Ending preventable maternal and child mortality

There has been a significant decline in child mortality in the South-East Asia Region over the past few decades, from 118/1000 live births in 1990 to 43/1000 live births in 2015, or a decline of about 64% while the regional maternal mortality ratio (MMR) declined from 525 to 164 per 100 000 live births, a reduction of about 69%. Over the same period, neonatal mortality has declined less rapidly from 53/1000 live births to 24/1000 live births. These declines in mortality, however, narrowly miss the MDG targets of 75% (three fourths) reduction in maternal mortality (MDG5) and 67% (two thirds) reduction in child mortality (MDG4).

In addition there are significant disparities in the achievements made in the Region in terms of social parameters such as poverty, education status and the status of women. The main barriers to progress have been constraints related to health financing, health workforce (midwives and skilled birth attendants, in particular) and to essential supplies and equipment.

With the launch of the Sustainable Development Goals (SDGs) and the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030), new targets have been set for all countries. This provides renewed impetus to the efforts to end preventable mortality among women, newborns and children through a broad-based multisectoral approach as well as to address areas such as adolescent health and early child development that received less attention during the MDG phase.

In April 2014, the WHO Regional Director for South-East Asia launched a Flagship Initiative on ending preventable maternal, newborn and child mortality with the focus on neonatal mortality. In support of this, the Regional Director convened a Regional Summit of H6 Leadership (WHO, UNICEF, UNFPA, UNAIDS, UN WOMEN and World Bank) in December 2015 that issued a joint statement for ending preventable mortality among newborns, children and mothers. This regional interagency platform will be effective for providing advocacy and technical assistance, promoting multisectoral action, and coordinating partner-donor support to Member States for the implementation of the Global Strategy.
The attached Working Paper was presented to the High-Level Preparatory Meeting for its review and recommendations. The recommendations made by the HLP Meeting for consideration of the Sixty-ninth Session of the Regional Committee are:

**Actions by Member States**

1. Update, based on the achievements and identified gaps in the progress, strategies and plans for RMNCAH, the framework for operationalizing the Global Strategy for Women’s, Children’s and Adolescents’ Health, and pay special attention to the principles of equity and the overriding SDG aim of “leaving no one behind”.

2. Continue to assume national leadership for effective planning, implementation and monitoring and reporting the progress in line with the monitoring framework of the Global Strategy and SDGs.

3. Focus on strategies to address major causes of mortality among mothers and newborns by strengthening midwifery skills, providing adequate financing, and expanding coverage with life-saving interventions with good quality of care.

**Actions by WHO**

1. Continue to provide technical guidance and support to Member States for operationalizing the Global Strategy based on regional- and country-level contexts and specificities.

2. Provide support to strengthen planning and implementation capacity in Member States for improving the health of women, children and adolescents and support innovative approaches for reaching the unreached and unserved or underserved populations.

3. Assist in preparing a draft Resolution focusing on ending maternal, newborn and child mortality for consideration of the Sixty-ninth Session of the Regional Committee.

This Working Paper and the HLP Meeting recommendations are submitted to the Sixty-ninth Session of the WHO Regional Committee for South-East Asia for its consideration and decision.
Introduction

1. The WHO South-East Asia (SEA) Region accounts for 26% of the world’s population and about 36% of the total annual births reported globally. In 1990, the baseline year for the Millennium Development Goals (MDGs), eight of the 11 Member States of the Region had maternal mortality ratios (MMR) above 400 per 100,000 live births and child mortality rates higher than 80 per 1000 live births. The situation has greatly improved since then. By 2015 only two countries\(^1\) had an MMR of 200 or above, with the regional MMR falling from 525 to 164 per 100,000 live births. Similarly, by 2015 only three countries\(^2\) had a child mortality rate of 40 or above.

2. There has been a significant decline in child mortality in the South-East Asia Region from 118/1000 live births in 1990 to 43/1000 live births in 2015, or a decline of about 64%. Over the same period, neonatal mortality has declined less rapidly from 53/1000 live births to 24/1000 live births, or about 50%.

3. The mortality decline still falls short of the MDGs target of 75% (three fourths) reduction in maternal mortality (MDG 5) and 67% (two thirds) reduction in child mortality (MDG 4). In addition there are significant disparities in achievements made by countries in terms of social parameters such as poverty, education status and the status of women.

4. The adoption of the Sustainable Development Goals (SDGs) and the launch of the UN Secretary-General’s Global Strategy for Women’s, Children’s and Adolescents’ Health 2016–2030 provide a new impetus to and expanded opportunities for increased attention to the crucial issues and barriers related to improving the health of women, children and adolescents. The new goals under the Sustainable Development Goal 3 and the Global Strategy are that all countries achieve maternal mortality ratios of at least 70 per 100,000 live births, and reduce under-five mortality to at least 25 and newborn mortality to at least 12 per 1000 live births by 2030.

5. SDG 3 that calls for ensuring “healthy lives and promote well-being for all at all ages” will also depend on coordinated action across sectors, particularly nutrition (Goal 2), education (Goal 4), gender equality and empowerment of all women and girls (Goal 5), and water and sanitation (Goal 6).

Situation analysis

6. Pre-term birth and intrapartum complications and newborn sepsis account for 74% of neonatal deaths; hence the need to focus on care around the time of childbirth, and care of small and sick newborns. Improving care around the time of birth will also contribute to saving the lives of mothers, common causes of mortality among whom are haemorrhage, hypertension and sepsis. Post-neonatal child deaths in the Region mainly occur due to pneumonia and diarrhoea.

