PREVENTING CHILD AND MATERNAL DEATHS

2024 ANNUAL REPORT TO CONGRESS

USAID
FROM THE AMERICAN PEOPLE

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A MESSAGE FROM THE BUREAU FOR GLOBAL HEALTH LEADERSHIP

Dr. Atul Gawande, USAID Assistant Administrator
for the Bureau of Global Health

Since its inception, USAID has steadfastly pursued two enduring goals: 1) To narrow the vast disparities in survival rates between the world's wealthiest and poorest populations; 2) To simultaneously safeguard American lives against global health threats. Recognizing maternal and child mortality as a profound societal inequality, the agency embarked on a mission to construct solutions that would later serve as a foundation of our global health programming. In response, the agency confronted prominent drivers of maternal and child mortality such as childbirth complications, malnutrition, vaccine-preventable diseases, and also malaria — a disease that claimed the life of my own grandmother in early age, with my then-eleven-year-old father at her bedside, in a rural village in Maharashtra, India.

This past fiscal year, 2023, marked a reinvigorated commitment to this vision of ending preventable child and maternal deaths, following the crisis of the COVID pandemic. USAID launched its new strategic framework, "Preventing Child and Maternal Deaths: A Framework for Action in a Changing World," as a blueprint for enhancing coverage, quality, and equity of health care globally. Later, at the International Maternal Newborn Health Conference, over 1,700 global stakeholders united to accelerate proven solutions for increasing maternal and newborn survival through the creation and implementation of detailed national action plans. Further, through our strengthened partnership with the Global Financing Facility, hosted at the World Bank, we are advancing innovative financing to propel greater domestic and multilateral investment in maternal and child health services.

This work has played a critical role in the rollout of Primary Impact, USAID's initiative for advancing primary care delivery across the life course, as well. Through strategic country partnerships, USAID is supporting the reorientation of health systems towards primary healthcare and embracing innovative solutions for maternal and child survival. Among the solutions rolling out are game-changing tools and interventions such as the first malaria vaccines in history; E-MOTIVE — a revolutionary bundle of services demonstrated to reduce severe postpartum hemorrhage and adverse maternal health outcomes by 60 percent; and an expansion of m-mama, which connects pregnant women and newborns to emergency transport services.

I am proud to share that in 2023, USAID helped more than 92 million women and children access essential — and often lifesaving — care. This year's report illuminates how the United States' sustained commitment, financial investment, and responsive programming continues to make major strides in advancing maternal and child survival. I am deeply grateful for the unwavering support of Congress and the American people, whose generosity made this accomplishment, and the others detailed in this report, possible.

Looking ahead, I am optimistic that our collective dedication will foster even greater progress, ensuring healthier lives for families and communities worldwide.

92M Women and children accessed essential — and often lifesaving — care with the help of USAID in 2023.

INTRODUCTION

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

In 2014, USAID set forth an ambitious roadmap outlining a collaborative effort with countries, donors, and the private sector to scale up nine cost-effective and evidence-based interventions that could save millions of women's and children's lives, if adopted widely. These included four antenatal care visits; skilled attendant at delivery; health facility delivery; contraceptive prevalence rate; insecticide-treated net ownership; measles-containing vaccine first-dose; oral rehydration solution; households with handwashing stations; and households with improved water sources. Annually, USAID has reported on the progress of increasing the coverage of these interventions.

Since then, USAID's maternal and child survival programs have played a pivotal role in improving health care access and delivery, driving down global mortality rates, and saving millions of lives. Since 2000, we have seen a 55 percent drop in under-five mortality and a 42 percent decline in maternal deaths across USAID's 25 priority countries. USAID's programs have propelled these reductions, saving the lives of more than 7.4 million women and children over the past decade. This success has been made possible through USAID's stewardship, the generosity of the American people, and the bipartisan support of Congress.

Since 2000, remarkable progress on maternal and child survival has been made:

↓ 55%
decrease in under-five child mortality

↓ 42%
drop in maternal mortality across USAID's 25 priority countries

In 2023, USAID renewed our commitment to action on the foundational goal of ending preventable child and maternal deaths. USAID launched *Preventing Child and Maternal Deaths: A Framework for Action in a Changing World* at the beginning of the year. This refreshed direction underscores that achieving our shared global goals are feasible by concentrating on increasing the coverage of high-impact interventions tailored to individual countries, addressing inequities, and strengthening the quality of those health services.

PREVENTING CHILD AND MATERNAL DEATHS:
A Framework for Action in a Changing World, 2023-2030

VISION

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

GOALS

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

OBJECTIVES

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

FOCUS AREAS

1. Strengthen Quality
2. Enhance Equity

STRATEGIC APPROACHES

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

Under this revised framework, USAID is expanding its list of high-impact practices to encompass the 18 interventions outlined below:

- Demand for modern methods of family planning
- Four antenatal care visits
- Neonatal tetanus protection
- Treatment of pregnant women living with HIV with Antiretroviral Therapy (ART)
- Intermittent preventive treatment in pregnancy (IPTp)
- Early initiation of breastfeeding
- Postnatal care for mothers
- Postnatal care for newborns
- Exclusive breastfeeding
- Continue breastfeeding for one year
- Immunization - Pneumococcal Conjugate Vaccine, Third Dose (PCV3)
- Immunization - Rotavirus
- Care seeking for symptoms of Acute Respiratory Infection (ART)
- Insecticide treated net ownership (ITN)
- Diarrhea treatment with Oral Rehydration Solution (ORS)
- Vitamin A supplementation
- Population using at least basic drinking water services
- Population using at least basic sanitation services

In addition to tracking the coverage of these high impact interventions, this report also details on the Agency's support for the numbers of:

- Women giving birth in a health facility
- Newborns with postnatal care within two days after delivery
- Treatments to children for diarrhea and pneumonia
- People who gain access to basic drinking water
- Health workers trained in maternal and child health and nutrition
- Women and couples reached with voluntary family planning
- Pregnant women reached with nutrition programs
- Children reached with nutrition programs
- Preventive malaria treatments for children
- Preventive malaria treatments for pregnant women
- Mosquito nets distributed to protect communities against malaria

The framework further delineates six strategic approaches to guide our program implementation, emphasizing enhanced efforts to reach the most marginalized populations: foster local partnerships; strengthen primary healthcare systems; invest in healthcare workers; encourage commitment and accountability from national governments; and utilize data for informed decision-making.

This year's report encapsulates the impact of USAID's global programming in reducing maternal and child mortality rates, presenting comprehensive data and projections that illuminate progress towards shared targets. Through compelling stories of those touched by our programs, we witness the transformative effect of USAID's efforts firsthand. Additionally, the inclusion of newly published data underscores the significant strides made in maternal and child survival within USAID-supported countries, emphasizing the need for sustained collaboration and innovation to ensure a future where every mother and child not only survives but flourishes.

> We have everything we need to end preventable maternal and child mortality in a generation. We just have to get to work together.
>
> *– USAID Administrator Samantha Power*

The U.S. Government's Commitment to Maternal and Child Survival Advances Foreign Policy

The U.S. government's commitment to maternal and child survival is a significant aspect of its foreign policy for inclusive growth and development.

SAVE LIVES: The driving force of this commitment is the moral imperative to save lives. Preventable child and maternal deaths are often caused by factors such as lack of access to healthcare, malnutrition, inadequate sanitation, and limited education. Addressing these issues aligns with the U.S.'s values of promoting human rights, dignity, and well-being globally.

GLOBAL HEALTH SECURITY: Improving child and maternal health contributes to global health security. Healthy populations are more resilient to diseases and epidemics. By reducing the burden of preventable deaths, the U.S. government aims to enhance the overall health infrastructure and capacity of partner countries, thereby reducing the risk of disease outbreaks that could affect global stability and security.

ECONOMIC DEVELOPMENT: Healthy mothers and children are essential for sustainable economic development. When women and children are healthier, they can participate more fully in the economy, leading to increased productivity and economic growth. Improving health status is a precursor to improving economic status. This, in turn, can foster stability and prosperity in partner countries, which is beneficial for the U.S. and the global community.

DIPLOMATIC RELATIONS: Investing in maternal and child health can strengthen diplomatic relations with partner countries. It demonstrates the U.S.'s commitment to supporting the well-being of populations worldwide, which can enhance trust and cooperation between nations.

> There is no escaping our obligations: our moral obligations as a wise leader and good neighbor in the interdependent community of free nations – our economic obligations as the wealthiest people in a world of largely poor people, as a nation no longer dependent upon the loans from abroad that once helped us develop our own economy – and our political obligations as the single largest counter to the adversaries of freedom.
>
> *– John F. Kennedy, Former President of the United States, 1961*

DELIVERING LIFESAVING RESULTS FOR WOMEN, CHILDREN, AND COMMUNITIES

7.4M Women's and children's lives have been saved with the help of USAID's maternal and child survival programs over the past decade.

SINCE 2012, USAID:

Enabled **67.8M women** to give birth in a health facility, which enhances the likelihood of a safe and healthy delivery for both the mother and baby.

Reached **55.4M newborns** with care after delivery, recognizing that the first hours after birth are the most vulnerable for both mothers and infants.

Trained **14.2M health workers** in maternal and child health and nutrition, which empowers them with expertise to provide timely, skilled, and respectful health care.

Helped **29M people** gain access to basic drinking water, which helps prevent life-threatening waterborne diseases, like diarrhea and cholera.

Provided **139.5M treatments** to children for diarrhea and pneumonia, two of the leading causes of death among children under five years old.

IN 2023 ALONE, USAID:

Provided **24.3M women and couples** with voluntary family planning, which allows couples to plan and space their pregnancies.

Reached **28.2M children** with nutrition programs, which helps young children survive and thrive by supporting their overall health and early development.

Reached **11.4M pregnant women** with nutrition programs, which helps lower the chances of mothers dying and babies being born underweight.

Delivered **15M preventative malaria treatments**, protecting 5 million pregnancies.

Delivered **48M seasonal preventive malaria treatments**, protecting 12 million children.

Delivered **36.8M mosquito nets**, protecting **73.6 million people** against malaria.

STORY OF IMPACT:
PRIMARY HEALTH CARE

Convenient Care: How monthly clinics bring primary health care services closer to communities in Malawi

In the heart of Malawi's Dowa district, Elinat Robert sets out on a Friday morning with her baby, Trecious, to attend the monthly under-five health clinic in her village of Kainja, just a stone's throw away from her home. This clinic, supported by USAID, epitomizes convenience and accessibility, offering essential primary health care services for mothers and young children right in their community.

At the clinic, dedicated health surveillance assistants like John Chipangula are on the front lines, providing critical health services and education to prevent and treat childhood illnesses. John attests to the effectiveness of these clinics, stating, "The clinics are helping a lot. When I talk to the people and they understand and follow what I teach, the results are positive." His words underscore the importance of community engagement and education in driving positive health outcomes.

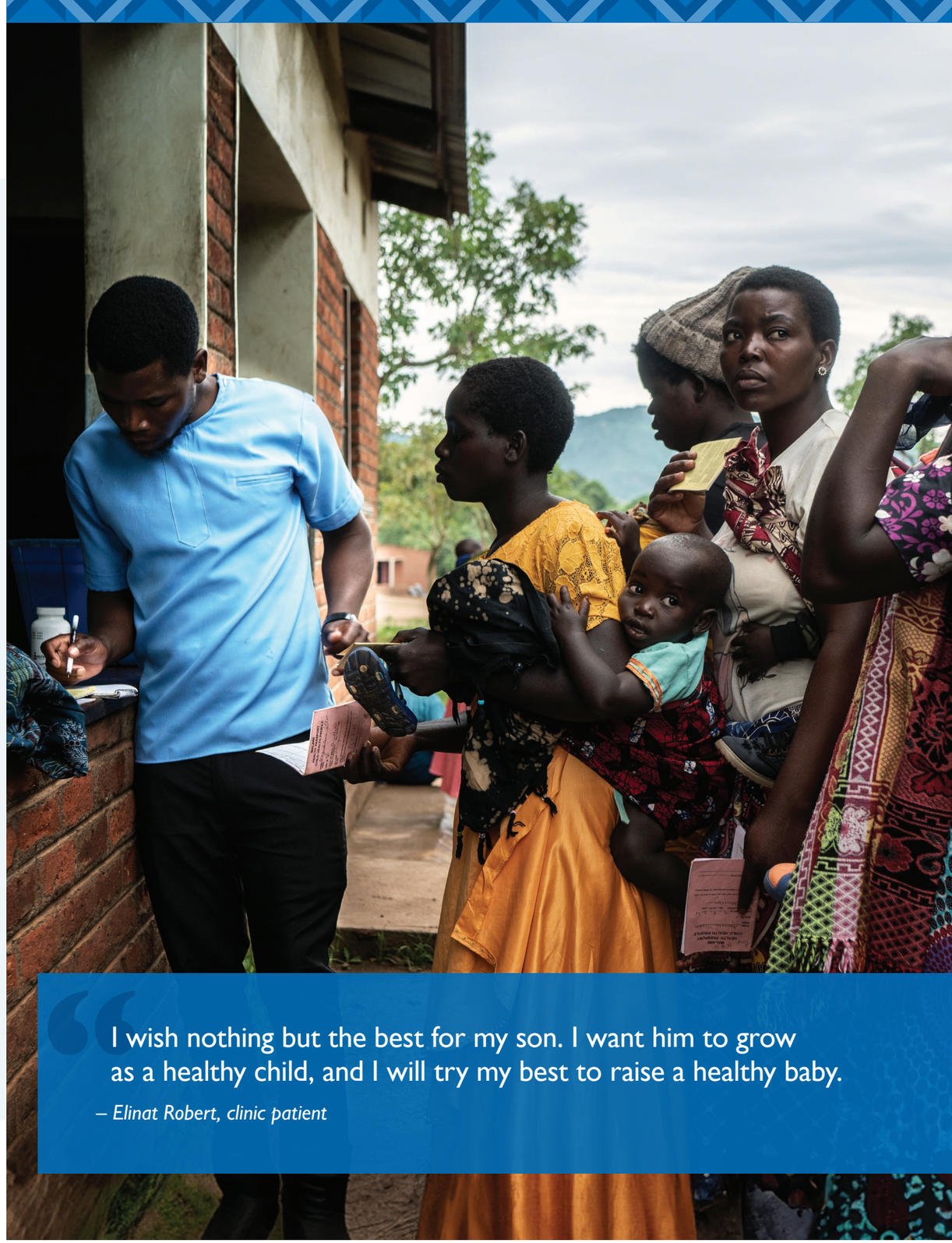
In addition to providing routine childhood vaccinations, the clinic serves as a vital communication channel, disseminating information about disease outbreaks and preventive measures.

