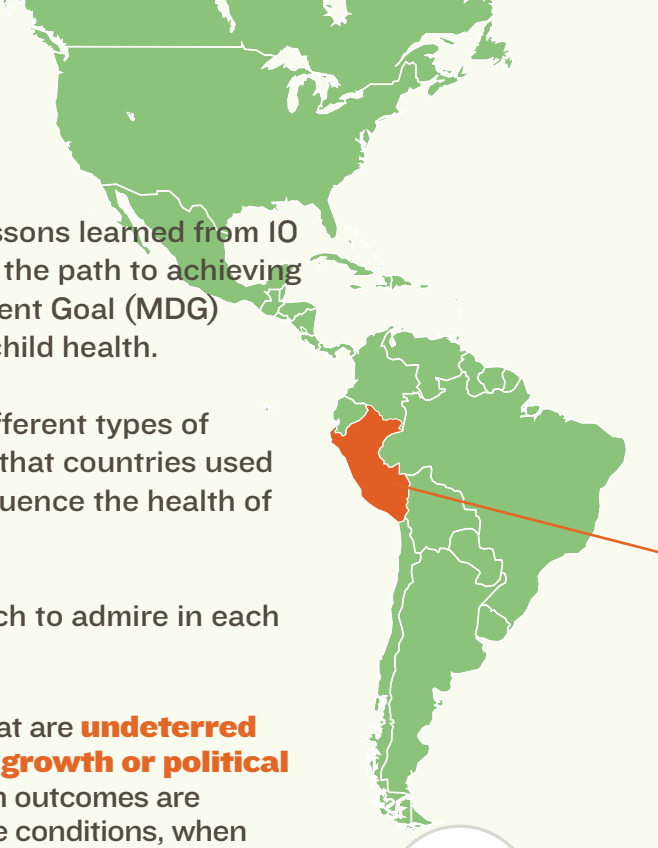
SUCCESS FACTORS

What can we learn about making progress on women's and children's health?

Findings from "Accelerating Progress for Women's and Children's Health", part of a two-year study of 136 countries over the past 50 years, coordinated by The Partnership for Maternal, Newborn & Child Health



This booklet highlights lessons learned from 10 countries that are well on the path to achieving the Millennium Development Goal (MDG) targets for maternal and child health.

This booklet illustrates different types of policies and programmes that countries used in key areas known to influence the health of women and children.

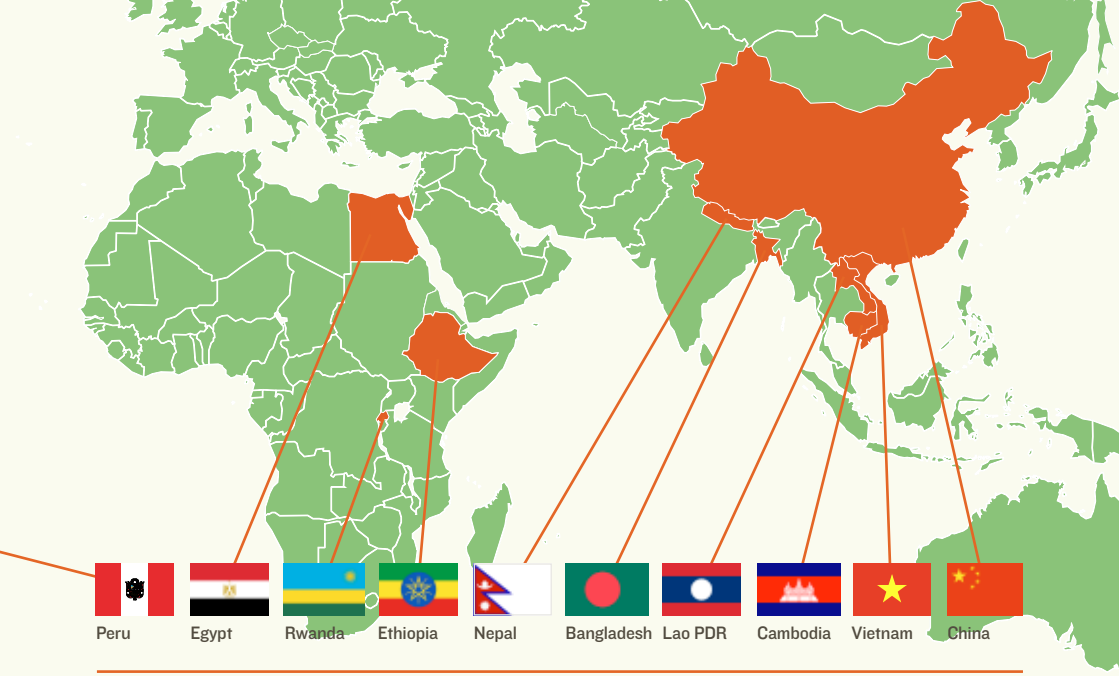
These countries have much to admire in each other:

