

Success Factors for Women's and Children's Health:

Policy and programme highlights from 10 fast-track countries



WHO Library Cataloguing-in-Publication Data

Success factors for women's and children's health: Policy and programme highlights from 10 fast-track countries.

1. Maternal Mortality. 2. Child Mortality. 3. National Health Programs. 4. Program Evaluation.
I. World Health Organization.

ISBN 978 92 4 150747 9 (NLM classification: WA 900)

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Printed in: South Africa.

Recommended citation: PMNCH, WHO, World Bank and AHPSR. (2014). Success Factors for Women's and Children's Health: Policy and programme highlights from 10 fast-track countries. Geneva: WHO.

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10 FAST-TRACK COUNTRIES: SUMMARY STATISTICS

Ten low- and middle-income “fast-track” countries (LMICs) have seen significant progress in their efforts to save the lives of women and children. They invested in high-impact health interventions such as quality care at birth, immunization and family planning. They also made significant progress across multiple health-enhancing sectors, including for education, women’s political and economic participation, access to clean water and sanitation, poverty reduction and economic growth. Good governance and partnerships across society underpinned progress overall. These are some summary statistics that set the stage for the policy and programme highlights discussed in this publication.

Bangladesh

- Reduced under-five mortality by 65% from 151 to 53 per 1000 live births between 1990 and 2011
- Decreased maternal mortality by 66% from 574 to 194 per 100 000 live births between 1990 and 2010
- Increased immunization coverage from 2% in 1985 to 82% in 2010
- Under-five birth registration increased from 10% in 2006 to more than 50% in 2009 through the use of information and communication technologies

Lao PDR

- Reduced under-five child mortality rates by 56% between 1990 and 2012 from 163 to 71 per 1000 live births
- Maternal mortality fell annually by 6.8% from 1990 to 2013, from 1100 to 220 per 100 000 live births
- Achieved close to universal primary education for girls from 54% in 1992 to 95% in 2012
- Increased access to clean water to all population groups from 40% in 1994 to 70% in 2011

Cambodia

- Reduced the under-five mortality rate by 57% between 1995 and 2010 from 127 to 54 per 1000 live births
- Reduced maternal mortality annually by 5.8% between 1990 and 2010 from 830 to 206 per 100 000 live births
- Increased the proportion of women delivering with a skilled birth attendant and at health facilities from 32% in 2000 to 71% in 2010
- Increased economic growth dramatically, growing per capita GDP by 54.5% between 2004 and 2011

Nepal

- Reduced under-five mortality by 66% from 162 to 54 per 1000 live births between 1991 and 2011
- Decreased maternal mortality by 80% from 850 to 170 per 100 000 live births between 1991 and 2011
- Reduced the total fertility rate from 5.3 in 1991 to 2.6 in 2011
- An interim constitution developed in 2007 guarantees the right to free basic health care services and establishes health as a fundamental right of every person

China

- Decreased under-five mortality by 80% from 61 to 12 per 1000 births between 1991 and 2013
- Decreased maternal mortality by 71% from 80 to 23 per 100 000 live births between 1991 and 2013
- Strengthened the health workforce with over 30 000 community workers trained as general practitioners
- Increased access to improved water sources from 86.7% in 1995 to 94.2% in 2011 in the rural population and access to improved sanitation facilities from 40.3% to 69% between 2000 and 2011

Peru

- Decreased under-five mortality by over 70% from 78 to 21 per 1000 live births between 1991 and 2013
- Decreased the rate of maternal mortality by 65% from 265 to 93 per 100 000 live births between 1991 and 2013
- Institutional births reached 85.9% in 2012 from 76% in 2007
- Chronic malnutrition in children under five declined from 27% to 17% between 2007 and 2013

Egypt

- Decreased under-five mortality by 75% between 1990 and 2012 from 85 to 21 per 1000 live births
- Reduced maternal mortality by 69% between 1992 and 2012 from 174 to 54 per 100 000 births
- Increased the youth literacy rate from 73% in 1996 to 86% in 2007, alongside a primary education completion rate of 98% in 2011
- Increased access to improved water sources from 93% in 1990 to 99% in 2011 and access to improved sanitation facilities from 72% to 95%

Rwanda

- Achieved under-five mortality reduction of 50% between 1992 and 2010 from 151 to 76 per 1000 live births
- Reduced maternal mortality by 22% from 611 to 476 per 100 000 births between 1992 and 2010 (and by 55% from 2000 to 2010 from an increase to 1071 to 476 per 100 000 live births)
- Increased coverage of skilled birth attendance from 31% in 2000 to 69% in 2010
- In 2013, women constituted 64% of parliamentarians, the highest % in the world

Ethiopia

- Reduced under-five mortality by 47% between 2000 and 2011 to from 166 to 88 per 1000 live births
- Although Ethiopia still has one of the highest maternal mortality rates in Africa it has reduced by 22% from 871 in 2000 to 676 per 100 000 live births in 2011
- Expanded community-based primary care for women and children through the deployment of close to 40 000 Health Extension Workers
- Achieved near parity in school attendance by 2008/09: at 90.7% for girls and 96.7% for boys from 20.4% and 31.7% respectively in 1994/1995

Viet Nam

- Reduced under-five mortality by 60% from 58 to 23.2 per 1000 live births between 1990 and 2012
- Reduced maternal mortality by 70% from 233 to 69 per 100 000 live births from 1990 to 2009
- Increased coverage of births attended by trained health workers from 77% in 1997 to 98% in 2012
- Stunting prevalence dropped from close to 40% in 1999 to 25.9% in 2013

Sources for all statistics are official national data, and international data, as agreed at the country multistakeholder policy reviews. More details about the country multistakeholder policy reviews can be found online at: <http://www.who.int/pmnch/knowledge/publications/successfactors/en/index2.html>

SUMMARY STATISTICS: FURTHER INFORMATION

In the country multistakeholder policy reviews, participants agreed to mainly use official national data, but also consulted global estimates. These estimates are provided here for further information.

Countries	Under-five mortality rate (U5MR) per 1000 live births ^a		Maternal mortality ratio (MMR) per 100 000 live births ^b	
	1990	2012	1990	2013
Bangladesh	144	41	550	170
Cambodia	116	40	1200	170
China	54	14	97	32
Egypt	86	21	120	45
Ethiopia	204	68	1400	420
Lao PDR	163	72	1100	220
Nepal	142	42	790	190
Peru	79	18	250	89
Rwanda	151	55	1400	320
Viet Nam	51	23	140	49

References:

- UN Inter-agency Group for Child Mortality Estimation. Levels and trends in child mortality. New York (NY): United Nations Children's Fund; 2013.
Available from: http://www.childinfo.org/files/Child_Mortality_Report_2013.pdf
- Trends in maternal mortality: 1990 to 2013. Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division. Geneva: World Health Organization; 2014.
Available from: http://apps.who.int/iris/bitstream/10665/112682/2/9789241507226_eng.pdf?ua=1





Introduction: Overview of the Success Factors for Women's and Children's Health studies

There have been substantial achievements towards MDGs 4 and 5 (to reduce child mortality and improve maternal health) from 1990 (the baseline for the MDGs) to date. Child and maternal deaths both decreased globally by around 50%, and contraceptive prevalence increased from 55% to 63%.¹⁻³ There is consensus on evidence-based, cost-effective investments and interventions and on enabling health and multisectoral policies.⁴⁻⁵

Despite these advances, every year 6.6 million children under five years of age die (44% as newborns) and 289 000 maternal deaths occur, all from mainly preventable causes.^{1,2} Progress varies widely across countries, even where levels of income are similar.^{6,7} There is a need for evidence on why some low- and middle-income countries (LMICs) do better than others in preventing maternal and child deaths, and on the strategies they use to accelerate progress.⁸ Understanding what works in accelerating progress to reduce maternal and child mortality is important to support countries achieving the MDGs and to inform post-2015 strategies.

To address this knowledge gap, discussions at the Partnership for Maternal, Newborn & Child Health Partners' Forum in 2010, led to a three-year

multidisciplinary, multicountry series of studies on Success Factors for Women's and Children's Health (hereafter referred to as the Success Factors studies).⁹ The Success Factors studies were supported by the Partnership for Maternal, Newborn & Child Health, the World Health Organization (WHO), the World Bank and the Alliance for Health Policy and Systems Research, working closely with ministries of health, academic institutions and other partners.

The Success Factors study series included: statistical and econometric analyses of data from 144 LMICs over 20 years;^{10,11} Boolean, qualitative comparative analysis (QCA) across all LMICs;¹² a literature review;¹³ and country multistakeholder policy reviews in 10 LMICs that were on the fast track, ahead of other comparable countries, in 2012 to achieving MDGs 4 and 5a (hereafter referred to as fast-track countries):¹⁴ Bangladesh; Cambodia; China; Egypt; Ethiopia; Lao PDR; Nepal; Peru; Rwanda; and Viet Nam.

A Bulletin of the World Health Organization journal article¹⁵ and editorial¹⁶ provide a synthesis of the findings across the Success Factors studies and discuss policy and practice implications.

FOR MORE DETAILS ON THE SUCCESS FACTORS STUDIES:

- Presern C, Bustreo F, Evans T & Ghaffar A. **Accelerating progress on women's and children's health.** Bulletin of the World Health Organization. 2014;92:467-467A. doi: <http://dx.doi.org/10.2471/BLT.14.142398>
- Kuruvilla S, Schweitzer J, Bishai D, Chowdhury S, Caramani D, Frost L, et al. **Success factors for reducing maternal and child mortality.** Bulletin of the World Health Organization. 2014;92(7):533-44. doi: <http://dx.doi.org/10.2471/BLT.14.138131>
- **Success Factors for Women's and Children's Health website:** <http://www.who.int/pmnch/knowledge/publications/successfactors/en/>

Multistakeholder policy reviews in 10 fast-track countries

In the 10 fast-track countries, the Ministry of Health, together with national and international development partners, reviewed and discussed the evidence on factors contributing to accelerated progress towards MDGs 4 and 5. Stakeholders from health and sectors outside of health participated, including from finance, planning, water and sanitation, nutrition and education sectors. The objective was to identify factors both within and outside the health sector that contributed to reductions in maternal and child mortality, focusing on how improvements were made, and emphasizing best practices in policy and programme management.

A country multistakeholder policy review guide helped to structure the process,¹⁷ which the country teams adapted as required. The country policy reviews included both quantitative and qualitative methods (Box 1). Wherever possible, the reviews were structured around one-day multistakeholder meetings, with additional key informant interviews and group meetings conducted with health and development stakeholders as required. Plausibility criteria for defining success factors were developed to link policy and programme inputs with potential mortality reductions (Box 2).



Box 1

SUCCESS FACTOR COUNTRY MULTISTAKEHOLDER POLICY REVIEW METHODS

- **Literature review** of peer-reviewed and grey literature, policy documents, programme evaluations and sector strategies and plans.
- **Review of quantitative data and trends** from population-based surveys, routine data systems, international databases and other sources.
- **Multistakeholder policy review meeting**, wherever possible, stakeholders participated in a one-day meeting to review and discuss the evidence and reach consensus on the key policy and programme milestones to reducing maternal and child mortality.
- **Additional key informant interviews and group meetings** to address information gaps, help validate findings on success factors based on interviewees' expertise and experience.
- **Review of the final country policy report** by national stakeholders and experts, with final sign-off by ministries of health.

Box 2

PLAUSIBILITY CRITERIA TO HELP IDENTIFY SUCCESS FACTORS

Policy and programme inputs had to meet four plausibility criteria to be considered as success factors:

- Potential impact (likely to have contributed to mortality reduction based on an impact framework and available data);
- Temporal association (had been implemented long enough to have influenced mortality);
- Scale (had reached a large enough target population to influence mortality); and
- Consensus (broad agreement between key stakeholders within and outside the health sector).



