

A close-up photograph of a woman with dark skin and hair, wearing a black top and a necklace, looking down at a newborn baby. The baby is wearing a blue knit hat and a blue shirt, and is lying in a white hospital gown. The background is a blurred hospital room with a window and a table.

**Women, newborns,
children and
adolescents:
life-saving
momentum after a
slow start**

After decades of stagnation, political will to cut the number of needless deaths of mothers and children emerged in 2010 with the United Nation's US\$ 40 billion Every Woman Every Child initiative. Dramatic progress came from better data collection, more births in health facilities, better nutrition and vaccines against diarrhoea and pneumonia, the biggest child killers. A revised global strategy views the focus on maternal, newborn, child and adolescent health as an entry point for increasing universal health coverage.

In 1985, *The Lancet* published a pivotal, thought-provoking commentary that riveted attention on a neglected tragedy: maternal mortality. "Where is the M in MCH?" the authors asked. The article opened with the WHO estimate that complications of pregnancy, unsafe abortions and childbirth were killing at least half a million women in developing countries every year. Left out of that calculation were many more poor adolescents and women who suffered life-long complications from unsafe abortions and deliveries.

In part, the article attracted so much attention because it challenged the widespread assumption that most maternal deaths could be prevented by detecting at-risk women during antenatal care and screening. As pointed out, a sizeable proportion of serious complications occur among women with no recognizable risk. When those complications occur, the authors stressed, most life-saving interventions require emergency obstetric care in hospital facilities staffed with highly trained doctors, midwives and nurses. A reliance on traditional birth attendants would not save those lives.

In other words, an agenda that aimed to get the death rate down needed to be an agenda that improved access to essential health services, including emergency obstetric care and facility-based birth with skilled attendants. Citing the excellent maternal health care provided in Cuba and China, the authors concluded that **lack of political will to face the problem was the biggest reason why a tragedy on this scale continued.**

In the published debate that followed, some authors questioned whether MCH really needed an M at all. The better focus was on women, and this needed to be a focus on the health of girls and women throughout the life course. Though women's reproductive functions made them vulnerable to health problems, an exclusive focus on these functions reduced the status



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of women to vessels for procreation. Both the health needs of women and their contributions to society were much, much broader.

All of these concerns were eventually reflected in formal WHO policies and strategies.

The situation in 2007: dire prospects for progress

In 2007, WHO, UNICEF and the UN Population Fund issued new country-specific estimates for maternal mortality. Though 22 years had passed, the "neglected tragedy" looked no better than in 1985. The estimated number of maternal deaths stubbornly stood at 536 000 worldwide, with developing countries accounting for 99% of those deaths. In sub-Saharan Africa, around 900 women died during pregnancy and childbirth per 100 000 live births. In wealthy countries, that figure dropped 100-fold to just 9. The statistics were the starkest in all of public health. For example, the adult lifetime risk of dying during pregnancy and childbirth in Niger was 1 in 7. In Ireland, it was 1 in 48 000.

As the new estimates showed, maternal mortality had decreased at an average of less than 1% annually between 1990 and 2005, far below the 5.5% decline needed to achieve the fifth MDG. The decline in sub-Saharan Africa was the lowest, estimated at 0.1%.

The news for child mortality was better, but just barely. In 2006, the annual number of children dying before their fifth birthday fell to 9.7 million, marking the first time that yearly childhood deaths dropped below 10 million since records began. Though the slight decline was welcome, the millions and millions of deaths from largely preventable causes looked outrageous six years into the MDG era.

On its part, WHO recommended a life-course approach to the health of both women and children, ranked the leading causes of morbidity and mortality, and identified the interventions that were likely to have the biggest life-saving impact. WHO developed norms, tools, clinical standards, protocols and guidelines in areas ranging from antenatal care and the management of sexually transmitted infections, to the treatment of maternal peripartum infections and a simple colour-coded tool for the detection of anaemia, to human rights and contraception, optimal nutrition for girls and women, and appropriate feeding practices for infants. WHO also made a major effort to improve access to sexual and reproductive health services offering a wide choice of modern family planning options, and issued safe abortion guidance for use in countries where abortions are legally permitted.