1 They are countries that are **undeterred by weak economic growth or political unrest.** Strong health outcomes are achievable, even in adverse conditions, when there is focused **political commitment.**

2 They insist on the use of **robust evidence to guide policy and investment** decisions.

3 They **invested in development basics,** such as girls' education, clean water and roads. They have made choices that extend well beyond immediate investments in the health sector itself, taking a joined-up approach to development.

4 They have brokered **strong partnerships between government, civil society, the private sector and development partners** to achieve their goals.



These 10 countries have made substantial progress to achieving MDG 4 and 5 targets.

The lessons presented in this booklet have emerged through an analysis of 10 countries which are on-track for meeting their Millennium Development Goal (MDG) targets for maternal and child health by 2015.

This analysis is part of a major two-year study by government, multilateral, and academic partners, coordinated by The Partnership for Maternal, Newborn & Child Health: "Accelerating Progress for Women's and Children's Health". Study partners include: World Health Organization, World Bank, the United States Agency for International Development, Alliance for Health Policy and Systems Research, Johns Hopkins University, Global Health Insights, London School of Hygiene and Tropical Medicine, University of St Gallen, Cambridge Economic Policy Associates and MamaYe – Evidence for Action. In addition to the country analysis, the study looked at data and trends across 136 low- and middle-income countries over the past 50 years to answer a key question: "What can we learn from countries to speed our progress towards women's and children's health?".

Understanding what works is critical as we embark on the approach to 2015.

For more information:
www.who.int/pmnch/knowledge/publications/successfactors/en/

LESSON 1:
STAYING THE COURSE

Political commitment has been key for the 10 countries that are on track for achieving their MDG goals for maternal and child health. Furthermore many countries have done so despite challenging circumstances, including weak economic growth, post-conflict environments, and a history of civil unrest.

HOW HAVE COUNTRIES DONE THIS?

POLITICAL PRIORITIZATION OF CHILD HEALTH

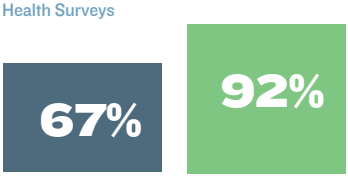
EGYPT

Egypt set a national goal in 1985 to achieve universal coverage of immunization.

% of children aged 12-23 months who received all vaccinations

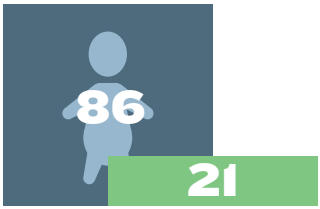
(BCG, a measles or MMR vaccination, three DPT vaccinations, and three polio vaccinations)

Source: Egypt Demographic and Health Surveys



Child Mortality Rate (per 1,000 live births)

Source: World Bank Database



IN 2006 EGYPT ELIMINATED NEONATAL TETANUS

POLITICAL PRIORITISATION OF MATERNAL & REPRODUCTIVE HEALTH

CAMBODIA

Cambodia's political commitment to family planning has improved the health of women and children.

Political Action

In the early 1990s, Cambodia prioritized improving access to family planning methods. This resulted in increased knowledge and use of modern contraception methods.

