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Regional progress in survival of newborns, children and mothers: Moving towards Global Strategy targets

The Region achieved significant reduction in mortality among women, newborns and children in the Millennium Development Goals (MDG) phase. Further reduction has continued in the Sustainable Development Goals (SDG) phase. Reduction in maternal mortality in the South-East Asia (SEA) Region (69% between 1990 and 2015) is the highest among all WHO regions. The SEA Region has reduced child mortality by 67% since 1990 and achieved the MDG4 target in 2016; however, decline in neonatal mortality has been relatively slow (57%).

Progress in mortality reduction was possible only because of sustained national commitment and continued domestic investment by Member States of the Region. Seven Member States achieved the MDG4 and three Member States achieved the MDG5A targets by 2015. All Member States continue to remain committed and geared up towards achieving the ambitious SDG targets.

WHO has worked closely with Member States to strengthen actions to end preventable maternal and child mortality with a focus on newborn mortality. The Regional Flagship for Ending Preventable Mortality has been instrumental in catalysing action in these high-priority Member States. The regional strategic frameworks supported the updating of national strategies and plans to increase coverage and address inequities, thus accelerating reduction in mortality in the past five years. The Regional Office has convened the Regional H6 Working Group involving other UN agencies to ensure harmonized and collaborative efforts, and galvanized joint support to Member States.

The Meeting of Parliamentarians held during 26–27 July 2018 witnessed lawmakers and champions from Member States rededicate their commitment to enhancing efforts towards ending preventable maternal and child mortality and reducing stillbirths. They also focused on adolescent health and achieving the Global Strategy objectives.

The attached Working Paper was presented to the High-Level Preparatory (HLP) Meeting for its review and recommendations. The HLP Meeting reviewed the paper and made the following recommendations for consideration by the Seventy-first Session of the Regional Committee:

REGIONAL COMMITTEE DOCUMENT

Actions by Member States

- Continue to work using an integrated approach with reproductive, newborn, maternal, child and adolescent health (RMNCAH) programme activities remaining at the heart of universal health coverage through increased accessibility for women, children and adolescents, and ensuring quality of care while "leaving no one behind".
- Devote particular attention to address wealth and social inequities by financial protection and innovative mechanisms to improve the access to quality essential services for underserved populations.
- Continue to ensure that national commitments are sustained and that there is provision of enhanced domestic resources - including financial, human resources - and essential supplies through greater allocation of domestic budgets.

Actions by WHO

- Continue to provide strategic guidance and technical support for addressing gaps in coverage, quality and accountability, towards further acceleration of processes to reduce maternal, neonatal and child mortality and towards achieving the "thrive" objective.
- Support capacity-building in monitoring of programmes and resource mobilization for RMNCAH programme activities in the countries

This working paper and the HLP Meeting recommendations are submitted to the Seventy-first Session of the WHO Regional Committee for South-East Asia for its consideration.

Introduction

1. The WHO South-East Asia (SEA) Region has moved towards the goal of ending preventable mortality among women, children and newborns. The Region as a whole was able to reach the MDG4 target for the under-5 mortality rate of 39 deaths per 1000 live births in 2016, within one year of the MDG end-date of December 2015, with Seven Member States of the Region achieved the MDG4 target. Over the same period, reduction in the neonatal mortality rate (NMR) was relatively slower, with the Region achieving a 57% decline in neonatal mortality between 1990 and 2016.

2. The SEA Region also experienced a significant reduction in the maternal mortality ratio (MMR) of 69% between 1990 and 2015, based on the latest global maternal mortality estimates of 2015 – the highest MMR reduction among all WHO regions. MMR in the SEA Region declined from 525 in 1990 to 164 per 100 000 live births in 2015.

3. National commitment and resolve to ending preventable mortality led to this achievement, despite persisting challenges related to economic development and health system constraints in the Member States of the Region.

