Remarkable progress, new horizons and renewed commitment

Ending Preventable Maternal, Newborn and Child Deaths in South-East Asia Region

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Regional Office for South-East Asia

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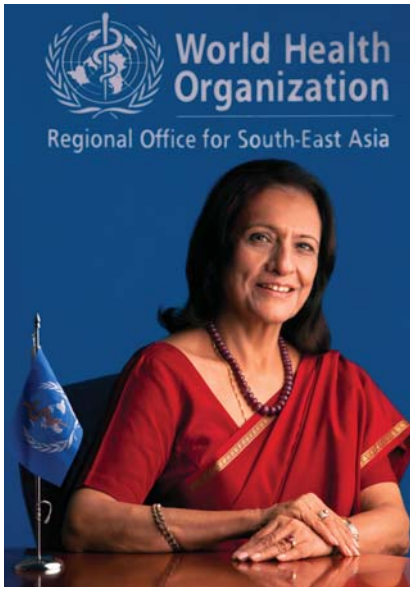
Foreword



MDGs 4 and 5 inspired unprecedented efforts by countries to reduce maternal and child mortality, and the results have been impressive. Between 1990 and 2015, the global maternal mortality ratio (MMR) decreased by 44% and under-five child mortality rate (U5MR) by 52%. The MMR in the South-East Asia Region declined from 525 per 100 000 live births in 1990 to 164 in 2015, and under-five mortality rate from 118 per 1000 live births to 43 during the same period.

The Region has performed much better than the global averages, with a 69% drop in MMR and 64% decline in U5MR when compared with levels in 1990. Indeed, our progress on MDG 5, which is considered more difficult to achieve, has been better than all other WHO regions. Although SEAR as a whole missed MDGs 4 and 5 narrowly, our performance has been remarkable. Of the 11 countries, 7 achieved MDG 4 and 3 attained MDG 5 by December 2015. Thus, the heartening reality is that Member States of the Region have been able to avert millions of maternal, newborn and child deaths, year after year, compared with the 1990s. In 2015, the Region had 149 000 fewer maternal deaths and 3 million fewer child deaths compared with 1990. This is indeed unprecedented progress.

Despite these achievements, challenges remain. Realizing the importance of accelerating reduction in neonatal mortality, where the least gain was made during the MDG era; in 2014, I included “ending preventable maternal, newborn and child deaths with focus on neonatal deaths” as one of the seven Flagship Priorities for the Region, to give it the focus and resources needed.

As we move to the post-2015 phase, the world has committed to new horizons in health and development. The Sustainable Development Goals (SDGs) cover the world’s most pressing economic, social and environmental challenges. Further, in 2015, the UN Secretary-General unveiled the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030). The World Health Assembly endorsed the Strategy and its operational framework in May 2016.

Incorporating and aligned to the SDGs, the Global Strategy has become the guiding precept for advancing health of women, children and adolescents worldwide in the next 15 years. The Global Strategy draws its purpose and power from the SDGs. The three cardinal objectives of the Strategy, namely, *Survive, Thrive and Transform,* portray the aspiration to not only end preventable mortality, but also to avert illness, ensure well-being, as well as usher in a productive and empowered future.

The 2030 targets of SDG 3 and the Global Strategy include the unfinished agenda of maternal, newborn and child survival, but with absolute reductions in MMR (per 100 000 live births); neonatal mortality rate (NMR) and U5MR (per 1000 live births) to equal to or less than 70, 12 and 25, respectively, worldwide. In addition, the Strategy envisages addressing adolescent health, stillbirths, congenital anomalies and disabilities, childhood obesity, noncommunicable diseases in women (in particular cardiovascular disorders and carcinoma cervix and breast) and gender-based violence.

This monograph is an effort to capture the remarkable achievements on MDGs 4 and 5 by Member States; to picture the post-2015 horizons shaped by the SDGs and the Global Strategy; and to signal my renewed commitment, and preparedness, for a more inclusive and more dynamic flagship action for women's, children's and adolescents' health and development in our Region.