Contraceptive Prevalence Rate % (modern methods)

Source: United Nations Statistics Division

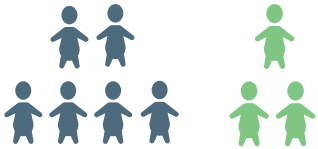
1990
7%

2011
35%

The percentage of women in Cambodia aged 15 - 49 who are married or are in a concensual union currently using modern methods of contraception has increased by 28% between 1990 and 2011.

Total Fertility Rate (average number of children per woman)

Source: World Bank Database



Maternal Mortality Ratio (deaths per 100,000 live births)

Source: World Bank Database

MORE MONEY FOR HEALTH, MORE HEALTH FOR MONEY

Investing in health is meaningful when countries combine investments in both short-term responses and long-term solutions.

Countries that are 'on-track' for MDGs 4 and 5 have increased spending on health AND promoted alignment of resources around health priorities.

In **Nepal**, pooled donor funding and community ownership of health services helped ensure a continuum of care for women and children even during the war.

In **Rwanda's** decentralized health system, domestic and external partners are required to align to the government's legislation, policies and strategies to help delivery equitable and efficient health services.

In **Ethiopia** an MDG Pool fund has been established to channel all available health funds from private and public sectors through the government.

	1995	2011
Peru	$105	$278
Egypt	$51	$125
Cambodia	$7	$30
Nepal	$9	$23
Bangladesh	$4	$10
Rwanda	$8	$76
Lao PDR	$22	$38
Vietnam	$17	$93
Ethiopia	$4	$30
China	$27	$242

General government expenditure on health per capita (NCU per US$)
Source: WHO Global Health Expenditure Database

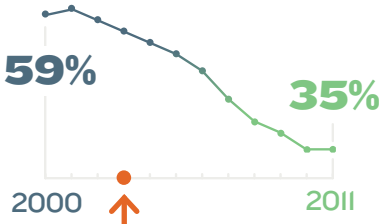
MORE MONEY FOR HEALTH, MORE HEALTH FOR MONEY

More money and better alignment of resources for health can drive improvements in women's and children's health, even in countries facing political and economic challenges.

CHINA

Out of pocket expenditure for health as a % of total expenditure of health

Source: WHO Global Health Expenditure Database



Towards Universal Coverage

China introduced the New Rural Cooperative Medical Scheme in 2003. It included a maternal healthcare care benefits package. Over 95% of eligible people enrolled in the Scheme. Subsidies reduced out-of-pocket costs and were associated with more women giving birth in health facilities.

RWANDA

Health Insurance

"Mutuelles De Sante" - the community based health insurance scheme - launched in 2002. Rwandans pay $2 a year to join the scheme plus a 10% co-payment for each episode of illness. The money pays health care providers and covers key services. By June 2012, 90% of the Rwandan population was enrolled.

Mutuelles have improved usage of health services and are associated with a higher degree of financial risk protection; they were made compulsory in 2008.

Photo: © Rwanda's New Times.

