual use of available services, either because families find it difficul to pay for care, particularly for inpatient care, they lack awareness, or they adhere to traditional practices, including social norms restricting the transportation of newborns. These are more common in high-mortality countries.

Some countries identified a need to update their protocols to support newer interventions, such as chlorhexidine, dispersible amoxicillin, antenatal corticosteroids for pre-term labor, and zinc for diarrhea, as well as to revise their policies to allow the shifting of these services to lower-level facilities or to the community.

Although issues of timeliness, continuity and quality of services were more frequently identified as bottlenecks i medium and lower-mortality countries, these problems are likely also common in higher-mortality settings. Ultimately, identifying barriers to progress is an exercise in relativity. In countries with very basic system failures, timeliness and quality are not yet the highest priorities.

**3.2 Examples of strategies for addressing bottlenecks in clinical services**

Commodities:

- Extend systems of planning, forecasting, procurement and distribution used for other health programs to cover all key RMNCH commodities.
- Build logistics capacity to handle the increased load. For example, Nigeria traditionally did not conduct national forecasting or procurement for any maternal, newborn or sick child commodities, leaving these issues to the state level. With the launch of the Saving One Million Lives program in 2012, the government has worked with the UN Commission on Life-Saving Commodities to now carry out forecasting exercises and procurement plans for a wider range of key commodities — building up the previously weak and divided national logistics systems to handle these commodities.
- Utilize innovations that are being developed to improve supply systems:
  - Mobile technology to increase the speed, transparency and level of detail of stock information, such as mTrac.
  - "Vendor managed supply systems" (outsourcing facility stock quantification to the supp y service)
  - Results-based financing schemes that delegate supply purchase decisions to health facilities

### TABLE 6. CAUSES OF BOTTLENECKS FOUND FOR CLINICAL SERVICES

| COVERAGE BOTTLENECKS | CAUSES OF BOTTLENECKS FOUND | HIGHER UNDER-5 MORTALITY RATE (OVER 80) | MEDIUM UNDER-5 MORTALITY RATE (61–80) | LOWER UNDER-5 MORTALITY RATE (60 OR BELOW) |
|---|---|---|---|---|
| Social Norms | Misconceptions about origin of disease and effectiveness of interventions | MLI | KEN | NEP,TZA, MDG |
| | Limited decision power of pregnant women and mothers | MLI | MWI, | TZA |
| | Entrenched preference for traditional methods/ practitioners | MOZ, SSD | KEN | MDG |
| Policies & Legislation | Outdated policies/strategies (excludes current technologies/good practices) | AFG, PAK, ZMB, NGA | KEN, UGA | BGD, IND, SEN |
| | Inadequate/unclear policies/strategies | SSD | UGA, MWI, | NEP, IDN |
| | Policies/strategies existing, but poorly applied | NGA | GHA | MDG,TZA |
| | Lack of policies/strategies | SSD,PAK | | IDN, MDG,TZA |
| | Ineffective regulation for private providers | | | BGD |
| Budget & Expenditure | Insufficient/inadequate allocation due to l w political priority | COD, SSD, NGA, MOZ, PAK | UGA, GHA, LBR | BGD,TZA, MDG |
| | Unpredictable/ insufficient w of funds to lower levels | ZMB | UGA, GHA | |
| | Excessive dependency on donors | SSD | | TZA |
| | Excessive reliance on user payments | COD | KEN | NEP, RWA |
| | Funding volatility due to political instability | | | YEM, MDG |
| Management & Coordination | Inadequate/lacking mechanisms for coordination of partners/stakeholders | MLI, MOZ, PAK | | IND, RWA |
| | Weak management capacities and processes | COD, PAK, ZMB | UGA, KEN | IDN, RWA |
| | Unclear institutional leadership and accountabilities | MOZ | KEN | |
| | Inadequate information systems | AFG | UGA, MWI | |

### TABLE 6. CAUSES OF BOTTLENECKS FOUND FOR CLINICAL SERVICES

| COVERAGE BOTTLENECKS | CAUSES OF BOTTLENECKS FOUND | HIGHER UNDER-5 MORTALITY RATE (OVER 80) | MEDIUM UNDER-5 MORTALITY RATE (61–80) | LOWER UNDER-5 MORTALITY RATE (60 OR BELOW) |
|---|---|---|---|---|
| Availability of Commodities | Inadequate policies and budgets for supplies | DOC | ETH | BGD, MDG, TZA |
| | Poor planning/forecasting | AFG, NIG, PAK, SSD, ZMB | KEN, MWI | |
| | Insufficient/del yed procurement/local production | NIG, PAK, ZMB | KEN, LBR, UGA | BGD |
| | Weak management of distribution of commodities | DOC, NIG, PAK, SSD, ZMB | ETH, LBR, UGA | BGD, MDG, TZA |
| | Inadequate equipment, infrastructure and means for storage and transport | | ETH | |
| | Inadequate maintenance/quality of equipment for service delivery | DOC, PAK, SSD | | RWA |
| Availability of Human Resources | Insufficient umber of staff | PAK, MOZ, AFG, NIG, SSD | MWI, KEN, UGA | BGD, YEM, TZA, MDG, IND, NPL, SEN, RWA |
| | Poor distribution of staff | AFG, NIG | LBR, KEN, GHA | MDG, IND, TZA, NPL, SEN |
| | Staff lack capacity to do job | SSD, PAK, MOZ | ETH, MWI, UGA, LBR | NPL |
| | Insufficient y motivated/poorly managed staff | MLI | KEN, ETH | |
| Geographical Access | Insufficient functional facilities/pr viders | ZMB, SSD, MOZ, AFG | UGA, LBR, KEN, GHA | MOZ, COD, YEM, SEN, MDG, IND, BGD |
| | Inadequate geographical distribution of facilities/ providers | | KEN | |
| | Inadequate transport and communications for referral | SSD, NIG, AFG | MWI, KEN | TZA, SEN, RWA |
| | Contextual challenges (insecurity, illegal settlements, difficult te rain, nomadism) | SSD | KEN | MDG, IDN |

### TABLE 6. CAUSES OF BOTTLENECKS FOUND FOR CLINICAL SERVICES

| COVERAGE BOTTLENECKS | CAUSES OF BOTTLENECKS FOUND | HIGHER UNDER-5 MORTALITY RATE (OVER 80) | MEDIUM UNDER-5 MORTALITY RATE (61–80) | LOWER UNDER-5 MORTALITY RATE (60 OR BELOW) |
|---|---|---|---|---|
| Initial Utilization | Families unable to pay for direct and indirect costs to use services/adopt practices | AFG, COD, MLI, NIG, PAK, ZMB | GHA, MWI, UGA | IND, MDG, NPL, SEN |
| | Lack of awareness, misconceptions, traditional beliefs, and weak social support. | AFG, COD, MLI, PAK, ZMB | ETH,KEN, UGA | BGD, IDN, IND, SEN |
| | Poor interpersonal skills and attitudes of health workers | | ETH, KEN, UGA | BGD |
| Continuity | Late referral and delays in providing care | | GHA, UGA | NPL, IND, IDN,TZA |
| | Poor follow-up by health workers | | ETH, UGA | RWA,TZA |
| Quality | Inadequate skills and/or motivation of health providers | COD, NIG, PAK | GHA, LBR, ETH | NPL, SEN, BGD, IDN, IND,YEM, TZA |
| | Lack of supervision, monitoring, and accountability | NIG, PAK | KEN, MWI, ETH | SEN, MDG, RWA,TZA, BGD |
| | Inadequate management of services at the point of delivery | | LBR | |
| | Poor understanding and social support for practices/behaviors | | | NPL |

Human Resources:

- Careful task shifting to lower-level workers, including the community health workers (see box on iCCM).
- Find rapid administrative measures to improved human resource capacity (e.g. redistribution of staff, short-term contracting mechanisms) or financial means  or the same purpose (e.g. improved hardship incentives, performance based incentives).
- Develop better engagement with private providers where the private sector is a major source of care. In Nigeria, for example, Patent Medicine Vendors (drug shops) are the single largest source of care for sick children. As a result, National Essential Medicines Coordination Mechanism's strategy includes focusing on improving both public and private supplies of key commodities, and including large-scale training of drug shop employees to improve advice and care.

Initial Utilization:

- To reduce out-of-pocket payments — including both direct costs, such as user fees, and indirect costs, such as transportation — some approaches include expansion of community or social insurance or even cash transfers to patients. In Mali, advocacy is building to reduce user fees by two-thirds. In 2005, India launched the Janani Suraksha Yojana, the largest conditional cash transfer program in the world. In the nine states with relatively lower socioeconomic levels, this program provides a cash incentive to all women for birthing in health institution. As a result, the proportion of institutional births increased from a pre-program average of 20% to 49% in fi e years.[v]
- Increase awareness of caregivers on identification of danger signs and appropriate response, as Bangladesh, Senegal, Zambia, and others have done.
- Countries such as Afghanistan, Kenya, and Pakistan are putting in place integrated demand creation campaigns, including mass media, advocacy, community mobilization, and interpersonal communication

Quality:

- Address the gaps in health workers skills and motivation through better quality training, mentoring and incentives, as well as strengthening accountability and supervision. For example, performance-based  nancing with special emphasis on quality of care is being implemented in several countries, including Afghanistan, Haiti, Nigeria Senegal, and Zambia.
- Updating national guidelines to reflect the global WHO/UNICEF recommendations and to disseminate them widely so both public and private health care providers are aware.

# ACTING ON THE CALL

## USAID: Technical Approaches to Proven Interventions

For the 24 priority countries, the activities for ending preventable child and maternal deaths span a continuum of care. This section presents proven interventions within eight clusters of technical approaches: Newborn Health; Immunization; Prevention and Treatment of Childhood Illness; Nutrition; Maternal Health; Family Planning; Ensuring Healthy Behaviors; and Water, Sanitation, and Hygiene. Importantly, each of the approaches is grounded in USAID's cross-cutting activities in health system strengthening, including innovative financing essential commodities, health workforce, leadership and governance, health information, and service delivery.

Ending preventable child and maternal deaths requires a health service delivery system that provides high-quality, equitable, and sustainable essential services to women, newborns, and children. USAID's equity-focused approach prioritizes services for the poorest and the most marginalized. This approach is supported by work in health governance to increase government effectiveness and responsiveness to population needs for equitable provision of high-quality maternal and child survival services.

The availability, distribution, and performance of health workers must be appropriately aligned to achieve child and maternal survival goals. To increase equity, USAID places strong emphasis on utilization of community health workers, whose roles can range from providing health information messages to communities and families to the management of childhood illness for diarrhea and pneumonia and severe infections in newborns.

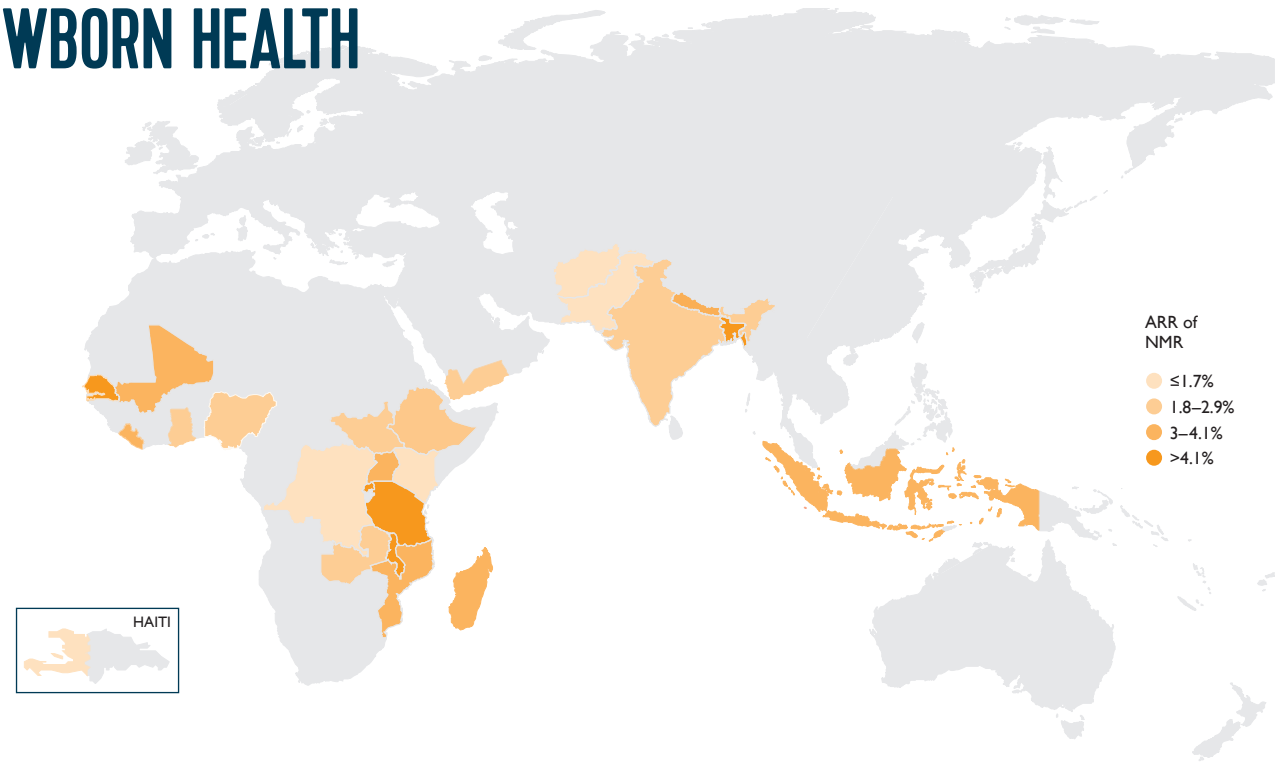
To ensure essential commodities reach end-users, USAID's approach recognizes that improvements must be made along the entire product value chain. This work includes accelerating the development and introduction of groundbreaking innovations, ensuring sufficient supp y of quality-assured products, improving country procurement and distribution systems for priority commodities, and supporting the sustained delivery of — and demand for — priority commodities.

The provision of understandable, quality health information to both beneficia ies and stakeholders in a way that allows for rapid communication of key messages is important. It promotes accountability for health outcomes at all levels of the health system. USAID supports efforts to ensure that data used for decision-making are of high quality and that accountability mechanisms are sound. These information systems support country capacity to ensure transparent and accountable policy, planning and management. In addition, better use of quality information by communities helps to hold providers and health facilities accountable to standards of care.

Health financing governance, and leadership are supportive functions that contribute to a country's ability to accelerate progress. For example, USAID works with countries to support programs to increase sustainable financing or RMNCH and nutrition services, reduce financial ba riers to access, improve incentives to providers for addressing needs of populations, and leverage innovative financin mechanisms to accelerate access to services. USAID works to improve overall health sector stewardship and regulatory capacity in support of improved service delivery for priority EPCMD services. Finally, USAID supports the development of a new generation of health system leaders at the national, regional and community levels as key champions of resilient health systems.

Photo: Copyright 2012 John Healey Photography

# NEWBORN HEALTH




Annual Rate of Reduction (ARR) in Newborn Mortality Rate (NMR) from 2000–2012. *WHO*

## Global Context

Neonatal mortality — death in the fi st 28 days of life — accounts for 44% of deaths (2.9 million) among children under fi e years old and 2.6 million stillborn babies. Up to three-fourths of newborn deaths occur during the fi st week after birth.[vi] Three causes accounted for more than 80% of neonatal mortality in 2012: complications of prematurity, intrapartum-related neonatal deaths including birth asphyxia, and neonatal infections.[vii] Complications of prematurity are currently the second leading cause of all under-fi e deaths.[ix] Ten million do not breathe at birth, of which six million require basic neonatal resuscitation of bag and mask ventilation.[x] More than 80% of newborn deaths occur in small babies who are preterm or small for gestational age in the highest burden settings.[xi]

## High-Impact Interventions

Most newborn and maternal deaths and complications can be prevented by ensuring provision of high-quality essential care for every pregnant woman and infant around the time of labor, childbirth and in the fi st week after birth. More than one third of stillbirths (1.2 million), 75% of newborn deaths (2 million) and 72% of maternal deaths (206,250) occur within this period.[xii] Up to 75% of newborn deaths can be prevented through attention to the following interventions across the continuum of care:

- **Care around labor, birth and first week:** (1) Skilled childbirth care (labor monitoring, clean practices, and emergency obstetric care); (2) management of asphyxia with basic newborn resuscitation (tactile stimulation, clearing airway, and bag and mask ventilation); (3) basic newborn care (drying, skin to skin care within an hour of birth) and exclusive breastfeeding, clean cord care, handwashing and chlorhexidine cord cleansing where appropriate, recognition of danger signs and care seeking); (4) management of preterm birth and low-weight babies (antenatal corticosteroids for preterm labor, antibiotics for premature rupture of membrane, kangaroo mother care, breastfeeding support, and hygiene); (5) management of severe newborn infections (early identification and antibiotic treatment); and (6) inpatient supportive care for sick babies (infection prevention and management, IV fluids/ eeding support, safe oxygen therapy, and jaundice case management).
- **Pre-Conception:** Spacing, delaying, and limiting births, as well as adolescent health (including reproductive health, immunization, and nutrition).
- **Care in Pregnancy:** Prevention and treatment of malaria in pregnancy,

syphilis, TB, and HIV, Tetanus toxoid immunization, nutrition, lifestyle practices (avoidance/cessation of smoking and alcohol use), and identification and treatment of urinary and reproductive tract infections

- **Postnatal care:** Close observation for 24 hours and at least three additional postnatal contacts: on day three, between days seven through 14, and six weeks after birth.[xiii]

## Priority Actions for Newborn Health

- **Mobilize Increased Support from the Global Community:** Newborn health suffers from a major gap in funding. Only four percent of donor disbursements for child health mention newborns, despite the fact that 44% of under-fi e child deaths occur in the newborn period. Donor support for newborn health increased between 2002 and 2010 but remains low, despite relatively broad-based support.

- **Support Countries to Strengthen Newborn Health Programs:** Neonatal health programs at the national, subnational and district level needs to be continuously updated. This will require continued coordination of technical inputs on planning, innovating, piloting, and monitoring.

- **Engage the Private Sector on Newborn Health:** The private sector is emerging as an important stakeholder in the field of newbo n health. USAID has spearheaded the creation of several public-private partnerships to leverage private sector resources for newborn health by initiating global development alliances: Helping Babies Breathe; Handwashing for Newborn Survival; Mobile Alliance for Maternal Action; Saving Mothers, Giving Life; and Survive and Thrive.

- **Involve Civil Society to Advocate for Newborn Health, Increase Demand, Empower Parents, and Hold Governments Accountable:** Civil society organizations at the global and country level have generally been slow to champion newborn health, although there have been significant global contributions made by some international NGOs.

- **Engage Health Professional Associations:** Health providers are the backbone of health services and need to be empowered, skilled, and equipped to provide quality newborn care. USAID has engaged international, regional, and national professional associations to support national programs to reduce newborn mortality.

- **Build on the Work of the UN Commission on Life-saving Commodities:** The Commission identified resources and recommended approaches to expand availability and appropriate use of 13 commodities, including four for newborns (resuscitation devices, injectable antibiotics, chlorhexidine for umbilical cord cleansing, and antenatal corticosteroids).

- **Foster Innovation:** Recent global initiatives have stimulated research and development of potentially game-changing innovations, including A Grand Challenge for Development: Saving Lives at Birth, the Grand Challenges Explorations, and the Laerdal Global Health grants.

- **Increase Linkages Across Platforms to Support Newborn Health:** Various global initiatives utilizing antenatal and postnatal care platforms (e.g., malaria in pregnancy, prevention of mother-to-child transmission of HIV, elimination of congenital syphilis, elimination of maternal and neonatal tetanus, nutrition, postpartum family planning, early infant male circumcision, and integrated community case management) can more effectively link to newborn healthcare, and vice versa.

- **Strengthen and Institutionalize Metrics and Build Capacity for Implementation Research on Newborn Health:** Efforts are underway to strengthen metrics to measure newborn health progress. There will be a need for a global normative body, such as WHO, to encourage governments to institute these indicators in their national health information management systems.[xiv] Implementation research aims to explore pathways to increase effectiveness, efficienc , and equity in the coverage of existing interventions. Expert researchers can help develop the capacity of local research groups to undertake implementation research to identify and surmount bottlenecks in implementation.

## USAID's Approach

Two million (70%) global newborn deaths occur in the 24 priority countries discussed in depth in this report; in these countries, newborn deaths account for 40 percent of deaths in children under

fi e. The pace of decline in the priority countries experienced an annual rate of reduction of 2.2 percent during 1990–2012, slower than the global rate of 2.8 percent.[xv] Increased coverage and quality of preconception, antenatal, intrapartum, and postnatal interventions by 2025 could avert 71% of neonatal deaths, 33% of stillbirths, and 54% of maternal deaths.[xvi] In full alignment with the Every Newborn Action Plan, USAID will increase investments in the following interventions in 24 priority countries:

*1. Focus on Increasing Coverage and Equity of Quality Care Around the Time of Birth*

Skilled labor and childbirth care and immediate newborn care at birth (including resuscitation if needed and early initiation of breastfeeding, warmth and clean cord care) within the fi st hour of life can prevent up to 41% of newborn deaths.[xvii] Births that are provided with quality care by skilled attendants have a better outcome than those that do not. Globally, 63% of births are attended by skilled health providers, and 61% take place in health facilities. Prevention of mother-to-child-transmission (PMTCT) activities contributes to ending preventable child and maternal deaths, as well as to creating an AIDS-free generation. Every year, more than one million infants are exposed to HIV. Despite progress, in 2012, an estimated 260,000 children were infected with HIV during pregnancy, labor or breastfeeding.[xviii] The majority of these transmissions occurred in sub-Saharan Africa where over 90% of all children with HIV live.

- **Actions in Priority Countries:** In countries that have low skilled birth attendance, USAID will strengthen community-based approaches and increase coverage of skilled birth attendance. In countries that have relatively high facility delivery, USAID will intensify efforts to improve the quality of care provided in those facilities. In countries with high HIV/AIDS prevalence, USAID will support a comprehensive approach to PMTCT. The key to interrupting transmission is timely and consistent anti-retroviral (ARV) use with appropriate co-trimoxazole prophylaxis as indicated. Ideally early in pregnancy and immediately after HIV diagnosis, mothers start on an ARV regimen that continues after childbirth, during the breastfeeding period, and possibly for life. Additionally, the HIV-exposed newborn must receive ARVs for 4–6 weeks after birth. Both mother and baby must be followed for medication adherence, adverse events, and complications of HIV infection or treatment.

*2. Focus on Increasing Coverage and Equity of Special Care for Sick and Small (Preterm/Low-Birth) Newborns*

More than 80% of newborn deaths are in preterm and low birth-weight babies.[xix] Care of sick and small babies would prevent 30% of newborn deaths.[xx] Many preterm and low birth-weight complications can be prevented by strengthening linkages with other health programs.

- **Actions in Priority Countries:** USAID will work with countries to strengthen linkages between newborn care and other health programs including HIV/AIDS, malaria, water and sanitation, nutrition, birth spacing, and reproductive health. It is vital to ensure that pre-term and low birth weight babies are attended to with a range of newborn interventions and these programs offer increased opportunities to provide services to these newborns. In 2012, 8.4 million newborns were born prematurely in the 24 priority countries.[xxi] Twenty countries have low birth weight rates that are above the global average of 14%. If the priority countries did as well as the "best performer" countries, increased attention to high-impact newborn interventions would save twice the number of newborns (two million) in fi e years compared to the current trajectory (one million).[xxii]

*3. Focus on Harnessing the Power of Parents, Families, and Communities*

Almost half of mothers do not receive skilled care during childbirth; more than 70% of babies born outside facilities receive no postnatal care;[xxiii] and many newborns die at home because their parents lack the awareness and knowledge about optimal newborn care practices and do not seek care when their babies are sick.

- **Actions in Priority Countries:** USAID will work with governments and communities to prevent maternal and newborn deaths

Photo: USAID 2014

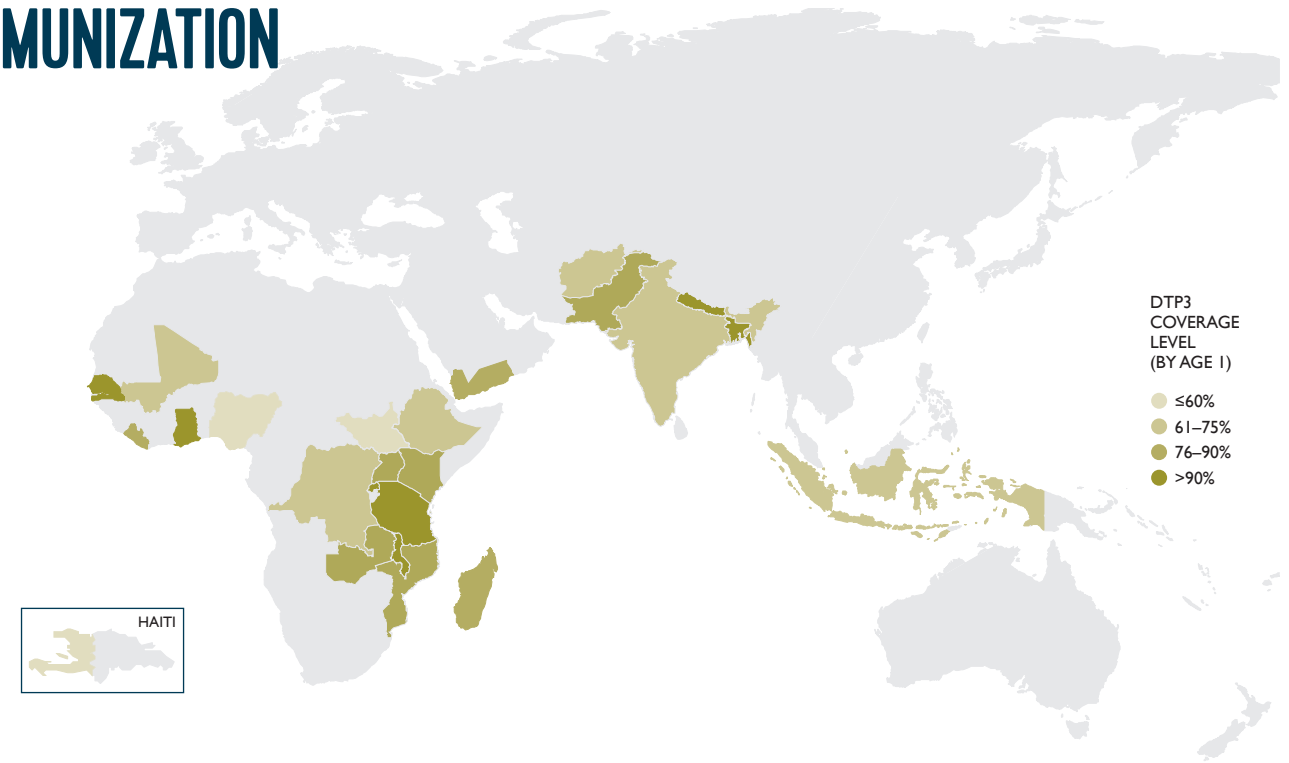
by changing social norms and expectations, equipping families with the knowledge and capacity for practicing optimal newborn care practices, increasing demand for quality newborn health care, and strengthening links between community and health facilities. USAID will further support availability of contraceptive choice to allow families to choose healthy spacing of births. Preventing unintended and high-risk pregnancies will prevent an estimated seven million under-fi e deaths (2012–2020), a significant po tion of which are newborn deaths.

