CHILD
HEALTH
NOW
Together we can end
preventable deaths

MORE THAN NUMBERS
Why better data adds up to saving the lives of women and children

Contents

Abbreviations

CBMS – Community-Based Monitoring System

CRVS – Civil Registration and Vital Statistics

CVA – Citizen Voice and Action

DHS – Demographic and Health Survey

iERG – independent Expert Review Group

MDGs – Millennium Development Goals

MDSR – Maternal Death Surveillance and Response

MICS – Multiple-Indicator Cluster Survey

PMNCH – Partnership for Maternal, Newborn and Child Health

PSG – Parent Support Group

PWD – People With Disabilities

VHT – Village Health Team

Report overview

Part 1 of this report draws attention to the existing inequalities faced by the most vulnerable children; it highlights the groups of children facing multiple deprivations who fall through the cracks in the health system; and it describes the limitations of current instruments, such as household surveys, to count the poorest and most vulnerable children and achieve reliable estimates of health outcomes at lower levels.

In Part 2, we outline the role of local-level approaches in complementing existing data collection and monitoring systems. We analyse current global and national commitments and actions towards counting every child. We review the existing Country Accountability Frameworks to identify the extent to which governments are prioritising the involvement of communities in monitoring and tracking vulnerable children and groups.

In Part 3, we propose our vision for counting every child, and showcase a number of examples of families and communities conducting their own monitoring, taking control of their own health and holding governments to account for the services they provide.

Part 4 provides conclusions and recommendations for governments and other stakeholders involved in reaching the MDGs and in the post-2015 and sustainable development agendas.

Executive summary

As a global community, and as individual countries and organisations, we have made progress that should be celebrated. An estimated 90 million lives have been saved in the past two decades due to our collective efforts to improve child survival. We are losing fewer children every year to measles, malaria and other childhood diseases. But we are still losing too many to the most preventable of causes.

As we gear up for the final push to the deadline of the Millennium Development Goals (MDGs), our focus needs to be on accelerating the progress we have made, and dramatically reducing further the number of children we lose every year. We have until 31 December 2015 to achieve our goals of reducing child mortality by two-thirds since 1990, and maternal mortality by three-quarters. Discussions are already well underway on what comes after the MDGs, and there is strong support for an ambitious target to end preventable maternal, newborn and child deaths within a generation. This is achievable only if we find ways to reach those babies, children and mothers who remain outside the scope of mainstream health systems and funding. We must find out who is still being left out – and why.

Every year, around the world, how many children die unseen, invisible, unregistered and unable to access the kind of health services that could save their lives? The reality is we don't know. The most educated guesses put the number of invisible and unreached people at between 250 and 500 million in developing countries.[1] How many of these are children? We should not have to guess. We should know where they are and how to reach them with health interventions.

We are not currently counting the most vulnerable children because there are significant gaps in the type of health information collected by countries. Only 20 per cent of countries have strong health information systems that count all births and deaths and track causes of death, alongside major household surveys. These are mostly more developed countries. Yet that is not where the majority of child deaths occur.

It is the right of every mother and child, everywhere, to be counted and included in government provision of services. When everyone is counted, governments and donors can more confidently invest in policies and programmes that target and reach the most vulnerable communities. We know that this will save more lives. In Uganda, it's a matter of a sick child being able to see a doctor or not. In Indonesia, it's a matter of the government providing enough funding for all children in one community to be immunised or not. In Afghanistan, it's a matter of a mother knowing what help to get when she goes into early labour and how to access it.

What we know for sure is that many child deaths and illnesses never reach a health facility and frequently go unreported. This makes expanding the reach of current information systems and investing in the collection of information at the community level, by communities, critical. World Vision works with communities to enable them to improve the well-being of their children. Key to this work is measuring, tracking and reaching the most vulnerable, often the invisible or unseen, children. We equip midwives with mobile phone health monitoring technology in Afghanistan and help community-based health workers in Indonesia to register the information of children attending public festivals, then follow up by placing stickers on houses with children under the age of 5 so health volunteers can easily identify houses that need continued support and attention.

It is the **right** of every **mother** and **child,** everywhere, to be **counted**.

We need political **champions** willing to stand up for **children**.

If we are going to end the preventable deaths of children under 5, we need to see more of these initiatives supported, integrated into national information systems and scaled up by governments. We need to see global-level endorsement of approaches that put real people – families and communities – at the front and centre of efforts to count and reach the most vulnerable children in the most need. We need political champions willing to stand up for those children furthest from health centres and people's minds and put them at the forefront of the next development agenda.

Every child has the right to be counted; the invisible deserve to be given visibility; and the most vulnerable children deserve to be given the opportunity to survive to fulfil their potential.

We believe the following steps need to be taken by national governments, donors, and global institutions, to fulfil the vision for counting every child and closing the health equity gap. These are steps not just to realise the future potential of millions but for immediate action to accelerate efforts towards the health-related MDGs.

National governments should:

- Ensure a consistent focus on addressing inequalities through improved counting and targeting of the most vulnerable children and the subsequent use of this data in policy setting, programme design, progress monitoring and reviews.

- Expand the health information system by systematically scaling up promising community-level approaches that generate data and analysis, particularly in areas of low information untouched by existing surveys and mapping, to help identify the most vulnerable, inform decision-making, improve health service delivery and have a positive impact on health outcomes.

- Increase investment in systems for civil registration and vital statistics towards universal and effective coverage.

- Institutionalise maternal death surveillance and response, and ensure that information gathering is structured to facilitate community participation in death-review processes.

- Bridge the gap between decision-makers at all levels and caregivers, families and communities by supporting community-based monitoring systems such as social audits and citizen report cards.

- Take explicit steps to prioritise local- to national-level accountability, including through civil society participation in planning, review and accountability mechanisms.

National and donor governments and international agencies should:

- Review and refocus existing efforts to accelerate progress towards the MDGs with a view to better counting and reaching the most vulnerable children.

- Give particular priority to the most vulnerable in the post-2015 development agenda, including through a high-level goal to end preventable maternal, newborn and child deaths and a strong commitment to significantly reduce the numbers of stunted children worldwide.

- Ensure that the monitoring of any new development goals includes strong metrics on equity beyond income and includes a commitment to disaggregate country health data at minimum by age, gender, location, ethnicity, income quintiles and disability.

- Commit to the scale-up of effective civil registration and vital statistics systems towards the achievement of universal coverage.

- Invest in and expand mechanisms for health monitoring, review and accountability, spanning local to global levels, that include effective participation from communities, civil society and all relevant stakeholders.

Part 1

Finishing the job: Saving lives with better data

In the small remote place of Bawomataluo in South Nias district of Indonesia, the front door of every house with a child under 5 shows a sticker containing the information of the child's weight, height and date of weighing. Volunteers and midwives in the community update this sticker every month and keep a database in the form of a book complete with every child's picture, date of birth and nutritional status. Before this mapping exercise began, coverage of health services was low, and nobody knew exactly how many children were in the area. With this community monitoring programme, every child and pregnant woman is accounted for, and health volunteers can use this information to better target essential health services and counselling.

The simple process of counting every child and monitoring their health status may be common practice in rich countries, but in poor, remote communities like Bawomataluo, such lists are rare and scores of children fall through the cracks, uncounted and invisible. Locally driven data can plug vital information gaps so that health services can target these most vulnerable children. Communities worldwide must be part of the effort to count every mother and every child.

Extraordinary progress has been made in saving children's lives: the number of children dying each year under the age of 5 has fallen from over 12 million to 6.6 million in the past two decades.[2] But at a time when major advances in global child health are being rightly applauded, millions of children around the world die unseen, invisible, unregistered and unable to access the kind of health services that could save their lives. An estimated 18,000 children under 5 still die every day, many from conditions that could have been prevented or effectively treated. Two million will die on the day they are born. Four million more won't make it to their fifth birthday.

We are in a time of unprecedented investment in health, globally and nationally. The Millennium Development Goals (MDGs) have presented an extraordinary global opportunity where the political community's focus has been on saving lives and reducing poverty. This political attention has brought with it financial investment and has led to the progress seen in recent years. But success stories in striving to reach the health-related MDGs are coupled with stories of groups of children who are missing out completely in the great strides being made. Too often, the poorest and most marginalised children will be excluded from the success stories.

The current MDGs have been equity-blind – the aggregated numbers used to assess global and national progress in achieving the MDGs have meant that some countries have been able to achieve their targets without addressing the needs of their most vulnerable children. Current measures of child health mask inequalities between the best off and worst off. Vast numbers of children are born but never counted, their fundamental right to an identity violated. Children and mothers die because we don't always know where they are and how to reach them. There are big holes in the type of health information collected by even the richest countries. This makes it difficult to understand who suffers as a result of health inequality, and it means that governments everywhere are likely to be underestimating the magnitude of inequalities between

and within countries. In poor countries in particular, this means we are losing the lives of mothers and children who could be saved by simple and cost-effective health interventions. The groups who suffer most – such as children not registered at birth, children with disabilities, orphaned children, children of ethnic minorities, stateless children and children born without the help of skilled birth attendants – are those who are generally not counted, remain invisible to health services and systems and are being left out of progress. This lack of information on who and where the most vulnerable children are has significant implications for the planning, resourcing and delivery of health services.