LESSON 2:
EVIDENCE INFORMS POLICY

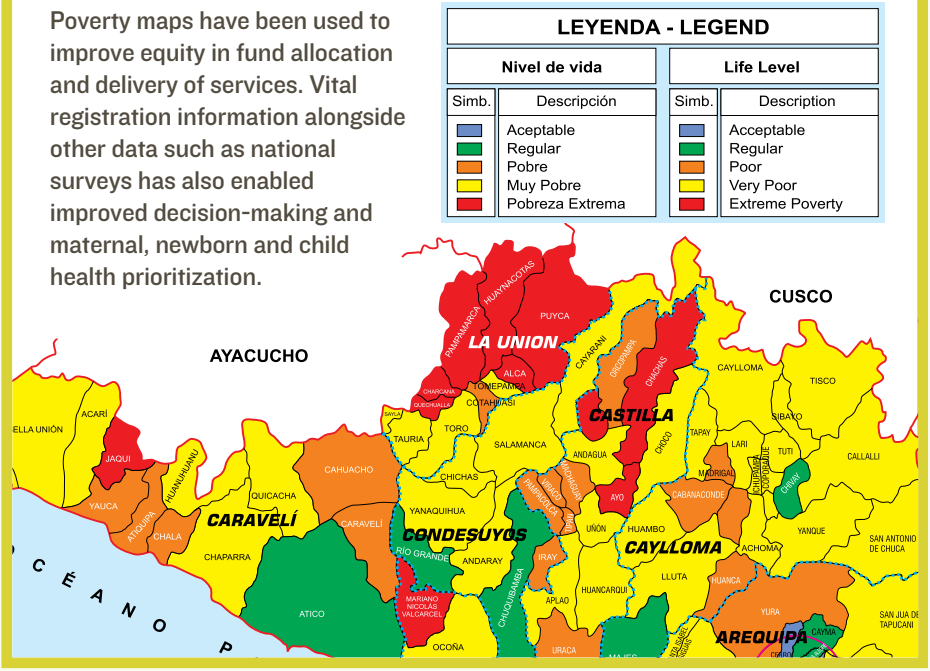
When evidence drives policies and investments outcomes are more effective and efficient. Relying on and responding to sound evidence can help improve the health of women and children.

In the 10 countries that are on-track to meet their MDG targets for maternal and child health there are many examples of sound evidence being used to improve services, and ultimately, save lives.

HOW HAVE COUNTRIES DONE THIS?

PERU

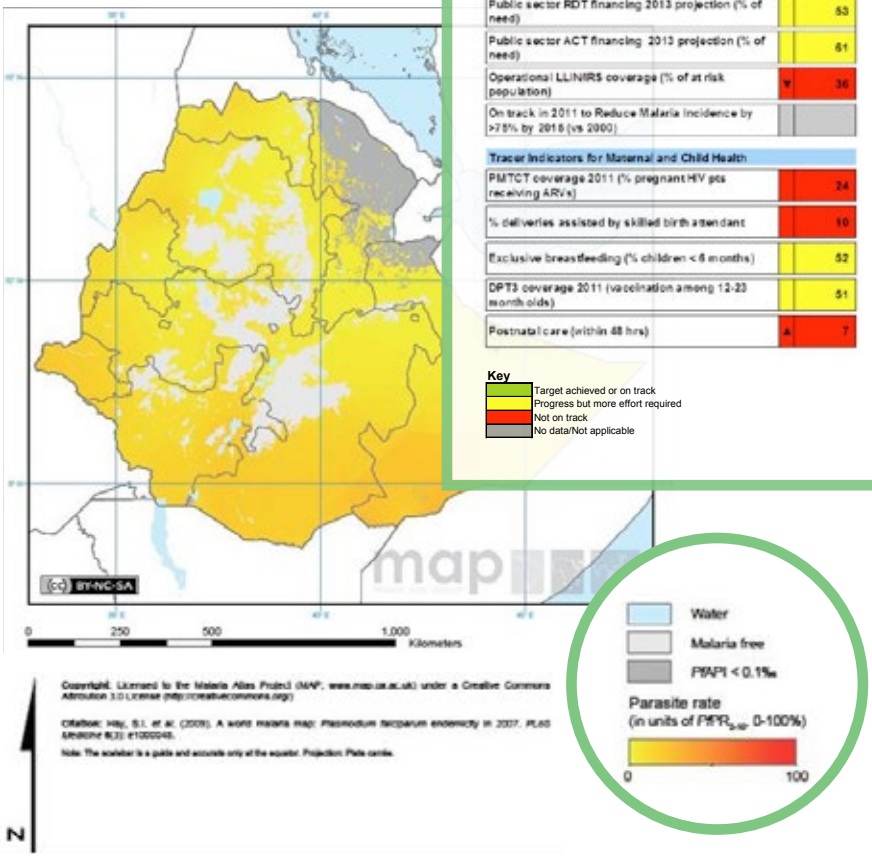
Poverty maps have been used to improve equity in fund allocation and delivery of services. Vital registration information alongside other data such as national surveys has also enabled improved decision-making and maternal, newborn and child health prioritization.



