WHEC UPDATE
Briefings of worldwide activity of Women's Health and Education Center (WHEC)
February 2014; Vol. 9, No. 2

Annual Project Report

What is universal health coverage? We all talk about it, need it, want it and it is right thing to do. Universal health coverage is the goal that all people obtain the health services they need without risking financial hardship from unaffordable out-of-pocket payments. It involves coverage with good health services – from health promotion to prevention, treatment, rehabilitation and palliation – as well as coverage with a form of financial risk protection. Another feature is universality – coverage should be for everyone. In essence, universal health coverage is the obtainment of good health services de facto without fear of financial hardship. It cannot be obtained unless both health services and financial risk protection systems are accessible, affordable and acceptable.

Improving access is one such step. Services must be physically accessible, financially affordable and acceptable to patients if universal health coverage is to be obtained. The requirement that services be physically accessible is fulfilled when these are available, of good quality and located close to people. Service readiness is said to exist when the inputs required to produce the services, e.g. buildings, equipment, health personnel, health products, and technologies are also available and of good quality. Financial affordability can be improved by reducing direct, out-of-pocket payments through insurance pre-payments and pooling – the collection of government revenues and/or health insurance contributions to fund health services – or through demand-side stimuli such as conditional cash transfers and vouchers. Social and cultural accessibility can be enhanced by ensuring that health workers and health system more generally treat all patients and their families with dignity and respect.

Universal health coverage is not possible without universal access, but the two are not the same. Access has three dimensions: physical accessibility; financial affordability; and acceptability. Addressing the broader social determinants of health will also improve access to health services; differences in access in particular will be ameliorated by reducing poverty and income inequalities. Improvements in education will raise the average income, make health services more affordable and equip people with the awareness needed to demand and obtain the health services they need.

Efforts to address these social determinants will help to reduce inequalities in income, service affordability and access to services, and this, in turn, will help to attenuate differences in health service coverage and in financial risk protection.

Universal access, although necessary, is not sufficient. Coverage builds on access by ensuring actual receipt of services. Thus, access to health coverage and universal access to health services are complementary ideas. Without universal access, universal health coverage becomes and unreachable goal. More recently, attention has shifted to just what the goal should be: whether universal coverage or universal access. Many authors in ***WomensHealthSection.com*** have focused on this question. I hope you find the information helpful to attain universal health coverage and universal access in your region.

Acceptability captures people's willingness to seek services. It is low when patients perceive services to be ineffective or when social and cultural factors such as language or the age, sex, ethnicity or religion of the health provider discourage them from seeking services.

Join our efforts to attain universal health coverage and universal access.

Making Healthcare Affordable

Rita Luthra, MD

2013 In Review - A Promise Renewed

WHEC would like to thank the authors and experts who donated their time and expertise this year to serve as peer reviewers and contributors. The editorial board invites interested experts to participate in the blinded peer-review process for the *Journal* – ***WomensHealthSection.com***. The reputation of *Journal* depends on the contributions of authors. But the standard of the *Journal,* the level of excellence, is also a consequence of the efforts of expert reviewers who evaluate submitted manuscripts and determine their appropriateness. There are many others who deserve credit are unsung heroes who serve on an ad hoc basis, responding to our requests for their expert analyses. We are indebted to our ad hoc reviewers throughout the world for the thoughtful comments that are integral to the eventual end product. We have added new features and changed formats, but always with the objective of how the information in the *Journal* would help the practicing healthcare providers.

To advance Every Woman Every Child, a strategy launched by United Nations Secretary-General Ban Ki-moon, Women's Health and Education Center (WHEC), and other UN organizations are joining partners from the public, private and civil society sectors in a global movement to accelerate reductions in preventable maternal, newborn and child deaths.

To meet the goals of - A Promise Renewed, our efforts must focus on scaling up essential interventions through the following three priority actions:

1. Evidence-based country plans: Governments will lead the effort by setting and sharpening their national action plans, assigning costs to strategies and monitoring five-year milestones. Development partners can support the national targets by pledging to align their assistance with government-led action plans. Private sector partners can spur innovation and identify new resources for maternal and child survival. And, through action and advocacy, civil society can support the communities and families whose decisions profoundly influence prospects for maternal and child survival.

2. Transparency and mutual accountability: Governments and partners will work together to report progress and to promote accountability for the global commitments made on behalf of women and children. WHEC and partners will collect and disseminate data on each country's progress. A global monitoring template, based on the indicators developed by the UN Commission on Information and Accountability for Women's and Children's Health, has been developed for countries to adapt to their own priorities. National governments and local partners are encouraged to take the lead in applying the template to national monitoring efforts.