Dr Poonam Khetrapal Singh
Regional Director

Content

Abbreviations

AHD	Adolescent Health and Development
AYFHS	Adolescent Youth-Friendly Healthcare Service
CB-IMNCI	Community-based Integrated Management of Neonatal and Childhood Illnesses
CoIA	Commission on Information and Accountability
CRVS	Civil Registration and Vital Statistics
DHS	Demographic and Health Survey
EmONC	Emergency Obstrtric and Newborn Care
ENAP	Emergency Newborn Action Plan
ENC	Essential Newborn Care
FCHV	Female Community Health Volunteers
GBV	Gender Based Violence
ICDF	Intensified diarrhoea control fortnight campaigns
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IPV	Intimate Partner Violence
MDG	Millennium Development Goal
MDG 4	Reduce Child Mortality
MDG 5	Improve Maternal Health
MDSR	Maternal Death Surveillance and Response
MOHFW	Ministry of Health and Family Welfare (MOHFW)
MMR	Maternal Mortality Ratio (per 100 000 live births)
MPDSR	Maternal and Perinatal Death Surveillance and Response
NMR	Neonatal Mortality Rate (per 1000 live births)
PNC	Post Natal Care
RKSK	Rashtriya Kishor Swasthya Karyakram
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SDG	Sustainable Development Goal
SEAR	South-East Asia Region
SDG 3.1	By 2030, reduce global maternal mortality ratio to less than 70 per 100 000 live births
TAG	Technical Advisory Group
U5MR	Under Five Mortality Rate (per 1000 live births)
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

Remarkable progress

The gains in Maternal, Newborn and Child Survival in the MDGs era are unprecedented

Remarkable progress

The gains in Maternal, Newborn and Child Survival in the MDGs era are unprecedented

The WHO South-East Asia Region (SEAR) accounts for 26% of the world's population and about 27% of total births.[1] As we transition from the Millennium Development Goals (MDGs) phase into the new and ambitious Sustainable Development Goals (SDGs) era, unprecedented gains in maternal, newborn and child survival have been made in the Region, during MDGs phase, particularly in the last decade.

In 1990, the baseline year for the Millennium Development Goals (MDGs), maternal mortality ratio (MMR) stood at 525 per 100 000 live births compared to the global average of 385 with eight of the 11 SEAR countries having MMRs greater than 400.[2] Similarly, the under-five mortality rate (U5MR) in the Region in 1990 at 118 per 1000 live births was higher than the global average of 91; six countries had U5MR of more than 100.[3]

Even though the Region narrowly missed MDGs 4 and 5, the gains in maternal and child survival are unprecedented.

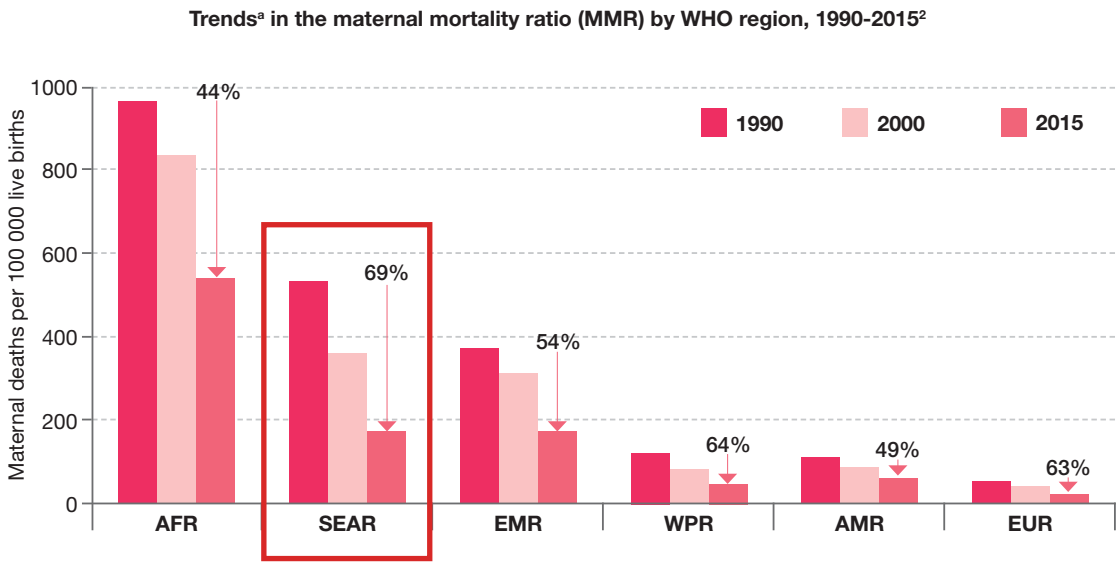
Both MMR and U5MR declined considerably, more than the global average.