*4. Focus on Measurement, Program Tracking, and Implementation Research*

While newborn mortality measurement has improved and is routinely reported, tracking of key indicators for newborn mortality is lagging. Such measurement is critical to understanding baselines, establishing targets, and monitoring and improving the process of implementation. In addition to the impact indicators, the Every Newborn Action Plan has identified the ollowing core set of coverage indicators: skilled birth attendant, early postnatal care, exclusive breastfeeding to six months, antenatal corticosteroid use, newborn resuscitation, kangaroo mother care, and treatment of sepsis.

- **Actions in Priority Countries:** USAID will continue to support Demographic Health Surveys, track the progress of coverage indicators articulated in the Every Newborn Action Plan, and measure equity of access to quality care.

# IMMUNIZATION




Coverage of three doses with DTP containing vaccine (DTP3) 2012. *UNICEF*

## Global Context

A cost-effective cornerstone of health systems, immunization programs are a public good that virtually all governments rely upon to advance the well-being of their populations. With new vaccines against major childhood killers diarrhea and pneumonia now available to low-income countries, immunization can prevent more than one out of every six child deaths.

But any vaccine, whether traditional or new, is only as effective as the health system that delivers it. While global immunization coverage with three doses of vaccine containing diphtheria, pertussis, and tetanus (DTP3, which is the standard indicator for immunization system strength) has increased from 73% in 2000 to 83% in 2012, it has stalled at the 82–83% level for over fi e years.[xxiv] This global figure mask important variations. For example, for the 73 lower-income countries supported by the GAVI Alliance, DTP3 coverage is estimated at 74%[xxv] — a major accomplishment but too low to reliably block transmission of highly infectious diseases. Within-country coverage variations are substantial, even in countries with high nationwide coverage. Demographic Health Survey data show that coverage is consistently lower in the poorest wealth quintile compared to the higher ones. The children who are missed are those most in need of the protection from vaccine preventable diseases and least likely to receive curative care for the common diseases immunization can prevent.

Achieving and sustaining the very high and equitable coverage that is needed to end deaths from vaccine preventable diseases requires strategic, creative approaches that recognize families and communities as partners with the health system. The managerial capability needed at national, district, and facility level to strengthen routine immunization can benefit the deli ery of other high-impact interventions, thereby working toward both immunization objectives and broader health system goals.

## High-Impact Interventions

Every year vaccination prevents an estimated 2.5 million deaths. The global community seeks to achieve the Decade of Vaccines (2011–2020) vision of all individuals and communities enjoying lives free from vaccine-preventable diseases. The Global Vaccine Action Plan provides the strategic framework to realize this vision.[xxvi] In the last 10 years, significant advances in developing and introducing new vaccines and expanding the reach of immunization programs mean that more people than ever before are being vaccinated. New and increasingly more sophisticated vaccines have become available in the last decade,

including pneumococcal conjugate vaccines and vaccines against rotavirus infection to combat leading causes of deaths among young children.

- **Pneumococcal Conjugate Vaccine.** WHO estimates that pneumococcal disease was responsible for 476,000 child deaths per year in 2008,[xxvii, xxviii] — prior to the introduction of the vaccine.

- **Rotavirus Vaccine.** An estimated 453,000 child deaths from diarrheal disease were caused by rotavirus in 2008. A substantial proportion of these deaths can be prevented each year if high coverage with rotavirus vaccine is achieved.[xxix]

GAVI plays a central role by co-financing these inn vative new vaccines and shaping the global vaccine market, making them more affordable and the supply more reliable. USAID has supported GAVI for over a decade, providing contributions totaling over $1 billion. GAVI has been catalytic in shortening the time frame in which new life-saving vaccines are introduced into developing countries.

The achievements in immunization are substantial and must be sustained. Since its launch 40 years ago, the Expanded Program on Immunization has proven to be an effective approach for service delivery, supervision, and program monitoring, able to reach into the periphery of a country and seek to immunize every child. Nevertheless, over 22 million children remained unprotected from vaccine preventable diseases. As of 2011, these children were almost evenly divided between "left-outs" (children who were completely unimmunized) and "drop-outs" (children who began but did not complete the vaccination schedule, usually due to unreliable or low quality services.)

## Priority Actions for Immunization

The Global Vaccine Action Plan has established immunization coverage targets of at least 90% national DTP3 coverage and at least 80% DTP3 coverage in every district. While the Reaching Every District approach has been used widely in the past decade to strengthen immunization programs, the plan calls for a move toward Reaching Every Community to ensure that the needs of underserved populations within even smaller geographic areas are recognized in planning and providing vaccination services. Countries can take a variety of actions to attain these targets, depending on their needs and the current status of their health system and immunization program. USAID, together with partners, can support country efforts to:

*Establish a strong base of leadership, management, and support*

- **Build long-term leadership, accountability, and management.** Educate decision-makers on what they can do to improve policies and provide reliable, appropriate, and sufficient resources to support immunization.

- **Provide an enabling environment.** Establish and strengthen national immunization technical advisory groups and engage with Interagency Coordinating Committees. Strengthen collaboration between immunization and other child health programs to work toward better prevention, control, and management of key childhood diseases.

- **Support the National Regulatory Authority.** Strengthen national regulatory authorities to ensure proper technical oversight regarding the licensing, procurement, and use of vaccines.

- **Secure sufficient financing for vaccines and immunization.** Increase domestic contributions to immunization programs to ensure sustainability.

- **Seek additional financial material, and technical support from GAVI and other partners.** Where eligible and appropriate, apply to GAVI to support new vaccine introduction, and health system strengthening and access to technical support, as needed.

*Strengthen the planning, management, delivery, and utilization of services*

- **Reinforce the capability for supply chain management.** Conduct assessments to identify cold chain and logistics needs at all levels, and use findings to ta e appropriate measures.

- **Improve service delivery.** Build the capacity of national, district, and health facility personnel to plan and provide high-quality services, using a mix of fi ed, outreach, and mobile strategies to reach all segments of the population. Use innovative approaches and technologies to improve program sustainability and integration with other services.

- **Support demand generation and community partnerships.** Work with civil society and other actors to partner with local leaders and communities to raise and satisfy demand for immunization services.

*Promote the use of data to optimize immunization systems*

- **Increase the use of data for decision-making.** Improve data systems, analysis, tools, and equipment, and support the use of health information at all levels to improve service delivery and better inform decision-makers.

- **Surveillance.** Coordinate and support investments in surveillance activities, including training for laboratory staff and surveillance office s, as well as training in adverse event monitoring, reporting and response.

- **Operations research and application of appropriate technologies.** Conduct research to answer key operational questions and test approaches and apply findings to impr ve program effectiveness and efficienc .

## USAID's Approach

USAID works closely with partners around the world including national governments, UNICEF, WHO, CDC, GAVI, and others to extend **equitable access** to life-saving vaccines in a timely, reliable, and sustainable manner. Approximately 75% of the world's unvaccinated children reside in the 24 priority countries, with the estimated average DTP3 coverage for these countries at 72%, lower than the global average of 83% in 2012. Leveraging vaccine purchase through GAVI and strong support to strengthen delivery and surveillance systems at country level is critical to our shared vision of ending preventable child and maternal deaths. USAID's approach includes:

- **Enhancing the effectiveness of Interagency Coordinating Committees** to help ensure the effective use of financial and technica resources and continuity with other agency investments in health; working at all levels to optimize coordination of immunization activities including applications for GAVI-support; advocating for increased commitment for immunizations; and providing technical support (e.g. implementation strategies to reach the unreached).

- **Strengthening the capability of national and district immunization managers** to record, analyze, and utilize information — both routine service statistics and disease surveillance data — to inform planning that better serves all populations, especially those that are traditionally unreached.

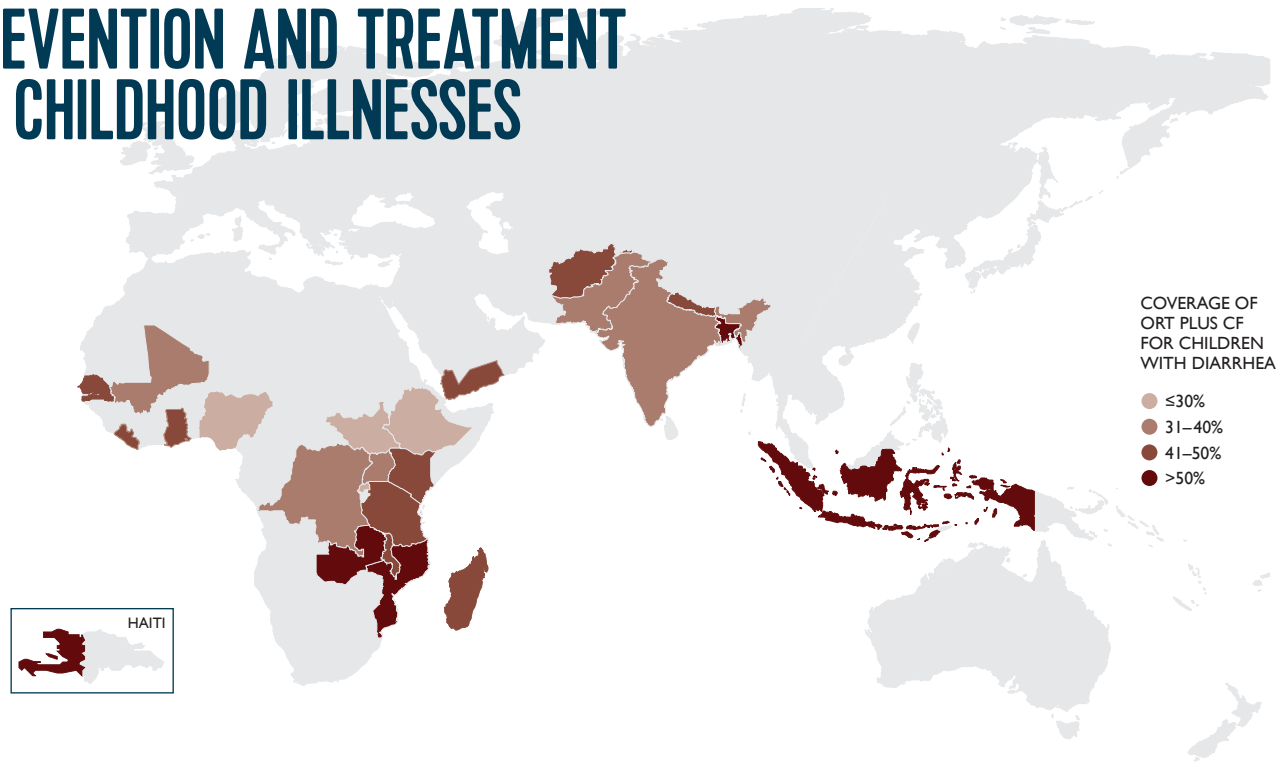
- **Reducing the equity gap** to increase health worker and health system capacity at all levels to plan, implement, manage, and monitor effective and timely routine immunization services targeted to all populations, including the underserved, so that caretakers can predictably receive reliable, quality services and be motivated to return to complete all recommended vaccinations.

- **Upgrading the quality, effectiveness, and efficiency of supp y chain management** to ensure that investments in (GAVI-supported and traditional MOH-supported) vaccines are maximized.

- **Supporting civil society partnerships** in immunization to build trust in immunization, improve the convenience of immunization services to communities, increase local support for reliable services, and promote their utilization.

- **Advocating with host governments** and other actors for the direct investment in the operational costs of delivering routine immunization services that are required for the long-term achievement of mortality reduction goals.

# PREVENTION AND TREATMENT OF CHILDHOOD ILLNESSES




Proportion of children under five years old with diarrhea receiving oral rehydration therapy (ORT) and continued feeding (CF). *DHS (most recent data available—varies by country)*

## Global Context

Despite incredible progress in child survival, infectious diseases remain the major causes of under-fi e deaths. Roughly one third of these deaths are caused by pneumonia (17%); diarrhea (nine percent); and malaria (seven percent). In the fi st month of life, an additional fi e percent is due to sepsis and meningitis.[1]

Some children are at much greater risk of death from these killers. Over 70% of under-fi e deaths are due to pneumonia, diarrhea, and malaria in the fi st two years of life. Children most at-risk for death include those with co-existing health problems, particularly prematurity, low birth weight, malnutrition, and HIV. Over 90% of these deaths occur in sub-Saharan Africa and Asia. In these two regions, deaths are increasingly concentrated within a shrinking subset of high-burden countries (e.g., India, Nigeria, the Democratic Republic of Congo, Pakistan, and Ethiopia). Progress is also uneven within countries, with striking inequities for rural, poor, and marginalized populations.

Getting appropriate care to sick children is a critical problem. Initial care likely will be sought within the home or community. Caregivers may also seek out an array of providers in both the public and private sectors, where the quality of care is quite variable. Ultimately, children do not get the treatment they need. In about 60% of the cases — where caregivers reported seeking appropriate care for suspected pneumonia — proper antibiotic treatment was given for about 31% of cases while 35% of children with diarrhea received oral rehydration therapy.[xxx]

Preventing malaria is a good example of the impact that can be achieved when efforts are focused, coordinated with global and in-country partners, and grounded in evidence. Just a decade ago, malaria ravaged wide swathes of the African continent, killing more than one million people and overburdening health systems. Over the past decade, dramatic progress has been made in reducing the burden of malaria in sub-Saharan Africa, and the disease is being rolled back. According to the World Health Organization, an estimated 3.3 million lives were saved as a result of the scale-up of malaria control interventions between 2000 and 2012. Over the same period, malaria mortality rates for children in sub-Saharan Africa were reduced by an estimated 54%. Nearly 70% of these lives saved were in the 10 countries with the highest malaria burden and among children under fi e years of age.

[1] Neonatal sepsis/meningitis is addressed in a separate technical brief on neonatal conditions.

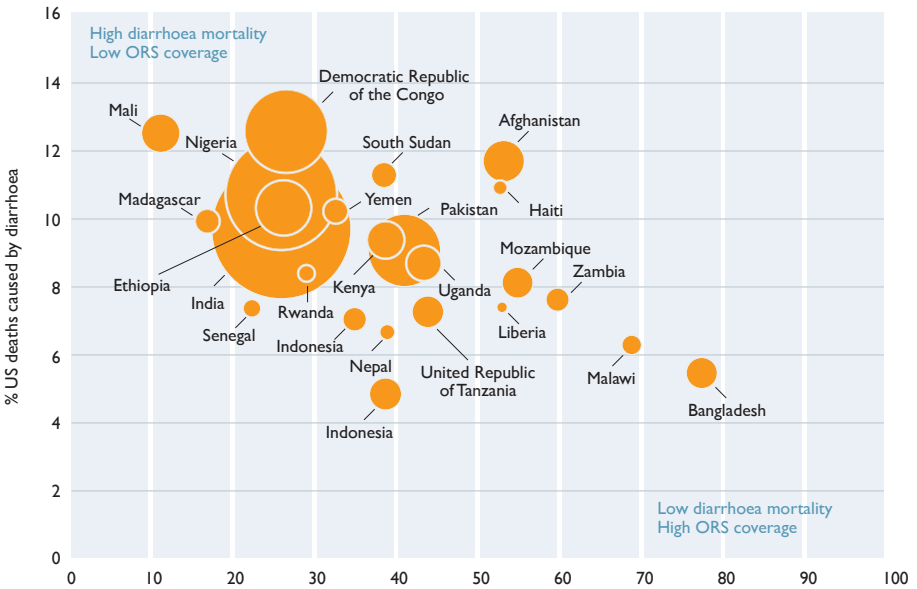
## High-Impact Interventions

There are effective preventive and treatment interventions for pneumonia, diarrhea, and malaria.[xxxi] For malaria, these activities seek to protect against exposure to the mosquito vector and to prevent infection — with mothers and children sleeping under insecticide-treated nets, residual spraying of the insides of houses with insecticides that kill adult mosquitoes, and intermittent preventive treatment of malaria in pregnancy. The President's Malaria Initiative, led by USAID and implemented together with CDC, works with national malaria programs targeting pregnant women and children under fi e — the most vulnerable groups — and delivering equitable prevention and care.

Under-fi e deaths from pneumonia and diarrhea can be averted through a number of high-impact prevention measures including but not limited to:

- Provision of vitamin and mineral supplements in pregnancy and early childhood;
- Vaccines (mainly pneumococcal, H. Influenzae type , and rotavirus);
- Breastfeeding for at least two years, including exclusively for the fi st six months;
- Household water treatment and safe storage; and
- Sanitation and hand washing with soap.

### CHILDHOOD DIARRHEA DEATHS AND ORS COVERAGE




(Source: UNICEF analysis based on UNICEF global databases 2014, IGME 2013, WHO and CHERG 2014)

- Implementation of preventive measures, along with treatment, will have a greater impact than treatment alone. The key treatment interventions include:
- Amoxicillin for pneumonia;
- Oral rehydration solution and zinc for diarrhea; and
- Artemisinin-based combination therapy, when a patient tests positive for malaria.

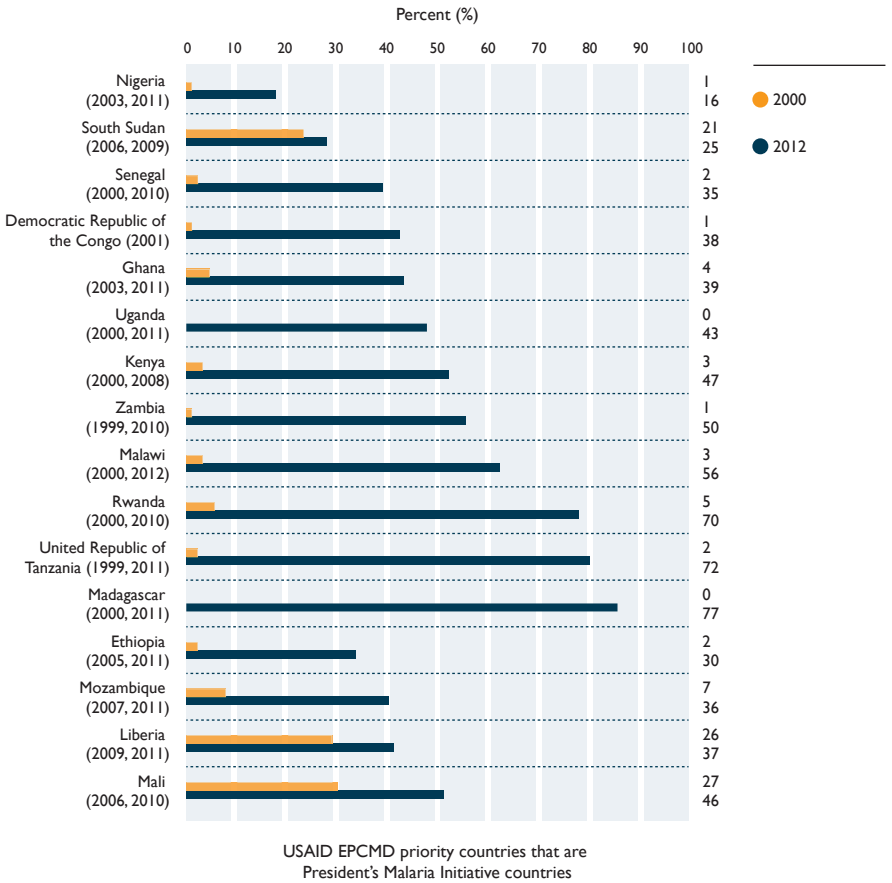
Additional high-impact treatment interventions include continued feeding for children with diarrhea plus injectable antibiotics and oxygen for severe pneumonia. Greater impact will be achieved when appropriate recognition, care seeking, and referral occurs through caregiver education and health worker use of treatment algorithms/guidelines (i.e., Integrated Management of Childhood Illnesses in facilities or integrated community case management in community settings).

## Priority Actions

The Integrated Global Action Plan for Pneumonia and Diarrhea[xxxii] highlights key actions to accelerate efforts to eliminate preventable deaths from these diseases by:

- Integrating implementation across communities, clinics, districts, institutions, and countries since prevention and control of pneumonia and diarrhea can only be adequately dealt with through integrated programs;

## PERCENT OF CHILDREN UNDER-FIVE SLEEPING UNDER INSECTICIDE-TREATED BED NETS, AROUND 2000 AND 2012




(Source: UNICEF analysis based on UNICEF global databases 2014)

- Addressing inequalities as children living in poor or remote communities are most at risk, and the burden pneumonia and diarrhea places on their families and health systems aggravates existing inequalities;
- Tailoring an integrated national package of effective and affordable interventions to national and local contexts and strengthening leadership at all levels as reducing pneumonia and diarrhea deaths requires engagement by a wide range of actors and sectors, as well as national political will; and
- Promoting inter-sectoral coordination and cooperation to include leaders and policymakers from national governments, ministries of health, sanitation and water, energy and environment and others, affected communities, international and local partners, and public, civil society, and private sector actors.

Per the recommendations of the UN Commission on Life-saving Commodities for Women and Children,[xxxiii] there is a need to improve demand forecasting, supply chain, availability in facilities and communities, and correct use of key commodities (including adherence to case management guidelines, for amoxicillin, and ORS with zinc).

Finally, there is a need to ensure that existing indicators for prevention and treatment of pneumonia, diarrhea, and malaria continue to improve, including their incorporation into routine systems for both detecting gaps in coverage of key interventions as well as ensuring accountability for results.

## USAID's Approach

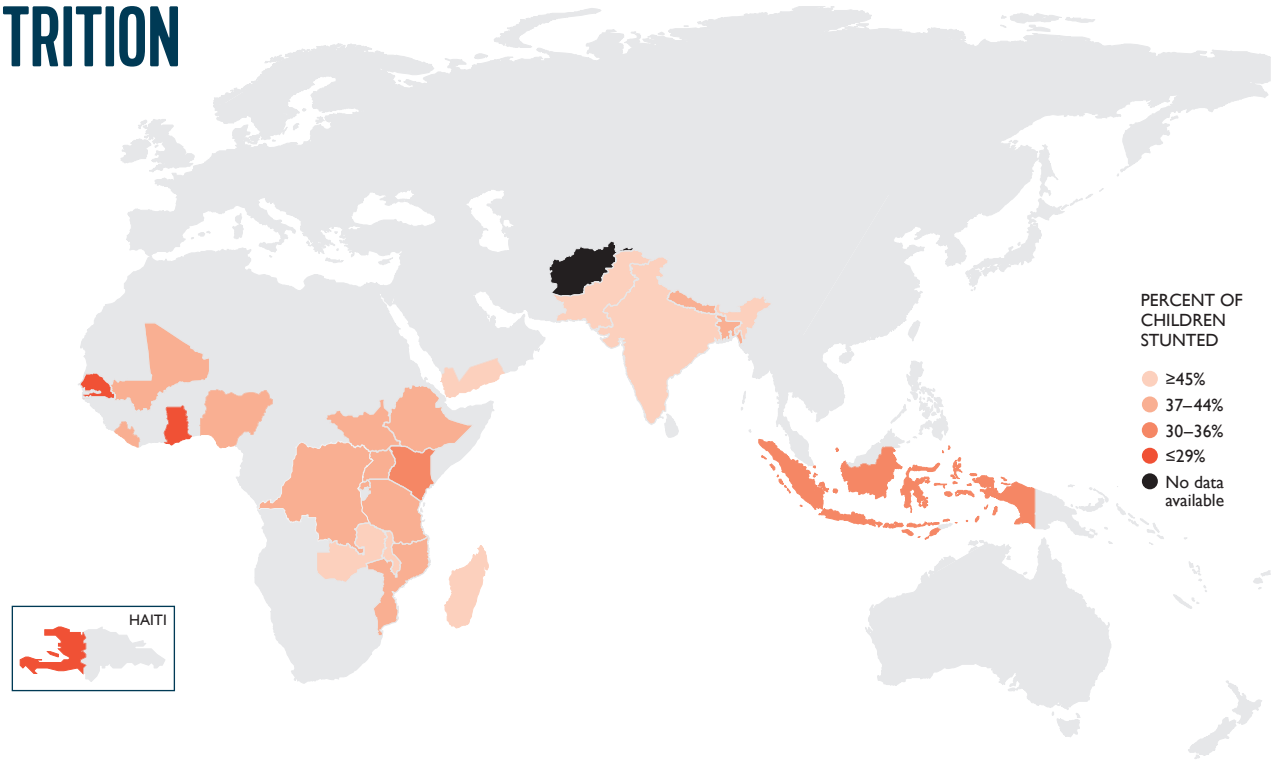
Fifteen of the 24 priority countries are also President's Malaria Initiative focus countries (DRC, Ethiopia, Ghana, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Nigeria, Rwanda, Senegal, Tanzania, Uganda, and Zambia). These are ideal priority countries for coordinated implementation around treatment of these conditions in the form of either primary care through Integrated Management of Childhood Illness or integrated community case management. Along with India and Pakistan, these 17 countries represent the greatest disease burden for

Photo: USAID 2014

pneumonia, diarrhea, and malaria combined. Further prioritization of these 17 countries occurs based upon a country's need and commitment, as well as the convergence of other external support that can address key implementation bottlenecks and optimize delivery strategies to reach all children needing treatment for pneumonia, diarrhea, and malaria. Key components of USAID's approach are:

- Working with government and other stakeholders to develop a clear country-level strategy and work plan, with key responsibilities assigned;
- Engaging and embedding critical partners in an integrated work plan and approaching from national to community levels;
- Coordinating implementation of key interventions including technical support;
- Promoting opportunities to include pneumonia and diarrhea treatment as part of malaria treatment; platforms, such as those supported by the Global Fund or under the President's Malaria Initiative;
- Promoting innovations, especially for overcoming barriers to service delivery;
- Generating demand and ensuring supply; and
- Promoting implementation research, quality improvement, and optimal modes of delivery of existing interventions in order to reach those most in need.