Outcomes of the country multistakeholder policy reviews

The country multistakeholder policy review process brought participants together to discuss how different sectors contributed to progress in reducing preventable maternal and child mortality. The reviews provided an opportunity to synthesize evidence and lessons from a range of data sources, to capture different stakeholder perspectives, from both within and outside the health sector, and to help document the country's policy story on improving women's and children's health.



Each country multistakeholder policy review led to the development of a policy report. The report documents each country's policy story on how improvements were made and the key initiatives and investments in health, and sectors outside of health, shown to influence maternal and child mortality. It also discusses the role key actors, governance and leadership played in countries' progress and concludes with lessons learned and future priorities. These policy reports contribute to ongoing national and global efforts to improve reproductive, maternal, newborn and child health. In sharing each country's policy story, opportunities are also created for learning across countries, that could help support progress towards the MDGs and inform the post-2015 strategies under preparation.

- The full country policy reports and more information about the Success Factors for Women's and Children's Health studies can be found online at: <http://www.who.int/pmnch/successfactors/en/>
- World Bank Health, Nutrition and Population Notes on countries' progress on maternal and child health are available at: www.worldbank.org/hnppublications

This publication summarizes and highlights some of the key policy and programme milestones on fast-track countries' pathways to progress.

Shared strategies, unique approaches: Lessons learned from fast-track countries

The Success Factors studies show us that maternal and child mortality can decline rapidly in low- and middle-income countries when different actors across society collaborate to improve women's and children's health. Remarkable results can be achieved when this approach is underpinned by robust data and strategies tailored to countries' unique situations – especially if the political will and resources exist to maintain long-term focus.

All the 10 fast-track countries in this report have demonstrated some or all of these qualities and strategies. In each country the mix has been different, depending on local context and priorities. However, the clear message is that coordinated multistakeholder partnerships, multisector action, guided by sound data and strategic vision, delivers results. We've summarized the three main elements of this approach as:

1. **Multisector progress** – progressing on MDGs 4 and 5 as well as most of the other MDGs (e.g. reducing poverty and hunger and improving education and gender equality).
2. **Catalytic strategies** – optimizing the use of resources and maximizing health outcomes through effective leadership, evidence-informed decision-making and partnerships across society.

Guiding principles – using widely accepted principles, legal frameworks – including for human rights and development effectiveness – and political and economic models to shape policies and focus action.



In practical terms, this breaks down into a number of broad strategies that characterize fast-track success.

Fast-track countries focus first where they know they can make a difference quickly and sustainably. Often this means strengthening the capacity of the health system to provide basic RMNCH services that people in high-income countries might take for granted. Since 1990, investments in proven high-impact interventions, such as skilled care at birth, immunization and family planning, have accounted for about 50% of the reduction in child mortality. However, in many cases implementation has been novel, and adapted to country conditions.

The highlights from **Nepal** show how women from remote mountain areas have benefited from increased provision of maternal and neonatal services and cash incentives to use them. As a result, many more mothers are delivering safely, keeping themselves healthy and giving their babies a better start to life. In **Bangladesh**, the lives of many children under five have been saved by the coordinated efforts of Community Health Workers and NGOs, working under the umbrella of the national Expanded Programme on Immunization (EPI).

The focus on getting the basics in place, and involving community-based partners, is common to fast-track countries. Approaches differ depending on available resources and factors such as political stability and cultural norms, but the emphasis is always on strengthening the capacity to deliver proven interventions in ways that best suit local conditions. **Ethiopia**, one of the world's lowest-income countries, is a good example. By prioritizing community-based primary care and deploying almost 40 000 health extension workers, it found a way of delivering essential RMNCH interventions, such as antenatal care and contraception, to women and children in rural communities. **Viet Nam** faced different challenges in the aftermath of war and reunification. It created a strong platform for rebuilding health infrastructure and delivering RMNCH interventions, while developing a community focus through its network of village health workers and health centres. This approach enabled an increase in coverage interventions such as contraception, tetanus immunization during pregnancy and skilled birth attendance.



Fast-track countries are also distinguished by their long-term vision and ability to look at what is needed to transform the health of populations over several years or even decades. This is linked to a flexible policy approach that can adapt to changing circumstances. **Bangladesh** saw that the widespread and increasing use of mobile phone technology at all levels of society offered a new and effective vehicle for health system strengthening, health promotion, and communication between health professionals and patients. **Peru** recognized that cultural barriers were as important as geographical ones in preventing women from accessing antenatal and delivery services. In response, it found affordable new ways to deliver modern maternity and newborn care in a culturally sensitive context. **Cambodia** exploited the reach of mass media to launch a campaign promoting exclusive breastfeeding, which even included a TV soap opera. **China** identified subsidies as a way to encourage women to deliver their babies in hospital, and supported this with referral networks for high-risk pregnancies.

Multistakeholder partnerships across sectors are needed to maximize the impact of far-reaching catalytic strategies, augmenting the community-based partnerships described earlier. **Egypt's** Healthy Mother/Healthy Child Programme was implemented by the MoHP with assistance from USAID and John Snow Inc. As noted above, **Cambodia's** breastfeeding initiative involved numerous partners from government, the health sector, the media, the private sector and NGOs. **Peru's** programme against stunting (A Good Start in Life) was a collaboration between the national government, USAID and UNICEF, and made extensive use of local governments, communities, health facility staff and NGOs. **China's** pilot project for child nutrition in poor areas included coordinated action by the All-China Women's Federation and the health, finance and poverty-alleviation sectors. **Ethiopia's** National Nutrition Programme took a multisectoral approach and moved away from an earlier focus on food aid. And the government of **Viet Nam** worked closely with WHO and UNICEF while introducing laws and policies to improve nutrition.

Catalytic strategies often contain a key mechanism that unlocks progress in women's and children's health. A good example is results- or performance-driven financing in countries such as **Rwanda**, **Peru** and **Nepal**. This has helped to reduce inequities in access to maternal and child health services – improving efficiency and creating foundations for



improved care and reduced mortality and morbidity. Affordability of health care is often a barrier to access. To address this, **Egypt** is looking at options to move towards universal health care and its objectives of equitable access to quality services and financial risk protection.

Another key catalytic mechanism is the collection of timely, robust health data to inform policy-making and drive accountability. In **Lao PDR**, locally generated data have informed the policy shift towards free care for pregnant women and the under-fives. In **Bangladesh**, development of ICTs in the health sector is driving the collection of real-time health data on pregnant women and the under-fives and the creation of an online registration system for births and deaths.

Fast-track countries recognize the role played by sectors outside the health sector in creating and sustaining an environment that supports the work of health systems and health partners. In some areas, specifically education, the benefits are broad-based, supporting a better-informed, more equal society. In others, such as sanitation and water supply, the results directly reinforce the positive influence of health programmes.

Ethiopia shows how investments in education can benefit women and children by giving girls the same educational opportunities as boys. Likewise, the Community Schools initiative in **Egypt** has increased access to primary education in remote areas, especially for girls.

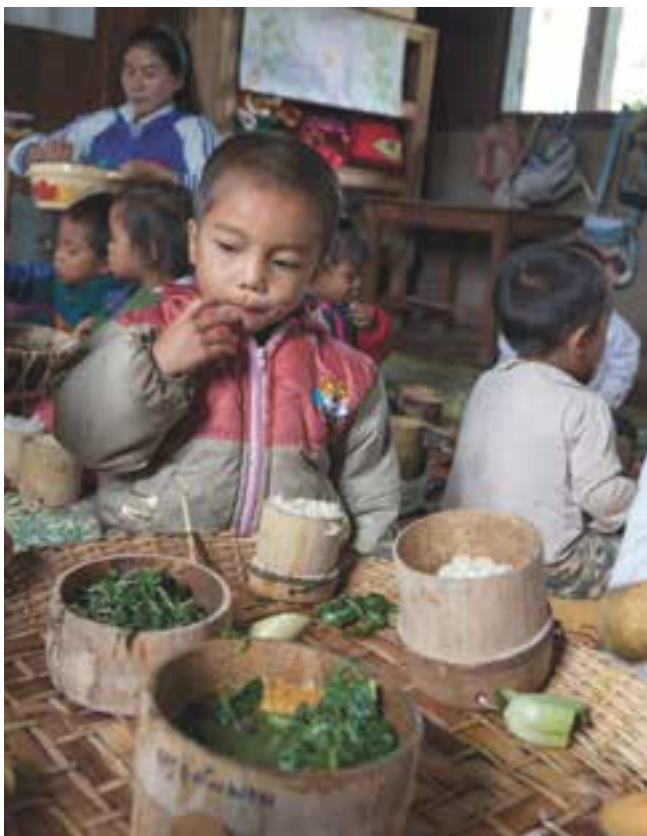
Cambodia offers an example of non-health investments

that create health-sustaining environments, through its policies of targeting economic growth and giving people who were living in poverty, including women, more opportunities to work for wages. Likewise, **China** and **Viet Nam** demonstrate the benefits of upgrading infrastructure for drinking water and sanitation to serve all levels of society.

Large-scale systemic transformations within countries are rarely achieved without sustained political will by governments and politicians.

Bangladesh has achieved polio-free status and eliminated neonatal tetanus, largely due to sustained government focus on its immunization programme and a readiness to work alongside development partners. Political stability helps but is not a prerequisite for progress, as shown by **Nepal**. There the Ministry of Health, supported by harmonized international donor funding, has kept health improvements on track despite political instability and rapid turnover in leadership. Good governance is also important for accountability, effective policy-making and efficient use of resources. **Rwanda** has introduced policies that include an annual Governance Scorecard, zero tolerance of corruption and a programme of health-sector decentralization.

Women in politics frequently provide catalytic leadership to achieve results for women's and children's



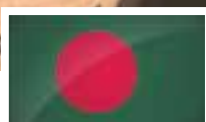
health – the **Rwanda** Women's Parliamentarian Forum and the Women's Caucus in **Lao PDR** are powerful forces in those countries. Equally, policies that entrench women's rights in law create an effective platform for change. **Lao PDR** has instituted laws that specifically protect women and promote their political and socioeconomic participation, and in **Nepal** many government strategies and policies related to safer motherhood, neonatal health, nutrition and gender are underpinned by principles of human rights.

Despite all their success in reducing maternal and child mortality and morbidity, the fast-track countries are not complacent about the challenges that lie ahead. All have said they intend to address national health priorities by strengthening elements of their health-sector workforce, facilities and quality of care. Another shared priority is care and services around pregnancy, birth and the postnatal period. And most countries have identified increased equity and targeting of hard-to-reach, marginalized communities as key areas for improvement.

Fast-track countries plan to address these challenges in a variety of ways. For example, **Bangladesh** wants more women to give birth in facilities, receive skilled care at birth, and benefit from the availability of EmONC and postnatal care. **China** aims to ensure migrant communities and ethnic minorities have access to RMNCH services. **Lao PDR** plans to target malnutrition and stunting. **Rwanda** aims to strengthen its midwifery workforce, family planning provision and nutritional programme. **Viet Nam** wants to raise youth awareness of reproductive health issues.

Underpinning these diverse approaches is a common commitment to focus on results and continue investing where the potential health benefits are greatest, such as maternal and newborn care. It is also clear that strong health sectors, supported by modern data systems, play an important role in accelerating progress on women's and children's health. And that collaborating effectively with multiple stakeholders and other sectors is a proven route to success. These and other learnings from the 10 Success Factors fast-track countries are highlighted in the following sections of this publication. These highlights of fast-track countries' policies and programmes demonstrate some of the key strategies and modes of working that can support accelerated progress to achieve MDGs 4 and 5, and to shape a truly transformative post-2015 agenda for women and children, their families and communities.





