Accelerating progress towards achieving maternal and child health Millennium Development Goals (MDGs) 4 and 5 in South-East Asia

Report of a high-level consultation
High-level consultation
to accelerate progress towards achieving
maternal and child health Millenium
development Goals (MDGs) 4 and 5 in South-East Asia

Ahmedabad, India, 14-17 October 2008
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<th>Acronym</th>
<th>Full Form</th>
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<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
</tr>
<tr>
<td>AIDS</td>
<td>acquired immune deficiency syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>antenatal care</td>
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<tr>
<td>ANM</td>
<td>auxiliary nurse–midwife</td>
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<tr>
<td>ARI</td>
<td>acute respiratory infection</td>
</tr>
<tr>
<td>ARV</td>
<td>antiretroviral (drug)</td>
</tr>
<tr>
<td>ASHA</td>
<td>accredited social health activist</td>
</tr>
<tr>
<td>BCC</td>
<td>behaviour change communication</td>
</tr>
<tr>
<td>BMGF</td>
<td>Bill and Melinda Gates Foundation</td>
</tr>
<tr>
<td>BMN</td>
<td>Basic Minimum Needs</td>
</tr>
<tr>
<td>BPL</td>
<td>below poverty line</td>
</tr>
<tr>
<td>CAH</td>
<td>(Department of) Child and Adolescent Health</td>
</tr>
<tr>
<td>CEDPA</td>
<td>Center for Development and Population Activities</td>
</tr>
<tr>
<td>CEmOC</td>
<td>comprehensive emergency and obstetric care</td>
</tr>
<tr>
<td>CHC</td>
<td>Community Health Centre</td>
</tr>
<tr>
<td>CM</td>
<td>community midwife</td>
</tr>
<tr>
<td>DFID</td>
<td>Department for International Development</td>
</tr>
<tr>
<td>DH</td>
<td>District Hospital</td>
</tr>
<tr>
<td>DHS</td>
<td>demographic and health survey</td>
</tr>
<tr>
<td>DOTS</td>
<td>directly observed treatment, short-course</td>
</tr>
<tr>
<td>DPT</td>
<td>diphtheria, pertussis and tetanus (vaccine)</td>
</tr>
<tr>
<td>EBF</td>
<td>exclusive breastfeeding</td>
</tr>
<tr>
<td>FCHV</td>
<td>female community health volunteer</td>
</tr>
<tr>
<td>FOGSI</td>
<td>Federation of Obstetricians and Gynaecologists of India</td>
</tr>
<tr>
<td>FP</td>
<td>family planning</td>
</tr>
<tr>
<td>FRU</td>
<td>first referral unit</td>
</tr>
<tr>
<td>GAVI</td>
<td>Global Alliance for Vaccines and Immunization</td>
</tr>
<tr>
<td>GFATM</td>
<td>Global Fund to fight AIDS, Tuberculosis and Malaria</td>
</tr>
<tr>
<td>HHS</td>
<td>health and household survey</td>
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<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
</tr>
<tr>
<td>HMIS</td>
<td>health management information systems</td>
</tr>
<tr>
<td>ICDDR,B</td>
<td>International Centre for Diarrhoeal Diseases Research, Bangladesh</td>
</tr>
<tr>
<td>ICDS</td>
<td>Integrated Child Development Scheme</td>
</tr>
<tr>
<td>IEC</td>
<td>information, education and communication</td>
</tr>
<tr>
<td>IFA</td>
<td>iron and folic acid (supplementation)</td>
</tr>
<tr>
<td>IIHMR</td>
<td>Indian Institute of Health Management Research</td>
</tr>
<tr>
<td>IIIMA</td>
<td>Indian Institute of Management, Ahmedabad</td>
</tr>
<tr>
<td>IMCI</td>
<td>Integrated Management of Childhood Illnesses</td>
</tr>
<tr>
<td>Acronym</td>
<td>Full Form</td>
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<td>-----------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>IMNCI</td>
<td>Integrated Management of Neonatal and Childhood Illnesses</td>
</tr>
<tr>
<td>IMR</td>
<td>infant mortality rate</td>
</tr>
<tr>
<td>IYCF</td>
<td>Infant and Young Child Feeding</td>
</tr>
<tr>
<td>JSY</td>
<td>Janani Suraksha Yojana</td>
</tr>
<tr>
<td>MCH</td>
<td>maternal and child health</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
</tr>
<tr>
<td>MHPSI</td>
<td>Maldives Health Promoting Schools Initiative</td>
</tr>
<tr>
<td>MICA</td>
<td>Mudra Institute of Communications, Ahmedabad</td>
</tr>
<tr>
<td>MMR</td>
<td>maternal mortality ratio</td>
</tr>
<tr>
<td>MNCH</td>
<td>maternal, newborn and child health</td>
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<tr>
<td>MNH</td>
<td>maternal and neonatal health</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>MOHFW</td>
<td>Ministry of Health and Family Welfare</td>
</tr>
<tr>
<td>NABH</td>
<td>National Board of Accreditation of Hospitals</td>
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<tr>
<td>NABL</td>
<td>National Board of Accreditation of Laboratories</td>
</tr>
<tr>
<td>NCWC</td>
<td>National Commission for Women and Children</td>
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<tr>
<td>NESDP</td>
<td>National Economic and Social Development Plan</td>
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<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
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<tr>
<td>NMR</td>
<td>neonatal mortality rate</td>
</tr>
<tr>
<td>NRHM</td>
<td>National Rural Health Mission</td>
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<tr>
<td>OOP</td>
<td>out-of-pocket (expenditure)</td>
</tr>
<tr>
<td>ORS</td>
<td>oral rehydration solution</td>
</tr>
<tr>
<td>Pap</td>
<td>Papanicolaou</td>
</tr>
<tr>
<td>PHC</td>
<td>primary health care</td>
</tr>
<tr>
<td>PHFI</td>
<td>Public Health Foundation of India</td>
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<tr>
<td>PHM</td>
<td>public health midwife</td>
</tr>
<tr>
<td>PHS</td>
<td>public health standards</td>
</tr>
<tr>
<td>PMTCT</td>
<td>prevention of mother-to-child transmission (of HIV)</td>
</tr>
<tr>
<td>PNC</td>
<td>postnatal care</td>
</tr>
<tr>
<td>PPP</td>
<td>public–private partnership</td>
</tr>
<tr>
<td>RCH-II</td>
<td>Reproductive and Child Health-II</td>
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<tr>
<td>RIMS</td>
<td>routine immunization monitoring system</td>
</tr>
<tr>
<td>RTI</td>
<td>reproductive tract infection</td>
</tr>
<tr>
<td>SBA</td>
<td>skilled birth attendant</td>
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<tr>
<td>SEAR</td>
<td>South-East Asia Region</td>
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<td>SEARO</td>
<td>Regional Office for South-East Asia</td>
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<td>SEWA</td>
<td>Self Employed Women’s Association</td>
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<tr>
<td>STI</td>
<td>sexually transmitted infection</td>
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<tr>
<td>TB</td>
<td>tuberculosis</td>
</tr>
<tr>
<td>TBA</td>
<td>trained birth assistant</td>
</tr>
<tr>
<td>TFR</td>
<td>total fertility rate</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>WB</td>
<td>(the) World Bank</td>
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<td>WHO</td>
<td>World Health Organization</td>
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</table>
The South-East Asia (SEA) Region accounts for more than 174,000 maternal and 1.3 million neonatal deaths every year, which is approximately a third of the global burden. The Region also accounts for one million stillbirths and 3.1 million deaths of children under five years of age annually. Thus, the SEA Region faces a great challenge in reducing maternal, newborn and child mortality as targeted in the Millennium Development Goals (MDGs) 4 and 5.

### MILLENIUM DEVELOPMENT GOALS (MDGs) 4 and 5

<table>
<thead>
<tr>
<th>MDG 4</th>
<th>Goal: Reduce Child Mortality.</th>
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<tr>
<td>Target:</td>
<td>Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MDG 5</th>
<th>Goal: Improve Maternal Health.</th>
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<tbody>
<tr>
<td>Target:</td>
<td>(a) Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio.</td>
</tr>
<tr>
<td></td>
<td>(b) Achieve by 2015, universal access to reproductive health.</td>
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</table>

Maternal, newborn and child health (MNCH) outcomes are the results of a number of social, cultural, economic, environmental determinants and other factors. The aim of this high-level consultation was to address the above issues and come up with a regional consensus on a set of well-defined actions that would make a significant impact on countries’ efforts to achieve MDGs 4 and 5. The consultation was attended by participants from all Member States of the Region except DPR Korea, and brought together policy-makers and programme managers from health and health-related sectors, health providers, academia, professional organizations and donors. The consultation provided a forum for discussions and exchange of information on MNCH, focusing on the current situation, progress made and challenges towards achieving MDGs 4 and 5, and exploring avenues for accelerating progress in the South-East Asia Region.
The general objective was to facilitate Member countries of the South-East Asia (SEA) Region in accelerating progress towards the achievement of Millennium Development Goals (MDGs) 4 and 5 in a sustainable manner through strengthening health systems using the primary health care (PHC) approach.

The specific objectives were:

- To review progress and identify barriers to achieving MDGs 4 and 5 in SEA Region countries
- To share evidence-based interventions and best practices on maternal, newborn and child health (MNCH) from the health and other sectors
- To agree on a multisectoral framework for accelerating and sustaining the achievement of MDGs 4 and 5.
Ms Rita Teaotia, Principal Secretary, Health, Government of Gujarat welcomed the participants and said that the State of Gujarat, India, is committed to place MNCH at the centre of the development agenda and is testing innovative and evidence-based strategies to that effect. The government health system in Gujarat has networked extensively with the private and voluntary sectors to increase the reach and coverage of the health sector, and looked forward to learning from the consultation the best practices followed in SEA and incorporate the same in the work of State of Gujarat, she said.

Ms Aradhana Johri, Joint Secretary, Ministry of Health and Family Welfare, Government of India, stated that this stock-taking session was very timely for India because the country is poised in the middle of the National Rural Health Mission (NRHM) and the Reproductive and Child Health-II (RCH-II) programme in India. RCH-II is the main vehicle for the delivery of maternal and child health by the health system. There are specifically targeted programmes for MCH and the aim is to create a core of facilities so that women can deliver safely, and sick infants can get adequate care.
at the right time. However, there is a palpable huge shortage of human resources.

**Dr Samlee Plianbangchang**, Regional Director, WHO South-East Asia Region sent a message to the participants of the consultation. The message was delivered by **Dr Dini Latief**, Director, Family and Community Health, WHO/SEARO, New Delhi, India.

In his message, Dr Samlee Plianbangchang said that the international community has made several commitments over the past years to improving MNCH. The WHO Regional Committee for South-East Asia also adopted resolutions on the newborn health and skilled care at every birth in 2003 and 2005, respectively, he recalled.

The SEA Regional Conference on revitalizing primary health care held in Jakarta in August 2008 emphasized the importance of strengthening health systems using the PHC approach. Equity is one of the salient features of PHC and is rooted in the social determinants of health. Pro-poor health policies have been shown to promote better equity in health. Thus, to achieve the MDGs in MCH, the PHC approach remains ubiquitous and relevant. While the Region has made considerable progress in reducing child mortality, maternal and neonatal mortality continue to pose a challenge.

In delivering health care to mothers, newborns and children, a continuum of care must be ensured at different levels. Unless all components of the health system operate in synergy, considerable reduction in morbidity and mortality will not be feasible.

The importance of demand-side factors must also be acknowledged while designing interventions to ensure that due cognizance is given to social, cultural, economic and religious imperatives. In the absence of this, meaningful progress in MNCH will not be made.

The Regional Director also pointed out in his message that the nutritional status of women and children in large parts of the Region is a matter of concern. Interventions to reduce anaemia, if not supplemented with nutritional interventions, might fail to yield the expected results.

It is important to approach the challenges in MNCH in a multidisciplinary, holistic and multisectoral manner. WHO is committed to assisting countries in attaining their development goals, including the MDGs, by 2015.