But efforts to reduce both maternal and childhood mortality shared two major challenges. First, the quality of country-specific data was abysmal. Some 85 countries, representing 60% of the world population, had no reliable systems for civil registration and vital statistics. **Births, deaths, and causes of death were not registered, leaving countries and their partners working in the dark.** In 2008, countries with medically certified vital registration accounted for only 4% of the 8.8 million childhood deaths estimated for that year.

Second, efforts to reduce maternal and child mortality had no single commodity, like antiretroviral therapy for HIV, cocktails of inexpensive drugs for tuberculosis, or insecticidal nets for malaria, that could be scaled up to have a dramatic impact on morbidity and mortality. Widely-used childhood vaccines were highly effective in protecting children from leading infectious killers, averting up to 3 million deaths each year, but that still left nearly 9 million yearly deaths occurring from largely preventable causes. As WHO argued, maternal and childhood deaths would not go down until access to quality health services improved. For maternal health, evidence was mounting that even the vastly improved access to services that followed the elimination of user fees would have little impact on deaths and "near misses" in the absence of high-quality standards of care.

Everyone agreed that, as economies grew and living conditions improved, many of the conditions – like undernutrition and especially anaemia, poor water supply and little sanitation, dirty environments, and dirty indoor air – that made women and children so vulnerable to early death would gradually get better. But that would take decades. No one wanted to wait.

In line with the culture of measurement and accountability that drove the MDG era, those dismal figures halfway to the 2015 deadline provoked the international community to take aggressive action on multiple fronts. Several new partnerships, initiatives and strategies were launched and operational by 2010. The results over the next five years would be dramatic.

A new global strategy puts accountability on the map

At the UN General Assembly in 2010, the Secretary-General launched a new global strategy for women's and children's health, which became known as the Every Woman Every Child initiative. That high-profile event initially attracted commitments of \$40 billion in funds for the five-year period leading to 2015. Full implementation of the strategy was expected to save the lives of 16 million children, prevent 33 million unwanted pregnancies, end stunting in 88 million children, and protect 120 million children from pneumonia by 2015. The political will, so tragically missing in 1985, had arrived. The strategy was almost immediately backed by the findings of a UN Commission that identified 13 life-saving commodities for women and children that were vastly underutilized. **The Commission estimated that wide and proper use of these 13 commodities alone could save the lives of at least 6 million women and children.**

The new strategy was shaped by the expertise and practical experiences of WHO and members of the Partnership for Maternal, Newborn and Child Health, which coordinated the work of more than 80 agencies, country programmes, civil society initiatives, academic groups, and donors. WHO was asked to lead the strategy's implementation. In an unprecedented step, WHO was further asked to convene a Commission on Information and Accountability for Women's and Children's Health. The Commission's objective was to develop a framework for ensuring that promises of resources for women's and children's health were kept and that results were measured. The Commission was established in December 2010 and delivered its final report in May 2011.

Members of the Commission agreed on 10 recommendations, with related indicators, to help ensure that the \$40 billion pledged to support the global strategy were spent in the most effective way, and that both donors and recipients were held accountable. The report linked accountability for resources to the results, outcomes, and impacts they produce, and to the capacity of recipient countries to measure those results. The Commission also called for the establishment of an independent Expert Review Group to issue critical annual reports on implementation of the strategy and its impact.

The appointment of an independent Expert Review Group joined the Independent Monitoring Board of the Global Polio Eradication Initiative as “firsts” for global health. Their emphasis on measurement and accountability reshaped the design of global health strategies and action plans at WHO to consistently include accountability frameworks. Highly innovative initiatives, like the Pandemic Influenza Preparedness Framework, also appointed independent expert monitoring boards to assess impact and recommend strategic course corrections. **Measurement and accountability formally moved into the mainstream as part of the definition of a well-conceived strategy designed to produce results.**

However, accountability means counting. As the first reports of the independent Expert Review Group made clear, reliable measurement was greatly impeded by the absence of systems for civil registration and vital statistics in the vast majority of high-burden countries. As long as countries lacked the capacity to measure results, progress would be impaired, especially at a time of financial austerity when parliamentarians in donor countries needed to show that investments in health development brought results.