BANGLADESH

Country context summary

Bangladesh lies at the northern end of the Bay of Bengal and shares most of its border with India. It is the world's eighth most densely populated country, with 153 million people on a landmass of 147 570 square kilometres. Most people (75%) live in rural areas, although urbanization is increasing. The population is 85% Muslim and 10% Hindu, and the remaining 5% is Buddhist or Christian. The Liberation war of 1971 left the country devastated, and it has suffered severely from poverty, political turmoil and frequent natural disasters. However, Bangladesh has made dramatic improvements over the past four decades by increasing life expectancy, reducing fertility and improving child health, literacy and disaster preparedness.

Key trends and RMNCH gains

UNDER-FIVE MORTALITY

Between 1990 and 2011, under-five mortality decreased from 151/1000 to 53/1000 live births. The infant mortality rate fell less rapidly, from 87/1000 to 43/1000 live births over the last 18 years. These changes are associated with improved coverage of effective interventions to prevent or treat the most important causes of child mortality and with improvements in socioeconomic conditions. Strategies such as IMCI, high coverage of vaccine-preventable diseases, ORT use rate and a focus on newborn health interventions, have been crucial to these reductions.

MATERNAL MORTALITY

Between 1990 and 2010, maternal mortality in Bangladesh decreased from 574/100 000 to 194/100 000 live births. This may be associated with the decline in total fertility rate from 5 births per woman in 1990, to 2 in 2011. The proportion of deliveries in facilities remains small, but deliveries with skilled attendance rose from 5% in 1991 to 26.5% in 2010. Programmes such as the Maternal Health Voucher Scheme and Emergency Obstetrical Care Services, and the rapid development of the private sector, have also contributed to reducing maternal mortality.



Health sector initiatives and investments

The government has worked hard to scale up key interventions such as immunization, oral rehydration therapy and family planning, and to ensure they are accessible and affordable within communities. This strategy has benefited even the most disadvantaged populations, and has contributed significantly to reducing child and maternal mortality. It has combined with policies and health sector strategies that consistently support improved service delivery, and encourage partnership with NGOs and the private sector.

Health sector highlight



THE EXPANDED PROGRAMME ON IMMUNIZATION (EPI)

EPI was launched in Bangladesh in 1979 and has been identified as the largest single contributing factor in the reductions to under-five child deaths.¹ Large-scale coverage was achieved through the government's commitment after 1985 to achieve universal immunization coverage by 1990, a community-based outreach approach, and strong support and funding from donor agencies and NGOs.

A community-outreach strategy for vaccinations was integrated into the primary health care system, and backed by intensive media campaigns to create demand. Government community health workers provided vaccinations at EPI sites, satellite clinics and static clinics, and also through household visits to motivate and educate families. A unique feature of the programme was that the communities were required to provide space for these outreach services, even in the most poor and marginalized areas. Immunization coverage rose from less than 2% in 1985 to 65% in 1992 and 82% in 2010.² Routine immunization has enabled the country to maintain polio-free status from 2001 and eliminate neonatal tetanus in 2008. In 2009, a vaccine against Hib (Haemophilus influenza type B) was incorporated into a new pentavalent combination vaccine protecting against diphtheria, tetanus, pertussis and Hepatitis B. There are plans to introduce a pneumococcal vaccine for prevention of acute respiratory infections such as pneumonia in 2014.

NGOs played an important role in mobilizing communities to attend EPI delivery sites. They continue to provide technical assistance for training, management and monitoring, and in

urban areas they manage the majority of immunization services. National Immunization Days (NIDs) have been held since 1995 for the distribution of oral polio vaccine and vitamin A capsules. Civil society participation is important to the success of NIDs. More than 600 000 volunteers enable them to reach over 90% (24 million) of children in a single day, with follow-up later for the remaining 10%. In 2014, NIDs reached a coverage of 100%.³

EPI has increased coverage among the lowest wealth quintile from 49% in 1994 to 80% in 2005.⁴ Between 1997 and 2011, measles coverage among children aged 12 to 23 months rose from 75% to 94% in urban areas, and from 69% to 93% in rural populations.⁵



Initiatives and investments outside the health sector

In 2010, the United Nations recognized Bangladesh for its exceptional progress towards MDGs 4 and 5 to reduce child and maternal mortality in the face of many socioeconomic challenges. Success has been achieved through targeted and well-designed programmes, and a government willing to experiment with service delivery and to work collaboratively with partners such as NGOs and the private sector. Other contributing factors have included a focus on women's education and empowerment and gender equity, and improvements in road networks and information and communication technology.

Highlights from sectors outside of health



INFORMATION AND COMMUNICATION TECHNOLOGY (ICTs)

Bangladesh is aiming for a fully digital government health service by 2016.⁶ In 2012, all health facilities in rural areas were given wireless broadband and laptops, and government community health workers received tablet devices. With NGO support, this enables collection of quality health data on subjects such as pregnancy, children under five and registration of births and deaths.⁷ In 2006 only 10% of births were registered, now over 50% of children under the age of five have been registered.

Mobile phone and eHealth technology has been used to improve reporting, data collection, access to data, data storage and referrals.^{8,9} Patients have benefited from new services such as a 24/7 mobile phone link for people in rural areas to an on-duty physician, and weekly text messages offering pregnancy advice to registered mothers.¹⁰ New technology now supports 28 telemedicine centres, with another 15 planned for 2014.

In education, school pupils are using the internet to hear online lectures from external teachers and to access hundreds of eBooks online.¹¹ In agriculture, Grameen Intel Ltd. has begun providing farmers with customized information on seed selection, soil and fertilizers.¹²



Ongoing challenges and future priorities

According to current estimates Bangladesh has achieved MDG 4 and is on track to meet its MDG 5 targets, however it continues to face several challenges. If addressed, the following could further accelerate progress in reducing maternal and child mortality.

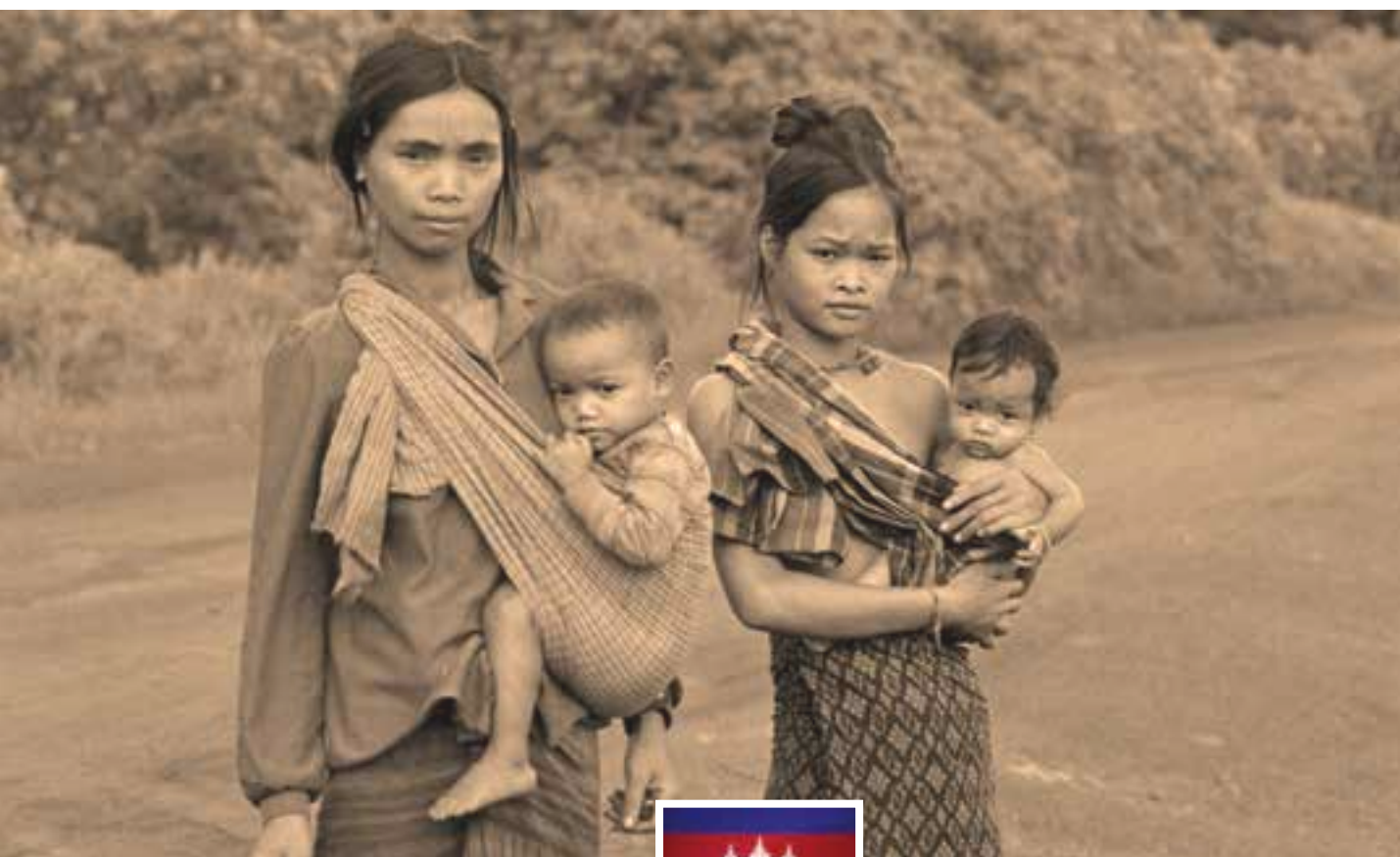
Challenges and future priorities of maternal health:

- Increase delivery by skilled providers
- Availability of emergency obstetrical care services
- Increase coverage of postnatal care
- Addressing equity gaps in services

Challenges and future priorities of newborn health:

- Increase coverage of facility-based deliveries
- Scaling up preterm management (ACS and KMC) and sepsis management
- Strengthening of 'Helping Babies Breathe' programme to prevent deaths due to birth asphyxia
- Prevention of preterm and still births

The full Bangladesh Success Factors policy report can be found online at:
<http://www.who.int/pmnch/successfactors/en/>



CAMBODIA

Country context summary

Cambodia neighbours Lao PDR, Thailand and Viet Nam on the Indochinese Peninsula, and has a coastline facing the Gulf of Thailand. It is comprised of lowlands and mountains and has a population of 15 million, which is 80% rural (90% of the country's poor are rural dwellers). The Paris Peace Accords of 1991 included a Declaration on the Rehabilitation and Reconstruction of Cambodia, whose population suffered severely under the genocidal regime of the Khmer Rouge from 1975 to 1979.

Key trends and RMNCH gains

UNDER-FIVE MORTALITY

Between 1995 and 2010, under-five mortality in Cambodia declined by 57% (from 127/1000 to 54/1000 live births). This is associated both with improved coverage of effective interventions to prevent or treat the most important causes of child mortality (in particular with immunizations, early and exclusive breastfeeding and vitamin A) and with improvements in socioeconomic conditions. Reductions in severe stunting and underweight are also noted.

MATERNAL MORTALITY

Between 1990 and 2010, maternal mortality fell with an estimated annual rate of decline of 5.8%. This is associated with a halving of the total fertility rate between 1990 and 2012 from 6 to 3, and associated increases in birth interval and reductions in births to very young or old mothers. In addition, there have been significant increases in the proportion of women attending at least four antenatal care visits, making more of these visits early in pregnancy, delivering with a skilled birth attendant and delivering at health facilities. The number of facilities providing comprehensive emergency obstetric and newborn care (EmONC) has increased significantly.