Source: Francke P. Peru's Comprehensive Health Insurance and New Challenges for Universal Coverage. Washington, D.C., The World Bank, 2013.
Map source: http://quechuabenefit.org/maps-of-peru/peru-poverty-map

ETHIOPIA

Scorecards based on health management information systems data used to promote accountability and encourage action.



Source: Ethiopia Health Sector – Federal Ministry of Health Case Study. 2013
Scorecard source: http://www.alma2015.org/sites/default/files/country-facts/title_raw/q2_2013_qr_ethiopia.pdf

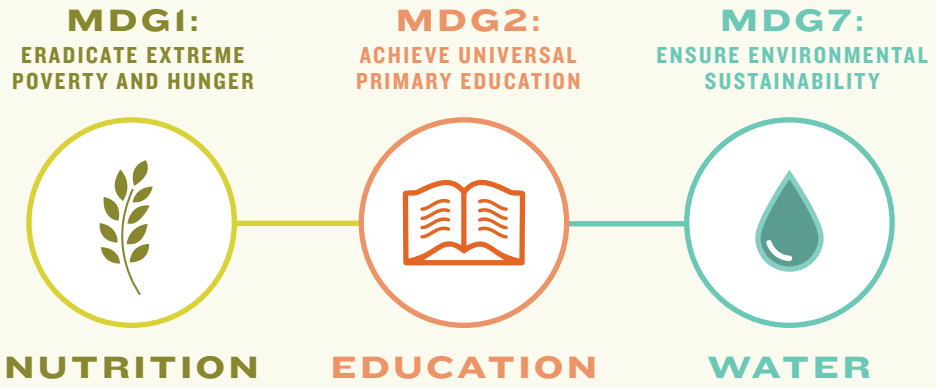
LESSON 3:
WORKING ACROSS SECTORS

Pathways to accelerating development extend beyond the health sector. Nutrition, water and sanitation and education for girls can all contribute to the survival of women and children.

A joined-up approach to development and investment in these development basics can significantly accelerate progress.

HOW HAVE COUNTRIES DONE THIS?

Countries that are improving the health of women and children are also making progress in achieving other MDGs:



NUTRITION

Overcoming challenges of undernutrition are critical to improving child survival. Worldwide these conditions underlie nearly 3.1 million deaths of children under five years annually and represent almost 45% of deaths in this age group.*

* Sources: Black R, et al. Maternal and child undernutrition and overweight in low-income and middle-income countries. The Lancet, 2013, 382:427-451. Bhutta ZA, et al. Evidence-based interventions for improvement of maternal and child nutrition: what can be done and at what cost? The Lancet, 2013, 382:452-477.

PERU

A multi-sector approach to reduce chronic malnutrition

Along with civil society, international NGOs and the donor community, the Peruvian Government implemented CRECER ('Grow') by combining health, education, water and sanitation, housing and agricultural policies to reduce stunting and anaemia.

CRECER Interventions:

- conditional cash transfers with health and education components
- improvement of water supply and sanitation infrastructure
- education programmes
- prioritisation of care for women and children

Results:

- by 2008 CRECER covered 755,044 beneficiaries
- targeted districts with the highest rates of poverty and malnutrition
- scale-up of the programme has contributed to reductions in childhood chronic malnutrition, from 23% to 18% in 2005 and 2010 respectively, with accentuated reductions in rural areas

Lavigne M. Social protection systems. Santiago, Chile, ECLAC, Ministry for Economic Cooperation and Development & GIZ, 2013.
Acosta M. Analysing Success in the Fight against Malnutrition in Peru. Institute of Development Studies, 2011.
Wilbur J. Join up, Scale up; How Integration can defeat Disease and Poverty. Action Against Hunger, Actino for Global Health, End Water Poverty, PATH, Tearfund & WaterAid, 2011.

GIRLS' EDUCATION

Girls' education is linked to improved child survival rates and uptake of reproductive and maternal health services.