3. Global communication and social mobilization: Governments and partners will mobilize broad-based social and political support for the goal of ending preventable maternal and child deaths. As part of this effort, the search for small-scale innovations that demonstrate strong potential for large-scale results will be intensified. Once identified, local innovations will be tested, made public, and taken to scale. By harnessing the power of mobile technology, civil society and the private sector can encourage private citizens, especially women and young people, to participate in the search for innovative approaches to maternal and child survival.

In support of *A Promise Renewed*, WHEC is publishing yearly reports on maternal and child survival to stimulate public dialogue and help sustain political commitment. This year's report presents:

Trends and levels in maternal mortality and under-five mortality over the past two decades:

- Causes of and interventions against maternal and child mortality;
- Brief examples of countries that have made radical reductions in maternal and child deaths over the past two decades;
- A summary of the strategies for meeting the goals of A Promised Renewed.
- Statistical tables of child mortality and causes of under-five deaths by country and UNICEF regional classification.

The analysis presented in this report provides a strong case for proceeding with optimism. The necessary interventions and know-how are available to drastically reduce maternal and child deaths in the next two decades. The time has come to recommit to maternal and child survival and renew the promise.

Create a Page/Space in ***WomensHealthSection.com!***
Get the Big Picture!

It served **12.2 million** readers / subscribers in 225 countries and territories with an average of about 1 million visitors / subscriber per month in 2013 with links to about 65,000 websites and 95-102 search strings every month. On average 112,000 files, 7,600 URLs and 18,600 pages were accessed every month. It expanded from 22 to 28 sections and we hope to continue to grow. In the spirit of growth in this digital age, it was upgraded in 2013 for global dissemination. We have rearranged content so that it is easier for you to find what you need. We welcome your feedback and hope you find the *Journal* to be useful – a continuing mission.

Top 15 Countries out of 225 Countries and Territories, where **WHEC Global Health Line** / **WHEC Net Work** is accessed frequently: USA; Canada; China; Australia; Argentina; Russian Federation; Saudi Arabia; Belgium; U.K.; Germany; Venezuela; Spain; India; Mexico; and France.

Top 5 Groups out of 25 groups for educational purposes: US Educational; US Commercial; US Government; US Military and International (Int).

Top 5 User Agents out of 784: Microsoft (MSIE 8.0, 6.0 and 9.0); Google (Googlebot / 2.1 and / imgres); Yahoo (Yahoo! Slurp and Yahoo! Slurp China); MSN (msnbot-media); bingbot/2.0

Top 5 most popular sections out of 28: 1) Obstetrics; 2) WHEC Update; 3) Gynecologic Oncology; 4) Gynecology; 5) Diagnostic Ultrasound.

Top 10 most read comprehensive review articles out of 230 *Practice Bulletins*: 1) End of Life Decision Making; 2) Psychiatric Disorders During Pregnancy; 3) Female Sexual Dysfunction; 4) End-of-Life Care: Pain Assessment and Management ; 5) Stillbirth: Evaluation and Management ; 6) Medical Liability: Risk Management; 7)Medical Liability: Tort Reform; 8) Medical Liability: Coping With Litigation Stress 9) Sexual Violence 10) Exercise during Pregnancy and Postpartum

Beneficiaries: Visitors of *WomensHealthSection.com* (more than 100 million readers / subscribers so far worldwide and growing fast)

Looking forward to 2014!

You dream it.
We'll create it.

A Promise Renewed

Your Questions, Our Reply

Can I sleep well at night secure in the knowledge that if anything happens to me or a member of my family, good health services will be accessible and affordable, that is, obtainable without risk of a severe and long-term impact on my financial well-being?

Our Efforts for Universal Health and Access: The first aspect of universal health coverage (use of needed services of good quality) corresponds closely to the concept of effective coverage, i.e. the probability that an individual will get an intervention that they need and experience better health as a result.

This concept can be disaggregated into the following elements:

- Reducing the gap in a country's population between the need for services and the use of those services, which implies that: (i) all persons who need an intervention are aware of their need; and (ii) all persons who are aware of their need are able to use the services that they require;

- Ensuring that services are of sufficient quality to increase the likelihood that they will improve (or promote, maintain, restore, etc., depending on the nature of the intervention) the health of those who use them.

Measuring effective coverage across all services and the entire health system is not feasible. To date, this has been done only in the case of individual health conditions and interventions, such as immunization coverage or hypertension control; a specific set of interventions within one aspect of care, such as maternal and neonatal health interventions; or a wide but still limited set of interventions. Despite this difficulty with measurability, the concept of effective coverage is useful for orienting health policy.