Health sector initiatives and investments

Cambodia has put in place policies and programmes in three areas to improve delivery of key RMNCH interventions for women and children: laws, standards and guidelines; essential health systems; and improved delivery strategies. Health financing efforts include increasing government allocations to health, and the development and expansion of three health-care financing schemes: performance-based financing, health equity funds and vouchers. All three have helped to improve access to essential RMNCH services and reduce inequity. Policies for the health workforce have focused on improving numbers, capacity and distribution of workers (particularly midwives). A government midwife incentive scheme has been associated with a dramatic improvement in deliveries at facilities and with skilled attendants.



Health sector highlight

HEALTH PROMOTION AND BEHAVIOUR CHANGE FOR BREASTFEEDING^{1,2}

Exclusive breastfeeding rates for infants under six months increased from 11% in 2000 to 60% in 2005 and to 74% by 2010. A concerted effort to promote early initiation of breastfeeding with no pre-lacteal feeds, and exclusive breastfeeding, began in 2004. A mass-media campaign was developed by the MOH and the National Centre for Health Promotion, focusing on the themes of diarrhoea, acute respiratory illness, immunization and child nutrition. It included the promotion of early initiation and exclusive breastfeeding and pre- and postnatal care. Communication methods included: TV spots

with messages on exclusive breastfeeding emphasizing that “not even water” should be given to young infants; radio spots using a “breastfeeding song”; and a 24-episode TV soap opera, which included breastfeeding messages.

Activities for World Breastfeeding Week included a toolkit for health staff and NGO partners, which promoted the same messages using leaflets, posters, banners and songs. A BBC World Service Trust evaluation of the mass-media campaign was conducted in 2006. The proportion of respondents who believed children should receive food or liquids other than breastmilk decreased from 60% to 18%, and knowledge of immediate breastfeeding increased from 38% to 67%. Health system support to train health staff in nutrition and breastfeeding topics began in earnest in the early 2000s with efforts to scale up training to all health staff over the next decade. NGOs simultaneously provided nutrition breastfeeding education to families at the community level. In 2004, the Baby Friendly Hospital and Baby Friendly Community Initiatives were launched at health facility and community levels.

Investments and initiatives outside the health sector

Improvements in education, nutrition and access to improved water and sanitation have been central to mortality declines and better health. Policy and programme inputs in these areas have included: increased resource allocation and partnerships with development partners, NGOs and civil society; clear policies and strategies; identification and targeting of high-risk groups and populations (particularly the poor); and forming links between different sectors.

Highlights from sectors outside of health

POLICIES HAVE REDUCED POVERTY AND SUPPORTED PRO-POOR DEVELOPMENT

Between 2004 and 2011, economic growth in Cambodia increased dramatically and per capita GDP (in constant US\$) grew by 54.5%, ranking 15th among 174 countries. As a result, the poverty rate dropped from 52% to 21%.³ Policy lessons learned included:

- **Actions were focused where 90% of the poor live (rural areas) and supported improvements in people's existing work – principally cultivation of land and labour.**

Poverty reduction in rural areas was driven by a 37% increase in the market price of rice, which in turn drove increases in rice production. Improvements in rice production were also driven by policies that removed price controls and placed no taxes on production. Policies to improve rural infrastructure (roads, communication, rural irrigation) supported improved productivity.

- **Poverty reduction in urban areas was driven by increases in salaried employment.**

The share of urban workers in salaried employment increased to over 50% in 2011. This was driven by policies supporting universal education – salaried workers had more years of education than other workers. Improvements in industrial production were driven by business-friendly industrial policies, which promoted investments in industry.

- **Changes in minimum wage standards benefited women in the garment industry.**

The garment industry is one of the largest employers of salaried workers in the country. About 85% of workers in the industry are women, and higher wages have benefited this group.



Ongoing challenges and future priorities

Although Cambodia is on track to achieve MDGs 4 and 5, it continues to face several challenges. If addressed, the following could further accelerate progress in reducing maternal and child mortality:

- **Reduce socioeconomic inequities** – through health equity funds, health vouchers and initiatives to decrease high out-of-pocket expenditure.
- **Improve quality of care** – targeting EmONC and immediate postpartum and postnatal care, and doubling the number of midwives to achieve equitable distribution.
- **Develop community-based approaches** – improving nutritional status and the management of children with pneumonia and diarrhoea, and promoting health-related behaviour change.
- **Continue non-health-specific investments** – particularly in education, water and sanitation and poverty reduction.

The full Cambodia Success Factors policy report can be found online at:
<http://www.who.int/pmnch/successfactors/en/>



CHINA

Country context summary

The People's Republic of China is the world's most populous country, with 1.37 billion people, and with the US is geographically the joint-third largest country in the world. There are over 50 ethnic groups and hundreds of spoken languages. In 2010, China became the second largest economy in the world in terms of gross domestic product. However, the increase in wealth has led to rising inequality in areas such as income and education.



Key trends and RMNCH gains

UNDER-FIVE MORTALITY

Between 1991 and 2013, under-five mortality in China decreased from 61/1000 to 12/1000 live births. This is associated both with improved coverage of effective interventions to prevent or treat the most important causes of child mortality and with improvements in socioeconomic conditions.

MATERNAL MORTALITY

Between 1991 and 2013, maternal mortality in China decreased from 80/100 000 to 23/100 000 live births. This is associated with extensive modernization of the health system, including provision of antenatal and delivery services at community level in rural areas.

Health sector initiatives and investments

Government health expenditure per capita increased at an annual rate of more than 13% from US\$ 53 in 1995 to US\$ 480 in 2012. China has made intensive policy and planning efforts to improve health over the last two decades. Major efforts have been made in areas such as health workforce recruitment and training, health data collection and surveillance and health insurance. Health system strengthening has resulted in a comprehensive three-tier medical and

health service network that extends from province to township and village level. This structure includes professional MCH institutions at province, prefecture and county levels, providing women's and children's public health and basic medical services. The Law on Maternal and Infant Health Care and the National Programme for Women/Child's Development provide the basis of a relatively complete policy and legal framework on MCH.

Health sector highlight

PROGRAMME TO REDUCE MATERNAL MORTALITY AND ELIMINATE NEONATAL TETANUS



This programme included three main measures to improve hospital delivery: health education, health infrastructure and social mobilization. After a UNICEF pilot, with technical support from WHO and UNFPA, it was implemented jointly by the National Working Committee for Children and Women, the Ministry of Health and the Ministry of Finance. Starting in 2000 in several counties in west China, by 2004 it had been extended to 1000 rural counties in mid-west China.

The programme encouraged hospital deliveries by allowing pregnant women to access subsidies from the local government or maternal care institutions managed by local government. It also enabled obstetric experts from provincial tertiary hospitals to support primary maternal care centres, in terms of initiating referral and training staff,¹ and provided referral networks for high-risk pregnancies and pregnant women at village, township and county levels.²

As a result, hospital delivery costs – previously a heavy burden for poor women – were reduced and reimbursements increased. The hospital delivery rate increased by an average of 46% between 2001 and 2007, and evidence suggests this was associated with reductions in maternal mortality.² By 2012 neonatal tetanus had been eliminated in China.



Investments and initiatives outside the health sector

Multiple non-health sectors and actors have contributed to improvements in women's and children's health in China over the last two decades. This has been achieved in the context of widespread poverty reduction, increased wealth and socioeconomic improvements. The State Council issued the National Programme for Children's Development in China and the National Programme for Women's Development in China. These integrated women's health care, including reproductive health, into the overall strategic plans for socioeconomic development.

Enhancements to health-sustaining infrastructure have included over 200 000 projects to supply safe drinking water to 220 million rural residents. Access to improved sanitation facilities improved from 40.3% in 2000 to 69.2% in 2011. China is on track to achieve 100% literacy among 15 to 24-year-olds due to advances in education, including the elimination of gender inequities in primary and secondary education. The government formulated the Outline for the Development of Food and Nutrition in China (2001–2010). This contributed to strong progress in reducing the percentage of underweight children under-five (from 13% in 1990 to 4% in 2010), and the percentage of under-five stunted children (from 32% in 1990 to 10% in 2008).

Ongoing challenges and future priorities

Although China has met its MDG 4 target and is on track to meet its MDG 5 target, it continues to face several challenges. If addressed, the following could further accelerate progress in reducing maternal and child mortality:

- **Reduce socioeconomic inequities** – targeting regional variations in mortality rates, and the specific issue of gender equality, particularly in the workforce.
- **Strengthen health systems** – focusing on health workforce capacities and sustainable financing.
- **Fulfil unmet needs and address new challenges** – including for family planning and access to health care in rural areas, and with regards to migrant communities and ethnic minorities.
- **Encourage knowledge sharing** – strengthening opportunities for international and south-south collaboration.

Highlights from sectors outside of health

CHILDREN NUTRITION IMPROVEMENT PILOT PROJECT IN POVERTY-STRICKEN AREAS

In China, the rate of stunting in children under the age of five reduced from over 30% in 1990 to 9.9% in 2010. However, malnutrition and anaemia are still key issues that endanger children's health especially in some remote and rural parts of China, despite the widespread advances in other parts of the country. To address this problem, the China Development Research Foundation (CDRF) piloted the Programme of Early Childhood Development in Poor Rural Areas in 2009 in two counties of Qinghai Province.³ Interventions included: free nutrition tablets; soybean flour-based Ying Yang Bao (YYB) foods containing microelements for young children; prenatal check-ups for pregnant women; and regular medical examinations for infants.

The pilot proved successful and provided the basis for the Children Nutrition Improvement Pilot Project in Poverty-stricken Areas.⁴ This was launched in 2012 by the Ministry of Health and the All-China Women's Federation in 100 counties of Shanxi, Shaanxi, Hubei, Hunan, Chongqing, Guizhou, Yunnan. By 2013, the project had covered 300 counties and 822 000 children. Central government provided a special grant for the project area. Children aged between six months and two years were provided with free nutritional supplements (i.e. YYB) to prevent malnutrition and anaemia. Action by the All-China Women's Federation and the health, finance, poverty alleviation and other sectors resulted in a diverse range of activities to promote child nutrition. These included: training courses on infant and young child nutrition and feeding practices; coordinated procurement and quality control of YYB, management of YYB distribution; and a variety of health education activities.

The full China Success Factors policy report can be found online at:
<http://www.who.int/pmnch/successfactors/en/>

A World Bank Health, Nutrition and Population (HNP) note on China's Progress on Maternal and Child Health is also available at:
www.worldbank.org/hnppublications



EGYPT

Country context summary

Egypt is a desert plateau divided by the Nile valley and has coastlines on the Mediterranean Sea and Red Sea. Rural Upper Egypt in the south has particularly high maternal mortality, while Lower Egypt in the north is more urbanized and affluent, with better health outcomes. About 50% of the 86 million population (2013) is aged under 15 and less than 4% over 60. Egypt is a lower-middle-income country. Although its gross domestic product grew by 5.3% in 2010, it has since slowed to 2.2% (2012/13) due to dramatic changes in the political landscape.

Key trends and RMNCH gains

UNDER-FIVE MORTALITY



Egypt has met its MDG 4 target with a decline of 73% in under-five mortality between 1990 and 2011.

The current under-five mortality rate is 21/1000 live births. This is likely associated with high rates of immunization coverage, and appropriate care seeking for sick children, as well as improvements in overall socioeconomic conditions.