# NUTRITION




Percentage of children under-five moderately or severely stunted (defined as less than two standard deviations below the mean for the reference population). *WHO and UNICEF (most recent DHS, MICS, other national household surverys since 2007)*

## Global Context

Under-nutrition inhibits the body's immune system from fighting disease and impedes cognitive, social-emotional, and motor development. Under-nutrition contributed to 3.1 million (45%) of child deaths worldwide in 2011.[xxxiv] Between 1990 and 2011, stunting (low height-for-age), a measure of chronic under-nutrition, declined by 35%, while wasting, a measure of acute under-nutrition, declined by 11%. With population growth, however, the absolute number of children affected has remained unchanged. In 2011, stunting and wasting affected more than 165 million and 52 million children under-fi e, respectively.[xxxv] Ninety percent of stunted children were concentrated in 34 countries located mainly in Sub-Saharan Africa and South Asia.[xxxvi]

Acute malnutrition, caused by a decrease in food consumption and/or illness resulting in sudden weight loss or edema, threatens the survival of children both in emergency and non-emergency settings. Severe Acute Malnutrition, a condition in which children suffer severe wasting, edema, or edematous wasting affects almost 20 million children under fi e worldwide, mostly in the South Asia and Sub-Saharan Africa regions; severe acute malnutrition contributes to nearly 1 million child deaths each year. Globally, moderate acute malnutrition affects a greater number of children (approximately 36 million) than severe acute malnutrition and if not treated, can progress to severe wasting and high risk of mortality.[xxxvii]

An estimated two billion people worldwide suffer from micronutrient deficiencies particularly vitamin A, zinc, iodine, and iron deficiencies [xxxviii]

Micronutrient deficiencies combined with stunting, diminish opportunities for healthy physical and cognitive development.[xxxix] The immediate effects of micronutrient deficiencies are maternal and infant morbidity and mortality while deficiencies in iodin , iron, and zinc in early childhood can have lasting negative ramifications on childhood development and impaired school performance.[xl, xli] Nutritional anemia, caused by deficiencies in iron and other micronutrients, as well as other factors (e.g., parasites), is one of the most widespread and dangerous nutrition-related conditions. Anemia during pregnancy can cause pre-term births, low birth weights, and developmental delays in children, and increases a woman's risk of hemorrhage and death. In 2011, an estimated 19% of pregnant women and 18% of children under fi e suffered from iron deficiency anemia [xlii]

Photo: Behrouz Mehri

The determinants of malnutrition are multifaceted, ranging from individual health status; to household access to safe, nutritious, and diverse foods; to water, sanitation, and hygiene; to feeding and caring practices; to family size and birth intervals.[xliii] The most immediate causes of under-nutrition in children are insufficient ene gy and other nutrient intake combined with infectious diseases, especially diarrhea. Fundamental to these basic determinants is a complex array of underlying determinants including gender equality and women's empowerment, early marriage/child marriage, education, and environmental, sociocultural, economic, demographic, and political factors.

Malnutrition contributes significant y to maternal and child mortality, decreases resistance to infectious diseases and prolongs episodes of illness, impedes growth and cognitive development. The damage caused by under-nutrition, especially during the 1,000-day window of opportunity, may be irreversible.[xliv] Women who are undernourished before or during pregnancy are at an increased risk of mortality and their children are at greater health risk.[xlv] Under-nutrition impairs cognitive, socio-emotional, and motor development, which leads to lower levels of educational attainment, reduced productivity later in life, lower lifetime earnings, and slowed economic growth of nations.[xlvi, xlvii]

## High-Impact Interventions

Effective interventions must reach across disciplines to address the multi-factorial determinants of malnutrition. In the past, many nutrition initiatives have been vertical programs implemented through isolated delivery systems; however, there has been a recent recognition that multi-factorial causation is best addressed with multi-sectoral interventions.[xlviii] Gender equality and empowerment of women are critical to achieve nutrition objectives. Evidence has shown that when women are empowered, educated, and can earn and control income, infant mortality declines, child health, nutrition, and development improve, agricultural productivity rises, population growth slows, economies expand, and cycles of poverty are broken.[xlix] Applying a gender lens on all nutrition programs is crucial for successful interventions.

Timely ***nutrition-specifi*** interventions, at critical points in the lifecycle, can have a dramatic impact on reducing malnutrition globally if taken to scale in high-burden countries. If scaled to 90% coverage, it is estimated that 10 evidence-based, nutrition-specific interventions could reduce stunting by 20% and severe wasting by 60%: In addition, effective prevention and management of infectious diseases can also decrease the harmful effects of illness on nutritional status.[l, li]

Nutrition-specific inte ventions alone will not eliminate under-nutrition. In combination with ***nutrition-sensitive*** interventions, however, there is enormous potential to enhance the effectiveness of nutrition investments worldwide. Emerging evidence shows the opportunities for nutrition impact with nutrition-sensitive interventions, including (see below):

## USAID's Approach

*Set and Monitor Nutrition Targets:*

- Within targeted intervention areas, concentrate resources (e.g., Feed the Future, Global Health, the Office of Food for Peace) and regularly monitor impact to reduce the number of stunted children by a minimum of two million, reflecting a 20% reduction over fi e years, and set measurable targets at the end of this time period.
- Reach tens of millions of vulnerable people with nutrition information and services with additional investments (e.g., the Office of Food or Peace, the Office of .S. Foreign Disaster Assistance; maternal and child health;

## NUTRITION-SPECIFIC INTERVENTIONS

- Management of severe acute malnutrition
- Preventive zinc supplementation
- Promotion of breastfeeding
- Appropriate complementary feeding
- Management of moderate acute malnutrition
- Peri-conceptual folic acid supplementation or fortificatio
- Maternal balanced energy protein supplementation
- Maternal multiple micronutrient supplementation
- Vitamin A supplementation
- Maternal calcium supplementation

## NUTRITION-SENSITIVE INTERVENTIONS

- Family Planning: healthy timing and spacing of pregnancy
- Water, sanitation, and hygiene (WASH)
- Nutrition-sensitive agriculture
- Food safety and food processing
- Early childhood care and development
- Girls' and women's education
- Economic strengthening, livelihoods, and social protection

U.S. Government's President's Emergency Fund for AIDS Relief (PEFPAR); resilience; water, hygiene, and sanitation (WASH); and other nutrition-sensitive activities).

- In humanitarian crises, mitigate increases in acute malnutrition through improved coverage and quality of emergency nutrition services to the extent possible with the goal of maintaining severe acute malnutrition below the emergency threshold of 15%.
- In programs aiming to end preventable child and maternal deaths, track nutrition contributions to maternal and under-fi e mortality reductions whenever possible.

*Manage Nutrition Funds and Programs in a Rigorous Manner:*

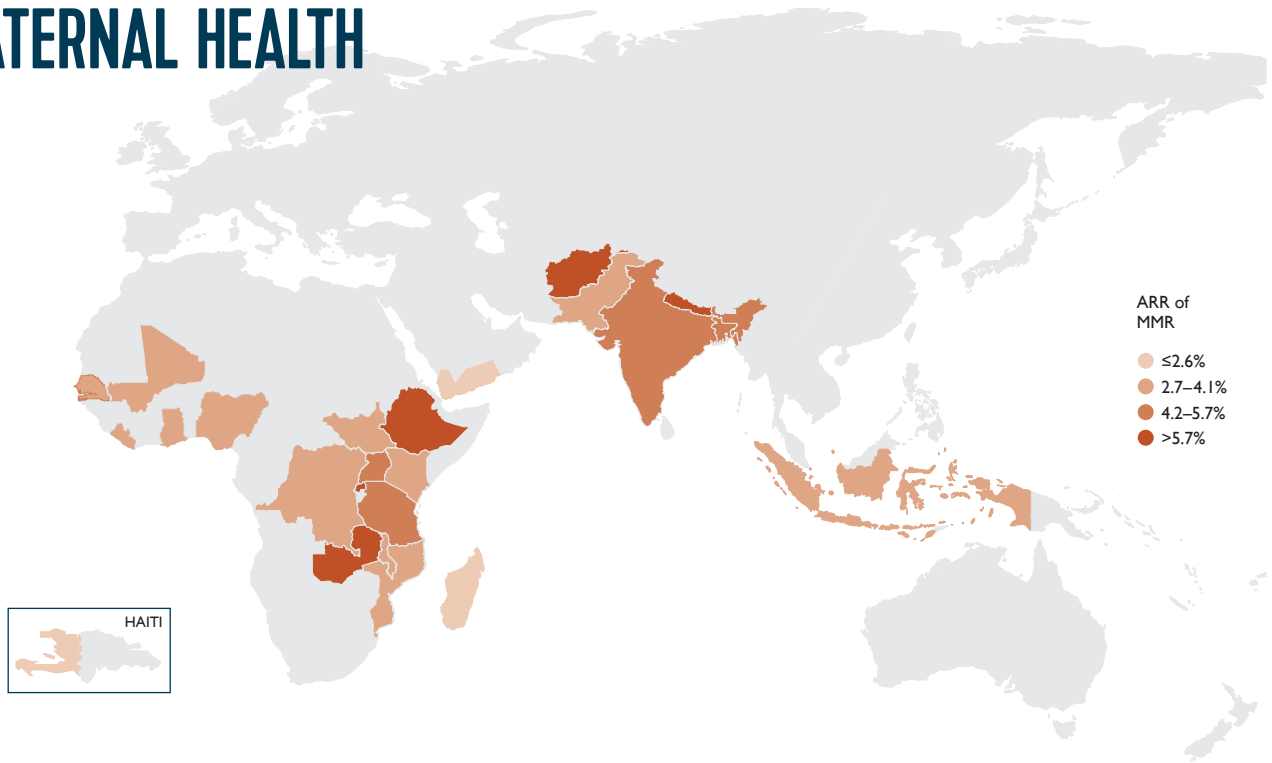
- Concentrate the available nutrition resources in targeted countries and provide adequate funding levels.
- Work within nutrition priorities articulated by countries themselves to ensure that programs (1) include clear objectives at the outcome and impact levels, (2) reflect the coordinated programming of all sources of nutrition funding (e.g. Feed the Future, Global Health Initiative, PEPFAR, and the Office of Food or Peace development funds), and (3) directly support the country's own nutrition strategy. The Office of Food or Peace and the Office of .S. Foreign Disaster Assistance emergency assistance will support country frameworks where appropriate.
- Undertake long-term nutrition programming, linked to humanitarian response, in chronically vulnerable communities to enhance their resilience in the face of climate-related events and other shocks and stresses.
- Actively coordinate USAID nutrition programs with other United States Government nutrition programming in each country.
- Include updates in existing reports (e.g., the Feed the Future and Global Health annual reports) that summarize progress in nutrition.
- Promote increased, responsible private sector engagement in targeted countries to encourage the production and consumption of nutritious and safe foods, and harness the expertise of the private sector to shape healthy consumption patterns.
- Improve the cost-effectiveness of nutrition funding by better coordinating nutrition efforts across health, agriculture, the Office of Food for Peace, and humanitarian and resilience programs
- Make agriculture, WASH, and gender programs more nutrition sensitive; expand research nutrition-sensitive agriculture where there are significant syne gies; and regularly monitor nutrition outputs, outcomes, and impact to make programs more data-driven.

*Focus on High-Impact Interventions:*

Evidence suggests that the 1,000-day period between pregnancy and a child's second birthday is the most critical time to ensure optimum physical and cognitive development. USAID nutrition programs will give special focus to this important period. In particular, USAID will:

- Support good maternal nutrition, optimal breastfeeding (immediate and exclusive for six months), and appropriate complementary feeding (e.g., dietary diversity in children 6–23 months, continued breastfeeding) tracking change over time in populations served by development nutrition programs.
- Integrate key hygiene actions (safe drinking water, handwashing with soap, safe disposal of excreta, and food hygiene) as essential components in all targeted nutrition programs.
- Scale up community management of acute malnutrition in emergency and development settings.
- Increase significant y the number of professionals and frontline workers, especially women, formally trained and employed in nutrition, to meet country needs across sectors.
- Strengthen the evidence base for and scale up proven nutrition-specific and nutrition-sensitive interventions.

# MATERNAL HEALTH




Annual Rate of Reduction (ARR) in Maternal Mortality Ratio (MMR) 2000–2013. *WHO*

## Global Context

Complications of pregnancy and childbirth account for 289,000 maternal deaths each year. While there has been progress between 1990 and 2013 worldwide with a 45% reduction in the maternal mortality ratio (MMR), Millennium Development Goal 5 remains largely elusive. Most of these deaths are preventable. Furthermore, maternal mortality remains one of the greatest inequalities of our time. Over a lifetime, a woman's risk of dying as a result of pregnancy and childbirth in sub-Saharan Africa is more than 47 times higher than in the U.S.[lii] These deaths disproportionately affect the poorest, the youngest, the marginalized, those who live in rural areas and urban slums, those with the highest fertility rates and those with the poorest access to health services within weak health systems; 99% of them occur in developing countries. This is a consequence of more children born per woman and the risk of death they face with each pregnancy. Among the 122 million women across the world who have a live birth every year, 10% result in potentially life-threatening complications and disability.[liii] The major direct causes of maternal death are hemorrhage, hypertensive disorders, sepsis, unsafe abortion, embolism, other direct causes including obstructed labor, and indirect causes including HIV-related mortality.[liv]

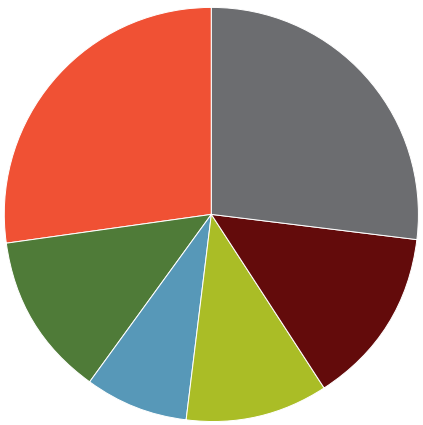
## High-Impact Interventions

The majority of maternal deaths and complications can be prevented by (1) provision of family planning and post-abortion care, (2) ensuring access to high quality antenatal, labor and delivery, and postpartum care, and (3) focused attention to significant co morbidities such as HIV, malaria, TB, and malnutrition. Supporting programs that ensure care and improve pregnancy outcomes is also vitally important for newborn survival. All interventions suggested below need to be considered with respect to the local epidemiology, the state of the prevailing health system, and where women give birth.

Care for women must be provided across the continuum from pre-conception through postpartum, and integrated with perinatal care. It needs to include family planning, infectious disease control, optimal nutrition, and attention to water, sanitation, and hygiene in a strong health system that links households and communities to health care facilities.

- **Pre-Conception:** Delaying, limiting and spacing birth; nutrition; and identification and management of infections and non-communicable diseases.
- **Care in Pregnancy:** Iron folate supplementation; tetanus toxoid immunization; malaria intermittent treatment; bednets; counseling and testing for HIV, TB, and syphilis; education for birth preparedness; promotion of facility delivery; dietary diversity and micronutrients; and hygienic practices.

## GLOBAL CAUSES OF MATERNAL DEATH AND SELECT KEY INTERVENTIONS




Source: Say et al, 2014

- **Care During Labor and Birth:** Skilled attendance at birth; respectful care; companion at birth; monitoring of labor; infection prevention; and prophylactic uterotonics.
- **Postpartum Care:** Assessment and treatment of complications and morbidities, and initiation of family planning.
- **Treatment of complications (whenever they occur):** Post-abortion care; uterotonics; magnesium sulphate; anti-hypertensives; antibiotics; labor induction; assisted vaginal delivery; Caesarean section; blood transfusion; and treatment for HIV, malaria, TB, syphilis, and other conditions.

## Priority Actions for Maternal Survival and Health

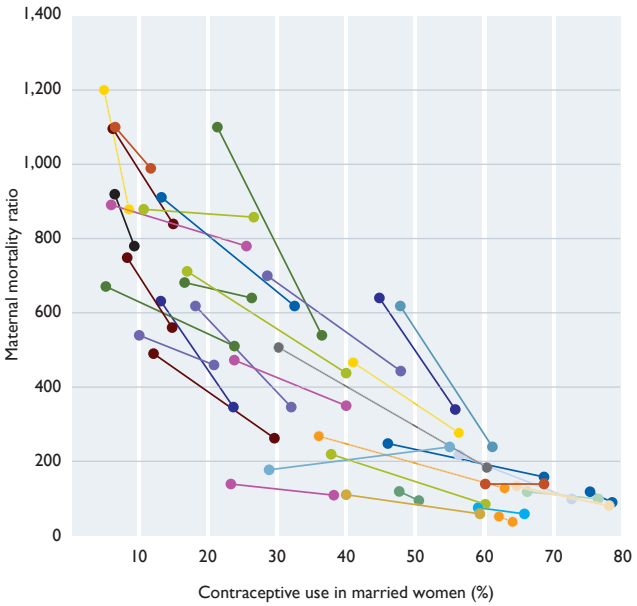
*Individual, community, and societal enablers for improved maternal and fetal health*

1. **Improve individual, household, and community behaviors and norms for self-care and use of life-saving services.** Community mobilization is critical to building the capacity of men, women, and communities to actively engage with one another and for health providers and managers to hold health systems accountable. Women need knowledge, motivation, and support to choose when to become pregnant, to enter pregnancy as healthy as possible with good nutritional status, and to maintain healthy behaviors by accessing life-saving services.
2. **Improve equity of, access to, and use of services for the most vulnerable.** Age, marital status, social, cultural, geographic, economic, legal, and political barriers all can put pregnant women and their newborns at peril. Women and girls must have access to affordable, quality, respectful maternity care, while men, boys and other decision-makers must be engaged as advocates and change agents.

*Quality, respectful care to improve maternal and fetal health*

3. **Strengthen family planning services as prevention.** Family planning is an integral part of maternal health, acting through diminished annual numbers of births, reduction of high-risk pregnancies, and by meeting the modern contraceptive needs of millions of women who do not intend to become pregnant.
4. **Scale up quality maternal and fetal health care in antenatal, intrapartum, and postpartum periods.** Quality maternity care is best provided in facilities by skilled health providers working in teams to ensure that all women can be attended throughout the antepartum, intrapartum, and postpartum periods with quality care and back-up support through referral mechanisms. The content of skilled care should include key evidence-based, high-impact interventions that are proven to reduce morbidity and mortality and improve the health of both the mother and the baby.

## RELATION OF MATERNAL MORTALITY RATIOS TO CONTRACEPTION PREVALENCE OVER TIME




40 Countries. Median slope -8.5.

Each line represents a country.

(Source: Cleland, J et.al. *The Lancet*, 2012)

5. **Prevent, diagnose, and treat infectious disease and poor nutrition in pregnant women.** The main causes of maternal death vary across countries and regions. Indirect causes, including HIV and AIDS, TB, malaria, sexually-transmitted infections, urinary tract infections, opportunistic infections, and maternal malnutrition contribute to a large and growing proportion of maternal and fetal deaths and morbidities where these conditions are prevalent. Integration of maternal health services with newborn and child health, family planning, infectious disease prevention, water, sanitation and hygiene, and nutrition is a priority.

6. **Increase focus on averting and addressing maternal morbidity and disability.** A significant propo tion of women who give birth each year suffer complications of varying severity. For women who survive these complications, there can be long-term morbidities and disabilities resulting from the complication or its management, which go beyond biomedical conditions to include violence and economic consequences. Screening and treatment for complications and disabilities are essential.

7. **Advance respectful maternity care and improve working conditions for providers.** Growing evidence is providing a deeper awareness of disrespect and abuse of women giving birth, a time of intense vulnerability for women. Such disrespect and abuse, which may occur prior to, during, and following pregnancy, is both a violation of women's rights and a manifestation of poor quality of care. Many skilled birth attendants, especially female providers, work in extremely difficult stressful, isolated, and unsafe environments where they are often poorly paid, demoralized, and themselves disrespected. Focused attention to improve provider attitudes and workplace conditions is necessary for the rights of health workers and should include enabling and empowering them through sufficient resources respectful and safe working conditions, and an understanding of and commitment to respectful quality care.

*Strengthened health systems and continuous learning*

8. **Strengthen and support health systems for improved maternal and fetal health with particular focus on human resources, commodities, the referral system, and improvement of water, sanitation, and hygiene.** Improving maternal health is a health systems effort. Maternal health programs must actively engage health system governance to address factors directly affecting maternal outcomes, including financing devolution, urbanization and privatization, while strengthening all of the key health system building blocks.

Photo: USAID 2014

9. **Promote data for decision-making and accountability.** To track progress toward global, national, and local goals and targets, as well as to manage programs effectively, there is a need to strengthen availability, quality and use of data on maternal and fetal mortality and health care processes in order to inform decision-making, promote accountability and allow for targeted action.

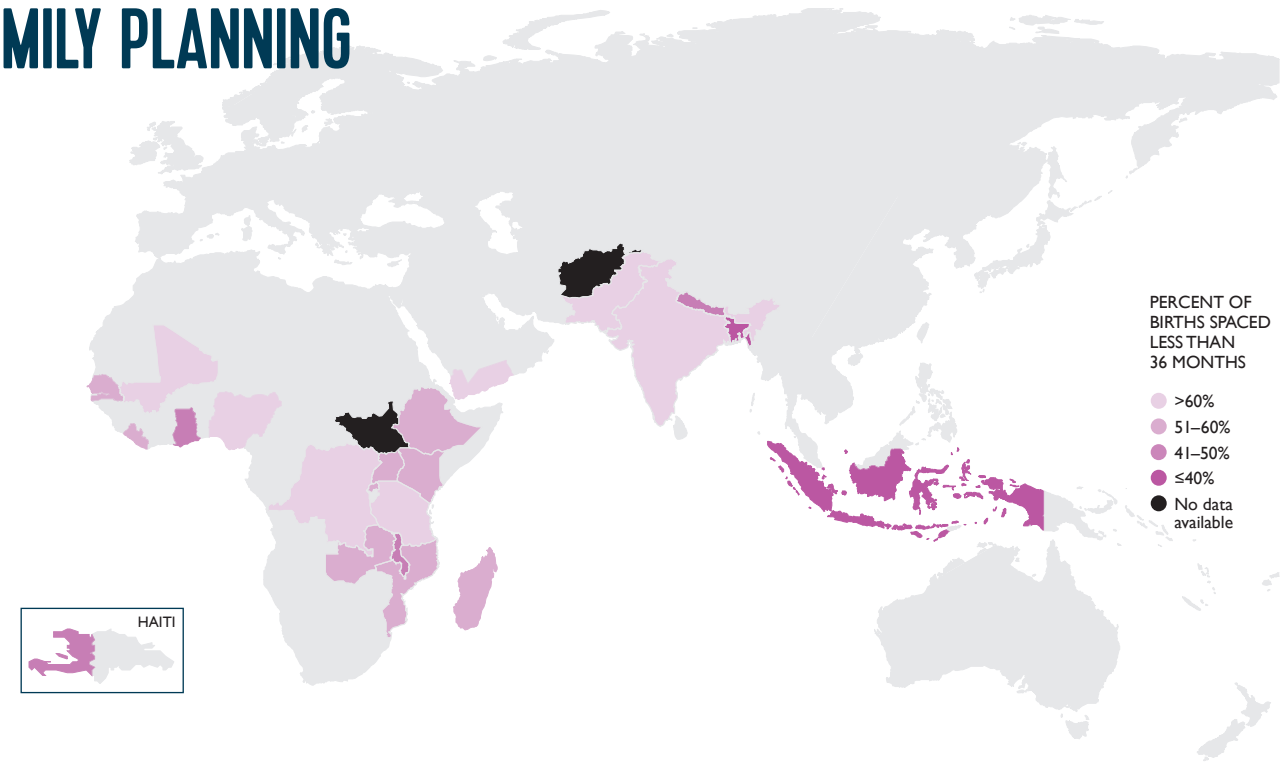
10. **Promote translation of innovation and research into programming.** New implementation approaches, as well as new technologies, will be transformative in galvanizing and accelerating action to achieve improved health care outcomes and strengthen health systems.