Dr Samlee thanked the Government of Gujarat, development partners, civil society and donors for their contribution to the common goal of improving the health of mothers and children in the Region. Dr Samlee hoped that the consultation would help further raise awareness on the present status, progress and challenges in MNCH in this part of the world, and assist in charting the course to achieve healthier mothers and children in the SEA Region.

The Honourable Health Minister of Gujarat, **Shri Jai Narayan Vyas**, noted that, halfway through to the MDGs in 2008, it is time to look back and make trajectory corrections and chart the further course of action. Education and wealth have a skewed distribution across the globe, and progress has been uneven in the past two decades despite spectacular breakthroughs in medical care. The problems include shortage of doctors and lack of political will and resources.

The achievements in the health sphere in Gujarat are the result of political will. Visionary schemes have been launched and societal participation encouraged.

**Mr Narendra Modi**, Hon’ble Chief Minister of Gujarat, inaugurated the Consultation. He welcomed all international and national
Maternal and child health (MCH) is a major initiative in Gujarat. The cumulative progress made by MCH schemes over the past 50 years was too slow and inadequate and a quantum jump was needed to yield tangible results in a very short time. Two years ago, the high infant mortality rate (IMR) and maternal mortality ratio (MMR) led to the launch of the Chiranjeevi Yojana. This scheme is based on the public-private partnership (PPP) model wherein the government and the private sector come together to ensure safe deliveries. Mothers are cared for right through pregnancy and are attached to a qualified doctor who supervises the delivery. The government bears all expenses for the delivery as well as for surgical interventions, if required. Expenses of the family member accompanying the mother are also taken care of by the government. This scheme has led to a large increase in institutional deliveries, from 54% three years ago to 87% at present. More than 90% of the beneficiaries are from the poor and deprived sections of society. Currently, 865 private gynaecologists are enrolled in this scheme and more than 235,000 safe deliveries have been carried out in Gujarat in the last two years. It is estimated that more than 9000 mothers and children have been saved due to this intervention.

An emergency medical transport service has been introduced, popularly known as “108”. This ambulance service has transported more than 45,000 of the poorest women from remote areas to health-care institutions for deliveries in the past few months, the Chief Minister informed.

He also outlined details of other health-care initiatives of the government. The Nirogi Balak or Healthy Child Scheme attempts a convergence of many sectors to ensure good health to children. It ensures safe deliveries, fights malnutrition, provides neonatal care, clean water and sanitation, and education of the child. It takes care of the child from the womb to adolescence.

In the Bal Bhog Yojana, micronutrients essential for the growth of a healthy child are provided in the form of a sweet candy. About
25,000 health workers under the Integrated Child Development Scheme (ICDS) and a number of medical officers have been trained in the Integrated Management of Neonatal and Childhood Illness (IMNCHI). Flour and edible oil have been fortified under the Micronutrient Programme. On one day every month, known as Mamta Divas, all children below the age of five and their mothers are monitored. These children are also enrolled in school and provided curricular education along with nutritious food.

Professionally qualified hospital administrators have been engaged to manage hospitals. Eight government hospitals plan to undergo accreditation with the National Board of Accreditation of Hospitals (NABH). These hospitals are being linked with state-of-the-art health management information systems (HMIS). To upgrade managerial skills in public health, the Indian Institute of Public Health was launched in collaboration with the Public Health Foundation of India (PHFI). Regular capacity-building of health workers and doctors is also carried out.

The Honourable Chief Minister also noted that the participants of the consultation would be visiting many of the sites to experience the innovations that have been put in place. He welcomed suggestions to improve MCH facilities and services in the state.
4.1 Setting the stage

4.1.1 What should we be doing? The evidence for effective public health interventions for continuum of MNCH care

The session was chaired by Ms Aradhana Johri, Joint Secretary, Family Welfare, Ministry of Health and Family Welfare, Government of India.

(a) Dr Monir Islam, Director, Department of Making Pregnancy Safer, WHO headquarters, Geneva, made a presentation entitled “It is no more about technology but about access, coverage and quality”.

Among all health indicators, most conspicuous and predominant is inequality in accessing services in the area of maternal

Figure 1: Proportion of Births attended by skilled health personnel in WHO Regions (2000-2006)

health. Inequality is greater among women from poor and rural households. The focus should be greater on such women in order to bring about a perceptible improvement in maternal and neonatal health (MNH).

South-East Asia and sub-Saharan Africa contribute to 90% of the maternal mortality in the world and less than 5% of all people in these regions have access to emergency services such as the caesarean section. There are also geographical disparities in accessing skilled care within countries. It is not acceptable that in low-income countries primary health centres should be synonymous with non-professional care with inadequate resources for use by the rural poor who cannot afford any better.

What needs to be done has been evident for a long time. These include access to a skilled birth attendant (SBA) during pregnancy, childbirth and the postpartum period; access to emergency obstetric and newborn care; and access to family planning services.

(b) Dr Elizabeth Mason, Director, Department of Child and Adolescent Health, WHO/HQ, Geneva, made a presentation on “the evidence for public health interventions across the continuum of care”.

Forty-two countries account for 90% of child deaths across the world. Almost 10 million children below the age of five years die every year from causes such as pneumonia, diarrhoea and malaria. Undernutrition is an underlying cause in about one-third of deaths among those less than five years of age. Available preventive and curative interventions can avert more than two-thirds of the child deaths.

Of the four million neonatal deaths (deaths in the first month of life), 60% are preventable through known interventions. Availability of immediate newborn care would reduce the neonatal mortality rate (NMR) by 15%; routine postnatal care (PNC) by 10%; extra care of low birth-weight infants by 10%; and, management of infections by 15%. However, in spite of the availability of effective tools, coverage with these interventions is low.

Severe acute malnutrition affects 20 million children under the age of five years and kills at least one million of them each year. Such children can be treated at home with highly fortified, ready-to-use therapeutic foods. The overarching framework for action to combat undernutrition is the Global Strategy on Infant and Young Child Feeding (IYCF). However, the strategy needs to be scaled up.

**Figure 2: Major causes of death among neonates and children under five years of age in the world, 2000-2003**

<table>
<thead>
<tr>
<th>Causes of under-five deaths</th>
<th>Causes of neonatal deaths</th>
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</thead>
<tbody>
<tr>
<td><strong>Diarrhoea</strong></td>
<td><strong>Tetanus</strong></td>
</tr>
<tr>
<td><strong>Pneumonia</strong></td>
<td><strong>Sepsis/Pneumonia</strong></td>
</tr>
<tr>
<td><strong>Others</strong></td>
<td><strong>Pre-term</strong></td>
</tr>
<tr>
<td><strong>Neonatal</strong></td>
<td><strong>Asphyxia</strong></td>
</tr>
<tr>
<td>17%</td>
<td>7%</td>
</tr>
<tr>
<td>19%</td>
<td>23%</td>
</tr>
<tr>
<td>10%</td>
<td>27%</td>
</tr>
<tr>
<td>36%</td>
<td>8%</td>
</tr>
<tr>
<td><strong>Others</strong></td>
<td><strong>Congenital</strong></td>
</tr>
<tr>
<td><strong>Injuries</strong></td>
<td><strong>Diarhoea</strong></td>
</tr>
<tr>
<td><strong>Malaria</strong></td>
<td><strong>3%</strong></td>
</tr>
<tr>
<td><strong>Measles</strong></td>
<td><strong>8%</strong></td>
</tr>
<tr>
<td><strong>3%</strong></td>
<td><strong>8%</strong></td>
</tr>
<tr>
<td><strong>3%</strong></td>
<td><strong>7%</strong></td>
</tr>
<tr>
<td><strong>25%</strong></td>
<td><strong>3%</strong></td>
</tr>
<tr>
<td><strong>Source</strong>: WHO</td>
<td><strong>Others</strong></td>
</tr>
</tbody>
</table>

Under-nutrition is an underlying cause of one-third of deaths among children under five years of age.
Almost two million under-five deaths occur each year due to pneumonia. Early access to treatment through community case management can save 42% of neonates, 36% of infants and 30% of those between 0–4 years of age.

Diarrhoea accounts for 1.6 million deaths in under-five children. Low osmolarity oral rehydration solution (ORS) and zinc supplementation as recommended by WHO and the United Nations Children’s Fund (UNICEF) can reduce deaths by 88%. However, less than 40% of children with diarrhoea in developing countries are treated with these. Guidelines to support these recommendations should be updated at the country level.

Paediatric HIV can be restricted by prevention of mother-to-child transmission (PMTCT) of HIV. However, antenatal coverage is low and access to treatment for HIV poor. The Department of Child and Adolescent Health, WHO headquarters, is advocating for care and treatment of HIV in children and building capacity in countries and identifying research priorities.

One of the reasons for the poor progress of MCH interventions in some countries is uneven coverage patterns across these interventions. To achieve equity, supportive policies need to be in place. Coupled with the formidable challenges in health financing and human resources, lack of policy measures poses a serious threat to the rapid scaling-up of effective MNCH interventions. The implementation of a systematic framework to assess policy and health system indicators at the country and global levels is critical to facilitating result-oriented action in this area.

4.1.2 Progress and challenges in MDGs 4 and 5 in the SEAR — Revitalizing PHC: a window of opportunity for MNCH strengthening

(a) Dr Dini Latief, Director, Family and Community Health, WHO/SEARO, made a presentation on “Accelerating progress in MNCH through multisectoral actions in the South-East Asia Region”.

The root causes of maternal, newborn and child mortality lie in gender inequality, low access to education, especially for girls; early marriage; adolescent pregnancy; sexual and reproductive health; and other social and economic determinants. MNCH is also affected by other health factors, such as nutrition, prevention and treatment of malaria, and HIV/AIDS. Coordinated, multisectoral action is needed to address these issues. Achievement of the MDGs can be accelerated by providing universal coverage of key public health interventions to address inequities in health, intersectoral collaboration and community participation.

The lives of mothers, newborns and children are also affected by the quantity and quality of health spending on MNCH. A public health expenditure of a minimum of US$ 35 per capita is needed to achieve universal coverage for MNCH care. Cost-effective interventions for MNCH need to be scaled up for universal access to a continuum of MNCH care.

The child health programme has been relatively successful in improving the health of infants and children aged between 1–59 months through immunization and management of common illnesses. A majority of the Member countries of the Region are on track for achieving MDG 4 although the child health programme faces new challenges. While continuing to address issues, we now need to pay more attention to ensuring optimal child development.

Situational analysis on MNCH – progress in achieving MDGs 4 and 5

In late 2007, the Inter-Agency Expert Group on MDGs inserted MDG 5B to the corpus of goals, viz. “Achieve, by 2015, universal access to reproductive health”.