At the time, Malawi was facing a widespread cholera outbreak and health officers like John played a crucial role in educating the community about the risks and necessary precautions.

USAID's support extends beyond the clinic walls, encompassing training for health workers, logistical assistance for outreach clinics, and vital supplies to ensure effective service delivery. This investment has yielded remarkable results, contributing to significant reductions in child mortality rates and positioning Malawi on track to achieve the United Nations' (UN) Sustainable Development Goal 3.2. which aims to aims to ensure healthy lives and promote well-being for all at all ages.

As Elinat reflects on her aspirations for Trecious, her words echo the hopes of countless mothers across Malawi: "I wish nothing but the best for my son. I want him to grow as a healthy child, and I will try my best to raise a healthy baby."

Through initiatives like Primary Impact, USAID is helping to turn these aspirations into reality, one community at a time.



> "I wish nothing but the best for my son. I want him to grow as a healthy child, and I will try my best to raise a healthy baby.
>
> *– Elinat Robert, clinic patient*

STORY OF IMPACT:
REACHING THE HARDEST TO REACH

The Delivery Diaries: How m-mama is revolutionizing emergency referrals to lifesaving health care for expectant mothers and their newborns experiencing complications in Tanzania

In Tanzania, the m-mama partnership, supported by the Vodafone Foundation, the Government of Tanzania, and USAID, is rewriting the narrative of maternal and newborn healthcare through its innovative emergency referral system. Miza Juma Juma's story stands as a testament to the lifesaving impact of this initiative. After facing prolonged labor and complications, Miza's journey to safety began with a call to the m-mama hotline, connecting her swiftly to medical care.

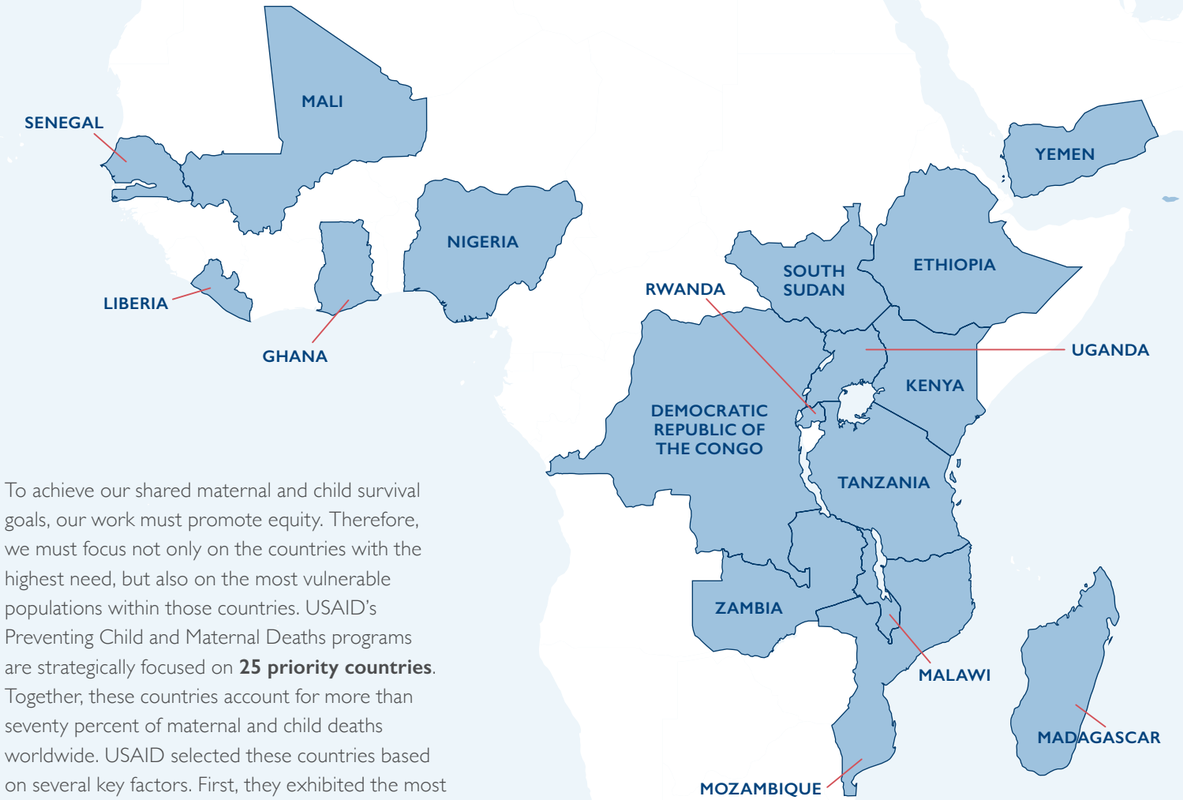
Behind the scenes, nurse dispatcher Fatma and a network of dedicated drivers orchestrated Miza's transport from her rural island home to a referral hospital on the mainland. Community drivers like Haji Ali Haji and Suleiman Juma Khamis ensured Miza's safe passage. Their commitment reflects a shared mission to support mothers and babies in need."We love this job a lot. Saving lives is a big deal!" Fatma said.

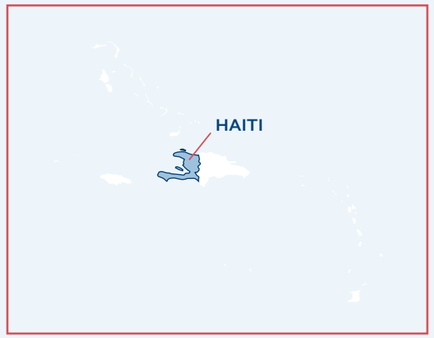
Upon arrival at the referral hospital, Miza found a team prepared to provide the specialized care she required, resulting in the successful delivery of her baby, Umulayman. This outcome is just one of many achieved by m-mama, which has transported over 28,000 women and newborns, significantly reducing maternal and newborn deaths and complications.

The success of m-mama extends beyond individual cases, offering vital insights into emergency maternal healthcare needs. With USAID's support, the Government of Tanzania is expanding m-mama's reach to the entire country, ensuring more mothers and babies across Tanzania and beyond receive the timely care they deserve. What started as a pilot in one region has become a national success story that is now being replicated in other countries.

> We love this job a lot. Saving lives is a big deal!
>
> *– Fatma, m-mama nurse dispatcher*

PARTNERING WITH NATIONAL GOVERNMENTS FOR SUSTAINABLE CHANGE





To achieve our shared maternal and child survival goals, our work must promote equity. Therefore, we must focus not only on the countries with the highest need, but also on the most vulnerable populations within those countries. USAID's Preventing Child and Maternal Deaths programs are strategically focused on **25 priority countries**. Together, these countries account for more than seventy percent of maternal and child deaths worldwide. USAID selected these countries based on several key factors. First, they exhibited the most urgent need. Second, they demonstrated a strong commitment to achieving lasting, efficient program outcomes. Finally, they offered the greatest potential for us to leverage U.S. government programs and platforms effectively.

USAID's maternal and child survival programs directly partnered with **63 LOCAL ORGANIZATIONS** in 2023, exemplifying our steadfast commitment to fostering inclusive, locally-driven development.

INVESTING GLOBAL HEALTH RESOURCES WISELY FOR OPTIMAL OUTCOMES

With the support of Congress and the American people, the U.S. government invested more than $28 billion from 2012 to 2023 in global health programming to prevent child and maternal deaths. These investments signify lives saved, dreams realized, and a brighter future for millions of women and children.

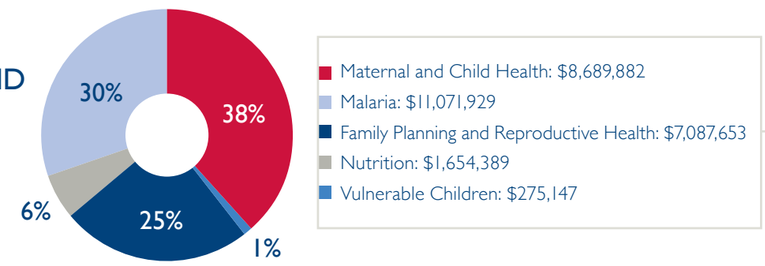
Fig 1: Priority Global Health Investments from 2012-2023

Department of State and USAID Fiscal Year:	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	TOTAL
($ Millions)	8,599	8,420	8,826	9,277	8,841	8,867	8,801	8,939	9,210	9,297	9,955	10,684	109,715
Preventing Child & Maternal Deaths	2,285	2,262	2,398	2,534	2,417	2,372	2,362	2,381	2,430	2,399	2,446	2,493	28,779
Controling the HIV/AIDS Epidemic	5,893	5,773	6,000	6,000	6,000	6,000	6,000	6,050	6,260	6,235	6,280	6,725	73,216
Combating Infectious Diseases	421	385	428	743	424	495	439	508	520	663	1,229	1,465	7,720

OUR INVESTMENTS IN PREVENTING CHILD AND MATERNAL DEATHS

Total Fiscal Year 2012-2023 Budget:

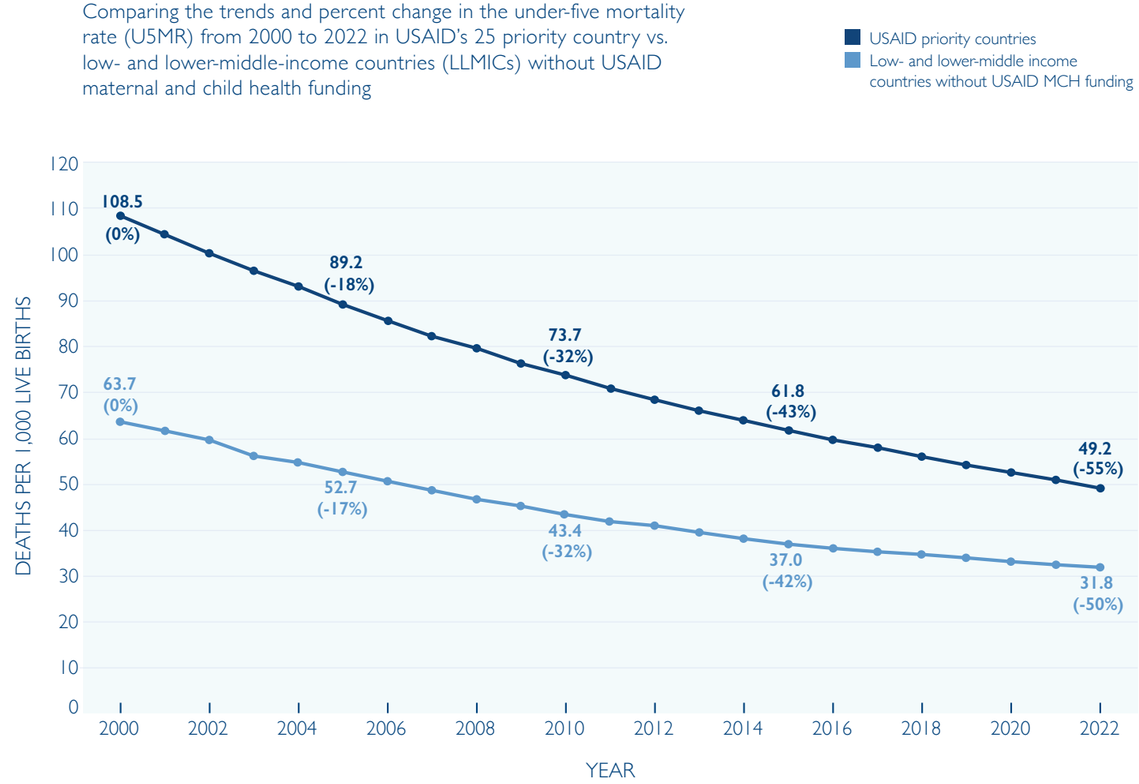
$28,779,000



Recent analyses underscore the considerable progress achieved by USAID's 25 priority countries in consistently enhancing child survival year by year, surpassing outcomes observed in other low- and middle-income countries. These findings suggest a notably greater reduction in mortality rates for both newborns and children under five—and underscore the effectiveness of USAID assistance. Notably, unlike many other low- and middle-income countries, the 25 priority countries on average maintained momentum post-2015, experiencing no significant slowing down in their progress.