> Finishing the unfinished business is not just about moving closer to global aggregate and national average targets. It is about ending preventable child deaths. And now, for most countries, it is mostly about who is still left out – and why.[3]

In 2007 a series of papers published in *The Lancet* drew attention to the 'scandal of invisibility' in which the poorest and most vulnerable people in society went unregistered, uncounted and uncared for.[4] This could be affecting between 250 and 500 million of the poorest of the poor in developing countries.[5]

Closing the health equity gap

Finishing the job of the MDGs and ending preventable child deaths means having health services that reach babies, children, mothers and families everywhere. It is the right of every mother and every child to be counted and to have access to good-quality health care. We must focus much more on the lives of individual mothers and children, not just on the national or global aggregates. This means addressing the reasons that mothers and babies die, supporting more families with information to prevent child stunting, and extending basic health, water and sanitation services to neglected areas. Going the extra mile will be tough, and it means finding measures to reach children who suffer from not just one but multiple deprivations. This can include children in the poorest families in rural areas, or children with disabilities within internally displaced or refugee populations.

Closing the health equity gap is a necessary foundation for accelerated progress to end preventable child deaths. Investing in health and closing the health equity gap within and between countries also has the potential to deliver great economic returns. The 2013 Lancet Commission on Investing in Health reported that reductions in mortality accounted for about 11 per cent of recent economic growth in low- and middle-income countries.[6] A cost-benefit analysis by the Lancet Commission reveals that spending just US$23 a head in the poorest nations, an extra $25 billion, would yield a $216 per capita increase in economic growth. The 2012 Copenhagen Consensus, a research-driven examination of the smartest solutions to global challenges, found that all five of the top development investment opportunities were in health or nutrition, as were four of the next ten.[7]

> The risk of social exclusion and inattention to vulnerable populations is ever present. The omission of equity considerations is not only bad for women's and children's health. It also misses an important opportunity to accelerate progress. Equity-focused initiatives themselves could lead to faster decreases in mortality, enhanced cost-effectiveness, and reduced inequality.[8]

Without tackling inequalities, the task of ending poverty cannot be achieved. As a result, there is much discussion on the importance of addressing health inequalities to

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achieve the 'unfinished business' of the MDGs and establish an equitable, sustainable development agenda to follow. Drawing attention to the 'wide and often mutually reinforcing disparities' that are evident within countries, a recent Issues Brief on Promoting Equality prepared by the UN Technical Support Team for the Eighth Session of the Open Working Group on Sustainable Development Goals, went on to point out that these inequalities will make the attainment of universal, or 'zero-based' goals in any new development framework especially challenging.[9]

Significant discussions are underway with regards to strengthening important methodologies such as vital registration systems, household surveys and routine data collection at the facility level to improve health equity monitoring. However, existing monitoring systems do not go far enough to capture smaller groups of children suffering multiple deprivations, who remain invisible to health services and excluded from progress to save lives. Health information systems in many countries have remained focused on meeting the data needs of central governments, donors or global databases, largely without locally driven views and experiences. Significantly more work is needed to ensure that health information systems are counting and reaching the most marginalised groups.

Reaching the children who slip through the cracks will require greater input from people and communities themselves, reflecting their distinct needs. Since many child deaths and illnesses never reach a health facility and frequently go unreported, the collection of information at the community level, by communities, is critical. Local innovations that empower communities to conduct their own data collection and monitoring can help generate rich information which reflects these needs, and can complement conventional data collection methods and plug information gaps in the health status of women and children. Communities can help to gather information on children and mothers who fall through the data cracks, to understand who and where they are, what health services they have access to and what they are dying from.

A new movement for better data

In reaching the health-related MDGs and the goals to be agreed as part of the next development framework, data on inequalities present a major constraint – such data are very poor or non-existent in many countries, particularly for factors of health and well-being that go beyond income, and for the poorest and most marginalised social groups. Health information systems should be designed with a focus not just on generating data for data's sake but on improving the health of individuals in the community and achieving health equity. The question we raise in this report is, *How do we strengthen systems to measure not just more, but to measure smarter, in a way that captures the realities of every child and engages the most marginalised groups?* This is the only way we can save the lives of mothers and children who are missing out on current efforts.

The call for more and better data is not new, but the debate being generated by the 'data revolution' proposal presents a significant opportunity to strengthen the systems we use to monitor progress in child health.

Paying particular attention to the inequalities holding back progress in child health and development, the report of the High-Level Panel of Eminent Persons on the Post-2015 Development Agenda made a powerful case for focusing on excluded and disadvantaged populations, calling for a transformative shift to 'leave no one behind':

The next development agenda must ensure that in the future, neither income nor gender, nor ethnicity, nor disability, nor geography, will determine whether people

live or die, whether a mother can give birth safely, or whether her child has a fair chance in life.[10]

Recognising that efforts to tackle inequalities depend hugely on the availability of the right data, the panel proposed that a 'data revolution for sustainable development' should gather information disaggregated by gender, geography, income, disability and other categories to shine a light on the most vulnerable groups who would otherwise remain hidden. Putting that spotlight on those communities means many lives could be saved through more targeted interventions to improve health outcomes.

Similar calls for a new approach to data, in the context of the next development agenda in particular, have been articulated by a wide range of stakeholders across a number of processes. The independent Expert Review Group on Information and Accountability for Women's and Children's Health (iERG), in their 2013 report *Every Woman, Every Child: Strengthening Equity and Dignity through Health*, called for a 'new movement for better data' and for a post-2015 development target related to civil registration and vital statistics (CRVS).[11] The UN Issues Brief on Promoting Equality suggests,

> Methods for the practical measurement of inequalities include strengthening current household surveys and vital registration systems with more extensive disaggregation of data and data collection on poorly-covered populations. These could progressively be combined with tracking, performance and progress monitoring using 'new data' from, e.g., crowd-sourcing, social audits and citizen report cards, thereby enhancing participation and accountability.[12]

The good news is that these innovative ways of collecting more and better data allow for better targeting of resources and interventions and mean that many more lives can be saved. This is in contrast to traditional means of data collection and monitoring, which have generally been top down, externally controlled and deeply extractive. Information systems in many countries have focused on meeting the data needs of national governments, donors or global databases, largely without locally driven views, ideas, experiences and solutions. National and global databases and registries are critical, but nationally aggregated data from surveys and censuses cannot provide detailed, current, local information useful for individuals, communities, local authorities and health service providers. Information generated at the community level gives authorities a far better chance of accommodating the poorest and most vulnerable groups in their health services.

Reaching the children who slip through the cracks will require greater input from citizens reflecting children's real and distinct needs. Individuals, families and communities can play a significant role in shaping and monitoring health systems, but to extend current health information systems to the local level will require political champions who can help drive changes to existing models and methods.

More than a data revolution: An accountability revolution to transform communities

Community involvement in data generation and monitoring can do more than contribute to revolutionising data. Local monitoring can help drive accountability at local, national and global levels. It can serve to empower communities, improve community and government relationships and transform government systems to deliver benefits for the most marginalised women and children. True accountability means

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The invisible **deserve** to be given **visibility,** and the most **vulnerable** deserve the **opportunity** to **survive** beyond five years to **reach** their **full potential**.

counting every woman and every child and is the only way we will be able to measure tangible progress in saving lives.

Presenting the findings of *A Million Voices Survey*, which captured the views of more than 1 million citizens across 190 countries, including women and excluded groups such as children, people with disabilities and displaced people, the Administrator of the United Nations Development Programme, Helen Clark, reported that the world's people

> …want to continue to have a say, to ensure that their views are taken into account, to monitor the real-time progress in their countries, and to hold their governments accountable for results…. They have called for a revolution in data – so that regularly updated, reliable and disaggregated data is available about their communities, countries and world. They see a data revolution as the foundation for an accountability revolution.[13]

The elements of equity, participation, empowerment and accountability were largely missing from the MDGs and their targets. In the less than two years remaining before the end of the MDGs, and as we advance the post-2015 and sustainable development agendas, we are faced with an imperative to agree on a transformative agenda for action where health metrics and human rights stand together. All governments, institutions and organisations must recognise that, like the children in Bawomataluo, Indonesia, every child has the right to be counted and reached by health services. The invisible deserve to be given visibility, and the most vulnerable deserve the opportunity to survive beyond 5 years of age and to reach their full potential.

The invisible children: Slipping through the data cracks

The children and families who have not benefitted from gains in child health and survival in the past two decades are neither randomly nor evenly distributed within countries. It is the most disadvantaged groups who tend to fare consistently worse on all indicators to measure progress towards the MDGs and who are left behind in their country's overall improvements. In the most extreme cases, not being counted means lives are lost as government services completely bypass those communities living on the margins. Income levels go a long way to explaining the gaps in health equity. From 2006 to 2011, income inequality increased within most countries around the world. Income poverty often means sub-standard living conditions, poor diets, exposure to the most illnesses and the fewest opportunities to overcome these adversities.