7. There are inequities in the coverage of health-care interventions, both in terms of wealth quintiles and rural/urban access to health services. The most equitable indicator is immunization with DPT3, with virtually equal coverage between the lowest and highest quintiles. Met need for

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\(^1\) Nepal and Timor-Leste
\(^2\) India, Myanmar, Timor-Leste
contraception is also relatively equal with high coverage in Bangladesh and Indonesia, and relatively high coverage with a moderate equity differential in India and Nepal.

8. However, for four antenatal care visits, skilled attendance at birth and postnatal care, there are vast differences in coverage. ANC4 in Bangladesh and India reaches only 10% of the lowest quintile and 55% and 78% of the highest quintile respectively; only 10% of the lowest quintile in Bangladesh and Nepal receive skilled attendance at birth, while 60% and 80% respectively of the highest quintile in the two countries receive this care.

9. Quality assessments have been conducted in some countries of the Region. The common quality gaps reported in these countries include suboptimal newborn care, non-compliance with standard treatment protocols, poor emergency care, weak laboratory support, inadequate supplies and functioning of equipment, and a deficiency in basic amenities.

10. The overall financing for health in the Region has improved in the past 15 years, with all governments increasing their expenditure on health. South-East Asia nonetheless remains the Region with a low total expenditure on health as a percentage of gross domestic product (3.7%). Furthermore, in most countries of the Region less than 50% of the health expenditure is provided by the government. Although donor contributions are considerable in some of the countries, the main source of health spending remains out-of-pocket.

11. The gap in human resources is exemplified by the need for skilled birth attendants and midwives to bolster care for mothers and newborns. The density of doctors, nurses and midwives of 12.5 per 10 000 population in the Region is far less than the new WHO recommended minimum of 44.5 health workers per 10 000 population for attaining the SDGs. Although some countries have put in place strategies to increase the number of health workers, particularly midwives, severe inequities exist, predominantly urban-rural, public-private and hospital-primary care.

The way forward

12. WHO has supported countries in developing their national plans according to the global Every Newborn Action Plan (ENAP) Framework; and some countries are integrating newborn care into their existing national health plans. The implementation of Essential Newborn Care (ENC) and newborn action plans is challenging. A bottleneck analysis was carried out in four countries of the Region—Bangladesh, India, Myanmar and Nepal. Bottlenecks were found to be similar in all high-burden countries and related to the six blocks of the health system, and more specifically to health financing, health workforce and essential supplies.

13. Countries need to expand the coverage of essential evidence-based life-saving interventions and ensure quality of care. At the same time countries need to work towards better information systems to be able to keep count of each birth and each maternal, perinatal and newborn death to strengthen the national accountability mechanism. Only a few quality indicators are included in routine reporting. Global indicators of quality have recently been agreed upon and will be crucial for quality improvement.

3 Consultation on improving measurement of the quality of maternal, newborn and child care in health facilities, WHO 2014
14. In April 2014 the Regional Director launched a Flagship Initiative\textsuperscript{4} for accelerating reduction of maternal, newborn and child mortality in all SEA Region Member States with a focus on neonatal mortality. Regional strategies developed to address specific issues across the continuum of care include the framework for implementing the Reproductive Health Strategy in the SEA Region 2008–2014, the SEA Regional Strategic Framework for improving Neonatal and Child Health and Development 2013–2017, Strategic Directions for Improving Adolescent Health in the SEA Region 2011–2015, and the Regional Framework for Improving Quality of Care.

15. A SEA Region Technical Advisory Group for Women’s and Children’s Health has been established to provide technical guidance to accelerate reduction in maternal, newborn and child mortality. At the first meeting of the TAG an action pathway was developed to support countries accelerate the reduction of their newborn mortality. Based on the situation analysis and experience in the countries of the Region, priority actions have been identified for accelerating the reduction of maternal, newborn and child mortality in the SEA Region through addressing gaps in coverage and equity, and in quality and accountability.

16. WHO is working with Member States to identify high-impact, country-specific approaches, especially “accelerators”, for reducing newborn mortality that have the additional benefits of reducing stillbirths and maternal mortality. In addition, underlying and social determinants such as nutrition, early marriage, girls’ education, water and sanitation, gender equity and women’s empowerment also need to be addressed to maximize benefits through intersectoral work.

17. The Regional Office for South-East Asia has already initiated capacity-building in Member States by institutionalizing quality improvement of maternal and newborn care at health facilities and for maternal-perinatal death surveillance and response. This is part of the Regional Office’s efforts to support the implementation of the Global Strategy.

18. At the same time the Regional Office has prioritized actions for the “Survive” and “Thrive” domains of the Global Strategy and plans to work with countries to promote early childhood development and adolescent health in line with the existing regional strategies. A collaborative approach across multiple sectors will need to be followed for these dimensions to promote overall well-being and maximize human potential among women, children and adolescents.

19. The Regional Director convened a Regional Summit of H6 Leadership (WHO, UNICEF, UNFPA, UNAIDS, UN WOMEN and World Bank) in December 2015 that issued a joint statement for ending preventable mortality among newborns, children and mothers. An H6 Regional Working Group is being formed to provide a regional interagency platform that will support advocacy and technical assistance, promote multisectoral action, and also coordinate partner-donor support to Member States for implementation of the Global Strategy. Similar country-level H6 platforms are set to be established.

20. The Regional Office will support Member States to strengthen national ownership and commitment to accelerating progress towards ending preventable mortality among women, newborns and children in all populations, paying special attention to unreached groups of populations so that no one is left behind.

\textsuperscript{4} 2015 and beyond: the unfinished agenda of MDGs 4&5 in South-East Asia. Report of a regional meeting 29 April – 1 May 2014, Kathmandu, Nepal