Fig 2: USAID Assistance Fuels Greater Mortality Declines in Partner Countries

Comparing the trends and percent change in the under-five mortality rate (U5MR) from 2000 to 2022 in USAID's 25 priority country vs. low- and lower-middle-income countries (LLMICs) without USAID maternal and child health funding



Note: The solid lines show the trend in U5MR mortality estimates for USAID's 25 priority countries and for LLMICs without USAID maternal and child health funding, from 2000 to 2022. For each point estimate, the percent change shown in parentheses is the percent change compared to the year 2000.

Source: UN IGME 2023: United Nations Inter-agency Group for Child Mortality Estimation (UN IGME), 'Levels & Trends in Child Mortality: Report 2023, Estimates Developed by the United Nations Inter-agency Group for Child Mortality Estimation', United Nations Children's Fund, New York, 2024. (Calculations of percent change done by USAID contractors based on data provided by UN IGME).

STORY OF IMPACT:
COMMITMENT AND ACCOUNTABILITY

Hope on the Horizon: USAID's impact in reducing postpartum hemorrhage risk in India

In Bagli Community Health Center in Madhya Pradesh, India, Sanajana Tumria welcomed her newborn son into the world. Thanks to the timely administration of heat-stable carbetocin, a drug to prevent excessive bleeding after childbirth, both mother and baby emerged from childbirth safely.

This newer heat-stable formulation of carbetocin, eliminates the need for refrigeration. This feature is proving to be invaluable, and since it can withstand higher temperatures, it is a strong example of how USAID is adapting its programs to be more climate resilient.

In the words of Dr. Sadhna Varma, the Head of Gynecology for District Hospital Dewas, carbetocin has ushered in a new era of confidence. "Our worries about postpartum hemorrhage have diminished," she asserts. "With carbetocin, we spend less time monitoring and less money on additional drugs."

In Madhya Pradesh, the introduction of heat-stable carbetocin has already yielded remarkable results. Last year, there were no deaths due to postpartum hemorrhage among mothers who received heat-stable carbetocin, compared to several deaths in previous years, prior to the drug's introduction. Encouraged by this success, the Government of Madhya Pradesh is taking proactive steps to institutionalize carbetocin into the state's healthcare budget, ensuring sustained access to this lifesaving medication.

This is why USAID is partnering with the Government of Madya Pradesh to roll heat-stable carbetocin out across all public facilities in the state. This initiative will not only demonstrate the efficacy of heat-stable carbetocin but also lay the groundwork for scaling its use across the country. By helping generate data about what works, USAID is paving the way for a global exploration of the drug's transformative potential in combating postpartum hemorrhage.

> "Our worries about postpartum hemorrhage have diminished. With carbetocin, we spend less time monitoring and less money on additional drugs.
>
> *– Dr. Sardha Varma, Head of Gynecology for District Hospital Dewas*

MEASURING GLOBAL PROGRESS TOWARDS THE SUSTAINABLE DEVELOPMENT GOALS

USAID continues to work hand-in-hand with countries to support achieving the United Nations' Sustainable Development Goals (SDGs), which provide specific and measurable targets for preventing child and maternal deaths. The UN Sustainable Development Goal (SDG) 3 aims to ensure healthy lives and promote well-being for all at all ages. Within this broad goal, two targets prioritize ending preventable child and maternal mortality by 2030, while numerous others are inextricably linked to improving maternal and child survival.

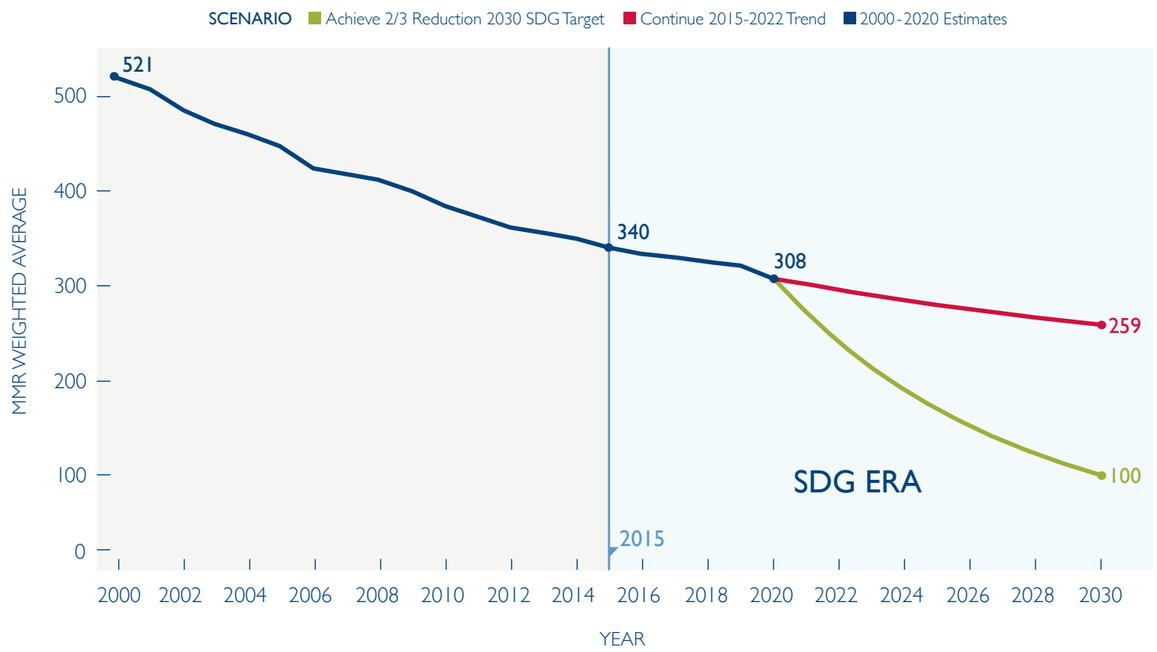
The figures that follow convey a clear message: There has been significant progress in reducing maternal, newborn, and child deaths from 2000 to 2022, but the path forward to 2030 remains uncertain. The historical trend indicates a commendable decrease in mortality rates, reflecting a positive global health outcome. However, looking ahead, if mortality rates continue to decline at the current rates experienced in our priority countries, the reductions would be substantial but insufficient to meet the SDG targets. The green projection lines suggest an alternate, more ambitious path toward the SDG target by 2030, a scenario that requires additional efforts or measures to significantly accelerate the decline in mortality rates beyond the current trend.

TARGET 3.1: REDUCE MATERNAL MORTALITY

By 2030, reduce the global maternal mortality ratio to less than 70 deaths per 100,000 live births. In addition, no country should have a maternal mortality ratio greater than 140 per 100,000 live births.

Fig 3: BENDING THE CURVE: Progress and Projections in Maternal Survival

Maternal mortality ratio trends and projections, 2000 to 2030



Note: The global SDG target for maternal mortality reflects a two-thirds decrease in mortality from the global average in 2010. The average maternal mortality ratio (MMR) in USAID priority countries in 2010 was higher than the global average. Accordingly, the green line on this graph illustrates a two-thirds reduction in maternal mortality among these countries. The end point is higher than the global SDG target of 70 because of the higher MMR average among these countries in 2010.

Source: Trends in maternal mortality 2000 to 2020: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division. Geneva: World Health Organization; 2023. Licence: CC BY-NC-SA 3.0 IGO.

TARGET 3.2: REDUCE NEWBORN AND CHILD MORTALITY

By 2030, end preventable deaths of newborns and children under five years of age, with all countries aiming to reduce newborn mortality to at least as low as 12 per 1,000 live births and under-five mortality to at least as low as 25 per 1,000 live births.

Fig 4: BENDING THE CURVE: Progress and Projections in Child Survival

Under-five mortality rate (U5MR) trends and projections, 2000 to 2030

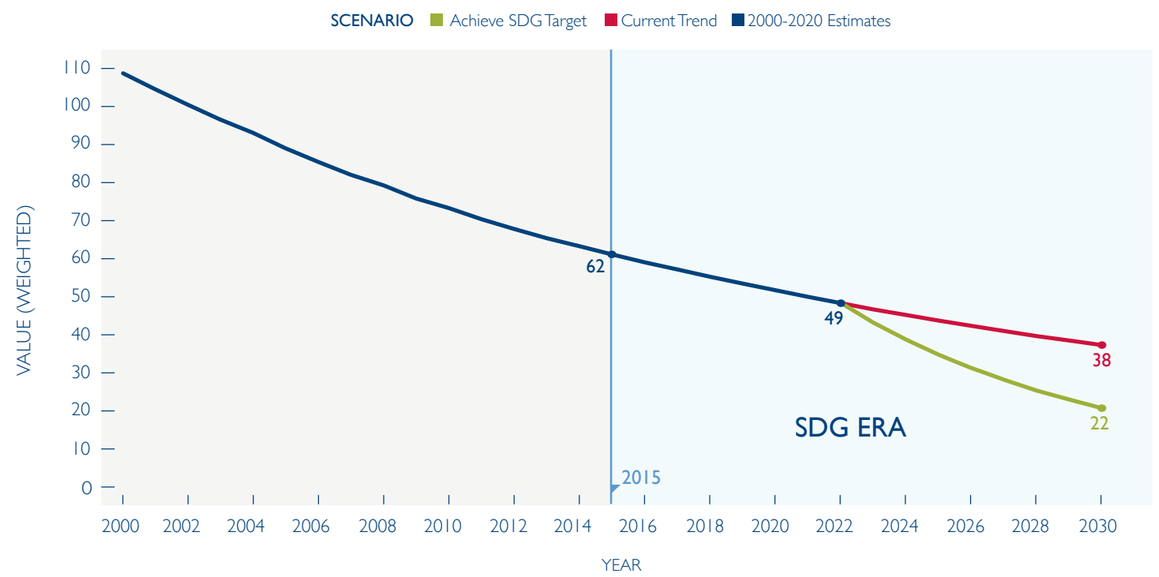
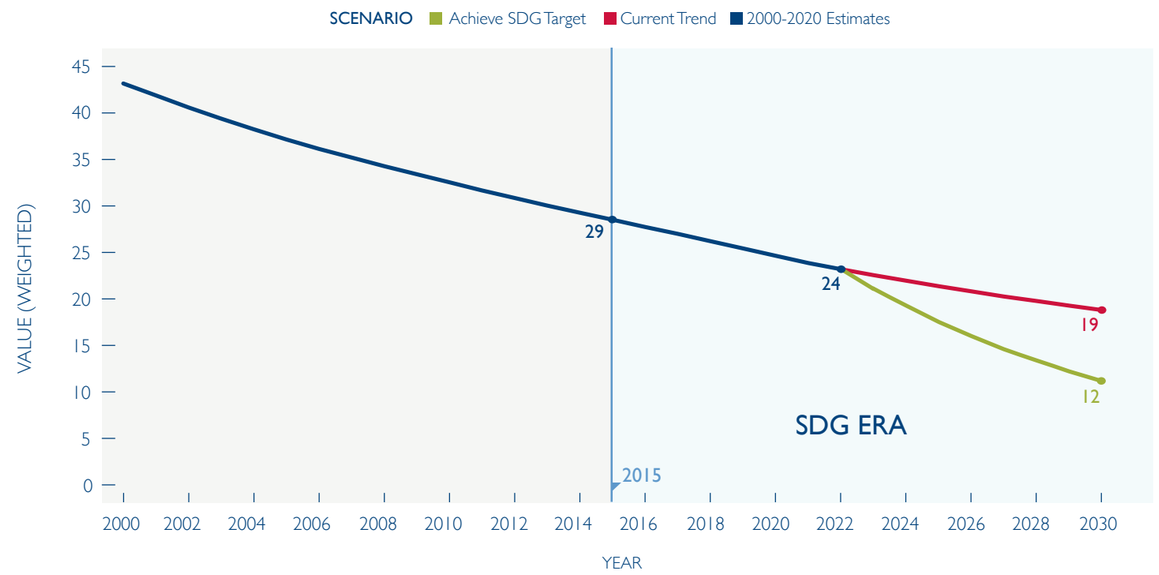