But as a recent Global Health Index from World Vision highlights, a country's overall material wealth alone does not guarantee good health for all people.[14] Children who fall through the cracks in the health system often face not one but multiple inequalities at once, making them harder to count, harder to reach with essential health interventions and left out of progress in child health. The children most at risk will come from the poorest households, reside in rural locations, belong to an ethnic minority or low-caste group, and have parents, particularly mothers, with little or no education.[15]

The many deprivations that individual children may face mean that average measures of health will hide the inequalities between the best-off and worst-off children. The health of the most vulnerable children is therefore not routinely documented or acknowledged and they remain invisible to the health services they desperately need. It is clear that missing out on these services has an impact on health outcomes. Summary data can also be deceptive: in Nepal, the child mortality rate in Dalit communities is at least 50 per cent higher than the national child mortality rate, and in Peru, although child

stunting is lower in urban areas than rural areas, poorest children in urban areas are four times more likely to be stunted than children from the least poor quintile in rural areas.[16]

Significant effort has gone into improving how to measure key health outcomes such as child mortality or nutrition status; coverage of health interventions such as immunisation status, antibiotic use for childhood pneumonia and presence of a skilled attendant at birth; or the quality of health care. Often ignored is a critical denominator to this equation: how well do we count populations and, in particular, children and the poor? Without knowing this information, targeting interventions where they are most needed is a haphazard task and, as this report argues, it is the most vulnerable who will miss out.

Against the backdrop that the MDG goals and indicators have neglected inequalities in child health, there is increasing concern about rising health inequality between and within countries, and attempts are being made to quantify and measure these gaps:

- The Commission on Information and Accountability for Women's and Children's Health has highlighted the limitations of aggregate national-level statistics. It has requested that the 11 indicators for women's and children's health be reported for the lowest wealth quintile, gender, age, urban or rural residence, geographical location, ethnicity and, where feasible and appropriate, that mother's education, marital status, number of children, and HIV status is also reported.[17]

- The Countdown to 2015 initiative includes equity analyses as a regular component of its reporting on progress towards MDG 4 (reduce child deaths) and MDG 5 (improve maternal health) for 75 countries. It provides a breakdown of 18 indicators for essential reproductive, newborn, maternal and child health interventions by maternal education, gender of the child, wealth quintiles, urban or rural location, and region of the country.

- Household surveys, including the UNICEF-supported Multiple-Indicator Cluster Surveys (MICS) and the USAID-supported Demographic and Health Surveys (DHS), are the primary data source of health coverage indicators for children and women for most countries, and they usually provide disaggregated information on urban and rural location, wealth, gender, age groups and nationally defined ethnic groups.[18]

The measures of inequality listed above are those best captured by existing modes of data collection. But the real faces of inequality extend well beyond the data currently being compiled. The most vulnerable children may be the most excluded from statistics and essential health services, and most at risk of losing their rights to health, protection and identity.

A recent review of interventions to improve equity in the health-related MDGs found an almost complete lack of studies addressing social and cultural issues in relation to maternal and child health. Almost all of the studies addressed income poverty, reinforcing the idea that inequality in health is mostly considered to be a matter of income and that other inequalities are neglected.[19] Yet we know that economic development is not enough for improving health for all. Despite efforts to measure and analyse child health, an understanding of the realities faced by the most vulnerable children and communities continues to elude governments, policymakers and planners.

Children who fall through the **cracks** in the in the **health system** often face not one but **multiple inequalities** at once.

World Vision's *The Killer Gap* report identified the following vulnerable groups of children for whom information is not routinely collected and who miss out on essential health services:[20]

- children uncounted at birth and in death

- mothers and newborns who die around the time of childbirth

- indigenous children and ethnic minorities

- refugees and displaced children

- children living with disabilities

- child labourers and trafficked children

- orphaned children.

This report adds to this list children living in urban slums as another marginalised, uncounted group.

While there is far less evidence to assess their situation, and while present data constraints limit the scope for monitoring these children, we must raise our ambition to make sure they are counted and reached with the essential health services needed to save lives.

Conventional counting methods: Can they reach the most vulnerable children?

Health information systems generally use data gathered from population-based sources such as household surveys, vital registration and censuses, from facility-based sources such as hospital service records and individual patient records, and from surveillance systems to monitor health inequalities.

Routine data from facilities can provide continuous information at lower administrative levels such as districts, but health information systems are generally too weak to collect and utilise quality data, and these sources fail to capture groups – often the poorest and most marginalised – who do not access health facilities and thus go uncounted. There are several types of surveillance systems, including outbreak disease surveillance systems, which aim to track cases of diseases that could become epidemics, as well as their risk factors. Many low- and middle-income countries have established demographic surveillance sites, where information is collected for a particular defined population over a long period of time.[21] These surveillance systems produce higher-quality data but for limited geographic areas that are not representative of national populations.

Amidst enthusiasm to realise the 'data revolution', there is much discussion on the role of household surveys as one of the most valuable sources of information for areas covered in the new development framework and as the primary source of information on child mortality for most countries. Nationally representative household surveys are the method of choice for measuring reproductive, maternal, newborn and child health in low- and middle-income countries and for assisting in national and global decision-making for health interventions. This is likely to remain the case for the foreseeable future.[22,23] The MICS and DHS programmes have contributed greatly to strengthening national capacities to collect high-quality data on a wide range of development indicators, including more than 20 MDG indicators.[24]

But the ability of household surveys to monitor whether the poorest and most marginalised children are being reached with essential health services is limited. The

sample size of DHS surveys (15,000 households) and MICS surveys (10,000 households) is enough to produce reliable information on most indicators at the national, rural/urban and regional levels but not at lower administrative levels such as districts and within communities for small population groups. To identify and highlight the experiences of smaller numbers of marginalised groups, household surveys can be used to oversample particular groups.[25] But oversampling and adding questions to surveys makes them time-consuming and costly, and the added value of producing information at lower levels needs to be balanced with the logistical challenges. Figure 1 summarises the strengths and limitations of key data sources for monitoring health inequality.

Figure 1: Strengths, limitations and possible areas for improvement of key data sources for health inequality monitoring (reproduced from World Health Organization [2013] *Handbook on Health Inequality Monitoring*, WHO Geneva)

Data source	Examples	Advantages	Disadvantages	Possible improvements
Census	National population and household censuses implemented every 10 years	Data cover the entire population (or nearly so), providing accurate denominator counts for population subgroups	Contains only limited information on health Timing of data collection is not consistent	Include individual or small-area identifiers
Vital registration system (civil registration and vital statistics system)	National birth, death or marriage registries	Can be used to generate reliable estimates for mortality rate, life expectancy and sometimes cause-of-death statistics Often linked to information on sex, geographical region, occupation, education	Incomplete in most low- and middle-income countries Does not regularly include information on equity stratifiers other than sex	Expand coverage Include at least one socioeconomic indicator Include cause of death, birth weight and gestational age (when not included)
Household survey	Demographic and Health Survey, Multiple Indicator Cluster Survey, World Health Survey, Study on Global Ageing and Adult Health, Living Standards Measurement Study	Data are representative for a specific population (often national) Have rich data on a specific health topic as well as living standards and other complementary variables Often repeated over time, allowing for measurement of time trends Conducted in multiple countries, allowing for benchmarking	Sampling and nonsampling errors can be important Survey may not be representative of small subpopulations of interest (so cannot be used to assess cross-district inequality)	Repeat surveys on a regular basis Enhance comparability over time and between countries by harmonizing survey questions Increase sample sizes
Institution based records (administrative data)	Resource records (e.g. number of hospitals, health workers) Service records (e.g. number of immunizations given) Individual records (e.g. medical charts)	Data are readily and quickly available Can be used at lower administrative levels (e.g. district level)	Data may be fragmented or of poor quality Often data cannot be linked to other sources Data may not be representative of whole population	Include individual or small-area identifiers Create standardization of electronic records across institutions
Surveillance system	Outbreak disease surveillance Sentinel surveillance Risk factor surveillance Demographic surveillance	Can provide detailed data on a single condition or from selected sites Sentinel surveillance site data useful for correction of overreporting or underreporting	Not always representative of population Some systems may collect little information relevant to equity stratifiers	Include individual or small-area identifiers Integrate surveillance functionality into larger health information systems with full coverage

There has been no **systematic attempt** to estimate the numbers of **children missing** from surveys.

While household surveys are critical for data collection, now and in the future, the majority of the poorest and most vulnerable children, families and communities are simply not in the survey sampling frame and will continue to go uncounted with these methods alone. The design of household surveys neglects individuals who are not in households, such as children living on the streets; those who are in institutions, including refugee camps; and mobile or landless populations. Surveys will also under-represent many of the hardest-to-reach and vulnerable groups, including urban-slum dwellers and those in fragile or multiple-occupancy households.[26] Children facing multiple deprivations are even less likely to be captured by the sampling frames of surveys due to their small numbers.

The lack of recognition of the plight of the world's most vulnerable children and the inability of existing counting methods to give them visibility, means there has been no systematic attempt to estimate the numbers of children missing from surveys, where they are located or how to reach them with essential services. In Annex 1 we outline the limitations of current approaches for each of the most vulnerable groups of children we are concerned with.

Part 2

Local-level data collection and monitoring: How communities can extend the health information system to reach the most vulnerable

To date the greatest improvements in health have been made amongst communities that are the easiest to reach, while millions of children and families continue to suffer and die in remote, hard-to-reach or hard-to-count locations. But many health information systems are designed and implemented without measuring and understanding the specific characteristics and contexts in which the most marginalised children and groups live. Without this information, these vulnerable groups will continue to miss out on the efforts under the MDGs and other similar agreements.

> Health information is too important to be left to statisticians and politicians. Strengthening health information systems is also about imagining and creating a better world for all.[27]

In light of this, community-based systems are a necessary investment to strengthen and expand the reach of national health information systems. Established methods for generating and using data to monitor progress in the health of women and children can be complemented with innovations that empower families and communities to conduct local-level monitoring. Communities can help to gather information on children and mothers who fall through the cracks in the data system – to understand who and where they are, what health services they have access to and what they are dying from. Since many deaths and illnesses never reach the level of the health facility and frequently go unreported, the collection of information *at the community level, by communities*, is paramount. Political will, local government engagement and the participation of communities are critical factors in developing innovative methods suitable for local conditions and experiences.