4. This progressive reduction in maternal and child mortality is a good start to the journey towards achieving the more ambitious 2030 targets under the Global Strategy for Women's, Children's and Adolescents' health (Global Strategy) and SDG3. The average reduction in global MMR is targeted at 70/100 000 live births by 2030, as per the Ending Preventable Maternal Mortality (EPMM) target, and no Member State should be left with an MMR more than 140/100 000 live births by 2030. To achieve the global target of 70 per 100 000 live births or less, all Member States should reduce the MMR by at least two thirds of their 2010 level. The respective country targets for under-5 mortality are 25 per 1000 live births, for neonatal mortality 12 per 1000 live births, and stillbirth 12 per 1000 births by 2030.

5. The Regional Flagship on Ending Preventable Maternal, Newborn and Child Mortality, which addresses the unfinished MDG agenda, provides a much-needed sense of urgency for action in Member States. The South-East Asia Region (SEAR)-Technical Advisory Group (TAG) for women's and children's health constituted by the Regional Director has provided additional strategic guidance through its deliberations and recommendations to Member States and partner agencies to undertake prioritized actions for ending preventable maternal, newborn and child mortality. A Regional Working Group (H6 RWG) of H6 agencies – UNICEF, UNFPA, UN Women, UNAIDS, World Bank and WHO – has been convened to provide coordinated and harmonized support for reproductive, maternal, newborn, child and adolescent health (RMNCAH) in Member States of the Region.

6. The Global Strategy 2016–2030 has moved beyond ending preventable mortality and articulated the three main objectives of "Survive", "Thrive" and "Transform". These include a wide array of health and development targets across the life-course continuum of RMNCAH.

WHO continues to work with Member States in collaboration with H6 agencies to plan and move towards this broad agenda of the Global Strategy as well as SDGs.

Current situation, response and challenges

Reduction in neonatal and child mortality

7. The global child mortality estimates based on 2016 data by the United Nations Inter-agency Group for Child Mortality Estimation (UN IGME 2017) based on 2016 data confirmed that the Region had achieved the MDG4 target for under-5 mortality by reaching the level of 39 per 1000 live births, which marks a two third reduction from the baseline level of 119 per 1000 live births in 1990. This means a 67% reduction in under-5 mortality in the Region between 1990 and 2016. This is significant as it translates into saving the lives of an additional 3.2 million children in the Region in 2016 compared with the corresponding figures for 1990. During this period, the newborn mortality rate declined by 57%, indicating that about 1.2 million additional newborns were saved in the Region in 2016 compared with 1990.

8. Neonatal mortality contributes to a little less than 60% of under-5 mortality, with complications associated with prematurity being the topmost cause of child deaths. Further analysis of the major causes of death among children in high-priority Member States with high levels of child mortality – Bangladesh, India, Indonesia, Myanmar, Nepal and Timor-Leste – suggests that pneumonia and diarrhoea are the major causes of post-neonatal mortality. Presently, pneumonia is the second-most common cause of under-5 mortality following prematurity in the Region.

Progress in reducing neonatal and child mortality towards SDG target 2030

9. Table 1 summarizes the current status and estimated future projections (based on average annual reduction or AAR) in child and neonatal mortality. It is observed that, according to 2016 estimates, the Democratic People's Republic (DPR) of Korea, Maldives, Sri Lanka and Thailand have already achieved the SDG under-5 mortality target of 25 deaths or less per 1000 live births, and the newborn mortality target of 12 deaths or less per 1000 live births. At the current rate of progress, the Region as a whole and all its Member States (except Myanmar and Timor-Leste) are likely to achieve the SDG target for under-5 mortality by 2030. However, at the current rate of progress, the Region will be able to achieve the SDG target for neonatal mortality (12 per 1000 live births) only after 2030.