Towards action on universal coverage - Health financing for universal health coverage reflects how health financing arrangements (and reforms to these) can influence universal health coverage goals and intermediate objectives.

In The World Health Report 2010, three broad strategies were summarized as:

- "More money for health" (raising more funds);
- "Strength in numbers" (larger pools); and
- "More health for the money" (improving efficiency and equity in the use of funds through reforms in purchasing and pooling as well as actions not directly related to health financing).

Universal coverage can be justified from a political perspective as a reflection of underlying values such as social cohesion, the belief in every individual's right to the highest attainable level of health, or as a "right to health" or "right to equitable access to health services", specified in many national constitutions.

Universal means universal. The appropriate unit of analysis when planning or analyzing reforms is the entire population. How a particular financing scheme affects its members is not of interest per se; what matters is how the scheme influences universal health coverage goals at the level of the entire population. A concern only with specific schemes is not a universal coverage approach in our initiatives. Schemes can contribute to system-wide universal health coverage goals, but they need to be explicitly designed to do so. Otherwise, increased population coverage with health insurance can actually become a potential obstacle to progress towards universal health coverage.

"Health financing for universal coverage" implies that reforms in collection, pooling, purchasing and benefit design are aimed specifically at improving one or several of those objectives and goals, as measured at the population or system level. All health financing systems perform these functions, and this is why, every country can do something to move towards universal health coverage.

United Nations At A Glance

United Nations Economic Commission for Africa

Africans must seek growth that is primarily anchored on their priorities and that is capable of delivering structural transformation

Established by the Economic and Social Council (ECOSOC) of the United Nations (UN) in 1958 as one of the UN's five regional commissions, ECA's mandate is to promote the economic and social development of its member States, foster intra-regional integration, and promote international cooperation for Africa's development.

Made up of 54 member States, and playing a dual role as a regional arm of the UN and as a key component of the African institutional landscape, Economic Commission for Africa (ECA) is well positioned to make unique contributions to address the Continent's development challenges.

ECA's strength derives from its role as the only UN agency mandated to operate at the regional and sub-regional levels to harness resources and bring them to bear on Africa's priorities. To enhance its impact, ECA

places a special focus on collecting up to date and original regional statistics in order to ground its policy research and advocacy on clear objective evidence; promoting policy consensus; providing meaningful capacity development; and providing advisory services in key thematic fields.

ECA also provides technical advisory services to African governments, intergovernmental organizations and institutions. In addition, it formulates and promotes development assistance programs and acts as the executing agency for relevant operational projects. Specialized regional advisory services and meaningful capacity development support to member States is provided in the following priority areas:

- Promotion of industrialization;
- Design and implementation of macroeconomic policy;
- Design and articulation of development planning;
- Supporting mineral resources contract negotiations;
- Promoting the proper management of natural resources for Africa's transformation.

Details: http://www.uneca.org/pages/overview

Collaboration with World Health Organization (WHO)

WHO | Algeria

Algeria WHO Country Office

The mission of the WHO Algeria Country Office is to promote the attainment of the highest sustainable level of health by all people living in Algeria through collaboration with the government and other partners in health development and the provision of technical and logistic support to country programmes.

Maternal mortality ratio (per 100 000 live births)

Rationale for use: complications during pregnancy and childbirth are leading causes of death and disability among women of reproductive age in developing countries. Maternal mortality ratio (MMR) represents the risk associated with each pregnancy, i.e. the obstetric risk. It is also an MDG indicator for monitoring goal 5 of improving maternal health.

Definition: number of maternal deaths per 100 000 live births during a specified time period, usually one year.

Methods of estimation: measuring maternal mortality accurately is difficult except where comprehensive registration of deaths and their causes exist. Else-where, censuses or surveys can be used to measure levels of maternal mortality. Data derived from health services records are problematic where not all births take place in health facilities because of biases whose dimensions and direction cannot be determined.

Reproductive-age mortality studies (RAMOS) use triangulation of different sources of data on deaths of women of reproductive age including record review and/or verbal autopsy to accurately identify maternal deaths. Based on multiple sources of information, RAMOS is considered the best way to estimate levels of maternal mortality. Estimates derived from household surveys are usually based on information retrospectively collected about the deaths of sisters of the respondents and could refer back up to an average 12 years and they are subject to wide confidence intervals. For countries without any reliable data on maternal mortality, statistical models are applied. Global and regional estimates of maternal mortality are developed every five years, using a regression model.