Community-based systems can be extremely cost effective as a solution to improving data collection. In the case of the community-based monitoring system (CBMS), an approach involving community members and local officials that is being implemented to track poverty and development issues at the household level in 14 countries across Africa, Asia and Latin America, the per-household cost of carrying out CBMS is much lower than the cost of household surveys undertaken by national statistical offices. The cost of CBMS in Vietnam is only around US$0.30 per household, and in the Philippines it is $0.70.[28] Local governments generally bear the cost of implementation. Commitment from local governments and municipalities is key to overcoming capacity and resourcing blocks.

Community-based **systems** are a **necessary investment** to **strengthen** and **expand** the **reach** of national health information systems.

Community-based systems can be extremely **cost effective** as a **solution** to **improving** data collection.

Global efforts to improve data, accountability and health equity: Lives counted equal lives saved

Some governments and national statistical offices are making specific attempts to focus on the most disadvantaged children and families in child health and survival efforts and have responded to a demand for local-level information by supporting community-based systems. For example: [29]

- Zambia has adopted a new national agenda for equity in child survival which will identify the most deprived districts and focus on the needs of the most deprived women and children.

- Bangladesh has launched the initiative *Ending Preventable Child Deaths by 2035: Bangladesh Call for Action*, in which equity is a central feature. The plan will have a particular focus on urban slums, areas with ethnic minorities, such as the Chittagong Hill Tracts, and low-performing districts. The government plans to expand the use of communications technology to generate local health reports and maps and to support accountability mechanisms, involving stakeholders from the local through to legislative levels.

However, only 39 of 192 WHO member states have a relatively strong information system in terms of health equity. That is, they have functioning vital registration systems to count births and deaths and track causes of death, alongside a major household survey. Most of these are developed countries. It is a major concern that the 90 countries have systems with very weak equity-analysis capability, only one census or household survey, or no data generating capacity at all.

Of countries supported by the Commission on Information and Accountability, 58 have completed or are in the process of completing Country Accountability Frameworks. Twelve of these – Benin, Cameroon, Ethiopia, Lao PDR, Madagascar, Malawi, Mauritania, Nepal, Papua New Guinea, Solomon Islands, Tanzania and Togo – have submitted their first progress reports, which show that frameworks are in use.[30]

Countries are making progress towards the Commission's ten recommendations. For example, on Recommendation 1 (vital events and maternal death surveillance and response [MDSR]),[31] 40 countries have completed a rapid civil registration and vital statistics assessment, and 53 countries are oriented towards a revised approach for MDSR. On Recommendation 3 (eHealth),[32] 27 countries have developed and are implementing national eHealth strategies linked to the health of women and children.

But the assessments completed as part of the Country Accountability Frameworks demonstrate that most countries have a long way to go to ensure that communities are participating in efforts to strengthen data collection, and that their views and experiences are being heard.

We analysed those country assessments available on the website of the World Health Organization[33] to get a snapshot of how well countries are faring on:

- community reporting for births and deaths

- community reporting and feedback to communities on maternal deaths

- equity, with health data being disaggregated for key indicators such as sex, income, minority and location used extensively in reviews

- use of qualitative information from communities.

Each country has provided a self-assessment of where it sits on a rating scale in these areas: *not present, needs to be developed; needs a lot of strengthening; needs some strengthening; and already present, no action required.* This rating scale is presented in Annex 2 for the 60 countries with frameworks publically available.

On community reporting of births and deaths, the rating scale and explanations provided by each country reveal that while there are examples of community reporting, this is not being undertaken across countries in a systematic way. In Congo, village chiefs register births and deaths in their communities and take recordings but quality is often limited; in Malawi there is a commitment to CRVS strengthening, with plans to undertake mass birth registration using mobile community vans and pilot electronic reporting.

There is limited use of technologies such as mobile phones at the community level – SMS recording of births and deaths tends to occur at the health facility level. There is some evidence of community involvement in verbal autopsy, a method that uses standardised interview tools to question the families of the recently deceased person about the symptoms before the death, but this is not widespread and is generally undertaken as part of pilot experiments or research studies (e.g. in Burkina Faso, Nepal, Zambia and Guinea). In Rwanda, verbal autopsy is being implemented in one-third of the country.

On reporting of maternal deaths, there is some evidence of communities reporting deaths to health centres (e.g. in Pakistan, in areas where Lady Health Workers are present, and in Cambodia and Gambia). But even where reporting is taking place, it is generally not within the recommended 24-hour period. Data collection from communities on births and deaths tends to be an extractive process – there are very limited mechanisms for community feedback and involvement in review processes.

Many countries report that they are disaggregating health data by sex, age and geographic location. There are a limited number of cases of disaggregating data for minority groups, and no evidence of intentionally tracking the poorest and most marginalised groups we have identified in this report. Even where data is being disaggregated, countries report a limited use of equity data in health reviews or limited integration of community-level information into health information systems.

Analysis of qualitative information obtained from communities is generally inadequate, and where it is reported (for example, in Ghana) it is not being undertaken systematically. Some countries, such as Malawi and Pakistan, report that qualitative information may be collected and available, but full use of this data is not being made in health reviews or to make informed decisions about health policies and programmes. This reinforces the need to 'measure smarter' and make better use of existing information on community experiences, views and priorities.

Country Accountability Frameworks offer a critical opportunity to track how governments are implementing their commitments to better track resources and results for women's and children's health. Despite the intention for these to be developed and reviewed by a group of national stakeholders, including parliamentarians and civil society, to date many have been restricted to government and UN agency involvement. As the country frameworks and related roadmaps are reviewed and updated there must be greater transparency and increased opportunities for input from civil society, including in the review and monitoring of the particular elements highlighted in our analysis.

There must be **greater** transparency and **increased** opportunities for **input** from civil society.

Community participation in data collection and monitoring can **generate** accurate and rich information to complement national statistics and **plug** information gaps.

Part 3

Our vision for counting every child

Community participation in data collection and monitoring can generate accurate and rich information to complement national statistics and plug information gaps. Communities can help collect information on the health status of the poorest and most marginalised children that surveys cannot and can ensure that governments are in touch with the realities of people in the community. (See Figure 2.) This means health systems and government services can be better designed and implemented to meet the needs of all portions of the community. Local-level approaches to data generation can support not only the flow of information from the community level through to the national level and back again but can create opportunities for real dialogue between marginalised groups and authorities at each level.

Figure 2: Complementing national data collection with community approaches
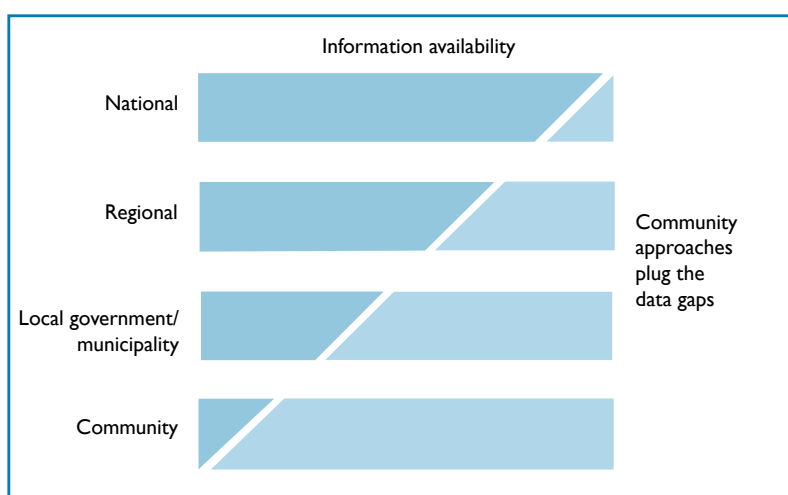
Adapted from: Reyes, Celia and Due, Evan (2009). *Fighting Poverty with Facts*, International Development Research Centre.

At present, there are no policy blueprints for generating and monitoring data at the local level with the participation of community members. We have identified four fundamental principles for expanding current health information systems to ensure that all children are counted, visible and reached with essential health services, and for putting equity at the heart of the numbers and statistics. By putting these principles into action, governments can expand their data systems to better capture information about the most vulnerable and improve their targeting of the most marginalised communities.

1. **Every child matters:** All mothers and children have the right to be counted from birth to death.

2. **The poorest and most marginalised children deserve special attention:** Local information on inequalities in health supports efforts to count the uncounted children.

3. **Local authorities should be partners in generating and using local information:** To count and reach the most marginalised children requires engaged and committed local authorities and leaders.

4. **Beyond data – community empowerment and accountable institutions:** Generating local information can be a participatory empowering process for communities and an opportunity for governments, communities and individuals to work together to reduce health inequality.

Local people generate information in many ways, through mapping, scoring, comparing and measuring. The methods and innovations are varied; they range from simple approaches, such as community scorecards and focus-group discussions, to high-tech systems, such as mobile phones and geographic information systems. Innovations in community monitoring are being carried along by the ever-increasing role of information and communication technologies. Recent advances in mobile phone technologies have increased the opportunities for bringing community participation and empowerment to data collection.