Table 1: Current status and future projections of under-5 mortality and newborn mortality (estimates)

	Under-5 mortality rate (U5MR)				Neonatal mortality rate (NMR)			
	U5MR (per 1000 live births)	MDG target 2/3 reduction (%)	Annual rate of reduction (%)	Likelihood of reaching SDG U5MR target of 25 deaths or less per 1000 live births with current AAR	NMR (per 1000 live births)	Decline in NMR slower than U5MR	Neonatal share of U5MR has increased	Likelihood of reaching SDG NMR target of 12 deaths or less per 1000 live births with current AAR
	2016	1990–2016	1990–2016	With current trends	2016	2016	2016	With current trends
Bangladesh	34	76	5.5	By 2030	20	69%	59%	By 2030
Bhutan	32	75	5.3	By 2030	18	58%	56%	By 2030
DPR Korea	20	53	3.0	Already achieved	11	48%	55%	Already achieved
India	43	66	4.1	By 2030	25	56%	58%	By 2030
Indonesia	26	69	4.5	By 2030	14	53%	54%	By 2030
Maldives	9	90	9.2	Already achieved	5	88%	56%	Already achieved
Myanmar	51	56	3.2	After 2030	25	48%	49%	After 2030
Nepal	35	75	5.4	By 2030	21	64%	60%	Between 2017 and 2030
Sri Lanka	9	57	3.1	Already achieved	5	62%	56%	Already achieved
Thailand	12	68	4.3	Already achieved	7	67%	58%	Already achieved
Timor-Leste	50	71	4.8	By 2030	22	61%	44%	After 2030
SEA Region	39	67	4.3	By 2030	23	57%	59%	After 2030
Global	41	56	3.2	After 2030	19	49%	46%	After 2030
	Achieved MDG target of 2/3 reduction as estimated by UNIGME Child Mortality Report							
	Achieved relevant SDG target (U5MR/NMR) as estimated by UNIGME Child Mortality Report							

Source: UNIGME 2017

Reduction in maternal mortality

10. The SEA Region has achieved a significant reduction in maternal mortality. Based on the latest global maternal mortality estimates of 2015, the Region achieved a 69% reduction in the maternal mortality ratio (MMR) between 1990 and 2015, the highest MMR reduction among all WHO regions. MMR in the SEA Region declined from 525 in 1990 to 164 per 100 000 live births in 2015.

11. In the process, the Region reduced the annual number of deaths by 73% – a total of 61 000 maternal deaths occurred in the Region in 2015 compared with 207 312 in 1990. This reduction was significantly greater than the global reduction of 43%, from approximately 532 000 deaths in 1990 to an estimated 303 000 in 2015. It is estimated that Bhutan, Maldives and Timor-Leste achieved the MDG5 goal of reducing maternal mortality by three quarters by the end of 2015. However, the SEA Region as a whole is still lagging behind with regard to the MDG5 targets.

Progress in reducing maternal mortality towards SDG target 2030

12. All Member States are likely to achieve the three fourth reduction in MMR (MDG5a target) by 2020 with the current rates of decline. However, meeting the SDG global target on maternal mortality reduction of 70/100 000 live births (target 3.1) will be a challenge for some Member States of the Region. As stated in the Ending Preventable Maternal Mortality (EPMM) Strategy, the target for Member States is a two third reduction from the 2010 level, and that no country should have an MMR of more than 140/100 000 live births. Member States reporting a low

baseline MMR by 2010 indices need to achieve equity in MMR for vulnerable populations at the subnational level. To reach the 2030 target, the ARR in maternal mortality needs to be accelerated. Considering the percentage ARR over the period 2010–2015 to estimate the same projection, it emerges that four Member States will achieve their corresponding SDG/EPMM target: Bangladesh, Bhutan, Nepal and Timor-Leste. The three Member States that started with a low baseline MMR in 2010 – Maldives, Sri Lanka and Thailand – should currently concentrate more on equity. Four Member States – DPR Korea, India, Indonesia and Myanmar – may still miss the SDG/EPMM target with their current levels of ARR (see Table 2). However, the 2030 MMR needs to be reprojected based on the current ARR after the release of new interagency estimates for MMR in late 2018.