## USAID Approach in Priority Countries

In April 2014, representatives from 30 countries agreed on a 2030 target MMR of a global average of 70/100,000 live births, with no country level greater than 140. This target moves toward a proposed maximum of 50 deaths per 100,000 live births in every country by 2035, which is equivalent to the high end of the Organization for Economic Cooperation and Development countries in 2010, thus reducing all preventable maternal deaths worldwide. By achieving the global target of 50 by 2035, a woman's chance of surviving pregnancy will not be dependent on the country in which she lives. To that end, USAID will advance the following approaches:

- Focus on women, girls, and gender equity with specific attention to the mother and baby throughout the maternity period;
- Promote and advocate for women's informed choice in use of family planning, maternity care, and other health services;
- Strengthen the continuum of care from household to hospital to improve outcomes;
- Promote policies and programs based on the best available evidence and local ownership; and
- Build capacity for scale and sustainability.

# FAMILY PLANNING




Percentage of births that are spaced less than 36 months apart (birth to birth). *DHS (most recent data available—varies by country)*

## Global Context

Voluntary family planning[1] helps women avoid unintended pregnancy, and time and space their pregnancies to ensure the healthiest outcomes. Family planning improves women's, infants', and children's health in two ways:

- **Demographic Impact:** Family planning contributes directly to improved health by reducing the number of unintended pregnancies and births, thus lowering the number of women, infants, and children exposed to pregnancy-related health risks.[lv] A recent analysis was undertaken of the 74 countries that account for 95% of maternal and child deaths. The study found that, between 2013–35, scaling-up family planning and preventing unintended pregnancies would avert 78 million (53%) of the 147 million child deaths that could be prevented with accelerated investments.[lvi] With respect to maternal survival, analysis of data from 172 countries found that, in one year, family planning prevented an estimated 272,000 maternal deaths, a 40% reduction.[lvii]

- **High-Risk Pregnancy Impact:** Family planning also contributes to health impact by reducing the proportion of pregnancies that are high-risk: those that occur too early or late in age, too close together, or are considered too many. Family planning helps women bear children at the healthiest times of their lives — when women and their children are then more likely to survive and stay healthy. The healthiest times for a pregnancy are between the ages of 18 and 34 and at least 24 months after a birth (ensuring about three years between births [lviii]), while avoiding more than four births.

Recent analyses have concluded that:

- Preventing unintended pregnancies and improving birth-to-pregnancy spacing will have the greatest impact on under-fi e mortality, including newborn mortality, and stunting; and

- Preventing unintended pregnancies, especially to older women and women with more than four children, will have the greatest impact on maternal mortality.[lix]

[1] For the purposes of this technical brief, we define "family planning" as the services, policies, information, attitudes, practices, and commodities, including contraceptives, that give women, men, couples, and adolescents the ability to avoid unintended pregnancy and choose whether and/or when to have a child. When we use the term "family planning," it refers to all of these elements.

USAID, working with the United Nations Population Fund and other partners, has proposed a post-2015 measure to track progress in increasing access to family planning: the percentage of the demand for family planning satisfied with mode n contraceptive methods. This measures the proportion of sexually active women of reproductive age who wish to avoid pregnancy and are using modern contraceptive methods. The benchmark is that at least 75% of demand for family planning is satisfied with modern contraceptives in all countries by 2030.

*Family Planning and Health Outcomes*

## PREGNANCY SPACING AND NEWBORN MORTALITY/ADVERSE PERINATAL OUTCOMES.

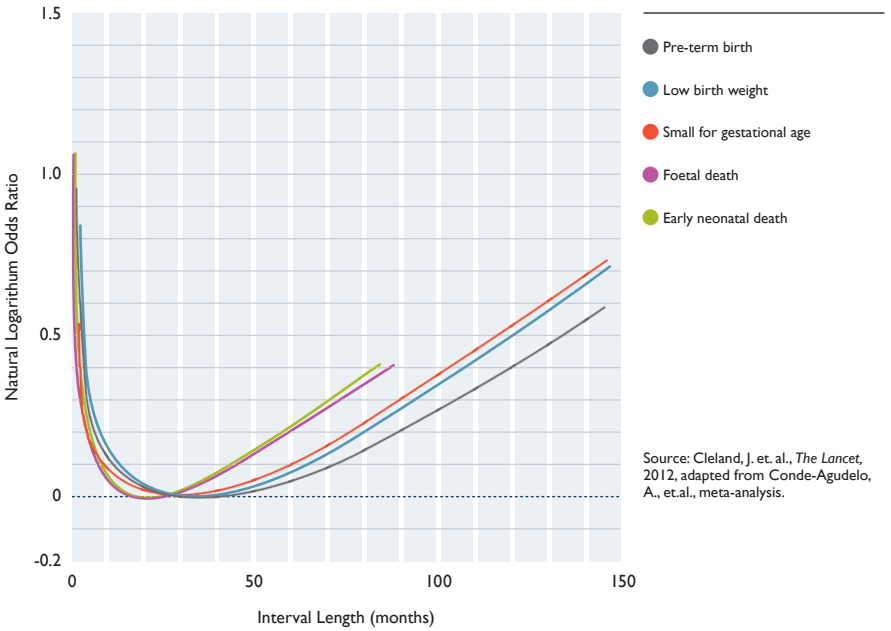


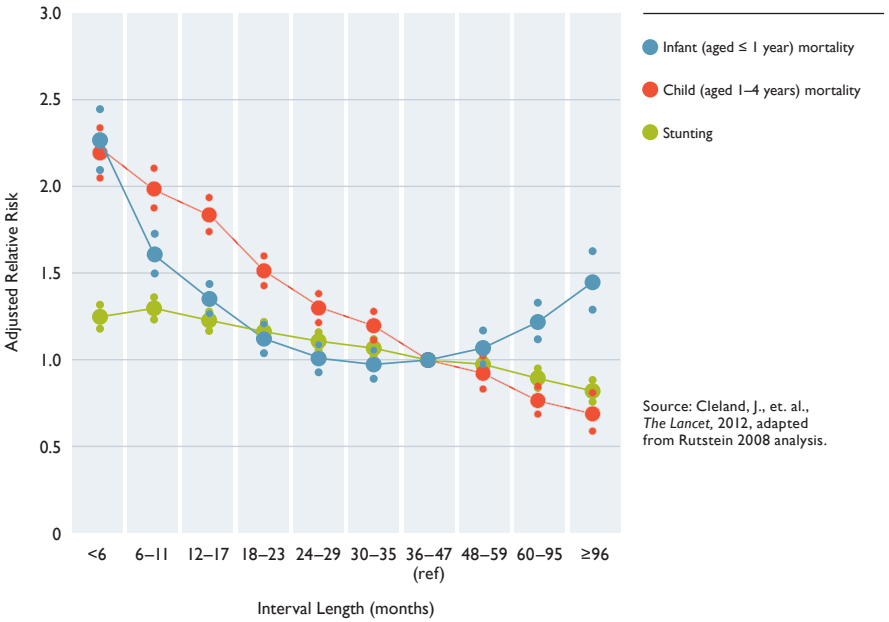

*Figure 1: Odds Ratio of Adverse Perinatal Outcomes According to Inter-Pregnancy*

In proposing this benchmark, USAID is committed to ensuring that family planning and reproductive health information, products, and services are provided in a context of voluntarism, informed choice, respect for reproductive rights, and equity in access. We are partnering with countries to expand availability, accessibility, affordability, and acceptability of high quality, voluntary family planning information, services, and methods; and to enhance women's and couples' ability to choose whether, when, and how often to become pregnant.

Family planning helps women prevent rapid, repeat pregnancy. When the interval between a birth and the next pregnancy is too short, the woman and her infant are at risk. Intervals of less than 20 months are linked to preterm birth, low birth weight, and small size for gestational age. Intervals of less than six months are linked to fetal and early neonatal death. In developing countries, the risk of prematurity and low birth weight doubles when conception occurs within six months of a previous birth.[lx] See Figure 1.

Newborn deaths account for approximately 40–60% of under-fi e deaths. Complications of prematurity are an important cause of newborn death, and the second-leading cause of all under-fi e deaths. Increasing access to family planning — to help women lengthen birth-to-pregnancy intervals — will contribute to reducing newborn deaths and a range of adverse perinatal outcomes, including preterm birth.

## PREGNANCY SPACING AND IMPACT ON INFANT AND CHILD MORTALITY AND STUNTING




Source: Cleland, J., et. al., *The Lancet*, 2012, adapted from Rutstein 2008 analysis.

*Figure 2: Adjusted[1] Relative Risk of Infant and Child Mortality, and Stunting, According to Interval between Birth and Conception in Months.*

Rapid, repeat pregnancy is also linked to infant and child mortality and stunting. Three recent studies documented the survival benefits or infants and children when birth intervals are at least three years apart.

- In an analysis of more than one million births from 52 Demographic and Health Surveys, researchers found that — for infants (children younger than one year) and children (ages 1–4) — birth-to-pregnancy intervals of less than 36 months are associated with significant y increased risk of mortality and stunting.[lxi] See Figure 2.
- A prospective study of 13,500 children in an urban Kenyan slum found that, in both infancy and early childhood, children born within 18 months of an elder sibling are twice as likely to die as those born after a birth-to-birth interval of 36 months, or more.[lxii]
- A prospective study of 125,000 births in Bangladesh found that newborns and children aged 1–4 were less likely to die after three year birth-to-birth intervals, compared to children born after shorter intervals.[lxiii]

Studies show that most women want longer birth-to-pregnancy intervals and that unmet need for postpartum family planning postpartum is high.[lxiv]

[1] These analyses adjusted for the following variables: Sex of child; Birth order; Mother's age at birth; Pregnancy duration; Whether multiple birth; Survival of the preceding child by conception of index child (if not fi st born); Sex of the preceding child; Number of prenatal visits; Type of provider of prenatal care; Timing of prenatal care, if any; Number of prenatal tetanus vaccinations; Type of person attending the delivery; Urban/rural residence; Mother's education; Index of household wealth; Source of drinking water; Refrigerator; Toilet facility; Wantedness of the child (wanted at conception, wanted later, did not want more children); Whether birth resulted from contraceptive failure; Imputation of dates forming birth interval.

**Family Planning and Maternal Mortality**
Family planning can help women avoid unintended pregnancies and plan their desired pregnancies to occur at the healthiest times of their lives — avoiding low or advanced maternal age and high parity pregnancies (i.e., many children per woman). Both are linked to increased risk of maternal death. Figure 3 shows that risk of maternal death increases significant y with more than four children.

## USAID's Approach

*Family Planning's Impact on Under-Five and Maternal Mortality in the 24 Priority Countries*

Impact as a result of increased use of family planning in the 24 priority countries between 2012–2020:

- **Demographic Impact:**[lix] Preventing unintended pregnancies would result in an estimated fi e million under-fi e and over 300,000 maternal deaths averted. This demographic impact (which reduces the number of deaths but not the mortality rate) is modeled in the country pages.
- **High-Risk Pregnancy Impact:**[1] If all births were spaced at least 36 months apart, under-fi e mortality would fall 28 percent and an estimated 1.3 million under-fi e deaths would be averted. If all women avoided pregnancy at high and low ages, as well as when they already have several children, an estimated additional 600,000 under-fi e and 150,000 maternal deaths could be averted.[lxv] The proportion of high-risk pregnancies (due to unhealthy spacing, timing, and many children per woman) would decrease, resulting in a lowering of the under-fi e mortality rate.[lxvi]

During 2012–2020, achieving both the demographic and high-risk pregnancy impacts would avert a combined estimated seven million under-fi e and 450,000 maternal deaths — a more ambitious assumption than utilized by the "best performer" methodology in this report.

### MATERNAL MORTALITY RATIOS BY BIRTH ORDER: SELECTED STUDIES WITH AVAILABLE BIRTH ORDER DATA

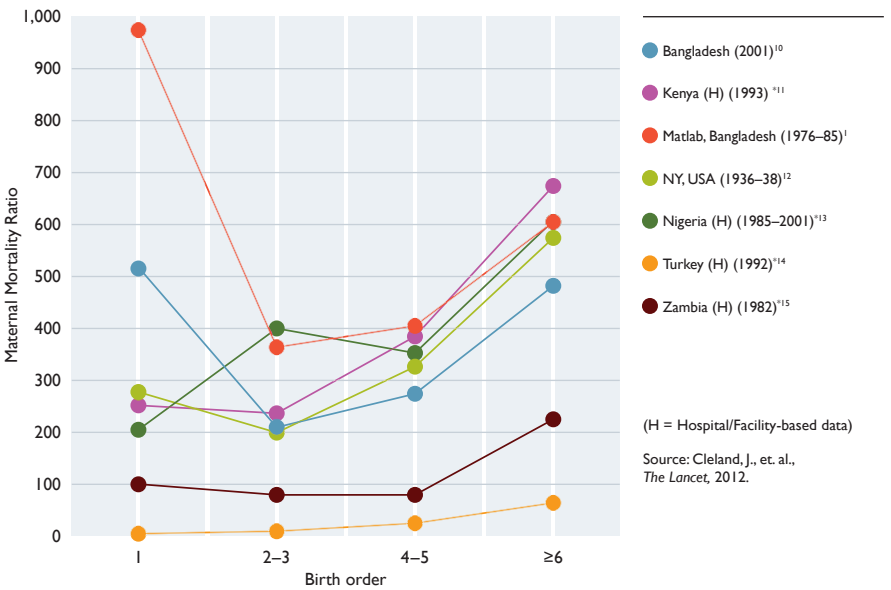



*Figure 3: Select Studies of the Relationship between Parity and the Maternal Mortality Ratio — Hospital or Facility-Based Data*

[1] This analysis was undertaken using DHS data from the following 22 USAID priority countries: Democratic Republic of Congo, Ethiopia, Ghana, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Nigeria, Rwanda, Senegal, Tanzania, Uganda, Zambia, Bangladesh, India, Nepal, Pakistan, Philippines, Indonesia, and Haiti. The following countries are also USAID priority countries but data were unavailable to undertake the needed analyses: Afghanistan, South Sudan, and Yemen.

**Family Planning and Reproductive Health Conditions in 24 Priority Countries**

In the years ahead, the numbers of children living in the world's poorest regions will continue to grow rapidly. "By mid-century, one in every three births will be African."[lxvii] These trends highlight the difficulties that will be encountered in expanding services to reach vulnerable populations. Current family planning and reproductive health conditions in the 24 priority countries call attention to the challenges ahead:

- Many Children per Woman: In fi e countries, the average number of children per woman is six or more; in six countries, women on average have between fi e and six children. In rural areas, the average is even higher.
- Short Birth Spacing: In the 22 countries with data, approximately 56% of births are spaced less than 36 months apart.
- Low Access to and Use of Modern Contraceptive Methods: Among married women of reproductive age, use of modern contraceptive methods ranges between less than seven percent in two countries; 7–14.9% in four countries; and between 15–30% in fi e countries. Use of modern contraception is almost always lower among adolescents, low income groups, and rural women.
- Adolescent Pregnancy Risks: Between 35–38% of adolescent females aged 15–19 are already parents or pregnant in three countries. In eight countries, between 20 and 35% of adolescents aged 15–19 are already parents or pregnant.
- Family Planning and Reproductive Health Indicators in Low Income Groups: In eight countries, the poorest women have, on average, seven children; in two countries they have eight. In seven countries, use of modern contraceptive methods by the poorest women ranges between one and four percent.

## High-Impact Interventions

Family planning is one of the most effective interventions in the history of public health. The objective is to provide everyone with the greatest possible choice of methods through the widest variety of accessible and quality platforms. In most countries, long-acting, reversible contraception and permanent methods have not been made widely available and are underutilized. Enhancing individual motivation by informing families and communities about the benefits of healt y timing and spacing of pregnancy is a priority. In the context of ending preventable child and maternal deaths, finding syne gies and common service platforms with MNCH interventions is also essential.

USAID has launched a comprehensive process to identify evidence-based, high-impact and promising practices in family planning and reproductive health in order to accelerate the transfer of knowledge about and scale-up of these practices to field missions in the 24 priority countries.[lxviii]

This effort will contribute to achieving child and maternal survival goals through increased strategic investments for all women and men, and girls and boys, in the poorest and most disadvantaged countries. Special attention will be given to select population groups who may experience high-risk pregnancies, such as adolescents, fi st time mothers, women with multiple children, women with closely spaced births or advanced maternal age, postpartum women, post-abortion clients, HIV-positive women, and low income individuals and couples.

Family planning investments must be supported by well-designed programs and activities leading to supportive policies, monitoring and evaluation, research, functional supply chains, relevant skills training, quality human resources, efficient management strong leadership, and quality services.

Priority USAID investments in high-impact and promising practices include the following:

*To reach all women and men, girls and boys:*

**Mobile Outreach:** Mobile teams of trained providers, including providers of long-acting, reversible contraception, as well as fertility awareness methods, provide family planning services in areas with limited or no access to services.

**Social Marketing:** A program that offers family planning products, information, and services at prices affordable to consumers and in ways that benefit clients and society in general. Social marketing programs are often effective in reaching adolescents.

**Social Franchising:** An approach to family planning service delivery that uses the organizing principles of a commercial franchise to achieve goals in family planning and reproductive health.

Photo: USAID 2014

**Community-Based Family Planning:** These activities bring family planning information and services to women and men in the communities where they live, rather than requiring them to travel to health facilities.

*To reach select population groups:*

**Postpartum Family Planning Programs:** Effective postpartum family planning services can be offered prior to discharge, after institutionalized delivery, or at routine immunization services, to meet the needs of women who want to prevent unintended pregnancy, space their next pregnancy, or end childbearing.

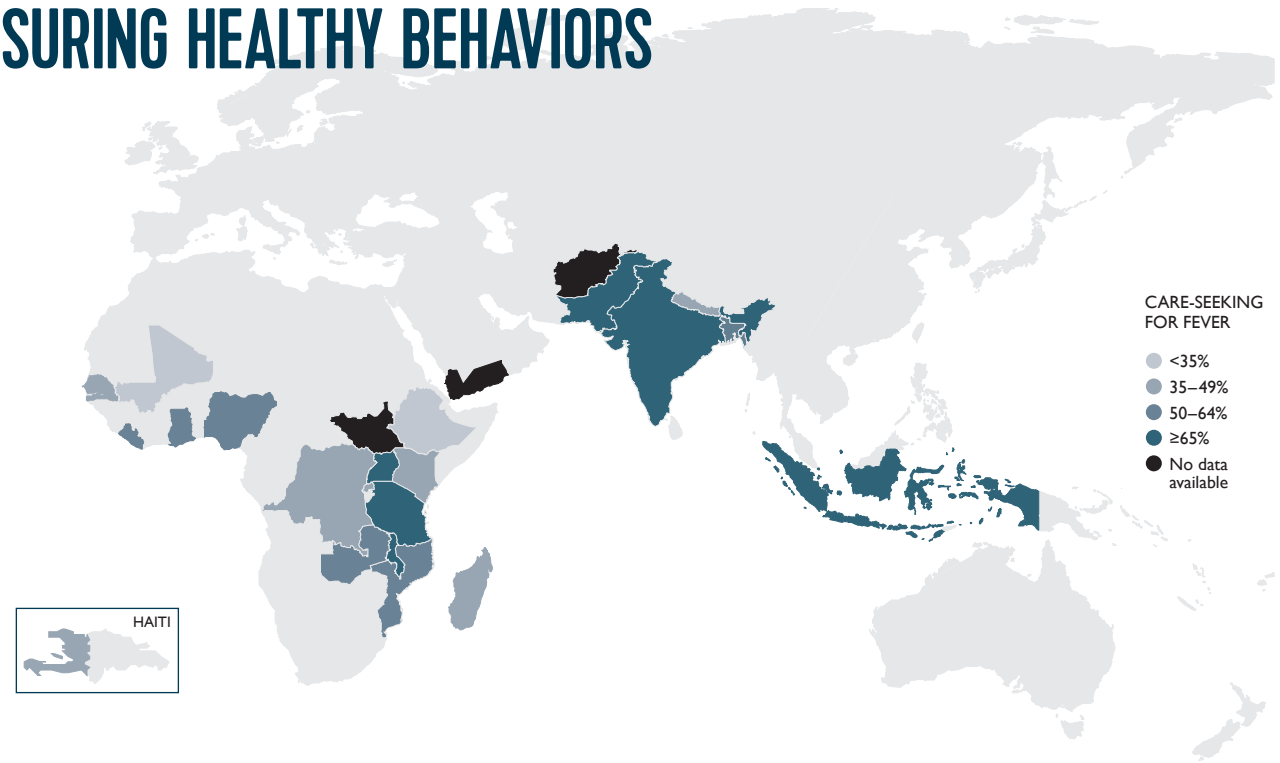
**Post-abortion Care:** Post-abortion care refers to the emergency treatment of complications of induced abortion or miscarriage, provision of family planning counseling and services, and referral to other health services. The inclusion of family planning in post-abortion services is critical to preventing a subsequent unintended pregnancy. Abortion-related complications are a leading cause of maternal death in many countries.

**Adolescent Reproductive Health Programs:** Effective adolescent reproductive health programs are holistic and cross-sectoral. They address the major transitions in adolescents' lives and strengthen protective factors that mitigate the risk of early and repeat pregnancy.

**Behavior Change Communication:** Effective socio-behavior change and communication activities raise awareness (and reduce misinformation) about family planning, motivate individuals to seek out family planning, and reduce barriers to access and use of family planning.

In June 2013, USAID and partners convened a Population-Level Behavior Change Evidence Summit for Child Health and Development, which identified "accelerator behaviors" in child and maternal health. Accelerator behaviors are a priority for programming because they have the highest potential to hasten the decline of child and maternal deaths. Spacing births at least three years apart has been identifie as a key accelerator behavior for priority programming.[lxix]

# ENSURING HEALTHY BEHAVIORS




Percentage of children under five years old with fever that sought advice or treatment.
*DHS (most recent data available—varies by country)*

## Global Context

Adoption of many of the necessary the necessary behaviors for healthy children lag despite the evidence suggesting that adherence to these behaviors around proven interventions saves lives. Worldwide, for example, only 39% of infants less than six months old are exclusively breastfed; only 31% of children with suspected pneumonia receive inexpensive antibiotics; and only 35% of children with diarrhea receive oral rehydration therapy.[lxx] In the 24 priority countries, these figure follow a lower but similar pattern. There is growing interest among international development agencies and donors — USAID included — in strengthening the social and behavior change dimension of their work as a way of achieving sustainable reductions in mortality and improvements in health.

## High-Impact Interventions

Social and behavior change contributes to improved child and maternal health outcomes. There are evidence-based interventions that result in the adoption of essential child survival behaviors, and the strength of evidence for some of these interventions compares favorably to evidence in clinical research fields This evidence includes interventions to improve access, coverage, quality, and demand creation and ranges from communication around correct and sustained handwashing to text messages for patient adherence and provider compliance.[lxxi]

Improving child survival requires the promotion of healthy behaviors, as well as efforts to address social exclusion, discrimination, and a range of social and behavioral determinants that cut across the life cycle. They include structural barriers, financial ba riers, individual and collective motivations, social and community norms, policy environments, and cultural systems that can enable or impede individuals and communities to adopt, change, or maintain a health behavior.

Adherence to medications, best practices for family planning and prenatal care, following recommendations for immunizations, and using bed nets are some areas where knowing better how to change the health behaviors of individuals, families, communities, and health systems would reap enormous rewards and impact the number of preventable deaths.

### *Priority Actions for Social And Behavior Change for Maternal and Child Health*

USAID has long been a leader in social and behavior change and will build on this experience to accelerate in-country, sustainable population-level behavior change at the individual, family,

community, and institutional level to scale up demand for, and use of, key reproductive, maternal, newborn, and child health interventions and practices.

USAID has identified 10 ey "accelerator" behaviors. The 10 behaviors are selected among other behaviors that contribute to ending preventable deaths because they have low uptake (e.g., low ORS use), yet impact a major cause of child and/or maternal mortality across the continuum of care/lifecycle (e.g., iron tablet consumption during pregnancy, postnatal care-seeking). A related behavior contributes to improving the enabling environment to effectively carry out the accelerator behavior.