Citizen report cards and scorecards have emerged as powerful tools for monitoring, advocacy and accountability. Information can be collected by community health workers, community volunteers, village health committees, women's groups or local health providers. Community members can also be part of the process of analysing, validating and disseminating information.

Whatever the approach, any community health information system should have clear channels of information dissemination and feedback loops between the community and the service providers/governments. It should be designed with a focus not just on extracting data for data's sake, but on improving the health of individuals in the community, and achieving equity in a participatory, accountable way. Good policy choices for empowering the poorest and most vulnerable groups can best be made when local authorities work together with communities, who are given the opportunity to participate in health planning and implementation.

The following case studies on local-level data collection and monitoring demonstrate the many functions and benefits of local-level data collection and monitoring conducted with the participation of community members These have great potential for national governments and international institutions as a means of counting and reaching more women and children, finishing the job of the health-related MDGs and setting a strong foundation for the next development agenda. Yet by and large, such stories remain project based, with varying degrees of interest for scale-up or integrating local-level information with national health information systems. Local communities must be part of the effort to count and reach every mother and child. By following these principles and the recommendations laid out on page 26, national governments and international stakeholders can improve and expand their current approaches to data, information and targeting.

Citizen report cards and scorecards have emerged as **powerful tools** for monitoring, advocacy and accountability.

Recent advances in **mobile phone technologies** have **increased** the **opportunities** for bringing community **participation** and **empowerment** to data collection.

Every child matters

All mothers and children have the right to be counted from birth to death

The right of every child to be registered at birth, and for the experience of every mother who dies in childbirth to be made visible, is driving global and national efforts to strengthen CRVS systems and MDSR systems. There has been insufficient focus on strengthening relationships between national statistics offices, health workers and communities to improve awareness, responsiveness, efficiency and coverage of data collection. The lack of representation of vulnerable and disadvantaged mothers and children in these endeavours is contributing to poor or non-functioning vital statistics systems.[34]

The use of information technologies is aiding efforts to improve monitoring of vital events – births, deaths and causes of death. Technologies are powerful tools to enable individuals, families and communities to participate in local monitoring efforts. People in many of the poorest countries now have vastly greater access to diverse sources of information and to inexpensive means of connecting and conversing with each other.[35] SMS and mobile phone technology – known as 'mobile health' or 'mHealth' – is being leveraged for more rapid, real-time data collection and monitoring alongside supporting the delivery of community-based health interventions. The Health Metrics Network MOVE-IT initiative aims to improve monitoring of vital events through the use of technologies across Africa and Asia.[36]

Counting pregnant women to reduce maternal deaths in Afghanistan[37]

World Vision's mHealth programmes aim to empower the most vulnerable households and community health workers and volunteers through the use of multi-functional and collaboratively designed mobile health solutions to deliver essential community health interventions. Programmes focus at the household and community levels to improve health service delivery and data collection, but they also form a link with the health information system and support strengthening of the evidence base at higher levels.

For years women in Afghanistan have had to gamble against one of the world's highest maternal mortality rates. Poor access to maternal and newborn care services through geography, insecurity and constraints against women leaving the home without male companionship or receiving care from male health workers have all conspired to create a situation where the poorest and most marginalised women are desperate for innovative solutions.

Understanding both the urgent demand for a solution and the limitations of traditional brick-and-mortar facilities, World Vision partnered with the Ministry of Public Health, USAID, the Bakhtar Development network and Dimagi to design and implement the Better Health for Afghan Mothers and Children (BHAMC) programme. BHAMC circumvents geographic, security and cultural barriers by deploying a network of community health workers equipped with mobile technology that helps strengthen linkages of the most marginalised households and communities to health posts and hospitals and enables the provision of basic life-saving services at home.

The mobile-platform-supported community health worker (CHW) couples – typically a male-female team – visited pregnant women at specific times during pregnancy to discuss their health and prenatal care. CHWs uploaded information related to the women's pregnancies onto BHAMC and World Vision databases. In addition to using the application to provide mothers with information including antenatal care visits and birth planning, CHWs used the mobiles to make referral calls to the nearest birthing facility when women went into labour.

After 20 months of project implementation, data indicates significant change in maternal and newborn health indicators.

- Antenatal care visits have risen by 20 per cent.

- The number of mothers who have received iron supplements has increased by 14 per cent.

- The number of mothers who have birth plans has risen by 12 per cent.

- The number of infants delivered in a health facility has risen by 22 per cent.

Additionally, and importantly, through the pilot programme, community leaders have witnessed the value of mHealth interventions and now actively support the replication of this system in more communities. This vital endorsement alone will not change the situation for all Afghan mothers, but it is one step closer to ensuring access to quality health services for some of the most marginalised.

Despite technology playing an ever-important role there are still many people without access, and lower-tech solutions to counting every mother and child are critical. Such solutions can be used to directly gather the experiences and perceptions of the poorest and most marginalised groups. A community-mapping project in a small district in Indonesia demonstrates a low-tech solution to counting and monitoring every child.

Counting every child in Indonesia[38]

Innovation is not limited to technological advances. In fact, often the most innovative solutions are tied to new efforts – not new technology.

In the South Nias District of Indonesia, identifying, monitoring and supporting pregnant women and children under 5 posed enormous challenges that resulted in inconsistent and stop/start maternal and child health initiatives. Issues included the geographic remoteness of the area and problems in maintaining a consistent database of children, where Nias custom dictated that children be renamed following bouts of illness.

Poor monitoring in the district resulted in poor planning, low coverage of health services and diminishing levels of trust between the community and the health centre. Assessing the challenges, World Vision and the Bawomataluo Health Centre came up with a low-tech, community-based solution to register and track all children under 5 in the catchment area.

Capitalising on a high turnout of community members at the local 'Child Festival', health workers photographed and weighed all children under 5 and created the community's first baseline database. Each child's photo and health information

Despite technology playing an ever-important role there are still **many people without access,** and **lower-tech solutions** to counting every mother and child are **critical**.

were compiled into a physical book, bypassing the need to record names and systematising monthly health tracking and updating.

Going one step further, health workers took the data gathered and created a village map – plotting all the houses with a baby, child under 5 or pregnant woman. A sticker was then placed on the front door of each household with a pregnant woman or a child under 5, enabling health volunteers to quickly identify households for follow up and appropriate counselling.

The map of households presented the village with a visual that more clearly illustrated where the most needs existed. Empowered with the evidence, the community and the health centre decided to move the growth monitoring centre closer to the families that would most benefit from the centre's services.

From these simple, low-tech innovations Bawomataluo is already witnessing observable changes. The efforts of health centre workers to consistently update and maintain a transparent database has helped repair trust between the community and the health centre, resulting in more pregnant women seeking antenatal care from midwives, increased immunisation visits and increased child attendance at the growth monitoring centre. The following are examples:

- The number of children attending the growth centre increased by 40 per cent over a six-month period.

- Women delivering babies with a skilled birth attendant has increased by 9 per cent.

- Exclusive breast feeding has increased by 4 per cent.

This low-tech mapping and targeting system has been presented to the District Health Chief and to all Health Centre Chiefs in the South Nias District, with ongoing discussions on its replication and wider use. The innovative approach ties in with efforts by the Government of Indonesia to scale up community participation in data gathering.

'Involving the community is "key" to finding residents who may qualify for social assistance, but are falling through safety nets.'
– Anna Winoto, UNICEF Indonesia[39]

The poorest and most marginalised children deserve special attention

Local information on inequalities in health supports efforts to count the uncounted children

A key way to ensure that no child is left behind is to make a special effort to prioritise children. This means giving the poorest and most marginalised groups the opportunity to define what matters most to them. Community participation in generating and monitoring data can help identify children who are lagging behind on key health indicators and can provide richer information on locally identified issues, priorities and needs from the perspective of the poor, rather than from that of policymakers, statisticians or academics. It can also serve to raise awareness in communities about the poorest and most vulnerable people and encourage them to accept and engage minority

groups. Occasionally, calling out specific vulnerable groups can leave them open to further stigma and discrimination within the community. In these contexts, processes need to be put in place to manage potential unintended consequences and negative local power dynamics.

Inclusive Parent Support Groups in Uganda[40]

In districts throughout Uganda, World Vision-supported Parent Support Groups (PSG) are holding monthly meetings to discuss good practice in maternal and child health and community health concerns. Organised in a way that encourages the participation of all parents of children under 2 and pregnant women, these parent groups are intentional in including community members from the district Disability Peoples Union.

Through their participation, community members with a disability have helped raise awareness of the needs of citizens with disabilities and have mobilised the PSGs to focus on an extraordinary advocacy campaign on access to health care by People With a Disability (PWD). The community identified the need for handicap-accessible walkways for health centres, for designated spaces for wheelchairs, for integrating sign language into primary health care information and for more handicap-accessible latrines. Bringing these concerns before the district council, PSG members worked with district council members and identified an existing regulation that addresses access issues. The community is now collaborating with the district council to strengthen regulation by monitoring local health centre compliance.

