

# ***Country Countdown:***

**Accelerating progress to 2015 and beyond**

***A guide for countries  
and partners***



In support of



EVERY WOMAN  
EVERY CHILD

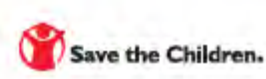


COMMITTING TO CHILD SURVIVAL  
A PROMISE RENEWED

## Countdown to 2015 global partners



THE LANCET



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### *Acknowledgements*

## **Foreword**

Countdown to 2015 grew from a vision of a world in which women, newborns, and children no longer die — by the millions — from causes that can be routinely prevented or treated. A world where every baby is born with the care of a skilled birth attendant; where every woman and child receives preventive care to stay healthy, and effective treatment when ill. A world where there is health care for all, no matter how remote the village, crowded the city, or poor the family.

In the 75 countries where Countdown tracks progress on reproductive, maternal, newborn and child health (RMNCH) — countries that account for more than 95% of all the world's maternal and child deaths — this inspiring vision is shared by thousands of dedicated policy makers, health professionals, scientists, programme managers, advocates, and community leaders.

In pursuit of this vision, Countdown to 2015 harnesses the power of *data*: to tell us where we've come from and where we stand right now; to help us develop strategies for accelerating progress; to show us what works, and why.

The Country Countdown offers a comprehensive and powerful set of methods and tools for making data an effective instrument of change at the country level. It brings old and new partners together around a rigorous, country-led process that can lend new energy to national efforts to improve women's and children's health. It helps countries ensure that policy follows evidence, and that investments of precious health resources support interventions proven to save lives. It empowers decision makers with the information they need to address momentous issues of life and death; efficiency, effectiveness, and equity. It aligns with the international and regional frameworks that have been put in place to support and monitor countries' fulfilment of their RMNCH commitments. It provides a template for objectively and consistently tracking progress and ensuring accountability.

This guide, together with the other documents and tools in the Country Countdown Toolkit, presents country-level stakeholders with information, informed by experience, on ways to plan and carry out a successful Country Countdown. It offers suggestions, not prescriptions, and we fully expect and encourage organisers to bring your creativity — and your deep knowledge of your country's unique context — to this rewarding and urgently important task.

On behalf of the global Countdown to 2015 team, we stand ready to help countries and partners build a better future for women and children.

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# ***Country Countdown:***

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## ***Introduction: Why undertake a Country Countdown?***

For countries striving to achieve the health-related Millennium Development Goals — and particularly MDGs 4 (reduce child mortality) and 5 (improve maternal health) — information is a powerful and essential force for change. Understanding which interventions are being delivered effectively and which are not, knowing the geographic areas where coverage levels are lagging, analysing the impact of policies and programmes on health outcomes, and ensuring accountability can all help renew the momentum behind national commitments to saving women's and children's lives.

A Country Countdown can make a unique, catalytic contribution to national efforts to improve reproductive, maternal, newborn, and child health (RMNCH) through the use of data and technical analysis tools. It brings to the table a diverse group of players to assess and accelerate equitable, sustained, and measured reductions in maternal, newborn, and child mortality. A Country Countdown can help policy makers, health programmers, and advocates to:

- Increase public and policy attention to RMNCH, and to achievement of MDGs 4 and 5
- Focus national health strategies, investments, and programming to achieve high and equitable coverage of high-impact interventions
- Increase and more efficiently allocate financial resources for RMNCH
- Strengthen capacity to assess and analyse data, and to use data for evidence-based action
- Improve the quantity and quality of data, as national leaders become more aware of its importance and of current data gaps
- Foster accountability, both for committed actions and for outcomes

A Country Countdown is a practical way for countries to follow through on commitments to the Global Strategy for Women's and Children's Health and [\*Every Woman Every Child\*](#), and on pledges to end preventable child deaths through the Commitment to Child Survival and [\*A Promise Renewed\*](#). It enables countries to take stock, review recent progress, identify remaining challenges and actions required to accelerate progress, and ensure accountability.

The Country Countdown process is led by in-country partners and aligned with national health strategies and with complementary efforts such as [\*Born Too Soon\*](#) and [\*Family Planning 2020\*](#). Based on their own assessment of national priorities and needs, countries can choose to give special emphasis, within the broader context of the continuum of care, to specific health problems that need more attention: these may include reproductive health and family planning, newborn health, preterm birth, diarrhoea and pneumonia, or other areas that require special focus.

A Country Countdown can raise the profile of the health MDGs, highlighting areas where progress has been slow, and building consensus on ways to overcome challenges; engage more partners and increase the commitment and accountability of current partners; and mobilise additional resources, especially where a greater focus on the continuum of care leads to development of more integrated plans.

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## ***How to use this Guide***

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The global Countdown team is committed to supporting and facilitating country-led Country Countdown processes by developing and disseminating tools and by sharing relevant experiences from both the global and country levels.

This Guide outlines a step-by-step process for organising and executing a successful Country Countdown. However, the suggestions provided here are not meant to be prescriptive, but rather to provide support and guidance for a country-led process. Because every country starts with its own unique set of baseline conditions, policy and planning approaches, health objectives, and other contextual factors, there is no single model for implementing a Country Countdown. Each country should, with partners, determine the best approach for carrying out a Country Countdown that contributes to improved analysis, action, and accountability.

This Guide forms the core part of a toolkit that Countdown has developed to assist countries in undertaking robust and effective Country Countdowns. The [Country Countdown Toolkit](#) includes definitions of key indicators; detailed case studies of Country Countdown experiences; PowerPoint presentations describing Countdown and its most recent global findings; and PowerPoint presentations customised for each Countdown country to show data from the 2012 country profile. Drafts of sub-national profiles are also available, with suggestions for their adaptation and use. The Country Countdown Toolkit — in addition to global Countdown materials that include all global Countdown Reports, all country profiles, and research papers describing Countdown findings in detail — is available for download from the Countdown website ([www.countdown2015mnch.org](http://www.countdown2015mnch.org)).

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## ***What is Countdown to 2015?***

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Established in 2005 as a multi-disciplinary, multi-institutional collaboration, Countdown to 2015 for Maternal, Newborn and Child Survival is a global movement of academics, governments, international agencies, health-care professional associations, donors, and nongovernmental organisations (NGOs). Countdown uses country-specific data to track, stimulate, and support country progress on maternal, newborn, and child survival. Countdown tracks progress towards achieving the health-related MDGs, with a focus on MDGs 4 and 5, in the 75 countries where more than 95% of all maternal and child deaths occur. Countdown tracks coverage of effective interventions — the proportion of individuals needing a health service or intervention who actually receive it — and analyses the distribution of coverage across socioeconomic, ethnic, gender, and other population groups within countries. Countdown proposes new actions to reduce child mortality and improve maternal health, identifies knowledge and data gaps, and examines the policy, health system, and financial factors that are crucial to determining coverage levels, patterns, and trends. In addition, Countdown recognises that a broader set of political, economic, social, technological, cultural, environmental, and other contextual factors affect coverage and mortality.

Countdown promotes accountability from governments and development partners, and contributes to the follow-up agenda of the [Commission for Information and Accountability for](#)



[Women's and Children's Health](#) by providing annual reporting and analysis of country-specific information on key indicators of coverage. Countdown's work, at the global and country levels, is closely linked to that of the [Independent Expert Review Group](#) (iERG), and is supportive of efforts to track and ensure fulfilment of commitments to the [Global Strategy for Women's and Children's Health/Every Woman Every Child](#) and to [A Promise Renewed/Committing to Child Survival](#).

Countdown supports tracking of progress by:

- Producing individual country profiles for each of the 75 priority countries, which include data on mortality, demographics, coverage, equity, policies and health systems, and financing
- Providing tools to support countries in carrying out national and sub-national analyses of progress on reproductive, maternal, newborn and child health indicators
- Helping organise events with policy-makers and other stakeholders to discuss the implications of the data and analyses for national strategy development, planning, budgeting, and programme implementation

## Countdown to 2015 partners

Countdown includes independent academics, UN agencies, NGOs and other members of civil society, professional organisations, as well as national governments and leaders bringing change in their own countries. Current Countdown partners are represented by the logos that appear on [page ii](#) of this guide.

## Countdown working groups

Countdown's analytical work is overseen by a coordination committee, and its analyses and research are carried out by technical working groups on coverage, equity, health systems and policies, and health financing. Appendices [E](#), [F](#), and [G](#) provide detailed guidance for countries wishing to apply Countdown's methodologies for examining equity, health systems and policies, and financing.

## Events and products

Global Countdown conferences are held intermittently and reports are now published annually. Numerous Countdown articles on results and research have been published in *The Lancet* and other professional journals. All Countdown reports and articles are available for download from [the Countdown website](#).

## Origins of the Country Countdown

After the first-ever global Countdown to 2015 meeting, held in London in 2005, Senegal initiated its own national Countdown event, which led to a number of new commitments including the development of a new plan for child survival to complement the existing national Roadmap for Maternal Health. Zambia organised a similar national Countdown event following the global Countdown conference in Cape Town in 2008: one concrete action that resulted was an increase in places at Zambian midwifery schools. In 2010, following the global Countdown meeting held at



the Women Deliver conference in Washington, D.C., Nigeria produced a national report and sub-national profiles, which were used at national and local-level events to identify progress and constraints, leading to increased commitments by the government and its partners. Case studies describing the Country Countdown processes in Zambia, Nigeria, and Senegal are available at [www.countdown2015mnch.org/about-countdown/country-level-work](http://www.countdown2015mnch.org/about-countdown/country-level-work).

Country interest broadened when the [Commission on Information and Accountability for Women's and Children's Health](#) identified the Country Countdown as an important strategy for improving monitoring and follow-through on the Commission's recommendations, as well as on the Pledge to end preventable child deaths.

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## ***Country Countdown principles and process***

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### **Principles**

The guiding principles for a Country Countdown are summarised below:

- ***Focus on data quality and data for action:*** Compile and analyse national and sub-national data on outcomes, coverage for proven interventions, and determinants of coverage; and review and improve data quality
- ***Consider the full continuum of care and all population groups:*** Recognise links across reproductive, maternal, newborn, and child health (RMNCH) and nutrition, and focus on equity of coverage
- ***Align with country processes:*** Strengthen national institutions and mechanisms for monitoring and evaluating progress
- ***Involve all stakeholders:*** Recognise government's key role, but involve independent technical experts and civil society to ensure inclusion and accountability
- ***Use flexible approaches:*** Begin with standard Countdown indicators and tools, but adapt to the country's unique conditions, needs, and objectives
- ***Ensure adequate funding:*** Mobilise sufficient financial support for a successful Country Countdown process
- ***Maintain ongoing process and maximise accountability:*** Ensure uptake of findings and recommendations into national policies and plans

### **Process**

The Country Countdown process is based on a dynamic, ongoing improvement and accountability cycle, rather than a one-time event. Important elements of a successful Country Countdown include the following:

- Defining and obtaining geographic and time-specific data for key RMNCH indicators, and tracking them over time
- Working in partnership to review and improve data quality and availability

- Using data to construct time- and geographic-specific profiles that present indicator coverage levels, trends, and breakdowns by key equity considerations
- Developing summary findings and key messages that highlight progress and policy/programme areas that need investment and improvement
- Sharing these results with decision makers and media in ways that support their use in strengthening RMNCH policies and programmes
- Assessing the effectiveness of each cycle and acting on what is learned to improve performance in the next cycle

The expected results of this process include evidence-based decisions, leading to stronger and more equitable RMNCH programmes. The figure below shows the cyclical contributions of a Country Countdown within the national planning context:



## ***Organising a Country Countdown... Step by step***

This section provides a step-by-step guide to planning and executing a Country Countdown process. An [implementation checklist](#), to assist organisers in managing the process, can be found at the end of this Guide.

### ***Step 1: Ensuring that Country Countdown links to the national planning process***

To be successful, a national Countdown process should complement the national planning process for reproductive, maternal, newborn, and child health (RMNCH). Planning and carrying out a Countdown process will require the investment of time and energy by already busy health planners and managers; however, carrying out a Country Countdown can be integrated into the national process in a way that adds value, builds skills, and brings results. For many countries with an Annual Health Review, Mid-term Review, 5-Year Development Plan, MDG Review, or Sector-wide Review, the Countdown process can add value by drawing in a wider group of stakeholders and supporting a more in-depth analysis of available evidence.

A Country Countdown event focuses on reviewing key evidence-based interventions, related policies and health systems measures, and equity considerations; and includes a broad range of partners (NGOs, academics, professional associations, parliamentarians, and the private sector, as well as the traditional partners of the Ministry of Health, donors, and UN agencies). A Countdown analysis can generate simple messages that the media can use to inform the public. A Country Countdown report and profiles can provide an excellent stimulus for discussion and has been shown to lead to new levels of action and accountability for many partners. By bringing the Countdown process to the sub-national level, plans can be adjusted to consider differences in coverage levels and needs.

A country-level team can best analyse *if* and *how* the Country Countdown can add value. One country might decide to attach a Countdown event to the Annual Review or other pre-existing event; another may adopt the components of the Countdown in their regular planning meetings and discussions. There are many ways that Countdown can be a part of a national planning process: in deciding the role of Countdown at the country level, Ministry of Health representatives and its partners may wish to consult with global Countdown members or with individuals and agencies that have attended Countdown events.

### ***Step 2: Creating an organising committee and working groups***

Developing a Country Countdown begins with forming a Countdown Organising Committee or identifying an existing RMNCH-focused group — which brings together government, UN agencies, NGOs, professional associations, academics, and communications groups — that could serve this purpose. Involving these partners in the planning process increases the accountability and commitment of important partners at the local, national, and even global levels. Working groups can then be formed to manage and execute specific tasks; these typically include working groups that focus on the Country Countdown's scientific work, on event planning, on communications

and the media, and on financial and budgeting tasks. [Appendix C](#) includes detailed suggestions for the composition and responsibilities of the organising committee and working groups.