Improving information systems

Improving information systems became the next objective, spearheaded by the government of Canada with its G8 Muskoka Initiative in 2010. That initiative, which secured commitments of more than \$7.3 billion in funding over the next five years, put information and accountability firmly on the agenda of plans for improving maternal and child health. As health officials increasingly recognized, the information collected in a well-performing system for civil registration and vital statistics saved lives but also provided proof of legal identity. Having that legal identity facilitated access to essential social services, including health and education.

The international community had much to build on. Country-specific estimates of maternal and child mortality had been steadily improving since 2004, when WHO, UNICEF and the World Bank launched two interagency groups to produce yearly estimates of maternal and child mortality. The interagency groups used a standardized methodology that brought consistency and greater precision to what had been widely varying estimates separately issued by the three agencies. Membership of the interagency group was later expanded to include the UN Population Division and several national and academic institutes devoted to the improvement of statistical data. Over the years, the modelling approach was refined to optimize the use of diverse country-specific data sources and provide more precise estimates of uncertainty. The two annual estimates of maternal and child mortality became the foundation for other

annual reports, including UNICEF's *The State of the World's Children*, the World Bank's *World Development Indicators*, and WHO's *World Health Statistics*.

The estimates from the interagency groups also informed the annual reports, starting in 2005, of the Countdown to 2015 for Maternal, Newborn and Child Survival initiative, which became the principal instrument for monitoring and accountability in the 75 countries that bear 99% of the burden of maternal and child mortality. Drawing on the expertise of more than 40 participating institutions and agencies, including WHO, Countdown gave measurement a strong technical component, with a standardized methodology that brought confidence in the data and facilitated reliable country comparisons and charting of trends.

Countdown's annual reports assessed coverage with specific life-saving interventions and gave particular attention to health systems and financing as the two main drivers of coverage. With their focus on the situation in individual countries, the reports showed how building on existing systems for monitoring and reporting was the best way to achieve realistic and sustainable improvements.

In 2010, the heads of WHO and seven other agencies working in global health issued a call to improve health data in response to demands for evidence of results and accountability. The agency heads called for a shift away from the current focus on defining indicators and reporting requirements towards building the capacity of information systems within countries. They also noted that systems for civil registration and vital statistics had shown virtually no improvements over the past several decades.

At the time, maternal mortality estimates were based on statistical models, which increase global awareness of the problem, but do not provide information needed for a targeted and timely response. To improve the situation, WHO built on the established methodology for conducting maternal death reviews to put forward a comparatively new approach, Maternal Death Surveillance and Response, based on the premise that **each maternal death has a story to tell and, if properly investigated, can yield data on ways to prevent future deaths among women in similar circumstances**. The emphasis was firmly placed on taking action in a continuous cycle of investigation, learning, and introducing improvements. Using the approach, investigation leads to identification of the barriers women faced, the resources available, and the care they received, benchmarked against standards of best practice where available. Apart from supporting progressive improvements in the prevention of maternal deaths, the approach made health professionals accountable for ongoing self-assessment.

WHO also issued guides showing how ICD-10, the standard coding tool, could be used to accurately capture and classify the causes of perinatal and maternal deaths.

Women: delivering far more than babies

In 2010, a new initiative, Scaling Up Nutrition, was launched following publication of a policy paper and framework for action in the *Food and Nutrition Bulletin*. The framework for action drew on broad consensus among UN, multilateral and bilateral development agencies, foundations,

developing countries, civil society organizations, researchers, and the private sector. WHO promptly endorsed the policy paper and called for its wide support. More than 80 institutions responded to that call, and the SUN movement was born.

The SUN movement focused on scientific evidence that **nutrient intake during the first 1000 days of life – from pregnancy to two years of age – was a window of opportunity when good nutrition would have the highest impact** in reducing nutrition-related deaths and disease and avoiding irreversible harm to the child. The movement also aimed to correct a situation in which nutrition frequently appeared as an afterthought in development priorities, both within countries and at the international policy level.

By 2010, concern about the stalled progress for MDGs four and five had created a more favourable context for scaling up nutrition as a set of interventions with demonstrated life-saving potential. The movement became operational in 2012, offering a unique focus on country ownership, structured sharing of best practices among participating countries, and networks of agencies offering external assistance. When countries join the SUN movement, they commit to develop and cost a national nutrition plan and to establish a multi-stakeholder platform and budget line for nutrition. As the initiative evolved, it offered guidance on coherent multisectoral policies backed, where appropriate, by laws, and strategies for raising domestic resources and working with the business community.