MATERNAL MORTALITY

Egypt is also on track to achieve its MDG 5a maternal mortality target of 58/100 000 live births. Its MMR declined from 174/100 000 in 1992 to 54/100 000 in 2012. Gains in reducing maternal mortality are likely associated with high rates of family planning use, antenatal care and skilled birth attendance. However, the national data hide large discrepancies between rich and poor and urban and rural populations.

Health sector initiatives and investments

Government expenditure on health has remained relatively constant over the last decade. Egypt is looking at options to move towards universal health coverage (UHC), pushed notably by the new constitution (2014) which has set a target for effectively doubling public health expenditure. In 2010, the health workforce was comprised of 2.8 doctors and 3.5 nursing and midwifery personnel per 1000 population. The Ministry of Health and Population (MoHP) in collaboration with partners (UNICEF, UNFPA and WHO) has developed the Egypt National MCH acceleration plan (2013-2015) with different activities, including improving the quality of obstetric and emergency care, and increasing access to family planning, improving training and professionalizing midwifery and nursing. The MoHP is also integrating vertical programs into primary health care and prioritizing PMNCH interventions to enhance the implementation of the acceleration plan. It has a wide network of approximately 5000 primary health care facilities, complemented by private and specialized facilities.

Health sector highlight

The first National Maternal Mortality Study (1993) determined that the majority of maternal deaths across Egypt were avoidable, with a high percentage of the deaths occurring in Upper Egypt.

The Healthy Mother/Healthy Child Programme (1993–2009) focused on reducing the risk factors of maternal and neonatal mortality in nine governorates of Upper Egypt – a region associated with poor health outcomes. The programme was designed to systematically address the major causes of maternal deaths in areas with the highest maternal mortality. An essential package of maternal and child health services and standards was developed for: antenatal and postnatal care; delivery; obstetric care; neonatal care; and preventive services for child health. It was accompanied by a wide range of activities to raise standards through improved training and supervision, and by upgrading facilities and equipment and setting up new maternal and child healthcare facilities. Supporting strategies included: a policy to promote medical providers and phase out traditional birth attendants; midwifery training for nurses; and improved quality of care. The programme was implemented by the MoHP with assistance from USAID and John Snow Inc.



As a result of this programme, an estimated 22 million people in nine Upper Egypt governorates and two low-income urban areas had improved access to essential obstetric and neonatal care. This contributed to 2.6 million females of reproductive age and approximately 660 000 infants born in the region each year having better access to essential obstetric and neonatal care. Medically assisted delivery increased from 38% in 1988 to 80% in 2008.¹

Investments and initiatives outside the health sector

Egypt has made educational reform a priority since the early 1990s, instituting targeted initiatives to improve access to education for underserved populations and girls. Egypt is on track to meet most of its MDG targets including MDG 1c (to halve the proportion of people suffering from hunger). Additionally, the country has prioritized innovation and research through its National Academy of Science and Technology and by building linkages between health research programmes and policy formulation by decision-makers.

Highlights from sectors outside of health

COMMUNITY SCHOOL INITIATIVE

Egypt is on track to achieve MDG 2 for universal primary education and MDG 3 to promote gender equality. As an example of a key contributing programme, the Community School Initiative was financed and launched by UNICEF and the Egyptian Ministry of Education. It was implemented in Upper Egypt through local NGOs in three phases from 1992 through 2006. It aimed to create a model

for increasing access to primary education in remote areas, with a special focus on girls.

The schools offered courses outside of regular schools hours, including non-formal adolescent education. Young women were recruited locally and trained as facilitators.

By 2003, there were 227 community schools in the three governorates with 5500 students in total, of whom 66% were girls. The community school model was a success in terms of students able to pass official Ministry of Education examinations in the third

and fifth grades. The schools were considerably more cost-effective than public schools at producing fifth-grade completers who could pass the national examination. Lessons learned from the initiative included methods for providing effective education to girls and children in remote areas; and how to engage students, teachers and communities in active learning and democratic decision-making.²



Ongoing challenges and future priorities

Although Egypt has achieved MDGs 4 and is on track to achieve MDG 5a, it continues to face several challenges. If addressed, the following could further accelerate progress in reducing maternal and child mortality:

- **Improve access to services across Egypt** – targeting services to improve health outcomes in Upper Egypt and other rural areas, including more equitable distribution of the health workforce, better referral systems and higher quality of care in rural areas.
- **Reduce gender disparities** – increasing women's participation in the workforce.
- **Reverse childhood malnutrition trends** – improving nutrition (evidence suggests that rates of underweight and stunting in children are actually increasing).
- **Moving towards universal health coverage** – establishing policy framework and putting in place possible health system reforms that will ensure reaching the UHC objectives of equitable access to quality services and financial risk protection.

The full Egypt Success Factors policy report and references can be found online at: <http://www.who.int/pmnch/successfactors/en/>

A World Bank Health, Nutrition and Population (HNP) note on Egypt's Progress on Maternal and Child Health is also available at: www.worldbank.org/hnppublications



ETHIOPIA

Country context summary

Ethiopia is a large landlocked country in East Africa (population 85.8million: 2013), bordering Eritrea, Kenya, Somali, Sudan and South Sudan. It has nine largely rural regional states and two city administrations. The terrain ranges from mountainous highlands to tropical forests. Christianity and Islam are the main religions, and there are more than 80 ethnic groups and 90 languages. One of the world's poorest countries, Ethiopia has a Human Development Index of 0.396, giving it a rank of 173 out of 187 countries.

Key trends and RMNCH gains

UNDER-FIVE MORTALITY

Between 2000 and 2011, under-five mortality in Ethiopia declined by 47% to 88/1000 live births. This is associated both with improved coverage of effective interventions to prevent or treat the most important causes of child mortality and with improvements in socioeconomic conditions. Improvements in primary care and expansion of the health workforce are also significant.

MATERNAL MORTALITY

Although maternal mortality has reduced, Ethiopia still has one of the highest maternal mortality rates in Africa at 676/100 000 live births.



Health sector initiatives and investments

Since its launch in 1997/8, Ethiopia's Health Sector Development Plan (HSDP) has prioritized RMNCH, improving the quality of services and access to them. The HSDP has strengthened areas such as immunization, nutrition and community- and facility-based services. Ethiopia has invested in training and expanding its health workforce, increasing the number of medical schools from six to 24 between the late 1990s and 2013 and expanding primary care provision for women and children through health extension workers (see HEP below).

Health sector highlight

THE HEALTH EXTENSION PROGRAMME

The Health Extension Programme (HEP) in Ethiopia was launched in 2004 with support from development partners. It promotes community-based primary care and is implemented by salaried health extension workers (HEWs) – a new cadre of community-based, mostly female health workers selected by their communities. HEWs work to increase access to care by providing 17 health interventions focusing on: maternal, child and newborn health; disease prevention and control; personal and environmental hygiene and sanitation; and health education. More than 38 700 HEWs have been deployed and more than 16 000 health posts have been constructed, increasing coverage of primary RMNCH services in rural communities.¹ The percentage of women

making four or more antenatal visits nearly doubled between 2000 and 2011 and contraceptive coverage for modern methods quadrupled from 6% to 27% over the same period. The U5MR declined from 123 deaths/1000 live births in 2005 to 88/1000 live births in 2011. Access to latrines in the country also increased, from 7.4% in 2005 to 15.5% in 2010.²

HEWs are closely involved in delivery of the National Nutrition Programme (NNP), launched by the government in 2008 to tackle malnutrition. The NNP takes a multisectoral approach and moves away from an earlier focus on food aid. As part of the NNP, the Community-based Nutrition Programme deploys HEWs to improve the nutrition of children under 24 months. The HEWs help communities to recognize undernutrition and identify its causes, and to use resources more effectively. In five years, the programme has extended from 39 to 228 districts; by 2012, 71% of children aged 6–59 months were receiving vitamin A supplements and 52% of children aged 0–5 months were being exclusively breastfed. The prevalence of stunting has decreased from 58% (2000) to 44% (2011), with a similar decrease in children underweight.²

The effectiveness of the HEP has been ascribed to factors such as: multisectoral collaboration; attention to local contexts; strong ownership and leadership by government and local communities; strong partnerships; and greater investment in health, capacity building and systems strengthening, including through health workforce training and multisector linkages.



Investments and initiatives outside the health sector

Improvements in water and sanitation and access to safe drinking-water are factors in the reduction of under-five mortality, and there is overlap with the community-education work of HEWs (see above) on safe sanitation practices. Access to primary and secondary education has improved significantly and the road network has been expanded.

Highlights from sectors outside of health

GIRLS AND WOMEN BENEFIT FROM FOCUS ON EDUCATION AND GENDER PARITY



Ethiopia has seen unprecedented government-led expansion of its education system since 1994. Approximately 3 million pupils were in primary school in 1994/95, but primary enrolment had risen to 15.5 million by 2008/09 – an increase of over 500%. In 1992, around four of five primary school-age children were out of school; in 2008, it was only one in five. Secondary school enrolment also grew more than fivefold in this period.³

Improvements in access to education have helped narrow the gender gap and have benefited the poorest, aided by initiatives such as encouraging women's employment in the civil service, gender-sensitive teaching methods and increasing the minimum marriage age to 18. Near gender parity had been achieved in school attendance by 2008/09 (90.7% for girls and 96.7% for boys).⁴

The achievements in education and gender parity can be attributed to contributing factors such as sustained central government commitment, an expanded role for regional and local government and effective working with development partners. Public spending on education increased to 23.6% of total expenditure by 2008/09 from under 10% in the 1980s. Ethiopia has also endorsed pro-poor education policies, such as school feeding programmes and abolition of some school fees.



Ongoing challenges and future priorities

Although Ethiopia is on track to achieve MDG 4 it continues to face several challenges, particularly around maternal mortality. If addressed, the following could further accelerate progress in reducing maternal and child mortality:

- **Strengthen the health workforce** – increasing the numbers of midwives, doctors and integrated surgical officers. Improved education and training are key to this challenge.
- **Improve quality of care** – using data from maternal death surveillance and review to inform this process.
- **Target newborn health** – deploying a range of community-based interventions, including antenatal care.
- **Finance health services** – finding ways to increase per capita spending on health and to reduce out-of-pocket expenditure.

The full Ethiopia Success Factors policy report and references can be found online at: <http://www.who.int/pmnch/successfactors/en/>



LAO PDR

Country context summary

Lao PDR is a landlocked, mountainous country on the Indochinese Peninsula, bordering Cambodia, China, Thailand, Myanmar and Viet Nam. About two-thirds of the 6.4 million population live in rural areas and over one-third is under 15. Many rural areas do not have paved roads and are difficult to access. Lao PDR is one of the most ethnically diverse countries in the world, with 49 official ethnic groups. Lao PDR was recently reclassified as a lower-middle-income country, but in 2012 it ranked 138 out of 186 countries on the Human Development Index.

Key trends and RMNCH gains

UNDER-FIVE MORTALITY

Between 1990 and 2012, under-five child mortality in Lao PDR declined by 56% (from 163/1000 to 71/1000 live births). This reduction is associated both with improved coverage of effective interventions to prevent or treat the most important causes of child mortality and with improvements in socioeconomic conditions.



MATERNAL MORTALITY

Between 1990 and 2012 maternal mortality fell with an estimated annual rate of decline of 5.9%. This is associated with a halving of the total fertility rate between 1990 and 2012 from 6 to 3, and associated increases in birth interval. Fertility declines are associated with improvements in the contraceptive prevalence rate – and socioeconomic and educational improvements.