In addition to mobilising the community to hold the district government accountable to the needs of minority groups, the intentional inclusion of PWDs in organised community groups raises communal consciousness of these needs as well. Communities themselves are then empowered to come up with local solutions. For example, through the same advocacy exercise, PSGs identified the heightened risk of food insecurity amongst disabled community members. This simple information gathering and dissemination exercise mobilised the community to support disabled households by supplementing their livelihood sources by raising rabbits and chickens. The animals not only helped supplement income but provided a protein source to boost previously poor diets amongst disabled community members.[41]

Without comprehensive systems to track maternal deaths, innovative methods involving communities to reach the most vulnerable families who suffer the loss of a mother, wife or daughter in childbirth are gaining greater attention. Verbal autopsy is a relatively well known method that is used to gather important information from families of the recently deceased person about their symptoms before death. Social autopsy is a more recent, complementary method that explores in detail the family's social situation and health-seeking behaviours, any preventive care or treatment received at home or elsewhere and any barriers encountered during care seeking. The data generated by social autopsy can create awareness that maternal and child deaths are preventable, empower communities to actively participate in interventions for reducing maternal and child deaths and increase health programme responsiveness and accountability.[42] Social autopsy is not yet widely used and lacks standard methods for data collection and analysis, but it is a tool that is sorely needed to count all women and children who are dying.

A key way to ensure that no **child is left** behind is to make a **special effort** to prioritise children.

Local governments and municipalities form a **vital bridge** between national governments and communities.

Local authorities should be partners in generating and utilising local information

To count and reach the most marginalised children requires engaged and committed local authorities and leaders

Local governments and municipalities form a vital bridge between national governments and communities. Local decision-makers can benefit from the use of locally generated information to inform the direction of policies and programmes. Strong and accountable relationships between communities and the local authorities are critical success factors for community participation in data collection and monitoring in targeting the most marginalised mothers and children.

Complementing national statistics with community-based monitoring in the Philippines[43]

Most national statistical systems in developing countries are focused largely on meeting the information needs of central governments. This is often accomplished through national censuses, which generate data that is rigorous and comprehensive at the national level but lacks the disaggregated detail local governments need to plan targeted interventions. This is where the community-based monitoring system (CBMS) comes in.

CBMS is grounded in the principle that poverty can best be understood through the lives and experiences of poor people themselves. The system tracks multiple dimensions of poverty and development at the household level, involving community members as partners in data collection, alongside local government officials. CBMS incorporates indicators developed in consultation with community representatives, local government officials and other stakeholders, which reflect local needs. The indicators provide information not only on how poor a community is, but also on who in the community is poor and marginalised and where those people are.

Unlike national census surveys, CBMS generates data at the individual household level. In doing so, this system facilitates evidence-based decision-making – which both improves local governance and promotes transparency and accountability. The system neither replaces national statistical systems nor creates a parallel system, but rather adds to and complements them with detailed, disaggregated local-level data. While national census data is useful in providing big-picture trend information, CBMS provides highly localised, highly detailed information that is crucial for local, bottom-up budgeting and interventions.

Training and mobilising community members as data collectors and enumerators, CBMS manages the cost of this level of data collection and actively engages the community in ensuring accurate results. Localising data collection and feeding the data upwards – rather than the other way around – ingrains a validation mechanism into the process. During the data verification process, communities not only ensure accurate results and prioritise areas for intervention but are also encouraged to identify root causes and potential solutions. Confronted with empirical evidence of the state of their communities, citizens are empowered to

demand quality interventions from their governments and collaborate to design solutions. Finally, because CBMS updates household data every three years, communities can easily monitor results based on changes against the original baseline data.

The decentralisation of government structures in the Philippines has encouraged districts to localise data collection and monitoring. Since its inception, CBMS initiatives have spread to nearly 50 per cent of all Philippine *bangarays* (villages) and are being resourced by local governments. While the national statistics office cannot finance CBMS implementation at scale, the office has provided oversight to local CBMS initiatives by validating CBMS questionnaires. In the future, CBMS co-creator Dr. Celia Reyes has suggested further partnership with national statistics offices, positing that local data collection and monitoring systems could benefit from greater rationalisation and oversight by national statistics offices.

'Many local monitoring systems are project based – which isn't really sustainable. Local governments have the responsibility to collect and monitor data well, but communities have a responsibility to help.' – Dr. Celia Reyes

Beyond data: Community empowerment and accountable institutions

Generating local information can be a participatory empowering process for communities and an opportunity for governments, communities and individuals to work together to reduce health inequality

Community participation in local data collection, analysis and monitoring goes beyond plugging information gaps and can serve to empower the most marginalised families and communities. By providing a process through which they can actively identify the issues most important to them, citizens' awareness of rights and services to which they are entitled can be heightened. This is often enough of a catalyst to spark positive collaboration between communities and their governments. Data collected by communities can be analysed in collaboration with local authorities and used to inform health service priorities. This intersection between data collection, awareness raising and community-led advocacy is where World Vision's Citizen Voice and Action (CVA) methodology lies.

World Vision's Citizen Voice and Action approach[44]

Citizen Voice and Action is a local-level advocacy method that seeks to transform the dialogue between communities and governments to improve services such as health and education. By using a simple set of tools, communities monitor local public facilities and measure the realities against government commitments. It facilitates a process to ultimately improve those services. World Vision has found CVA to be transformative in the areas in which it operates.[45]

The intersection between **data collection,** awareness raising and **community-led advocacy** is where World Vision's Citizen's Voice and **Action** methodology lies.

In communities throughout Kitgum District in Uganda, Parent Support Groups are empowering and mobilising communities to advocate for more accountable and accessible maternal, newborn and child health services. World Vision–supported PSGs are composed of parents of children under 2 and pregnant mothers. Parents are asked to attend the groups together, reinforcing the active participation of both men and women in health concerns.

Through PSG monthly meetings, trained Ministry of Health Village Health Teams (VHT) are invited to lead discussions related to maternal and child health. During these meetings VHTs promote health care practices, familiarise parents with their rights and entitled services and create a forum where community concerns can be discussed and addressed. Using a common monthly reporting format to identify ongoing issues and to chronicle longitudinal change against initial baseline data, the PSGs also proactively discuss which community health concerns they can solve at the community level and which issues need to be elevated to district, regional or national-level forums.

Since the formation of these groups, quantitative and qualitative data gathered through the PSGs has been successfully brought to district-level forums. Making sure that the information gathered does not just flow upwards, all community information shared and subsequent decisions made at the district or national level are communicated directly back to the communities. Because this feedback loop is established and ingrained, communities are empowered to track district and national policy discussions and hold their representatives accountable to continue to push community priorities.

So far, PSGs have successfully created a link between households and the broader health system. This has resulted in increased and improved health services and significant behaviour change of families in maternal and child health, nutrition, and sanitation and hygiene practices in the project areas.

For example, through the PSGs, the number of integrated health outreach service points offering antenatal and postnatal care, family planning promotion, growth monitoring promotion, anaemia testing, HIV couple testing and counselling, and health and nutrition education has increased from 18 to 36, which has led to an increase in services being utilised. Between July 2012 and June 2013:

- the number of mothers accessing antenatal counselling services increased from 361 to 1,026

- the number of mothers accessing postnatal counselling increased from 161 to 1,758

- the number of children accessing Growth Monitoring Programmes increased from 2,665 to 15,519.

Additionally, communities report that health facilities have improved the quality of services offered and ensured that reporting on quality is now standard for the Ministry of Health.

Empowerment, ownership and collective action can drive communities to hold governments and service providers to account for better data and better quality services, and they can ultimately help deliver better health outcomes. Data collection and monitoring are the first steps towards greater accountability. However, it is access to information in combination with improved relationships between communities and governments or service providers that can lead to the most sustainable improvements in health services. Institutions that listen to and respond to the poorest and most marginalised community groups, and who show a willingness to collaborate with communities to bring about change, are central to closing the health equity gap.

A randomised trial on a community-based monitoring approach in Uganda has shown that social accountability is an effective approach that can be used for significant and measurable improvements in the delivery of essential health services. The focus of the trial was to find a mechanism of accountability that enabled poor people to scrutinise whether or not those in authority had fulfilled their responsibilities related to health. The study showed that the increase in monitoring and the improvement in provision of health services resulted in improved quantity and quality of care. A year after the intervention there was a significant difference in the weight of infants and a 33 per cent reduction in under-5 mortality. Use of general outpatient services was 20 per cent higher. In particular, the study found that the most vulnerable children benefitted from the community monitoring project. With coverage of 50 communities, the trial showed that community-based monitoring of essential services can be implemented at some degree of scale.[46]

Of course community accountability mechanisms do not always work.[47] An enabling environment ensuring access to information and freedom of expression is critical for inclusive and effective participation in local accountability mechanisms. More research is needed to understand such systems better. But this should not inhibit our ambitions. Our stories illustrate that community involvement in data generation and monitoring can do more than contribute to revolutionising data. The meaningful engagement, participation and empowerment of families and communities can help to transform communities, transform community and government relationships, and transform government systems to deliver benefits for the most marginalised women and children.

Data collection and monitoring are **first steps** towards **greater** accountability.

Part 4

Achieving the vision for counting and reaching every child, every newborn and every mother

The elements of equity, participation, empowerment and accountability were largely missing from the MDGs and their target indicators. In the less than two years remaining before the expiry of the MDGs and as we advance the next development agenda, we are faced with an ideal opportunity to agree upon a transformative agenda for action where data and statistics are not only part of an information system for governments and agencies, but are behind the faces of real people, are part of an empowering process for local people and will lead to better child health outcomes. This is where health metrics and human rights stand together.

We believe that, to fulfil our vision for counting every child and closing the health equity gap, the following steps are needed by national governments, donors and global institutions. These are steps not just for the future but for immediate action to accelerate efforts towards the health-related MDGs.