**Major tasks to be undertaken by the committee and working groups include:**

- Advocating for the Country Countdown with all relevant partners
- Ensuring that interested partners from all constituencies are represented in the Countdown planning process
- Developing a budget and identifying resources for data analysis, preparation of products, events, communications, and follow-up
- Liaising with the Global Countdown team to obtain support or technical inputs if required
- Reviewing available data; identifying additional data or research studies, including sub-national data; and detecting data gaps
- Analysing data, including comparing available data to data presented on the Countdown country profile; looking at trends over time; comparing districts or regions; assessing coverage levels for indicators delivered through different delivery channels; analysing coverage levels by equity considerations such as income group and gender; etc.
- Developing the national and sub-national profiles, based on country priorities and data availability
- Reaching consensus on findings and key messages
- Producing the Country Countdown report and supplemental materials
- Developing a communications strategy
- Preparing for national and local events to discuss findings
- Identifying opportunities to involve specific constituents, briefing for parliamentarians, etc.
- Following up recommendations from national and sub-national discussions

***Step 3: Developing a workplan and timeframe for the Country Countdown process***

The main Organising Committee, in coordination with the working groups, will determine the timeframe and workplan for the planning and implementation of the Country Countdown. A minimum of three months of preparation time will likely be required for pulling together the available data, analysing the data, and creating national and local country profiles. If financing is not readily available, mobilising those resources will be an early step in the process. Planning Countdown events such as a national meeting, briefing for senior officials, and media outreach can begin while data are being prepared. If a report is to be produced for discussion at the national meeting, time will be required for preparation, review, and printing. Starting the planning process early, even a year in advance, can help governments and their partners include Countdown activities in their plans and budgets. The [Implementation Checklist](#) at the end of this Guide may be helpful in developing the workplan.

#### **Step 4: Reviewing data needs and availability**

The Scientific Working Group can begin this step by reviewing the relevant Countdown country profile to determine which indicators and other information would be useful to compile, analyse, and report on for the Country Countdown, and whether profiles would ideally be developed for each region, state, and/or district. The group then develops a master worksheet of data needs and priorities, which can be used as the basis for reviewing available data.

Scientific Working Group members, or potentially a data consultant, should request copies of reports and data sets from each potential information source. These may include household or health facility surveys, routine reports generated by the national Health Information System, or special studies.

In addition to national estimates, countries can opt to reference United Nations inter-agency estimates of maternal, neonatal, and child mortality. These estimates, which may differ from mortality statistics that are produced and commonly used in-country, have been used in the country profiles produced by global Countdown. The UN inter-agency teams use national and other data sources and apply statistical modelling techniques in order to generate these mortality estimates, which are comparable across countries and can be monitored over time; more information is available at [www.childinfo.org](http://www.childinfo.org) and in the Countdown co-publication *Monitoring maternal, newborn and child health: understanding key progress indicators*. A successful Country Countdown is not required to reconcile these separate sources of mortality data. The Scientific Working Group, after consideration and review, may select either data source or may choose not to include these mortality measures on the profiles. The primary focus of the Country Countdown should be on coverage of key interventions and on determinants of coverage (equity, financing, health systems and policies, and broader contextual factors).

For each data source, information should be recorded on the master data worksheet indicating:

- The year(s) data were collected
- Whether the data are representative at national, regional, and state/district levels, and whether indicator results are reported at these levels
- Whether the original data are available for re-analysis if needed
- Whether the data are complete (i.e., how many missing values are present in the data set for each indicator), and whether the data for a particular indicator adhere to a standard definition
- Any concerns about the quality or validity of the data that should be addressed

The completed master worksheet can serve as a basis for making decisions about which indicators can be reported in the Country Countdown, and whether sufficient data are available to construct profiles at specific sub-national levels. Showing that there is missing data for particular indicators is also an important part of the process, particularly if the indicators relate to major causes of death or otherwise represent areas of high priority.

This information should be presented to the Organising Committee as a basis for making final decisions about the content and level of disaggregation of the national and sub-national profiles.

A final copy of the master worksheet should be retained to serve as reference documentation for the data used in the Countdown.

### ***Step 5: Analysing the data and identifying key messages***

This step is the responsibility of the Scientific Working Group, which can involve additional country or international experts as needed. The focus in this step is on suggestions for [analysis of sub-national data](#) on coverage (guidance notes on analyses of coverage determinants tracked by Countdown — equity, health systems and policies, and financing — are available in Appendices [E](#), [F](#), and [G](#), respectively). Geographic sub-national unit are referred to in this Guide as “districts,” although this nomenclature varies across countries, and countries may decide to examine data at regional or zonal levels based on how budgets are allocated or on statistical power issues. Normally, analyses should be conducted for the units for which sub-national profiles are to be created. A basic analysis plan for the sub-national data on coverage might include the following:

- Produce a simple frequency distribution for each coverage indicator, showing the level of coverage in each district, for each of the time points for which data are available. Rank order the results from highest to lowest coverage and summarise in a table or graph, including the median coverage and range (highest and lowest district). Examine the results to see if there are any obvious reasons for differences in indicator levels by district (e.g., different epidemiological needs, accessibility, presence of conflict, etc.). Search for patterns in the results that might reflect the RMNCH strategies that are being implemented in the country. For example, are interventions that are being delivered through mass campaigns showing higher coverage than those being delivered through routine services? Are interventions being delivered in the community showing higher coverage than those being delivered in facilities? Are differentials in health funding affecting coverage trends for different interventions? Take other data, including estimates of health service utilisation, information on existing health policies or financing mechanisms, etc., into account while considering these issues.
- For indicators with data for more than one time period, summarise the coverage change for each indicator by district. Measurements for all districts are likely to have been made at the same time through a national household survey, so the absolute change in percentage points between any two surveys can be calculated for each district. The standard Countdown graphs, found on the country profile, may offer other ideas about how best to present trends by district. Examine the results to identify possible explanations for further analyses that might be useful.
- Review the global Countdown report and articles to help generate ideas for further analysis: for example, for a special focus on quality of care, or tracking met need for family planning. The Countdown Country PowerPoint presentations also have graphs and tables that may provide a useful basis for analysis.
- Explore alternative ways of presenting the coverage results that may yield more insights. For example, try presenting the most recent coverage results by district along the continuum of care. The toolkit includes global and country-specific presentations of 2012 data that can be adapted for this purpose.



- Generate some preliminary key messages based on analysis of the data, and discuss and refine them with the Countdown Organising Committee and other stakeholders. Continue analysing the data to examine these key messages and ensure that they are supported by the data.
- Consider additional analyses focused on equity, health systems and policies, or financing, drawing on the guidance available in Annexes [E](#), [F](#), and [G](#). These analyses should help with interpretation of the coverage findings and with the generation of key messages.

### **Step 6: Creating national and sub-national profiles**

The next step is to develop a template for the national and sub-national profiles. A close review of the [country profiles](#) prepared by the global Countdown is a useful starting point. (Detailed information on how to use the Countdown country profile can be found [here](#); definitions of all Countdown indicators are in [Appendix D](#).) The global Countdown to 2015 encourages all countries to engage in [sub-national analysis and discussions](#). For sub-national profiles, examples from Tanzania and Nigeria, provided in [Appendix B](#), highlight the variation in content that is possible depending on available data and country priorities:

- Tanzania decided to prepare profiles at the zonal level (for seven zones, plus Zanzibar), because there was not adequate statistical power to perform the necessary analysis at the district level. In addition, content was enhanced by the country's recently-conducted national Service Provision Assessment survey, which provided details on essential drugs, human resources, and other measures related to service readiness.
- In Nigeria, the profiles produced for each of the country's 36 states mirrored the national Countdown profiles, with charts showing progress on MDGs 4 and 5 and coverage across the continuum of care. A graph of missed opportunities for coverage and quality of care was included, and served as a key part of the action agenda. After the launch of the report, bilateral partners and NGOs supported certain state ministries of health in organising local events that utilised sub-national profiles to stimulate discussion of RMNCH issues. The analyses of findings and recommendations were specifically appropriate for those areas of the country.

Both of these sample sub-national profiles reflect country priorities and the particular focuses of their national processes, within the context of the RMNCH continuum of care. During this step of the process, each country can adapt and expand upon these models, as well as the global Countdown country profiles, in developing its own, specific template that reflects national priorities and the decisions made in step 4 and 5. Regardless of the format being used and indicators selected, it is important to ensure that all indicators are clearly identified on the profile and that agreement is reached on indicator definition and data source.

Populating the profile template with data is an important step that requires careful attention to quality. For some indicators it may be necessary to re-analyse existing data; this is likely to require the assistance of someone with experience in analysing large data sets. Once the draft profiles are ready they should be checked against the original data sets to ensure that they are accurate.



Formatting and printing the country profiles can be done by one of the Countdown partners in country, or outsourced to a private company. Experience suggests that a proof or single copy of the profiles should be printed and checked thoroughly for errors before completing the print run.

### ***Step 7: Agreeing on findings and key messages***

Based on the data and graphs produced for the national and sub-national profiles, as described in steps 5 and 6, the Scientific Working Group and the Communications and Media Working Group will need to summarise findings and construct key messages in ways that will be effective in communicating with important target audiences. Having the Organising Committee discuss and approve the final version will help ensure commitment to the findings and follow-up actions.

Asking questions such as those below can help in the message development process.

- Why are coverage levels for some interventions much higher than for other interventions? Does categorizing interventions by delivery mode help explain differing coverage levels?
- Which interventions have shown the largest increases in coverage over time? Why?
- Have special efforts been utilised to speed up coverage rates of certain interventions? Which interventions? Have these been successful? Have these extra efforts also helped other interventions, or hindered them?
- Why is coverage stagnating or regressing for some interventions?
- Are sufficient human and financial resources being provided for each of the interventions covered in the Countdown profile?
- Are there significant differences in coverage for some regions or districts? Why?
- Which interventions show the largest gaps in coverage according to income or other equity considerations such as gender or urban/rural location?
- Is it possible to identify the most neglected interventions for women's health, for children's health, and for newborn health?
- Which policies identified in the Countdown profiles have been adopted by the country, but not fully implemented? Which ones have not been adopted? Are there other policies that would be beneficial that should be adopted by the country?

### ***Step 8: Planning a national and/or sub-national meeting and media events***

An Events Working Group will generally be responsible for organising a national Countdown event. Depending on partners and resources available, this working group may be combined with a Communications and Media Working Group. In either case, the body charged with developing and implementing event planning should include representation both from relevant government ministries and from other interested constituencies, including NGOs, donors, UN agencies, professional associations, academic institutions, and parliamentarians, in order to ensure that the needs, concerns, and schedules of those various constituencies are adequately reflected in event agendas. Event planning can generally proceed simultaneously with the implementation of the Country Countdown's scientific work, although as outlined below it is important to correlate

the two streams of work so that the technical products are ready by the time the event is held. Some guidelines for event planning include the following:

- **First, develop a clear concept:** Before a working group initiates event planning, the Countdown Organising Committee should ensure that there is broad agreement around the aims, goals, size, funding source, and overall structure of the event.
- **Ensure broad, multi-sectoral participation:** As throughout the Countdown process, it is important that the national Countdown event draw diverse participation, in order to include multiple voices and maximise attention from the public, policy makers, and the media.
- **Decide on appropriate timing:** The Countdown event provides an opportunity to gain attention for national needs and priorities in RMNCH, and to mobilise support for ongoing, focused action. Typically, the key Countdown products (detailed country profile, sub-national profiles, report or policy brief, etc.) would be launched at the event, so it is important to be sure that these products will be ready when setting the event dates. It can be helpful to link the timing of the Countdown event with existing national review processes.
- **Develop a realistic budget:** Holding a national, multi-day meeting can be a costly enterprise. It is important to realistically assess the costs, and to ensure that adequate financial resources are available to ensure a successful event.
- **Consider retaining a professional event planner:** A successful event has many moving parts: finding and managing the venue; developing the agenda; identifying and inviting speakers and participants; arranging transportation, meals, and other logistics, etc. Typically, many committee members are not experts in these functions, and it is often wise to retain event planning professionals or contract an NGO that is experienced in event organising to manage the complex logistics.
- **Have a media strategy:** The national, regional, and local media (potentially including newspapers, TV, radio, online media, and bloggers) are critically important to getting policy maker attention and building public momentum. The Event Planning and Communications and Media Working Groups should work closely together to ensure that key media figures are aware of, attend, and provide coverage for the event. At minimum, the media strategy should include releasing a media advisory several weeks in advance of the event, issuing a press release to coincide with the event and/or the launch of Countdown products, and holding a media briefing or press conference with key speakers and/or high-level government supporters. If the budget allows, it can be helpful to retain a media agency to advise on media strategy, coordinate press contacts, and organise a press conference.
- **Gain high level policy engagement:** Prepare cabinet memos, policy briefs, and ministerial statements to parliament in order to get engagement at the highest levels.
- **Report on the event outcomes:** Plan and budget for development and distribution of a concise report that summarises the event's presentations and discussions, shares all commitments, and clearly expresses the meeting's outcomes and conclusions.
- **Don't forget the follow-up:** The event should be viewed not as an end, but as the beginning of the next stage of an ongoing national process, and consideration of next steps should be a part of the event planning process.

## Step 9: Preparing the meeting agenda and presentations

A national meeting can provide an excellent opportunity for dialogue by presenting the current situation, including trends in coverage and equity of coverage, policy adoption and implementation, and health financing. With a well-designed agenda, partners from various constituencies can work together to identify strengths in the health system and progress being made on coverage of key interventions for RMNCH. They can also identify low-coverage interventions, including possible causes and potential solutions, as well as missing data that can highlight the need for strengthened data collection processes.