When girls and women are educated, they are more likely to survive, thrive and have healthy families.

CHINA

Compulsory education particularly in rural areas was identified as an important component of China's national development strategy. From 1995, China invested in infrastructure including the provision of basic school facilities, training teachers and principals and the free distribution of textbooks.

By 2000, China achieved:

- Primary school enrolment reached **99%**
- Lower secondary school enrolment reached **91%**
- The school infrastructure was strengthened with the establishment of **4,000 new schools** and renovation or expansion of **30,000 existing schools**.
- Teacher competencies were built up with a mass training programme involving around **450,000 teachers and 70,000 principals**

Zhang Tiedao , Zhao Minxia , Zhao Xueqin, Zhang Xi, Wang Yan, Universalizing Compulsory Education for Poverty Reduction in Rural China, 2004

WATER AND SANITATION

Safe water and sanitation promotes good health and more education - as women and girls spend less time to find and fetch water.

Photo: © World Bank Photo Collection

A study of child mortality inequalities in Bangladesh highlighted that:

"water supply and availability of sanitary facilities had a strong association with child mortality, even after controlling for the effects of socioeconomic and geographical variables"

Halder, A.K. and M. Kabir, Child mortality inequalities and linkage with sanitation facilities in Bangladesh. J Health Popul Nutr, 2008. 26(1): p. 64-73.

LAO PDR

Community-based water supply and sanitation project with revolving funds:

Lao PDR launched a community-based water supply and sanitation project using revolving funds in 2006. Households were able to apply for interest free loans from the fund in order to pay for a water connection or to construct a latrine. The fund helped make the scheme accessible to the poorest households.

By 2008, 156 households had received a loan from the revolving fund for water connection and 73 households had received a loan from the latrine fund. The revolving fund expanded to other villages and in 2010, over 640 households had used over US$65,000 of revolving funds for water connection or latrine construction.

UN Habitat. United Nations Human Settlements Programme (UN-HABITAT) WATER AND SANITATION TRUST FUND annual report 2006; Nordic Consulting Group. External Evaluation of UN-HABITAT's Water and Sanitation Trust Fund Part 2: Regional and Country Reports March 2011, UN Habitat. Revolving Funds for Water and Sanitation.

LESSON 4:
WORKING BETTER TOGETHER

Everyone has a role to play to ensure that women and children survive and thrive. Communities, health care providers, the private sector, civil society, academics, and faith leaders all have a role to play.

HOW HAVE COUNTRIES DONE THIS?

1. COMMUNITY

NEPAL

"The practice of recruiting local persons to work has been helpful to deliver services even during the insurgency period, when the movement of even service providers was restricted. Some of the volunteers are semi-literate, but do their assigned work well"

– Public Health Expert Nepal

Photo: © 2007 Dilip Chandra Poudel, Courtesy of Photoshare

2. HEALTHCARE PROVIDERS

VIETNAM

"Midwifery and midwifery practice play a crucial role in Vietnam's maternal and newborn health care system. A skilled midwifery workforce, the majority of skilled birth attendants, with high competencies, motivated and supported by the health care system, is key to successfully reducing maternal and newborn mortality and contributes to achieving MDGs 4 ,5 and 6."

– Vice Minister of Health, Vietnam (2011)

3. PRIVATE SECTOR

BANGLADESH

In 2011 just over half the births in Bangladesh that took place in a health facility occurred in private sector health facilities. The Government supports the role of the private sector in the provision of health services. It contracts privately owned information and service centres to use telemedicine, as a way to increase access to services, particularly for underserved populations.

4. CIVIL SOCIETY

EGYPT

Population policies and programmes in Egypt have built on a landmark civil society initiative.

In 1937, in response to religious opposition to family planning methods, a group of university professors formed the "Happy Family Society." They worked with religious leaders to obtain a fatwa (religious declaration) that Islam is not against family planning under certain circumstances.

This paved the way for far-reaching advances in population policies and programmes, which contributed to improved health for women and children.

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This booklet is developed by

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