*Examples of Two Accelerator Behaviors*

Handwashing

Handwashing with soap and water is the most cost effective health intervention to reduce the incidence of both diarrhea and pneumonia in children under fi e.[lxxii] Handwashing with soap by caretakers reduces the risk of diarrhea among children under fi e by up to 44%[lxxiii] and the risk of acute respiratory infections among children under fi e by 50%.[lxxiv]

Knowledge is necessary but insufficient to influence consistent and co rect handwashing. Even as knowledge rises to an almost universal level, practice rarely follows if other factors are not

## ACCELERATOR BEHAVIORS

- **Diarrhea:** Caregivers provide appropriate treatment for children at onset of symptoms.
- **Water Sanitation and Hygiene (Handwashing):** Handwashing with soap at critical times (after defecation, after changing diapers, and before food preparation and eating).
- **Healthy Timing and Spacing of Pregnancies:** After a live birth, spacing next pregnancy at least 24 months to ensure approximately three years between births
- **Nutrition:** Early initiation (within one hour) and exclusive breastfeeding for six months after delivery
- **Immunizations:** Caregivers seek full course of timely vaccinations for infants.
- **Malaria:** Caregivers recognize symptoms of malaria and seek prompt diagnosis and appropriate care.
- **Pneumonia:** Caregivers seek prompt and appropriate care for signs and symptoms of acute respiratory infection.
- **Prevention of Mother-to-Child Transmission:** Active use and demand at household level for identification/t eatment of all HIV-infected pregnant women.
- **Maternal:** Women of reproductive age including adolescents take the recommended amount of iron.
- **Newborn:** Seek appropriate care for newborn illness to reduce preventable newborn/child deaths.

addressed in interventions. Traditionally, interventions rely heavily on providing information on the disease prevention benefits of handwashing However, such knowledge has not been shown to be a relevant motivator of handwashing behavior.[lxxv] Moreover, numerous studies have documented the disconnect between knowledge and handwashing practice, as indicated by high levels of knowledge or self-reported behavior but low levels of observed handwashing[lxxvi, lxxvii, lxxviii, lxxix, lxxx]

**Handwashing stations can:** (1) facilitate correct handwashing by allowing for fl wing water in the absence of a spigot; (2) address the barrier of water availability by providing handwashing stations that use about one-quarter to one-half of the water used under other conditions; and importantly, (3) serve as a reminder or "cue to action" when householders leave the latrine or start to cook or feed and see the handwashing station.[lxxxi, lxxxii]

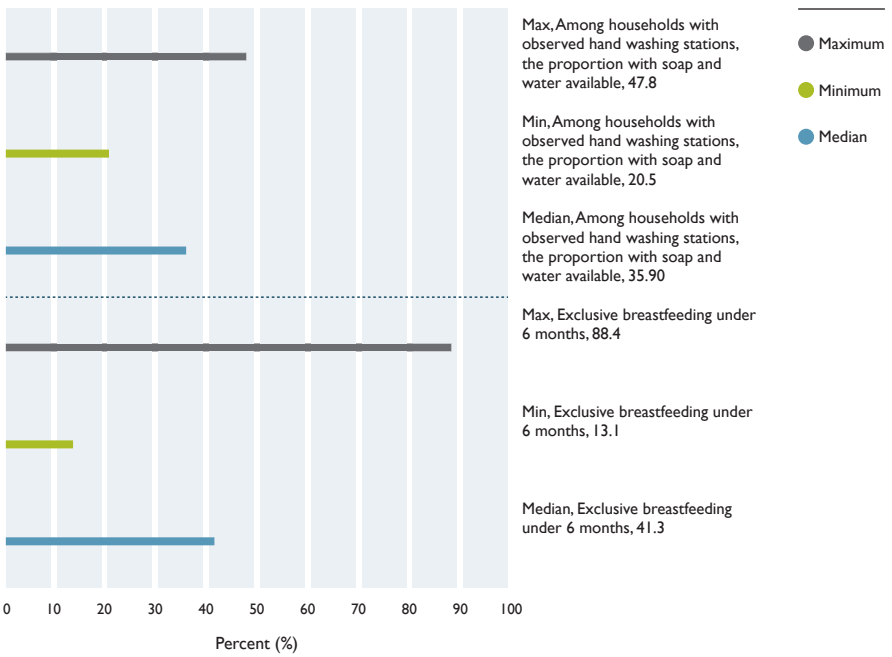
**Accelerator Behavior:** ***Handwashing with soap at critical times*** (i.e., after defecation, after changing diapers and before food preparation and eating).

**Related Behavior:** Setting up or purchasing a handwashing station (e.g., tippy tap) with soap and water in a fi ed place.

**Proven Interventions:** Design and implement a behavior change strategy to create demand for handwashing in conjunction with marketing of do-it-yourself or commercial hand washing stations.

**Indicator:** Percentage of households with soap and water at a HW facility commonly used by family members.

## ACCELERATOR BEHAVIOR AND RELATED BEHAVIORS




*Exclusive Breastfeeding*

Suboptimum breastfeeding accounts for more than 800,000 child deaths globally each year.[lxxxiii] Existing data on feeding practices provide compelling evidence that interventions for improving exclusive breastfeeding and complementary feeding must be strengthened and expanded. Children in developing countries are poorly fed: only 36% of infants younger than six months were exclusively breastfed, and less than one-third of six to 23-month-old children met the minimum criteria for dietary diversity. Coverage data are lacking on key nutrition interventions.[lxxxiv] It is important to note that only 34% of infants younger than six months were exclusively breastfed in the 29 African countries, and this rate declined to 17% among infants aged four to fi e months.[lxxxv]

**Accelerator Behavior:** Early initiation (within one hour) after delivery and exclusive breastfeeding for six months after birth.

**Related Behaviors:** (1) Mother's competence on continued breastfeeding and complementary foods (i.e., children age 6–23 months are fed adequate dietary diversity and meal frequency). (2) Educated households and community members, supportive of breastfeeding, and knowledgeable about opportunity costs and control of diseases.

Photo: USAID 2014

**Proven Interventions:**[lxxxvi, lxxxvii]
(1) Train community members to form breastfeeding and maternal, infant, and young child nutrition support groups for mothers and other influential fami y members. (2) Assist community health workers/providers to integrate nutrition counseling and messages across the continuum and across sectors (e.g., WASH, Antenatal/Postnatal, PMTCT). (3) Align policy makers and donors in supporting "optimal practices" and friendliness of early breastfeeding, especially at birthing facilities and workplaces. (4) Involve community members such as men and other influence s (e.g. mothers-in-law) in behavior change activities.

**Indicators:**

- The percentage of mothers parenting last-born children born in the past two years who started breastfeeding within one hour of birth
- Proportion of infants 0–5 months of age who are fed exclusively with breast milk

## USAID's Approach in Priority Countries

USAID focuses on population-level behavior change efforts for the ten accelerator behaviors for maternal and child health. For each of the accelerator behaviors, USAID identifies proven behavior change approaches for individuals and caretakers as well as for communities and health providers. USAID has engaged in a rigorous examination of the evidence to ensure the effectiveness of these approaches and of their ability to scale up and sustain population-level change. USAID-supported programs aim to achieve measureable public health impact and build on clear indicators and measures of behaviors rather than just knowledge or attitudes.

USAID is working with the Foundation for the National Institutes of Health and UNICEF to articulate a clear research agenda going forward to fill crucial evidence gaps in the field of population level behavior change for child and maternal health. Specific research areas address the sustainability of widespread change, the effectiveness of new technologies such as mHealth, and method to engage and support community level shifts in behaviors.

# WATER SUPPLY, SANITATION, AND HYGIENE (WASH)

Percentage of population with access to improved sanitation. *WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation.*

## Global Context

Globally, diarrhea is a leading cause of death in children under fi e years of age, accounting for approximately 9% of deaths each year and an even higher percentage in the post-neonatal cohort. Diarrhea is a leading cause of malnutrition in children under fi e, and 45% of child mortality is linked to undernutrition. UNICEF estimates that 58% of deaths from diarrheal illnesses can be attributed to unsafe water and inadequate sanitation and hygiene practices. Evidence shows that interventions for improving the quantity and quality of domestic water supply, ensuring the use of improved sanitation and safe hygiene practices, can reduce diarrhea prevalence by one-third or more. The role of improved WASH in health facilities for infection control is increasingly recognized as an important intervention for reducing postpartum maternal and neonatal sepsis.

## High-Impact Interventions

USAID's *Water and Development Strategy 2013–2018* provides a comprehensive overview of USAID's water and health objective. Key interventions include increased access to water supply and sanitation infrastructure, as well as increased adoption of evidence-based hygiene practices (household water treatment and safe storage of water, handwashing with soap, safe feces disposal, and food hygiene). While major infrastructure activities require concerted multisector efforts, including leveraged financing USAID health activities place significan emphasis on the behavioral components and household dimensions of WASH, especially sanitation and hand washing. WASH practices have been proven to reduce diarrhea rates by 30–40%.

- **Increased access to water supply infrastructure:** Increase access to safe drinking water in sufficient quantity and quality.
- **Optimal handwashing:** Handwashing with soap, carried out at critical times (before preparing food, eating, or feeding, after defecating, cleaning a baby, or changing a diaper), and supported by a designated handwashing station with water and soap.

- **Treatment and safe storage of water for drinking:** Treatment of water to remove pathogens by chlorination, boiling, solar disinfection, filt ation, combined coagulation, flocculation and disinfection. Storage of water in a clean and appropriate vessel with narrow neck, tap, and lid.

- **Sanitation:** Increased access to improved household sanitation including a functional sanitation supply chain. An at-scale approach includes a focus on strengthening national institutions, fostering strong private sector participation, and enabling behavior change, rather than merely building toilets.

- **Food hygiene:** Promotion of the World Health Organization's Five Keys to Safer Food: keeping food preparation areas clean, separating raw and cooked food, cooking food thoroughly, keeping foods at safe temperatures, and using safe water and raw materials.

## Priority Actions for Wash

*Individual, community, and societal enablers for improved WASH*

1. **Increase emphasis and investment in sanitation.** Encourage at-scale national or sub-national sanitation interventions, using communal approaches such as Community-Led Total Sanitation and Sanitation Marketing. Investments must consider a focus on countries that are both off-track to meet the MDG for sanitation and with a high prevalence of both diarrhea and undernutrition, as well as how to reach the unserved and facilitate a comprehensive and functional sanitation supply chain with improved governance and engagement of the private sector.

2. **Engage government.** Different levels of government (national, provincial and district) should be included to strengthen their capacity and ownership of the WASH sector. By working with the relevant units within ministries — including health, agriculture, water, public works, and education — partners can work together with the ministries to develop multifaceted WASH interventions, including infrastructure, behavior change strategies, and an enabling policy and institutional environment.

3. **Develop standardized messages and effective materials.** Counseling materials should be based on consumer and field research or us existing messaging that is confi med as appropriate for the audience. These materials should be grounded on formative research that recognizes current practices, beliefs, and facilitating and constraining factors.

4. **Negotiate improved practices.** Both health workers and nutrition and agricultural extension agents can be taught to work with mothers and others to assess the current WASH practices in the family, reinforce existing positive actions, and help identify a few actions to be improved.

5. **Promote enabling technologies in conjunction with the private sector.** Handwashing stations that have water and soap provide a visible cue to wash hands when leaving the latrine and before preparing food or eating. Similarly, many combinations of pit, slab, and superstructure provide hygienic sanitation that can be marketed and provided through the private sector.

6. **Integrate WASH into other health and non-health programs.** Examples include HIV/AIDS, nutrition, education, neglected tropical diseases, and antenatal care platforms.

## USAID Approach in Priority Countries

USAID promotes the global vision to save lives and advance development through improvements in water supply, sanitation, and hygiene programs. USAID operates on the development hypothesis that WASH improvements have the greatest and most sustainable impact on health when a balance of the following three elements is achieved:

1. Expanded access to hardware (e.g., water and sanitation infrastructure and hygiene commodities)

2. Required behavior changes for sustained improvements in water and sanitation access/service and hygiene practices (e.g., social marketing, community participation, counseling, school programs)

3. An improved enabling policy and institutional environment (e.g., supportive policies, capacity building, partnerships, financing community mobilization).

Photo: AFP

# CONCLUSION

Two years ago, the world came together to issue a bold new call to action in maternal and child survival. Since that day, countries have launched national efforts, sharpened national strategies, and written scorecards to ensure that every maternal and child health investment is focused on saving lives.

In the past two years, we have seen many promising results.

The Saving Mothers, Giving Life partnership reduced maternal mortality by 30% in target districts in Uganda and 35% in target facilities in Zambia. Despite overwhelming odds, Ethiopia joined ve other high-mortality, USAID priority countries in achieving MDG 4 early. In 2013 alone, USAID's health programs treated 3.2 billion liters of drinking water, supported vaccines against rotavirus and pneumococcus, protected 45 million people with a prevention measure against malaria, and helped 84 million women access modern contraception.

Despite these successes, on our current trajectory, we will not achieve the global goal of ending preventable child and maternal death by 2035. With 24 results-oriented, country-led action plans, we now take another important and coordinated step forward to bend the curve of progress and ensure no woman or child dies from causes we know how to prevent.

Ultimately, we can save15 million children and nearly 600,000 women by 2020 only if we work together to target and scale proven solutions and relentlessly measure our results. We remain steadfast in our commitment to saving lives in partnership with faith communities, civil society organizations, the private sector, and — most importantly — national, regional, and community leaders. Because when we save the life of a mother or her newborn, we transform not only the health of families and the strength of communities, but also the prosperity and stability of our global society.

Photo:AFP / Behrouz Mehr

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**USAID** staff included representatives from: Office of Afghanistan and Pakistan Affairs; Bureau for Africa; Bureau for Asia; Bureau for Global Health (GH) Office of Count y Support; GH Office of Health Infectious Diseases and Nutrition; GH Office of Health Systems; GH Office of olicy, Programs and Planning; GH Office of opulation and Reproductive Health; Bureau for Latin American and the Caribbean; Bureau for Legislative and Public Affairs; Bureau for Management; Bureau for Policy, Planning and Learning; and Office of Budget and Resource Management; 24 USAID Missions

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# ANNEX A: DATA SOURCES AND METHODOLOGY

## Lives Saved "Best Performer" Data Sources and Methodology

### Data Sources:

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 umbers used within countries.

*Total Population, Population Under Five, Number of Births:*

**http://www.census.gov/population/international/**
The U.S. 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 or 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 exists for almost every country and is updated annually; these single year estimates reflect the demographic impact of sudden events, such as earthquakes, wars, and refugee movements. The UN maintains the only other similar source of estimates for all countries, but updates its data less frequently; its estimates do not yet reflec the precise timing of sudden events.

*The Census International Data Base did not have estimates for India, South Sudan or Yemen. For these countries data on total population and population under fi e from 2010 was taken from the UN Population Division http://esa.un.org/unpd/wpp/unpp/panel_population.htm. Data on number of births was calculated using the under-fi e mortality rate and the number of under-fi e deaths (see sources below).

*Under-Five Mortality Rate and Under-Five Deaths:*

**http://www.childmortality.org/**
Estimates produced by the Interagency Group for Child Mortality Estimation (IGME), comprising UNICEF, WHO, World Bank, and the U.N. Population Division. IGME is advised by leading academic scholars and independent experts in demography and biostatistics, who review mortality data, and publishes annual country level estimates of under-fi e 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 inte vals, the Technical Advisory Group of the IGME fits a smoothed trend cu ve 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 2012.

*Maternal Mortality Ratio:*

From the recently released report: Trends in Maternal Mortality: 1990 to 2013. Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division: **www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2013/en/index.html** The 2010 round of UN estimates (**World Health Organization et al., 2010**) provided an integrated evaluation of maternal mortality over the full interval from 1990 to 2008, 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 172 countries (or territories), with reference to 5-year time intervals centered on 1990, 1995, 2000, 2005, and 2008.

The methodology for 2013 estimates is similar to that for 2008 and 2010 estimates. However, given that the global database used for the current 2013 increased in country-years of data by fi e percent, estimates of total female deaths in the reproductive age group were updated, and the number of countries increased from 181 to 183, the current estimates should be used for interpretation of trends in maternal mortality from 1990 to 2013, rather than comparing to or extrapolating estimates from previously published estimates.

## Lives Saved and "Best Performer" Methodology[lxxxviii]

Accelerating coverage of key quality reproductive, maternal, newborn, child health, and nutrition interventions in the priority countries, with alignment across all actors, would result in 15 million fewer child deaths from 2012-2020 and 500,000 fewer maternal deaths, compared to current intervention coverage. The Lives Saved Tool (LiST), which has been used in a number of countries to identify priority interventions to accelerate child and maternal mortality reductions, was used to estimate the potential impact on lives saved.

The lives saved information on the country pages provides estimates for child and maternal lives that could be saved over current coverage rates. These lives saved are calculated by comparing different scenarios based on projected coverage rates of effective interventions. Coverage trends were projected from the historical rates by analyzing the trends in coverage of interventions and contraceptive prevalence for the period 1990 to 2010, from the nationally-representative surveys that provide coverage data for these interventions.[1] Country-specific projections of c verage changes were then developed for key maternal newborn and child health interventions from the most recent measurement to 2020. There were two variants of these projections. First, the "historical trend" projects coverage of the interventions based on the country-specific histo ical information. The second projection was the "best performer"[2] scenario where coverage change for each intervention was not based on the country data but rather based on the best performing country (within categories). This projection yields much higher scale up of coverage than the "historical trend" scenario but is limited to rates of coverage change that have been achieved in the past by countries at similar levels of development. In addition to estimated coverage change, for introduction and coverage of new vaccines we used the GAVI country-specific roll out plans. The information presented on the country pages reflects the "best performer" scenario since it allows analysis of expected impact vis-à-vis current coverage rates under optimal conditions. However, comparisons between "best performer" projections and historical projections were also used to understand the net effect of our efforts over and above current progress and are reflected in top-line messaging

With this projection of coverage change, LiST was used to estimate under-fi e mortality reduction between 2012 and 2020 based on the changes in coverage and contraceptive prevalence rate (CPR). For each country four scenarios were created. One scenario modeled the impact of scaling both CPR and MNCH interventions to the "best performer" level; the "Family Planning only" scenario increased CPR and held MNCH interventions constant at current levels of coverage; the "MNCH only" scenario held CPR (and as result total fertility rate) constant and raised coverage of the MNCH interventions; and a "no change" scenario kept both CPR and MNCH interventions constant at their current level of coverage. Running these four scenarios in LiST enables estimation of the number of under-fi e deaths that would occur in a country from 2013 to 2020. Comparing the four scenarios allowed for estimations of the relative importance of family planning[3] and MNCH interventions under these "best performer" assumptions of change on the number of under-fi e deaths. In addition, for the MNCH interventions we are able to disaggregate the impact of different interventions on the reduction in under-fi e deaths.

The LiST analysis presented here does not include components related to the relative cost to scale interventions, the quality of service delivery, or sub-national differences in prioritization. These dimensions, therefore, must be considered along with other variables in determining programming priorities going forward.

## Sharpening the Focus Data Sources and Methodology

In 2010, UNICEF launched an effort to refocus on equity and reorient its efforts toward reaching the disadvantaged and most deprived women, children and adolescents. This refocus was underpinned by the study "Narrowing the gaps to meet the Goals," a 15 country analysis that projected that an equity-focused approach to child-survival and nutrition can indeed help accelerate progress for the deprived and hard-to-reach populations and be

[1] The surveys were primarily DHS, MIC, MIS and some AIS surveys. The surveys were reanalyzed to ensure that standard methods were used to measure coverage.

[2] The "best performer" values were developed based on analyses of the full set of 75 countdown countries but stratified according to similar inte ventions type and level of baseline coverage to arrive at a "best performer" rate of change for each intervention within each country.

[3] Bangladesh, Nepal, and Indonesia were used as the reference countries for the demographic impact best performer model. For this reason, there will be no additional lives saved due to demographic impact in these countries.

more cost-effective than the current path. In 2011, UNICEF developed the "Monitoring of Results for Equity" as a framework to operationalize the equity vision through results-oriented programming, strengthened implementation management, and real-time decentralized monitoring of bottleneck reductions.

This framework included ten inter-related determinants, i.e., 'conditions' that are needed to increase the coverage of high-impact health and nutrition interventions for the disadvantaged populations. The ten determinants are organized in 4 broad categories: enabling environment, supply, demand and quality. The enabling environment refers to upstream social and political conditions, such as policies and legislation, financing and  udget, management and coordination and social norms. The supply includes the availability of essential commodities, skilled human resources and geographical accessibility. The demand refers to the willingness and ability of target populations to use the services or adopt healthy behaviors. The quality includes the minimum standards for effectiveness. This approach has been adapted to different contests and used in conjunction with governments and partners.

*The Bottleneck Analysis Methodology*

The bottleneck analysis forms part of a broader equity analysis approach that includes six key steps. First, it identifies the populations of greatest deprivations using mortality, nutrition and coverage indicators. Second, it identifies the mos effective interventions to equalize MCH outcomes between the least and most deprived populations. Third, it assesses and prioritizes the main bottlenecks across the ten determinants of coverage described above that constrain coverage of the key interventions prioritized. Fourth, it undertakes an in-depth causality analysis to identify and prioritize the root causes of bottlenecks. Fifth, it prioritizes the most effective and context-speci c solutions and identifies  ncentives to facilitate optimal implementation. Sixth, it establishes a system of real-time decentralized monitoring to track the reduction of bottlenecks and take timely corrective actions.

This analytical approach has been applied in the context of *A Promise Renewed* to child survival, Scaling Up Nutrition initiative, elimination of mother to child transmission of HIV, integrated management of childhood illnesses, maternal and neonatal care, and immunizations. The process has been led by national and sub-national managers with the participation of UN organizations, international NGOs and bilateral agencies. Depending on the context, the analysis has involved a triangulation of data from health information systems, household surveys, health facility surveys, and qualitative assessments through key informant interviews and focus group discussions with service providers and communities.

*Step 1. Gathering of required information on bottlenecks and strategies*

The current analysis focuses on the 24 high priority countries identified by USAID that were grouped in three categories according to their under-fi e mortality rates (Table 1 in the report). A number of countries included in this report conducted the bottleneck analysis primarily in the deprived districts where the under-fi e mortality and burden of disease were the highest. This information has been complemented by other country analyses that used somewhat different approaches (as described in this annex). As can be expected, the level of rigor of the sources used in this analysis varies sensibly across countries. In spite of the diversity of sources of information used, the comparative analysis across countries shows quite systematic trends and clear findings

*Step 2. Mapping bottlenecks and strategies identified to the 10 determinant framework*

For the purpose of aggregation and comparability, all the available information was reanalyzed and synthesized using the bottleneck analysis framework described above. Information was fi st categorized by the 7 main interventions analyzed (Table 2 in the report). The text for each country and health service was either copied directly from the source document or paraphrased to capture the key issues being identified In some cases additional information was added by the panel or other UNICEF staff, including country office staff based on personal knowledge of the country or program situation.

For each of the analyzed interventions, the available information was then organized by each of the 10 determinant. Some of the source documents used the 10 determinant framework (or some adaptation of it), while others used different conceptual frameworks for looking at health services. For example, the newborn reviews followed a seven item list mostly based on the WHO six elements of health services. In these cases the text was examined and placed into the appropriate category of the 10 determinant model used here. In

addition, many of the source documents listed greater or lesser problems under all or nearly all the 10 determinants.

*Step 3. Consolidation of information of bottlenecks and strategies by Delivery Platform*

The information (bottlenecks and strategies) from each determinant for the 7 interventions was then consolidated and summarized into the 3 "delivery platforms" (Community-based interventions, Outreach/ Schedulable Services, Clinical services) as described in Table 2 of the report. Health services within a service platform were combined since they are expected to experience similar bottlenecks.

*Step 4. Prioritization of bottlenecks*

The purpose of a UNICEF bottleneck analysis, however, is to identify a relatively small number of key issues that are the most important factors preventing progress in the health service in question at present. Therefore lower priority issues were left out in our analysis. In general at most two of the four enabling determinants and three of the six supply/demand/quality factors were selected for each health service and each country. Sometimes only one or two key bottlenecks were selected if the source document clearly indicated they were the highest priority. In cases where it was not evidence from the source documents which of the issues represented the highest priority bottlenecks, additional information was sought (such as DHS reports that identify explicitly "reasons for non-use of services" reported by women). As a last resort the panel of UNICEF experts with hands-on experience on the relevant countries provided its expert judgment as to which would be the most critical bottlenecks.

*Step 5. Identification of main causes of bottlenecks*

The text describing the priority bottlenecks under the 10 determinants were reviewed and key ideas and recurring themes were identified These were consolidated by the UNICEF panel into a limited number of "causes" for these bottlenecks. Each priority bottleneck by country and health service was then assigned to one or more of these "bottleneck causes" for that determinant depending on the text. In total 46 "bottleneck causes" were identified for the 10 determinants.

*Step 6. Data presentation*

The results are presented in Tables 4, 5 and 6 of the report summarized for three groups of countries (according to their under- fi e mortality rates). For each determinant/bottleneck cause, a three-letter code for each country is given under the column showing the service platform and country group, if that determinant was found to be a priority bottleneck for one or more of the health services included, and if that cause was found in the text for that determinant. Each group of countries has between seven and nine members. If a particular bottleneck cause was mentioned frequently then up to that number of countries will be listed in that cell. If only a few countries listed that cause as a priority, then the cell will have fewer entries or even none.

*Step 7. Analysis*

The text in the main chapter provides the results of the analysis. Explicit emphasis was put in identifying "vertical" relations, which expressed plausible relationships between causes found in different determinants, as well as in identifying differences between different categories of countries.

## Data Sources

Every Newborn Action Plan country consultations (2013): Afghanistan, DRC, Ethiopia, India, Indonesia, Nigeria, Pakistan, South Sudan, Uganda, Yemen.

Expanded Immunization Programme Situation Analyses (UNICEF, 2013): Afghanistan, Bangladesh, DRC, India, Kenya, Malawi, Nepal, Nigeria, Pakistan, Uganda, Vietnam.

Mass media campaigns, support to mothers groups, advocacy and community mobilization, the third in a Series of four papers about childhood pneumonia and diarrhea. www.thelancet.com. Published online April 12, 2013 http://dx.doi.org/10.1016/ S0140-6736(13)60314-1. (1) vaccines to prevent pneumonia and diarrhea, (2) zinc, (3) ORS, (4) abx for pneumonia for the following countries: Bangladesh, India, Pakistan, Vietnam, Kenya, Nigeria and Zambia. Additional countries with information on abx for pneumonia, information was gathered for: Kenya, Ethiopia, Tanzania, Uganda, DRC and Niger.

- Country qualitative data were obtained from key informants representing countries that contribute 80% of the world's pneumonia and diarrhea deaths by the three work streams (see below). These work streams were funded and managed independently, although

with extensive consultation among the project leaders; data for this review were combined post hoc.

- *The Global Action Plan for Pneumonia (GAPP),* spearheaded by WHO and UNICEF.
- *The Diarrhea and Pneumonia Working Group (DPWG),* cochaired by UNICEF and the Clinton Health Action Initiative.
- *The Diarrhea Global Action Plan (DGAP),* spearheaded by Aga Khan University, Pakistan is a collaboration between academic institutions (Boston University School of Public Health [MA, USA], Johns Hopkins Bloomberg School of Public Health [MD, USA], and the University of Toronto [Canada]) in consultation with WHO and UNICEF.

DHSS: UNICEF is supporting a number of countries through a process of District Health Systems Strengthening (DHSS) — an iterative process of decentralized monitoring, identification of bottlenecks and root causes, and corrective actions. The DHSS process is being used to address the main barriers to effective coverage of low-cost and high-impact facility maternal, newborn, and child health and community-based nutrition interventions targeting the main causes of child mortality amongst the most vulnerable populations.