Health sector initiatives and investments

Lao PDR has put in place policies and programmes in three areas to improve delivery of key RMNCH interventions for women and children: laws, standards and guidelines; essential health systems; and improved delivery strategies. Policies for the health workforce have focused on improving numbers, capacity and distribution of workers (particularly midwives) by improving training, accreditation systems and incentives for remote placement. Lao PDR has launched an integrated routine system to extend delivery of key RMNCH services across the country. Other strategies include vertical programmes for immunization and malaria, selective use of campaigns, and partnerships with development partners, NGOs and other civil society groups to expand delivery to all districts and communities in the country.

Health sector highlight

LOCAL DATA DRIVE POLICY SHIFT TO REMOVE USER-FEES TO IMPROVE SKILLED BIRTH ATTENDANCE¹



In 1996, financial constraints led the government of Lao PDR to legalize user fees for specified procedures after more than 30 years of government-funded health services. A year later, fees were extended to create a Revolving Drug Fund (RDF) system at health facilities. Subsequently, government facilities throughout Lao PDR relied heavily on user fees, including for deliveries.

This status quo was reviewed in 2009, when the government supported a pilot study to examine the effects of removing user fees in four high-priority poor districts in the Savannakhet Province. In two districts, all costs associated with facility deliveries were paid, including transportation to higher-level facilities and support at these facilities if complications arose. Two districts acted as controls.

An evaluation of the pilot found a tripling of facility-based delivery rates in the intervention areas, compared to a 40% increase in the two control areas. These findings suggested that facility-based delivery fees are an important barrier to use, even in the presence of other access and cultural barriers.

Subsequently, study findings were part of the evidence used to support the government decision to provide free care for pregnant women and the under-fives (Prime-Ministerial decree 178/M 2010). This approach is now being scaled up nationally. The willingness to use data to inform policy has driven health progress in Lao PDR.



Investments and initiatives outside the health sector

Improvements in education, access to improved water and sanitation, and a 40% reduction in poverty over the last 20 years have been central to mortality declines and better health. Policy and programme inputs have included: increased resource allocation and partnerships with development partners, NGOs and civil society; clear policies and strategies; targeting of high-risk groups and populations (with an emphasis on reaching the poor); and use of data for making programme decisions. The government of Lao PDR has put in place policies and programmes designed to improve women's rights and participation at all levels of society. Over the last 15 years, women's gender parity has improved in primary and secondary education and female literacy. The share of women in wage employment in nonagricultural sectors has increased from about 20% in 1990 to 34% in 2010 – a key marker of women's improved ability to get higher-paid work. In addition, significantly more women are participating in the national parliament of Lao PDR.

Ongoing challenges and future priorities

Although Lao PDR is on track to achieve MDGs 4 and 5, it continues to face several challenges. If addressed, the following could further accelerate progress in reducing maternal and child mortality:

- **Increase state health financing** – implementing government commitments to increased health expenditure and to the National Health Financing Strategy 2011–2015.
- **Strengthen the health system** – improving access to, and distribution of, health services, and enhancing health workforce skills and numbers.
- **Prioritize malnutrition and stunting** – focusing the attention of the government and the development community on improving nutrition, especially in poor and rural populations.
- **Improve quality of care** – targeting increased skilled birth attendance and improved EmONC, intrapartum and early essential newborn care.

The full Lao PDR Success Factors policy report and references can be found online at: <http://www.who.int/pmnch/successfactors/en/>

Highlights from sectors outside of health

GENDER PARITY AND RIGHTS FOR WOMEN TO HEALTH



In Lao PDR, the share of women in waged employment in nonagricultural sectors increased from around 20% in 1990 to 34% in 2010. In addition, in 2011 women constituted 25% of the Lower House of parliament. Policies and programmes inputs to improve women's gender parity and rights have included:²

A revised Constitution and other laws to guarantee rights for women.

These include the Law on the Development and Protection of Women (2004) and a revised Labour Law (2006), which requires equal access to employment for men and women. In addition, the government has committed to key international conventions and treaties that support rights for women, including ratifying the UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (1981).

Key policies that outline approaches to improving gender rights in routine programming.

These include the National Strategy on the advancement of Women, the National Growth and Poverty Eradication Strategy and the National Social Economic Development Plan. In addition, the National Plan of Action for Basic Education for All aims to increase female literacy and enrolment in schools.

Development of institutions for advocacy, programme implementation and oversight.

The Lao Women's Union, established in 1955, works to protect and advance the rights of women throughout the country. It has an important role in advocacy and information dissemination at all levels. The Women's Caucus, made up of the female members of the National Assembly, was formed in 2003 to support women in government and help them develop and maintain skills. The National Commission on the Advancement of Women, established in 2003, works with the government to set policy and develop strategies for women, linked with ongoing programmes.





NEPAL



Country context summary

Nepal is a low-income, landlocked country that borders China to the north and India to the south. There are significant disparities in health, education, wealth and access to care between the 126 distinct ethnic/caste groups in the population of 26.6 million, and between people living in different regions (mountains, hills, plains). It has experienced considerable political instability since democracy was introduced in 1990, including a decade-long armed conflict that ended in 2006. An Interim Constitution was formed in 2007, but the country remains politically unstable.

Key trends and RMNCH gains

UNDER-FIVE MORTALITY

Between 1991 and 2011, under-five child mortality in Nepal declined by 66% (from 162/1000 to 54/1000 live births). This is associated with improved coverage of effective interventions to prevent or treat the most important causes of child mortality. However, the newborn mortality rate has remained stagnant at around 33/1000 live births since 2006.

MATERNAL MORTALITY

Between 1991 and 2011, maternal mortality in Nepal declined by 80% (from 850/100 000 to 170/100 000 live births). This is associated with a fall in the total fertility rate from 5.3 to 2.6, despite near stagnation in the contraceptive prevalence rate (CPR) between 2006 and 2011.



Health sector initiatives and investments

Nepal's progressive policy environment has developed rapidly since the introduction of the National Health Policy in 1991, and the government has adopted innovative, context-specific and evidence-based strategies. It has implemented a series of effective programmes at different levels of the health system, focused on improving maternal and newborn outcomes, such as the community-based Integrated Management of Childhood Illness Programme, the National Immunization Programme and the National Newborn Care Package. The government has prioritized the promotion of contraceptive use within its family planning strategy by making contraceptives available in health facilities and within communities.



Health sector highlight

INCREASING SKILLED BIRTH ATTENDANCE, AT FACILITIES AND IN THE COMMUNITY



In 2001 less than 10% of women in Nepal gave birth with the help of a skilled birth attendant.¹ The issue was particularly acute in poor and marginalized populations. To improve access and ensure better outcomes, the government introduced programmes that addressed both supply and demand-side barriers to service uptake through cash incentives and support to mothers. However, the percentage of deliveries in facilities did not markedly increase.

Research found that the institutional cost of delivery remained a significant barrier.² As a result, user fees for delivery care were removed and a free delivery scheme began in 2009, offering cash incentives to mothers for completion of four ANC visits, with free delivery care and other benefits. Health staff are also incentivized to attend deliveries, and health facilities receive additional funding tied to providing delivery services. By 2011, the Nepal Demographic and Health Survey found that rates of skilled birth attendance had risen to 36%.³ Maternal and newborn care in remote areas was strengthened by the use of female community health volunteers to support mothers with practical help and advice.

Investments and initiatives outside the health sector

Women's educational status has been inversely linked with maternal and neonatal mortality in Nepal. In recent years, girls' enrolment in schools has increased, driven partly by targeted free education policies. In addition, women's and children's health has benefited from improvements in transport infrastructure, communications, water quality and sanitation, and from a multisectoral approach to nutrition.

Highlights from sectors outside of health

POLITICAL WILL AND COMMUNITY OWNERSHIP KEEPS NEPAL ON TRACK WITH HEALTH IMPROVEMENTS



Political prioritization of reproductive, maternal, newborn and child health has been central to improving women's and children's health in Nepal. The Local Self Government Act (1999) made special provision for women and other vulnerable groups. It also gave operational and management responsibility of health services to village-level committees, making community ownership a key factor in Nepal's progress. Nepal's interim constitution (2007) declared the State's commitment to the health of its people for the first time in Nepal's history.⁴ It guaranteed that "every citizen will have the right to have free basic health care services as provisioned by the State" and established health as a fundamental right of every person. This high-level political will is also seen in a sector-wide approach to health financing (2004) and participation in the International Health Partnership, which also promotes donor harmonization and sector-wide approaches.

Despite rapid turnover in leadership and political instability, the MoHP has led in policy formulation

and advocacy, promoted good coordination with health sector external development partners (EDPs) and continued its annual review and planning cycle. The health sector EDPs hold monthly coordination and joint planning meetings to ensure alignment with government priorities.

Even in an unstable environment, Nepal has enacted numerous new policies and strategies that have impacted women's and children's health. Under national long-term plans, the National Planning Commission (NPC) has a strong leadership role in coordinating EDPs' activities. For example, the 2011 Multisectoral Nutrition Plan (MSNP) was prepared by five government sectors and is led by the NPC in collaboration with EDPs. It addresses malnutrition in pregnant women and children under five years through a strategic package of interventions intended to reduce malnutrition by one third in five years, and effectively eradicate it in the long term.⁵

Ongoing challenges and future priorities

Although Nepal is on track to achieve MDGs 4 and 5, it continues to face several challenges. If addressed, the following could further accelerate progress in reducing maternal and child mortality:

- **Tackle inequalities and access to care in remote areas** – improving outreach services and quality of care, and addressing financial barriers to uptake of services e.g. transport costs.
- **Target neonatal mortality** – strengthening quality of care for newborns, backed by better provision and distribution of midwives and research into causes of neonatal deaths.
- **Improve uptake of family planning** – widening access to contraception and encouraging its use.
- **Reduce undernutrition** – prioritizing multisector coordination and collaboration.
- **Improve political accountability and democratic governance** – enabling wider participation in decision-making and reducing corruption and misappropriation.

The full Nepal Success Factors policy report and references can be found online at: <http://www.who.int/pmnch/successfactors/en/>

A World Bank Health, Nutrition and Population (HNP) note on Nepal's Progress on Maternal and Child Health is also available at: www.worldbank.org/hnppublications



PERU

Country context summary

Peru has a long Pacific coastline and borders Bolivia, Brazil, Chile, Colombia and Ecuador. Eighty per cent of its 30 million inhabitants live in the large cities of the coast, highlands and rainforest. It has over 50 recognized indigenous communities and about 16 linguistic families. For the last 15 years, the country has been politically stable, and sustained economic growth has allowed significant social progress. However, there remain significant inequalities and a large segment of the population lacks basic services.

Key trends and RMNCH gains

UNDER-FIVE MORTALITY

Between 1991 and 2013, under-five mortality decreased from 78/1000 to 21/1000 live births. This is related to the increase in health services coverage and the introduction of cost-effective interventions to prevent or treat the most important causes of child mortality. In this context, an important role has been played by the Basic Health for All Programme (PSBPT), the Project 2000 and the Health and Nutrition Project, implemented nationwide in the second half of the 90s.

MATERNAL MORTALITY

Between 1991 and 2013, maternal mortality decreased from 265/100 000 to 93/100 000 live births. This is associated with the family planning programmes implemented in the early 1990s, and the expansion of prenatal care and institutionalized childbirth. Other factors included the reduction of economic, geographic and cultural barriers, which impeded access to health services among the rural and indigenous population (see examples below).