High-Level consultation to accelerate progress towards achieving maternal and child health Millenium Development Goals (MDGs 4 and 5) in South-East Asia
<table>
<thead>
<tr>
<th>Indicators</th>
<th>Bangladesh</th>
<th>Bhutan</th>
<th>DPR Korea</th>
<th>India</th>
<th>Indonesia</th>
<th>Maldives</th>
<th>Myanmar</th>
<th>Nepal</th>
<th>Sri Lanka</th>
<th>Thailand</th>
<th>Timor-Leste</th>
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<th>World</th>
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<tbody>
<tr>
<td>Maternal health</td>
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<td>Antenatal care - 4 or more visits</td>
<td>16</td>
<td>-</td>
<td>95</td>
<td>51</td>
<td>81</td>
<td>91</td>
<td>66</td>
<td>29</td>
<td>-</td>
<td>74</td>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contraceptive prevalence</td>
<td>58</td>
<td>31</td>
<td>69</td>
<td>56</td>
<td>60</td>
<td>39</td>
<td>37</td>
<td>48</td>
<td>70</td>
<td>72</td>
<td>10</td>
<td>57</td>
<td>63</td>
</tr>
<tr>
<td>Skilled attendant at delivery</td>
<td>20</td>
<td>51</td>
<td>97</td>
<td>47</td>
<td>66</td>
<td>84</td>
<td>57</td>
<td>19</td>
<td>97</td>
<td>97</td>
<td>19</td>
<td>48</td>
<td>65</td>
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<tr>
<td>Neonatal tetanus protection (2006)</td>
<td>92</td>
<td>84</td>
<td>90</td>
<td>86</td>
<td>83</td>
<td>94</td>
<td>87</td>
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<td>88</td>
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<td>Child health</td>
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<td></td>
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</tr>
<tr>
<td>Measles immunization (2006)</td>
<td>81</td>
<td>90</td>
<td>96</td>
<td>59</td>
<td>72</td>
<td>97</td>
<td>78</td>
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<td>99</td>
<td>96</td>
<td>64</td>
<td>65</td>
<td>80</td>
</tr>
<tr>
<td>Exclusive breastfeeding* (&lt;6 months)</td>
<td>37</td>
<td>-</td>
<td>70</td>
<td>46</td>
<td>40</td>
<td>10</td>
<td>15</td>
<td>53</td>
<td>53</td>
<td>53</td>
<td>5</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>Breastfed with complementary feeding*</td>
<td>52</td>
<td>-</td>
<td>31</td>
<td>56</td>
<td>75</td>
<td>85</td>
<td>66</td>
<td>75</td>
<td>-</td>
<td>43</td>
<td>82</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vitamin A supplementation (6-59 months, at least one dose)*</td>
<td>83</td>
<td>-</td>
<td>95</td>
<td>64</td>
<td>76</td>
<td>-</td>
<td>95</td>
<td>96</td>
<td>61</td>
<td>-</td>
<td>35</td>
<td></td>
<td></td>
</tr>
<tr>
<td>With ARI symptoms taken to facility</td>
<td>19.9</td>
<td>-</td>
<td>-</td>
<td>69**</td>
<td>61</td>
<td>-</td>
<td>-</td>
<td>34</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>With diarrhea receiving ORT</td>
<td>83.4</td>
<td>-</td>
<td>-</td>
<td>43**</td>
<td>61</td>
<td>-</td>
<td>-</td>
<td>41</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>11</td>
</tr>
</tbody>
</table>

Table 1: Coverage levels of key effective interventions in SEA (2000–2006)

*State of world’s children 2008
**National Family Health Survey(2005-06) India
While four countries of SEA Region (DPR Korea, Maldives, Sri Lanka and Thailand) have or have almost achieved universal access to skilled care at birth, in three other countries (Bangladesh, Nepal and Timor-Leste) the proportion of deliveries attended by SBAs is only 20% or less. India and Bhutan have a proportion of around 50%, while Indonesia and Myanmar have a proportion closer to 60–70%. On the issue of reducing the MMR by 75% by 2015, which is the target for MDG 5, seven countries in the Region are unlikely to achieve the same given their current rates of progress.

The progress in achieving MDG 4 is more encouraging. Eight of the eleven SEA Region countries are firmly on track towards achieving MDG 4 by 2015. Two countries, Sri Lanka and Thailand, have already achieved a low level of child mortality. Neonatal mortality remains an issue in almost all Member countries, as it is closely linked with maternal health. The relative slow rate of decline in child mortality in India is worrying as it accounts for 78% of under-five child deaths in the Region.

**Nutritional status**

Approximately 30% of women are underweight and 12–16% have a short stature (indicative of previous chronic malnutrition), while the prevalence of iron deficiency anaemia ranges from 13.4% in Thailand to 87% in India. The Region also has the highest burden of low birthweight infants (ranging from 9% in Thailand to 30% in India) and underweight children (ranging from 9% in Thailand to 48% in Bangladesh). The prevalence of moderate-to-severe stunting ranges from 12% in Thailand to almost 50% in Timor-Leste, Nepal and India.

**Adolescent pregnancy**

Adolescent pregnancy is prevalent in Bangladesh, India, Nepal and Timor-Leste (15–25%). Such pregnancies increase the vulnerability to sexually transmitted infections (STIs) and HIV infection.

**Abortion**

WHO estimates that the abortion rate in 2003 in SEA Region was 23/1 000 women in the age group of 15-49 years. Unsafe abortions contribute to about 13% of maternal deaths. Abortions are legally permitted in DPR Korea, India and Nepal, and restricted in other Member countries. Even in countries where abortion is legal, access to safe services is restricted in the case of the vast majority of women. Sex-selective abortion is prevalent in India, despite concerted government efforts to address the issue.

**Other conditions affecting MNCH**

STIs and HIV infection also affect the health of mothers, children and the newborn. Though they have a relatively low incidence among pregnant women in many countries of the Region, their prevalence is increasing. They enhance the risk factors for poor maternal health and adverse pregnancy outcomes. Mother-to-child transmission of HIV is another threat. In 2004, there were 155 400 pregnant HIV-infected women in the SEA Region while 49 600 children became infected with HIV and another 31 000 children developed full-blown AIDS. Adequate interventions are needed for these populations.

Malaria in pregnancy remains a challenge, especially in endemic areas. Pregnant women are vulnerable to infection, which increases the risk of maternal mortality and morbidity due to anaemia. Other infections may result from reduced immunity, abortion, stillbirth, premature delivery and low birthweight infants.

**MNCH intervention package for universal coverage**

WHO-recommended interventions for improving MNCH include survival in a continuum of care from pregnancy, childbirth, postpartum and newborn care — to be delivered through the health services, the family and the community.
**Child health care interventions for universal coverage**

Interventions for essential newborn care must be continued and basic immunization ensured. In the area of nutrition, early and exclusive breastfeeding (EBF) followed by complementary feeding after six months with micronutrient supplementation would help ensure growth at this early stage. For children, the focus should be on prevention and management of malnutrition including child growth monitoring, and Integrated Management of Childhood Illness (IMCI), especially acute respiratory infections and diarrhoeal diseases. This would help move beyond survival towards a quality of life so that children can achieve their full potential.

(b) **Dr N. Kumara Rai**, Acting Director, Department of Health Systems Development, WHO/SEARO, made a presentation on “Revitalizing primary health care to accelerate the achievement of MDGs 4 and 5”.

The most valuable aspect of PHC is equity and social justice. PHC involves a package of essential and universally accessible health care that is geographically, economically and socially feasible, and evolves from time to time and country to country. The focus of PHC is on public health, which consists of preventive, promotive and disease control activities, without neglecting the need for medical care. Revitalization of PHC is imperative to reduce the disease burden.

The PHC approach encompasses the following elements: (i) universal coverage with interventions, or equity of access; (ii) use of appropriate technology in an efficient and cost-effective manner; (iii) community participation; and (iv) intersectoral collaboration.

**Selective versus comprehensive PHC**

Comprehensive PHC was being promoted in the initial years of the PHC movements. This involved the implementation of a package that contained at least eight elements. However, many development partners wanted to achieve results or eliminate health problems involving a very high mortality and morbidity, for which a horizontal approach was not appropriate. For example, child survival, making pregnancy safer, and smallpox/leprosy eradication require a vertical approach. To achieve good and sustainable results with a vertical approach or selective PHC, health systems need to be strengthened. To this end, the Global Alliance for Vaccines and Immunization (GAVI), the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) and other agencies have agreed to set aside some funds for health systems strengthening.

The new health systems framework consists of six building blocks: service delivery; health workforce; information; medical products, vaccines and technology; and financing and leadership/governance. The two that are most important are health workforce and financing. There is a strong positive correlation between health workforce density and service coverage and health outcomes. Most countries experience a mismatch in urban–rural distribution, medical care and public health, and supply and demand. Added to this is the factor of external and internal migration. The focus of the initiative to revitalize PHC should be the community health worker, whose roles and numbers should be expanded.

In most Member countries of the Region, health care relies on out-of-pocket (OOP) spending. This can lead to colossal expenditures on the part of the citizen that can culminate in exacerbating poverty. Each year, 100 million people are impoverished by OOP expenditure. Now, social security is being advocated so that health financing is funded through a tax-base corpus or social insurance. The efficiency of resources can be enhanced by ensuring that the spending is on an appropriate mix of activities and interventions, both allocative and technical.
The health inequities in the area of MNCH are striking. The ratios of inequities in access to skilled care at birth are most striking in Bangladesh and Nepal, while differences in access are significant in India, Indonesia and Nepal. The inequities in child health services are less striking — although they still need improvement — than those in MNH and other reproductive health areas.

There are inequities in the coverage of the third dose of diphtheria, pertussis and tetanus vaccine (DPT3). India has the lowest coverage rates, while Sri Lanka and Thailand have the highest in the Region. Significant differences across income groups are seen in Bangladesh, India, Indonesia, and Nepal, although the gap between the rich and poor has narrowed in Indonesia and Nepal. On the other hand, coverage rates among the rich and poor in Sri Lanka and Thailand are similar, suggesting that attaining near universal coverage may be critical in reducing socioeconomic inequities for this indicator. The inequities in measles immunization coverage are less striking with the highest levels of difference found in India.

Figure 3: Use of basic maternal and child health services by lowest and highest economic quintiles, 50+ countries

Addressing challenges of inequity in MNCH: policy implications

- Universal coverage of MNCH services eliminates health inequities and is, therefore, critical in accelerating progress towards achieving MDGs 4 and 5.
- There is an urgent need to increase per capita health expenditure (and public health expenditure) in countries to at least meet the minimum requirement for achieving universal access to basic health services, including MNCH services (estimated at US$ 35 per capita).
- Addressing the shortage of human resources for MNCH care, especially of SBAs at the community/primary-care level, is crucial for achieving universal access to MNCH care.
- Identifying and creatively addressing key strategic issues in MNCH at the national and subnational levels are crucial for prioritizing intersectoral collaboration in a coordinated manner.
- The achievement of MDGs 4 and 5 is closely related to the achievement of several other MDGs.
- Effective intersectoral collaboration and actions are needed to address health inequities in MNCH. This will involve engaging other government sectors at different levels, the private sector, institutions, professional organizations, international and national NGOs, as well as civil society and local communities.
- Exchange of information and experiences between countries provides opportunities for learning.

4.1.3 Making an investment case in maternal, newborn and child health

Dr Elizabeth Mason, Director, Department of Child and Adolescent Health and Development, WHO/HQ, Geneva, made a presentation on “Investing in maternal, newborn and child health — a case for Asia and the Pacific”.

This investment case was made by several partners who have come together [WHO, UNICEF, Asian Development Bank (ADB), Bill and Melinda Gates Foundation (BMGF), United States Agency for International Development (USAID), and the World Bank (WB), among others] to ascertain how mothers and children can be better cared for. The objectives of this investment case were to highlight the need to accelerate progress to achieve MDGs 4 and 5; mobilize additional resources from governments and development partners to invest in MNCH; identify “best buys”, or cost-effective interventions that will have the most impact on maternal and child mortality; change incentives and behaviours by improving the efficiency (technical and allocation) of spending on health; and improve equity by protecting the poor against catastrophic spending on health.

Why invest in maternal, newborn and child health?

(1) The health of women and children is vital in itself. This is the basic principle behind most developmental work and has been recognized in several UN conventions.
(2) There are proven, affordable ways of saving the lives of women and
children, which could prevent about two-thirds of child deaths and a significant proportion of maternal deaths.

(3) Investing in MNCH makes economic sense. Preventing illness can save up to US$ 700 million globally per year for child survival alone. Every dollar spent on family planning saves four or more dollars of spending on complications of unplanned pregnancies.

(4) Investing in MNCH has political benefits, including social stability and human security.

(5) Investment in MNCH along the continuum of care from pre-pregnancy to infancy and beyond strengthens the health system. If a country can provide 24-hour emergency care of good quality for complications during delivery, it is a sign that necessary physical and human resources are in place.

The experience of Malaysia, Sri Lanka and Thailand has shown that progress is possible. These nations have achieved palpable reductions in MMR since the 1960s.