- Mali: all districts of Kayes and Sikasso regions, February 2013.
- Zambia: Chiengi, Samtya, Luwingu, Mungwi.
- Malawi: Lilongwe, Karonga, Mzimba North, Mzimba South, Balaka, Chiradzulu, Phalombe, Mwanza, Nsanje.
- DRC: Mbanza Ngungu, Kenge, Tshilenge, Mikalay and Kiroche.

RMNCH landscape reports for: Ethiopia, Tanzania, Sierra Leone, Malawi, Uganda (May 2013 RMCNH bottleneck meeting).

A number of national reports, plans, and UNICEF country office documents were also consulted, including:

- Kenyan investment cases for Maternal, Newborn and Child Health: Technical Reports (Garissa, Turkana Counties, Kakamega), June 2013.
- Presentation on overview of key deprivations and experience with decentralised monitoring in Ghana. UNICEF 2013.
- Mid-term review of the national road map strategic plan to accelerate reduction in maternal newborn and child deaths in Tanzania (2008-2015). Ministry of Health and Social Welfare. January 2014.
- Yemen. Acceleration maternal and child health plan (2013-2015). 2013. 43 pages. Draft.
- Bangladesh ARP preparation partner working meeting report, May 2013.
- Sénégal Plan d'action survie de l'enfant 2013-2015, June 2013.
- Indonesia. Child Survival & Development: Incorporating Elements of MoRES into Decentralized Planning and Monitoring Systems UNICEF, 2014: *Formative Evaluation of UNICEF'S Monitoring Results for Equity Systems (MoRES): Indonesia Country Report, Final Draft.*
- Liberia Routine Immunization Coverage and Equity Improvement Plan, October 2013.
- DR Congo, Decentralized Monitoring for Action in the Democratic Republic of Congo. April 2013.
- Malawi. Bottlenecks analysis report for the high-impact SUN interventions in Mulanje. 2013.

Photo:AFP / USAID 2014

# ANNEX B: AWARD DATA

## Tables on principal USAID awards by country

USAID is maximizing the health impact of every dollar invested by targeting resources towards countries with the highest need; demonstrable commitment to achieving sustainable health impacts; and the greatest potential to leverage U.S. Government programs, as well as those of other partners and donors. The USAID awards whose primary purpose is ending preventable child and maternal deaths are identified in this annex and include $6 billion in aggregate remaining value (as of April 30th 2014, on a base of $13 billion total estimated value). The awards represent currently active projects; many projects and partners have contributed to the progress to date and will be engaged again as we go forward. The awards have been grouped into the following categories: Behavior Change and Health System Strengthening, Service Delivery, Supply Chain and/or Commodities, and Other. Each bilateral award will also indicate the type of alignment towards ending preventable child and maternal deaths that have and will continue to take place in annual workplans. The alignment categories are:

### Scaling up of high-impact interventions (S):

- Sharpening programs to focus on expanded access of proven interventions or models to reach under-served geographic areas or additional populations groups.
- For example, focusing USAID programs on policy or systems-level interventions to increase reach through existing systems, and more strategic partnering or leveraging of existing or new actors.

### Technical realignment (T):

- Shifting of programs to place greater emphasis on high-impact interventions.
- For example, adding new interventions to packages of services, or refinin approaches to ensure that both supply and demand-related barriers to access are addressed; the choices made are informed by the local context; and focus is on quality and appropriate use of interventions.

### Geographic realignment (G):

- Shifting of programs to focus more intensely on one or more geographic groups where scaling up interventions is expected to have a large impact.
- For example, shifting the focus to those geographic areas or populations where coverage is low or health status is particularly poor.

Finally, the award table includes the funding categories that have been obligated into the awards to date. Funding categories have been abbreviated to the following:

**FP** Family Planning
**HIV** HIV/AIDS
**TB** Tuberculous
**MAL** Malaria
**MCH** Maternal and Child Health
**NUT** Nutrition
**WASH** Water, Sanitation, and Hygiene

# SUMMARY TABLES

| | TOTAL ESTIMATED VALUE | VALUE REMAINING (April 30, 2014) |
|---|---|---|
| **AFGHANISTAN** | | |
| Behavior Change Communication and Health Systems Strengthening | — | — |
| Other | — | — |
| Service Delivery | $236,455,840 | $46,168,930 |
| Supply Chain/Commodities | $24,499,936 | $6,147,690 |
| Total | $260,955,776 | $52,316,620 |
| **BANGLADESH** | | |
| Behavior Change Communication and Health Systems Strengthening | $53,069,587 | $46,943,950 |
| Other | $32,453,695 | $14,163,448 |
| Service Delivery | $166,169,495 | $99,254,405 |
| Supply Chain/Commodities | $34,248,165 | $13,595,294 |
| Total | $285,940,942 | $173,957,097 |
| **DRC** | | |
| Behavior Change Communication and Health Systems Strengthening | $21,500,000 | $11,971,822 |
| Other | $633,850 | $118,850 |
| Service Delivery | $139,767,129 | $40,385,915 |
| Supply Chain/Commodities | $25,000,000 | $17,625,000 |
| Total | $186,900,979 | $70,101,587 |
| **ETHIOPIA** | | |
| Behavior Change Communication and Health Systems Strengthening | — | — |
| Other | $69,506,307 | $50,273,238 |
| Service Delivery | — | — |
| Supply Chain/Commodities | — | — |
| Total | $69,506,307 | $50,273,238 |
| **GHANA** | | |
| Behavior Change Communication and Health Systems Strengthening | $10,500,000 | $10,500,000 |
| Other | $5,305,000 | $5,105,079 |
| Service Delivery | — | — |
| Supply Chain/Commodities | — | — |
| Total | $15,805,000 | $15,605,079 |
| **HAITI** | | |
| Behavior Change Communication and Health Systems Strengthening | $42,655,811 | $19,640,329 |
| Other | — | — |
| Service Delivery | $95,849,069 | $68,071,273 |
| Supply Chain/Commodities | — | — |
| Total | $138,504,880 | $87,711,602 |

| | TOTAL ESTIMATED VALUE | VALUE REMAINING (April 30, 2014) |
|---|---|---|
| **INDIA** | | |
| Behavior Change Communication and Health Systems Strengthening | $20,381,000 | $0 |
| Other | — | — |
| Service Delivery | $43,115,026 | $23,622,026 |
| Supply Chain/Commodities | — | — |
| Total | $63,496,026 | $23,622,026 |
| **INDONESIA** | | |
| Behavior Change Communication and Health Systems Strengthening | — | — |
| Other | $19,986,100 | $11,315,299 |
| Service Delivery | $126,451,392 | $38,650,684 |
| Supply Chain/Commodities | — | — |
| Total | $146,437,492 | $49,965,983 |
| **KENYA** | | |
| Behavior Change Communication and Health Systems Strengthening | $194,802,647 | $77,609,947 |
| Other | — | — |
| Service Delivery | $585,323,657 | $228,130,184 |
| Supply Chain/Commodities | $79,996,901 | $6,805,905 |
| Total | $860,123,205 | $312,546,036 |
| **LIBERIA** | | |
| Behavior Change Communication and Health Systems Strengthening | $23,197,190 | $5,072,880 |
| Other | — | — |
| Service Delivery | $111,577,854 | $25,338,517 |
| Supply Chain/Commodities | — | — |
| Total | $134,775,044 | $30,411,397 |
| **MADAGASCAR** | | |
| Behavior Change Communication and Health Systems Strengthening | — | — |
| Other | $4,000,000 | $1,940,000 |
| Service Delivery | $59,767,425 | $30,483,402 |
| Supply Chain/Commodities | $36,823,053 | $22,456,870 |
| Total | $100,590,478 | $54,880,272 |
| **MALAWI** | | |
| Behavior Change Communication and Health Systems Strengthening | $24,000,000 | $13,556,000 |
| Other | — | — |
| Service Delivery | $65,000,000 | $46,206,704 |
| Supply Chain/Commodities | — | — |
| Total | $89,000,000 | $59,762,704 |

| | TOTAL ESTIMATED VALUE | VALUE REMAINING (April 30, 2014) |
|---|---|---|
| **MOZAMBIQUE** | | |
| Behavior Change Communication and Health Systems Strengthening | $21,257,019 | $3,482,831 |
| Other | — | — |
| Service Delivery | $42,532,824 | $993,727 |
| Supply Chain/Commodities | $700,000 | $0 |
| Total | $64,489,843 | $4,476,558 |
| **NEPAL** | | |
| Behavior Change Communication and Health Systems Strengthening | $87,636,441 | $30,910,178 |
| Other | $10,000,000 | $0 |
| Service Delivery | $63,714,809 | $29,898,557 |
| Supply Chain/Commodities | $2,197,006 | $1,755,756 |
| Total | $163,548,256 | $62,564,491 |
| **NIGERIA** | | |
| Behavior Change Communication and Health Systems Strengthening | — | — |
| Other | — | — |
| Service Delivery | $247,659,059 | $63,209,238 |
| Supply Chain/Commodities | — | — |
| Total | $247,659,059 | $63,209,238 |
| **PAKISTAN** | | |
| Behavior Change Communication and Health Systems Strengthening | $46,383,904 | $29,383,904 |
| Other | — | — |
| Service Delivery | $118,790,485 | $86,982,467 |
| Supply Chain/Commodities | — | — |
| Total | $165,174,389 | $116,366,371 |
| **RWANDA** | | |
| Behavior Change Communication and Health Systems Strengthening | $43,929,818 | $17,661,094 |
| Other | $35,065,756 | $10,206,960 |
| Service Delivery | $67,154,331 | $22,937,677 |
| Supply Chain/Commodities | — | — |
| Total | $146,149,905 | $50,805,732 |
| **SENEGAL** | | |
| Behavior Change Communication and Health Systems Strengthening | $61,999,066 | $21,803,971 |
| Other | — | — |
| Service Delivery | $96,941,000 | $33,327,742 |
| Supply Chain/Commodities | $22,000,000 | $7,415,000 |
| Total | $180,940,066 | $62,546,713 |

| | TOTAL ESTIMATED VALUE | VALUE REMAINING (April 30, 2014) |
|---|---|---|
| **SOUTH SUDAN** | | |
| Behavior Change Communication and Health Systems Strengthening | — | — |
| Other | $66,740,106 | $23,744,556 |
| Service Delivery | $85,000,000 | $52,522,733 |
| Supply Chain/Commodities | $39,409,689 | $22,277,009 |
| Total | $191,149,795 | $98,544,298 |
| **TANZANIA** | | |
| Behavior Change Communication and Health Systems Strengthening | $49,999,000 | $25,262,000 |
| Other | $50,300,000 | $16,553,825 |
| Service Delivery | $139,353,465 | $50,551,468 |
| Supply Chain/Commodities | — | — |
| Total | $239,652,465 | $92,367,293 |
| **UGANDA** | | |
| Behavior Change Communication and Health Systems Strengthening | $69,978,210 | $60,431,520 |
| Other | $70,654,635 | $30,172,481 |
| Service Delivery | $84,266,043 | $39,008,170 |
| Supply Chain/Commodities | $123,819,402 | $54,519,508 |
| Total | $348,718,290 | $184,131,679 |
| **YEMEN** | | |
| Behavior Change Communication and Health Systems Strengthening | $23,500,000 | $16,648,238 |
| Other | $11,865,280 | $1,533,111 |
| Service Delivery | — | — |
| Supply Chain/Commodities | — | — |
| Total | $35,365,280 | $18,181,349 |
| **ZAMBIA** | | |
| Behavior Change Communication and Health Systems Strengthening | $196,885,329 | $5,076,654 |
| Other | — | — |
| Service Delivery | — | — |
| Supply Chain/Commodities | — | — |
| Total | $196,885,329 | $5,076,654 |
| **GH BUREAU** | | |
| Behavior Change Communication and Health Systems Strengthening | $977,691,536 | $535,377,704 |
| Other | $10,774,143 | $2,835,962 |
| Service Delivery | $4,642,848,727 | $2,939,327,369 |
| Supply Chain/Commodities | $3,129,238,563 | $916,289,575 |
| Total | $8,760,552,969 | $4,393,830,610 |

| | |
|---|---|
| **TOTAL: TOTAL ESTIMATED VALUE** | **$13,092,321,776** |
| **TOTAL: VALUE REMAINING (APRIL 30, 2014)** | **$6,133,254,629** |

### USAID AFGHANISTAN

| VENDOR | AWARD NUMBER | AWARD | |
|---|---|---|---|
| | | | |
| **PRIMARY PURPOSE OF AWARD: SERVICE DELIVERY** | | | |
| Partnership Contracts for Health Service (PCH) Program | 306-08-IL-06 | Government to Government | |
| **PRIMARY PURPOSE OF AWARD: SUPPLY CHAIN/COMMODITIES** | | | |
| Management Sciences For Health, Inc. | AID-306-A-00-11-00532 | Cooperative Agreement | |
| **TOTAL** | | | |

### USAID BANGLADESH

| VENDOR | AWARD NUMBER | AWARD | |
|---|---|---|---|
| | | | |
| **PRIMARY PURPOSE OF AWARD: BEHAVIOR CHANGE COMMUNICATION AND HEALTH SYSTEMS STRENGTHENING** | | | |
| Sesame Workshop | AID-388-A-13-00005 | Cooperative Agreement | |
| JHPIEGO Corporation | AID-388-LA-13-00004 | Other | |
| **PRIMARY PURPOSE OF AWARD: OTHER** | | | |
| Save The Children Federation Inc | AID-388-A-00-10-00034 | Cooperative Agreement | |
| Save The Children | AID-388-A-13-00006 | Cooperative Agreement | |
| Brac University | AID-388-F-12-00001 | Grant | |
| **PRIMARY PURPOSE OF AWARD: SERVICE DELIVERY** | | | |
| FHI 360 | AID-388-A-13-00003 | Cooperative Agreement | |
| Food And Agriculture Organization Of The United Nations | AID-388-G-00-05-00055 | Grant | |
| Engenderhealth, Inc. | AID-388-LA-13-00002 | Contract | |
| Pathfinder Inte national | AID-388-C-13-00002 | Contract | |
| World Bank Office Of The Publisher | AID-388-IO-12-00001 | Indefinite Quantity Contract | |
| **PRIMARY PURPOSE OF AWARD: SUPPLY CHAIN/COMMODITIES** | | | |
| Social Marketing Company | AID-388-A-12-00003 | Cooperative Agreement | |
| Tetra Tech Dpk | AID-EPP-I-00-04-00035 | Indefinite Quantity Contract | |
| **TOTAL** | | | |

| | | | AWARD DATES | | ALIGNMENT CATEGORIES | FUNDING CATEGORIES |
|---|---|---|---|---|---|---|
| | TOTAL ESTIMATED VALUE | VALUE REMAINING (APRIL 30, 2014) | | | | |
| | | | START | END | | |
| | | | | | | |
| | $236,455,840 | $46,168,930 | 07-20-2008 | 01-31-2015 | S | MCH, FP, NUT |
| | | | | | | |
| | $24,499,936 | $6,147,690 | 08-29-2011 | 08-27-2015 | S | MCH, FP |
| | **$260,955,776** | **$52,316,620** | | | | |

| | | | AWARD DATES | | ALIGNMENT CATEGORIES | FUNDING CATEGORIES |
|---|---|---|---|---|---|---|
| | TOTAL ESTIMATED VALUE | VALUE REMAINING (APRIL 30, 2014) | | | | |
| | | | START | END | | |
| | | | | | | |
| | $3,100,000 | $2,210,654 | 07-01-2013 | 06-30-2016 | S | MCH, NUT |
| | $49,969,587 | $44,733,296 | 09-24-2013 | 09-23-2017 | S, G, T | MCH, FP, NUT |
| | | | | | | |
| | $14,063,557 | $1,973,310 | 02-18-2010 | 02-17-2015 | T | MCH, FP |
| | $15,390,138 | $11,190,138 | 09-29-2013 | 09-28-2017 | T | MCH, FP |
| | $3,000,000 | $1,000,000 | 07-05-2012 | 07-04-2015 | T | MCH, FP, TB |
| | | | | | | |
| | $9,000,000 | $5,610,000 | 07-01-2013 | 06-30-2016 | S, G, T | NUT, MCH |
| | $14,422,998 | $1,352,846 | 06-22-2005 | 09-30-2015 | S, G, T | MCH, NUT |
| | $20,000,000 | $16,243,817 | 10-01-2013 | 09-30-2017 | S, G, T | MCH, FP |
| | $82,746,497 | $58,047,742 | 12-10-2012 | 12-09-2017 | S, G, T | MCH, FP, NUT, TB |
| | $40,000,000 | $18,000,000 | 02-05-2012 | 12-31-2016 | S, T | MCH, NUT, TB |
| | | | | | | |
| | $15,000,000 | $7,925,203 | 07-26-2012 | 07-25-2016 | S, T | MCH, FP, NUT, TB |
| | $19,248,165 | $5,670,091 | 12-21-2010 | 03-29-2015 | S | MCH, FP |
| | **$285,940,942** | **$173,957,097** | | | | |

### USAID
### DEMOCRATIC REPUBLIC OF CONGO

| VENDOR | AWARD NUMBER | AWARD | |
|---|---|---|---|
| | | | |
| **PRIMARY PURPOSE OF AWARD: BEHAVIOR CHANGE COMMUNICATION AND HEALTH SYSTEMS STRENGTHENING** | | | |
| FHI 360 | AID-660-LA-12-00001 | Leader with Associate | |
| **PRIMARY PURPOSE OF AWARD: OTHER** | | | |
| Catholic Relief Services | AID-660-A-12-00002 | Cooperative Agreement | |
| **PRIMARY PURPOSE OF AWARD: SERVICE DELIVERY** | | | |
| Management Sciences For Health. Inc | AID-OAA-A-10-00054 | Cooperative Agreement | |
| **PRIMARY PURPOSE OF AWARD: SUPPLY CHAIN/COMMODITIES** | | | |
| Population Services International | AID-623-A-12-00028 | Cooperative Agreement | |
| **TOTAL** | | | |

### USAID
### ETHOPHIA

| VENDOR | AWARD NUMBER | AWARD | |
|---|---|---|---|
| | | | |
| **PRIMARY PURPOSE OF AWARD: OTHER** | | | |
| Ethiopian Medical Association | AID-663-A-13-00020 | Cooperative Agreement | |
| Ethiopian Economics Association | AID-663-A-13-00023 | Cooperative Agreement | |
| Confederation Of Ethiopian Trade Unions | AID-663-A-13-00026 | Cooperative Agreement | |
| Rohi Weddu Pastoral Women Development Organization | AID-663-A-14-00002 | Cooperative Agreement | |
| Consortium Of Reproductive Health Associations (CORHA) | AID-663-A-14-00003 | Cooperative Agreement | |
| Whiz Kids Workshop Plc | AID-663-F-13-00002 | Grant | |
| United Nations Children's Fund | AID-663-IO-14-00001 | Indefinite Quantity Contract | |
| Family Health International | AID-663-LA-14-00001 | Leader with Associate | |
| JHPIEGO Corporation | AID-663-A-12-00008 | Cooperative Agreement | |
| Organization For Development In Action | AID-663-A-13-00022 | Cooperative Agreement | |
| World Health Organization | AID-663-IO-11-00001 | PIO | |
| **TOTAL** | | | |

| | | | AWARD DATES | | ALIGNMENT CATEGORIES | FUNDING CATEGORIES |
|---|---|---|---|---|---|---|
| | TOTAL ESTIMATED VALUE | VALUE REMAINING (APRIL 30, 2014) | | | | |
| | | | START | END | | |
| | | | | | | |
| | $21,500,000 | $11,971,822 | 08-01-2012 | 07-31-2015 | S | MAL, MCH, FP, WASH, HIV, TB |
| | | | | | | |
| | $633,850 | $118,850 | 08-20-2012 | 08-19-2015 | S | MCH |
| | | | | | | |
| | $139,767,129 | $40,385,915 | 09-30-2010 | 09-29-2015 | S, T, G | MAL, MCH, FP, WASH, HIV, TB |
| | | | | | | |
| | $25,000,000 | $17,625,000 | 10-18-2012 | 10-17-2017 | S, T | MAL |
| | **$186,900,979** | **$70,101,587** | | | | |

| | | | AWARD DATES | | ALIGNMENT CATEGORIES | FUNDING CATEGORIES |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | START | END | | |
| | | | | | | |
| | $929,629 | $629,629 | 09-29-2013 | 09-30-2016 | | FP |
| | $891,000 | $591,000 | 10-01-2013 | 09-30-2016 | | FP |
| | $864,358 | $664,358 | 10-01-2013 | 09-30-2016 | S | FP |
| | $1,500,000 | $1,250,000 | 01-02-2014 | 12-31-2016 | G | FP |
| | $881,320 | $681,320 | 03-17-2014 | 03-16-2017 | | FP |
| | $1,200,000 | $900,000 | 10-01-2013 | 09-30-2016 | | FP, MCH |
| | $2,140,000 | $1,140,000 | 12-10-2013 | 06-30-2015 | | FP, MCH |
| | $4,200,000 | $3,628,808 | 12-12-2013 | 12-11-2017 | S, T | FP, MCH |
| | $55,000,000 | $40,088,123 | 05-18-2012 | 05-18-2017 | S, T | MCH, FP, MAL, TB |
| | $900,000 | $700,000 | 10-01-2013 | 09-30-2016 | G | FP |
| | $1,000,000 | $0 | 08-01-2011 | 07-31-2014 | S | MCH |
| | **$69,506,307** | **$50,273,238** | | | | |

## USAID GHANA

| VENDOR | AWARD NUMBER | AWARD | |
|---|---|---|---|
| | | | |
| **PRIMARY PURPOSE OF AWARD: BEHAVIOR CHANGE COMMUNICATION AND HEALTH SYSTEMS STRENGTHENING** | | | |
| USAID/Evaluate for Health | AID-641-Q-14-00001 | Indefinite Quantity Contract | |
| **PRIMARY PURPOSE OF AWARD: OTHER** | | | |
| KNUST — Dept. of Community Health | 641-AAIL-FY12-04 | Government to Government | |
| Ghana Health Service Institutional Care Division - Clinical Labs Unit | 641-AOIL-FY12-05 | Government to Government | |
| Northern Regional Coordinating Council | 641-A11-13-IL#07 | Government to Government | |
| Central Gonja District Assembly | 641-A11-13-IL#08 | Government to Government | |
| East Mamprusi District Assembly | 641-A11-13-IL#09 | Government to Government | |
| Nanumba North District Assemly | 641-A11-13-IL#10 | Government to Government | |
| Nanumba South District Assembly | 641-A11-13-IL#11 | Government to Government | |
| **TOTAL** | | | |

## USAID HAITI

| VENDOR | AWARD NUMBER | AWARD | |
|---|---|---|---|
| | | | |
| **PRIMARY PURPOSE OF AWARD: BEHAVIOR CHANGE COMMUNICATION AND HEALTH SYSTEMS STRENGTHENING** | | | |
| Partners Of The Americas Inc | AID-521-A-13-00007 | Cooperative Agreement | |
| Population Services International | AID-521-A-00-10-00006 | Cooperative Agreement | |
| Futures Group International, Llc | AID-521-C-13-00005 | Contract | |
| AECOM Water | AID-EDH-I-00-08-00024 | Indefinite Quantity Contract | |
| **PRIMARY PURPOSE OF AWARD: SERVICE DELIVERY** | | | |
| University Research Co., Llc SSQH-North | AID-521-C-13-00010 | Contract | |
| Pathfinder Inte national SSQH South and Central | AID-521-C-13-00011 | Contract | |
| **TOTAL** | | | |

| | | | AWARD DATES | | ALIGNMENT CATEGORIES | FUNDING CATEGORIES |
|---|---|---|---|---|---|---|
| | TOTAL ESTIMATED VALUE | VALUE REMAINING (APRIL 30, 2014) | | | | |
| | | | START | END | | |
| | | | | | | |
| | $10,500,000 | $10,500,000 | 04-22-2014 | 04-21-2019 | T | FP, MAL, WASH, MCH, HIV, NUT, |
| | | | | | | |
| | $55,000 | $25,212 | 10-01-2012 | 06-30-2014 | T | FP |
| | $250,000 | $182,891 | 10-01-2012 | 09-30-2014 | T | MAL |
| | $1,000,000 | $979,283 | 09-01-2012 | 09-30-2017 | G | NUT, WASH |
| | $1,000,000 | $978,036 | 07-29-2013 | 09-30-2017 | G | NUT, WASH |
| | $1,000,000 | $980,394 | 07-29-2013 | 09-30-2017 | G | NUT, WASH |
| | $1,000,000 | $980,743 | 07-29-2013 | 09-30-2017 | G | NUT, WASH |
| | $1,000,000 | $978,519 | 07-29-2013 | 09-30-2017 | G | NUT, WASH |
| | **$15,805,000** | **$15,605,079** | | | | |

| | | | AWARD DATES | | ALIGNMENT CATEGORIES | FUNDING CATEGORIES |
|---|---|---|---|---|---|---|
| | TOTAL ESTIMATED VALUE | VALUE REMAINING (APRIL 30, 2014) | | | | |
| | | | START | END | | |
| | | | | | | |
| | $12,000,000 | $8,000,000 | 05-24-2013 | 05-23-2016 | S | NUT |
| | $8,946,668 | $55,668 | 09-15-2010 | 03-14-2015 | T | HIV |
| | $7,801,700 | $5,677,218 | 02-25-2013 | 02-24-2017 | S | HIV, MCH, FP, MAL |
| | $13,907,443 | $5,907,443 | 03-29-2012 | 03-28-2017 | S | WASH |
| | | | | | | |
| | $39,146,476 | $27,405,539 | 09-30-2013 | 09-29-2018 | S | HIV, MCH, NUT |
| | $56,702,593 | $40,665,734 | 09-30-2013 | 09-29-2018 | S | TB, MCH, FP, NUT |
| | **$138,504,880** | **$87,711,602** | | | | |