Be sure that the agenda contributes to achieving the event goals. It should be structured to fulfil the aims identified by the Organising Committee, most likely focusing on building consensus around policy change, programme priorities, scale-up strategies, and mobilisation of resources.

The use of high-quality presentations, hand-outs, and publications that policymakers can understand is critical. Profiles play an important role in Countdown discussions: for all countries, but especially for large, decentralised countries, sub-national profiles will be invaluable. Countdown has specialised in re-packaging data for action and tracking — so countries are encouraged to include figures representing their continuum of care, equity analysis, and trends in financial flows. Including data on policies and health system indicators can provide useful information for further understanding of strengths and weaknesses in service delivery and system constraints. Guidance notes for analysing data on [equity, health systems and policies](#), and [financing](#) can be found in the appendices.

### *Example: Presentations at Zambia's conference:*

- Progress on key MNCH interventions
- Policy framework, investment, and infrastructure
- Human resources for health and MNCH
- Commodities
- Overview of maternal, newborn, and child health
- Maternal and child nutrition: scale of the problem, trends, and current efforts
- Presentations on all indicator themes from the country profile
  - Infant and young child nutrition
  - Immunizations
  - Community case management for pneumonia and malaria, and community-based newborn care
  - Diarrhea in children and oral rehydration
  - Water and sanitation
  - Focused antenatal and postnatal care
  - Community-based family planning
  - Emergency obstetric and newborn care
- Community engagement and care-seeking behavior
- Community-based prevention of mother-to-child transmission of HIV
- Pediatric HIV
- Results-based financing
- The role of hospitals in achieving MDGs 4 & 5
- The way forward: assigning follow-up roles

As the agenda develops, arrange for all conference sessions to be moderated by people (either paid facilitators or conference participants) who are experienced and skilled at meeting facilitation, in order to ensure that discussions stay on topic and that the event proceeds on

schedule. Session moderators should work with presenters and panellists to be sure that they understand the goals of their session, that they are aware of time constraints, and that the content of their presentations fits with the session topic.

In national and sub-national meetings, small group sessions will allow participants to have more in-depth discussions. Group work sessions can be organised by geographic area, by theme (equity, policies, systems, financing), or by client group (women, newborns, children). In its national meeting, Senegal included presenters from the local level, with practical examples of successes and challenges, in order to help formulate recommendations for system improvements. Nigeria's national event provided opportunities for partners to commit to future actions and agree to hold themselves to account for progress.

### ***Step 10: Involving broad participation in the Countdown discussions***

Throughout this Guide, there is a recurring emphasis on broad partnership. The Country Countdown is built on the principle that engaging all possible partners in planning and implementation builds positive energy and new or renewed commitments to action. A minimum list of partners would include the following:

- **Government officials:** The Ministry of Health (MOH) is a logical partner to lead the Countdown process. In each of the countries where Countdown events have been held, the MOH took strong leadership in data preparation and analysis, conference organising, and coordinating partners. It is also important to engage other ministries such as Planning and Finance.
- **Members of Parliament:** Parliamentarians have proven to be very interested in and supportive of the monitoring and action-planning functions of the Countdown process. Parliamentarians who understand the issues of RMNCH more deeply are likely to be willing to advocate for improved policies and further investment in interventions that save lives.
- **UN agencies:** The UN agencies are founding members of the Countdown at the global level, and their country representatives will be key partners in the Country Countdown process. Many country-based UN officials have attended global Countdown events and are familiar with the profiles, the indicators, and the issues covered. UN officers can offer expertise when serving on the organising group or working groups.
- **Nongovernmental organisations, both local and international:** These groups not only actively support health care delivery, but are also involved in advocacy, research, and data collection. Including them as partners ensures improved coordination and cross-learning with government programmes. They can play a unique role in bringing community voices into the process.
- **Health care professional associations:** Nurses, doctors, midwives, obstetricians and gynaecologists, paediatricians, and neonatologists all play an essential role in health care and are often served by national associations that can advocate for improved health practices and policies. Their voices add credibility and can increase commitment to better practices.

- **Academics and researchers:** These partners have much knowledge to share to enhance discussions on progress and challenges in many aspects of health care delivery, and on data collection, analysis, presentation, and use.
- **Donors:** Bilateral partners, foundations, and institutions are already investing in RMNCH and will want to be involved in discussions of progress and future plans. Experience in Nigeria showed that accountability can be increased by partner involvement throughout the process.
- **Private sector:** Partners from the business sector are often concerned about health care and willing to play a positive role. By learning more, the private sector has more opportunity to make a useful contribution.
- **Media:** Persuading a diverse range of constituents and decision makers is always a challenge. Involvement of print and broadcast media is crucial for increased understanding and support to RMNCH. Involving popular figures and role models can also be empowering, as demonstrated in Nigeria when a “Nollywood” star spoke out for newborn care.

As leaders and institutions become engaged with the Country Countdown, and throughout the process, encourage key stakeholders to make concrete commitments to develop and implement specific evidence-based policies, advance programmes, procure or provide financial resources, build grassroots or media support, etc. In Nigeria, a process similar to Countdown resulted in very specific, signed commitments by the government and partners.

The three country case studies, available at [www.countdown2015mnch.org](http://www.countdown2015mnch.org), provide lists of partners and their involvement and can be referred to for more ideas on specific partner engagement.

### **Step 11: Maximising accountability for acting on recommendations**

A clear, high-quality [report of the event](#) should be produced; it should summarise the discussions, share all commitments, and outline conclusions and decisions. Disseminate this report to all meeting participants, other Countdown constituents, and interested media figures and policy makers.

Based on experiences to date, it is expected that a Country Countdown will result in numerous positive outcomes, both in terms of increased cooperation, coordination, and resource mobilisation for RMNCH, and of identifying additional actions for bringing increased coverage and reduced mortality for women, children, and newborns.

By reviewing key findings and messages, and by asking how improvements can be made, country partners can identify actions to overcome the identified constraints. Referring to the questions in [step 7](#) may be useful in helping to identify recommendations for action at the national as well as sub-national levels.

Important follow-up events may include a parliamentary briefing; a series of publications; development of an accountability framework to track fulfilment of commitments; ongoing media contacts and/or media briefings; and planning for future national Countdown events and processes. Sub-national Countdown meetings may be planned to communicate Countdown

findings to provincial or local audiences, and to foster constructive dialogue about local strategies and approaches for addressing challenges identified through the Countdown process.

Concrete actions agreed and implemented in some Country Countdowns have included:

- Appointing a RMNCH coordinator for each district
- Development of a new national strategic plan
- Carrying out new costing and planning exercises
- Harmonizing the definition of intervention packages at each level
- Agreement by the MOH to include a specific budget line for newborn health
- Support for passing the Health Bill in the National Assembly
- Steps to address equity issues in human resources
- Identification of best practices, through data gathered by the university for national consultations
- Increasing enrolment in midwifery schools
- Updating regulations and procedures for implementation of community interventions
- Commitments by 13 partners specifying their contributions to improving RMNCH in relation to the priorities and recommendations described in the national report

How these recommendations are followed up will likely determine whether they are successfully implemented or remain a list of hopeful intentions. The national Countdown Organising Committee can designate lead roles and a timeframe for action. Using active inter-governmental and agency groups with reputations for follow through can speed the process of implementation. Some countries have established national partnerships for maternal, newborn, and child health, with membership echoing that of the [seven constituencies](#) of the global [Partnership for Maternal, Newborn & Child Health \(PMNCH\)](#).

In Zambia, after the national Countdown conference, a meeting was held at which the Organising Committee members reviewed the specific agreed-upon actions of all stakeholders. Follow-up letters were then sent to all stakeholders, reminding them of commitments for action made by their respective organisations. The Zambia Countdown Conference report was then prepared by selected members of the Organising Committee and distributed to all stakeholders who participated in the conference, all health institutions through Provincial Health Offices, and all partners during the annual donor consultative meeting.

In Senegal, the Country Countdown meeting was followed up with a health costing and planning exercise used for developing the *Plan National Stratégique pour la Survie de L'Enfant 2007-2015* (National Strategic Plan for Child Survival 2007-2015), which complements the Senegal Roadmap for Maternal and Newborn Health.



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## ***Adapting the process for a sub-national focus***

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As described in [step 6 above](#), undertaking a national Countdown process can provide a useful stimulus for understanding RMNCH progress and challenges. This value can be multiplied many times over by adding a sub-national focus. Progress and problems differ greatly within countries depending on the geography, urban/rural population distribution, cultural differences, and local resources. By having sub-national Countdowns, problems and strengths can be specifically addressed and solutions more realistically proposed.

A sub-national Countdown process typically should include creation of individual profiles for regions, provinces, states, or districts. The level can be decided based on available data as described in steps 4 and 5 above. Sources of data for sub-national profiles are often the same as for the national profiles, although they might include additional data from other surveys, vital registration, routine data, etc. For some indicators, only national-level data will be available; in these cases, the national data can be presented on the sub-national profile. All sub-national profiles will contain a mix of national and local data that should be clearly labelled to specify level. Examples of sub-national profiles can be found in [Appendix B](#).

During the national Countdown process, representatives from the regions and districts should be active participants. One option is to begin the Country Countdown process by first mobilizing the regions to prepare and review their local data. Another option is to begin with a national Countdown, train the regions or districts in the process, and repeat the Countdown process sub-nationally. A third option is to start with sub-national Countdowns and build to a national event, with actions to follow up on together.

Whichever approach is chosen, Countdown committees or working groups formed at sub-national levels can help prepare and analyse data and organise events and discussions with local officials, community representatives, health personnel, NGOs, and other partners. Bringing partners together at district-level or other sub-national events can provide opportunities for experience sharing, starting with discussions on how to scale up delivery of the interventions noted on the Countdown profile. Local organisers should call upon the national Countdown Organising Committee for technical support when required.

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## ***Reporting on the Country Countdown experience***

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Each country will want to document its Countdown experience for sharing widely throughout the country and with external partners. Products that can be produced and shared include the following:

- The country profile
- Sub-national profiles for provinces, states, or districts
- A national report detailing progress, constraints, and recommendations
- Media briefings of findings and messages
- Agenda and presenters at the national meeting



- Presentations shared at the national meeting
- Commitments and follow-up actions

Additional documentation could include lists of committee or working group members, lists of all data sources, etc.

In Nigeria, the report-writing process was undertaken using a lead author from a national university, a managing editor from a partner NGO, and both national and international reviewers. The report was produced before the national event, thereby making the analysis available as a basis for the meeting discussions. In Zambia, in contrast, the report followed the national conference and incorporated the findings and recommendations from the meeting.

Posting materials on the internet, in addition to making hard copies available to meeting participants and decision makers, can enhance outreach, broaden the Country Countdown's impact, and save on publication costs. In addition, posting reports and documentation on the global Countdown website, as well as on the PMNCH website, will facilitate information-sharing with other countries and international partners, enabling each country to learn from the experiences of those who have gone before.

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### ***Continuing the Countdown monitoring process***

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Planning and carrying out a Country Countdown will have required the investment of substantial time and energy by busy health planners, managers, policy makers, technical experts, and advocates. Experience shows, however, that a Country Countdown, integrated into the national health planning process, can build new skills, engage new partners, drive improved results, and help save lives. To ensure success, continued monitoring and follow-up is critical.

The Countdown experience can bring ongoing support to the national RMNCH planning process by being integrated into annual reviews at each level. Each of the indicators on the profile can be regularly monitored and updated as new information becomes available. For some indicators, data will be available annually. For others, new data will only be available as new DHS, MICS, or other nationally representative surveys are undertaken. Regardless of the number of data changes, an annual process in which a wide range of constituents review progress, identify constraints, and seek solutions should help to increase accountability and foster ongoing dialogue and problem-solving. During the annual review, giving emphasis to the Countdown indicators, including the subset of [key indicators identified by the UN Commission on Information and Accountability for Women's and Children's Health](#), can be particularly helpful in setting priorities. Reviewing policies, human resources, commodity and equipment needs, and health financing in relation to the Countdown indicators and national or local priorities is a strategic approach for identifying opportunities for policy and programming improvement.

## Country Countdown Implementation Checklist

**Note:** This Implementation Checklist, built on the step-by-step process outlined in this Guide, can and should be adjusted based on decisions made by each country's Organising Committee and working groups. Responsibility for each step or sub-step can be assigned to individuals and/or committees, in order to ensure accountability and maintain momentum.