In line with WHO advice and global nutrition targets approved in 2012, the SUN platform for action focused on the delivery of a limited number of affordable and feasible interventions backed by solid evidence of their impact. A package of just 13 interventions was put forward in the categories of good nutrition practices, like breastfeeding and hand hygiene, the provision of vitamin supplements to children and their mothers, population-wide approaches, like salt iodization and iron fortification of staple foods, and therapeutic feeding for severely undernourished children, including the use of ready-to-use therapeutic foods. Even with only 50% coverage with these interventions, estimates showed that 500 000 young lives could be saved each year.

By 2016, 57 developing countries had joined the SUN movement. Between 2012 and 2016, the worldwide number of stunted children dropped by 9 million. SUN-supported monitoring recorded the most dramatic reductions in Bangladesh, Nepal, Lesotho, and El Salvador.

In 2016, at the Women Deliver Conference in Copenhagen, Denmark, SUN launched a series of case studies showing how the empowerment of women and girls can build a sisterhood of success for food security. Doing so was considered another essential line of action. In developing countries, women farmers were responsible for 60% to 80% of food production. However, their rights and socioeconomic status were rarely equal to those of men. As the case studies showed, when women farmers were empowered, they were not only more productive, but as the main source of food for their children, they gave future generations a better start in life.

The first Women Deliver conference, held in 2007, brought together nearly 2000 advocates, researchers, policy makers and global leaders from 115 countries. It put the world on notice: the deaths of more than half a million women each year in pregnancy and childbirth would no longer be tolerated. The evidence and arguments presented during the conference brought new ammunition to the case for investing in maternal and newborn health. Subsequent conferences,

held at three-year intervals, rapidly increased the visibility of these issues and the impact of the many new initiatives that grew out of the meetings.

The 2016 conference drew nearly 6000 participants from 169 countries and was covered by more than 500 journalists. That conference had a simple but powerful message: sustainable development is possible only when girls and women are healthy and thriving. Investment in women and girls has a ripple effect. All of society wins in the end.

Scaling up new vaccines

Over a 20-year period, several new vaccines had been licensed for use in children, including vaccines that protect against *pneumococcus* and rotavirus infections, leading causes of childhood deaths from pneumonia and diarrhoea. Though prequalified by WHO, the vaccines were initially not being utilized in developing countries where the vast majority of deaths from pneumonia and diarrhoea occur. Historically, new vaccines have taken from 10 to 15 years to gradually trickle into the immunization programmes of developing countries. Again, no one wanted to wait. Everyone looked to WHO for guidance.

WHO issues authoritative position papers on vaccines, published in its *Weekly Epidemiological Record*, when new data on safety, efficacy, benefits or dosing schedules emerge, especially from studies conducted in resource-constrained settings, or when new products are licensed. These position papers shape Gavi policies and are also widely used by the managers of immunization programmes everywhere, but especially in the developing world, to align their strategies with the latest technical evidence and recommendations from WHO. In preparing the position papers, WHO scientists draw heavily on the Strategic Advisory Group of Experts on immunization.

The introduction of the new rotavirus vaccines in wealthy countries rapidly cut in half the number of hospital admissions of children with acute gastroenteritis. However, high rates of undernutrition and co-infections with other enteric pathogens raised doubts about whether similar positive outcomes could be expected in developing parts of Africa and South Asia. In its first position paper on rotavirus vaccines, issued in 2007, WHO was not prepared to recommend the inclusion of rotavirus vaccines in the national immunization programmes of these countries.

That position changed following the completion of studies in developing countries where sanitation was poor, mortality from diarrhoeal disease was high, and maternal infections with HIV were widespread. In 2013, a new position paper on rotavirus vaccines was issued in response to additional evidence on vaccines, their safety, and the duration of protection. **WHO recommended that rotavirus vaccines should be included in all national immunization programmes and considered a priority**, particularly in countries in Africa and South Asia with high mortality associated with gastroenteritis caused by rotavirus infection. In those countries, WHO further recommended that vaccination be part of a comprehensive package of prevention and treatment interventions.