National governments should:

- Ensure a consistent focus on addressing inequalities through improved counting and targeting of the most vulnerable children and the subsequent use of this data in policy setting, programme design, progress monitoring and reviews.

- Expand the health information system by systematically scaling up promising community-level approaches that generate data and analysis, particularly in areas of low information untouched by existing surveys and mapping, to help identify the most vulnerable, inform decision-making, improve health service delivery and have a positive impact on health outcomes.

- Increase investment in systems for civil registration and vital statistics towards universal and effective coverage.

- Institutionalise maternal death surveillance and review, and ensure that information gathering is structured to facilitate community participation in death-review processes.

- Bridge the gap between decision-makers at all levels and caregivers, families and communities by supporting community-based monitoring systems such as social audits and citizen report cards.

- Take explicit steps to prioritise local- to national-level accountability, including through civil society participation in planning, review and accountability mechanisms.

National and donor governments and international agencies should:

- Review and refocus existing efforts to accelerate progress towards the MDGs with a view to better counting and reaching the most vulnerable children.

- Give particular priority to the most vulnerable in the post-2015 development agenda, including through a high-level goal to end preventable maternal, newborn and child deaths and a strong commitment to significantly reduce the numbers of stunted children worldwide.

- Ensure that the monitoring of any new development goals includes strong metrics on equity beyond income and includes a commitment to disaggregate country health data at minimum by age, gender, location, ethnicity, income quintiles and disability.

- Commit to the scale-up of effective civil registration and vital statistics systems towards the achievement of universal coverage.

- Invest in and expand mechanisms for health monitoring, review and accountability, spanning local to global levels, that include effective participation from communities, civil society and all relevant stakeholders.

Annex I

Limitations of current measurement approaches for vulnerable children

Children uncounted at birth and in death

The biggest data gap is likely to be the number of children who are not registered at birth or who die without being counted. Only two-thirds of all children born in 2011 had their births registered – in some contexts, lower registration levels are found amongst the poorest and most vulnerable groups. More than 100 countries do not have a system that registers births and deaths, and only 34 countries produce quality cause-of-death data.[48] These countries rely mostly on household surveys to estimate child mortality.

Vital registration systems, where they function well, serve as the most reliable source for births, deaths, cause-of-death data and information for monitoring health inequality. The lack of investment to improve civil registration and vital statistics was characterised in *The Lancet* as 'the single most critical development failure over the past 30 years'.[49] Without birth registration, children remain invisible to governments and health services, and their rights to health, education, legal identity and protection are unrealised.

In 2012 the UN Human Rights Council adopted a resolution dedicated to birth registration and legal identification for all without discrimination. Providing free and universal birth registration was recently identified as a key target for the post-2015 development agenda by the High-Level Panel of Eminent Persons. In its 2013 report, the iERG called for universal and effective civil registration and vital statistics systems to be a target of the post-2015 development agenda.[50]

Mothers and newborns who die around childbirth not included in official figures

Pregnancy and childbirth are the biggest killers of mothers in developing countries today. Around three-quarters of neonatal and maternal deaths occur in the first week of the child's life. Many women in developing countries may die at home without ever seeking health care for maternal complications, and many who do seek care do not receive effective treatment. The number of mothers who die in childbirth are under-reported because of poorly functioning vital statistics systems. It is estimated that fewer than one-third of the 350,000 maternal deaths and 6.6 million child deaths occurring annually are medically certified.[51] Censuses identify only pregnancy-related deaths, not maternal deaths. A MDSR system that includes death identification can provide the essential information to improve the measurement of maternal deaths and guide interventions to prevent future deaths, but a lack in legal protection mechanisms to facilitate death inquiries limits the potential of such systems.

Despite increasing attention and investment in maternal and newborn health, few of the highest-impact interventions for newborn care are systematically measured by national surveys. There are currently very few, if any, newborn indicators in the routine data collection systems of most high-burden countries. Millions of families experience stillbirths, but these deaths remain uncounted and unsupported, excluded from any current metrics system. DHS and MICS are working on an optional newborn module,

but sample sizes for some interventions are likely to be too small for disaggregation, and innovative methods to complement survey research are needed.[52] A number of stakeholders are developing a new action plan to scale up efforts to count and reach mothers and newborns with essential interventions – the Every Newborn Action Plan – due for release in 2014.

Indigenous children and ethnic minorities overlooked

Ethnic or linguistic minority children are often not well represented in surveys. Latin America is one of the few developing regions that has systematically collected and synthesised data disaggregated by ethnicity in relation to the MDGs, including numbers of indigenous children.[53] The Inter-American Development Bank is supporting regions to incorporate ethnicity into national census reports, civil registries and household surveys through its Everyone Counts programme. Around 33 per cent of the population in Latin America and the Caribbean is indigenous or of African descent. Indigenous groups tend to live in the more remote and hard-to-reach parts of their countries, often pushed out of more productive areas by non-indigenous groups. Children from indigenous groups are more likely to die and suffer undernutrition than those from non-indigenous groups.

Data on ethnicity and poverty or health is not systematically collected across Asia and the Pacific or Africa, with the exception of South Africa. In some countries, region or geographical location is used as a proxy for ethnicity.

Refugees and displaced children invisible

Refugees are rarely captured by surveys, national population censuses and in some cases even vital registration, because they are not considered part of any nation's population. Yet in many countries, refugees and displaced people represent large populations with the poorest health outcomes and limited access to health services. The United Nations High Commissioner for Refugees estimates that the overall world total of registered refugees, internally displaced persons and stateless persons is 36.5 million – and *almost half of these are children.*[54] These figures do not include the large number of illegal immigrants, most of whom will not be counted in censuses or household surveys.

Children with disabilities ignored

Nationally represented household surveys or censuses provide limited or no data on children with disabilities, and data-collection instruments are likely to underestimate the number of children with disabilities. Global estimates put the number of children aged 14 or younger who are living with a disability at 93 million, but the real figure could be much higher.[55]

Data gaps on people with disabilities can be filled by targeted household surveys.[56] However, even large household surveys may not reveal the true number of children with disabilities, and special approaches may need to be designed for them. Data collection is further complicated by the varying nature and severity of disabilities and the need to apply age-specific definitions and measures. It can be very difficult to distinguish disability from variations in normal child development. Poor quality of data on child disability also comes from a limited understanding of what disability is in children, or from stigma and exclusion. Data on disability should also be interpreted in context – for example, low reported numbers of children with a disability may be the consequence of low survival rates, or it may reflect uncounted children who live in institutions or on the streets or who are hidden away by families.

UNICEF, in partnership with the Washington Group on Disability Statistics and others, is holding consultations to improve the methodology used to measure child disability in MICS and other data collection efforts. A toolkit is being designed to enable teachers, community workers and other trained professionals to administer the survey to strengthen local capacity to identify and assess children with disabilities at risk of social exclusion.

Child labourers and trafficked children too difficult to track

Children who have been forced into labour or who have been trafficked often fall outside of the counting process. There are an estimated 215 million child labourers worldwide, and of these, 115 million are predicted to be in the worst forms of child labour such as any form of slavery, trafficking, forced labour, prostitution and illegal activities. Fears of victims coming forward to report, difficulties in law enforcement correctly identifying victims, and inconsistent definitions of trafficking make it virtually impossible to provide reliable statistics for trafficked children. However many child labourers and trafficked children there are, they will not be covered by household surveys.

Orphaned children neglected

Orphaned children – including those orphaned by HIV – fall between the counting cracks, left to fend for themselves or rely on already-burdened family and community members. Surveys differ in their ability to count orphaned children residing in households. In DHS surveys, the bulk of information on children under 5 is collected from their biological mothers in the Women's Questionnaire; information is not collected for children who are orphaned or not living with their biological mothers.[57] In MICS surveys, information on children under 5 is collected from mothers or primary caregivers in the household, making it possible to collect information on all children, including orphans and foster children.

When the household structure is fragmented, as in the case of large households with fostered or orphaned children, counting the numbers in the household is ambiguous and can lead to those children being excluded from the survey. Counting the numbers of children orphaned by HIV and AIDS is hugely problematic due to the sensitivies in dealing with such a stigmatised issue. Published statistics therefore often ignore groups of children that prove too problematic for quantification.

The current estimate of 153 million orphans worldwide does not include children living in institutions such as orphanages or group homes or on the streets. Household surveys fail to count homeless and street children. Estimating numbers is plagued with difficulties. Over 20 years ago, UNICEF estimated that there were about 100 million street children – a figure still commonly cited today, but with little substantiation.[58]

Children in urban slums missing from data

Household surveys provide equity data by urban and rural location, but information is rarely disaggregated for slum populations. This places the experiences of slum dwellers on an equal footing with wealthy city dwellers. UN Habitat estimates that there are more than a billion people living in urban slums in developing countries, but the poorest populations are often not included in data gathering because of the chaotic conditions.[59] Vulnerable children are even less likely to be counted.

Countries such as Bangladesh and India have made special efforts to count those living in slums. But since they use special counts of the numbers in specific marginalised groups, the numbers are not included in the sampling frames of household surveys.

Annex 2

Country Accountability Frameworks

This table reveals the rating provided by each country (self-assessed) across four areas related to community reporting of births and deaths, equity and use of qualitative information from communities to inform reviews.