Step	Resources, in addition to this Guide (see <a href="#">Appendix A</a> )	Responsible Parties	Date Completed
<b>1. Ensure links to national planning process</b> <ul style="list-style-type: none"> <li>✓ Identify all relevant existing processes (annual review, 5-year plan development, MDG review, etc.)</li> <li>✓ Define Country Countdown's value-added in context of existing processes</li> <li>✓ Brief decision-makers from partner agencies</li> </ul>	<ul style="list-style-type: none"> <li>✓ Documentation of national RMNCH planning processes</li> <li>✓ Countdown pamphlets, PowerPoint presentations (global, and customised country presentation), reports, articles, and website</li> </ul>	(Initial organisers)	
<b>2. Identify or create an organising committee and working groups</b> <ul style="list-style-type: none"> <li>✓ Consider existing groups that could serve as (or be modified to serve as) an organising committee</li> <li>✓ Constitute Organising Committee, ensuring participation of MOH and all relevant sectors</li> <li>✓ Identify Secretariat or organisational staffing</li> <li>✓ Constitute Scientific Working Group and invite members</li> <li>✓ Constitute Events Working Group and invite members</li> <li>✓ Constitute Media/Communications Working Group and invite members</li> <li>✓ Constitute Finance/Budget Working Group and invite members</li> </ul>	<ul style="list-style-type: none"> <li>✓ <a href="#">Appendix C</a></li> </ul>	(Initial organisers, Organising Committee members, MOH)	
<b>3. Develop a workplan and timeframe</b> <ul style="list-style-type: none"> <li>✓ Determine all steps needed to prepare the products and events and develop an activity-based budget and associated timeframe</li> <li>✓ Mobilise adequate funding for each stage of process, including national/sub-national events</li> <li>✓ Ensure adequate time for scientific work before scheduling events</li> <li>✓ Consult with all relevant working groups in developing timeframe and scheduling events</li> </ul>	<ul style="list-style-type: none"> <li>✓ Countdown's Country Case Studies (Nigeria, Senegal, Zambia)</li> </ul>	(Organising Committee, all working groups)	

Step	Resources, in addition to this Guide (see <a href="#">Appendix A</a> )	Responsible Parties	Date Completed
<b>4. Review data needs and availability</b> <ul style="list-style-type: none"> <li>✓ Review Countdown country profile and equity profile, and national priorities and plans</li> <li>✓ Develop master worksheet of data needs and priorities</li> <li>✓ Identify/collect data sources; record findings on master data worksheet</li> <li>✓ Identify relevant geographic units for sub-national profiles</li> <li>✓ Determine indicators and other information to be included in national/sub-national profiles</li> <li>✓ Present findings and recommendations to Organising Committee for ratification of profile contents and process</li> </ul>	<ul style="list-style-type: none"> <li>✓ Countdown country profile</li> <li>✓ Countdown equity profile (if available)</li> <li>✓ Country Case Studies and documentation</li> <li>✓ Sample sub-national profile</li> <li>✓ Countdown indicators and definitions (<a href="#">Appendix D</a>)</li> <li>✓ <a href="#">Monitoring MNCH: understanding key progress indicators</a></li> <li>✓ National/sub-national health survey data, health information reporting, relevant research studies</li> </ul>	(Scientific Working Group, possibly with data consultant)	
<b>5. Analyse coverage data and identify key messages</b> <ul style="list-style-type: none"> <li>✓ Compile and analyse the most recent available trend data on each selected indicator</li> <li>✓ Identify coverage differences across geographic units, including differences in changes over time</li> <li>✓ Consider patterns/messages suggested by results</li> <li>✓ Consider most effective ways of graphically presenting each indicator or set of results</li> <li>✓ Generate and validate preliminary key messages</li> <li>✓ Pursue additional analysis of equity, health systems/policies, and health financing</li> </ul>	<ul style="list-style-type: none"> <li>✓ Global Countdown Report</li> <li>✓ Countdown country profile</li> <li>✓ Countdown equity profile</li> <li>✓ Guidance notes on <a href="#">equity</a>, <a href="#">health systems/policies</a>, and <a href="#">financing</a></li> <li>✓ Country case studies and documentation, including sample sub-national profile</li> <li>✓ National/sub-national health survey data, health information reporting, relevant research studies</li> </ul>	(Scientific Working Group)	
<b>6. Create national and sub-national profiles</b> <ul style="list-style-type: none"> <li>✓ Develop templates for national and sub-national profiles, ensuring that indicators are clearly identified and defined</li> <li>✓ Populate profiles with data, re-analysing data where necessary</li> <li>✓ If key data is unavailable, consider noting on profile to highlight data gaps</li> <li>✓ Check all profiles against original data sets</li> <li>✓ Format profiles, check proofs, print profiles</li> </ul>	<ul style="list-style-type: none"> <li>✓ Countdown country profile</li> <li>✓ Countdown equity profile</li> <li>✓ Country case studies and documentation</li> <li>✓ Sample sub-national profile</li> <li>✓ Data sets</li> </ul>	(Scientific Working Group)	

Step	Resources, in addition to this Guide (see <a href="#">Appendix A</a> )	Responsible Parties	Date Completed
<b>7. Agree on findings and key messages</b> <ul style="list-style-type: none"> <li>✓ Review draft messages (from step 5)</li> <li>✓ Interrogate data and findings for significance and policy/programme implications</li> <li>✓ Ensure that key messages are expressed in language that is clear, persuasive, and meaningful to key audiences</li> <li>✓ Review final messages with Organising Committee</li> </ul>	<ul style="list-style-type: none"> <li>✓ Data sets, analytical findings, profiles</li> <li>✓ Global Countdown Report</li> <li>✓ Research papers related to Countdown coverage indicators (Lancet, BJM, JAMA, etc)</li> </ul>	(Scientific Working Group and Communications/Media Working Group)	
<b>8. Plan national and/or sub-national meetings and events</b> <ul style="list-style-type: none"> <li>✓ Decide type(s) of event to be planned, and ensure Organising Committee buy-in on concept and goals</li> <li>✓ Determine event timing, ensuring that scientific work (including profiles and reports) will be completed in time</li> <li>✓ Ensure that adequate event funding is available, or mobilise additional funding if needed</li> <li>✓ Identify and retain a professional event planner, or assign planning/organisational responsibilities</li> <li>✓ Develop media strategy</li> </ul>	<ul style="list-style-type: none"> <li>✓ Country case studies and documentation</li> </ul>	(Events Working Group)	
<b>9. Prepare meeting agenda and presentations</b> <ul style="list-style-type: none"> <li>✓ Ensure that the agenda aligns with event concept/goals</li> <li>✓ Arrange for skilled session facilitation</li> <li>✓ Develop realistic event schedule, allowing discussion of all key issues and enabling event to stay on schedule</li> <li>✓ Communicate event/session objectives to all facilitators and presenters, and ensure they understand their roles</li> <li>✓ Ensure that agenda leaves room for active discussion and consensus-building</li> <li>✓ Develop consistent, high-quality presentation materials</li> <li>✓ Leave room at end of agenda for stakeholders to make concrete, forward-looking commitments</li> </ul>	<ul style="list-style-type: none"> <li>✓ Country case studies and documentation</li> <li>✓ Global Countdown PowerPoint presentations</li> <li>✓ Country-specific PowerPoint presentation with country profile data</li> </ul>	(Events Working Group)	

Step	Resources, in addition to this Guide (see <a href="#">Appendix A</a> )	Responsible Parties	Date Completed
<b>10. Involve broad participation in discussions</b> <ul style="list-style-type: none"> <li>✓ Engage all organising committee and working group members and partners to ensure event participation by all relevant sectors</li> <li>✓ Prepare policy briefs, memos, and other documents to engage senior members of government and parliament</li> </ul>	<ul style="list-style-type: none"> <li>✓ Country case studies and documentation</li> <li>✓ <a href="#">Appendix C</a></li> </ul>	(Organising Committee and all working groups)	
<b>11. Maximise accountability for acting on recommendations</b> <ul style="list-style-type: none"> <li>✓ Focus event discussions on concrete commitments and agreement on policy change and programme priorities</li> <li>✓ Emphasise how recommendations will impact on women's and children's lives and positively affect RMNCH coverage and outcomes</li> <li>✓ Report on event outcomes; disseminate report to all participants and stakeholders, post on internet, and share with global Countdown</li> <li>✓ Agree on ongoing organisational structure to ensure follow-up and fulfilment of commitments</li> <li>✓ Develop timeframe for follow-up</li> <li>✓ Develop plan for ongoing events (parliamentary briefings, media briefings, sub-national meetings, etc.)</li> <li>✓ Ensure that Countdown findings, profiles, and report are integrated into ongoing annual health review and planning processes</li> </ul>	<ul style="list-style-type: none"> <li>✓ Country case studies and documentation</li> </ul>	(All participants)	

# ***Appendices***

## Appendix A: The Country Countdown Toolkit

**Note:** The contents of the Country Countdown Toolkit will be expanded over time, as additional documents useful to countries considering or planning their own Country Countdowns become available. Please visit [the Countdown to 2015 website](#) for the most up-to-date listing of Toolkit contents and for links to all documents.

### Global Countdown materials:

1. [Countdown to 2015: History and Structure](#) — 4-page pamphlet that describes the history, objectives, governance, and working group structure of Countdown to 2015
  - *This pamphlet may be a useful tool to give to potential partners who are considering participation in an Organising Committee or Country Countdown event, but are not familiar with Countdown.*
2. PowerPoint presentations: [Introduction to Countdown to 2015](#), [The Countdown Report: Data, Methods & Country Profiles](#), and [The 2012 Countdown Report: Major Findings](#)
  - *These presentations may be useful for introducing Countdown, its methodology, and its global findings at conferences or at introductory Organising Committee meetings.*

In addition, a wide variety of relevant materials — including all Countdown [reports](#), [profiles](#), [research papers](#), and [briefing notes](#) — is available on [the Countdown website](#).

### Country Countdown materials:

3. *Country Countdown: Accelerating progress to 2015 and beyond* — A guide for countries and partners (**this document**) including:
  - Countdown Country [Implementation Checklist](#)
  - Sample sub-national profiles ([Appendix B](#))
  - Suggestions for forming organising committee and working groups ([Appendix C](#))
  - Definitions of Countdown indicators ([Appendix D](#))
  - Guidance Notes for analyses of Equity ([Appendix E](#)), Health Systems and Policies ([Appendix F](#)), and Health Financing ([Appendix G](#))
  - *This document provides detailed guidance for the planning and implementation of a Country Countdown.*
4. [Countdown to Success: Building momentum with a Country Countdown](#) — 2-page pamphlet that briefly describes the benefits, principles, and process of conducting a Country Countdown
  - *This pamphlet offers a useful introduction to Country Countdown for potential partners who are considering participation in an Organising Committee or Country Countdown event.*
5. [Countdown country profiles](#) for all 75 Countdown countries, and [How to use the Countdown country profile](#)



- *The country profile for your country is a crucial starting point for the scientific work of the Country Countdown, and profiles for neighbouring countries may also offer interesting points of comparison; the 'How to use' document offers a detailed guide to understanding the profile.*
6. [Countdown equity profiles](#) for 58 Countdown countries (for which equity data was available as of 2012), and [How to read the 2012 equity profile](#)
    - *In countries where it is available, the equity profile provides invaluable data disaggregating national coverage on socioeconomic, gender, and geographic dimensions, and provides an excellent starting point for the Country Countdown's equity and sub-national analysis; the 'How to read' document offers a detailed guide to understanding the equity profile.*
  7. Sample sub-national profiles ([Appendix B](#))
    - *While each country's Countdown will develop its own format for its sub-national profiles, based on the country's priorities, data availability, and selected geographical units, these samples can provide a useful starting point for the Scientific Working Group's discussions.*
  8. Customised (and customizable) [PowerPoint presentations](#) for each of the 75 Countdown countries, with introductory information on Countdown, an introduction to the Country Countdown process, and detailed presentation of all data on the Countdown country profile
    - *This presentation, with custom content based on your country's Countdown country profile, can be useful **both** as an introduction to the Country Countdown process **and** as a way of introducing policy makers, media, advocates, and other stakeholders to a set of essential data on the country's current situation with regard to reproductive, maternal, newborn, and child health.*
  9. Country Case Studies detailing Country Countdown experiences in [Nigeria](#), [Senegal](#), and [Zambia](#); electronic copies of reports, PowerPoint presentations and other documents relevant to past Country Countdown experiences are also available for download at the Countdown website
    - *Country Countdown Organising Committees and working groups can benefit from the experiences of countries that have already implemented national Countdown initiatives.*
  10. [Monitoring maternal, newborn and child health: understanding key progress indicators](#) (Countdown to 2015, Health Metrics Network, UNICEF and WHO, 2011) — a report summarising opportunities and challenges to effective monitoring of 11 select, core RMNCH indicators selected by the Commission on Information and Accountability for Women's and Children's Health
    - *This publication provides detailed explanations of core RMNCH indicators (all of which appear on the Countdown country profile), and can provide guidance to countries seeking to improve the quality and availability of key data on outcomes and coverage.*

## Appendix B: Sample sub-national profiles

### Sample sub-national profile: Tanzania

#### CHAPTER 5: DATA FOR ACTION

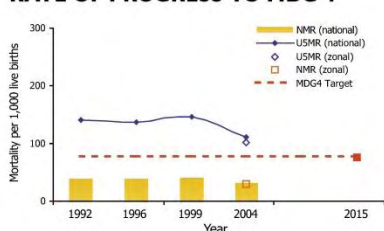
### ZANZIBAR – PEMBA NORTH, PEMBA SOUTH, TOWN WEST, ZANZIBAR NORTH, ZANZIBAR SOUTH



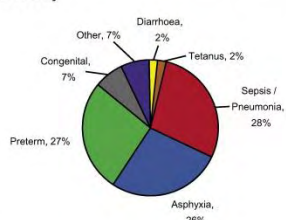
#### BIRTHS AND DEATHS

Total population (2002)	1,004,000
Annual births (2002)	46,000
<b>MOTHERS</b>	
Maternal mortality ratio per 100,000 live births (national, 2004)	578
Annual maternal deaths	300
<b>NEWBORNS</b>	
Neonatal mortality rate per 1,000 live births (2004)	29
Annual neonatal deaths	1,300
<b>CHILDREN</b>	
Under 5 mortality rate per 1,000 live births (2004)	101
Annual under 5 deaths	4,600
Neonatal mortality % of under 5 mortality	29%