Fig 5: BENDING THE CURVE: Progress and Projections in Newborn Survival

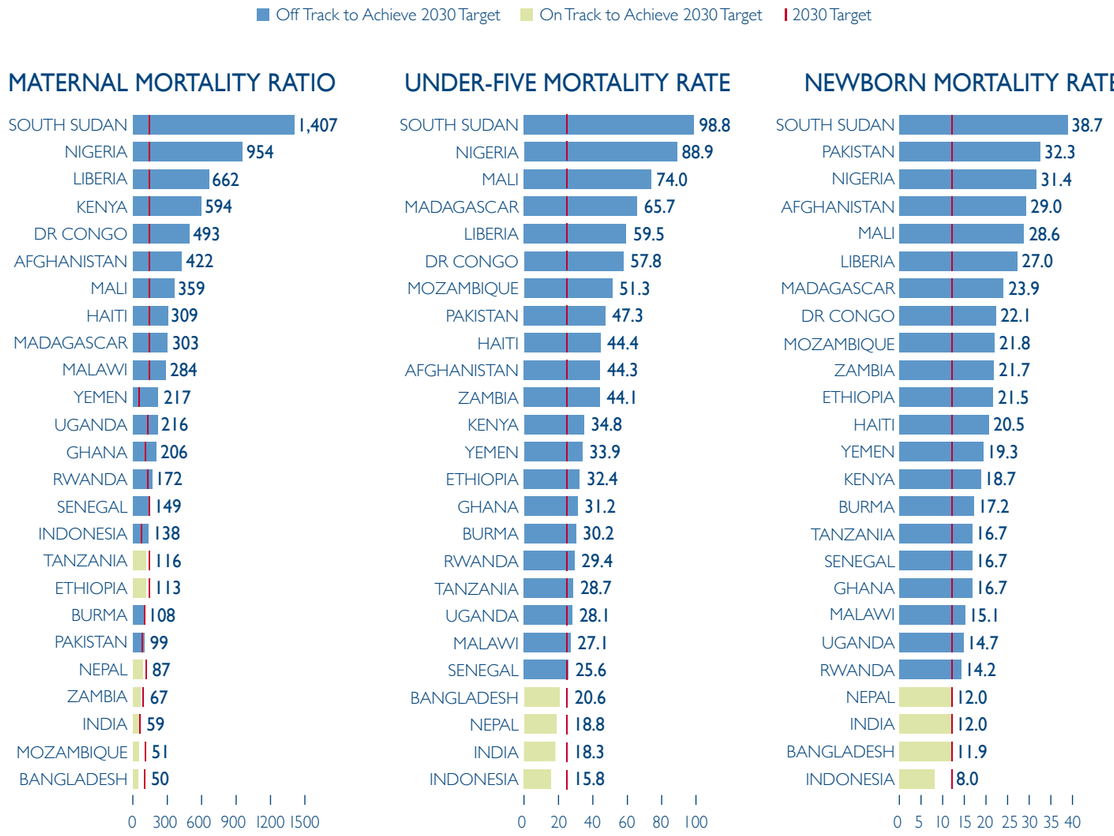
Newborn mortality rate (NMR) trends and projections, 2000 to 2030



Source: UN IGME 2023: United Nations Inter-agency Group for Child Mortality Estimation (UN IGME), 'Levels & Trends in Child Mortality: Report 2023, Estimates Developed by the United Nations Inter-agency Group for Child Mortality Estimation', United Nations Children's Fund, New York, 2024.

Fig 6: **BENDING THE CURVE: Country By Country Progress and Projections**

Projections of mortality levels in 2030 based on current trends and expected SDG target achievement



Note: The SDG target for maternal mortality is unique for each country. The SDG target for the under-five mortality rate is 25 deaths or lower in 2030; the target for the newborn mortality rate is 12 deaths or lower by 2030.

Source: U5MR and NMR: UN IGME 2023: United Nations Inter-agency Group for Child Mortality Estimation (UN IGME), 'Levels & Trends in Child Mortality: Report 2023, Estimates Developed by the United Nations Inter-agency Group for Child Mortality Estimation', United Nations Children's Fund, New York, 2024.

MMR: Trends in maternal mortality 2000 to 2020: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division. Geneva: World Health Organization; 2023. Licence: CC BY-NC-SA 3.0 IGO.

STORY OF IMPACT:
LOCALIZATION

Seeds of Change: Women leading the fight against malnutrition in Democratic Republic of the Congo

In South Kivu, Democratic Republic of the Congo, amidst the challenges of conflict and constant upheaval, women of the Kasihe community are leading a transformative effort to combat malnutrition. With support from USAID, these women have formed a "groupe de soutien," a women's support group dedicated to mentoring and educating their neighbors on good nutrition.

Led by individuals like Winnie Mwachibiri, formerly a health worker, the group conducts a monthly training on nutrition, which includes discussion on the importance of breastfeeding and appropriate complementary feeding for young children. During the training, Winnie emphasizes the critical role of nutrition in overall health, advocating for exclusive breastfeeding and appropriate complementary feeding for young children. The group's efforts also extend beyond education. They empower the community to integrate locally-available nutritious foods into their diets including providing access to wholesome food through participation in community gardens.

Community member Claudine Mulonda attended her first meeting, and her favorite part was learning how to cook with local crops, "I'm so happy because this is the first time I've come to the training...It gave me ideas to improve the food at home." Nsimire, another beneficiary, envisions a future where every household maintains a garden — a sustainable solution to combat malnutrition. "With this food, we can fight malnutrition, and we want to expand this program so every person has a garden. Our dream is that each person in her community has a garden behind her house."

Through initiatives like these, USAID is empowering women like Winnie and Claudine with better knowledge and access to nutritious food for themselves and their families, paving the way for healthier and resilient communities in Democratic Republic of the Congo and beyond.

> "With this food, we can fight malnutrition, and we want to expand this program so every person has a garden. Our dream is that each person in her community has a garden behind her house.
>
> *– Nsimire, program participant*

STORY OF IMPACT:
DATA FOR DECISION-MAKING

Checklist Champion: Samaou Abdourhamane's dedication to data-driven care during childbirth in Mali

In Mali's Gao region, Samaou Abdourhamane, an obstetric nurse at the Forgho Community Health Center, embodies the transformative power of data-driven healthcare.

At the heart of this transformation lies the World Health Organization's Safe Childbirth Checklist, a tool designed to ensure adherence to clinical best practices during care around the time of birth. It effectively targets major causes of maternal mortality, such as hemorrhage, infection, obstructed labor, and inadequate delivery care, while also addressing neonatal deaths resulting from asphyxia, infection, and complications associated with premature birth.

While Samaou had prior familiarity with the checklist, it was the comprehensive training and practical mentoring sessions supported by USAID that equipped her with the skills and confidence to implement it effectively.

From December 2022 to February 2023, Samaou diligently applied the checklist during 60 deliveries at the Forgho Community Health Center's maternity ward. Through meticulous monitoring and early risk detection, she intervened in 10 cases, safeguarding the health of both mothers and newborns.

Beyond clinical excellence, this tool fostered a culture of communication and collaboration, strengthening Samaou's relationship with patients and their families. "The most important positive change that the checklist has made in my daily practice," Samaou reflects, "includes the tracking of inventory and the availability of essential drugs that can be used in urgent situations during or just after childbirth."

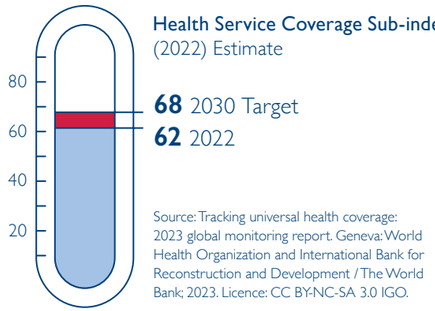
Reflecting on her journey, Samaou advocates for the widespread adoption of the checklist across all healthcare facilities in Mali, a region grappling with high maternal and newborn mortality rates. In a landscape shaped by adversity, Samaou's dedication to data-driven care offers a glimpse of a brighter future for generations to come. "At each delivery, the checklist is like a 'life jacket' for women in labor and their newborns," Samaou emphasizes, echoing her message to fellow healthcare providers. "It's something that helps keep them safe in difficult situations."

> At each delivery, the checklist is like a 'life jacket' for women in labor and their newborns. It's something that helps keep them safe in difficult situations.
>
> *– Samaou Abdourhamane, obstetric nurse*

IMPROVING THE COVERAGE, EQUITY, AND QUALITY OF HEALTH SERVICES FOR WOMEN AND CHILDREN

Fig 7: Increasing Coverage Levels of Lifesaving Interventions

WHO's Universal Health Coverage (UHC) service coverage sub-index on reproductive, maternal, newborn and child health

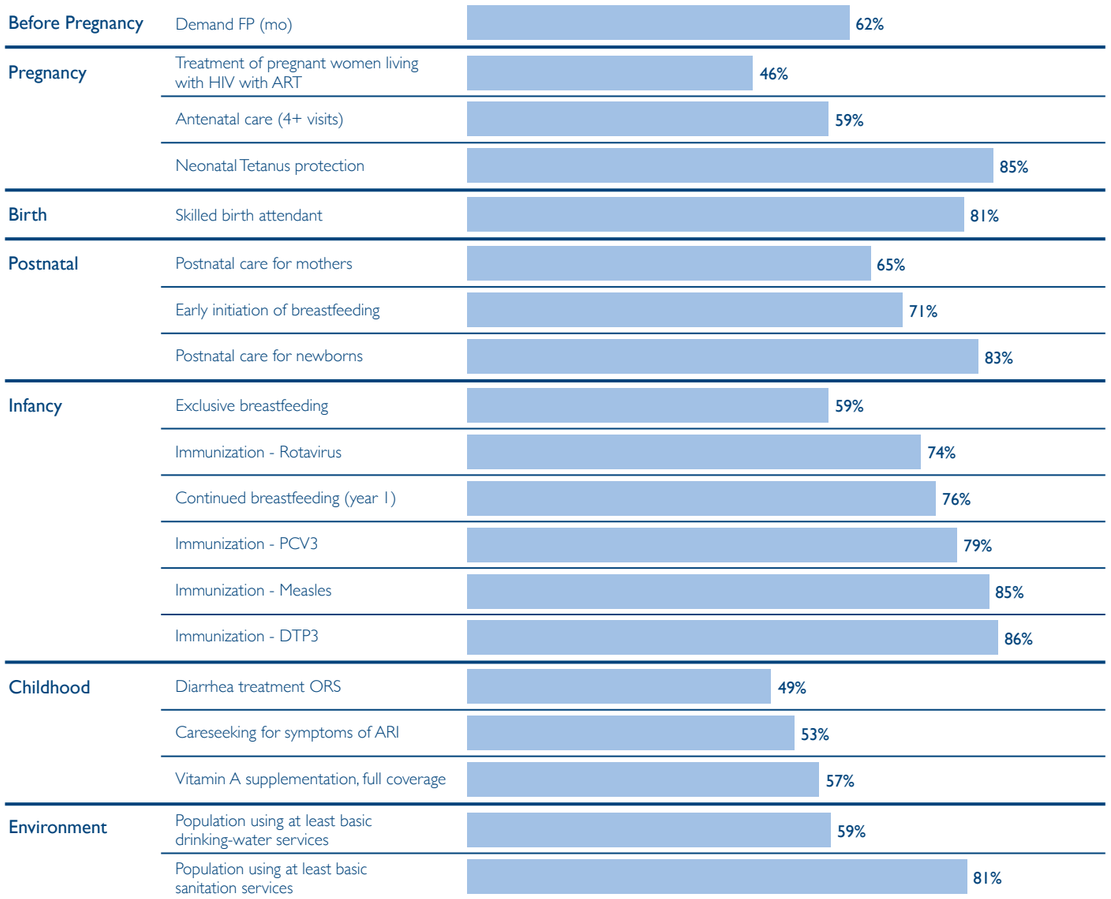


Source: Tracking universal health coverage: 2023 global monitoring report. Geneva: World Health Organization and International Bank for Reconstruction and Development / The World Bank; 2023. Licence: CC BY-NC-SA 3.0 IGO.

The Universal Health Coverage Service Coverage sub-index on reproductive, maternal, and child health captures priority interventions proven to reduce mortality among mothers, newborns, and children. Interventions included in the sub-index are considered feasible for universal implementation in low-income countries. USAID is working with our partners to reach an average measure of 68 on the sub-index across our priority countries by 2030. The estimates included in Figure 8 illustrate that countries are beginning to recover from the impact that the COVID-19 pandemic had on health services, and reaching an average measure of 68 by 2030 is a goal within reach.

Fig 8: COVERAGE: Expanding Coverage of Lifesaving Interventions is Essential to Save More Lives

Percent of those in need receiving key interventions, 2023 Estimates



Note: Published data for indicators taken from 2000-2023. Missing values are linearly interpolated and extrapolated. For the PCMD aggregate, yearly values are weighted by country using live births. Only countries for which there is data are included (by indicator). Malaria indicators of intermittent preventive treatment in pregnancy (IPTp) and insecticide treated net ownership are reported annually through the U.S. President's Malaria Initiative (PMI). These data are available in Annex 3.

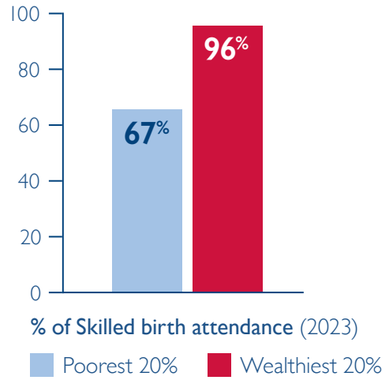
Source: Demographic and Health Survey (DHS), Multiple Indicator Cluster Survey (MICS), and/or HIV/AIDS and Malaria Indicator Surveys, with the exception of measles immunization coverage (source: WHO UNICEF Estimates of Vaccine Coverage: 1997-2022; <https://data.unicef.org/topic/child-health/immunization/>).

Coverage of the health care interventions that can save lives varies dramatically across key interventions. While some interventions, such as immunization with DTP3 at age one year or neonatal tetanus protection, approach universal coverage, other interventions are reaching less than half of the population in need across priority countries. An increased focus on expanding low-coverage interventions can boost survival and accelerate progress toward the 2030 SDGs.