Seven of the 11 countries have attained their respective MDGs 4.

The South-East Asia Region witnessed the greatest decline in maternal mortality among all the WHO regions.

By the MDGs' end line in 2015, the situation had improved considerably. Member States reduced maternal and child mortality more than the world average during the same period (Graph 1).

Graph 1: Trends in Maternal Mortality Ratio (MMR) by WHO Region, 2015



[a]Percent change over the period 1990-2015 is shown at the top of each region

Source: *Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the UnitedNationsPopulationDivision.*

In 2015, MMR in the Region was estimated at 164 per 100 000 live births, a decline of 69% since 1990 that is more than the global reduction of 44% since 1990.[2] The Region registered the highest decline in MMR in the MDGs era among all the WHO Regions.[2] Improvement in child survival has been equally impressive. U5MR in the Region came down to 43 per 1000 live births by 2015, a reduction of 64% since 1990 compared to a world average of 52%.[3] By 2015, seven of the 11 Member States had attained their respective MDGs (Table 1).

Table 1: Progress on MDGs 4 and 5 in South-East Asia Region

	MMR		U5MR	
	MMR 2015	MDG 5 Target	U5MR 2015	MDG 4 Target
Bangladesh	176	142	38	48 [Achieved]
Bhutan	148	236 [Achieved]	33	45 [Achieved]
DPRK	82	19	25*	14
India	174	139	48	42
Indonesia	126	112	27	28 [Achieved]
Maldives	68*	169 [Achieved]	9*	31 [Achieved]
Myanmar	178	113	50	37
Nepal	258	225	36	47 [Achieved]
Sri Lanka	30*	19	10*	7
Thailand	20*	10	12*	12 [Achieved]
Timor-Leste	215	270 [Achieved]	53	59 [Achieved]
South-East Asia Region	164	131 (69% decline since 1990)	43	39 (64% decline since 1990)
World	216	96 (44% decline since 1990)	43	30 (52% decline since 1990)

*Achieved SDG target

Source: *Levels & Trends in Child mortality - Report 2015: Estimates Developed by the UN Inter-agency Group for Child Mortality Estimatio*
Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division.

[a]Bangladesh, Bhutan, Indonesia, Maldives, Nepal, Thailand, Timor-Leste

1.1 The flagship priority action boosted the final push to MDGs 4 and 5 in the South-East Asia Region

In early 2014, Dr Poonam Khetrapal Singh, Regional Director, WHO South-East Asia Region, released her Strategic Vision for the Region. She identified seven flagship areas of priority action. One of these directly focuses on the unfinished agenda of MDGs 4 and 5.

The first 28 days of life – the "neonatal period" is the most vulnerable time for a child's survival. By 2010, 51% of under-five deaths in the Region were occurring in the neonatal period.[3] Therefore, addressing neonatal mortality was identified as a crucial element of achieving the MDG 4 target. It was clear that acceleration toward MDG 4 required acceleration in neonatal survival.

Bearing this in mind, the Regional Director articulated, and committed to, the 'Unfinished MDGs 4 and 5 agenda: ending preventable maternal, newborn and child deaths with focus on neonatal deaths' as one of the regional flagship areas. To translate the commitment into action, a number of advocacy and strategic measures were implemented by the regional office. These actions built on the country initiatives and were intended to not only sustain achievements, but also accelerate progress with a sense of urgency. The objective was to assist Member States in boosting their progress in the penultimate phase of the run up to the MDG end point by 2015.

Advocacy, Partnership and Technical Assistance

Regional meeting on '2015 and beyond: the unfinished agenda of MDGs 4 and 5 in the South-East Asia Region

In May 2014, the Regional Director convened a meeting of policy makers, partners, experts and other stakeholders of SEAR Member Countries to review progress towards achieving MDGs 4 and 5. The aim was to share successful experiences and best practices for scaling up to deliberate on global initiatives and mechanisms for MDGs 4 and 5, and to promote their coordination and implementation in countries; in order to strengthen the regional monitoring mechanism for tracking progress on MDGs 4 and 5.