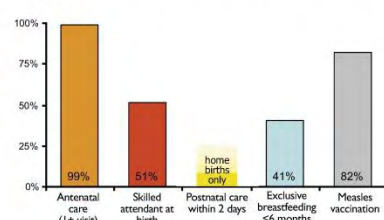
#### RATE OF PROGRESS TO MDG 4



#### CAUSES OF NEONATAL DEATH (national)



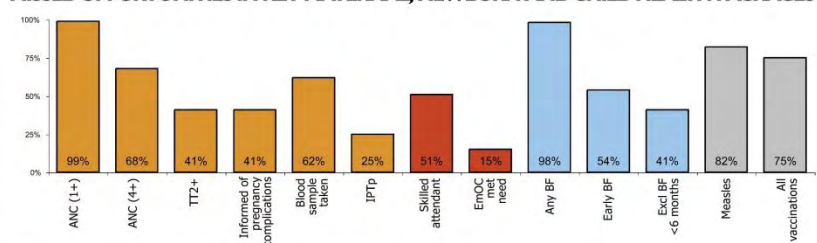
#### COVERAGE ALONG THE CONTINUUM OF CARE



#### HEALTH SYSTEMS, POLICY AND FINANCE

Met need for contraception (%)	34	Number of hospitals; health centres	-
HIV prevalence, women 15-49 (%)	32	Nursing officers per 1,000 population	-
Knowledge of PMTCT (%)	-	EmOC facilities per 500,000 pop: basic; comprehensive	1.3; 0.4
Caesarean section (%)	2	Health facilities offering newborn respiratory support (%)	38
Low birth weight prevalence (%)	14	Health facilities offering PNC services (%)	56
Median duration exclusive breastfeeding (months)	-	Facilities with first-line drugs for child illness (%)	58
Care seeking for acute respiratory infection (%)	66	Facilities with pre-referral drugs for child illness (%)	33
Children with a birth certificate (%)	63	Annual health budget (TSH thousands)	-
Health facilities charging user fees for child services (%)	32	Per capita annual allocation (TSH thousands)	-

#### MISSED OPPORTUNITIES IN KEY MATERNAL, NEWBORN AND CHILD HEALTH PACKAGES



58

Source: [Situation analysis of newborn health in Tanzania](#). Current situation, existing plans and strategic next steps for newborn health. Ministry of Health and Social Welfare of The United Republic of Tanzania with Save the Children, 2009. All sub-national profiles for Tanzania are presented in this publication.

## Sample sub-national profile: Nigeria



### Kaduna State

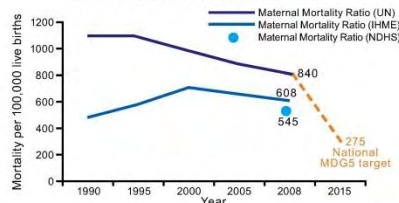
#### CHAPTER 5: STATE NEWBORN HEALTH DATA PROFILES

Indicator data are state-specific data for 2008, unless otherwise noted.  
Please see page 74 for indicator definitions and data sources.

##### BIRTHS AND DEATHS

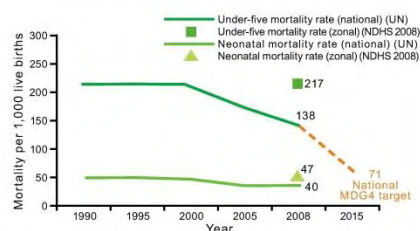
Population	6,552,000
Annual births	262,000
Neonatal mortality rate per 1000 live births (zonal)	47
Annual number of neonatal deaths	12,300
Under-five mortality rate per 1000 live births (zonal)	217
Annual number of under-five deaths	57,000
Maternal mortality ratio per 100,000 live births (national)	545
Annual number of maternal deaths	1400

##### NATIONAL PROGRESS TO MDGs AND REPRODUCTIVE HEALTH

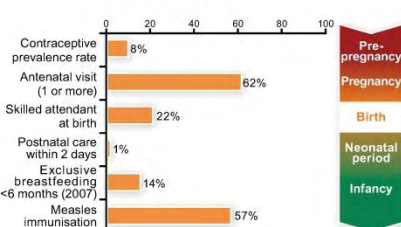


Total fertility rate	6.3
Adolescents who have begun childbearing (%)	32
Female genital cutting (%)	2
Unmet need for family planning (%)	21
C-section rate (%)	1.0

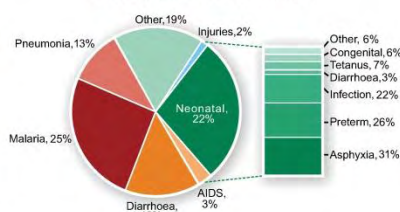
##### NATIONAL PROGRESS TO MDG4



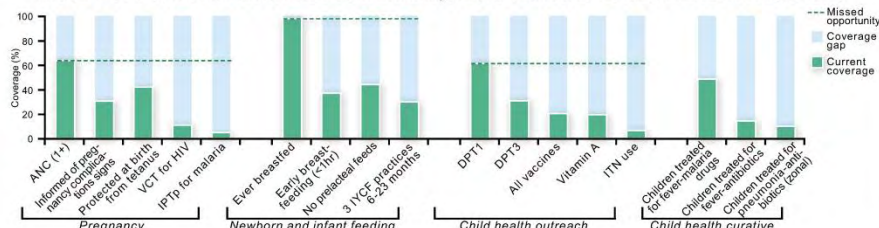
##### COVERAGE ALONG THE CONTINUUM OF CARE



##### CAUSES OF NEONATAL AND UNDER-FIVE MORTALITY



##### MISSED OPPORTUNITIES IN KEY MATERNAL, NEWBORN AND CHILD HEALTH PACKAGES



##### HEALTH SYSTEMS

Health information: Birth registration (%)	26
Human resources: Nurses and midwives & community health officers (per 10,000 pop)	88 & 83
Governance and leadership: IMNCH strategic planning initiated	Yes
Financing for health: IMNCH strategy costed	Yes
Medicines and equipment: Proportion of 20 essential child health medicines available at district health facilities	No data

##### MATERNAL, NEWBORN AND CHILD LIVES SAVED AT 90% COVERAGE

% maternal lives saved	52%
Number of maternal lives saved	720
% neonatal lives saved	71%
Number of neonatal lives saved	8,800
% post-neonatal and child lives saved	75%
Number of post-neonatal and child lives saved	33,700

SAVING NEWBORN LIVES IN NIGERIA

Source: [Saving newborn lives in Nigeria](#): Newborn health in the context of the Integrated Maternal, Newborn and Child Health Strategy. 2nd edition. Abuja: Federal Ministry of Health, Save the Children, Jhpiego; 2011. All sub-national profiles for Nigeria are presented in this publication.

## ***Appendix C: Forming a Country Countdown Organising Committee and Working Groups***

### ***National Countdown Organising Committee***

Ideally, the Organising Committee will be part of or will link to an existing structure or group focused on national reproductive, maternal, newborn, and child health strategy. For example:

- In Nigeria, the Core Technical Committee of the Nigeria Partnership for Maternal, Newborn and Child Health (NPMNCH) oversaw the preparation of the national report and updated profiles.
- In Zambia, a high-level organising committee was formed with the Ministry of Health as chair. All working groups reported back to this main committee.
- In Senegal, the Organising Committee included delegates from the Ministry of Health as well as from international agencies.

In all three countries, government, UN, and NGO committee members who participated in global Countdown meetings were able to use their familiarity with the indicators, country profiles, process, and methodology to help lead the national efforts. Experience in Senegal suggests that the presence of international champions for RMNCH can add strength to Country Countdown efforts.

The Organising Committee may meet monthly, or more frequently when necessary, to review progress and to organise the national Countdown event.

**Responsibilities of the Organising Committee** might include the following:

- Setting up and overseeing working groups to undertake data preparation and analysis, profile development, document preparation, budgeting, communications, and event planning
- Advocating for the Countdown process with all relevant partners and ensuring that interested partners from all constituencies are represented in the Countdown planning
- Ensuring that all Countdown planning is well-coordinated and fits within the ongoing national health planning process
- Liaising with the global Countdown to obtain support when required
- Identifying and mobilising resources to carry out the Countdown process
- Reviewing and approving the findings and messages for development of the national report, national and sub-national profiles, and media releases
- Following up recommendations from national and sub-national discussions
- Planning for next steps in the national Countdown process

### ***Scientific Working Group***

Membership of the Scientific Working Group might include the relevant MOH departments, including those responsible for health information, health research, and finances. Academics and research institutions, the UN agencies, international partners, and local NGOs and professional associations can all provide valuable input in reviewing and adding to the information required for the country profiles and for the subsequent analysis and findings. Having expertise on human resources, health financing, and equity analysis will be important. Members from a cross-section of regions and districts will bring a valuable sub-national perspective to the group.

**Responsibilities of the Scientific Working Group** might include the following:

- Reviewing available data
- Identifying additional data or research studies, especially from more recent surveys and any relevant sub-national data
- Analysing data, including comparisons with global Countdown data, looking at rates of change, comparing districts or regions, considering indicators based on different delivery methods, analysing coverage levels by income group, gender, etc.
- Linking with national or external experts, and possibly with the global Countdown team, to add more detailed analyses of equity, financial flows, or health systems and policies
- Preparing tables and graphs showing current coverage and trends
- Preparing the national and sub-national profiles with assistance from the Communications Working Group
- Assisting Communications Working Group with message development and media briefings
- Assisting with identification of topics and speakers for the national Countdown meeting

### ***Events Working Group***

Membership of the Events Working Group would ideally include members of the Ministry of Health, together with NGOs, members of Parliament, UN agency and donor partners, and professional associations. It would also be useful to include the private sector. Hiring a conference organiser can help to lessen the workload for the MOH and partners.

**Responsibilities of the Events Working Group** might include the following:

- Overall planning for the national Countdown conference, sub-national events, a media briefing, and a parliamentary briefing
- Identifying and inviting participants
- Selecting and booking appropriate venues, seating, sound systems, etc.
- Developing a budget
- Preparing agendas
- Arranging tea/coffee breaks and lunches



### ***Communications and Media Working Group***

Membership of the Communications and Media Working Group might include the communications, advocacy, and/or health education staff of the Ministry of Health, the UN partners, and participating NGOs. Representatives of the media will also be important partners. Professional associations and academics can add a useful perspective.

**Responsibilities of the Communications and Media Working Group** might include:

- Developing messages to share with the public based on findings of the national and sub-national profiles and report
- Producing short briefings in partnership with the Scientific Working Group
- Assisting with the production of the national report and national and sub-national profiles
- Arranging for dissemination of reports, profiles, and other Country Countdown products to key stakeholders
- Arranging media briefings and press releases
- Arranging television and radio interviews
- Assisting with event planning and providing relevant communication materials
- Documenting the conference discussions and conclusions

### ***Finance/Budget Working Group***

Membership of the Finance/Budget Working Group should include a senior member of the Ministry of Health, donor partners, and UN and NGO officers. Additionally, including the private sector, a member of parliament, and a professional association representative will demonstrate wide commitment to the national Countdown effort.

**Responsibilities of the Finance/Budget Working Group** might include:

- Reviewing budget needs for the planned events and publications
- Identifying MOH and other national resources to meet budget requirements and identifying potential shortfalls
- Contacting donor, UN, NGO, and private sector partners to secure the necessary funding
- Accounting for funds and reporting to donors