Health sector initiatives and investments

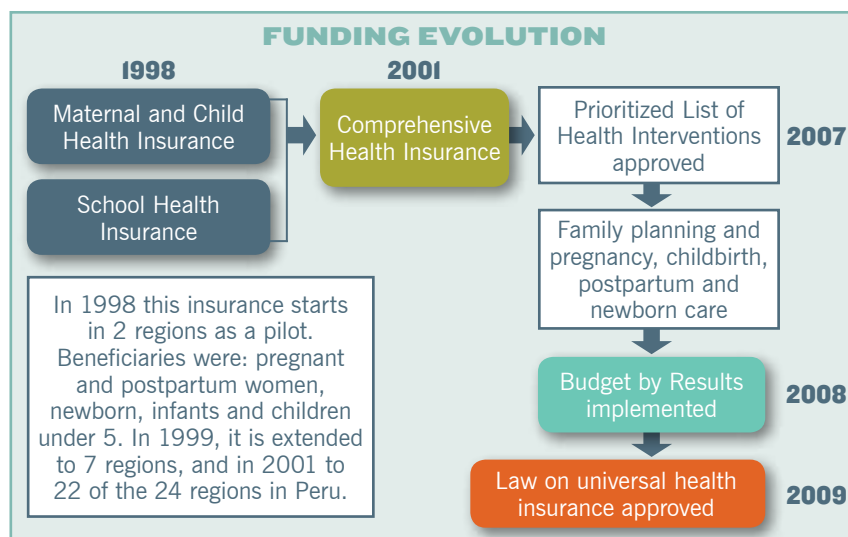
Public and private health expense per capita increased from US\$ 194 in 1995 to US\$ 496 in 2011 (PPA Int \$), with a general trend to prioritize women's health care. Significant contributions have been made to improving the quantity and quality of institutional deliveries by the Comprehensive Health Insurance, the Support Programme for Health Reform (PARSalud) and other programmes and investments. Particular emphasis has been placed on the cultural appropriateness of health services. The health and nutrition of mothers and children in Peru have benefited from implementation of the budgetary strategic programme for maternal and neonatal health and child nutrition.

Health sector highlight

REMOVING ECONOMIC, CULTURAL AND GEOGRAPHIC BARRIERS

Comprehensive Health Insurance

Comprehensive Health Insurance ("Seguro Integral de Salud" or SIS in Spanish) emerged out of School Health Insurance and Maternal and Child Health Insurance in the late 1990s. SIS provides health care for mothers and children in extreme poverty. Gradually, SIS has been consolidated and is the basis for Universal Health Insurance in Peru.¹



Cultural appropriateness of childbirth

In 2006, the Ministry of Health approved a regulation to allow women to exert the right to choose their preferred delivery position. This facilitated the adaptation of health-care facilities to accommodate vertical childbirth. The strategy has contributed to an increase in institutional delivery rates in rural areas.²



Maternal delivery waiting house

The waiting house is a temporary hostel close to a health centre, which houses pregnant women from rural and remote areas. Women can stay in these facilities with their children, and an adult companion, in the days leading up to their delivery. This strategy was developed in 1997 by the Ministry of Health, with the technical support of UNICEF and USAID, with the purpose of reducing the geographic barriers to institutional childbirth. In 2012, approximately 504 houses had been established in the rural areas of the highlands and rainforest of Peru.³ As an example of impact, in the Ayacucho district between 2005 and 2010, this scheme contributed to the halving of maternal mortality.⁴

Initiatives and investments outside the health sector

Non-health sectors and stakeholders have contributed significantly to improving women's and children's health in Peru over the past two decades. First, through the "National Agreement", all political forces recognized the need to prioritize health and nutrition for mothers and children. Second, stability and sustained economic growth allowed a larger social investment, which resulted in a reduction of poverty and extreme poverty. A significant impact on the health and nutrition of mothers and children has also been made by programmes such as: the National Water and Sanitation Programme; the "Juntos" conditional cash transfer programme; the National Literacy Programme; and the National Strategy to Combat Child Chronic Malnutrition. From 2007 to 2013, chronic malnutrition in children under five declined from 27% to 17%.

Ongoing challenges and future priorities

Although Peru is on track to achieve MDGs 4 and 5, it continues to face several challenges. If addressed, the following could further accelerate progress in reducing maternal and child mortality:

- **Reduce socioeconomic inequities** – targeting regional variations in mortality rates, and the specific issue of gender equality and intercultural aspects, particularly in the indigenous population.
- **Strengthen health systems** – focusing on improving the capacity of the health facilities to address obstetrics and neonatal emergencies; this implies human resources, equipment and supplies. Improvement of the health information system on MCH.
- **Fulfil unmet needs and address new challenges** – strategic health care interventions adequate to the ethnic, cultural and geographic context of the rural and indigenous population.

Highlights from sectors outside of health

A GOOD START IN LIFE

In 1999, a programme called A Good Start in Life ("Buen Inicio") was initiated in three regions of the Peruvian Andean highlands (Cusco, Cajamarca and Apurímac) and one region of the Amazon rainforest (Loreto). It was a collaboration between the government of Peru, USAID and UNICEF. The programme has focused on the prevention of stunting among children under the age of three, and on pregnant and lactating women. It uses community-based interventions such as: growth and development promotion; antenatal care; promotion of adequate food intake during pregnancy and lactation; exclusive breastfeeding and improved complementary feeding from six months; control of iron and vitamin A deficiency; improved early stimulation; promotion of iodized salt; and personal and family hygiene.

The programme team, led by local governments, worked with local communities, staff of health facilities and local nongovernmental organizations. Emphasis was given to the strengthening of the capacities and skills of women counsellors and rural health promoters.

In 2004, the programme covered about 75 000 children under the age of three, and 35 000 pregnant and lactating women living in 223 rural communities. A comparison between 2000 and 2004 showed that, in the communities covered by the programme, the stunting rate among children under three years of age declined from 54.1% to 36.9%, while anaemia rates declined from 76% to 52.3%.

Because of these results, Buen Inicio was made the basis for the national strategy CRECER (Creating Conditions for Economic Revitalization). This was launched in 2007 by President Garcia to combat chronic child malnutrition, and continues today through the strategy "Incluir para Crecer" (Inclusion for Growth) under President Humala's administration.⁵





RWANDA

Country context summary

Rwanda is a landlocked country in central East Africa with both mountainous terrain and plateaus, bordering Burundi, Tanzania, Uganda and Democratic Republic of Congo (DRC). After the 1994 genocide, which left two million people homeless, the government began to rebuild the country and to stimulate economic growth, with a focus on agriculture (81% of the 10.5 million population lives in rural areas) and the service sector. GDP per capita rose from US\$ 707 in 1990 to US\$ 1167 in 2012.



Key trends and RMNCH gains

UNDER-FIVE MORTALITY

Rwanda achieved an under-five mortality rate of 76/1000 live births in 2010: a reduction of 50% since 1992. This is associated with improved coverage of effective interventions to prevent or treat the most important causes of child mortality. However, neonatal mortality still accounts for 39% of all child deaths.

MATERNAL MORTALITY

Between 1992 and 2010 maternal mortality decreased from 611/100 000 to 476/100 000 live births – a reduction of 22%. From an increase in MMR to 1071 per 100 000 live births in 2000, the period 2000 and 2010 saw a reduction of 55%. This is associated with improvements in the contraceptive prevalence rate and skilled birth attendance, which increased respectively from 4% to 45% and 31% to 69% between 2000 and 2010.



Health sector initiatives and investments

The Government of Rwanda prioritized reproductive, maternal, newborn and child health (RMNCH) in the face of very high rates of maternal and child mortality after the 1994 genocide. Policies to strengthen the health system addressed a severe shortage of health workers (especially midwives), limited health infrastructure and barriers to health-care access.

Health sector highlight

COMMUNITY-BASED HEALTH INSURANCE AND PERFORMANCE-BASED FINANCING

The government established Mutuelles de santé, an innovative community-based health insurance scheme, to provide universal health care and reduce financial barriers to primary RMNCH services. The scheme was piloted in 1999 and extended nationwide in the mid-2000s; by June 2012, 90% of the population was enrolled. The scheme insures members against the risk of catastrophic out-of-pocket payments, and provides access to health care (including a standard set of RMNCH services) through 30 district-based mutuelles, district facilities and national referral hospitals. Community committees mobilize and register members, collect fees and clear health facility bills. Premiums are based on wealth categories plus a 10% co-payment for each episode of illness. A measure of the scheme's impact is that, between 2000 and 2007, growth in utilization of health services was greatest among the poorest quintile.¹

Rwanda has also implemented performance-based-financing (PBF) nationwide. This scheme financially rewards all health facilities and community health worker (CHW) cooperatives based on achievements against a number of indicators, such as the proportion of women delivering at health facilities; the percentage of children receiving a full course of basic immunizations; and other measures such as the correct use of a partograph. The PBF system incentivizes health services and referrals provided by CHWs and fosters competition between facilities and districts, since users of the PBF web database can monitor their targets against the performance of other service providers. To minimize manipulation of data and

corruption, government and community-based verification and audit systems are in place.²

Several studies show that PBF increases utilization of maternal health services, family planning coverage and numbers of institutional deliveries. Out-of-pocket health expenditure is also reduced.³



Highlights from sectors outside of health

GOOD GOVERNANCE, GENDER EQUITY AND DECENTRALIZATION



Good governance is prioritized in Rwanda's national development policies, which include zero tolerance of corruption, a national gender policy and an annual Governance Scorecard.⁴ The MoH and development partners participate in bi-annual Joint Health Sector Reviews and Health Sector Working Groups (including a RMNCH working group).

Rwanda has also instituted structures to empower women. The Rwanda Women Parliamentarian Forum advocates for policies that improve the welfare of women, and in 2006 introduced a bill to parliament on gender-based violence, which passed in 2008. Women currently hold an overall majority of seats in parliament (40% in the senate and 64% in the lower house – the highest in the world). The Women's Council, established in 1996, informs women about health and their basic rights, and includes organized structures from the grassroots to the national level.

A programme of health-sector decentralization is implemented through the Social Affairs Cluster of Ministries and the District Council, which is the decision-making and coordinating body at district level. This is supported by a monthly Joint Action Development Forum for all partners, local and international. This level of coordination is repeated at local level, and has contributed to Rwanda's ability to scale up key interventions within and outside of the health sector.

Investments and initiatives outside the health sector

The Government of Rwanda has prioritized multisector approaches in areas such as education, nutrition and water and sanitation. A strong focus on eliminating gender disparity in education has resulted in 90% of girls of primary school age being enrolled in school. Rwanda has led in the use of mobile technology, as evidenced by its RapidSMS programme that links community health workers to pregnant women.

Ongoing challenges and future priorities

Although Rwanda is on track to achieve MDGs 4 and 5, it continues to face several challenges. If addressed, the following could further accelerate progress in reducing maternal and child mortality:

- **Strengthen the midwifery workforce** – targeting 586 additional midwives to attain 95% skilled birth attendance by 2015.
- **Improve geographical access** – investing in infrastructure and equipment for underserved areas.
- **Improve quality of care** – focusing on continuous improvement, quality of care and health outcomes, and targeting newborn health.
- **Sustain focus on family planning** – addressing unmet need and adopting an integrated approach.
- **Target malnutrition** – increasing budget allocation and multisector coordination.



The full Rwanda Success Factors policy report and references can be found online at: <http://www.who.int/pmnch/successfactors/en/>



VIET NAM

Country context summary

Viet Nam is the easternmost country on the Indochinese Peninsula, bordering Cambodia, Lao PDR and China. The terrain is a mix of highlands, forests, coastal lowlands and river deltas. The Viet or Kinh ethnic group constitutes 86% of the 88.8 million population, of which about 32% are urban dwellers (up from 19.2% in 1991). In 2010, Viet Nam graduated from being classified as a low-income country to a lower-middle-income country. Its per capita income rose from US\$ 972 in 1990 to US\$ 4998 in 2012.