Similar procedures were followed in 2012 when WHO issued a position paper on the new pneumococcal conjugate vaccines, protective against 10 and 13 common serotypes of *Streptococcus*

pneumoniae. The position paper concluded that the new conjugate vaccines were safe and efficacious and represented significant progress in the fight against pneumococcal morbidity and mortality, especially in the developing world. WHO therefore recommended the inclusion of the vaccines in childhood immunization programmes worldwide. In developing countries, WHO recommended that vaccination be viewed as complementary to the use of other measures to control pneumonia.

A cornerstone objective of Gavi is to accelerate the introduction of new vaccines. By 2015, 19 countries had added rotavirus vaccines to their routine immunization schedules with GAVI support. By the end of 2015, more than 36 million children had been immunized with the vaccines. Beginning in 2010, GAVI supported rollout of the new pneumococcal vaccines in more than 50 countries. By the end of 2015, WHO estimated that nearly 80 million children had been protected. Thanks to these efforts, children in the world's poorest countries were receiving the world's best vaccines simultaneously with children in rich countries.

Introduction of the new vaccines was a show of solidarity and a willingness to innovate.

Through the mechanism of an advance market commitment, the governments of Italy, the United Kingdom, Canada, the Russian Federation, and Norway, further supported by the Bill and Melinda Gates Foundation, contributed \$1.5 billion to stimulate manufacturing of the pneumococcal conjugate vaccines for the developing country market. The mechanism was innovative but the signal was straightforward: if companies invest in expanded manufacturing capacity, the money will be there to purchase the products. The advance market commitment mechanism brought a substantial reduction in the price of the pneumococcal vaccines for use in the poorest countries. It also encouraged new manufacturers, including those in developing countries, to invest in the development of vaccines, potentially contributing to further price reductions in the long term.

Higher ambitions: building on success

With all these initiatives working in concert through WHO coordination, childhood deaths began to decline dramatically, with the fastest declines recorded in sub-Saharan Africa. Maternal mortality finally broke free of the historical half-a-million yearly figure, though the decline was still too slow to meet the MDG targets. As so often happens in public health, when deaths from one set of causes begin to recede, they reveal another set of deadly problems hidden beneath. This proved true for neonatal mortality.

In 2012, WHO published *Born too soon: the global action report on preterm birth*. The groundbreaking report set out the first-ever national, regional and global estimates of preterm birth. It demonstrated the extent to which preterm birth was on the rise in most countries, ranking as the second leading cause of death globally for young children, after pneumonia. The report made addressing preterm birth an urgent priority for reaching MDG four. To encourage targeted action, the report argued that rapid change is possible and identified the priority interventions that could contribute most substantially to reductions in preterm births, especially in low-resource settings. The *Every newborn action plan to end preventable deaths* followed in 2014.

Other ambitious goals followed research that allowed simplified approaches to the leading childhood killers. In 2013, WHO and UNICEF issued an integrated global action plan for *Ending preventable child deaths from pneumonia and diarrhoea by 2025*. The plan responded to some dire statistics. **Together, pneumonia and diarrhoea accounted for nearly 30% of all childhood deaths, amounting to the loss of two million young lives every year.** Though effective interventions were available for prevention and treatment, only 60% of children with suspected pneumonia received appropriate care. Even fewer were being reached with life-saving treatments: only 31% of children with suspected pneumonia received antibiotics and only 35% with diarrhoea received oral rehydration salts.

The integrated strategy for ending both diseases made perfect sense. Since the determinants largely overlap, preventive strategies and platforms for delivery could be shared. Maximum benefits would come when effective interventions for both were promoted together. Previous groundbreaking research supported by WHO and USAID had shown that antibiotics for the treatment of pneumonia could be safely and effectively delivered in homes. Apart from the advantage of easy access, home-based treatment of pneumonia spared sick children from the risk of exposure to other pathogens in crowded hospital wards.

Other neglected problems moved into the spotlight. In 2014, WHO issued its first report fully focused on the health needs of the world's one billion adolescents. *Health for the world's adolescents: a second chance in the second decade* provided a state-of-the-art assessment of health status and unmet needs of people in the age group of 10–19 years. Issued as a dynamic, multimedia online report, it explained why adolescents need their own set of interventions, distinct from those designed for children and adults. The report's evidence and arguments were later included when the Global strategy for women's and children's health was revised.

