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The 11 indicators of maternal, newborn and child health

One set of indicators has been selected to monitor the status of women's and children's health:

- maternal mortality ratio (deaths per 100,000 live births);
- under-5 child mortality, with the proportion of newborn deaths (deaths per 1,000 live births);
- children under 5 who are stunted (percentage of children under five years of age whose height-for-age is below minus two standard deviations from the median of the WHO Child Growth Standards).

These three health status indicators are essential for MDG monitoring. Stunting, a nutrition indicator, is also important for understanding not only outcomes, but also determinants of maternal and child health. Nutrition is also a useful proxy indicator for development.

Because these indicators are relatively insensitive to change and do not show progress over short periods (in the absence of birth and death registration systems they can only be measured with substantive time lags), there is also a need for more sensitive and timely data that can monitor almost real-time changes in a set of key interventions to improve women's and children's health. This objective can be achieved by monitoring a tracer set of seven coverage indicators:

- met need for contraception;
- antenatal care coverage (percentage of women aged 15-49 with a live birth who received antenatal care by a skilled health provider at least four times during pregnancy);
- antiretroviral prophylaxis among HIV positive pregnant women to prevent mother-to-child transmission of HIV, and antiretroviral therapy for women who are treatment-eligible;
- skilled attendant at birth (percentage of live births attended by skilled health personnel);
- postnatal care for mother and babies (percentage of mothers and babies who received postnatal care visit within two days of childbirth);
- exclusive breastfeeding for six months (percentage of infants ages 0–5 months who are exclusively breastfed);
- three doses of the combined diphtheria, pertussis and tetanus vaccine (percentage of infants 12-23 months who received three doses of diphtheria/pertussis/tetanus vaccine);
- antibiotic treatment for pneumonia (percentage of children ages 0–59 months with suspected pneumonia receiving antibiotics).

These eight coverage indicators have been selected because they are strategic and significant: each one represents a part of the continuum of care and each one is connected with other dimensions of health and health systems. A measure of contraception is needed as a tracer for reproductive health. Antenatal care provides a measure of access to the health system and is critical to ensure proper coverage of care to identify maternal risks and improve health outcomes for the mother and newborn. HIV-related indicators are included to emphasize the need to move towards a new era for integrating vertical health initiatives. Skilled birth attendance, postnatal care and breastfeeding are clearly critical elements of the continuum. The recommended vaccine is delivered routinely and so helpfully measures a child's first interaction with the health system. Finally, case management of childhood pneumonia is an indicator of access to treatment. Although a vaccine will have long-term impact on pneumonia, in the short-term, case management will remain an important measure of success.

1. Vital events: By 2015, all countries have well-functioning health information systems and have taken significant steps to establish a system for registration of births, deaths and causes of death, including through surveys, facility data and administrative sources.

2. Health indicators: By 2012, the same 11 indicators on reproductive, maternal and child health (see panel), disaggregated for gender and other equity considerations, are being used for the purpose of monitoring the *Global Strategy*.

3. Innovation: By 2015, all countries have integrated the use of information and communication technologies in their national health information systems and health infrastructure.

4. Resource tracking: By 2015, all 74 countries where 98% of maternal and child deaths take place are tracking and reporting, at a minimum, two aggregate resource indicators: 1) total health expenditure by financing source, per capita; and 2) total reproductive, maternal, newborn and child health expenditure by financing source, per capita.

5. Country compacts: By 2012, in order to facilitate resource tracking, "compacts" between country governments and all major development partners are in place that require reporting, based on a format to be agreed in each country, on externally funded expenditures and predictable commitments.

6. Reaching women and children: By 2015, all governments have the capacity to regularly review health spending (including spending on reproductive, maternal, newborn and child health) and to relate spending to commitments, human rights, gender and other equity goals and results.

7. National oversight: By 2012, all countries have established national accountability mechanisms that are transparent, that are inclusive of all stakeholders, and that recommend remedial action, as required.

8. Transparency: By 2013, all stakeholders are publicly sharing information on commitments, resources provided and results achieved annually, at both national and international levels.

9. Reporting aid for women's and children's health: By 2012, development partners request the OECD-DAC to agree on how to improve the Creditor Reporting System so that it can capture, in a timely manner, all reproductive, maternal, newborn and child health spending by development partners. In the interim, development partners and OECD implement a simple method for reporting such expenditure.

10. Global oversight: Starting in 2012 and ending in 2015, an independent "Expert Review Group" is reporting regularly to the UN Secretary-General on the results and resources related to the *Global Strategy* and on progress in implementing this *Commission*'s recommendations.