Key trends and RMNCH gains

UNDER-FIVE MORTALITY

Between 1997 and 2012, under-five mortality in Viet Nam declined from 58/1000 to 23.2/1000 live births. Between 1990 and 2012, infant mortality declined from 49/1000 to 15.4/1000 live births. These trends are associated with improved coverage of effective interventions to prevent or treat the most important causes of child mortality, improvements to the health workforce and socioeconomic factors.



MATERNAL MORTALITY

Between 1990 and 2009, maternal mortality declined from 233/100 000 to 69/100 000 live births. This is associated with a decline in the fertility rate from 6 in the 1970s to 4 by the early 1990s and 2 by 2000, and with an increase in the contraceptive prevalence rate from 73.9% in 2001 to 76.2% in 2012 for the 15-49 age-group. Other factors are improvements in the health workforce and increases in deliveries in facilities and skilled birth attendance.

Health sector initiatives and investments

Per capita government spending on health has increased more than five-fold since 1990, and Viet Nam has also expanded its network of health care facilities and workers. It has established a professional midwives' association, and boosted the health workforce by the targeted use of community health workers. Overall coverage of births attended by trained health workers increased from 77% in 1997 to 97.9% of births in 2012. Special programmes targeting women's and children's health implemented during the 1990s included immunization; establishment of inter-communal polyclinics; family planning promotion; and more recently an ethnic village midwife initiative to motivate women to access antenatal care and deliver at health facilities.



Health sector highlight

INVESTING IN HUMAN RESOURCES AND HEALTH FACILITIES¹

Viet Nam's health-care system was rebuilt from the late 1970s onwards after the war and reunification. It now extends from national hospitals down to primary health care facilities at commune level: 99% of communes have health centres; 93% have midwives or obstetric/paediatric assistant doctors and 76% have doctors; 84% of hamlets and villages have village health workers; and all hamlets and residential blocks have family planning collaborators.

In addition, Viet Nam has built an extensive network of village health workers supported by

health centre staff, who contribute to the delivery of preventive services. Inpatient care is largely catered for through public facilities with 980 hospitals (39 central, 331 provincial and 610 district), with an average of 24 inpatient beds per 10 000 population.

By 2012, the number of doctors or assistant doctors per 10 000 population had increased to 13 from four in 1990. In the period 2002 to 2010, the number of nurses and midwives per 10 000 population increased from eight to 10. Together these meet the WHO recommended minimum threshold of 23 doctors, midwives or nurses per 10 000 population, established as necessary to meet MDGs 4 and 5.

Health-system strengthening has supported specific policies and strategies to reduce maternal and child mortality. These include: family planning; access to safe abortions; a minimum of three antenatal care consultations; skilled birth attendance; health facility deliveries; EmONC; and reproductive health education (especially for adolescents).

Investments and initiatives outside the health sector

Enhancements to health-sustaining infrastructure and services have contributed significantly to improvements in women's and children's health in Viet Nam. Access to clean drinking water increased from 58% of the population in 1990 to 96% in 2011. In the same period, access to sanitation facilities increased from 37% of the population to 75%. Between 1990 and 2009, total primary school net enrolment increased from 87% to 97%, while secondary school enrolment more than doubled between 1993 and 1998, from 30% to 62%, and to 79% by 2006. The government has introduced a number of laws and policies to tackle nutrition issues, with support from multilateral agencies, such as WHO and UNICEF.

Highlights from sectors outside of health

MULTISECTOR EFFORTS TO IMPROVE NUTRITION^{2,3}

The government established the National Institute of Nutrition in 1980 under the Ministry of Health to improve nutrition after the war. It introduced the first National Plan of Action for Nutrition 1995-2000, and subsequent National Nutrition Strategies (2001-2010 and 2011-2020). These multisectoral strategies have all had high level endorsement by the Prime Minister and focused on improving knowledge; reducing maternal and child undernutrition; reducing micronutrient deficiencies; and improving food security at household level. The 2001-2010 strategy was linked to the Hunger Eradication and Poverty Alleviation Strategy and initiatives for safe water and environmental sanitation.

The integration of nutrition programmes and alignment of policies, stakeholders and donors across sectors have been effective in Viet Nam. The government has worked with multilateral

agencies on interventions such as: developing behaviour-change communication campaigns; promoting breastfeeding; regulating the trading and use of breastmilk substitutes; extending maternity leave from four to six months; and improving the nutrition surveillance system. The benefits of improved nutrition have been reinforced by improved sanitation (particularly a decrease in open defecation) and improved supplies of safe drinking water.

Reduction of underweight children has continued, with stunting prevalence dropping from close to 40% in 1999 to 25.9% in 2013. But reductions in stunting stalled in the mid-2000s. In 2008, the National Institute of Nutrition, with support from partners, developed the Plan of Action to Accelerate the Reduction of Child Stunting. This was subsequently incorporated into the National Nutrition Strategy 2011-2020.

Ongoing challenges and future priorities

Although Viet Nam is on track to achieve MDG 4 and MDG 5a, it continues to face several challenges. If addressed, the following could further accelerate progress in reducing maternal and child mortality:

- **Increase equitable access** – addressing financial barriers, investing in health systems in marginalized areas and strengthening communication and transportation networks.
- **Improve health service quality** – building on existing gains in maternal and child health, particularly by improving care and referrals for newborns, and targeting inaccessible populations.
- **Reduce malnutrition and stunting** – improving coordination between sectors and ministries, increasing budget allocations and upgrading routine data collection.
- **Raise youth awareness of reproductive health issues** – targeting adolescents and their specific needs to reduce unmet need for contraception.
- **Scale up sanitation and hygiene** – improving the policy, institutional and funding environment and promoting critical hygiene behaviours.

The full Viet Nam Success Factors policy report and references can be found online at: <http://www.who.int/pmnch/successfactors/en/>

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ACKNOWLEDGEMENTS

Dale Davis, Purusottam Dhakal, J.R. Dhakwa, Bhogendra Raj Dotel, Kapil Gyawali, Robin Houston, Hari Koirala, Preeti Kudesia, Rajendra Kumar BC, Jit Ram Lama, Susheel Lekhak, Clifford Lubitz, Mangala Mananadhar, Baburam Marasini, Praveen Mishra, Tara Nath, Peter Oylo, Badri Raj Pandey, Laxmi Raj Pathak, Ramji Pathak, Krishna Paudel, Latika Maskey Pradhan, Radha Krishna Pradhan, YV. Pradhan, Carole Presern, Asha Pun, Pooja Pandey Rana, Kiran Regmi, Edwin Salvador, Sunil Raj Sharma, Gyanendra Shrestha, Surya Kumari Shrestha, Ishwori Shrestha, Dependra Raman Singh, Chahana Singh, Shanda Steimer, Anjana KC Thapa, Meera Upadhyay, Senendra Raj Upreti, Shyam Raj Upreti, Naimy Zainab.

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Bui Thu Ha, Craig Burgess, Do Phuong Ha, Socorro Escalante, Hoang Thi Bang, Kari Hurt, Susan Jack, Le Bach Mai, Luu Thi Hong, Nghiem Xuan Hanh, Nguyen Duc Vinh, Nguyen Kim Phuong, Nguyen Thanh Huong, Nguyen Thi Mai, Phan Thi Le Mai, Ton Tuan Nghia, Tran Tuan, Tran Thu Ha.

Technical support from regional and international partners: Prima Alam, Jamela Al-Raiby, Sharon Arscott-Mills, Sarah Bandali, Sadia Chowdhury, Rafael Cortez, Bernadette Daelmans, Andres de Francisco, Jennifer Franz-Vasdeki, Sameh El-Saharty, Susan Harmeling, Rachael Hinton, Susan Jack, Gael Kernen, Nicole Klingen, Shyama Kuruvilla, Rawal Lal, Haifa Madi, Akiko Maeda, Blerta Maliqi, Alaa Mahmoud Hamed Abdel-Hamid, Syed Masud Ahmed, Elizabeth Mason, Lori McDougall, Tigest Mengestu, John Murray, Carol Nelson, Deborah Neveleff, Triphonie Nkurunziza, Ana Cristina Nogueira, Hiromi Obara, Carole Presern, Seemeen Saadat, Intissar Sarker, Howard Sobel, Gina Tambini, Pritha Venkatachalam, Albertus Voetberg, Shiyong Wang, Martin Weber, Shuo Zhang.

Please note these Acknowledgements list those who directly participated in the country multistakeholder reviews. Others who have provided significant technical and logistical inputs to the Success Factors studies include colleagues at WHO and H4+ partner organisations, academic institutions including Johns Hopkins University, Bloomberg School of Public Health, University of St Gallen and London School of Hygiene and Tropical Medicine, and consulting groups including Options Consultancy, Cambridge Economics Policy Associates and Global Health Insights. The full list of the Success Factor Study Groups and contributors is available online at:
<http://www.who.int/pmnch/knowledge/publications/successfactors/en/>

Design and graphics: Roberta Annovi and MamaYe-Evidence for Action.

Editing: Richard Cheeseman, Robert Taylor Communications.

Photo credits: page 6, The World Bank/Dominic Chavez World Bank; page 7, The World Bank/Aisha Faquir; page 8, Flickr Creative Commons License/Maxime Guilbot; page 9, UNFPA/Ellen Krijgh; page 10, Department for International Development/Leonard Tedd; page 11, The World Bank/Bart Verweij; page 12, The World Bank/Scott Wallace; page 13, © UNICEF/HQ06-0969/Shehzad Noorani; page 14, The World Bank/Scott Wallace; page 15, UN Photo/Pernaca Sudhakaran; page 16, WHO/Stephenie Hollyman; page 17, UN Photo/J Mohr; page 18, The World Bank/Steve Harris and The World Bank/Liang Qiang; page 19, WHO/TDR/Simon Lim; page 21, © 2004 Deborah Doyle, Courtesy of Photoshare; page 22, WHO/Heba Farid; page 23, Flickr Creative Commons License/Ernesto Graf; page 24, Department for International Development/Yasmin Abubeker and © WaterAid/Anna Kari; page 25, USAID Ethiopia/Nena Terrell; page 26, UN Photo/Eskinder Debebe; page 27, The World Bank/Bart Verweij; page 28, UNFPA/Douangchanh Xaymounvong; page 30, USAID/Valerie Caldas and Department for International Development/Robert Stansfield; page 31, WHO/Christopher Black; page 33, UN Photo/J Frank; page 34, ©UNICEF Perú; page 36, Flickr Creative Commons License/Ivo Posthumus and Department for International Development/Tiggy Ridley; page 37, UN Photo/Eskinder Debebe; page 38, © UNICEF/RWAA2011-00075/Shehzad Noorani; page 39, The World Bank/Chau Doan; page 40, UNFPA/Nguyen Thi Hong.

Some low- and middle-income countries are accelerating progress towards Millennium Development Goals (MDGs) 4 and 5 (to improve maternal and child health). How have they done this? And why, with similar resources, have others struggled to make progress? These questions strike at the heart of how countries can accelerate progress to achieve the MDGs and shape transformative strategies for 2015 and beyond.

To find answers, the Partnership for Maternal, Newborn & Child Health, World Health Organization, World Bank and Alliance for Health Policy and Systems Research closely collaborated with governments, academic institutions and other partners on a three-year series of multidisciplinary studies on “Success Factors for Women’s and Children’s Health”.

Analysing 20 years of data from 144 low- and middle-income countries, the studies included multistakeholder policy reviews in 10 countries that are on the fast-track to reducing maternal and child mortality ahead of comparable countries. The 10 countries are: Bangladesh, Cambodia, China, Egypt, Ethiopia, Lao PDR, Nepal, Peru, Rwanda and Viet Nam. This publication highlights some of their key achievements, and flags up promising strategies for the future.

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ISBN 978 92 4 150747 9