## USAID INDIA

| VENDOR | AWARD NUMBER | AWARD | |
|---|---|---|---|
| | | | |
| **PRIMARY PURPOSE OF AWARD: BEHAVIOR CHANGE COMMUNICATION AND HEALTH SYSTEMS STRENGTHENING** | | | |
| FHI 360 | AID-386-TO-11-00001 | Contract | |
| **PRIMARY PURPOSE OF AWARD: SERVICE DELIVERY** | | | |
| Population Foundation Of India | AID-386-A-00-09-00305 | Cooperative Agreement | |
| IPE Global | AID-386-A-14-00001 | Cooperative Agreement | |
| Water Health India Pvt. Ltd. | AID-386-A-14-00003 | Cooperative Agreement | |
| Impact Foundation | AID-386-A-13-00002 | Cooperative Agreement | |
| **TOTAL** | | | |

## USAID INDONESIA

| VENDOR | AWARD NUMBER | AWARD | |
|---|---|---|---|
| | | | |
| **PRIMARY PURPOSE OF AWARD: OTHER** | | | |
| Indonesian International Education Foundation | AID-497-C-12-00004 | Contract | |
| **PRIMARY PURPOSE OF AWARD: SERVICE DELIVERY** | | | |
| Research Triangle Institute | AID-497-A-10-00003 | Cooperative Agreement | |
| Development Alternatives Inc | AID-497-C-11-00001 | Contract | |
| JHPIEGO Corporation | AID-497-A-11-00014 | Cooperative Agreement | |
| **TOTAL** | | | |

| | | | AWARD DATES | | ALIGNMENT CATEGORIES | FUNDING CATEGORIES |
|---|---|---|---|---|---|---|
| | TOTAL ESTIMATED VALUE | VALUE REMAINING (APRIL 30, 2014) | | | | |
| | | | START | END | | |
| | | | | | | |
| | $20,381,000 | $0 | 10-15-2010 | 12-12-2014 | S, G, T | MCH, FP |
| | | | | | | |
| | $10,778,627 | $349,627 | 10-01-2009 | 09-30-2015 | S, G, T | MCH, FP |
| | $24,885,399 | $18,772,399 | 05-26-2014 | 05-25-2018 | S, G, T | MCH, FP |
| | $451,000 | $0 | 05-14-2014 | 05-13-2015 | | MCH |
| | $7,000,000 | $4,500,000 | 03-04-2013 | 03-03-2018 | S, G, T | MCH, FP |
| | **$63,496,026** | **$23,622,026** | | | | |

| | | | AWARD DATES | | ALIGNMENT CATEGORIES | FUNDING CATEGORIES |
|---|---|---|---|---|---|---|
| | TOTAL ESTIMATED VALUE | VALUE REMAINING (APRIL 30, 2014) | | | | |
| | | | START | END | | |
| | | | | | | |
| | $19,986,100 | $11,315,299 | 08-08-2012 | 08-07-2017 | S, G, T | MCH, TB, FP |
| | | | | | | |
| | $32,754,989 | $5,410,991 | 09-30-2010 | 02-28-2015 | G | MCH, TB, FP |
| | $38,696,403 | $10,127,800 | 03-04-2011 | 03-03-2016 | S, G, T | MCH, TB, FP |
| | $55,000,000 | $23,111,893 | 09-20-2011 | 09-19-2016 | S, G, T | MCH, FP |
| | **$146,437,492** | **$49,965,983** | | | | |

## USAID KENYA

| VENDOR | AWARD NUMBER | AWARD | |
|---|---|---|---|
| | | | |
| **PRIMARY PURPOSE OF AWARD: BEHAVIOR CHANGE COMMUNICATION AND HEALTH SYSTEMS STRENGTHENING** | | | |
| Intrahealth International | AID-623-A-12-00011 | Cooperative Agreement | |
| Internews Network | AID-615-A-13-00002 | Cooperative Agreement | |
| ABT Associates | AID-623-TO-11-00005 | Contract | |
| Population Services International | AID-615-A-12-00002 | Cooperative Agreement | |
| Management Sciences For Health | AID-623-LA-10-00003 | Contract | |
| IBTCI | AID-623-TO13-00021 | Contract | |
| University of North Carolina | AID-623-LA-12-00001 | Contract | |
| **PRIMARY PURPOSE OF AWARD: SERVICE DELIVERY** | | | |
| Program For Appropriate Technology In Health | AID-623-A-11-00002 | Cooperative Agreement | |
| Family Health International 360 | AID-623-A-11-00007 | Cooperative Agreement | |
| JHPIEGO Corporation | AID-623-A-11-00008 | Cooperative Agreement | |
| Pathfinde | AID-623-A-11-00009 | Cooperative Agreement | |
| AMREF | AID-623-A-12-00015 | Cooperative Agreement | |
| Moi Teaching and Referral Hospital | AID-615-A-12-00001 | Cooperative Agreement | |
| Centre for Health Solutions | AID-615-A-13-00006 | Cooperative Agreement | |
| Family Health International 360 | AID-623-A-00-08-00013 | Cooperative Agreement | |
| **PRIMARY PURPOSE OF AWARD: SUPPLY CHAIN/COMMODITIES** | | | |
| Management Sciences For Health. Inc. | AID-623-LA-11-00008 | Contract | |
| Kenya Medical Supplies Agency | 615-IL-003-013 and 012 | FARA | |
| **TOTAL** | | | |

## USAID LIBERIA

| VENDOR | AWARD NUMBER | AWARD | |
|---|---|---|---|
| | | | |
| **PRIMARY PURPOSE OF AWARD: BEHAVIOR CHANGE COMMUNICATION AND HEALTH SYSTEMS STRENGTHENING** | | | |
| The School For International Training | AID-669-A-00-10-00057 | Cooperative Agreement | |
| Global Communities | 669-A-00-10-00087-00 | Cooperative Agreement | |
| **PRIMARY PURPOSE OF AWARD: SERVICE DELIVERY** | | | |
| JSI Research and Training Institute,Inc. | AID-669-A-00-09-00001 | Cooperative Agreement | |
| Ministry of Health and Social Welfare | 669-FARA-A11-11-01 | Fixed Amount Reimbursement | |
| **TOTAL** | | | |

| | | | AWARD DATES | | ALIGNMENT CATEGORIES | FUNDING CATEGORIES |
|---|---|---|---|---|---|---|
| | TOTAL ESTIMATED VALUE | VALUE REMAINING (APRIL 30, 2014) | | | | |
| | | | START | END | | |
| | | | | | | |
| | $40,000,000 | $19,232,424 | 02-24-2012 | 02-23-2017 | S | FP |
| | $8,000,000 | $4,521,700 | 01-01-2013 | 12-31-2016 | S | MCH, FP |
| | $32,802,647 | $17,809,082 | 06-01-2011 | 05-31-2016 | S | MAL, MCH, FP |
| | $36,000,000 | $4,684,709 | 03-21-2012 | 03-20-2015 | S | MAL, MCH, FP |
| | $20,000,000 | $2,630,554 | 04-16-2010 | 04-15-2015 | S | FP |
| | $23,000,000 | $5,660,703 | 08-23-2013 | 08-22-2018 | S | FP |
| | $35,000,000 | $23,070,775 | 10-31-2012 | 10-30-2017 | S | MAL, FP |
| | | | | | | |
| | $142,691,684 | $36,178,712 | 01-01-2011 | 12-31-2015 | S, G | MAL, MCH, FP, NUT |
| | $94,744,448 | $39,744,448 | 01-01-2011 | 12-31-2015 | G | MCH, FP, NUT |
| | $99,999,921 | $26,906,389 | 01-01-2011 | 12-31-2015 | G | MCH, FP, NUT |
| | $61,000,000 | $0 | 01-01-2011 | 10-31-2014 | G | MCH, FP |
| | $49,985,210 | $21,830,453 | 03-15-2012 | 03-14-2017 | G | MCH, FP, NUT |
| | $74,900,000 | $49,316,165 | 03-17-2012 | 03-16-2017 | G | MCH, FP |
| | $40,500,000 | $34,751,623 | 06-27-2013 | 06-26-2018 | S | TB |
| | $21,502,394 | $19,402,394 | 03-14-2008 | 05-31-2014 | S | NUT |
| | | | | | | |
| | $24,996,901 | $6,805,905 | 04-01-2011 | 03-31-2016 | S | MAL, FP |
| | $55,000,000 | $0 | 10-27-2012 | 10-26-2015 | S | MCH, FP |
| | **$860,123,205** | **$312,546,036** | | | | |

| | | | AWARD DATES | | ALIGNMENT CATEGORIES | FUNDING CATEGORIES |
|---|---|---|---|---|---|---|
| | TOTAL ESTIMATED VALUE | VALUE REMAINING (APRIL 30, 2014) | | | | |
| | | | START | END | | |
| | | | | | | |
| | $13,197,190 | $5,072,880 | 12-31-2009 | 12-27-2014 | T | MCH |
| | $10,000,000 | $0 | 02-01-2010 | 02-01-2015 | T | WASH |
| | | | | | | |
| | $69,512,598 | $1,823,389 | 11-05-2008 | 10-31-2014 | S, G, T | MCH, FP, MAL |
| | $42,065,256 | $23,515,128 | 09-16-2011 | 06-30-2015 | G, T | MCH, FP, MAL |
| | **$134,775,044** | **$30,411,397** | | | | |

## USAID MADAGASCAR

| VENDOR | AWARD NUMBER | AWARD | |
|---|---|---|---|
| | | | |
| **PRIMARY PURPOSE OF AWARD: OTHER** | | | |
| Institut Pasteur De Madagascar | AID-687-G-13-00003 | Grant | |
| **PRIMARY PURPOSE OF AWARD: SERVICE DELIVERY** | | | |
| JSI Research and Training Institute,Inc. | AID-687-A-00-11-00013 | Cooperative Agreement | |
| Management Sciences For Health, Inc. | AID-687-C-13-00001 | Contract | |
| **PRIMARY PURPOSE OF AWARD: SUPPLY CHAIN/COMMODITIES** | | | |
| Population Services International | AID-687-A-13-00001 | Cooperative Agreement | |
| **TOTAL** | | | |

## USAID MALAWI

| VENDOR | AWARD NUMBER | AWARD | |
|---|---|---|---|
| | | | |
| **PRIMARY PURPOSE OF AWARD: BEHAVIOR CHANGE COMMUNICATION AND HEALTH SYSTEMS STRENGTHENING** | | | |
| John Hopkins University | AID 612-A-11-00001 | Cooperative Agreement | |
| **PRIMARY PURPOSE OF AWARD: SERVICE DELIVERY** | | | |
| JHPIEGO Corporation | AID-612-A-11-00003 | Cooperative Agreement | |
| **TOTAL** | | | |

## USAID MALI

| VENDOR | AWARD NUMBER | AWARD | |
|---|---|---|---|
| | | | |
| **PRIMARY PURPOSE OF AWARD: BEHAVIOR CHANGE COMMUNICATION AND HEALTH SYSTEMS STRENGTHENING** | | | |
| E D C | AID-688-A-00-10-00167 | Cooperative Agreement | |
| Non Profit O ganisation | AID-688-F-13-00006 | Grant | |
| **PRIMARY PURPOSE OF AWARD: SERVICE DELIVERY** | | | |
| ASDAP | AID-688-F-13-00003 | Grant | |
| CARE USA | AID-688-A-13-00003 | Cooperative Agreement | |
| Save The Children | AID-688-A-13-00004 | Cooperative Agreement | |
| **TOTAL** | | | |

| | | | AWARD DATES | | ALIGNMENT CATEGORIES | FUNDING CATEGORIES |
|---|---|---|---|---|---|---|
| | TOTAL ESTIMATED VALUE | VALUE REMAINING (APRIL 30, 2014) | | | | |
| | | | START | END | | |
| | | | | | | |
| | $4,000,000 | $1,940,000 | 10-01-2013 | 09-30-2018 | T | MCH, FP, MAL |
| | | | | | | |
| | $34,999,935 | $11,215,052 | 05-23-2011 | 05-22-2016 | S | MCH, FP, MAL |
| | $24,767,490 | $19,268,350 | 08-01-2013 | 07-31-2018 | S | MCH, FP, MAL |
| | | | | | | |
| | $36,823,053 | $22,456,870 | 01-01-2013 | 12-31-2017 | S | MCH, FP, MAL |
| | **$100,590,478** | **$54,880,272** | | | | |

| | | | AWARD DATES | | ALIGNMENT CATEGORIES | FUNDING CATEGORIES |
|---|---|---|---|---|---|---|
| | TOTAL ESTIMATED VALUE | VALUE REMAINING (APRIL 30, 2014) | | | | |
| | | | START | END | | |
| | | | | | | |
| | $24,000,000 | $13,556,000 | 09-16-2011 | 09-15-2016 | S | MAL, FP, NUT, MCH |
| | | | | | | |
| | $65,000,000 | $46,206,704 | 11-08-2011 | 11-06-2016 | S | FP, MCH, MAL, NUT, HIV |
| | **$89,000,000** | **$59,762,704** | | | | |

| | | | AWARD DATES | | ALIGNMENT CATEGORIES | FUNDING CATEGORIES |
|---|---|---|---|---|---|---|
| | TOTAL ESTIMATED VALUE | VALUE REMAINING (APRIL 30, 2014) | | | | |
| | | | START | END | | |
| | | | | | | |
| | $30,000,000 | $8,533,502 | 10-01-2010 | 09-30-2015 | S, T | |
| | $1,500,000 | $908,940 | 10-01-2013 | 09-30-2016 | T | HIV, FP |
| | | | | | | |
| | $1,500,000 | $500,000 | 12-14-2012 | 12-31-2015 | S, G | MCH, NUT |
| | $9,997,313 | $7,997,313 | 10-01-2013 | 09-30-2018 | S, T | NUT |
| | $9,894,427 | $7,438,590 | 10-01-2013 | 10-01-2013 | S, G | NUT, MCH, MAL |
| | **$52,891,740** | **$25,378,345** | | | | |

## USAID MOZAMBIQUE

| VENDOR | AWARD NUMBER | AWARD | |
|---|---|---|---|
| | | | |
| **PRIMARY PURPOSE OF AWARD: BEHAVIOR CHANGE COMMUNICATION AND HEALTH SYSTEMS STRENGTHENING** | | | |
| Population Services International | AID-656-A-00-11-00107 | Cooperative Agreement | |
| Fundacao Manhica | AID-656-F-12-00001 | Grant | |
| **PRIMARY PURPOSE OF AWARD: SERVICE DELIVERY** | | | |
| Pathfinder Inte national | AID-656-A-00-10-00104 | Cooperative Agreement | |
| JHPIEGO Corporation | AID-656-A-00-11-00097 | Cooperative Agreement | |
| **PRIMARY PURPOSE OF AWARD: SUPPLY CHAIN/COMMODITIES** | | | |
| CMAM | AID-656-013-PILFAR-14-022 | Government to Government | |
| **TOTAL** | | | |

## USAID NEPAL

| VENDOR | AWARD NUMBER | AWARD | |
|---|---|---|---|
| | | | |
| **PRIMARY PURPOSE OF AWARD: BEHAVIOR CHANGE COMMUNICATION AND HEALTH SYSTEMS STRENGTHENING** | | | |
| RTI International | AID-367-C-13-00001 | Contract | |
| Family Health International | AID-367-C-10-00001 | Contract | |
| John Hopkins University Centre for Communication Programs | OAA-A-12-00058 | Cooperative Agreement | |
| Save The Children | AID-367-A-11-00004 | Cooperative Agreement | |
| Ministry of Health and Population | 367-IL-0182 | Government to Government | |
| **PRIMARY PURPOSE OF AWARD: OTHER** | | | |
| Peace Corps | 367-IAA-P-00-12-00001 | Inter-agency agreement | |
| **PRIMARY PURPOSE OF AWARD: SERVICE DELIVERY** | | | |
| Family Health International | AID-367-A-11-00005 | Cooperative Agreement | |
| Winrock International | AID-367-C-13-00004 | Contract | |
| DfID | N/A | D2D | |
| Nepal CRS Company Pvt Ltd | AID-367-A-10-00002 | Cooperative Agreement | |
| **PRIMARY PURPOSE OF AWARD: SUPPLY CHAIN/COMMODITIES** | | | |
| Lifeline Nepal | AID-367-C-13-00005 | Contract | |
| **TOTAL** | | | |

| | | | AWARD DATES | | ALIGNMENT CATEGORIES | FUNDING CATEGORIES |
|---|---|---|---|---|---|---|
| | TOTAL ESTIMATED VALUE | VALUE REMAINING (APRIL 30, 2014) | | | | |
| | | | START | END | | |
| | | | | | | |
| | $20,557,019 | $3,082,831 | 09-27-2011 | 09-26-2014 | T | MAL, MCH, FP, NUT, HIV |
| | $700,000 | $400,000 | 09-01-2012 | 10-31-2014 | S | MCH |
| | | | | | | |
| | $12,697,644 | $993,727 | 06-15-2010 | 07-14-2014 | S | FP, HIV |
| | $29,835,180 | $0 | 04-13-2011 | 03-12-2015 | S | MAL, MCH, FP, HIV |
| | | | | | | |
| | $700,000 | | 01-1-2014 | 12-31-2014 | | MCH |
| | **$64,489,843** | **$4,476,558** | | | | |

| | | | AWARD DATES | | ALIGNMENT CATEGORIES | FUNDING CATEGORIES |
|---|---|---|---|---|---|---|
| | TOTAL ESTIMATED VALUE | VALUE REMAINING (APRIL 30, 2014) | | | | |
| | | | START | END | | |
| | | | | | | |
| | $18,253,072 | $13,579,322 | 12-17-2012 | 12-16-2017 | | FP, MCH |
| | $9,883,369 | $2,885,604 | 08-06-2010 | 08-05-2015 | T | FP, MCH, NUT, HIV |
| | $5,000,000 | $0 | 01-01-2014 | 09-1-2017 | S | FP |
| | $46,000,000 | $14,445,252 | 08-30-2011 | 08-29-2016 | S, G | FP, MCH, NUT |
| | $8,500,000 | $0 | 12-01-2012 | 12-01-2017 | S | FP, MCH |
| | | | | | | |
| | $10,000,000 | $0 | 12-16-2011 | 09-30-2016 | S | MCH, NUT |
| | | | | | | |
| | $27,500,000 | $14,172,541 | 09-30-2011 | 09-30-2016 | T | HIV, FP |
| | $20,414,809 | $13,786,016 | 02-14-2013 | 02-13-2018 | T, G | NUT |
| | $10,000,000 | $0 | 09-01-2014 | 09-30-2018 | S | FP |
| | $5,800,000 | $1,940,000 | 05-01-2010 | 04-30-2015 | S, G | FP, MCH, NUT, HIV |
| | | | | | | |
| | $2,197,006 | $1,755,756 | 09-26-2013 | 09-25-2018 | | FP |
| | **$163,548,256** | **$62,564,491** | | | | |

## USAID NIGERIA

| VENDOR | AWARD NUMBER | AWARD | |
|---|---|---|---|
| | | | |
| **PRIMARY PURPOSE OF AWARD: SERVICE DELIVERY** | | | |
| JSI Research and Training Institute, Inc. | AID-620-A-00-09-00014 | Cooperative Agreement | |
| FHI 360 | AID-620-A-00-10-00017 | Cooperative Agreement | |
| Society For Family Health | AID-620-A-11-00001 | Cooperative Agreement | |
| Marie Stopes International Or Ganization Nigeria | AID-620-A-14-00001 | Cooperative Agreement | |
| ABT Associates Inc. | AID-620-LA-11-00001 | Cooperative Agreement | |
| **TOTAL** | | | |

## USAID PAKISTAN

| VENDOR | AWARD NUMBER | AWARD | |
|---|---|---|---|
| | | | |
| **PRIMARY PURPOSE OF AWARD: BEHAVIOR CHANGE COMMUNICATION AND HEALTH SYSTEMS STRENGTHENING** | | | |
| John Hopkins University | AID-391-A-14-00002 | Cooperative Agreement | |
| John Snow International | AID-391-A-13-00002 | Cooperative Agreement | |
| **PRIMARY PURPOSE OF AWARD: SERVICE DELIVERY** | | | |
| Marie Stopes Society | AID-391-A-13-00007 | Cooperative Agreement | |
| JHPIEGO Corporation | AID-391-LA-13-00001 | Cooperative Agreement | |
| **TOTAL** | | | |

| | | | AWARD DATES | | ALIGNMENT CATEGORIES | FUNDING CATEGORIES |
|---|---|---|---|---|---|---|
| | TOTAL ESTIMATED VALUE | VALUE REMAINING (APRIL 30, 2014) | | | | |
| | | | START | END | | |
| | | | | | | |
| | $85,453,015 | $2,209,256 | 08-12-2009 | 08-30-2015 | S,T | MCH, FP, MAL |
| | $79,908,667 | $28,074,845 | 10-15-2010 | 09-30-2015 | G | MAL |
| | $57,899,979 | $18,447,739 | 04-05-2011 | 04-04-2016 | T | MCH, FP, MAL |
| | $9,000,000 | $8,000,000 | 03-04-2014 | 03-03-2017 | | FP |
| | $15,397,398 | $6,477,398 | 08-22-2011 | 08-21-2016 | T | MCH, FP |
| | **$247,659,059** | **$63,209,238** | | | | |

| | | | AWARD DATES | | ALIGNMENT CATEGORIES | FUNDING CATEGORIES |
|---|---|---|---|---|---|---|
| | TOTAL ESTIMATED VALUE | VALUE REMAINING (APRIL 30, 2014) | | | | |
| | | | START | END | | |
| | | | | | | |
| | $24,500,000 | $16,500,000 | 04-25-2014 | 01-24-2019 | S | MCH, FP |
| | $21,883,904 | $12,883,904 | 04-03-2013 | 04-03-2018 | S | MCH, FP |
| | | | | | | |
| | $72,290,485 | $53,482,467 | 10-02-2013 | 10-01-2018 | S | FP |
| | $46,500,000 | $33,500,000 | 02-05-2013 | 09-30-2017 | S | MCH |
| | **$165,174,389** | **$116,366,371** | | | | |

## USAID RWANDA

| VENDOR | AWARD NUMBER | AWARD | |
|---|---|---|---|
| | | | |
| **PRIMARY PURPOSE OF AWARD: BEHAVIOR CHANGE COMMUNICATION AND HEALTH SYSTEMS STRENGTHENING** | | | |
| Society For Family Health Rwanda | AID-696-A-13-00001 | Cooperative Agreement | |
| Management Sciences For Health, Inc. | AID-GHS-I-00-07-00006 | Indefinite Quantity Contract | |
| Primary Purpose of Award: Other | | | |
| Social And Scientific Systems Inc. | AID-696-C-00-08-00118 | Contract | |
| DAI Washington | AID-696-C-12-00003 | Contract | |
| Global Communities | AID-696-A-11-00008 | Cooperative Agreement | |
| **PRIMARY PURPOSE OF AWARD: SERVICE DELIVERY** | | | |
| Family Health International 360 | AID-696-A-13-00005 | Cooperative Agreement | |
| Chemonics International Inc | AID-696-C-12-00001 | Contract | |
| Caritas Rwanda | AID-696-A-12-00003 | Cooperative Agreement | |
| **TOTAL** | | | |

## USAID SENEGAL

| VENDOR | AWARD NUMBER | AWARD | |
|---|---|---|---|
| | | | |
| **PRIMARY PURPOSE OF AWARD: BEHAVIOR CHANGE COMMUNICATION AND HEALTH SYSTEMS STRENGTHENING** | | | |
| ADEMAS | AID-685-A-12-00002 | Cooperative Agreement | |
| National Cooperative Business Association | AID-685-A-00-11-00002 | Cooperative Agreement | |
| Primary Purpose of Award: Service Delivery | | | |
| Intrahealth International | AID-685-A-11-00003 | Cooperative Agreement | |
| Family Health International | AID-685-A-11-00004 | Cooperative Agreement | |
| Christian Childrens Fund Inc | AID-685-A-11-00005 | Cooperative Agreement | |
| MOH/National Malaria Control Program | | Government to Government | |
| MOH/National Malaria Control Program | | Government to Government | |
| University of Cheilh Anta Diop (UCAD) | | Government to Government | |
| MOH/Direction Reproductive Health and child Survival | | Government to Government | |
| **PRIMARY PURPOSE OF AWARD: SUPPLY CHAIN/COMMODITIES** | | | |
| ABT Associates Inc | AID-685-A-11-00002 | Cooperative Agreement | |
| **TOTAL** | | | |

| | | | AWARD DATES | | ALIGNMENT CATEGORIES | FUNDING CATEGORIES |
|---|---|---|---|---|---|---|
| | TOTAL ESTIMATED VALUE | VALUE REMAINING (APRIL 30, 2014) | | | | |
| | | | START | END | | |
| | | | | | | |
| | $9,383,276 | $5,647,276 | 10-25-2012 | 10-24-2017 | T, G | FP, NUT, HIV, MAL, MCH, WASH |
| | $34,546,542 | $12,013,818 | 11-03-2009 | 11-01-2014 | T, G | FP, HIV, PMI, MCH |
| | | | | | | |
| | $7,920,662 | $1,011,866 | 01-07-2008 | 07-30-2014 | | FP, NUT, HIV, MAL, MCH |
| | $14,850,000 | $4,900,000 | 04-30-2012 | 04-30-2017 | | HIV, FP, MCH |
| | $12,295,094 | $4,295,094 | 07-13-2011 | 07-12-2016 | T | NUT |
| | | | | | | |
| | $7,500,000 | $5,300,000 | 10-01-2013 | 09-30-2016 | S | MCH, FP, HIV |
| | $54,999,050 | $16,964,063 | 02-03-2012 | 09-30-2016 | S | FP, NUTR, HIV, MAL, MCH, WASH |
| | $4,655,281 | $673,614 | 09-12-2012 | 09-11-2015 | S | NUT, MCH, HIV |
| | **$146,149,905** | **$50,805,732** | | | | |

| | | | AWARD DATES | | ALIGNMENT CATEGORIES | FUNDING CATEGORIES |
|---|---|---|---|---|---|---|
| | TOTAL ESTIMATED VALUE | VALUE REMAINING (APRIL 30, 2014) | | | | |
| | | | START | END | | |
| | | | | | | |
| | $22,000,000 | $8,049,000 | 03-01-2012 | 09-30-2016 | S | HIV, MAL, MCH, FP, NUT |
| | $39,999,066 | $13,754,971 | 11-01-2010 | 09-30-2015 | S | NUT |
| | | | | | | |
| | $32,000,000 | $9,861,000 | 10-01-2011 | 09-30-2016 | S, G | HIV, TB, MAL, MCH, FP, NUT |
| | $22,000,000 | $8,408,742 | 10-01-2011 | 09-30-2016 | S | HIV, TB, MAL, FP, NUT |
| | $40,000,000 | $15,058,000 | 10-01-2011 | 09-30-2016 | S | OPHT, TB, MAL, MCH, FP, NUT |
| | $410,000 | $0 | 06-01-2012 | 05-31-2014 | S | MAL |
| | $1,531,000 | $0 | 04-05-2013 | 04-04-2014 | S | MAL |
| | $500,000 | $0 | 08-08-2013 | 08-07-2014 | | |
| | $500,000 | $0 | 08-08-2013 | 08-07-2014 | | FP, MCH |
| | | | | | | |
| | $22,000,000 | $7,415,000 | 10-01-2011 | 09-30-2016 | S | HIV, MAL, MCH, FP, NUT |
| | **$180,940,066** | **$62,546,713** | | | | |