13. The main causes of maternal mortality in the Region are haemorrhage, hypertensive disease and infections. The majority of deaths due to these causes are preventable. This requires high coverage of institutional deliveries and availability of good-quality skilled care at birth. At the same time, access to comprehensive emergency obstetric care is required to manage the complications of pregnancy and childbirth in referral care hospitals.

14. The contraceptive prevalence rate in the Region improved from 37% in 1990 to 60% in 2015. Most Member States have reached or are reaching the replacement level of fertility (total fertility rate [TFR] 2 or less than 2). In the SEA Region, 74% of married or in-union women of reproductive age satisfy their need for family planning with modern methods.

Table 2: Status of maternal mortality and 2030 projection

	Maternal mortality ratio (per 100 000 live births)	Percentage reduction since 1990 (MDG baseline)	AAR % Last 5-year accelerated decline rate	Specific EPMM/SDG target for 2030 (2/3 reduction from 2010 MMR)	Projected MMR in 2030 with current AAR of (2010–2015)
	2015	2017	2010–2015		
Bangladesh	**176**	**69**	**6.2**	**82**	**68**
Bhutan	**148**	**84**	**6.2**	**69**	**56**
DPR Korea	**82**	**-**	**3.3**	**33**	**50**
India	**174**	**69**	**4.1**	**73**	**92**
Indonesia	**126**	**72**	**5.3**	**56**	**56**
Maldives	**68**	**90**	**4.8**	**30**	**32**
Myanmar	**227**	**50**	**2.8**	**70**	**117**
Nepal	**258**	**71**	**5.9**	**119**	**104**
Sri Lanka	**30**	**60**	**3.0**	**12**	**19**
Thailand	**20**	**50**	**2.8**	**8**	**13**
Timor-Leste	**215**	**80**	**7.5**	**108**	**67**
SEA Region	**164**	**69**	**4.5**	**70**	
	Achieved MDG target of MMR				
	Unlikely to achieve 2/3 reduction from 2010 level (EPMM 2030 target)				

Source: Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division.

Challenges in maternal, newborn and child health

15. The main reasons for missing the MDG targets for maternal, neonatal and child mortality include low and uneven coverage of evidence-based life-saving interventions across the life-course – adolescence (health and nutrition of girls, early pregnancy), antenatal care, intranatal care, postnatal care of mothers and newborns, and care of sick newborns and children. Institutional deliveries, with care provided by competent birth attendants, is critical for reducing maternal and neonatal mortality, but its coverage has remained low in Bangladesh, Bhutan, Myanmar, Nepal and Timor-Leste. In addition, there are wide disparities in coverage related to social and economic parameters. There is a big gap in skilled attendance at birth among poor women in the SEA Region – 54% in the lowest quintile and 91% in the wealthiest quintile .

16. Another cause is that the quality of care provided to girls, women, newborns and children is of suboptimal quality. The quality of care is especially important around the time of childbirth to avert preventable deaths of newborns and mothers.

17. Member States have faced health system constraints related to inadequate resources (financial and human) for RMNCAH, inadequate health infrastructure (e.g. comprehensive emergency obstetric and neonatal care facilities) and issues with the logistics of essential supplies and commodities.

The way forward

18. The Regional Office has identified Bangladesh, India, Indonesia, Myanmar, Nepal and Timor-Leste as high-priority Member States because of their high maternal and child mortality rates or burden or both.

19. Strategic priority actions have been identified to focus on the care of mothers and newborns at the time of birth. These have the triple benefit of reducing newborn and maternal mortality as well as stillbirths; and provision of care for sick and small newborns at newborn care units. At the same time, post-neonatal mortality must continue to receive adequate attention.