Fig 9: EQUITY: Reducing Inequity in Healthcare Can Help Reach More Women and Children

Skilled birth attendance in the poorest 20% and wealthiest 20%, 2023 estimates

Many communities across our priority countries do not have equitable access to health services, as illustrated by the income disparity in skilled attendance at birth. Beyond income inequality, social determinants including residence, ethnic or religious group, age, or disability can also lead to inequities in use of health services and health outcomes. To increase child and maternal survival, there must be a concerted focus on interventions and strategies that reach poor, marginalized, or vulnerable women and children.



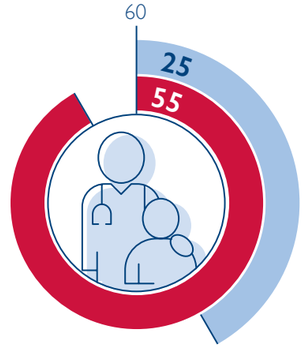
Note: Published data for indicators taken from 2000-2023. Missing values are linearly interpolated and extrapolated. For the PCMD aggregate, yearly values are weighted by country using live births. Only countries for which there is data are included.

Source: Delivering for Women: Improving maternal health services to save lives. United Nations Children's Fund. New York: UNICEF; 2022. <https://data.unicef.org/wp-content/uploads/2022/05/Delivering-for-women_brochure_8-May-2022.pdf>

Fig 10: QUALITY: Increasing the Number of Trained Healthcare Workers can Improve the Quality of Healthcare Services

Skilled health workers per 10,000 people, latest published values

Across priority countries, the average number of health workers falls well below the global median of 54 health workers per 10,000 people. This shortage of health workers limits countries in reaching their populations with essential health services. Sustained improvements in maternal and child survival require increasing the quantity and equitable distribution of health workers with the critical skills needed to provide quality, respectful care.



Note: Density of skilled health workers created by combining latest published country values for density of medical doctors, and nursing and midwifery personnel per 10,000 population. The global median is the median for all countries. For the PCMD aggregate, values are weighted by country using population. Only countries for which there is data are included.

Source: The National Health Workforce Accounts database, World Health Organization, Geneva <https://apps.who.int/nhwaportal, https://www.who.int/activities/improving-health-workforce-data-and-evidence>

COMMUNITY TO CAPITOL:
USAID Works at Every Level to Improve Health Outcomes

In the Community with local partners and community health workers:
USAID programs educate community members on healthy behaviors, such as attending antenatal care visits; delivering at health facilities; proper nutrition; handwashing; and latrine use. Community health workers are trained to diagnose and treat common childhood illnesses and deliver routine immunizations, particularly for those hard-to-reach communities.

In **PAKISTAN**, to improve access to quality healthcare in rural areas, USAID provided four mobile laboratories stocked with state-of-the-art equipment and testing machines to improve diagnosis quality and turnaround time. These mobile labs, operational in remote settings and flood-affected border areas, directly contribute to maternal and child survival efforts by ensuring timely and accurate medical care, even in challenging environments.

At the Primary Health Center with trained health care providers:
USAID invests in training health workers, including doctors, nurses, midwives, and community health workers, to improve their skills in providing essential maternal child health and nutrition services within primary care settings. These USAID-supported primary health centers help eliminate health disparities and refer women and children to more specialized care when needed.

In **INDIA**, through collaborative efforts with government partners, USAID has facilitated the transformation of 32,505 health facilities into primary healthcare centers (commonly referred to as Ayushman Bharat-HWCs) spanning 12 states. This initiative has significantly broadened healthcare accessibility for more than 143 million individuals, particularly women, children, and newborns, residing in remote regions of the country.

At the Health Facility in hospitals equipped with specialized health care providers, essential commodities, and supplies:
USAID trains health providers to follow clinical standards, ensure safe and hygienic facilities, and deliver care that is high-quality and respectful. Our programs enable women and children to access specialized care at health facilities, such as managing high-risk pregnancies and births, care and feeding for small and sick newborns, and treatment for malnutrition or severe illness.

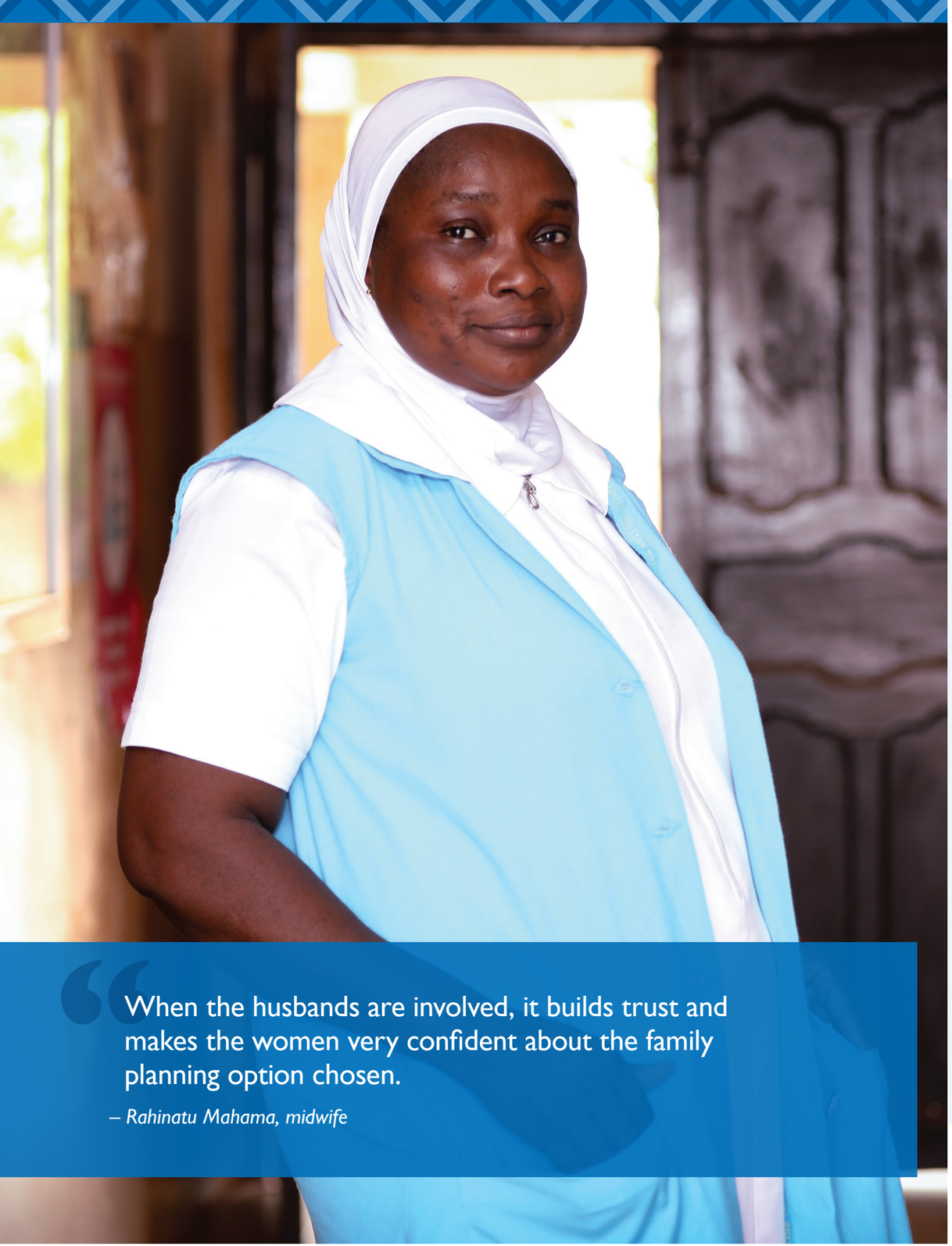
In **RWANDA**, the government established its Food and Drugs Authority (FDA) with a regulatory mandate in 2018. USAID has since supported the FDA to develop a business plan that will strengthen its financial management, enhance accountability, and eventually reduce its dependency on government and donor funding. This plan has been adopted as part of the FDA's strategy to grow into a stable, world-class regulatory authority. By ensuring the availability of safe and quality essential medicines used in childbirth and to treat common childhood illnesses, the FDA supports efforts to enhance maternal and child health across Rwanda.

At the National level with country governments and private sector partners:
USAID supports government and country partners to increase national budget lines for maternal and child health and nutrition services, and make investments that grow the health workforce, strengthen health systems, and achieve country development goals. Through government and private sector partnerships, USAID strengthens country expertise in managing supply chains for essential commodities and national data and health information systems.

In **HAITI**, USAID's collaboration with the Ministry of Public Health includes mapping community health workers, providing essential data to identify gaps in health coverage. This targeted approach supports maternal and child survival efforts by enabling stakeholders to direct interventions to the communities most in need.

Globally, in collaboration with global leaders and health experts:
USAID advocates for policies and country investments that reflect best practices in maternal, newborn, child, and primary health care. Our scientific research and expertise shape global clinical guidelines. Additionally, our programs expand access to new and underutilized vaccines, like the cancer-preventing HPV vaccine and groundbreaking malaria vaccines, in partnership with Gavi, the Vaccine Alliance.

Through **USAID'S PRIMARY IMPACT INITIATIVE**, we are advancing primary health care models that deliver integrated and coordinated, people-centered care and championing their uptake with our global partners. This approach prioritizes building health awareness through disease prevention, diagnosis, and treatment; and advocates for delivering care in community settings. With integrated primary health care services, every health care touchpoint is an opportunity to identify and deliver care that promotes good health for women, children, and families, at every stage in life.



> When the husbands are involved, it builds trust and makes the women very confident about the family planning option chosen.
>
> *– Rahinatu Mahama, midwife*

STORY OF IMPACT: HEALTH WORKERS

A Midwife's Mission: A story of dedication to improving postpartum family planning in Kanvilli, Ghana

Nestled on the outskirts of Tamale, the northern regional capital of Ghana, lies a small community called Kanvilli. This vibrant community relies on the Kanvilli Health Center for its primary healthcare needs. With its yellow walls, the center may seem simple, but its role in the community is vital.

For over nine years, Rahinatu Mahama has been a beacon of care as a midwife at the Kanvilli Health Center. Her gentle demeanor and expert knowledge have earned her the respect and admiration of everyone in the community. Rahinatu not only delivers babies but also advocates for postpartum family planning, addressing misconceptions and promoting informed choices.

Rahinatu took part in refresher training programs supported by USAID, aimed at improving reproductive health services. Through these programs, she gained confidence in counseling families on various family planning methods, dispelling myths and addressing concerns.

Recognizing the importance of involving husbands in family planning decisions, Rahinatu developed strategies to engage them during counseling sessions. This approach has led to increased trust, confidence, and acceptance of family planning services among families in Kanvilli. As a result, there has been a notable rise in the number of families seeking family planning services at the health facility. "When the husbands are involved, it builds trust and makes the women very confident about the family planning option chosen," says Rahinatu.

Rahinatu's dedication and innovation have not gone unnoticed. She was honored as the Best Nurse/Midwife in her district during the 2022 Ghana Registered Nurses and Midwives Association awards. Her story exemplifies the impact of the capacity building initiatives that USAID supports, which empower healthcare providers like Rahinatu to deliver quality care and drive positive change in their communities.

SPOTLIGHTING CHILD MORTALITY TRENDS AND CAUSES

Recently published global estimates of child mortality underscore a critical reality: Improving child survival is possible because the leading causes of deaths among newborns and young children are largely attributable to preventable causes. We already have effective solutions with the power to save more lives — the challenge we face is reaching all children with high-quality health services to deliver those solutions.

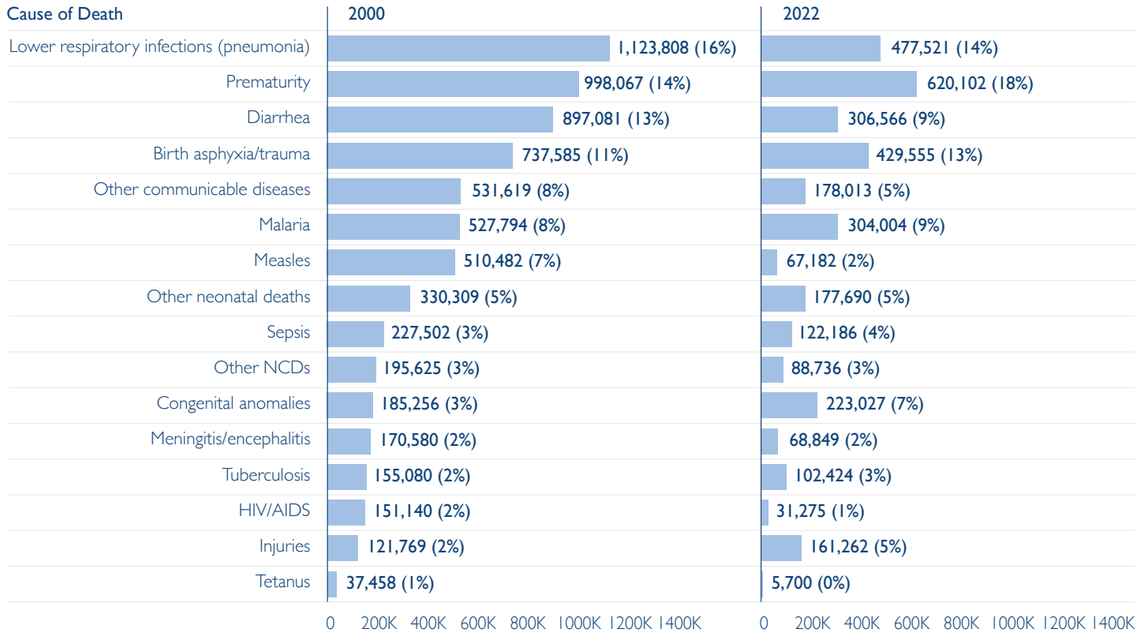
Since 2000, child mortality has fallen by 55 percent in USAID's priority countries for preventing child and maternal deaths. During this time period, the causes of child mortality have also undergone a meaningful shift. Figure 11 compares the number and percent of deaths among children under five by various causes for the years 2000 and 2022 in USAID priority countries.