**Why invest in the Asia-Pacific Region?**

(1) The Asia-Pacific region accounts for 40% of all maternal and child deaths (SEAR 30%). Half of all global newborn deaths occur in Afghanistan, Bangladesh, China, India, Indonesia and Pakistan. About one-third of countries are unlikely to achieve MDGs 4 and 5 at the current rates.

(2) The high maternal and child mortality and morbidity is due to several causes. The coverage of many key interventions is low; for example, only 41% of mothers in South Asia have access to an SBA and access to emergency care is inadequate. Many common childhood diseases go untreated. The recent increase in the cost of food is likely to aggravate the existing poor nutritional status.

**Why spending is critical?**

(1) Spending on health is inadequate. South Asia spends US$ 26 per capita per year compared to the world’s average spending of US$ 32 per capita per year. Spending on MNCH as a percentage of total health spending is low.

(2) Spending on health is inefficient. Scarce resources are often not allocated to areas where they will have the biggest impact. Global spending on acute respiratory infections (ARIs) attracts less than 3% of donor funding, although it accounts for 21% of the total burden of disease leading to child deaths. Nutrition programmes remain chronically underfunded, though undernutrition contributes to 35% of mortality in children and a huge proportion of morbidity in mothers.

(3) Spending on health is inequitable. Poor people often have to pay out-of-pocket, which drives them to even greater poverty or compel them to forego care.

(4) Incentives are needed in spending. Incentives can be a powerful way of changing the behaviours of providers and patients. However, payments to institutions and people are not linked clearly enough to performance or good outcomes.

(5) Implementation is often incomplete. Funding for key programmes that build health systems and determine MNCH outcomes are not fully implemented,
often because funding is not adequate. Programmes and interventions are often not implemented along the continuum of care from pre-pregnancy to infancy and beyond, which results in a fragmented approach to MNCH. In addition, quality of care is often variable and not optimal.

What to invest in and how much will it cost?

(1) How much will the core package cost? The precise composition of the “best buys” will vary from country to country, and over time, depending on health burdens, costs, capacities, etc.

(2) How much will additional interventions cost to achieve MDGs 4 and 5? Core interventions such as antenatal care, skilled birth attendance, basic family planning, essential newborn care, promotion of exclusive breastfeeding and immunization, among others, would cost less than US$ 3 per capita per year (US$ 1.21 for child health and US$ 1.76 for maternal and neonatal health) to implement. This includes the cost of supportive delivery strategies such as conditional cash transfers, provider incentives for home visits, improved training and supervision and the like.

Implementation of expanded interventions in addition to core ones such as complementary and therapeutic feeding, zinc supplementation, new vaccines and family planning would cost less than US$ 5 per year. This includes the cost of putting in place supportive delivery strategies such as performance incentives and health systems investments to strengthen human resources and infrastructure at the PHC level.

<table>
<thead>
<tr>
<th>Category</th>
<th>Examples of interventions</th>
<th>Examples of strategies to support delivery of interventions</th>
<th>Additional cost per capita per year (US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core</td>
<td>Antenatal care, skilled birth attendance, basic family planning, essential newborn care, promotion of exclusive breastfeeding, immunization, vitamin A supplementation, oral rehydration &amp; zinc, case management of childhood diseases (for example, pneumonia, diarrhoea, malaria), hand-washing promotion, insecticide-treated bednets</td>
<td>Conditional cash transfers, provider incentives for home visits, improved training and supervision</td>
<td>Less than 3</td>
</tr>
<tr>
<td>Expanded</td>
<td>In addition to core interventions: Complementary and therapeutic feeding, zinc supplementation, new vaccines, family planning</td>
<td>Performance incentives and health systems investments to strengthen human resources and infrastructure at primary health care level</td>
<td>4-6</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>In addition to core and expanded interventions: emergency obstetric and neonatal care, anti-retrovirals for HIV/AIDS, water and sanitation</td>
<td>Performance incentives and health systems investments to strengthen human resources and infrastructure at referral-level care</td>
<td>8-12</td>
</tr>
</tbody>
</table>

Source: Estimates based on on-going inter-agency analysis by individuals in the Maternal, Newborn and Child Health Network for Asia and the Pacific for the development of country-specific investment cases. Strategies and numbers vary depending upon the country-specific context.
Implementation of comprehensive interventions (in addition to core and expanded ones) such as emergency obstetric and neonatal care, antiretrovirals (ARVs) for HIV/AIDS, water and sanitation would cost less than US$ 10 per capita per year, inclusive of performance incentives and strengthening human resources.

What is new in the investment case that gives the confidence that it will work?

The investment case is grounded in the latest evidence and identifies the “best buys”. It uses the power of money to provide incentives and change behaviour. Supporting the investment case is the partnership of governments and development partners.

Investing in MNCH: Key messages

- Investing in MNCH is an investment in social justice, social stability and economic productivity.
- The “business as usual” approach to MDGs 4 and 5 is failing too many people in the Asia-Pacific.
- Unless significant additional resources are mobilized, MDGs 4 and 5 will not be achieved.
- Additional investment of <US$ 3 per person per year can make a significant contribution towards reaching MDGs 4 and 5.
- To achieve MDGs 4 and 5, larger and long-term investment is needed, particularly in the health system.
4.2 Theme 1: Social determinants — implications for MNCH programming

This session was chaired by Dr K.R. Nayar, Professor, Centre of Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi. He also made a presentation on “Social determinants and Maternal Newborn and Child Health”.

An approach to the social determinants of health has to be part of a wider strategy to grapple with the problem of MNCH. It requires a triadic but interrelated framework consisting of: (i) universal factors, (ii) regional factors, and (iii) country-specific factors.

**Universal factors — Poverty and development**

Data show differentials between developed and developing countries with regard to health status, mortality and morbidity. They show possible linkages between development, poverty and physical condition. Exceptions such as Sri Lanka need further explanation, and highlight the possible role of lower income differentials but better social provisioning. Unequal distribution of wealth, political power, cultural assets, class and occupational status, etc. could also be important determinants of health outcomes.

The actions proposed by the international community to achieve MDGs 4 and 5 are:

- establishing national policies;
- laying down standards and regulatory mechanisms for safe motherhood and developing systems to ensure their implementation;
- promoting appropriate community practices;
- monitoring maternal and newborn health-care status and access to services; and
- supporting programmes for immunization, the use of ORS, nutrition, and water and sanitation interventions.

**Regional factors — Diversities**

These involve intersectoral linkages that comprise social sector actions and health development. Two scenarios are possible — one is distribution-based and the other growth-based. The first scenario is discernable in Sri Lanka and Kerala state in India, among others. It includes measures such as redistribution policies in land which benefit poor peasants; focus on rice-growing peasantry, the poorest social group, which led to a reduction in regional disparities and inequalities; fulfillment of basic needs; a selective programme on housing which benefits landless labour; expanding a protected water supply programme; making higher investments in education; eradication of poverty; and overall improvement in the quality of life. These policies and programmes are being implemented since the 1970s and have remarkably contributed to the progress in the health status of some countries.

The second scenario is seen in some countries such as Thailand. Growth and expansion of the economy was accorded more importance than distribution. High rate of growth in agriculture led to more employment and availability of food. Diversification of crops along with massive industrialization helped in export earnings, spread of education and literacy, programmes on basic needs, poverty alleviation and improvement of the quality of life.

Both the scenarios are important. Thus, there should be a differential approach to health development in the Region.
Country-specific factors — Need for a contextual approach

Issues to be tackled include differential mortality among girls and boys, and adverse sex ratios. Empowering women through appropriate economic and social programmes could be one of the ways to grapple with this “inequality trap” that women face, which may indirectly impact MNCH outcomes. Social exclusion refers to the inability of society to keep all groups and individuals within reach of what is expected of society to realize their full potential. Economic capability, gender, age, caste and religion, education, etc. are important variables that indicate exclusion from social and economic opportunities.

- Gender is one of the important social dimensions and requires a multidimensional approach, especially in the area of MNCH. The differential treatment of males and females with regard to food and medical care and the discrimination that females face during early childhood have contrary consequences on MNCH.

- Income differentials and socioeconomic status: A striking association was seen between the socioeconomic status of families and under-five mortality rates in a population of children in 43 resource-poor countries.

Thus, the focus has to be on the poorer classes and marginalized sections which are at a higher risk of diseases as well as have a higher probability of being excluded from the health services.

Implications for programming

Focused and affirmative actions and social mobilization are needed. This implies: (i) organization of marginalized groups in the villages (focused group actions) to address the problem of social exclusion and ensure equal opportunity and community participation; (ii) formation of empowered action groups of women which could influence other women in moving towards a safe and vibrant MNCH programme; and (iii) a decentralized data-gathering mechanism can be evolved through the channels mentioned above. These data can also be used as a needs-assessment strategy.

Levels of social sector actions on maternal and child mortality

The need of the hour is intersectoral convergence and focus on PHC. More pro-active actions are needed including policy statements incorporating social determinants to ensure “a world in which all people have the freedom to live and have reason to value”.

4.2.1 Case studies

4.2.1.1 The basic minimum needs programme and MNCH: Thailand

This case study was presented by Dr Nanta Auamkul, Director, Bureau of Technical Advisors, Department of Health, Ministry of Public Health, Thailand.

Basic minimum needs (BMN) is household information on the different aspects of the quality of life of household members at a specific period. These aspects are together defined as a living standard that one should attain to live happily in society. Essential needs in a family are dwelling, food, clothes, and access to medicines, safe drinking water, water supply, sanitation, health services, education, etc.

BMN and the quality of life

BMN indicators are tools for supporting the learning process of villagers to monitor their own progress in achieving the BMNs. The principle is to help promote people’s participation in community development. A village/community participates in collecting data, identifying
problems, conducting a needs analysis and risk factor identification. The results of BMN act as a guide in approving as well as creating projects/programmes and activities from the national to the household level. The results are used for planning and implementation. Activities are implemented at three levels: (i) by the government sector; (ii) by the community and government sector; and (iii) by individuals/households/community.

**Administration of BMN data collection**

A BMN questionnaire has been developed to collect data and the 2008 report on the quality of life of the Thai people has been published.

**Evolution of BMN and MNCH.**

BMN was introduced in the Third National Economic and Social Development Plan (NESDP) (1972–1976) for rural development. Information collection for BMN began in 1985 with the Fifth NESDP (1982–1986). The current NESDP (2007–11) collects information on six categories through 42 indicators. Family Bonding Hospitals and Mother Support Groups have been expanded throughout the country for comprehensive care of mother and child. Multisectoral partnerships across various government departments have been initiated.

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**Future challenges for the Basic Minimum Needs programme in Thailand**

- BMN needs to be converted to an actual community action plan and innovation. The vision is health self-care, with the ability to respond to the social and physical environment in a proper manner, along with the ability to initiate and implement social measures.

- This calls for a paradigm shift and shows a need to balance a process-oriented approach and an output/outcome-orientated approach, as well as shift from a service-oriented to a development-oriented approach.
4.2.1.2 Health-promoting schools: A case study on school health in the Maldives

Mr Ahmed Shafeeu, Director-General, Ministry of Education, Maldives, presented the case study. Maldives is on track for achieving MDGs 4 and 5. MDG 4 was achieved in 2005.

Maldives Health Promoting Schools Initiative (MHPSI)

The school health programme was initiated in 1986. The education and health sectors of Maldives work hand-in-hand to create a “health literate” community. The MHPSI was initiated in 2004 and has been very successful. The main purposes of the MHPSI are:

- To provide support to schools for increasing the number and variety of health-related activities.
- To promote involvement of entire school communities in health-related activities and school life.
- To help schools become healthier places for students and staff to learn, work and develop.

Coordination and management

The MHPSI is organized and coordinated by the School Health Unit, Ministry of Education and linked with national policies and strategies, especially those related to health and education. It is steered by a National Advisory Group, which provides advice and direction on the development of the initiative.