20. The Regional Committee adopted resolution SEA/RC69/R3 in 2016 on Ending preventable maternal, newborn and child mortality in the South-East Asia Region, in line with the SDGs and the Global Strategy on Women's, Children's and Adolescents' Health. In response to the resolution, several actions have been initiated by WHO in collaboration with Member States and partner agencies.

21. Ending preventable maternal, newborn and child mortality with a focus on reducing newborn mortality has been identified as a Regional Flagship Priority. This has galvanized urgent actions in Member States to accelerate mortality reduction. The SEAR-TAG for women's and children's health constituted by the Regional Director has provided additional strategic guidance through its deliberations and recommendations to Member States and partner agencies to undertake prioritized actions for ending preventable newborn and child mortality.

22. The Regional Working Group of H6 agencies (UNICEF, UNFPA, UN Women, UNAIDS, World Bank, WHO) has been convened to provide coordinated and harmonized support for RMNCAH in Member States of the Region.

23. Dissemination and adaptation needs to be undertaken at the national level of all current WHO recommendations on antenatal care, intranatal care for positive pregnancy experiences, newborn care and family planning.

Actions by Member States

24. Member States need to ensure universal health coverage for RMNCAH services, accelerate expansion of coverage of interventions, and implement new WHO recommendations on maternal and newborn and child health across populations, leaving no one behind. At the same time, they should ensure that services are of good quality. The initial focus on care of mothers and newborns around the time of birth will help to reduce maternal and neonatal mortality as well as stillbirths.

25. Adequate financial resources should be made available from domestic resources and donors to cover the budgetary needs for ensuring service delivery of RMNCAH.

26. Adequate numbers of health workers with an optimal skills mix, especially the midwifery workforce, must be ensured. This will be critical for accelerating progress towards ending preventable maternal, newborn and child mortality.

27. In order to strengthen accountability, civil registration and vital statistics need to be strengthened, and maternal and perinatal death surveillance scaled up so that every death is reported and analysed, and actions taken to prevent such deaths subsequently.

Actions by WHO

28. WHO will provide support for strengthening national plans for maternal, newborn and child health to accelerate scaling up implementation of evidence-based RMNCAH interventions. For this, regional strategies have been prepared for newborn and child health, maternal–reproductive health as well as for adolescent health.

29. Assistance will be provided to build capacity to use equity analysis tools for designing strategies to reach unreached populations so that no one is left behind.

30. WHO will provide guidance and build capacity for improving the quality of care of MNCH services. The Regional Framework for improving the quality of care for RMNCAH has been prepared to guide Member States to develop national strategies and plans for quality improvement. Capacity-building packages for quality improvement – called point--care quality improvement (POCQI) – have been prepared and used to build the capacity of health-care teams in hospitals across Member States of the Region to improve the quality of care for mothers and newborns at the time of birth, and of small and sick newborns.

31. WHO will assist Member States to implement the actions recommended by SEAR-TAG for addressing high newborn mortality through strengthening care at birth, postnatal care and care of preterm and sick babies, as well as addressing pneumonia and diarrhoea, which are responsible for about 25% of child mortality. WHO will also work with partner agencies for to provide coordinated and harmonized support for RMNCAH in Member States of the Region. A joint mission with H6 agencies will be undertaken in high-priority Member States to understand the progress in RMNCAH programmes and provide joint technical assistance.

32. The overall focus on sexual and reproductive health and rights (SRHR) in the Region must be on improving the quality of contraceptive services. A wide range of contraceptive methods should be offered and counselling provided to help individuals prevent the pregnancies they do not want and achieve their reproductive goals.

Conclusion

33. Strategic actions have been identified by working together with high-priority Member States and in harmonized collaboration with H6 agencies, based on evidence and TAG recommendations, to accelerate reduction in maternal, newborn and child mortality. Close follow up and monitoring of progress is being undertaken to identify and address the challenges to implementation in Member States and provide the required technical assistance.