## USAID
## SOUTH SUDAN

| VENDOR | AWARD NUMBER | AWARD | |
|---|---|---|---|
| | | | |
| **PRIMARY PURPOSE OF AWARD: OTHER** | | | |
| UNOPS | AID-668-A-12-00001 | Cooperative Agreement | |
| **PRIMARY PURPOSE OF AWARD: SERVICE DELIVERY** | | | |
| JHPIEGO Corporation | AID-668-LA-12-00003 | Other | |
| **PRIMARY PURPOSE OF AWARD: SUPPLY CHAIN/COMMODITIES** | | | |
| Abt Associates Inc. | AID-668-A-13-00001 | Cooperative Agreement | |
| Family Health International | AID-GHH-I-00-07-00043 | Indefinite Quantity Contract | |
| **TOTAL** | | | |

## USAID
## TANZANIA

| VENDOR | AWARD NUMBER | AWARD | |
|---|---|---|---|
| | | | |
| **PRIMARY PURPOSE OF AWARD: BEHAVIOR CHANGE COMMUNICATION AND HEALTH SYSTEMS STRENGTHENING** | | | |
| Population Services International | AID-621-A-00-10-00020 | Cooperative Agreement | |
| **PRIMARY PURPOSE OF AWARD: OTHER** | | | |
| Ifakara | AID-621-A-13-00006 | Cooperative Agreement | |
| JHU TCCP | 621-A-00-10-00032-00 | Cooperative Agreement | |
| **PRIMARY PURPOSE OF AWARD: SERVICE DELIVERY** | | | |
| University Research Co., Llc | AID-621-A-00-11-00011 | Cooperative Agreement | |
| Engenderhealth, Inc. | AID-621-LA-13-00001 | LWA | |
| JHPIEGO Corporation | AID-621-A-00-08-00023 | Cooperative Agreement | |
| Marie Stopes Tanzania | AID-621-A-13-00002 | Cooperative Agreement | |
| Vodafone Foundation | AID-621-A-13-00007 | Cooperative Agreement | |
| Arusha Zonal Training Center (CEDHA) | 621-0011.01 IL | Implementation Letter | |
| Iringa Zonal Training Center (PHCI) | 621-0011.01 IL | Implementation Letter | |
| Kigoma Zonal Training Center | 621-0011.01 IL | Implementation Letter | |
| Zanzibar Malaria Elimination Program | IL # 45 | Implementation Letter | |
| **TOTAL** | | | |

| | | | AWARD DATES | | ALIGNMENT CATEGORIES | FUNDING CATEGORIES |
|---|---|---|---|---|---|---|
| | TOTAL ESTIMATED VALUE | VALUE REMAINING (APRIL 30, 2014) | | | | |
| | | | START | END | | |
| | | | | | | |
| | $66,740,106 | $23,744,556 | 11-14-2011 | 11-13-2014 | G | MAL, MCH, FP,TB, WASH |
| | | | | | | |
| | $85,000,000 | $52,522,733 | 06-13-2012 | 06-12-2017 | S | FP, MCH, MAL, HIV, WASH |
| | | | | | | |
| | $24,946,525 | $20,502,885 | 12-05-2012 | 12-04-2017 | T | FP, MCH |
| | $14,463,164 | $1,774,124 | 12-01-2009 | 11-30-2014 | T | FP, MCH |
| | **$191,149,795** | **$98,544,298** | | | | |

| | | | AWARD DATES | | ALIGNMENT CATEGORIES | FUNDING CATEGORIES |
|---|---|---|---|---|---|---|
| | TOTAL ESTIMATED VALUE | VALUE REMAINING (APRIL 30, 2014) | | | | |
| | | | START | END | | |
| | | | | | | |
| | $49,999,000 | $25,262,000 | 05-15-2010 | 05-14-2015 | T | MCH, FP |
| | | | | | | |
| | $800,000 | $0 | 03-15-2013 | 03-14-2015 | T | FP |
| | $49,500,000 | $16,553,825 | 09-12-2010 | 09-11-2015 | T | MAL, FP, MCH |
| | | | | | | |
| | $23,988,103 | $14,140,601 | 03-01-2011 | 02-28-2016 | G | MAL, MCH |
| | $42,357,285 | $23,557,285 | 11-01-2012 | 10-31-2017 | S, T, G | FP |
| | $40,000,000 | $3,214,381 | 09-24-2008 | 05-31-2014 | S, T, G | MAL, MCH |
| | $9,643,231 | $4,957,231 | 12-01-2012 | 11-30-2014 | S | FP |
| | $7,000,000 | $4,681,970 | 07-01-2013 | 06-30-2017 | S, G | FP, MCH |
| | $6,554,545 | $0 | 03-23-2005 | 09-30-2014 | S, T | MAL, FP, MCH |
| | $4,612,835 | $0 | 03-23-2005 | 09-30-2014 | S, T | MAL, FP, MCH |
| | $3,197,466 | $0 | 03-23-2005 | 09-30-2014 | S, T | MAL, FP, MCH |
| | $2,000,000 | $0 | 02-17-2012 | 09-30-2014 | | MAL |
| | **$239,652,465** | **$92,367,293** | | | | |

## USAID
## UGANDA

| VENDOR | AWARD NUMBER | AWARD | |
|---|---|---|---|
| | | | |
| **PRIMARY PURPOSE OF AWARD: BEHAVIOR CHANGE COMMUNICATION AND HEALTH SYSTEMS STRENGTHENING** | | | |
| FHI 360 | AID-617-A-13-00003 | Cooperative Agreement | |
| PATH | AID-617-A-14-00004 | Cooperative Agreement | |
| **PRIMARY PURPOSE OF AWARD: OTHER** | | | |
| Qed Group, Llc, The | AID-617-C-13-00007 | Contract | |
| Cardno Emerging Markets USA, Ltd | AID-617-A-10-00003 | Cooperative Agreement | |
| **PRIMARY PURPOSE OF AWARD: SERVICE DELIVERY** | | | |
| Hospice Africa Uganda | AID-617-A-00-05-00010 | Cooperative Agreement | |
| Management Sciences For Health, Inc. | AID-623-A-13-00003 | Cooperative Agreement | |
| Marie Stopes Uganda | AID-617-A-10-00004 | Cooperative Agreement | |
| Plan USA | AID-617-A-12-00005 | Cooperative Agreement | |
| **PRIMARY PURPOSE OF AWARD: SUPPLY CHAIN/COMMODITIES** | | | |
| Reco Industries Ltd | AID-617-A-12-00004 | Cooperative Agreement | |
| Management Sciences For Health | AID-617-A-09-00003 | Cooperative Agreement | |
| ABT Associates | AID-617-C-12-00004 | Direct Award | |
| **TOTAL** | | | |

| | | | AWARD DATES | | ALIGNMENT CATEGORIES | FUNDING CATEGORIES |
|---|---|---|---|---|---|---|
| | TOTAL ESTIMATED VALUE | VALUE REMAINING (APRIL 30, 2014) | | | | |
| | | | START | END | | |
| | | | | | | |
| | $49,997,475 | $44,049,255 | 06-21-2013 | 06-20-2018 | S | MCH , FP, NUT, MAL, HIV |
| | $19,980,735 | $16,382,265 | 06-01-2014 | 05-31-2019 | | MCH , FP, NUT, MAL, HIV |
| | | | | | | |
| | $15,664,617 | $9,293,083 | 06-24-2013 | 06-23-2018 | | MCH ,FP, NUT, MAL, HIV, Basic Education |
| | $54,990,018 | $20,879,398 | 04-01-2010 | 04-01-2016 | | MCH , FP, NUT, MAL, HIV |
| | | | | | | |
| | $12,000,000 | $923,000 | 09-30-2008 | 09-30-2015 | T, G | HIV |
| | $12,275,135 | $8,842,170 | 01-02-2013 | 12-31-2017 | S, T | TB, HIV |
| | $9,990,908 | $316,682 | 05-21-2010 | 05-20-2015 | S, G | FP |
| | $50,000,000 | $28,926,318 | 08-01-2012 | 08-01-2017 | S | MCH , FP, NUT, MAL, HIV |
| | | | | | | |
| | $22,000,000 | $15,725,834 | 08-07-2012 | 08-06-2017 | S | NUT, HIV |
| | $37,832,647 | $9,846,735 | 07-17-2009 | 10-31-2014 | | MCH , FP, NUT, MAL, HIV |
| | $63,986,755 | $28,946,939 | 06-26-2012 | 06-23-2017 | S, G | MAL |
| | **$348,718,290** | **$184,131,679** | | | | |

### USAID YEMEN

| VENDOR | AWARD NUMBER | AWARD | |
|---|---|---|---|
| | | | |
| **PRIMARY PURPOSE OF AWARD: BEHAVIOR CHANGE COMMUNICATION AND HEALTH SYSTEMS STRENGTHENING** | | | |
| JHPIEGO Corporation | AID-279-LA-14-00006 | Associate Award | |
| **PRIMARY PURPOSE OF AWARD: OTHER** | | | |
| International Business And Technical Consultants | AID-RAN-I-00-09-00016 | Indefinite Quantity Contract | |
| **TOTAL** | | | |

### USAID ZAMBIA

| VENDOR | AWARD NUMBER | AWARD | |
|---|---|---|---|
| | | | |
| **PRIMARY PURPOSE OF AWARD: BEHAVIOR CHANGE COMMUNICATION AND HEALTH SYSTEMS STRENGTHENING** | | | |
| Abt Associates Inc | AID-GHS-I-00-07-00003 | Indefinite Quantity Contract | |
| Chemonics International Inc | AID-GHS-I-00-07-00004 | Indefinite Quantity Contract | |
| Population Services International | AID-GHH-I-00-07-00062 | Indefinite Quantity Contract | |
| **TOTAL** | | | |

| | | | AWARD DATES | | ALIGNMENT CATEGORIES | FUNDING CATEGORIES |
|---|---|---|---|---|---|---|
| | TOTAL ESTIMATED VALUE | VALUE REMAINING (APRIL 30, 2014) | | | | |
| | | | START | END | | |
| | | | | | | |
| | $23,500,000 | $16,648,238 | 03-01-2014 | 02-28-2019 | S,T | MCH, FP |
| | | | | | | |
| | $11,865,280 | $1,533,111 | 05-01-2010 | 09-30-2014 | | MCH, FP |
| | **$35,365,280** | **$18,181,349** | | | | |

| | | | AWARD DATES | | ALIGNMENT CATEGORIES | FUNDING CATEGORIES |
|---|---|---|---|---|---|---|
| | TOTAL ESTIMATED VALUE | VALUE REMAINING (APRIL 30, 2014) | | | | |
| | | | START | END | | |
| | | | | | | |
| | $88,092,613 | $3,458,164 | 06-15-2010 | 12-13-2014 | S,T | MCH, FP, MAL, NUT, HIV |
| | $43,337,946 | $140,265 | 07-08-2010 | 12-13-2014 | T | MCH, FP, MAL, NUT, HIV |
| | $65,454,770 | $1,478,225 | 08-01-2009 | 09-30-2014 | T | MCH, FP, MAL, NUT, HIV |
| | **$196,885,329** | **$5,076,654** | | | | |

## USAID
## BUREAU FOR GLOBAL HEALTH

| VENDOR | AWARD NUMBER | AWARD |
|---|---|---|
| **PRIMARY PURPOSE OF AWARD: BEHAVIOR CHANGE COMMUNICATION AND HEALTH SYSTEMS STRENGTHENING** | | |
| Johns Hopkins University | OAA-A-12-00058 | Cooperative Agreement |
| International Center for Research on Women | OAA-A-10-00071 | Cooperative Agreement |
| Population Council, Inc. | AID-OAA-E-10-00002 | Cooperative Agreement |
| FHI 360 | OAA-A-10-00040 | Cooperative Agreement |
| ABT Associates, Inc. | OAA-A-12-00080 | Cooperative Agreement |
| University of North Carolina | GHA-A-00-08-00003 | Cooperative Agreement |
| ICF MACRO, INC | OAA-C-13-00095 | Contract |
| Futures Group International, LLC | OAA-A-10-00067 | Cooperative Agreement |
| Population Reference Bureau, Inc. | OAA-A-10-00009 | Cooperative Agreement |
| Johns Hopkins University | OAA-A-13-00068 | Cooperative Agreement |
| U.S. Bureau of the Census | GHA-T-00-08-00002 | Interagency Agreement |
| Primary Purpose of Award: Other | | |
| Woodrow Wilson Center | OAA-A-10-00010 | Cooperative Agreement |
| Georgetown University School of Continuing Studies | OAA-A-10-00073 | Cooperative Agreement |
| **PRIMARY PURPOSE OF AWARD: SERVICE DELIVERY** | | |
| World Health Organization (WHO) | GHA-G-00-09-00003 | Grant |
| Georgetown University School of Continuing Studies | OAA-A-13-00083 | Cooperative Agreement |
| Population Council, Inc. | OAA-A-13-00087 | Cooperative Agreement |
| Georgetown University School of Continuing Studies | OAA-A-10-00066 | Cooperative Agreement |
| Intrahealth International, Inc. | GPO-A-00-09-00006 | Cooperative Agreement |
| Marie Stopes Health Clinic | OAA-A-10-00059 | Cooperative Agreement |
| Population Services International | OAA-A-10-00030 | Cooperative Agreement |
| ABT Associates, Inc. | GPO-A-00-09-00007 | Cooperative Agreement |
| Management Sciences for Health, Inc. | OAA-A-11-00015 | Cooperative Agreement |
| Pathfinder Inte national | OAA-A-11-00024 | Cooperative Agreement |
| JSI Research and Training Institute, Inc. | OAA-A-12-00047 | Cooperative Agreement |
| United Nations Children's Fund (UNICEF) | GHA-G-00-07-00007 | Grant |
| PATH | OAA-A-12-00057 | Task Order |
| International Federation of Red Cross and Red Crescent Society | GHA-G-00-08-00006 | Grant |
| ENGENDERHEALTH, INC. | OAA-A-14-00013 | Cooperative Agreement |
| World Health Organization (WHO) | AAG-G-00-97-00019 | Grant |
| United Nations Children's Fund (UNICEF) | AAG-G-00-97-00021 | Grant |
| World Vision, Inc | OAA-A-12-00031 | Cooperative Agreement |
| JHPIEGO Corporation | GHS-A-00-08-00002 | Cooperative Agreement |

| | | | AWARD DATES | | ALIGNMENT CATEGORIES | FUNDING CATEGORIES |
|---|---|---|---|---|---|---|
| | TOTAL ESTIMATED VALUE | VALUE REMAINING (APRIL 30, 2014) | | | | |
| | | | START | END | | |
| | | | | | | |
| | $98,999,944 | $75,892,594 | 09-26-2012 | 09-25-2017 | S, T, G | FP, MAL, MCH |
| | $3,792,924 | $1,382,924 | 09-30-2010 | 09-29-2015 | S | FP |
| | $5,000,000 | $745,000 | 09-30-2010 | 09-29-2015 | S | FP |
| | $100,000,000 | $63,452,757 | 09-30-2010 | 09-29-2015 | S, T, G | MCH |
| | $199,702,730 | $151,723,708 | 09-30-2012 | 09-29-2017 | S, T | TB, MAL, AI, NTD, MCH, FP, NUT |
| | $181,000,000 | $10,254,131 | 08-15-2008 | 08-14-2014 | S, G | TB, MAL, AI, NTD, MCH, FP, NUT |
| | $25,000,000 | $21,290,667 | 09-09-2013 | 09-08-2018 | S, T | TB, MAL, AI, NTD, MCH, FP, NUT |
| | $249,995,938 | $155,007,694 | 09-30-2010 | 09-29-2015 | S, T, G | AI, MCH, FP |
| | $19,400,000 | $2,592,998 | 08-31-2010 | 08-30-2015 | T | FP |
| | $40,000,000 | $34,900,000 | 09-11-2013 | 09-10-2018 | T | FP |
| | $54,800,000 | $18,135,232 | 03-31-2008 | 09-30-2016 | S, T | MCH, FP |
| | | | | | | |
| | $5,277,035 | $2,133,035 | 09-27-2010 | 09-26-2015 | T | FP |
| | $5,497,108 | $702,927 | 09-30-2010 | 09-29-2015 | T | FP |
| | | | | | | |
| | $425,000,000 | $99,557,907 | 09-11-2009 | 09-30-2016 | S, T | TB, MAL, AI, NTD, MCH, FP, NUT, HIV |
| | $19,794,023 | $15,814,023 | 10-01-2013 | 09-30-2018 | T | FP |
| | $69,427,198 | $64,251,198 | 10-01-2013 | 09-30-2018 | S, T | FP |
| | $5,527,906 | $1,587,906 | 09-30-2010 | 09-29-2015 | T | FP |
| | $300,000,000 | $249,891,148 | 09-30-2009 | 09-29-2015 | S, T, G | FP |
| | $43,714,980 | $4,089,163 | 09-30-2010 | 09-29-2015 | T | FP |
| | $39,877,031 | $7,463,011 | 09-30-2010 | 09-29-2015 | T | FP |
| | $94,999,702 | $8,973,921 | 09-30-2009 | 09-29-2014 | S, T, G | TB, MAL, AI, NTD, MCH, FP, NUT |
| | $198,935,961 | $128,294,245 | 09-25-2011 | 09-24-2016 | S, T, G | FP |
| | $230,000,000 | $184,444,464 | 09-30-2011 | 09-29-2016 | S, T, G | FP |
| | $210,494,494 | $187,025,654 | 10-1-2012 | 09-30-2017 | S, T, G | FP |
| | $300,000,000 | $184,392,383 | 09-28-2007 | 09-29-2015 | S, T | MCH, NUT |
| | $49,834,507 | $34,357,010 | 09-30-2012 | 09-29-2017 | S, T, G | MAL |
| | $43,683,000 | $35,398,000 | 09-30-2008 | 09-30-2018 | S, T | MAL |
| | $74,490,086 | $70,586,414 | 12-12-2013 | 12-11-2018 | T, G | MCH, FP |
| | $436,394,601 | $263,712,376 | 09-30-1996 | 09-30-2022 | S, T | MCH |
| | $250,000,000 | $114,757,865 | 09-30-1997 | 09-30-2022 | S, T | MCH |
| | $38,000,000 | $23,975,000 | 09-30-2012 | 09-29-2017 | S, T, G | MCH |
| | $600,000,000 | $297,613,408 | 09-30-2008 | 09-29-2014 | S, T, G | MCH, FP |

## USAID
## BUREAU FOR GLOBAL HEALTH

| VENDOR | AWARD NUMBER | AWARD | |
|---|---|---|---|
| | | | |
| JHPIEGO Corporation | OAA-A-14-00028 | Cooperative Agreement | |
| GAIN | GHA-G-00-06-00002 | Grant | |
| JSI Research and Training Institute, Inc. | OAA-A-11-00031 | Cooperative Agreement | |
| FHI 360 | OAA-A-12-00005 | Cooperative Agreement | |
| Johns Hopkins University | GHS-A-00-09-00004 | Cooperative Agreement | |
| JHPIEGO Corporation | OAA-A-11-00050 | Cooperative Agreement | |
| University Research Co, LLC | GHS-A-00-09-00015 | Cooperative Agreement | |
| University Research Co, LLC | OAA-A-12-00101 | Cooperative Agreement | |
| **PRIMARY PURPOSE OF AWARD: SUPPLY CHAIN/COMMODITIES** | | | |
| | Various | Contract | |
| John Snow, Inc. | OAA-TO-10-00064 | Contract | |
| FHI 360 | OAA-A-10-00060 | Cooperative Agreement | |
| WOMANCARE Global International | OAA-A-13-00088 | Cooperative Agreement | |
| Population Council, Inc. | OAA-A-13-00075 | Cooperative Agreement | |
| Eastern Virginia Medical School | OAA-A-10-00068 | Cooperative Agreement | |
| International Partnership for Microbicides, Inc. | OAA-A-11-00029 | Cooperative Agreement | |
| Eastern Virginia Medical School | OAA-A-11-00064 | Cooperative Agreement | |
| Population Council, Inc. | GPO-A-00-04-00019 | Cooperative Agreement | |
| ENGENDERHEALTH, Inc. | GPO-A-00-08-00007 | Cooperative Agreement | |
| John Snow, Inc. | OAA-TO-11-00012 | Task Order | |
| ABT Associates, Inc. | GHN-I-00-09-00013 | Multi-Award IQC | |
| RTI | GHN-I-00-09-00012 | Multi-Award IQC | |
| ABT Associates, Inc. | OAA-TO-11-00039 | Task Order | |
| Johns Hopkins University | GHS-A-00-09-00014 | Cooperative Agreement | |
| PATH | OAA-A-11-00051 | Cooperative Agreement | |
| United States Pharmacopeia | GHS-A-00-09-00003 | Cooperative Agreement | |
| Management Sciences for Health, Inc. | OAA-A-11-00021 | Cooperative Agreement | |
| **TOTAL:** | | | |

| | | | AWARD DATES | | ALIGNMENT CATEGORIES | FUNDING CATEGORIES |
|---|---|---|---|---|---|---|
| | TOTAL ESTIMATED VALUE | VALUE REMAINING (APRIL 30, 2014) | | | | |
| | | | START | END | | |
| | $500,000,000 | $485,085,000 | 03-17-2014 | 03-16-2019 | S, T, G | FP, NUT, MAL, MCH |
| | $35,000,000 | $12,140,962 | 09-29-2006 | 09-29-2015 | S, T | NUT |
| | $199,524,645 | $168,441,893 | 10-01-2011 | 09-30-2016 | S, T, G | NUT |
| | $203,167,189 | $141,501,619 | 02-08-2012 | 02-07-2017 | S, T, G | NUT |
| | $17,000,000 | $2,100,932 | 09-30-2009 | 09-30-2014 | S, T | MCH |
| | $24,999,917 | $15,467,948 | 10-01-2011 | 09-30-2016 | S, T | MCH |
| | $47,999,457 | $12,466,137 | 09-30-2013 | 09-30-2014 | S, T | TB, MAL, AI, NTD, MCH, FP, NUT |
| | $184,984,030 | $125,937,781 | 09-30-2012 | 09-29-2017 | S, T, G | TB, MAL, AI, NTD, MCH, FP, NUT |
| | | | | | | |
| | $654,915,295 | $197,697,951 | 09-30-1990 | 09-29-2018 | S | FP |
| | $150,000,000 | $3,080,893 | 09-30-2010 | 09-29-2014 | S | FP |
| | $3,098,356 | $1,608,356 | 09-30-2010 | 09-29-2015 | T | FP |
| | $21,275,062 | $20,275,062 | 10-01-2013 | 09-30-2018 | T | FP |
| | $20,454,317 | $17,254,317 | 10-01-2013 | 09-30-2018 | T | FP |
| | $4,999,876 | $1,988,626 | 09-30-2010 | 09-29-2015 | T | FP, HIV |
| | $2,000,000 | $685,000 | 09-30-2011 | 09-29-2016 | T | FP, HIV |
| | $2,000,000 | $678,750 | 09-30-2011 | 09-29-2016 | T | FP |
| | $137,250,000 | $1,915,000 | 07-01-2004 | 06-30-2015 | T | FP |
| | $240,000,000 | $190,333,630 | 09-24-2008 | 09-23-2014 | S, T, G | FP |
| | $976,766,481 | $241,601,326 | 03-28-2011 | 09-30-2015 | S | MAL |
| | $188,869,333 | $1,318,429 | 08-11-2011 | 08-10-2015 | G | MAL |
| | $106,403,641 | $6,649,095 | 09-30-2009 | 09-29-2014 | G | MAL |
| | $188,869,333 | $1,318,429 | 08-11-2011 | 08-10-2015 | G | MAL |
| | $100,000,000 | $69,858,000 | 09-30-2009 | 09-29-2014 | S, T, G | MCH |
| | $24,410,411 | $14,241,661 | 10-01-2011 | 09-30-2016 | S, T | FP, MCH, NUT |
| | $110,000,000 | $62,416,135 | 09-18-2009 | 09-17-2019 | S, T, G | TB, MAL, AI, NTD, MCH, NUT |
| | $197,926,458 | $83,368,915 | 09-23-2011 | 09-22-2016 | S, T, G | TB, MAL, AI, NTD, MCH, FP, NUT |
| | **$8,760,552,969** | **$4,393,830,610** | | | | |

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