Country	Community reporting of births and deaths:	Community reporting and feedback on maternal deaths:	Equity:	Synthesis of information and policy processes:
	Community births and deaths are reported, using ICT where appropriate, covering the whole country. Verbal autopsy is done for deaths without medical certification in the community.	All community maternal deaths are reported to districts within 24 hours. Electronic devices are used to get faster and more complete reporting from communities and to initiate response. Verbal autopsies are done for community maternal deaths. Communities receive feedback and are involved in the review.	Disaggregated health data on key indicators (sex, income, minority and location) are used extensively in reviews.	The reviews are informed by a systematic analysis of qualitative data, e.g. policy changes, public opinion, service provider opinions.
Afghanistan	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS SOME STRENGTHENING	NOT PRESENT, NEEDS TO BE DEVELOPED
Angola	NEEDS A LOT OF STRENGTHENING	NEEDS A LOT OF STRENGTHENING	NEEDS A LOT OF STRENGTHENING	NEEDS SOME STRENGTHENING
Bangladesh	NEEDS A LOT OF STRENGTHENING	NEEDS A LOT OF STRENGTHENING	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS SOME STRENGTHENING
Benin	NEEDS A LOT OF STRENGTHENING	NEEDS A LOT OF STRENGTHENING	NEEDS A LOT OF STRENGTHENING	NEEDS A LOT OF STRENGTHENING
Bolivia	NEEDS A LOT OF STRENGTHENING	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS A LOT OF STRENGTHENING	NOT PRESENT, NEEDS TO BE DEVELOPED
Botswana	NEEDS A LOT OF STRENGTHENING	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS A LOT OF STRENGTHENING	NEEDS SOME STRENGTHENING
Burkina Faso	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS SOME STRENGTHENING	NEEDS SOME STRENGTHENING
Burundi	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS SOME STRENGTHENING	ALREADY PRESENT, NO ACTION NEEDED
Cambodia	NEEDS A LOT OF STRENGTHENING	NEEDS A LOT OF STRENGTHENING	NEEDS SOME STRENGTHENING	NEEDS SOME STRENGTHENING
Cameroon	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS A LOT OF STRENGTHENING	NOT PRESENT, NEEDS TO BE DEVELOPED
Central African Republic	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS SOME STRENGTHENING	NEEDS SOME STRENGTHENING
Chad	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS A LOT OF STRENGTHENING	NOT PRESENT, NEEDS TO BE DEVELOPED
China	NEEDS A LOT OF STRENGTHENING	NEEDS SOME STRENGTHENING	NEEDS SOME STRENGTHENING	NEEDS SOME STRENGTHENING
Comoros	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS SOME STRENGTHENING	NEEDS SOME STRENGTHENING
Congo	NEEDS SOME STRENGTHENING	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS SOME STRENGTHENING	NEEDS A LOT OF STRENGTHENING
Cote d'Ivoire	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS A LOT OF STRENGTHENING	NOT PRESENT, NEEDS TO BE DEVELOPED
Democratic People's Republic of Korea	NEEDS SOME STRENGTHENING	NEEDS SOME STRENGTHENING	ALREADY PRESENT, NO ACTION NEEDED	NEEDS A LOT OF STRENGTHENING
Democratic Republic of Congo	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS SOME STRENGTHENING	NOT PRESENT, NEEDS TO BE DEVELOPED
Djibouti	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED

Country	Community reporting of births and deaths:	Community reporting and feedback on maternal deaths:	Equity:	Synthesis of information and policy processes:
Egypt	NEEDS A LOT OF STRENGTHENING	NEEDS A LOT OF STRENGTHENING	NEEDS A LOT OF STRENGTHENING	NOT PRESENT, NEEDS TO BE DEVELOPED
Gabon	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS SOME STRENGTHENING	NEEDS A LOT OF STRENGTHENING
Gambia	NEEDS A LOT OF STRENGTHENING	NEEDS A LOT OF STRENGTHENING	NEEDS A LOT OF STRENGTHENING	NOT PRESENT, NEEDS TO BE DEVELOPED
Ghana	NEEDS A LOT OF STRENGTHENING	NEEDS A LOT OF STRENGTHENING	NEEDS SOME STRENGTHENING	NEEDS SOME STRENGTHENING
Guatemala	NEEDS SOME STRENGTHENING	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS A LOT OF STRENGTHENING	NOT PRESENT, NEEDS TO BE DEVELOPED
Guinea	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS SOME STRENGTHENING	NOT PRESENT, NEEDS TO BE DEVELOPED
Guinea-Bissau	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS A LOT OF STRENGTHENING	NEEDS A LOT OF STRENGTHENING
Indonesia	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS SOME STRENGTHENING	NEEDS A LOT OF STRENGTHENING	NEEDS A LOT OF STRENGTHENING
Iraq	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS SOME STRENGTHENING	NEEDS SOME STRENGTHENING
Kenya	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED
Lao PDR	NEEDS A LOT OF STRENGTHENING	NEEDS A LOT OF STRENGTHENING	NEEDS A LOT OF STRENGTHENING	NEEDS SOME STRENGTHENING
Lesotho	NEEDS A LOT OF STRENGTHENING	NOT PRESENT, NEEDS TO BE DEVELOPED	ALREADY PRESENT, NO ACTION NEEDED	NEEDS SOME STRENGTHENING
Liberia	NEEDS A LOT OF STRENGTHENING	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS SOME STRENGTHENING	NEEDS SOME STRENGTHENING
Madagascar	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS A LOT OF STRENGTHENING	NEEDS A LOT OF STRENGTHENING	NEEDS SOME STRENGTHENING
Malawi	NEEDS A LOT OF STRENGTHENING	NEEDS A LOT OF STRENGTHENING	NEEDS SOME STRENGTHENING	NEEDS A LOT OF STRENGTHENING
Mali	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS SOME STRENGTHENING	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS A LOT OF STRENGTHENING
Mauritania	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED
Morocco	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS A LOT OF STRENGTHENING	NEEDS A LOT OF STRENGTHENING	NEEDS A LOT OF STRENGTHENING
Mozambique	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS SOME STRENGTHENING	NEEDS A LOT OF STRENGTHENING
Myanmar	NEEDS A LOT OF STRENGTHENING	NEEDS A LOT OF STRENGTHENING	NEEDS A LOT OF STRENGTHENING	NOT PRESENT, NEEDS TO BE DEVELOPED
Nepal	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS A LOT OF STRENGTHENING	NEEDS SOME STRENGTHENING
Niger	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS A LOT OF STRENGTHENING	NEEDS A LOT OF STRENGTHENING
Nigeria	NEEDS A LOT OF STRENGTHENING	NEEDS A LOT OF STRENGTHENING	NEEDS A LOT OF STRENGTHENING	NEEDS A LOT OF STRENGTHENING
Pakistan	NEEDS A LOT OF STRENGTHENING	NEEDS A LOT OF STRENGTHENING	NEEDS SOME STRENGTHENING	NOT PRESENT, NEEDS TO BE DEVELOPED
Papua New Guinea	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS A LOT OF STRENGTHENING	NEEDS SOME STRENGTHENING
Philippines	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS A LOT OF STRENGTHENING	NEEDS A LOT OF STRENGTHENING	NEEDS A LOT OF STRENGTHENING
Rwanda	NEEDS SOME STRENGTHENING	NEEDS SOME STRENGTHENING	NEEDS A LOT OF STRENGTHENING	ALREADY PRESENT, NO ACTION NEEDED
Sao Tome and Principe	NEEDS SOME STRENGTHENING	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS A LOT OF STRENGTHENING	NOT PRESENT, NEEDS TO BE DEVELOPED

Country	Community reporting of births and deaths:	Community reporting and feedback on maternal deaths:	Equity:	Synthesis of information and policy processes:
Senegal	NEEDS A LOT OF STRENGTHENING	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED
Sierra Leone	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS A LOT OF STRENGTHENING	NEEDS SOME STRENGTHENING	NEEDS SOME STRENGTHENING
Solomon Islands	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS A LOT OF STRENGTHENING
Somalia	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS A LOT OF STRENGTHENING	NOT PRESENT, NEEDS TO BE DEVELOPED
South Sudan	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED
Sudan	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS A LOT OF STRENGTHENING	NEEDS SOME STRENGTHENING	NOT PRESENT, NEEDS TO BE DEVELOPED
Tanzania	NEEDS A LOT OF STRENGTHENING	NEEDS A LOT OF STRENGTHENING	ALREADY PRESENT, NO ACTION NEEDED	NEEDS SOME STRENGTHENING
Togo	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS A LOT OF STRENGTHENING	NEEDS A LOT OF STRENGTHENING
Uganda	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS SOME STRENGTHENING	NEEDS SOME STRENGTHENING
Vietnam	NEEDS A LOT OF STRENGTHENING	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS A LOT OF STRENGTHENING	NEEDS SOME STRENGTHENING
Yemen	NOT PRESENT, NEEDS TO BE DEVELOPED	NOT PRESENT, NEEDS TO BE DEVELOPED	NEEDS SOME STRENGTHENING	NEEDS SOME STRENGTHENING
Zambia	NEEDS A LOT OF STRENGTHENING	NEEDS A LOT OF STRENGTHENING	NEEDS SOME STRENGTHENING	ALREADY PRESENT, NO ACTION NEEDED
Zimbabwe	NEEDS SOME STRENGTHENING	NEEDS A LOT OF STRENGTHENING	ALREADY PRESENT, NO ACTION NEEDED	NEEDS A LOT OF STRENGTHENING

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