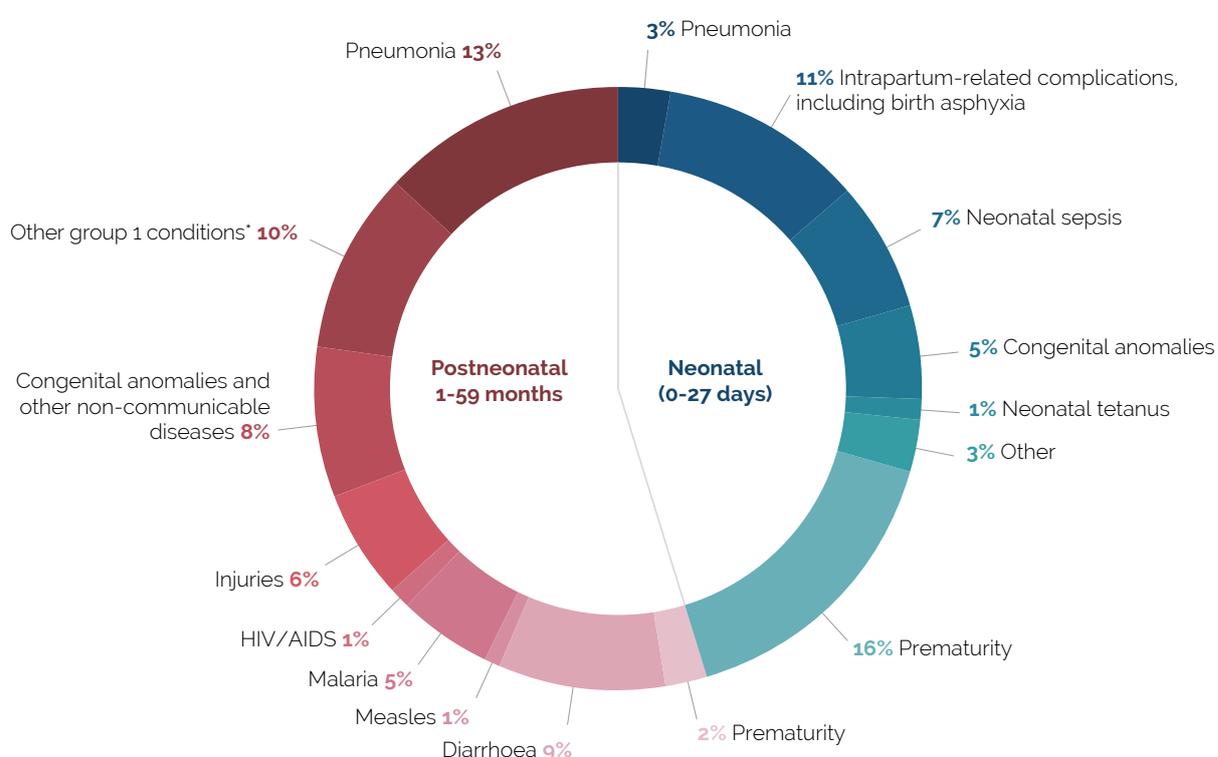
An indicator of fairness

As measurement improved for both maternal and child mortality, the data found additional uses, especially as an indicator of fairness in access to care. As addressing the social determinants of health and progress towards universal coverage emerged as priorities for global health, systems for detecting where inequalities exist and monitoring changes over time became essential instruments for health system reform and a tool for accountable public policies. **Improvements in equitable care for women and children were regarded as powerful indicators of overall equality within societies.**

In 2013, WHO issued a handbook on health inequality monitoring to enable countries to better monitor and evaluate their progress and performance with a high degree of accountability and transparency. The handbook was followed in 2015 with a report on the status of inequality in reproductive, maternal, newborn and child health. Using 22 indicators, the report profiled the status of inequality within and across countries, with data disaggregated by four dimensions of inequality: economic status, education, rural or urban residence and sex of the child. Where possible, the report tracked changes in health outcomes for population subgroups over time. It showed how a dedicated focus on inequality can compel targeted corrective action that gets to the heart of trouble spots concealed by national averages. For example, the proportion of births

attended by skilled health personnel differed by up to 80% between the richest and poorest subgroups. The use of modern contraceptives was at least twice as high among women with a secondary education or higher as among women with no education. For childhood mortality, deaths in rural areas exceeded those in urban areas by 16 child deaths per 1000 live births.