There is a notable decrease in the proportion of deaths from preventable causes such as pneumonia, diarrhea, measles, and other communicable diseases, suggesting a shift from infectious diseases to other conditions over the time span. At the same time, although the numbers of deaths have declined, the proportions of deaths due to causes such as prematurity and birth asphyxia/trauma have increased, suggesting a need for greater attention on preventable causes of death in the antenatal and newborn period.

Overall, these data illustrate a clear trend of decreasing deaths in most categories while providing insight as to how to direct programs and health services toward the preventable causes of death that continue to affect families in our priority countries.

Fig 11: **As Child Mortality Has Declined, Causes of Death Have Also Shifted**

Comparing the causes of under-five mortality, 2000 vs 2022



Note: Preliminary estimates from UN IGME by applying cause fractions from the Child and Adolescent Causes of Death Estimation project (2023) for 2000–2021 to UN IGME estimates for the years 2000–2022.

Source: Demographic and Health Survey (DHS), Multiple Indicator Cluster Survey (MICS), and/or HIV/AIDS and Malaria Indicator Surveys, with the exception of measles immunization coverage (source: WHO UNICEF Estimates of Vaccine Coverage: 1997-2022; <https://data.unicef.org/topic/child-health/immunization/>).

USAID is one of the largest and earliest investors in Gavi, the Vaccine Alliance, helping immunize over **1 BILLION CHILDREN** with lifesaving vaccines.

STORY OF IMPACT:
HEALTH WORKERS

Community Lifelines: How health workers help young children survive deadly illnesses like malaria and diarrhea in Mali

In Mali, community health workers like Founèba Traoré are the frontline heroes in the battle against deadly childhood illnesses like malaria and diarrhea. Setou's son, Fousseiny, fell ill with a fever, sparking fears of malaria, a prevalent threat in their community. Rushing to Founèba's doorstep, Setou found comfort in her immediate and expert care. Founèba's quick diagnosis ruled out malaria but identified a potentially dangerous case of diarrhea, swiftly providing hydration tablets and guidance for Fousseiny's recovery.

Founèba's impact extends beyond individual cases; she represents a lifeline for countless sick children in Mali. Before her presence in Wouloufiena, families faced daunting journeys to distant health facilities, especially at night when care was scarce. Now, with community health workers like Founèba, timely and more affordable care is within reach. "What I do is important for my community," Founèba said. "When they fall sick, they receive treatment quickly and easily at a lower cost since they don't have to travel to a health clinic."

Behind Founèba's tireless efforts lies the support of initiatives like the U.S. President's Malaria Initiative (PMI), which empowers thousands of community health workers across Mali. Through training, supervision, and the provision of supplies, PMI supports frontline healthcare for the most vulnerable, resulting in a significant reduction in child mortality rates.

Founèba's dedication doesn't stop at treatment; she educates her community on preventive measures, emphasizing early healthcare seeking behavior and the proper use of malaria prevention tools like mosquito nets.

Founèba and her colleagues embody resilience and hope in the face of adversity, forging a path towards a brighter tomorrow for Mali's children. Through their unwavering dedication, they exemplify the transformative impact of primary and community health care initiatives.

> What I do is important for my community. When they fall sick, they receive treatment quickly and easily at a lower cost since they don't have to travel to a health clinic.
>
> *– Founèba Traoré, community health worker*

LOOKING AHEAD

USAID remains steadfast in its commitment to fostering a future where every mother and child not only survives but thrives. Building upon the foundation of past successes, we are poised to continue our journey with our partners towards achieving our shared global goals.

By focusing on increasing the coverage, quality, and equity of health care services, we aim to further accelerate progress in maternal and child health. With commitment, collaboration, and innovation, we can shape a world where maternal and child survival isn't just a goal but a reality for generations to come.

ANNEX I ESTIMATION OF FUNDS AND RESULTS FOR HIGH-IMPACT INTERVENTIONS

The FY 2023 Congressional appropriation guidance directs the Administrator of USAID to include in annual maternal and child health reporting the amount spent each year on highest-impact, evidence-based child health interventions in bilateral global health programs, disaggregated by intervention, and outcomes achieved as a result of United States assistance.

Table 1 provides the FY 2022 budget across these budget categories as a proxy for expenditures in FY 2023 across all countries. The budget categories included in the report align with the requested details on interventions related to childhood pneumonia, malaria, diarrheal dehydration, severe acute malnutrition, immunizations and azithromycin, and neonatal sepsis. Of note, treatment of childhood illness includes both childhood pneumonia and diarrheal dehydration. Newborn care is inclusive of USAID's efforts to address neonatal sepsis. It does not include provision of azithromycin because azithromycin is not currently recommended by the World Health Organization (WHO) as a first line treatment for newborn sepsis both due to its cost and potential for contributing to antimicrobial resistance.

Table 1. FY 2022 Budget by Funding Category

FUNDING CATEGORY	FY 2022 BUDGET (000s)
Treatment of childhood illness*	$53,398
Malaria treatment**	$40,551
Newborn care and treatment*	$62,865
Immunizations (non-polio)***	$332,330
Nutrition interventions for children under five years of age******	$86,399

* USAID MCH funding supports a range of life saving interventions to treat childhood illnesses and address the major causes of newborn death. The data shown here are not an exhaustive list of interventions supported or results achieved with these categories of funding.

** Planned funding for malaria treatments is drawn from the U.S. President's Malaria Initiative's FY 2022 Malaria Operational Plans.

*** The budget for immunizations (non-polio) includes a significant U.S. government contribution to GAVI which is not reflected in the results achieved for immunizations.

**** The nutrition funding category encompasses many high-impact interventions. Nutrition funding is programmed using an integrated approach and funding is not tracked by intervention. The vast majority of USAID's support for severe acute malnutrition treatment is delivered through emergency programs as reflected in the annual report under the Global Malnutrition Prevention and Treatment Act, and results from emergency programs are not reflected in this table.

Table 2 provides a summary of FY 2023 achievements, mapped to each of these funding categories.

Table 2. Results For Select High-Impact Interventions to Prevent Child And Maternal Deaths by Funding Category

FUNDING CATEGORY	Standard reported high-impact interventions included in the funding category	FY 2023 RESULTS
Treatment of childhood illness*	Number of cases of child diarrhea treated in U.S. government-assisted programs	6,749,988
	Number of cases of childhood pneumonia treated in U.S. government-assisted programs	5,568,677
Malaria treatment**	Malaria treatments delivered by the U.S. government	63,333,806
Newborn care and treatment*	Number of newborns who received postnatal care within two days of childbirth in U.S. government-supported programs	11,324,454
Immunizations (non-polio)***	Number of children who received their first dose of measles-containing vaccine (MCV1) by 12 months of age in U.S. government-assisted programs	8,577,134
Nutrition interventions for children under five years of age******	Number of children reached with nutrition-specific interventions	28,223,683
	Number of children receiving treatment for severe acute malnutrition**	348,147

* USAID MCH funding supports a range of life saving interventions to treat childhood illnesses and address the major causes of newborn death. The data shown here are not an exhaustive list of interventions supported or results achieved with these categories of funding.

** Planned funding for malaria treatments is drawn from the U.S. President's Malaria Initiative's FY 2022 Malaria Operational Plans.

*** The budget for immunizations (non-polio) includes a significant U.S. government contribution to GAVI which is not reflected in the results achieved for immunizations.

**** The nutrition funding category encompasses many high-impact interventions. Nutrition funding is programmed using an integrated approach and funding is not tracked by intervention. The vast majority of USAID's support for severe acute malnutrition treatment is delivered through emergency programs as reflected in the annual report under the Global Malnutrition Prevention and Treatment Act, and results from emergency programs are not reflected in this table.

USAID investments reflect both direct and indirect support to improving maternal, newborn, and child health. USAID resources are used to improve the provision of healthcare, to develop and diffuse innovations, to update policies and protocols to reflect advancements in health sciences, and to ensure households and communities have access to quality primary and secondary healthcare. Of note, directly correlating investments with numbers of interventions implemented can be challenging for a number of reasons. First, USAID indicator reporting reflects results achieved during each fiscal year. Because investments may be implemented and generate results across multiple years, it is hard to connect one year of results to a corresponding fiscal year of investments. For example, results reported during FY 2023 may have been achieved with FY 2020, FY 2021, and/or FY 2022 investments. Second, within each funding category, USAID only tracks results for a select number of interventions, which do not provide a comprehensive accounting of the activities implemented or results achieved with that funding. Funding that supports activities beyond the measured indicators and the indicators tracked do not represent the full breadth of activities that are funded. As an example, USAID investment supports both the prevention (e.g., clean cord care and chlorhexidine cord care) and treatment of newborn complications per WHO guidelines. However, postnatal care and newborn resuscitation are the high-impact interventions reported on.

Despite these limitations, USAID continues to work to improve the effectiveness and visibility of our programs through improving our data about the reach of high-impact interventions we support, improving our decisions based on data, and improving our reporting to the American people.

ANNEX 2 PERFORMANCE PLAN AND REPORTING FOR KEY MATERNAL AND CHILD HEALTH INTERVENTIONS

The data included in this Annex reflect results voluntarily reported by USAID country programs receiving maternal and child health (MCH) funding for fiscal year 2023. Not every country reported on every result indicator included here.

Table 1. Estimated Potential Beneficiary Population for Maternal, Newborn, and Child Survival Program: Number of Live Births

PRIORITY COUNTRIES	
BANGLADESH	618,886
DEMOCRATIC REPUBLIC OF THE CONGO	1,663,486
INDIA	56,29,177
INDONESIA	622,787
KENYA	256,981
LIBERIA	90,428
MADAGASCAR	724,026
MALAWI	2,462,208
MALI	292,130
MOZAMBIQUE	293,163
NEPAL	183,277
NIGERIA	6,533,867
RWANDA	158,660
SENEGAL	152,387
TANZANIA	942,342
UGANDA	276,622
ZAMBIA	497,449

ADDITIONAL COUNTRIES RECEIVING MCH SUPPORT	
BENIN	153,754
BURKINA FASO	258,984
BURUNDI	1,068,776
CAMBODIA	67,564
COLOMBIA	79,009
CÔTE D'IVOIRE	239,148
GUATEMALA	9,601
SIERRA LEONE	17,634
SUDAN	5,257
TAJIKISTAN	52,885
ZIMBABWE	40,915

Table 2. Number of Women Giving Birth Who Received Uterotonics in the Third Stage of Labor (Or Immediately After Birth) Through U.S. Government-Supported Programs

PRIORITY COUNTRIES	
AFGHANISTAN	230,168
BANGLADESH	127,786
BURMA	6,361
DEMOCRATIC REPUBLIC OF THE CONGO	1,415,156
GHANA	57,931
HAITI	26,191
INDONESIA	188,033
KENYA	398,621
LIBERIA	89,038
MADAGASCAR	157,875
MALAWI	257,693
MALI	404,224
MOZAMBIQUE	326,695
NEPAL	57,094
NIGERIA	490,034
RWANDA	157,569
SENEGAL	114,272
SOUTH SUDAN	118,840
TANZANIA	926,543
UGANDA	269,824
ZAMBIA	373,236

ADDITIONAL COUNTRIES RECEIVING MCH SUPPORT	
BENIN	139,054
BURKINA FASO	223,761
BURUNDI	160,177
CAMBODIA	51,580
CÔTE D'IVOIRE	205,789
GUATEMALA	9,925
JORDAN	43,846
NIGER	114,521
SIERRA LEONE	17,430
SUDAN	4,597
TAJIKISTAN	53,105
ZIMBABWE	39,581

Table 3. Number of Women Giving Birth in a Health Facility Receiving U.S. Government Support

PRIORITY COUNTRIES	
BANGLADESH	134,078
BURMA	9,744
DEMOCRATIC REPUBLIC OF THE CONGO	1,669,558
ETHIOPIA	27,202
GHANA	57,931
HAITI	26,418
INDIA	4,166,075
INDONESIA	188,341
LIBERIA	91,339
MADAGASCAR	203,744
MALAWI	332,373
MALI	430,743
MOZAMBIQUE	388,143
NEPAL	104,386
NIGERIA	537,762
RWANDA	159,064
SENEGAL	128,435
SOUTH SUDAN	119,729
TANZANIA	925,804
UGANDA	281,703
ZAMBIA	408,802