Key achievements of the Health Promoting Schools Initiative in Maldives

- Existence of a policy framework within both the education and the health sectors.
- Inclusion of health promotional material in the curriculum.
- Joint programme by UNICEF, the Ministry of Health and the Ministry of Education to provide Vitamin A to children. Later, a deworming component was also included.
- A teacher-focal point carries out health awareness programmes in the atolls.
- Specific initiatives such as water safety, disaster preparedness, life-skills education, and an anti-smoking campaign were initiated and carried out as part of the school health education programme.
- The Global Health Promoting Schools Initiative was adopted and is being implemented in Maldivian schools.
- A Health Promoting School Handbook and a School Health Policy have been published and disseminated.
4.2.1.3 National Commission for Women and Children: Bhutan

Ms Sonam Palden, Assistant Programme Officer, National Commission for Women and Children (NCWC), Bhutan, made a presentation on the NCWC.

Bhutan is party to several international and regional treaties and agreements to improve the status of women in society. The National Commission for Women and Children (NCWC) was constituted in 2004 to overcome the absence of a ministry for women and children.

Membership of the NCWC includes the National Assembly, NGOs, the private sector, media, academia/academic institutions, Royal Bhutan Police, Office of Legal Affairs, Ministry of Labour and Human Resources, Ministry of Education, Ministry of Health and civil society.

Mandate and functions

These include coordination, monitoring and reporting on issues related to women and children.

Collaboration and NCWC inputs

Work started with sensitizing and creating awareness among the judiciary, legislative bodies, nongovernmental organizations (NGOs) and monastic institutions, executive bodies and the Royal Bhutan Police. Women- and child-friendly judicial and law enforcement procedures have been instituted and the juvenile justice system reviewed. The rights of women and children have been promoted among the legislature. A better understanding of human rights and its intricate association with Buddhist precepts has been promoted among monastic institutions and NGOs. The National Plan of Action for Gender is one of the biggest achievements and has received cross-sectional inputs.

4.2.1.4 Empowerment of women and its impact on women and children’s health: the SEWA model

Ms Mirai Chatterjee, Coordinator, Self Employed Women’s Association (SEWA) gave an overview and touched upon the salient activities undertaken by SEWA.

The Self-Employed Women’s Association (SEWA) is a trade union formed in 1972. It has spread to nine states of India and has a total membership of 1.1 million. The SEWA movement has more than 3 000 economic organizations of poor women, 100 cooperatives in a federation, self-help groups and four health cooperatives.

SEWA’s main goal is full employment, which includes work, income, food, social security, and self-reliance both economically and in taking decisions related to one’s life.

SEWA’s health programme is implemented mainly through the Lok Swasthya SEWA Cooperative. It is led, managed and owned by women. It has a health cooperative of midwives and health workers, and tries to provide holistic PHC at the doorstep in a sustainable way. Partnerships have been forged with the government and other partners for programmes such as the tuberculosis (TB) programme and others. It generates its own revenues and has a holistic and integrated approach—with work security, financial services and child care. SEWA also works closely with the state and central governments in addressing programmes aimed at the social determinants of health, such as the Chiranjeevi programme. SEWA was represented in WHO’s Commission on the Social Determinants of Health.

Elements of SEWA’s Women and Child Health Programme

The main elements of this SEWA programme are health education, maternal care, referral systems, children’s health, community-based monitoring, and capacity-building.
**Impact of the SEWA programme**

In its report, the Commission on the Social Determinants of Health found declines in the levels of maternal mortality and morbidity, and infant and child mortality and morbidity in areas covered by SEWA. This was brought about by empowering women to take control of their lives and those of their children. One of the major factors hampering progress in health was financial constraints resulting from debts. A decentralized doorstep approach led by women was perceived as most useful. An integrated approach—organizing for solidarity, financial services, employment, capacity-building and social security—was empowering.

**Lessons learned from the programmes of the Self-employed Women’s Association in promoting MNCH**

- A women-led approach is crucial.
- Sustainability is achievable even in the health sector. SEWA produces its own medicines which are sold door-to-door by a local trained force of “1 000 barefoot doctors”.
- The approach to health services should be decentralized and based on local villages and urban neighbourhoods.
- Most common health conditions can be ably attended to by a local worker.
- Supportive supervision of local workers on an ongoing basis is essential.
- A social determinants approach leads to better health outcomes.
- Equity and social justice in health and other sectors is achievable more often when women lead.
- Partnerships are mutually strengthening and lead to positive outcomes.
- Health insurance must be extended to all and not just to those below the poverty line (BPL).
- Grassroots action and mobilization must be linked to policy action.

**Challenges**

- Organizing (mobilizing) women, especially the poor, is a slow, steady and ongoing process.
- Recognition and proper remuneration must be given to local health workers.
- Capacity-building, especially of grassroots-level or “front-line” workers, has to be ongoing—it is time-intensive and requires human and financial resources.
- Sustainability is difficult, as reaching the poor involves high costs. Thus, partnerships have to be built with the government to underwrite the costs.
- Policy shifts are required in the direction of the social determinants.
4.3 Overview of MNCH innovations in Gujarat

Dr Amarjeet Singh, Principal Secretary, Family Welfare and Commissioner Health, Gujarat, gave an overview of the Gujarat experience on reducing maternal and child mortality.

**Gujarat’s goals in the health sector**

- Reduce maternal and child mortality and morbidity.
- Address the adverse sex ratio.
- Stabilize population growth.
- Effectively implement national health programmes and address locally endemic diseases such as leptospirosis, sickle cell anaemia and thalassaemia.
- Provide state-of-the-art health and medical education relevant to local needs.
- Make the health system more accountable, transparent and efficient to enhance equity, quality, access, cost-effectiveness and user satisfaction with the health services.
- Provide an environment in which the health team effectively achieves the above goals.
- Develop public health capacities and systems to effectively address the determinants of good health such as potable water, sanitation, nutrition and a healthy environment, as well as to promote healthy lifestyles.

**Chiranjeevi scheme**

Efforts to operationalize First Referral Units (FRUs) for provision of emergency obstetrics care have not been successful. Efforts to rope in insurance companies also failed. The tradition of Public-private Partnerships (PPP) in Gujarat made involvement of the private sector a viable option.

The Chiranjeevi scheme was launched to improve emergency obstetric care with the involvement of the private sector. The process involved a long consultative process of about a year with all stakeholders and the involvement of the Indian Institute of Management, Ahmedabad (IIMA) and GTZ, as well as meeting with all insurance companies, conducting a survey of private obstetricians and gynaecologists, in the State, and getting the Federation of Obstetricians and Gynaecologists of India (FOGSI) on board.

To start with, rates for deliveries were fixed with NGOs. The scheme was piloted in the five worst-affected districts. Meetings were held with the panchayat functionaries and elected representatives in these districts. An advance was given to obstetricians who signed the memorandum of agreement (MOU). Prompt payments were ensured and good doctors rewarded. Differential rates were fixed for deliveries, depending on the complications (such as Rs 800 for a normal delivery and Rs 5 000 for a caesarean section), with the proviso that one doctor could not perform more than 7% caesarean sections. The person accompanying the woman was also paid, as were transportation costs, irrespective of the mode of transport.

The entire State is connected to an ambulance service known locally as the “108” service after the number to be dialed for emergency transportation to a health facility. Several deliveries have been conducted in the ambulance. Currently, about 500 calls are attended to every day.

The outcome of the Chiranjeevi scheme is given below. However, about half the BPL women have yet to be reached. From about 63.5% institutional deliveries two years ago, the figure has now risen to 87%. The MMR has fallen to 136 per 100 000 live births but the aim is to reach 100 per 100 000 live births.
**Child and adolescent health**

Implementation of IMNCI started in 2006 in 18 districts. This is a convergence of the health sector with the Integrated Child Development Scheme (ICDS). The skills of doctors in emergency newborn care are being upgraded and government facilities are being strengthened (newborn corners, sick baby corners and neonatal care units). A PPP scheme for newborn care is under way and a paediatrician-on-call scheme is being launched in the entire State.

The Bal Sakha Schemes 1 and 2 are for BPL beneficiaries and involve private paediatricians who will be paid to look after newborns and children. Charges have been proposed for various services.

The Mamta Taruni model looks after adolescent girls with weight monitoring; iron and folic acid (IFA) supplementation; treatment for reproductive tract infection (RTI)/STI; information, education and communication (IEC) and behavioural change communication (BCC).

**Infrastructure and capacity building**

Institutions are being upgraded, strengthened and improved. Hospitals, laboratories and medical colleges are institutionalizing accreditation (National Board of Accreditation of Hospitals (NABH) and National Board of Accreditation of Laboratories (NABL)) in three phases. Eight hospitals are ready for accreditation. All institutions and hospitals plan to be accredited by the end of 2009.

Extensive training is being given to doctors in public health and, at any time, 50 doctors are under training. Twenty-five per cent of postgraduate seats are reserved for doctors working in remote and rural areas. Institutes such as the IIMA, Mudra Institute of Communications, Ahmedabad (MICA) and Indian Institute of Health Management Research (IIHMR) are being used for training in various disciplines such as management and communications. The Public Health Foundation of India (PHFI) has also set up an institute in Gujarat.

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**Table 3: Outcome of Chiranjeevi Scheme in Gujrat, India**

<table>
<thead>
<tr>
<th>Total deliveries under Chiranjeevi Scheme</th>
<th>Expected maternal deaths</th>
<th>Maternal deaths reported under Chiranjeevi Scheme</th>
<th>Mothers saved under Chiranjeevi Scheme</th>
<th>Expected newborn deaths</th>
<th>Newborn deaths reported under Chiranjeevi Scheme</th>
<th>Newborns saved under Chiranjeevi Scheme</th>
</tr>
</thead>
<tbody>
<tr>
<td>235 289</td>
<td>941</td>
<td>46</td>
<td>895</td>
<td>8941</td>
<td>987</td>
<td>7954</td>
</tr>
</tbody>
</table>

- Normal deliveries: 205 922
- C-Section: 14 535 (6.18%)
- Complicated deliveries: 14 832 (6.30%)
- Private specialist enrolled: 868

Source: Presentation made by Dr Amarjeet Singh at the consultation
4.4 Field visits

Mr Meghendra Banerjee, National Programme Officer, WHO Country Office India, was the coordinator for the field visits and gave brief details of each of 10 field sites where Gujarat’s progress in implementing innovative public health interventions could be seen. The main purpose of this presentation was to sensitize participants about the MNCH innovations in Gujarat. Participants could opt for field sites along 10 routes. Stalls describing each of the 10 routes were set up with facilitators at each of them to help participants make a choice and register their names. Leaflets describing each route were distributed.

The teams were briefed about what to ask at the sites and open-ended questions were suggested. For example,

- What are you most proud of?
- Tell us a story about a challenge you faced and how you overcame it.
- Why do you think your experience has been successful?
- What tips can you give to someone wanting to start the same thing?

The field visit sites were selected to demonstrate Gujarat’s innovative experiences in the following:

- Integrated outreach programme
- Emergency medical response
- Infrastructure development initiative
- Innovative human resources management
- Quality assurance strategies
- Community empowerment programmes
- Integrated programmes implemented by NGOs
- MNCH services in urban setting
- Meeting the key management team responsible for all the actions

4.4.1 Objective

The general objective of the field visits was to draw out key concepts that could lead to insights for improving the effectiveness of the MNCH programme in the respective countries of the participants.
Each team summarized what they had observed at the visit and presented the findings. The overall observations of participants from all the groups were as follows.