Causes of deaths among children under 5 years, 2015



Source: WHO

*Group 1 conditions are communicable diseases, maternal, perinatal and nutritional conditions.

What explains the success?

While the leading causes of maternal and child mortality have long been known, less data were available to explain why some countries at the same level of economic development have achieved superior results or what strategies were used to accelerate progress. In an effort to extract every possible lesson from the dramatic declines in mortality, WHO, the Partnership for Maternal, Newborn and Child Health, the World Bank, and several academic institutes looked at how ten of the world's poorest countries achieved outstanding success in reducing maternal and child mortality. The ten case studies were published in *Success factors for women's and*

children's health, a 2014 report which includes statistical and econometric analyses of data from 142 low- and middle-income countries over two decades, and policy reviews in the ten "fast-track" countries.

As demonstrated, the best results were obtained through investments in high-impact interventions such as quality care at birth, immunization, and family planning, combined with investments that target fundamental drivers of preventable mortality in other sectors, including education, nutrition, women's political and economic participation, and access to clean water, sanitation, and modern energy.

19 000 fewer deaths each day

As low-cost generic antiretroviral treatments for HIV became widely available, further progress in reducing maternal and childhood mortality came from the large number of countries that launched initiatives to eliminate mother-to-child transmission of HIV and followed WHO recommendations to "treat all", including pregnant women. The Medicines Patent Pool brought paediatric formulations of HIV treatment onto the market, extending the benefits of these medicines to more children. Significant drops in childhood deaths from malaria further contributed to the dramatic decline. Although the MDG goals for reducing maternal and childhood mortality were missed at the global level, the final Countdown report in 2015 recorded impressive progress.

The yearly number of maternal deaths dropped to around 289 000, with deaths still caused by conditions that could have been prevented through the provision of quality antenatal, delivery and postnatal care. Between 1990 and 2015, childhood mortality dropped by 53%. **Estimates for 2015 indicated 5.9 million childhood deaths that year, compared with 10.8 million in 2000. This reduction means that 19 000 fewer children are dying each and every day.**

The causes of childhood deaths showed a striking shift. In 2000, the leading causes of the 10.8 million deaths were neonatal conditions (33%), diarrhoea (22%), pneumonia (21%), malaria (9%) and AIDS (3%). In 2015, the leading causes of the 5.9 million deaths were preterm birth complications and other neonatal causes (45%), pneumonia (16%), diarrhoea (9%), malaria (5%), and AIDS (1%), strongly suggesting that scaled up coverage with interventions had a major impact. The sharp acceleration of declines in child mortality further suggested that even greater progress can be expected in the coming years. As the report noted, the growing concentration of deaths in the newborn period and the improved understanding about the causes of newborn deaths have sparked the scaling up of long-existing interventions and the development of new ones.

In Countdown countries, suboptimal nutrition, including fetal growth restriction, stunting, wasting and deficiencies of vitamin A and zinc along with suboptimum breastfeeding, were cited as an underlying cause of 45% of all childhood deaths, reinforcing the importance of initiatives like Scaling Up Nutrition. The collection of high-quality country data showed real progress. For example, the number of countries with information about postnatal care visits for babies increased from five during the period 2000–2006 to 35 by 2014. Against these positive trends, Countdown noted extreme inequalities, within and between countries, in coverage with life-saving interventions. Immunization was the notable exception, with coverage rates consistently reaching or exceeding 85% in most Countdown countries.

As an instrument for accountability, Countdown also tracked resource flows. Official development assistance surged after the MDG summit in 2000. Trends from 2003 to 2012 showed a tripling of development assistance to maternal, newborn, and child health, from \$2 billion to \$6 billion. Resource flows then slowed under the lingering effects of the 2008 financial crisis.