ADDITIONAL COUNTRIES RECEIVING MCH SUPPORT	
BENIN	155,790
BURKINA FASO	260,186
BURUNDI	194,522
CAMBODIA	61,926
COLOMBIA	35,303
CÔTE D'IVOIRE	224,031
GUATEMALA	9,601
GUINEA	135,723
NIGER	204,755
SIERRA LEONE	17,792
SUDAN	5,257
TAJIKISTAN	52,725
ZIMBABWE	41,100

Table 4. Number of Newborns Not Breathing at Birth Who Were Resuscitated in U.S. Government-Supported Programs

PRIORITY COUNTRIES	
AFGHANISTAN	12,417
BANGLADESH	19,119
BURMA	461
DEMOCRATIC REPUBLIC OF THE CONGO	35,095
ETHIOPIA	776
INDONESIA	11,181
LIBERIA	1,113
MADAGASCAR	3,448
MALAWI	9,405
MALI	15,981
MOZAMBIQUE	2,346
NEPAL	944
NIGERIA	6,647
RWANDA	2,371
SENEGAL	5,457
SOUTH SUDAN	2,316
TANZANIA	56,058
UGANDA	9,706
ZAMBIA	18,557

ADDITIONAL COUNTRIES RECEIVING MCH SUPPORT	
BENIN	5,840
BURKINA FASO	5,277
BURUNDI	1,443
GUATEMALA	591
NIGER	9,554
SUDAN	4,263
ZIMBABWE	1,022

Table 5. Number of Newborns Who Received Postnatal Care Within Two Days of Childbirth in U.S. Government-Supported Programs

PRIORITY COUNTRIES	
BANGLADESH	148,242
BURMA	10,075
DEMOCRATIC REPUBLIC OF THE CONGO	1,645,721
ETHIOPIA	28,567
GHANA	59,011
HAITI	29,274
INDIA	4,352,974
INDONESIA	163,671
KENYA	382,543
LIBERIA	89,895
MADAGASCAR	182,927
MALAWI	186,391
MALI	296,442
MOZAMBIQUE	322,321
NEPAL	106,337
NIGERIA	491,401
RWANDA	154,933
SENEGAL	104,835
TANZANIA	853,587
UGANDA	258,356
ZAMBIA	345,976

ADDITIONAL COUNTRIES RECEIVING MCH SUPPORT	
BENIN	116,391
BURKINA FASO	257,145
BURUNDI	173,338
COLOMBIA	35,303
CÔTE D'IVOIRE	223,770
GUATEMALA	9,597
GUINEA	48,675
NIGER	81,200
SIERRA LEONE	16,533
SUDAN	86
TAJIKISTAN	52,578
ZIMBABWE	34,169

Table 6. Number of Children Who Received Their First Dose of Measles-Containing Vaccine (MCVI) by 12 Months of Age in U.S. Government-Assisted Programs

PRIORITY COUNTRIES	
AFGHANISTAN	307,210
BANGLADESH	91,101
BURMA	24,234
DEMOCRATIC REPUBLIC OF THE CONGO	1,576,368
ETHIOPIA	46,758
GHANA	66,200
HAITI	90,895
KENYA	426,120
LIBERIA	104,592
MADAGASCAR	358,142
MALAWI	277,221
MALI	545,268
MOZAMBIQUE	511,022
NEPAL	51,664
NIGERIA	632,815
SENEGAL	139,657
TANZANIA	1,338,774
UGANDA	300,626
ZAMBIA	419,242

ADDITIONAL COUNTRIES RECEIVING MCH SUPPORT	
BENIN	139,658
BURKINA FASO	261,932
BURUNDI	133,828
GUATEMALA	26,080
GUINEA	155,745
JORDAN	64,492
NIGER	372,887
SIERRA LEONE	24,359
ZIMBABWE	21,114

Table 7. Number of Cases of Child Diarrhea Treated in U.S. Government-Assisted Programs

PRIORITY COUNTRIES		ADDITIONAL COUNTRIES RECEIVING MCH SUPPORT	
AFGHANISTAN	1,084,378	BENIN	31,542
BANGLADESH	6,336	BURKINA FASO	83,512
BURMA	18,148	BURUNDI	116,184
DEMOCRATIC REPUBLIC OF THE CONGO	1,347,103	GUATEMALA	6,323
ETHIOPIA	43,844	GUINEA	84,338
GHANA	50,079	JORDAN	11,027
HAITI	21,674	NIGER	450,396
INDIA	561,614	SIERRA LEONE	9,608
KENYA	353,241	TAJIKISTAN	16,453
LIBERIA	14,824	VENEZUELA	2,630
MADAGASCAR	156,029	ZIMBABWE	14,131
MALAWI	249,867		
MALI	121,183		
MOZAMBIQUE	49,719		
NEPAL	294,660		
NIGERIA	217,704		
RWANDA	149,189		
SENEGAL	62,221		
SOUTH SUDAN	390,990		
TANZANIA	291,874		
UGANDA	113,400		
ZAMBIA	195,638		

Table 8. Number of Cases of Childhood Pneumonia Treated in U.S. Government-Assisted Programs

PRIORITY COUNTRIES		ADDITIONAL COUNTRIES RECEIVING MCH SUPPORT	
AFGHANISTAN	312,964	BENIN	1,979
BANGLADESH	1,011	BURKINA FASO	992,723
BURMA	12,357	BURUNDI	65,980
DEMOCRATIC REPUBLIC OF THE CONGO	1,501,394	GUATEMALA	757
ETHIOPIA	32,863	GUINEA	326,802
GHANA	11,256	JORDAN	3,457
INDIA	38,544	SIERRA LEONE	16,374
KENYA	203,805	TAJIKISTAN	2,140
LIBERIA	26,798	ZIMBABWE	15,525
MADAGASCAR	75,113		
MALAWI	501,769		
MALI	190,023		
MOZAMBIQUE	139,828		
NEPAL	41,353		
NIGERIA	59,059		
RWANDA	233,023		
SENEGAL	14,608		
TANZANIA	342,833		
UGANDA	70,501		
ZAMBIA	65,874		

Table 9. Number of Children Under Five (Ages 0-59 Months) Reached With Nutrition-Specific Interventions Through U.S. Government-Supported Nutrition Activities

PRIORITY COUNTRIES		ADDITIONAL COUNTRIES RECEIVING MCH SUPPORT	
BANGLADESH	304,985	BURKINA FASO	1,375,578
BURMA	2,814	BURUNDI	1,197,515
DEMOCRATIC REPUBLIC OF THE CONGO	4,545,539	CAMBODIA	37,489
ETHIOPIA	615,978	GUATEMALA	117,875
GHANA	173,447	HONDURAS	7,543
HAITI	365,501	JORDAN	61,643
KENYA	972,810	KYRGYZ REPUBLIC	9,138
MADAGASCAR	818,395	NIGER	1,049,627
MALAWI	869,876	TAJIKISTAN	261,176
MALI	2,664,031	ZIMBABWE	41,744
MOZAMBIQUE	1,497,901		
NEPAL	1,178,705		
NIGERIA	3,794,204		
RWANDA	498,047		
SENEGAL	1,239,151		
SOUTH SUDAN	3,651		
TANZANIA	1,229,317		
UGANDA	1,034,453		
ZAMBIA	972,726		

Table 10. Number of Children Under Two (Ages 0-23 Months) Reached With Community-Level Nutrition Interventions Through U.S. Government-Supported Programs

PRIORITY COUNTRIES		ADDITIONAL COUNTRIES RECEIVING MCH SUPPORT	
BANGLADESH	6,137	BURKINA FASO	75,605
DEMOCRATIC REPUBLIC OF THE CONGO	1,801,182	BURUNDI	320,452
ETHIOPIA	221,587	CAMBODIA	4,427
GHANA	155,206	GUATEMALA	7,192
HAITI	246,983	JORDAN	11,040
INDONESIA	1,554	KYRGYZ REPUBLIC	6,600
KENYA	341,624	NIGER	426,613
MADAGASCAR	319,561	TAJIKISTAN	125,326
MALAWI	135,365	ZIMBABWE	39,062
MALI	593,756		
MOZAMBIQUE	151,722		
NEPAL	79,851		
NIGERIA	59,410		
RWANDA	198,330		
SENEGAL	354,898		
TANZANIA	17,155		
UGANDA	117,580		
ZAMBIA	92,761		

Table 11. Number of Pregnant Women Reached With Nutrition-Specific Interventions Through U.S. Government-Supported Programs

PRIORITY COUNTRIES		ADDITIONAL COUNTRIES RECEIVING MCH SUPPORT	
BANGLADESH	418,977	BURKINA FASO	467,389
DEMOCRATIC REPUBLIC OF THE CONGO	1,900,863	BURUNDI	314,524
ETHIOPIA	95,346	CAMBODIA	2,801
GHANA	64,025	GUATEMALA	16,885
HAITI	106,687	JORDAN	1,640
KENYA	235,474	KYRGYZ REPUBLIC	7,258
MADAGASCAR	431,737	NIGER	498,200
MALAWI	218,759	TAJIKISTAN	69,506
MALI	522,943	ZIMBABWE	29,562
MOZAMBIQUE	512,799		
NEPAL	217,478		
NIGERIA	2,530,864		
RWANDA	116,851		
SENEGAL	190,800		
TANZANIA	638,164		
UGANDA	1,102,450		
ZAMBIA	311,573		

Table 12. Number of Individuals Receiving Nutrition-Related Professional Training Through U.S. Government-Supported Programs

PRIORITY COUNTRIES		ADDITIONAL COUNTRIES RECEIVING MCH SUPPORT	
BANGLADESH	8,433	BURKINA FASO	2,240
BURMA	136,649	CAMBODIA	417
DEMOCRATIC REPUBLIC OF THE CONGO	2,100	EGYPT	2,780
ETHIOPIA	589	GUATEMALA	1,204
GHANA	3,464	HONDURAS	729
HAITI	359	JORDAN	422
INDIA	3,000	KYRGYZ REPUBLIC	920
KENYA	1,612	NIGER	5,162
MADAGASCAR	1,993	TAJIKISTAN	3,161
MALAWI	38,298	ZIMBABWE	919
MALI	23,520		
MOZAMBIQUE	5,857		
NEPAL	2,037		
NIGERIA	5,609		
RWANDA	2,275		
UGANDA	626		
ZAMBIA	471		

Data note: These figures come from the interagency foreign assistance reporting tool, Foreign Assistance Coordination and Tracking System (FACTS Info), which the U.S. Department of State manages. Official final result data will be released via the USAID Dollars to Results website by August 2024 The data presented in this report reflects submissions by countries at the close of the data entry period, but are not considered final until that time.

ANNEX 3 PERFORMANCE PLAN AND REPORTING FOR KEY MATERNAL AND CHILD HEALTH INTERVENTIONS

The U.S. President's Malaria Initiative (PMI) works in 30 countries in sub-Saharan Africa and the Greater Mekong Subregion in Southeast Asia that account for nearly 90% of the world's malaria cases and deaths. Sixteen of USAID's priority countries for preventing child and maternal death are also PMI partner countries. The tables included in this Annex report data on coverage of key malaria interventions, where available, for PMI partner countries in sub-Saharan Africa.

Table 1. Ownership of Insecticide-Treated Nets (ITNs) in PMI Partner Countries

	HOUSEHOLDS WITH AT LEAST ONE ITN (%)	SURVEY
ANGOLA	11 31	MIS 2006-2007 DHS 2015-2016
BENIN	25 92	DHS 2006 DHS 2017
BURKINA FASO	57 83	DHS 2010 DHS 2021 KIR
CAMEROON	36 72	DHS 2011 MIS 2022
CÔTE D'IVOIRE	68 72	DHS 2011-2012 DHS 2021
DEMOCRATIC REPUBLIC OF THE CONGO	51 63	MICS 2010 MICS 2018
ETHIOPIA	65 64	MIS 2007 MIS 2015-2016
GHANA	19 67	MICS 2006 DHS 2022 KIR
GUINEA	8 63	MICS 2007 MIS 2021
KENYA	48 54	MIS 2007 DHS 2022
LIBERIA	47 72	MIS 2009 MIS 2022
MADAGASCAR	57 69	DHS 2008-2009 DHS 2021
MALAWI	38 74	MICS 2006 MICS 2019-2020
MALI	50 91	DHS 2006 MIS 2021
MOZAMBIQUE	16 57	MIS 2007 DHS 2022-2023 KIR
NIGER	61 96	DHS 2012 MIS 2021 KIR
NIGERIA	42 56	MIS 2010 MIS 2021
RWANDA	15 66	DHS 2005 DHS 2019-2020
SENEGAL	36 61	MIS 2006 DHS 2023 KIR
SIERRA LEONE	60 68	MIS 2016 DHS 2019
TANZANIA	23 67	DHS 2004-2005 DHS 2022
UGANDA	16 83	DHS 2006 MIS 2018-2019
ZAMBIA	38 53	MIS 2006 MIS 2021
ZIMBABWE	29 37	DHS 2010-2011 MICS 2019

Note: Ownership is defined as the percentage of households that own at least one ITN.