Details: http://www.who.int/countries/dza/en/

WHO Reproductive Health Update

Conscientious objection to the provision of reproductive health care

Photo: R. Johnson

Conscientious objection is when healthcare professionals or institutions exempt themselves from providing or participating in care on religious and/or moral or philosophical grounds. While other barriers also hinder women's right to obtain reproductive health services, conscientious objection is unique because of the tension existing between protecting and fulfilling women's rights and health service providers' rights to exercise their moral conscience. This special supplement examines the prevalence, health consequences, and policy responses of conscientious objection and refusal to provide reproductive healthcare and includes commentaries on ethical and human rights obligations of States and service providers. HRP staff (and former staff) contributed a commentary on "Conscientious objection to provision of legal abortion".

Open access to the supplement

Bulletin of the World Health Organization; **Complete list of contents for Volume 92, Number 2, February, 77-152**

Collaboration with UN University (UNU)

UNU-WIDER (World Institute for Development Economics Research) *Expert Series on Health Economics:*

Aid and poverty: Why does aid not address poverty (much)?

Aid is not generally aimed at the poorest people, though most multilateral or bilateral agencies would like to think they get included. However, donors' strategies are generally blind to differentiation among the poor, and have not improved in this respect. The special provisions for the least developed countries, where many of the poorest people live, have not worked well. Aid to conflict-affected countries is itself in crisis. Much greater and more integrated aid is called for in both cases. Middle-income countries are themselves becoming donors, but the poorest populations of these countries have benefited from international partnerships which draw attention to the poorest and help foster innovative policy responses. Equity is far from being a strong principle of aid givers UNICEF is the exceptional agency. The human rights based approach to development, which would give much greater weight to the poorest, in practice languishes at the margins of development, though where this has been taken up in middle-income countries (e.g., India) donors have stood on the sidelines. Explanations of this fairly dismal state of affairs are offered in terms of political economy and organizational and profession incentives. Finally the paper sketches a set of issues which need to be incorporated into the post 2015 framework and its preparation if poverty is to be taken more seriously by donors.

The assumption throughout this conclusion is that the post-2015 development framework is an important moment for the eradication of poverty. To the extent the preparatory discussion and UN resolutions in 2015 are directed at (and probably by) developing countries, there is a chance this may be the case, since it is in developing country policies and programs that a substantial difference can be made. To the extent it is directed by and for international donors this may be less so, unless they change their ways and really focus deeply on eradicating absolute poverty. So far the focus of much aid has been superficial. The greater danger is that developing country governments and donors are already focused on a whole range of other 'goods'—economic growth, responses to climate change, democracy—and that poverty eradication will continue to get short shrift.

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ReCom. UNU-WIDER also gratefully acknowledges core financial support to its work program from the governments of Denmark, Finland, Sweden, and the United Kingdom.

(Details of the paper can be accessed from the link of UNU-WIDER on CME Page http://www.womenshealthsection.com/content/cme/)

United Nations Girls' Education Initiative (UNGEI)

The Effort to Advance the Global Strategy (Continued)

Global Partnership for Education Grants More than Half a Billion US Dollars for Quality Education for Children in 14 Low-income Countries

The Board of Directors of the Global Partnership for Education approved US$549 million in grants to 14 developing countries, providing critical funding and momentum toward quality education for all children. This new financing strongly reflects the Global Partnership's top priorities: increasing access to basic education in fragile states, improving the quality of education, improving teachers' effectiveness, generating measurable results and championing girls' education. The Board of Directors also confirmed that the Global Partnership for Education's next replenishment pledging conference will be held in Brussels on June 26, 2014. European Development Commissioner Andris Piebalgs recently announced that the European Union will host the replenishment conference.

Along with the approval of US$482 million earlier this year, the Board of the Global Partnership has approved a record amount of over US$1 billion in education grants to 27 countries in 2013. Yet, the demand for education funding, which the Global Partnership receives from its low-income partner countries, far exceeds this amount, showing these countries' strong commitment to education. At the same time, external aid commitments to basic education dropped by 16% between 2010 and 2011. The 14 new grants build on prior achievements and will help implement the national education plans developed by Cambodia, Cameroon, Central African Republic, Djibouti, Eritrea, Ethiopia, Gambia, Kyrgyz Republic, Niger, Sao Tome and Principe, Sierra Leone, Somalia, Tanzania and Uganda.

Cambodia will receive a grant of US$38.5 million to improve access to and quality of basic education, in particular by expanding access to early childhood education and for disadvantaged children.