A \$12 billion head start for the future

In July 2015, the UN, the World Bank Group and the governments of Canada, Norway and the USA launched the Global Financing Facility to support the revised Every Woman Every Child strategy, drawing an initial US\$ 12 billion in financial commitments. The Facility was designed to act as a pathfinder in a new era of financing for development by pioneering a model that shifts away from a principal reliance on official development assistance to an approach that combines external support, domestic financing and innovative sources for resource mobilization in a value-added way. The overarching objective is to build long-term domestic financing as the principal route to fiscal sustainability.

Building on the approach used by the International Health Partnership Plus, the Facility uses a financing platform that is country-driven and country-owned. Countries develop their own roadmap for improving the health of women and children, and their own financing, implementation and accountability frameworks. The frameworks, in turn, operate to harmonize funding from multiple initiatives, align joined-up funds around a single investment case, and simplify coordination.

The Facility has been hailed as a visionary leap forward for financing health development in the era of the 2030 Agenda for Sustainable Development. It views the focus on maternal, newborn and child health as an entry point for moving towards universal health coverage with people-centred integrated services that follow a life-course approach and offer a continuum of care. Its emphasis on capacity building is reflected in the principle of building on what is already working in the country, underscoring another key lesson from the Countdown monitoring reports. In other words, **existing health systems and infrastructures must be strengthened through the way financial support is channelled, and not circumvented by the creation of parallel systems run by development partners.**

Finally, the Facility recognizes that the broad determinants of women's and children's health require multisectoral collaboration to improve education, nutrition, water supply, sanitation, and gender equality – health determinants that all have targets under the Sustainable Development Goals.

Moving forward: supremely ambitious targets

In 2012, encouraged by the substantial reduction in mortality for young children, the international community, spearheaded by the governments of Ethiopia, India and the USA, in collaboration with WHO, UNICEF and others, put forward a vision of ending preventable child deaths. That vision was later echoed in new targets for maternal mortality. Preparatory work for revising the maternal health component of the global strategy included a series of technical consultations convened

by WHO. After broad discussions that tapped the views of country programme managers, scientists, donors and other partner agencies, consensus was reached on the bold vision of ending preventable maternal mortality. Based on five years of remarkable progress, the vision was considered both realistic and feasible.

The resulting report on *Strategies toward ending preventable maternal mortality* set out the conviction that a "grand convergence" is within reach, in which the highest levels of maternal death can be reduced to rates now observed in the best-performing middle-income countries. Doing so required a firm emphasis on the ability to count every maternal and newborn death, equality in the provision of both quality clinical care and the reduction of risk factors in the wider social environment, and an understanding that maternal mortality is not solely a health and development issue, but also a sign of discrimination against women.

The strategy was further adjusted to address the "obstetric transition", in which the primary causes of maternal death shift towards indirect causes as fertility and mortality decline. It called for a shift from an approach focused on emergency care for a minority of women to care focused on wellness for all. To help set realistic targets in line with each country's unique situation, the strategy proposed a methodology for tracking progress based on the achievement of milestone values adjusted to reflect the country's initial burden of maternal mortality as the starting point.

When the UN General Assembly approved the 2030 Agenda for Sustainable Development in September 2015, the updated Global Strategy for Women's, Children's and Adolescents' health was simultaneously launched as a showcase platform for implementation of the Agenda's ambitious targets and goals. Because the determinants of women's and children's health are so broad, the updated Global Strategy translated the holistic approach of the SDGs into a series of precise actions, ranging over multiple sectors and supported by an accountability framework, designed to meet the targets set for ending preventable deaths of newborns and young children and substantially reducing maternal mortality. Other targets that called for ending discrimination and violence against women and girls reflected areas where WHO studies had brought international attention to the related health harms, including the 2013 report of *Global and regional estimates of violence against women* and its subsequent health systems strategy for addressing interpersonal violence.

The strategy is supremely ambitious: **the world has all the knowledge and technology needed to end preventable deaths among all women, children, and adolescents and to greatly improve their health and well-being**, allowing them to realize their full human potential as a cornerstone of development. The effects of doing so will ripple throughout societies, contributing substantially to a more prosperous and sustainable future for all.

After a decade of sluggish then dramatic progress, women and children now have an agenda which makes their health needs a high priority and looks after them in a comprehensive and sustainable way. The political will to address the tragedy of millions of avoidable deaths each year has now fully arrived.

This report is available on WHO's website
www.who.int/publications/10-year-review/en/