Table 2. Access to ITNs in PMI Partner Countries

	ITN ACCESS (%)	SURVEY
ANGOLA	15 20	MIS 2006-2007 DHS 2015-2016
BENIN	15 77	DHS 2006 DHS 2017
BURKINA FASO	36 64	DHS 2010 DHS 2021
CAMEROON	56 64	MICS 2014 MIS 2022
CÔTE D'IVOIRE	64 65	MICS 2016 DHS 2021
DEMOCRATIC REPUBLIC OF THE CONGO	30 44	MICS 2010 MICS 2018
ETHIOPIA	2 49	DHS 2005 MIS 2015-2016
GHANA	2 67	DHS 2003 MIS 2019
GUINEA	2 42	DHS 2005 MIS 2021
KENYA	42 50	DHS 2008 DHS 2022 KIR
LIBERIA	25 52	MIS 2009 MIS 2022
MADAGASCAR	35 48	DHS 2008-2009 DHS 2021
MALAWI	19 57	DHS 2004 MICS 2019-2020
MALI	30 72	DHS 2006 MIS 2021
MOZAMBIQUE	37 69	DHS 2011 MIS 2018
NIGER	37 80	DHS 2012 MIS 2021 KIR
NIGERIA	29 43	MIS 2010 MIS 2021
RWANDA	9 51	DHS 2005 DHS 2019-2020
SENEGAL	18 58	MIS 2006 MIS 2020-2021
SIERRA LEONE	37 47	MIS 2016 DHS 2019
TANZANIA	16 53	DHS 2004-2005 DHS 2022
UGANDA	9 72	DHS 2006 MIS 2018
ZAMBIA	34 67	DHS 2007 MIS 2018
ZIMBABWE	20 27	DHS 2010-2011 MICS 2019

Access is defined as the percentage of the population who could sleep under an ITN if each ITN in the household were used by up to two people.

Table 3. Use of ITNs in PMI Partner Countries - Children Under Age Five (U5)

	U5 ITN USE (%)	SURVEY
ANGOLA	18 22	MIS 2006-2007 DHS 2015-2016
BENIN	20 78	DHS 2006 DHS 2017
BURKINA FASO	47 67	DHS 2010 DHS 2021 KIR
CAMEROON	21 58	DHS 2011 MIS 2022
CÔTE D'IVOIRE	37 59	DHS 2011-2012 DHS 2021
DEMOCRATIC REPUBLIC OF THE CONGO	38 51	MICS 2010 MICS 2018
ETHIOPIA	41 45	MIS 2007 MIS 2015-2016
GHANA	22 49	MICS 2006 DHS 2022 KIR
GUINEA	5 38	MICS 2007 MIS 2021
KENYA	39 51	MIS 2007 MIS 2022 KIR
LIBERIA	26 50	MIS 2009 MIS 2022
MADAGASCAR	46 56	DHS 2008-2009 DHS 2021
MALAWI	25 68	MICS 2006 MICS 2019-2020
MALI	27 73	DHS 2006 MIS 2021
MOZAMBIQUE	7 43	MIS 2007 DHS 2022-2023 KIR
NIGER	20 86	DHS 2012 MIS 2021 KIR
NIGERIA	29 41	MIS 2010 MIS 2021
RWANDA	13 56	DHS 2005 DHS 2019-2020
SENEGAL	16 37	MIS 2006 DHS 2023 KIR
SIERRA LEONE	44 59	MIS 2016 DHS 2019
TANZANIA	16 59	DHS 2004-2005 DHS 2022
UGANDA	10 60	DHS 2006 MIS 2018
ZAMBIA	24 46	MIS 2006 MIS 2021
ZIMBABWE	10 15	DHS 2010-2011 MICS 2019

Use is defined as the percentage of children under age five who slept under an ITN the night before the survey.

Table 4. Use of ITNs in PMI Partner Countries - Pregnant Women

	PREGNANT WOMEN ITN USE (%)	SURVEY
ANGOLA	22 23	MIS 2006-2007 DHS 2015-2016
BENIN	20 80	DHS 2006 DHS 2017
BURKINA FASO	45 71	DHS 2010 DHS 2021 KIR
CAMEROON	20 63	DHS 2011 DHS 2022
CÔTE D'IVOIRE	40 64	DHS 2011-2012 DHS 2021
DEMOCRATIC REPUBLIC OF THE CONGO	43 52	MICS 2010 MICS 2018
ETHIOPIA	43 44	MIS 2007 MIS 2015-2016
GHANA	3 48	DHS 2003 DHS 2022 KIR
GUINEA	3 39	MICS 2007 MIS 2021
KENYA	40 45	MIS 2007 DHS 2022 KIR
LIBERIA	33 53	MIS 2009 MIS 2022
MADAGASCAR	46 55	DHS 2008-2009 DHS 2021
MALAWI	15 66	DHS 2004 MICS 2019-2020
MALI	29 76	DHS 2006 MIS 2021
MOZAMBIQUE	7 47	MIS 2007 DHS 2022-2023 KIR
NIGER	20 90	DHS 2012 MIS 2021 KIR
NIGERIA	34 50	MIS 2010 MIS 2021
RWANDA	17 56	DHS 2005 DHS 2019-2020
SENEGAL	17 40	MIS 2006 DHS 2023 KIR
SIERRA LEONE	44 64	MIS 2016 DHS 2019
TANZANIA	16 58	DHS 2004-2005 DHS 2022
UGANDA	10 65	DHS 2006 MIS 2018
ZAMBIA	25 41	MIS 2006 MIS 2021
ZIMBABWE	9 25	DHS 2010-2011 MIS 2016

Use is defined as the percentage of pregnant women who slept under an ITN the night before the survey.

Table 5. Intermittent Preventive Treatment in Pregnancy (IPTp) Coverage in PMI Partner Countries - Two Doses

	IPTp2 (%)	SURVEY
ANGOLA	3 37	MIS 2006-2007 DHS 2015-2016
BENIN	3 34	DHS 2006 DHS 2017
BURKINA FASO	39 79	DHS 2010 DHS 2021 KIR
CAMEROON	27 67	DHS 2011 MIS 2022
CÔTE D'IVOIRE	18 58	DHS 2011-2012 DHS 2021
DEMOCRATIC REPUBLIC OF THE CONGO	21 31	MICS 2010 MICS 2018
GHANA	28 78	MICS 2006 DHS 2022 KIR
GUINEA	4 74	DHS 2005 MIS 2021
KENYA	14 20	MIS 2007 DHS 2022 KIR
LIBERIA	45 80	MIS 2009 MIS 2022
MADAGASCAR	6 41	DHS 2008-2009 DHS 2021
MALAWI	47 75	MICS 2006 MICS 2019-2020
MALI	10 57	DHS 2006 MIS 2021
MOZAMBIQUE	16 46	MIS 2007 DHS 2022-2023 KIR
NIGER	35 56	DHS 2012 MIS 2021 KIR
NIGERIA	13 46	MIS 2010 MIS 2021
SENEGAL	49 72	MIS 2006 DHS 2023 KIR
SIERRA LEONE	71 74	MIS 2016 DHS 2019
TANZANIA	22 58	DHS 2004-2005 DHS 2022
UGANDA	18 72	DHS 2006 MIS 2018
ZAMBIA	57 79	MIS 2006 MIS 2021
ZIMBABWE	8 36	DHS 2010-2011 MIS 2016

Data come from nationwide household surveys that measured coverage of IPTp2 for pregnant women, defined as the percentage of surveyed women who received at least two doses of sulfadoxine-pyrimethamine during their last pregnancy in the past two years.

IPTp is not part of the national policy in Ethiopia and Rwanda.

Kenya, Madagascar, and Zimbabwe implement IPTp subnationally because of heterogeneous malaria transmission with areas of low risk. Data here are national and likely underestimate coverage in priority areas.

Table 6. IPTp Coverage in PMI Partner Countries - Three Doses

	IPTp3 (%)	SURVEY
ANGOLA	1 19	MIS 2006-2007 DHS 2015-2016
BENIN	0 14	DHS 2006 DHS 2017
BURKINA FASO	5 57	DHS 2010 DHS 2021 KIR
CAMEROON	12 46	DHS 2011 MIS 2022
CÔTE D'IVOIRE	7 35	DHS 2011-2012 DHS 2021
DEMOCRATIC REPUBLIC OF THE CONGO	5 13	DHS 2013 MICS 2018
GHANA	27 60	DHS 2008 DHS 2022 KIR
GUINEA	30 50	MICS 2016 MIS 2021
KENYA	7 13	MIS 2007 DHS 2022 KIR
LIBERIA	10 63	MIS 2009 MIS 2022
MADAGASCAR	2 31	DHS 2008-2009 DHS 2021
MALAWI	14 48	DHS 2004 MICS 2019-2020
MALI	18 34	MIS 2015 MIS 2021
MOZAMBIQUE	10 25	DHS 2011 DHS 2022-2023 KIR
NIGER	9 25	DHS 2012 MIS 2021 KIR
NIGERIA	5 31	MIS 2010 MIS 2021
SENEGAL	7 38	MIS 2006 DHS 2023 KIR
SIERRA LEONE	31 36	MIS 2016 DHS 2019
TANZANIA	3 32	DHS 2004-2005 DHS 2022
UGANDA	6 41	DHS 2006 MIS 2018
ZAMBIA	41 68	DHS 2007 MIS 2021
ZIMBABWE	5 20	DHS 2010-2011 MIS 2016

Data come from nationwide household surveys that measured coverage of IPTp3 for pregnant women, defined as the percentage of surveyed women who received at least three doses of sulfadoxine-pyrimethamine during their last pregnancy in the past two years.

IPTp is not part of the national policy in Ethiopia and Rwanda.

Kenya, Madagascar, and Zimbabwe implement IPTp subnationally because of heterogeneous malaria transmission with areas of low risk. National coverage estimates included here are national and therefore likely underestimate coverage in priority areas.

DATA METHODOLOGY

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

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

http://www.childmortality.org/

Estimates for children under five years of age and newborns are produced by the Interagency Group for Child Mortality Estimation (IGME). IGME, established by the United Nations, has a membership of leading academic scholars and independent experts in demography and biostatistics who review mortality data and publish annual country-level estimates of under-five mortality. To do so, IGME compiles all available national-level data on child mortality, including data from vital registration systems, population censuses, household surveys, and sample registration systems, and weights these data based on quality measures. In order to reconcile differences caused by estimation techniques, error rates, and overlapping confidence intervals, the Technical Advisory Group of the IGME fits a smoothed trend curve to a set of observations and uses that to predict a trend line that is extrapolated to a common reference year, in this case 2022. The under-five mortality rate target for all countries is 25 per 1,000 live births or lower. The neonatal mortality rate target is 12 per 1,000 live births.

MATERNAL MORTALITY HISTORIC TRENDS AND GLOBAL 2030 TARGETS

Historic Trends

https://www.who.int/publications/i/item/9789240068759

The numbers and ratios of maternal deaths to live births were obtained from the United Nations Maternal Mortality Estimation Inter-agency Group (MMEIG) that works in a similar way to IGME estimates described above. The MMEIG shares and harmonizes data on maternal mortality in order to provide internationally comparable maternal mortality ratio estimates, up to 2020 in the latest report.

Global 2030 Targets

The 2030 global maternal mortality target is a reduction in the global average for the maternal mortality ratio to less than 70 deaths per 100,000 live births, with no individual country exceeding a maternal mortality ratio of 140 maternal deaths per 100,000 live births. Countries have their own national targets for 2030, depending on whether their baseline level of MMR in 2010 was lower or higher than 420: if lower than 420, their target is to reduce MMR by at least two thirds by 2030; if higher than or equal to 420, their target is to reach MMR of 140 or less by 2030.

INTERVENTION COVERAGE ESTIMATES AND INEQUITY

Intervention coverage rates were extracted from the most recently available Demographic and Health Survey (DHS), Multiple Indicator Cluster Survey (MICS), and/or HIV/AIDS and Malaria Indicator Surveys, with the exception of measles immunization coverage (source: WHO UNICEF Estimates of Vaccine Coverage: 1997-2022; <https://data.unicef.org/topic/child-health/immunization/>). Where recent data points were unavailable, coverage estimates were based on an application of the annual rate of change from the two closest available survey data points. Data provided for malaria intervention coverage is only available for PMI partner countries. Recent data points may not be available for countries affected by conflict, internal displacement, and migration; thus, coverage rates may overestimate or underestimate current access. New data are always forthcoming, so these estimates may slightly differ from year to year based on newly available data.

UNIVERSAL HEALTH CARE (UHC) AND RMNCH COVERAGE INDICES

Health service coverage indicators reflect the extent to which people in need of essential health services actually receive them. Essential services relevant for the prevention of child and maternal deaths include the following: care of women during pregnancy and childbirth; reproductive health services; immunization to prevent common childhood infections; vitamin A supplementation in children; and treatment for common childhood diseases. The main sources of data for these indicators are respondents' answers to questions about service use from household surveys such as the Expanded Programme on Immunization 30-cluster Survey, the UNICEF Multiple Indicator Cluster Survey, and the Demographic and Health Survey funded by USAID. The Universal Health Coverage (UHC) index of essential services coverage is a component of a group of indicators used to assess progress towards the Sustainable Development Goal Target 3.8: Achieve universal health coverage, including financial risk protection. A subset of the Universal Health Coverage index of essential services coverage is the RMNCH subindex of specific reproductive, maternal, newborn and child health components. These values are updated every other year. Note on alternate years from UHC updates, the World Population Prospects are updated and next year, an update of the PCMD preventable mortality index will be included in this report.

HEALTH WORKFORCE DENSITY

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

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