## Appendix D: Countdown indicators and definitions

### Definitions of Countdown indicators

Intervention	Indicator definition	Numerator	Denominator
<b>Maternal and newborn health</b>			
<b>Skilled attendant at birth*</b>	Percentage of live births attended by skilled health personnel	Number of live births to women ages 15–49 years in the X years prior to the survey attended during delivery by skilled health personnel (doctor, nurse, midwife or auxiliary midwife)	Total number of live births to women ages 15–49 in the X years prior to the survey
<b>Treatment of HIV*</b>	Percentage of HIV-positive pregnant women who received antiretroviral therapy for their own health	Number of HIV-positive pregnant women attending services for prevention of mother-to-child transmission in the past 12 months who are on lifelong antiretroviral therapy	Estimated number of HIV-positive pregnant women in the past 12 months who were eligible for antiretroviral therapy <sup>a</sup>
<b>Prevention of mother-to-child transmission of HIV*</b>	Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	Number of HIV-infected pregnant women who received antiretrovirals in the last 12 months to reduce mother-to-child transmission	Estimated unrounded number of HIV-positive pregnant women <sup>a</sup>
Antenatal care (at least one visit)	Percentage of women attended at least once during pregnancy by skilled health personnel for reasons related to the pregnancy	Number of women attended at least once during pregnancy by skilled health personnel (doctor, nurse, midwife or auxiliary midwife) for reasons related to the pregnancy in the X years prior to the survey	Total number of women who had a live birth occurring in the same period
<b>Antenatal care (four or more visits)*</b>	Percentage of women attended at least four times during pregnancy by any provider (skilled or unskilled) for reasons related to the pregnancy	Number of women attended at least four times during pregnancy by any provider (skilled or unskilled) for reasons related to the pregnancy in the X years prior to the survey	Total number of women who had a live birth occurring in the same period
<b>Demand for family planning satisfied*</b>	Percentage of women ages 15–49, either married or in union, who have their need for family planning satisfied	Women who are married or in union and currently using any method of contraception	Women who are married and in union and who are currently using any method of contraception or who are fecund, not using any method of contraception but report wanting to space their next birth or stop childbearing altogether
Intermittent preventive treatment for malaria during pregnancy	Percentage of women who received intermittent preventive treatment for malaria during their last pregnancy	Number of women at risk for malaria who received two or more doses of a sulfadoxine-pyrimethamine (Fansidar <sup>TM</sup> ) to prevent malaria during their last pregnancy that led to a live birth	Total number of women surveyed who delivered a live newborn within the last two years
Caesarean section rate	Percentage of live births delivered by caesarean section	Number of live births to women ages 15–49 in the X years prior to the survey delivered by caesarean section	Total number of live births to women ages 15–49 in the X years prior to the survey
Neonatal tetanus protection	Percentage of newborns protected against tetanus	Number of mothers with a live birth in the year prior to the survey who received two doses of tetanus toxoid vaccine within the appropriate interval prior to the infant's birth	Total number of women ages 15–49 with a live birth in the year prior to the survey
<b>Postnatal care for mothers**</b>	Percentage of mothers who received postnatal care within two days of childbirth	Number of women who received postnatal care within two days of childbirth (regardless of place of delivery)	Total number of women ages 15–49 with a last live birth in the X years prior to the survey (regardless of place of delivery)
<b>Postnatal care for babies*</b>	Percentage of babies who received postnatal care within two days of childbirth	Number of babies who received postnatal care within two days of birth (regardless of place of delivery)	Total number of last-born babies in the X years prior to the survey (regardless of place of delivery)
Low body mass index	Percentage of women ages 15–49 with a body mass index of less than 18.5 kg/m <sup>2</sup>	Number of women ages 15–49 with a body mass index of less than 18.5 kg/m <sup>2</sup>	Total number of women ages 15–49
<b>Child health</b>			
Measles immunization coverage	Percentage of infants immunized with measles containing vaccine	Number of children ages 12–23 months who are immunized against measles	Total number of children ages 12–23 months surveyed
<b>Three doses of combined diphtheria/tetanus/pertussis vaccine immunization coverage (DTP3)*</b>	Percentage of infants who received three doses of diphtheria/tetanus/pertussis vaccine (DTP3)	Number of children ages 12–23 months receiving three doses of diphtheria/tetanus/pertussis vaccine (DTP3)	Total number of children ages 12–23 months surveyed
Three doses of <i>Haemophilus influenzae</i> type B (Hib3) immunization coverage	Percentage of infants who received three doses of <i>Haemophilus influenzae</i> type B (Hib3) vaccine	Number of children ages 12–23 months receiving three doses of <i>Haemophilus influenzae</i> type B (Hib3) vaccine	Total number of children ages 12–23 months surveyed
Careseeking for pneumonia	Percentage of children ages 0–59 months with suspected pneumonia taken to an appropriate health provider	Number of children ages 0–59 months with suspected pneumonia in the two weeks prior to the survey who were taken to an appropriate health provider	Total number of children ages 0–59 months with suspected pneumonia in the two weeks prior to the survey
<b>Antibiotic treatment for pneumonia*</b>	Percentage of children ages 0–59 months with suspected pneumonia receiving antibiotics	Number of children ages 0–59 months with suspected pneumonia in the two weeks prior to the survey receiving antibiotics	Total number of children ages 0–59 months with suspected pneumonia in the two weeks prior to the survey



Intervention	Indicator definition	Numerator	Denominator
Oral rehydration therapy and continued feeding	Percentage of children ages 0–59 months with diarrhoea receiving oral rehydration therapy and continued feeding	Number of children ages 0–59 months with diarrhoea in the two weeks prior to the survey receiving oral rehydration therapy (oral rehydration solution or recommended homemade fluids or increased fluids) and continued feeding	Total number of children ages 0–59 months with diarrhoea in the two weeks prior to the survey
Oral rehydration salts	Percentage of children ages 0–59 months with diarrhoea receiving oral rehydration salts	Number of children ages 0–59 months with diarrhoea in the two weeks prior to the survey receiving oral rehydration salts	Total number of children ages 0–59 months with diarrhoea in the two weeks prior to the survey
Antimalarial treatment	Percentage of children ages 0–59 months receiving first line antimalarial treatment	Number of children ages 0–59 months who had a fever in the previous two weeks who received first-line treatment according to national policy	Total number of children ages 0–59 months who had a fever in the previous two weeks who received any antimalarial drugs
Insecticide-treated net use	Percentage of children ages 0–59 months sleeping under an insecticide-treated mosquito net	Number of children ages 0–59 months sleeping under an insecticide-treated net the night before the survey	Total number of children ages 0–59 months surveyed
<b>Nutrition</b>			
Early initiation of breastfeeding	Percentage of newborns put to the breast within one hour of birth	Number of women with a live birth in the X years prior to the survey who put the newborn infant to the breast within one hour of birth	Total number of women with a live birth in the X years prior to the surveyed
<b>Exclusive breastfeeding (for first six months of life)*</b>	Percentage of infants ages 0–5 months who are exclusively breastfed	Number of infants ages 0–5 months who are exclusively breastfed	Total number of infants ages 0–5 months surveyed
Introduction of solid, semisolid or soft foods	Percentage of infants ages 6–8 months who receive solid, semisolid or soft foods	Number of infants ages 6–8 months who received solid, semisolid or soft foods during the previous day	Total number of infants ages 6–8 months surveyed
Vitamin A supplementation (two doses)	Percentage of children ages 6–59 months who received two doses of vitamin A during the calendar year	Number of children ages 6–59 months who received two doses of vitamin A during the calendar year	Total number of children ages 6–59 months
<b>Water and sanitation</b>			
Use of an improved drinking water source	Percentage of the population using an improved drinking water source (piped on premises or other improved drinking water source)	Number of household members using improved and drinking water source (including piped on premises, public standpipe, borehole, protected dug well, protected spring and rainwater collection)	Total number of household members
Use of improved sanitation facilities	Percentage of the population using improved sanitation facilities	Number of household members using improved sanitation facilities (including connection to a public sewer, connection to a septic system, pour-flush latrine, simple pit latrine or a ventilated improved pit latrine)	Total number of household members

\* Indicators in bold are those recommended by the Commission on Information and Accountability for Women's and Children's Health.

a. More details on the HIV estimates methodology can be found at [www.unaids.org](http://www.unaids.org).

b. As used for postnatal care in the graph on coverage along the continuum of care on page 1 of each country profile.

Source: [Countdown Report 2012](#), Annex B

## ***Appendix E: Equity Analysis Guidance Notes***

### ***Why measure inequalities in health?***

Aggregate national-level statistics often hide important within-country inequalities. For example, it is quite common for under-five mortality of children from the poorest 20% of all families to be at least twice as high as the mortality rate in the richest 20%, or for coverage of interventions such as skilled birth attendance to vary substantially from urban to rural areas.

Inequalities or disparities in health are defined as any consistent differences in health outcomes between population subgroups. For example, boys usually show higher under-five mortality rates than girls, due to biological reasons. Inequities are inequalities that are not only unnecessary and avoidable, but in addition unfair and unjust (Whitehead 1992). For example, social class differences in child health are inequities, not only inequalities. And higher mortality among boys than girls represents inequality, but not inequity.

Equity analyses are important when considering human rights issues, but also because measurement and documentation of inequalities can help improve health programmes; for example by targeting specific population subgroups that are not being reached with life-saving interventions.

### ***What equity analyses are available from Countdown to 2015?***

Since its inception, Countdown has emphasised the need to address inequities in maternal and child health as a key strategy for improving health and survival (Victora, Wagstaff et al. 2003). Stratified analyses of key coverage indicators have been an essential part of Countdown reports (Countdown to 2015, 2005; Countdown to 2015, 2008; Countdown to 2015, 2010; Countdown to 2015, 2012), country profiles, and publications (Bryce and Victora 2005; Bryce, Terreri et al. 2006; Boerma, Bryce et al. 2008; Bhutta, Chopra et al. 2010; Barros, Ronsmans et al. 2012).

Within Countdown, the Equity Working Group is in charge of reanalysing national surveys, including Demographic and Health Surveys (DHS), Multiple-Indicator Cluster Surveys (MICS) and other surveys, to produce disaggregated analyses aimed at monitoring inequities in coverage of health interventions.

Five stratification variables are used in the Countdown analyses: gender, wealth, maternal education, urban/rural residence, and region of the country. All of these variables are self-explanatory, with the exception of wealth.

Asset indices have become the most commonly used approach for measuring wealth in population surveys (Filmer and Pritchett 1988). Typically, it is derived from a relatively short list of household possessions (radio, television, refrigerator, etc.) and characteristics of the house (building materials, toilet, electricity, etc.). These variables, available in surveys such as DHS and MICS, are subjected to principal component analysis, a data reduction technique that produces linear combinations of the variables, the components. The first component, or factor, is extracted in a way that it retains as much variability as possible from all of the variables (Jolliffe 2002), from which a continuous score is derived. Each household is then assigned a score that is usually

broken down into quintiles, or fifths of the population. The poorest quintile corresponds to the 20% of the households with the lowest scores in the asset index, and so on. Quintiles are labelled in Countdown analyses as Q1 to Q5, from the poorest 20% (Q1) to the richest 20% (Q5). Quintiles are relative, not absolute measures. For example, Q1 families in a middle-income country may be as rich as families in Q2 or Q3 in a low-income country.

Because of the large number of possible breakdowns of coverage indicators according to the five stratification variables used in the Countdown, analyses are restricted to 16 indicators that are widely available in surveys including:

- Need for family planning satisfied
- Contraceptive prevalence rate (modern methods)
- Antenatal care (at least one visit by skilled provider)
- Antenatal care (four or more visits, any provider)
- Skilled attendant at birth
- Caesarean section rate
- Early initiation of breastfeeding
- Postnatal care for babies who were born at home
- Postnatal care for all babies
- Bacille Calmette-Guerin (BCG) vaccine
- Three doses of combined diphtheria/ tetanus/pertussis vaccine (DTP3)
- Measles vaccine
- Vitamin A supplementation in the last 6 months
- Children under age 5 sleeping under insecticide-treated nets
- Oral rehydration therapy and continued feeding for children with diarrhoea
- Care seeking for pneumonia
- Improved drinking water source
- Improved sanitation facility

Indicator definitions are available at

[http://www.countdown2015mnch.org/documents/2012Report/2012Equity/How\\_to\\_use\\_2012\\_equity\\_profile.pdf](http://www.countdown2015mnch.org/documents/2012Report/2012Equity/How_to_use_2012_equity_profile.pdf)

Countdown equity analyses also include two summary indicators, which aggregate several coverage measures. These are the composite coverage indicator and co-coverage.

**Composite coverage indicator or CCI:** This is a weighted average of the coverage of eight interventions selected from four areas (family planning, maternity care, child immunisation, and case management). This indicator was developed for Countdown (Boerma, Bryce et al. 2008) with the aim of providing a summary measure of coverage that could be used to assess and report on equity in the context of multi-country and time-trend analyses. Its formula is:

$$CCI = 1/4 (FPS + (SBA + ANCS)/2 + (2DPT3 + MSL + BCG)/4 + (ORT + CPNM)/2)$$

where FPS stands for family planning needs satisfied, SBA for skilled birth attendant, ANCS for antenatal care with skilled provider, DPT3 for three doses of DPT vaccine, MSL for measles

immunisation, BCG for BCG immunisation, ORT for oral rehydration therapy for children with diarrhoea, and CPNM for care-seeking for pneumonia.

The CCI is calculated at group level, for example by wealth quintile or gender, by averaging coverage of the above-listed interventions in each group.

**Co-coverage:** The other combined indicator is co-coverage. In contrast to the CCI, which is calculated at group level, co-coverage is calculated at individual (mother and child) level. It is restricted to preventive indicators which should reach all mothers and children. It is obtained by adding the number of interventions received by each child; the eight core interventions include vaccines (BCG, diphtheria-pertussis-tetanus, and measles vaccines), tetanus toxoid for the mother, vitamin A supplementation, antenatal care, skilled delivery, and safe water. In countries with endemic malaria, a ninth intervention (insecticide treated nets for the child) is also included. Because curative interventions such as ORT or pneumonia care are not required by all children — but only for those who were ill in the period before the survey — they are not included in the co-coverage index. Co-coverage is therefore a score ranging from zero to eight (or nine, in malaria-endemic countries), which can be broken down by wealth quintiles, gender, urban/rural residence, etc.

All Countdown equity analyses took into account the survey design, including sampling weights and clustering. Country-level results for each indicator and country were checked against published results to verify the accuracy of our calculations.

### ***How can I access Countdown equity analyses for my country?***

Equity profiles are available on the Countdown website for all countries with recent MICS or DHS surveys that included information on household assets and other stratification variables (sex of the child, urban/rural residence, maternal education, and region of the country). These data are much more detailed than those included in the Countdown country profiles, or in the Countdown reports.

Equity analyses carried out for the 2012 Countdown Report can be downloaded at:

[http://www.countdown2015mnch.org/documents/2012Report/2012Equity/full\\_equity\\_profiles\\_2012.pdf](http://www.countdown2015mnch.org/documents/2012Report/2012Equity/full_equity_profiles_2012.pdf)

Equity analyses carried out in preparation for the 2010 Countdown report can be downloaded at:

<http://www.countdown2015mnch.org/documents/DHS-country-profiles.pdf>

For several countries, the data in both reports are the same, because there were no new surveys that were included in the 2012 report.

Detailed instructions on how to interpret the 2012 Countdown equity profiles are available at

[http://www.countdown2015mnch.org/documents/2012Report/2012Equity/How\\_to\\_use\\_2012\\_equity\\_profile.pdf](http://www.countdown2015mnch.org/documents/2012Report/2012Equity/How_to_use_2012_equity_profile.pdf)

### ***What other equity data are available elsewhere for my country?***

Equity data are also provided by sources other than Countdown. If your country has had a DHS survey, you can obtain equity breakdowns of several coverage, mortality, and nutrition indicators

using the STATcompiler calculator, which is very user-friendly. STATcompiler can be accessed at [www.statcompiler.com](http://www.statcompiler.com).

Sometimes the results obtained with STATcompiler are slightly different from those in the Countdown equity tabulations. This is due to different definitions of the indicators used and adopted by DHS and by Countdown.