### 4.4.2 Observations from field visits

#### At primary health centres

- Appropriate IEC materials on the walls of PHCs
- Observation of Mamta Divas (one Wednesday of every month)
- Interaction with local self-government—Rogi Kalyan Samiti
- Copper T insertion camp
- ANC check-ups being done by visiting gynaecologists
- Visiting paediatricians conducting check-ups
- Distribution of *sukhdi*, a fortified sweet to prevent malnutrition
- Good Health Management Information System (HMIS)—data available on all patients; all laboratory tests conducted to date; disaggregated data on confirmed cases of malaria, TB, HIV, among others
- Community ownership and involvement
- Standard preventive and curative services provided

#### At community health centres/district hospitals (CHC/DH)

- Many in the process of setting up quality assurance measures for accreditation by NABL and NABH accreditation
- Good HMIS, with networking and data-sharing among all PHCs and subcentres under the CHC/DH
- Disaggregated data available by age group
- Excellent examples of PPP
- Multisectoral integration of Government-run programmes such as ICDS and NRHM
- Streamlined delivery of MNCH services
- Decentralization of financial authority
- Conducting deliveries of HIV-positive women

#### At the Emergency Medical Research Institute

- Known locally as 108 services (number of emergency response services)
- Has saved the lives of innumerable women who would not have had access to institutional delivery
- Provides 24x7 transportation services
- Started in 2007. The entire state of Gujarat will be covered in the next few months
- Innovative ways of ensuring mother and newborn care, and reducing MMR and NMR
- Major share (95%) provided by government, partnered by private corporate partner
- Strong research and analysis component

#### Other observations

- Strong political commitment for providing MNCH and other services
- PHC revitalized
- Incredible increase in health financing despite relatively low per-capita health expenditure (Rs 700 per person, or US$ 18)
- Technical strengthening needed for collection of quality data
- Hygiene and sanitation could be improved in some places
- Additional space required in some district hospitals wanting to achieve accreditation.
4.5 Theme 2: Improving equitable access

This session was chaired by Dr Bulbul Sood, Country Director, Center for Development and Population Activities (CEDPA), New Delhi, India.

4.5.1 Session A: Improving equitable access to quality MNCH interventions

A presentation on “Improving equitable access to quality MNCH interventions” was delivered by Dr Sudhansh Malhotra, WHO/SEARO on behalf of Dr Vinod Paul, Professor and Chair, WHO Collaborating Centre for Training and Research in Newborn Care, All India Institute of Medical Sciences, New Delhi, who was unable to attend.

Equity is not only a moral imperative but also a programmatic necessity to attain the MDGs. When an intervention is introduced in any programme, the rich rapidly utilize it and it is almost 100% accessible to them, while the poor lag behind. However, if specific measures are taken for the poor, this gap can be reduced. The gap between the rich and poor is considerably narrower when it comes to PHC (23% uptake by the rich versus 15% by the poor). It is the responsibility of the social sector to promote health equity and its principles must be mainstreamed into the entire spectrum of health action. For example, if the objective is to reduce the IMR to <30 per 1000 live births by 2015 from 50 in 2005, it could be specified to reduce the IMR among the rural population to <50 per 1000 live births by 2015 from 75 in 2005 to bring in the equity dimension. Allocations for health priorities of the poor must find a place in budgeting.

Indicators for monitoring should be equity-sensitive. For example, an indicator such as the proportion of neonates who are breastfed exclusively at six months could have three components: infants of families below the poverty line, infants of tribal families who are exclusively breastfed at six months of age in addition to the overall exclusive breastfeeding rate at six months, and to assess how equitably programmes are implemented across populations.

Enhancing human and other resources for serving the poor should become a main plank of programmes. Community health workers and volunteers can play an important role in increasing the coverage of essential interventions for child survival. Under the aim of achieving universal coverage, direct and indirect targeting are important factors. In direct targeting, the beneficiary is identified and the intervention reaches the targeted individual, while indirect targeting can be done in various ways, for example by population group (e.g. farmers), geographical area (e.g. tribal districts), age (children), health problems of the poor (e.g. filariasis, diarrhoea), and universally applicable.

Targeting initiatives to the disadvantaged population segments can help achieve equity

- A well-designed, well-implemented targeted approach helps the poor and reduces inequity in health.
- Direct targeting can work, but needs particular care and effort.
- Targeting approaches may be combined for better effectiveness, e.g. geographical and individual targeting, age and illness targeting.
programmes. Both types of approaches are needed. An example of direct targeting could be to exempt the poor from user fees and an example of indirect targeting could be the geographical and rural focus of India’s National Rural Health Mission (NRHM).

Thailand has achieved spectacular success in reducing its under-five MR, from 27/1 000 live births in 1990 to 8/1 000 live births in 2006.

4.5.1.1 Case studies

4.5.1.1.1 Ensuring a continuum of MNCH care: the Sri Lankan experience

Dr Chitramalee de Silva, Acting Director MCH, Family Health Bureau, Ministry of Healthcare and Nutrition, Sri Lanka presented the Sri Lankan experience.

Sri Lanka has achieved universal MNCH coverage. Health and education are free. The MNCH service delivery system has a government and a private component. The government sector delivers curative as well as preventive care, while the private sector delivers curative and primary care. In the curative services, the lower levels of health services such as the district hospital, peripheral unit, rural hospital and maternity homes have a doctor, and others at higher levels provide comprehensive emergency obstetric services. In the preventive services, it is the family health bureau that covers maternal and child health.

The public health midwife (PHM) is the front-line health worker whose prime responsibility is MCH. She is trained for one-and-a-half years and looks after a population of 3000–5000. Her services are well accepted by the community, and she works according to a planned programme. She provides skilled assistance in the field.

A continuum of care is provided, which starts at the time of marriage. The family is registered by the PHM. They get pre-pregnancy care and then antenatal, intranatal, and postnatal care, as well as family planning and other services such as provision of services for cervical cancer screening.

Source: Presentation made by Dr Chitramalee de Silva at the consultation
Pre-pregnancy care has 98% coverage. Of the deliveries, 98% are in institutions and only 2% deliver at home; and 75% of deliveries take place in institutions where comprehensive emergency and obstetric care (CEmOC) services are available.

Postpartum care includes promotion of Exclusive Breastfeeding (EBF) (82% coverage), and 70% of postpartum mothers receive at least one domiciliary care by the PHM. The PHM refers for treatment if needed.

All maternal deaths are notified and investigated, and follow-up action taken.

**Specific interventions for reduction of maternal mortality**

Maternal death audits are in place at the field and institutional level, and reviews are conducted at district and national levels. CEmOC facilities have been strengthened and partograms are used for monitoring of labour. National guidelines on obstetric case management have been developed and followed.

**Specific interventions for reduction of neonatal mortality**

A continuum of newborn and child care is provided. Special interventions to reduce neonatal mortality and morbidity include essential newborn care in hospital and field settings with basic and in-service training for health staff, provision of comprehensive newborn care facilities at the district level, and quality improvement of newborn care through standard care practices with the development of national guidelines and protocols. There is a neonatal life support programme for hospital staff. An information system on perinatal and neonatal care as well as perinatal death audits has been pilot-tested and implemented.

**Infant and child care interventions**

Provision of domiciliary and clinic care includes the following:

- Registration of infants and regular follow-up.
- Promotion of EBF for the first six months and timely introduction of complementary feeding.
- Growth monitoring and promotion.
- Provision and promotion of age-appropriate immunization to all infants and children.
- Promotion of home-based care and monitoring the psychosocial development of children.
- Identification of risk factors at home which are detrimental to the psychosocial development of children.
- Protection of children from violence and all forms of danger.

However, undernutrition in the under-five age group still remains a challenge to overcome.

**School health services**

The PHC team visits all schools and conducts a medical inspection, supervises a healthy school environment and conducts health promotion and life-skills education. Referrals are made to specialized services if needed.

**Family planning**

Family planning (FP) services are integrated with the MCH services. Well-equipped FP services are available in all districts, and the uptake of contraceptives is 68%. There is an unmet need for FP of 10% and a relatively high rate of abortions.
4.5.1.1.2 Reaching out to the community: FCHVs in Nepal

Dr G.K. Shreshtha, Director, Health and Population Programme, National Planning Commission, Kathmandu, Nepal, made a presentation on this topic.

The Government of Nepal realized the weak implementation of health programmes at the community level and the importance of women’s participation, and started the Female Community Health Volunteer (FCHV) Programme in 27 districts in 1988. It was expanded to all 75 districts in a phased manner. In Nepal, the FCHV is the main social mobilizer and the person responsible for reaching the unreached. At present, there are 48,549 FCHVs. The goal of the FCHV programme is to reduce the neonatal, infant, child and maternal mortality rates, and the fertility rate. The smallest administrative unit in Nepal, which is the ward, has at least one FCHV. On an average, each FCHV looks after 80-120 households (a population of 1,000 approximately).

Main objectives of the FCHV programme

- To develop self-help mechanisms among rural women
- To enhance community involvement in PHC
- To promote community participation for the best utilization of available services.

FCHVs are selected by the local mothers’ group. The FCHV should be involved in social or other health activity, and could be from an ethnic minority/dalit community. Most are semiliterate or illiterate, and are non-paid volunteers. FCHVs receive 18 days of basic training after being enrolled and refresher training for five days once every five years. NGOs also provide the necessary education. After completion of training, the volunteer receives an identity card, a certificate, a medicine kit bag, flip charts for health education, and a bag and manual to assist her in discharging her duties.

Although over half the FCHVs are unable to read and write, they have remained key actors in several successful interventions. FCHVs are motivated to work voluntarily because of the social recognition they receive in their communities for their work.

Incentives to FCHVs An FCHV fund of NRs 50,000 is given to the Village Development Committee under which there are at least 9 FCHVs. FCHVs are provided free health services at district hospitals. There is mandatory FCHV representation in the Health Facility Management Committee, and they are involved in NGO/community-based organization health-
related activities. In-kind incentives are given by households. They are required to spend only five hours per week on their work.

**Positive aspects of the programme:**
The positive side of the programme includes government participation in all 75 districts covered; an FCHV database; door-to-door service delivery; increased access to and utilization of MCH services at the community level; and enhanced community participation and empowerment of women, which contributes to improved MCH.

**Challenges:** Deviation from volunteerism and lack of full community ownership remain challenges.

4.5.1.1.3 **Demand-side financing:**

**Maternal health voucher scheme in Bangladesh**

*Dr Md Abdul Halim*, Senior Consultant, Obstetrical and Gynaecological Society of Bangladesh (OGSB) Hospital & International Centre for Reproductive Health (IRCH), Mirpur, Dhaka, Bangladesh, made a presentation on behalf of the Bangladesh team.

**Maternal health scenario in Bangladesh**
The MMR in Bangladesh is 290–300/100 000 live births, and 88% of babies are delivered at home. SBAs attend only 18% of births and 80% of deaths occur during attempted deliveries at home. Among poor households, 69% do not have access to any ANC. Improvement of services through supply-side financing has not yet proved successful, and the degree of access to health services of poor and vulnerable people is not satisfactory.

**What is demand-side financing**
Demand-side financing directs subsidies to the target group to enable them to purchase specific services. A voucher is a form of demand-side financing; it is “a subsidy that grants limited purchasing power to an individual to choose from among an assigned set of goods and services”.

**Maternal Health Voucher Scheme**
The Maternal Health Voucher Scheme is a tool that addresses maternal and neonatal mortality by increasing the awareness and demand for maternal health services among poor pregnant
women. The MMR and NMR will reduce substantially by increasing institutional deliveries. The target beneficiaries are poor and vulnerable pregnant women who are effectively landless and earn less than Taka 2 500 per month.

**Entitlements of a voucher holder**

- Maternal health-care package: three ANC visits, safe delivery, one PNC visit within six weeks of delivery.
- Services for obstetric complications.
- Subsidy: Tk 500 (US$ 7) for transport costs to voucher-holders for institutional services and up to Tk 500 (US$ 7) for referral to district hospital.
- Gift to mother: Tk 500 (US$ 7).
- Cash to mother: Tk 2000 (US$ 29).

Services are provided by designated public, private and NGO providers, who are reimbursed through the Sonali Bank. Providers range from doctors, nurses and various levels of paramedical workers. A price structure has been laid down for various services. The first pregnancy is reimbursed and the second pregnancy is only if there is evidence of the use of contraceptives.

**Project support**

Technical and financial support has been extended by the Department for International Development (DFID), World Bank, United Nations Population Fund (UNFPA) and WHO. 73% coverage had been achieved between April 2007 and April 2008.