Cameroon's grant of US$53.3 million will focus on improving education service delivery in the early grades by supporting the conversion of community-paid teachers to contract teachers. It will also help to provide teaching and learning materials to schools, particularly in disadvantaged areas.

The Central African Republic will receive a grant of US$3.69 million through GPE's accelerated funding process to address urgent education needs in this conflict-affected country. The focus will be on restarting the national education system through repairing and equipping schools and supporting community-funded teachers, which will reduce parents' contributions.

Djibouti will receive a grant of US$3.8 million to construct and rehabilitate classrooms; improve early childhood development, early grade math, teacher training and student assessment.

Eritrea's grant of US$25.3 million will help children from disadvantaged communities gain access to school to receive and complete a quality education. The grant will focus on increased equitable access to basic education, improving the quality of teaching and learning, and strengthening the management and monitoring capacity of the Education Ministry.

Ethiopia will receive a grant of US$100 million to support the second phase of its General Education Quality Improvement Program (GEQIP). GEQIP includes key measures to improve the quality of basic education through curriculum reform, textbooks, learning assessment, teacher development, school improvement, capacity building, and the use of information and communication technology.

The Gambia will receive a grant of US$6.9 million to improve the quality of teaching and learning in primary schools, build new schools and strengthen the governance and management of the country's education system.

The Kyrgyz Republic will receive a grant of US$12.7 million focusing on increasing equitable access to pre-school education and improving the quality of learning. The funding will be nationwide and specifically target areas with vulnerable populations.

Niger's grant of US$84.2 million will help increase access to basic education in an equitable way and reduce the cost of school attendance to families. It will also focus on girls' education, school feeding interventions, and will help improve the quality of teaching and learning with a stronger focus on literacy and numeracy.

Sao Tome and Principe will receive a grant of US$1.1 million to improve teaching practices in primary schools through a new system of teacher training and the development of a system to assess student learning.

Sierra Leone will receive a grant of US$17.9 million to improve learning outcomes through results-based school grants and pilots for early childhood education. The funding will also strengthen education service delivery through improved teacher management, better measurement of learning outcomes and consistent school data collection.

Somalia's grant of US$6.8 million will support the training of 1,000 newly recruited teachers in South Central Somalia, develop a system for teacher salary payments and provide incentive payments for teachers with particularly low salaries.

Tanzania's grant of US$94.8 million will help improve literacy and numeracy in basic education, support non-formal basic education, early childhood development, and strengthen education coordination, planning and management.

Uganda will receive a grant of US$100 million to improve teacher and school effectiveness in the public primary education system, specifically with a focus on new approaches for early reading and numeracy and improved school facilities and accountability.

To be Continued……..

Top Two-Articles Accessed in January 2014

1. Healthy Mother Healthy Infant Through Nutrition;
   http://www.womenshealthsection.com/content/obs/obs029.php3
   WHEC Publications. Special thanks to WHO, NIH and US Office of Dietary Supplement for contributions and writers and editors for compiling the review.

2. Health Literacy, e-Health and Sustainable Development;
   http://www.womenshealthsection.com/content/heal/heal017.php3
   WHEC Publications. Grant provided by WHEC Initiatives for Global Health. Special thanks to reviewers for helpful suggestion.

From Editor's Desk

e-Institute

Reproductive Health: From Advocacy to Action

Over the last two decades, important changes have occurred in the policy and program environment for work on population and reproductive health. These changes embody renewed international commitments to human rights and gender equity as well as recognition of changing economic, demographic and epidemiological conditions in countries. The commitments were agreed during the series of international conferences and summits that took place during the 1990s, including the International Conference on Population and Development in Cairo (ICPD), the Fourth World Conference on Women (FWCW) and the Social Summit.
A key accomplishment of these conferences was to establish measurable goals towards which governments and development agencies could focus their efforts to improve the health and welfare of poor people around the world. Follow-ups to these conferences further sharpened global attention on outcomes expressed as the Millennium Development Goals (MDGs). Later discussions identified key challenges that governments and agencies face in their efforts to implement commitments made at the conferences. Chief among these challenges are shortfalls in financial support for needed actions, lack of implementation capacity in countries, and the rapidly changing policy and program environments in which the work must be done.

Details about e-Institute: http://einstitute.worldbank.org/ei/

Words *of* Wisdom

Slavery was not born of racism; rather, racism was the consequence of slavery.

– Dr. Eric Eustace Williams; 1st Prime Minister of Trinidad and Tobago (1962-1981)

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Monthly newsletter of WHEC designed to keep you informed on the latest UN and NGO activities

http://www.womenshealthsection.com/