UNICEF also produces equity breakdown of several indicators by country, according to gender, urban/rural residence, and wealth quintile. These are available at [http://www.childinfo.org/country\\_profiles.php?input=4](http://www.childinfo.org/country_profiles.php?input=4)

Lastly, the Global Health Observatory at the World Health Organization (<http://www.who.int/gho/en/>) also provides equity breakdowns on a large number of indicators related to maternal, newborn, and child health. These equity results will soon be made available at the GHO webpage, at which time a direct link will be provided on the Countdown website.

There is a considerable amount of overlap among the Countdown equity tabulations and those that may be obtained from the above sources, but country teams are encouraged to visit all of these sites in preparation for the Country Countdown.

### ***Should we carry out additional equity analyses to support our Country Countdown?***

As shown above, there are considerable amounts of information on inequities in the health of women and children available from different sources. If your country had a recent DHS or MICS, you will be able to download the raw data file, or else obtain a copy from the national institution that carried out the survey, often the National Statistical Office or Census Bureau.

However, the analysis of the raw data files is complex, and statistical procedures must take into account the clustered nature of the sample, and the sampling weights for different parts of the country. For these reasons, you should only embark on such analyses if the above-listed data sources do not already provide the information on inequities that you are interested in, and if you have the technical and financial resources necessary for carrying out original analyses.

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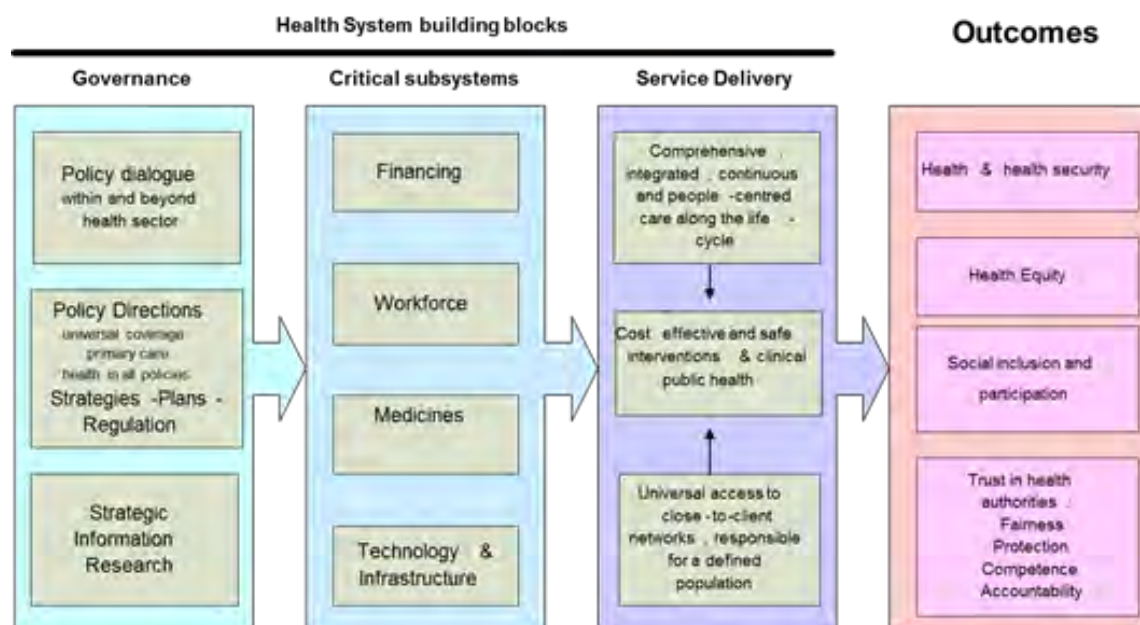


## Appendix F: Health Systems and Policies Guidance Notes

### Introduction

While evidence of effective interventions to improve reproductive, maternal, newborn, and child health (RMNCH) has been well established, coverage remains low in many settings. Programmes to address RMNCH are implemented through complex public and private organisations that rely on systems to provide medicines, to finance health services, to assure quality and efficiency of care, to manage the health workforce, and to generate information needed for effective operational decisions. Governance and leadership, expressed in clear policies, are necessary to provide strategic direction in all these areas. The development of functional health systems requires that a number of supportive policies (both within and outside the health sector) be in place to improve access to, quality of, and demand for effective interventions.

Countdown contributes to an understanding of the environment in which RMNCH services are delivered and health outcomes are produced, by assessing selected indicators of health policies and health systems. The indicators span across the six health system building blocks (leadership and governance, financing, human resources, medicines, equipment and commodities, and service delivery) and reflect the continuum of care, across the life course and levels of service delivery. These policy and system indicators are collected through special surveys or through key informants at the country level. The system indicators are globally agreed tracers of different aspects of the health systems and are derived from global, public data bases.





The Countdown [country profiles](#) contain 16 health systems and policy indicators that were selected both for their relevance in moving towards universal access and coverage of interventions among women and children, as well as their availability to be collected and monitored. At country level, additional policy and system issues can be reviewed and discussed.

### **Global policy and health system indicators**

The Countdown Reports published in 2008, 2010, and 2012 include a brief explanation on the policies and key health system and financing indicators covered by Countdown, as well as a compilation of the global findings. The indicator list, definitions, and data sources are available in the [2012 Countdown report](#) (see in particular Annexes A and C of the report). The indicators fall into four categories summarised here:

#### **1. Indicators obtained from global data bases**

- Indicator:* Maternity protection in accordance with Convention 183  
*Source:* International Labour Organization. Data base of Conditions of Work and Employment Laws (<http://www.ilo.org/dyn/travail/travmain.home>)
- Indicator:* Density of doctors, nurses and midwives (per 10.000 population)  
*Source:* Global Health Atlas (<http://apps.who.int/globalatlas/>)
- Indicator:* Per capita total expenditure on health  
*Source:* Global Health Expenditure Database (<http://apps.who.int/nha/database/PreDataExplorer.aspx>)
- Indicator:* General government expenditure on health as percentage of total government expenditure  
*Source:* Global Health Expenditure Database (<http://apps.who.int/nha/database/PreDataExplorer.aspx>)
- Indicator:* Out-of-pocket expenditure as share of total expenditure on health  
*Source:* Global Health Expenditure Database (<http://apps.who.int/nha/database/PreDataExplorer.aspx>)
- Indicator:* Density of health workers  
*Source:* Global Health Atlas (<http://apps.who.int/globalatlas/>)

#### **2. Indicators obtained from routine monitoring by UN organisations**

- Indicator:* Rota virus vaccine  
*Source:* WHO Department on Immunization, Vaccines and Biologicals database on new vaccines introductions ([http://www.who.int/immunization\\_monitoring/data/en](http://www.who.int/immunization_monitoring/data/en))
- Indicator:* Pneumococcal vaccine  
*Source:* WHO Department on Immunization, Vaccines and Biologicals database on new vaccines introductions ([http://www.who.int/immunization\\_monitoring/data/en](http://www.who.int/immunization_monitoring/data/en))

### 3. Indicators obtained from purposefully designed key informant surveys

The indicators in this category are derived from a questionnaire given to national government authorities and administered by the Department of Maternal, Newborn, Child and Adolescent Health at WHO. Responses are validated by UN agencies at the country level. Questions related to these indicators can be sent to [mncah@who.int](mailto:mncah@who.int).

*Indicators:*

- International Code of Marketing of Breast-milk Substitutes
- Specific notification of maternal deaths
- Midwifery personnel authorised to administer a core set of life-saving interventions
- Postnatal home visits in the first week of life
- Community treatment of pneumonia with antibiotics
- Low osmolarity oral rehydration salts and zinc for management of diarrhoea
- Costed national implementation plan for maternal, newborn and child health

### 4. Indicators calculated from country level service delivery survey

- National availability of emergency obstetric care services

A ranking system described in the indicator definitions (in Annex C of the [2012 Countdown Report](#)) is used in determining if a policy is adopted and being implemented. A “Yes” ranking is given for a policy that is both adopted and implemented. For some indicators, having formal intervention guidelines in place in addition to implementation is also considered a “Yes.” A “Partial” ranking might indicate having a policy in place but little or no implementation. Pilot projects to test a policy are not considered sufficient to state that a national policy and service is in place.

### ***Assessing the national policy and health systems environment***

Assessing the national policy and health system environment for RMNCH is a critical component of a national Countdown process. It enables policy makers, programme managers, and relevant other stakeholders to examine whether necessary measures to make the health system responsive to the needs of women and children have been initiated with high-level political commitment and support. This aspect of the Country Countdown also helps to identify gaps and remedial actions that can be addressed. Below are brief summaries on how to collect, compile and interpret data in the areas of health policy and the health workforce. Indicators on health financing are discussed in the next section.

## ***Reviewing country health policies***

The team preparing a Country Countdown can begin by looking at all of the current Countdown policy and system indicators as listed on the Countdown country profile. Definitions of these policy and health systems indicators can be found in Annex C of the [2012 Countdown Report](#); data sources are listed in Annex A of the same report.

Consider the following:

- Are the rankings and numerical records correct according to the current country situation? If not, what are the updated rankings or figures?
- If the country has a “No” or “Partial” ranking for a particular policy, what is the reason? Has there been policy dialogue on this issue? What are the barriers to adopting the policy?
- Have other countries in the region adopted the policy and is implementation proceeding in those countries? This information is available on each country profile for the 75 Countdown Countries. Can knowledge transfer with similar countries be useful?
- What is the evidence behind the policies that the country has not yet adopted? The regional offices of WHO, UNICEF, or UNFPA can assist in providing the most up-to-date evidence in regard to each policy, along with information on implementation issues.
- Is funding an issue for policy adoption and implementation? Is it useful to know how this was resolved in other countries? Can this issue be on the agenda of the Country Countdown meeting?
- Is availability of data a problem in updating these systems and policy indicators? How can this be resolved?
- What policy decisions take place at sub-national levels? Are these differences documented? Is a Country Countdown event a good time to discuss these differences?
- Are there geographic and other disparities in the adoption and implementation of policies and system improvements that should be considered?

Undertaking a Country Countdown is also an excellent opportunity to consider other policy and system issues relevant to the country but not included on the Countdown country profile. To this end, tools are being prepared that will allow for an in-depth examination of the policy environment for reproductive, maternal, newborn, child, and adolescent health more extensively, covering the six health system building block domains. Upon request, guidance can be made available to assist in preparing the policy analysis for a Country Countdown: for more information, please contact [mncah@who.int](mailto:mncah@who.int).

## ***Health financing indicators***

Health systems development will directly and indirectly benefit RMNCH services and the health of women and children. The Countdown approach has focused on certain key indicators as proxies for health systems development and performance. The health financing indicators reported on by the Health Systems and Policies Working Group look at the level of national resources available to the health sector, the importance the government places on health, and the reliance on out-of-pocket payments as a source of financing for health in the country. (See [Appendix G](#) for information on external donor resource flows tracked by the Countdown's financing working group.)

The level of national resources available to the health sector is indicative of country capacity, donor engagement, and government commitment to health. An adequate level of financing is required to build health systems as well as to provide essential services to populations, such as those affecting MDGs 4 and 5. Rough global estimates from international studies, such as that of the [Taskforce on Innovative International Financing for Health Systems](#), seem to indicate insufficient spending on health. However, exactly how much a country needs to spend on health is governed by many factors, and a costing of health objectives and the national health plan can provide guidance for countries in this domain. Similarly, a costed national implementation plan for RMNCH is essential in planning service delivery as well as understanding the resource needs for these services.

The degree to which governments prioritise health determines resource allocation and health spending overall. Private expenditure on health, particularly through unpooled out-of-pocket payments, has not been as effective in improving health outcomes and making services accessible to the people most in need. Two joint indicators of health financing can help paint a useful picture of this: the percentage of total government spending that is allocated to health, and the percentage of out-of-pocket payments in total health expenditure. Once again, international guidelines, such as the [Abuja Declaration](#) — in which African Union countries pledged to increase government funding for health to at least 15% — may be relevant thresholds for monitoring progress. However, countries can also look to neighbouring as well as well-performing countries to help define realistic goals.

Out-of-pocket payments as a share of total health expenditure show the extent of financial barriers and burden faced by people seeking health services within a given country. Out-of-pocket payments are directly responsible for undermining economic development through catastrophic health expenditure and impoverishment, and they discourage poor people from accessing needed health services, an effect that is gravely detrimental to achieving desired health outcomes. Accordingly, countries should strive to reduce their reliance on out-of-pocket payments as a way of financing health care. Reducing reliance on out-of-pocket payments as much as possible, while increasing or maintaining overall funds for health and providing quality health services, is the path towards universal health coverage.

The Countdown country profile provides an estimate of specific financing indicators that should be useful for stimulating discussion at country level.

## **Human Resource Indicators**

A review of national health human resource policies, skill levels, and authorities is an important aspect of a national Countdown. Countdown has used “density of health workers” to indicate the population’s access to a skilled health workforce. This information shows the proportion of physicians, nurses, and midwives who are available per 10,000 population. The Countdown indicator that looks at skill levels and authority to provide lifesaving services is “midwifery personnel authorised to deliver basic emergency obstetric and newborn care”. These two indicators can provide an opening for discussion on issues surrounding human resources for health using available country data.

Useful resources for additional guidance on human resource issues include:

- WHO, World Bank, USAID, 2009. *Handbook for Monitoring and Evaluation of Human Resources for Health*. Geneva: World Health Organization. Available for download at: [http://whqlibdoc.who.int/publications/2009/9789241547703\\_eng.pdf](http://whqlibdoc.who.int/publications/2009/9789241547703_eng.pdf).
- Gupta M, Maliqi B, França A, et al., 2011. “Human resources for maternal, newborn and child health: from measurement and planning to performance for improved health outcomes.” *Human Resources for Health*, 2011, 9:16. Available for download at <http://www.human-resources-health.com/content/9/1/16>.