**Experiences**

The scheme has received considerable local political and administrative support, and the Ministry of Health and Family Welfare (MoHFW) has completely stewarded it. There has been increased access to and utilization of maternal health services by poor pregnant women and those in hard-to-reach areas. Empowered poor pregnant women can procure maternal health services from service providers of their choice. Fifty per cent of ANC customers had safe institutional deliveries. The scheme has increased collaboration between service providers from different sectors. Complications are managed at the upazilla health centres.

**Figure 6: Demand-side financing improves maternal care in Bangladesh**

**Challenges in implementing the “voucher scheme” in Bangladesh.**

- Selecting the right reimbursement fee structure (to engage the private sector).
- Ensuring the availability of CEmOC at the Upazilla level (public and private).
- Patient safety concerns (blood safety for caesarean section, quality of care).
- Scaling up the SBA programme in upazillas.
- Placing and retaining consultants at the upazilla level.
- Lack of trained medical officers.
- Slow start-up of voucher reimbursement arrangement.
- Developing evidence to justify scale-up of pilot into national programme.

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**4.5.2 Session B: The challenges of going to scale with quality**

This session was chaired by Dr Vinit Sharma, Technical Adviser on Maternal Health, UNFPA Sub-Regional Office, Kathmandu, Nepal.

A presentation on “Scaling-up and quality challenges” was made by Dr Shams El Arifeen, Senior Scientist and Head, Child Health Unit, Public Health Sciences Division, International Centre for Diarrhoeal Diseases Research, Bangladesh (ICDDR,B).

The global coverage of preventive interventions is less than 50%. Evidence shows that if preventive interventions were universally available, child mortality could be reduced by 63%. Universal coverage with interventions for neonates could avert 41%-72% of neonatal deaths worldwide.

**Challenges with scaling up and quality: A health systems perspective**

Evidence is scarce on how to scale up the quality of maternal services. Some important questions that need to be asked by each country for scaling up include:

- Is there true political commitment?
- Is there an effective role of the local government?

**Table 4: Preventive Interventions and the proportion and numbers of child deaths that can be averted with universal availability**

<table>
<thead>
<tr>
<th>Prevention Intervention</th>
<th>Number of child deaths that can be prevented (x 10^3)</th>
<th>Deaths prevented as proportion of all child deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breastfeeding</td>
<td>1301</td>
<td>13%</td>
</tr>
<tr>
<td>Insecticide-treated materials</td>
<td>691</td>
<td>7%</td>
</tr>
<tr>
<td>Complementary feeding</td>
<td>587</td>
<td>6%</td>
</tr>
<tr>
<td>Zinc</td>
<td>459</td>
<td>5%</td>
</tr>
<tr>
<td>Hib vaccine</td>
<td>403</td>
<td>4%</td>
</tr>
<tr>
<td>Clean delivery</td>
<td>411</td>
<td>4%</td>
</tr>
<tr>
<td>Water, sanitation, hygiene</td>
<td>326</td>
<td>3%</td>
</tr>
</tbody>
</table>

• Do we have the appropriate policies and regulations?
• Are we providing effective supervision and accountability?
• Have we built the partnerships that we need?
• Do we have the right team? Are we providing incentives that will make a difference?
• Have we given adequate attention to system design, innovation and making choices?
• There is a need to think critically and make choices regarding the methods used to reduce maternal mortality.

**Health workforce**
• The questions that need to be answered in this area are:
  • Is there a predominance of short-term thinking?
  • Are we making existing workers more effective?
  • Do we have sufficient numbers and the right mix of staff?
  • Have we reviewed and redefined roles and tasks (as needed)—and provided the skills needed?
  • Are we providing ample support that the staff needs to do their job well?
  • Are we making the best use of the private sector and outsourcing?

**Health management information systems**
• At what point in our planning and implementation did HMIS become a priority?
• Does the HMIS involve production, analysis and use information of health systems performance? Are we responding to what we learn?
• Is the information reliable and timely? How are we ensuring this?
• Are we making the best use of technology and management science?
• Are we producing and using information on health status and health determinants? Are we going beyond the programme?
• Is there dissemination? Is there open access?

**Service delivery**
• Are we giving primacy to access, utilization and coverage while designing service delivery?
• Are we delivering effective and safe interventions, are we prioritizing, focusing?
• Are we able to effectively balance integration versus programme focus?
• Is equity and timeliness important?
• Have we invested in functional and systematic quality assurance systems? Have we examined the role of accreditation and certification?

**Financing**
• Are we making efficient use of existing funds?
• Are we able to raise adequate funds and use them? Are we being innovative?
• Are we able to protect people from financial catastrophe or impoverishment? What is the role of health as a “right”?

**Scaling up IMCI in Bangladesh**

The IMCI programme was started in 2002. A survey in 2003 showed that mortality was very high in some areas and it was decided to implement IMCI in those areas first. The emphasis was on quality training of health
workers, but maintaining the quality of training is an ongoing challenge. Attention is now being given to management support, supervision and monitoring, and information systems to maintain the quality of service delivery. Community-based interventions are being rolled out.

### 4.5.2.1 Case studies

#### 4.5.2.1.1 Improving reproductive and child health services in India—National Rural Health Mission

**Ms Aradhana Johri**, Joint Secretary, Family Welfare, Ministry of Health and Family Welfare, Government of India, New Delhi, spoke about the National Rural Health Mission (NRHM) of India.

The NRHM is the flagship programme of the Government of India and encompasses the whole gamut of health care, basically revitalizing PHC, and maternal and child care. It is a seven-year programme till 2012 to meet people’s health needs, particularly in rural areas. The availability of human resources has increased dramatically, as has the utilization of services even in the states in India that have not performed well with the development indices.

**Expected outcomes at the national level**

- IMR to be reduced to 30/1000 live births by 2012.
- Maternal mortality to be reduced to 100/100,000 by 2012.
- Total fertility rate (TFR) reduced to 2.1 by 2012.
- Reduction in mortality due to malaria, dengue and kala-azar; filaria elimination by 2015; 85% cure rate under directly observed TB treatment, short-course (DOTS).
- 460,000 cataract operations by 2012.
- Upgrading CHCs to Indian public health standards; increasing utilization of FRUs from 20% to 75%.
- Engaging 250,000 accredited social health activists (ASHAs) in 10 States of India.

**Expected outcomes at the community level**

- Availability of trained Accredited Social Health Activists (ASHAs) at village level, with a drug kit for generic ailments. The ASHA is drawn from the community and does not receive a salary but only incentives.
- Health Day at the Aanganwadi level on a fixed day of each month for provision of immunization, ante/postnatal check-ups and services related to mother and child care, including nutrition (convergence of services).
- Availability of generic drugs for common ailments at the subcentre/hospital level.
- Good hospital care through assured availability of doctors, drugs and quality services at the PHC/CHC level.
- Improved access to universal immunization.
- Improved facilities for institutional deliveries.
- Availability of assured health care at reduced financial risk through community health insurance.
- Provision of household toilets and proper sanitation.
- Improved outreach services through mobile medical units at the district level in difficult-to-reach areas.
Accreditation of private providers is a very big target. There are several examples of this, viz. the Chiranjeevi scheme in Gujarat (a package is promised for 100 deliveries and the money is disbursed after these are conducted by the provider); the Janani Suraksha Yojana (JSY) (the government provides a certain amount of money even if the woman chooses to go to an accredited private hospital). Private practitioners are also taken on payment and government facilities are often outsourced. Management and finance inputs have been given at every level.

**MCH in NRHM**

**Key maternal health strategies in RCH-II:**

- Essential and emergency obstetric care.
- Management of RTIs and STIs at PHCs and CHCs/FRUs.
- Safe abortion services at PHC level and FRUs.
- Critical services at 24x7 PHCs such as basic obstetric and neonatal care.
- Critical services at FRUs such as facilities for caesarean section, blood storage and referral linkages.
- Comprehensive RTI/STI services: convergence between RCH programme and National Aids Control Programme.

**Village health and nutrition day**

is a convergence strategy with the following components: registration of pregnancy, ANC, PNC, birth planning, immunization, counselling on nutrition and family planning, and services for sick children.

**Child health**

Interventions have been carved according to the requirement and causes of death. The key strategies for child health are as follows:

- IMNCI.
- Home-based newborn and child care.
- Facility-based newborn care.
- IYCF, including improving early and exclusive BF and complementary feeding.
- Malnutrition treatment centres, especially in areas of acute malnutrition.
- Reduction in morbidity and mortality due to ARI and diarrhoeal diseases.
- Supplementation with micronutrients: vitamin A and iron.
- The School Health Programme is to be launched with health-promoting schools.

**Achievements of the NRHM in India**

- A new level of confidence has been instilled in the public system of health delivery at all levels.
- Institutions within the umbrella of the Panchayati Raj institutions are accountable to the community at all levels.
- Flexibility to deliver and meet people’s needs—demand-side financing.
- Unprecedented gains in outpatient care, institutional deliveries and immunization.
- Innovative partnerships with nongovernment sectors.
4.5.2.1.2 The challenges of making Safe Motherhood a reality: Community midwives in Indonesia

Dr Sri Hermiyanti, Director of Mother’s Health, Ministry of Health, Republic of Indonesia made a presentation on the above topic.

Indonesia has already set its targets for MDGs 4 and 5.

MDG 4—Child health

Child survival and growth development programmes implemented in Indonesia have been successful in reducing the IMR (68 to 34 per 1,000 live births) and under-5MR (97 to 45 per 1,000 live births) from 1991 to 2007. However, the national target for the MDGs in 2015 is still far from being achieved (NMR to 9, IMR to 23, under-5MR to 32 per 1,000 live births).

MDG 5—Maternal health

“Safe Motherhood” programmes are being implemented in Indonesia since 1988. Though these efforts were successful in reducing the MMR from 450 in 1985 to 228 maternal deaths per 100,000 live births in 2007 (IDHS 2007), the national target (MDG) of 102 maternal deaths per 100,000 live births in 2015 is still far from being achieved. The Health and Household Survey (HHS) 2001 showed that the causes of maternal death are such that they cannot be handled by a TBA.

Community Midwives Programme in Indonesia

The community midwife (CM) is the frontline health worker delivering MCH services. Her role is to provide basic midwifery services, including life-saving skills, for obstetric and neonatal services and promotive-preventive-curative interventions for child health. viz.

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Figure 7: Maternal mortality ratio in Indonesia, 1992-2003

![Figure 7](image_url)

immunization, growth monitoring, vitamin A deficiency, IMCI, etc. Her tasks also include provision of maternal, neonatal and under-five health services, FP services and public health services such as early detection and prompt treatment of common ailments, and village alert (health problems and disaster).

The CM programme started in 1989. After graduation from a three-year nursing programme, the CM is given additional training for one year in midwifery skills. She is deployed in the villages as a government employee and works in the village maternity hut. Since 2001, the CM has undergone three-year training in a midwifery academy and has been employed on a three-year contract that can be extended. After the contract expires, CMs can be recruited as civil servants or go into private practice. At present, there are 51,867 CMs and 70% have maternity posts. They are posted in villages and serve 3000–5000 people.

Challenges in meeting the MDGs in Indonesia

- Indonesia has more than 17,000 islands; thus, there are geographical barriers.
- Distribution of the CMs, especially in remote areas, is inadequate (there are more than 100 districts).
- The quality of health facilities and equipment needs to be improved.
- The performance of CMs should be improved, particularly their management skills.
- Commitment of the central and local governments for sustainability and availability of the CM needs to be strengthened.
The chair for this session was Dr Pem Namgyal, Acting Team Leader, Immunization and Vaccine Development Unit, WHO/SEARO, New Delhi.

5.1 A framework for accelerated action for MNCH in South-East Asia

Dr Ardi Kaptiningsih, Regional Adviser, Making Pregnancy Safer and Reproductive Health & Research, WHO/SEARO, New Delhi, presented a draft framework for accelerating progress towards MDGs 4 and 5 under the following heads:

(a) Leadership and governance/stewardship.
(b) Scaling up service provision to achieve universal access to MNCH care.
(c) Strengthening human resources for MNCH.
(d) Multisectoral collaboration and community participation.
(e) Monitoring progress and exchange of information.