## ***Appendix G: Health Financing Analysis Guidance Notes***

Health plans — costed, budgeted and implemented — are critical factors for improving health outcomes. A robust policy framework with well-articulated priorities also requires that the necessary resources (financial, human, equipment, commodities) are made available and used efficiently to enable proper implementation. Tracking financial resource flows — that is, the allocation, disbursement and expenditure by the sector, along with out-of-pocket spending — provides valuable input for better planning. This is also true for RMNCH programmes. Tracking resources can contribute to greater effectiveness, equity, and accountability in the mobilisation and use of funds for RMNCH. Countdown's Financing Working Group contributes to the monitoring of official development assistance (ODA) and domestic flows to RMNCH.

A Country Countdown offers a valuable opportunity to support country-led initiatives to undertake an analysis of health spending on RMNCH. This can include government health budget analysis, external resource flows for RMNCH coming into the country, and non-government spending. Country-based financing analysis for RMNCH can inform the policy process in-country and make critical data, such as where resources are coming from, where they are going, and how they are utilised, available to all stakeholders. Tracking financial flows in the health sector and analysing these in relation to political commitments and performance, for example in terms of services provided and beneficiaries reached, can help highlight health gaps in the country, and can feed into key review and decision-making processes at the national and sub-national levels. Such analyses can highlight what is working well, key opportunities for improvement, and where bottlenecks to progress exist, providing an evidence base that can prompt a move towards more efficient, effective, and equitable resource allocation. Moreover, this information promotes transparency and can be used to hold the government, development partners, and other key stakeholders accountable, and to advocate for adequate and sustainable funding for RMNCH within the country. It can also be used to highlight the negative consequences of relying on out-of-pocket spending to pay for critical health interventions.

Undertaking health financing analysis as a collaborative effort with key stakeholders can help to facilitate access to information and foster greater collective ownership of the results and the recommendations that emerge. From the outset, this should include ministries of health, planning, and finance, as well as local government; civil society; development partners; and other key stakeholders. This approach is consistent with that of the Country Countdown process as a whole.

Following the recommendations of the Commission on Information and Accountability for Women's and Children's Health, there are efforts to strengthen coordinated resource tracking to which WHO provides support, working collaboratively with ministries of health, other UN agencies, and civil society organisations.

### ***Health financing policy***

When analysing progress towards MDGs 4 and 5, consideration of coverage of essential interventions and barriers to access (financial and physical) warrants an analysis of the health

financing policies that determine how resources are raised, pooled, allocated, distributed, and spent. Broadly, health financing analysis should include elements such as the political and policy environment; the performance of organisations that raise, pool, and disburse funds for health; and the effectiveness and efficiency of the use of funds — topics that extend beyond the scope of these guidance notes. This section briefly covers some general issues with respect to health financing policy. For more information, readers may consult WHO's [2010 World Health Report](#)<sup>1</sup>. The following section discusses the collection and use of data on health expenditures for RMNCH, the main focus in health financing of the Country Countdown.

The health system is generally financed by the public budget (general revenue taxation and social health insurance), private spending (including out-of-pocket payments and private health insurance expenditures), and external development assistance (resources that can be provided on budget and/or off-budget —that is, outside a government's public financial management systems and so not reflected in the national budget).

Many countries are committing to moving towards the goal of universal health coverage of essential interventions without financial hardship. The World Health Report 2010 provides clear recommendations for what approaches to achieving Universal Health Coverage should involve. These include the removal of out-of-pocket expenditure (OOPE) and increased prepayment (taxation and insurance) with large risk and resource pooling.

When analysing health financing policy, it is useful to consider three dimensions: who is covered (i.e., which citizens or groups within the population receive coverage); what for (i.e., for which services and interventions is coverage provided); and what share of costs is covered (i.e., the level of financial risk protection, reducing out-of-pocket spending at time of service). This type of analysis can be done for the health system overall or for parts of the system, such as those that finance and produce RMNCH services.

As there is a finite pool of resources in any health budget, trade-offs will have to be made across these dimensions, and this balance is determined by the national health financing policy. Most Countdown priority countries should carefully consider their financing strategies. When resources are limited, assuring coverage for priority services, such as those for RMNCH, can compete with demands for broader subsidies for secondary and tertiary care.

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<sup>1</sup> World Health Organisation (2010), *The world health report – Health systems financing: the path to universal coverage*, Geneva: WHO, available at: <http://www.who.int/whr/2010/en/index.html>



Measures of financial risk protection include the level of OOP<sup>2</sup>, and the extent to which OOP causes an excessive financial burden on households including health spending-related impoverishment and reduced coverage of critical interventions<sup>3</sup>. Where possible, indicators should be disaggregated to identify who is bearing the burden of health care costs.

### ***Analysing health financing and tracking resources for RMNCH***

Various tools exist to support analysis of health expenditure. Common standards exist for many of these tools, and it is useful to employ these standards since comparability over time and between countries is often desirable. Since different sources of information may not always give the same results, it is important to triangulate where possible to come up with the “best possible” estimates.

National Health Accounts (NHA) and NHA-based sub-accounts (accounts that focus on a specific health problem or area of health services) are the basic tools that provide systematic and consistent information on financing and financial flows, looking at how resources are raised, pooled and distributed. NHA includes information on public and private expenditures, activities, providers, disease-specific spending, population groups, and regions within the country.

The objective of NHA is to develop evidence on health expenditure flows that will inform policy development and implementation. They also allow for trends in expenditures to be monitored over time. Carrying out a comprehensive NHA analysis requires significant capacity and commitment at country level. Some countries do not have the resources or capacity to initiate or institutionalise NHA and have relied on external support or have had more infrequent production. A comprehensive NHA is a useful basis for tracking expenditures for RMNCH, but it is not essential. Much useful work can be done even when a complete NHA is not possible. As a first step, analysis of public expenditure can provide important information on RMNCH investments overseen by the government.

As with any measurement tool, the definitions of the topic being studied are important.

Standardised international classifications have been developed for NHA and for sub-accounts, including estimations related to RMNCH, and these can be adapted to national conditions<sup>4</sup> (see also reproductive and child health sub-account guidelines cited below).

The Country Countdown team should first determine whether a national mechanism for tracking national health expenditures using routine NHA updates exists and, if it does, study its work and seek its collaboration. The Country Countdown team could support and/or advocate for the relevant national agencies to improve the detail they report on in terms of disaggregating RMNCH spending, linking reported numbers to RMNCH activities more clearly, and encouraging

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<sup>2</sup> This is available in World Health Statistics, with indicators on OOP as a share of private expenditure, and private expenditure as a share of total health expenditure, available at:

[http://www.who.int/gho/publications/world\\_health\\_statistics/2012/en/](http://www.who.int/gho/publications/world_health_statistics/2012/en/)

<sup>3</sup> The WHO defines catastrophic expenditure as health expenditures that are equal to or greater than 40% of a household's non-subsistence income, i.e. income available after the basic needs have been met. See WHO (2005), 'Designing Health Financing Systems to Reduce Catastrophic Health Expenditure', *Technical Briefs for Policy-Makers*, Number 2, available at: [http://www.who.int/health\\_financing/pb\\_2.pdf](http://www.who.int/health_financing/pb_2.pdf)

<sup>4</sup> <http://www.who.int/nha/en/>; <http://www.who.int/nha/what/en/index.html>

greater timeliness where NHA is reported with substantial time lag. For this the Reproductive Health Sub-Account Guidelines and other disease tracking guidelines are useful.

If a country does not have a robust national NHA mechanism, the Country Countdown process can support ongoing efforts to develop and establish this, by advocating for it to be linked to the Country Countdown's objectives. This will also signal that the Country Countdown will be an important user of the data. If establishment of a robust regular NHA mechanism with built-in RMNCH reporting is not feasible in the short term, the Country Countdown team should support other ongoing expenditure tracking work, and may want to launch additional efforts to develop RMNCH resource tracking. An initial priority in many countries might be to boost tracking of public expenditures with reporting of RMNCH figures. Efforts could be made to improve details of expenditure analyses, with specific analyses and cost studies that tease out RMNCH in routine healthcare services. This approach can be undertaken at different levels of the health system, be more or less complex, and involve a range of stakeholders. A Public Expenditure Review (PER) — a framework that also contributes evidence to the development of NHA — reviews the allocation, distribution, spending, and management of government expenditures using policy-relevant breakdowns and classifications. PERs can be specifically designed to track public expenditure in the health sector with the ability to address specific programmes such as RMNCH. Guidance and tools are available to support countries in undertaking such exercises, and they have become an important part of public financial management programmes.

In many Countdown countries, private (non-government) financing and delivery of RMNCH services contributes a significant share of utilisation and coverage. Household expenditure surveys (often done as part of general economic statistics) and household healthcare use and spending surveys (often done specifically for the health sector or combined with other sectors) can be reviewed to provide evidence on this, especially for household out-of-pocket expenditures.

Private institutional funders may also be important. This can include private not-for-profit organisations (NGOs or Private Voluntary Organisations in different countries) and private for-profit companies. Data may be available on NGOs through government registration or regulatory bodies and on for-profit companies through trade or commerce organisations or tax records.

Other channels of funding may also be important to include. External resource flows into a country for RMNCH may be significant. National authorities or UNDP may maintain a database on external funders. It is important to be aware that some external flows may not appear in national budgets and may flow directly to sub-national agencies or be delivered in kind.

Policy interest in resource tracking for RMNCH can be stimulated through advocacy, resource mobilisation, and facilitating technical assistance. Very useful information can be generated with simple or partial efforts to track resources for RMNCH, so that the absence of comprehensive data or significant previous efforts should not discourage Country Countdown teams from getting started and making progress. Technical assistance may be available from national experts and through international partners.

Here is a list of useful resources that may be of help when considering how to undertake health budget analysis:

- Public Expenditure Reviews:
  - Preparing PERs for Human Development: Core Guidance<sup>5</sup>
- Medium Term Expenditure Frameworks:
  - Linking policies and budgets<sup>6</sup>
- National Health Accounts:
  - Guide to producing NHA<sup>7</sup>
  - Manual on the System of National Health Accounts, including classifications<sup>8</sup>
- Sub-accounts:
  - Reproductive health<sup>9 10</sup>
  - Child health<sup>11</sup>
  - Nutrition<sup>12</sup>
  - Human resources for health<sup>13</sup>
- Health budget advocacy:
  - Guide for civil society<sup>14</sup>
  - Maternal mortality guide<sup>15</sup>
- Official Development Assistance
  - Measuring country programmable aid<sup>16</sup>

### **Using evidence on financing RMNCH**

Global experience with health accounting and resource tracking has shown that it is of the greatest value when used to answer the questions that are of most interest and importance to health system stakeholders. Comprehensive NHA reports have often been dry and full of figures that do not capture the attention of those whose decisions and actions matter most for improving women's and children's health.

Country Countdown teams developing resource tracking for RMNCH should not focus only on the technical aspects of measuring health expenditure. They should also carry out a stakeholder analysis as part of initiating resource tracking work. A few interviews with key stakeholders, such

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<sup>5</sup> <http://www1.worldbank.org/publicsector/pe/PEAMMarch2005/PER-Core.pdf>

<sup>6</sup> <http://www.odi.org.uk/resources/odi-publications/briefing-papers/2005/policies-budgets-medium-term-expenditure-frameworks-prsp.pdf>

<sup>7</sup> <http://whqlibdoc.who.int/publications/2003/9241546077.pdf>

<sup>8</sup> <http://www.oecd.org/dataoecd/41/4/1841456.pdf>

<sup>9</sup> [http://www.who.int/nha/docs/guide\\_to\\_producing\\_rh\\_subaccounts\\_final.pdf](http://www.who.int/nha/docs/guide_to_producing_rh_subaccounts_final.pdf)

<sup>10</sup> <http://www.who.int/management/programme/MeetingMDGsUsingNHAsUnderstandRepHealthFinancing.pdf>

<sup>11</sup> <http://www.who.int/pmnch/topics/child/childhealthsubaccounts.pdf>

<sup>12</sup> [http://www.who.int/nha/docs/developing\\_a\\_resource\\_tracking\\_system\\_for\\_measuring\\_spending\\_on\\_nutrition\\_in\\_LIC\\_and\\_MIC.pdf](http://www.who.int/nha/docs/developing_a_resource_tracking_system_for_measuring_spending_on_nutrition_in_LIC_and_MIC.pdf)

<sup>13</sup> <http://www.who.int/nha/docs/HandbookMonEvalHRH/en/index.html>

<sup>14</sup> Save the Children UK (2012), *Health Sector Budget Advocacy: A guide for civil society organisations*, London: Save the Children. Available at: <http://www.savethechildren.org.uk/resources/online-library/health-sector-budget-advocacy-guide-civil-society-organisations>

<sup>15</sup> <http://righttomaternalhealth.org/sites/iimmhr.civicaactions.net/files/Missing%20Link%20WEB-2.pdf>

<sup>16</sup> <http://www.oecd.org/dataoecd/32/51/45564447.pdf>

as parliamentary leaders, civil society spokespersons, community representatives, and senior government officials, can help identify questions on RMNCH financing that most need to be addressed. Resource tracking efforts should seek to answer those questions specifically, which can help generate interest in the wider findings. A variety of methods should be considered for disseminating results. Long technical reports are important as technical background materials, but may not be the best way to assure that results are used. Country Countdown teams should be creative in presenting and distributing results.

Detailed reports of research conducted by Countdown's Financing Working Group can be found [on the Countdown website](#).

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