It was proposed that WHO would assist Member States in the following:

- Advocacy for increasing investment in MNCH and to achieve universal access to MNCH care.
- Addressing human resource management for MNCH services and to provide technical support in MNCH areas.
- Promoting the use and implementation of evidence-based policies, standards and tools for MNCH.
- Facilitating collaboration among stakeholders to address key issues and challenges of MNCH programmes.
- Enhancing knowledge and learning exchange, and supporting studies/research in priority areas of MNCH.

5.2 Group work

A brief presentation was made by Dr Sudhansh Malhotra outlining the objectives of the group work, formation of groups, time frame and expected outcomes of the deliberations of each group.

The participants were divided into five groups and asked to find solutions on the issues and challenges under each topic for achieving MDGs 4 and 5, and to develop actionable recommendations for the consideration of countries and partners.
Topics. The group-wise topics for discussion are given below:

- **Group 1**: Stewardship, policy and financing (Chairperson: Professor Dr Laksono Trisnantoro)
- **Group 2**: Packaging interventions, service delivery and management (Chairperson: Mr Manzurul Haque)
- **Group 3**: Community participation, multisectoral collaboration and demand-side interventions (Chairperson: Professor Dr Pensri Phijaisanit)
- **Group 4**: Human resources, infrastructure and supplies (Chairperson: Mr Gyanendra Kumar Shrestha)
- **Group 5**: Monitoring and evaluation (Chairperson: Dr PG Maheepala)

The expected outcome was to have an agreement on a multisectoral framework for achieving and sustaining MDGs 4 and 5 in Member States, and outline measures to accelerate their achievement.
The concluding session was presided over by Mr. Jay Narayan Vyas, Honourable Minister of Health, Government of Gujarat.

All five groups presented the results of their deliberations and consensus on the conclusions and recommendations.

6.1 Conclusions and recommendations

The following conclusions and recommendations were presented by Prof Laksono Trisnantoro, Director of Centre for Health Service Management, Gaja Mada University, Yogyakarta, Indonesia.

**Recommendations for Member States**

1. **Stewardship, policy and financing**

   The Member States should:

   - Establish empowered national/subnational bodies with multisectoral representation to ensure sustained political commitment to guide and review policies, and monitor progress towards achieving MDGs 4 and 5, and suggest corrective actions by tracking coverage and impact indicators at periodic intervals.
   - Proactively consider involving civil society in planning, implementing and monitoring MNCH interventions so that their felt needs and concerns are addressed and the health system made accountable.
   - Make long-term investments for MDGs 4 and 5 in health and related sectors, develop long-term financing plans and allocate adequate government resources for the identified investments.

2. **Evidence-based interventions, service delivery and management**

   The Member States should:

   - Rapidly enhance competencies and capacities for managing programmes at all levels to ensure rational planning, effective implementation of evidence-based MNCH interventions, effective monitoring, supervision and evaluation.
   - Identify areas and vulnerable groups within countries having the least coverage of MNCH services for rapid scaling up of interventions to ensure universal coverage.
(3) Multisectoral collaboration, community participation and demand-side interventions

The Member States should:

- Ensure coordination and linkage mechanism for MNCH between all levels of administration and the community among all sectors.
- Ensure empowerment of the community, especially women, in MNCH care and actions for improvement of the well-being of mothers, newborns and children; ensure access to health-care services; increase community awareness of MNCH issues through massive IEC; and pursue social mobilization with the involvement of the private sector.

(4) Human resources, infrastructure and supplies

The Member States should:

- Conduct needs assessment to identify existing gaps in human resources for MNCH and, in collaboration with the local government, increase deployment of appropriate skilled health providers, especially at the primary care level. Operational efficiencies should be enhanced by task-shifting.
- Ensure equitable distribution of health facilities, especially in underserved areas, and promote autonomy in the use of allocated funds for maintaining buildings, equipment and supplies.
- Build intersectoral collaboration for strengthening and maintaining infrastructure in the health and related sectors that would benefit mothers, newborns and children.

(5) Monitoring and evaluation

The Member States should:

- Strengthen monitoring for the MNCH programme using indicators that are sensitive to monitoring inequities by income, urban–rural, gender and geographical disparities.
- Strengthen intersectoral monitoring of the MDGs by involving high-level representatives from key sectors, and promote the involvement of civil society and the private sector in monitoring and tracking MDGs 4 and 5.

Recommendations for WHO

WHO should:

- Provide technical support to national technical bodies for policy development/review, decentralization, gap analysis, and implementation and monitoring in the area of MNCH.
- Assist countries to develop a case for investments in MNCH in terms of social and economic outcomes, and assist countries in accessing resources from donors and partners.
- Assist countries in developing equity-sensitive indicators for MDGs 4 and 5 and their monitoring.
- Facilitate and advocate for multisectoral coordination at various levels among Member States.
- Strengthen collaboration with UN agencies and other partners to provide synchronized support to countries.
6.2 Closing remarks

The Honourable Health Minister of Gujarat in his closing remarks stated that the MDGs have helped to substantially improve services and focus attention on important health issues. In Gujarat, through the Bal Chiranjeevi scheme, newborn care is receiving focused attention. Children will be tracked up to the 12th standard (adolescence). Thus, MDGs 4 and 5 will be addressed if strategies like child care, cleanliness, awareness and clean water supply are followed. In addition, emergency care, ORS and other items are also being provided to deliver a well-rounded package. He thanked the participants and hoped that the lessons learned from this consultation would help shape an agenda for accelerated action in South-East Asia.

6.3 Vote of thanks

Dr N. Kumara Rai, on behalf of the Regional Director, WHO/SEARO, thanked the Government of Gujarat and its team for all the cooperation extended. He pointed out that many of the innovations being undertaken in Gujarat were applicable to other countries of the Region and could be replicated to accelerate achievement of MDGs 4 and 5. He thanked the participants and governments of all Member States for their presence and contribution in providing very valuable recommendations.
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<td>DAY 1: Tuesday, 14 October 2008</td>
<td>Opening Session</td>
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<tr>
<td>08:00 - 09:00</td>
<td>Registration</td>
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<td>09:00 - 10:00</td>
<td>Setting the Stage</td>
<td>Monir Islam/ E. Mason</td>
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<td></td>
<td>• What should we be doing? The evidence for effective public health interventions for continuum of MNCH care.</td>
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<td>10:00 – 11:00</td>
<td>Inaugural Session</td>
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<td>11:00 - 12:30</td>
<td>Setting the Stage (contd...)</td>
<td>Dini Latief/ N. Kumara Rai/ E. Mason</td>
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<td>• Progress and challenges in MDGs 4 &amp; 5 in SEAR - revitalizing PHC: a window of opportunity for MNCH strengthening,</td>
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<td>• Making an investment case for MNCH</td>
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<td>• Discussion</td>
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<td>13:30 - 15:30</td>
<td>Theme 1: Social Determinants – Implications for MNCH Programming</td>
<td>K.R. Nayar</td>
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<td>Social determinants and MNCH</td>
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<td>Case Studies</td>
<td>Nanta Auamkul/ Ahmed Shafeeu/ Sonam Palden/ Mirai Chatterjee</td>
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<td></td>
<td>• The Basic Minimum Needs Programme, Thailand</td>
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<td>• School Health in Maldives</td>
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<td>• National Commission for Women and Children (NCWC), Bhutan</td>
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<td>• Empowering women – the SEWA model, India</td>
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<td>• Discussion</td>
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<td>16:00 - 17:00</td>
<td>Overview of MNCH innovations in Gujarat</td>
<td>Amarjeet Singh</td>
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<td>17:00 - 17:30</td>
<td>Briefing for field visit</td>
<td>M. Banerjee</td>
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<td><strong>DAY 2:</strong> Wednesday, 15 October 2008</td>
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<td>08:30 - 15:00</td>
<td>Field visit – 10 sites</td>
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<td>15:30 - 17:00</td>
<td>Feedback from Field Visits – Plenary</td>
<td>Amarjeet Singh</td>
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<td><strong>DAY 3:</strong> Thursday, 16 October 2008</td>
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<tr>
<td>08:30 - 10:30</td>
<td><strong>Theme 2: Improving equitable access</strong></td>
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<td><strong>Session A</strong></td>
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<td>Improving equitable access to quality MNCH interventions</td>
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<td>• Ensuring continuum of MNCH care – the Sri Lanka experience.</td>
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<td>• Reaching out to the community – FCHVs in Nepal.</td>
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<td>• Demand-side financing makes a difference – voucher scheme from Bangladesh</td>
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<td>• <strong>Discussant – CEDPA</strong></td>
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<td><strong>Session B</strong></td>
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<td>The challenges of going to scale with quality</td>
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<td>• Improving Reproductive and Child Health Services – National Rural Health Mission, India.</td>
<td>Shams El Arifeen</td>
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<td>• The challenges of making safe motherhood a reality – community midwives in Indonesia.</td>
<td>Aradhana Johri</td>
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<td>• IMCI scale-up in Bangladesh</td>
<td>Sri Hermiyanti</td>
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<td>• <strong>Discussant – UNFPA</strong></td>
<td>Bangladesh Vinit Sharma</td>
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<td>14:00 - 15:00</td>
<td><strong>The Way Forward – A framework for accelerated action for MNCH in South-East Asia</strong></td>
<td>Ardi Kaptiningsih</td>
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<td>15:00 - 15:15</td>
<td><strong>Briefing on Group Work: The Way Forward</strong></td>
<td>S. Malhotra</td>
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<td>15:45 - 17:30</td>
<td><strong>Group Work (5 groups)</strong></td>
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<td>Group I – Stewardship, policy and financing</td>
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<td>Group II – Service delivery and management</td>
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<td>Group III – Community participation and demand side interventions</td>
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<td>Group IV – HR &amp; infrastructure and supplies</td>
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<td>Group V – Monitoring, Evaluation and Operational Research</td>
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<td>19:30</td>
<td><strong>RECEPTION – hosted by Government of Gujarat</strong></td>
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| DAY 4: Friday, 17 October 2008 | 08:30 - 10:30 | Group Work (contd…)
| 11:00 - 12:30 | Group Work Presentations |
| 13:30 - 14:30 | Group Work Presentations (contd…)
| 15:00 - 16:00 | **Concluding Session**  
  • Framework for Accelerated Action for MNCH in South-East Asia  
  ➢ Recommendations for Member countries  
  ➢ Recommendations WHO  
  • Closing Remarks by Chief Guest (H.E. Health Minister, Government of Gujarat)  
  • Vote of Thanks by N. Kumara Rai, Ag. Director HSD | Presided over by H.E. Mr. Jay Narayan Vyas, Health Minister, Government of Gujarat |
The Member States of the WHO South-East Asia Region account for more than 3 million deaths of children under the age of five years and about 174,000 maternal deaths every year. This is about one-third of the annual global maternal and child deaths. Maternal and child mortality has many causes, including not only biomedical causes but social, cultural and economic factors that impact the status of maternal and child health.

Member States of the WHO South-East Asia Region are committed to achieving the Millennium Development Goals (MDGs). A High Level Consultation was organized by the WHO South-East Asia Regional Office in October 2008 to review the progress and barriers to achieving the child and maternal health MDGs in South-East Asia; to share evidence-based interventions and best practices on maternal, newborn and child health; and to agree on a multisectoral framework to accelerate and sustain progress in achievement of MDGs 4 and 5.

The consultation brought together policy-makers, programme managers from health and health-related sectors, health-care providers, academicians, professional organizations and donors from South-East Asia to deliberate upon the best ways to promote maternal, newborn and child health in South-East Asia. This report is an account of the proceedings of the consultation and recommendations for accelerating progress in the achievement of MDGs 4 and 5 in a sustainable manner by strengthening health systems using the primary health care approach.