At the meeting, the Regional Director shared her vision and plans for Flagship Action on the unfinished MDGs 4 and 5 agenda. "I am pleased to share that the WHO Regional Office for South-East Asia has recently launched a Flagship to support expansion of effective interventions with quality services in an efficient manner to achieve a higher annual rate of reduction of

maternal, newborn and child mortality. It is important that we have the support and agreement of the Honorable Ministers of Health from Member States for the Flagship," she said. The meeting declaration reaffirmed the commitment of Member States to accelerate progress toward MDGs 4 and 5.

SEAR Technical Advisory Group on Women's and Children's Health

The Regional Director constituted the Technical Advisory Group on Women's and Children's Health in March 2015, comprising of eminent global and regional experts identified in consultations with WHO country offices, UNICEF and UNFPA. The group will serve as a technical advisory mechanism to provide guidance to national governments, implementing partners and other stakeholders on how best to accelerate action towards attaining MDG 4 and 5 and prepare the technical and strategic ground for the new SDG targets beyond 2015.

Dissemination of technical updates

WHO-SEARO created opportunities to review progress in countries in key programmes and disseminate new technical guidelines from time to time. A regional meeting on Every Newborn Action Plan and Postnatal Care for mothers and newborns was organized in October 2014 to review the national newborn action plans and share successful experiences for scaling up. The WHO technical guidelines on Post-natal Care (PNC) for mothers and newborns were disseminated to ensure uniform and universal implementation of these in Member Countries. A regional meeting on adolescent health was organized in November 2014 to review progress in the countries, strengthen multi-sectoral approaches and provide technical updates on adolescent health.

WHO–UNICEF joint country missions

It was decided to undertake WHO–UNICEF joint missions to high priority countries in the Region to individually respond to country-specific needs of technical assistance and to improve the effectiveness of national programmes. Joint missions were undertaken to Bangladesh, Indonesia and Nepal in 2015 to review the progress in implementing national RMNCAH plans with a focus on newborn action plans. Technical assistance expected from WHO and UNICEF and responsibility for action among partner agencies was agreed upon and the action taken followed up.

Strengthening regional and national strategy frameworks and plans in RMNCAH

Regional and national strategies

WHO-SEARO has developed a number of strategy documents to provide direction and impetus to RMNCAH in recent years. A summary of the regional and national strategies on Women's, Children's and Adolescents' Health is shown in Table 2. Guided by the regional strategic framework, Member Countries developed respective frameworks in key areas to further accelerate progress toward ending preventable maternal, neonatal and child deaths.

Table 2: Status of regional and national strategies

	Maternal / Reproductive Health	Newborn and Child Health	Adolescent Health
Regional	• Regional MRH Strategy 2015* • Comprehensive Control of Cervical cancer Strategy 2015	• Newborn and Child Strategy 2013–2017 • Birth defects Strategy 2013–2017 • Strategy on Early Childhood Development 2011–2016	• Adolescent Health Strategy 2011–2015*
	• Regional Framework for improving quality of care for RMNCAH		
	• Regional Framework for RMNCAH**		
Bangladesh	• Maternal Health strategy** • National cancer control strategy 2009–2015	• Bangladesh Newborn Action Plan • Child Health Strategy** • National Plan on prevention & Control of Birth Defects	• Adolescents RH Strategy 2006–2016**
Bhutan	• Strategy for Prevention and Control of STIs 2009 • National RH Strategy 2012–2016	• IMNCI Strategy 2009 • National Child Health Strategy 2014–2018 • National Plan on prevention & Control of Birth Defects • Bhutan Newborn Action Plan	• Adolescent Health Strategy 2013–2018
Democratic People's Republic of Korea	• RH strategy 2015 • Development of National Framework on Quality Improvement in RMNCH*	• Newborn Action Plan • IMCI • ENC, sick newborn care	

India	• RMNCAH Strategy 2013–2018	• RMNCAH Strategy 2013–2018 • India Newborn Action Plan- September 2014 • RKSK- Birth Defects Plan	• RKSK- National Adolescent Health Strategy January 2014
Indonesia	• 2016–2030 Maternal Health National Action Plan	• National Child Health Strategy ** • Newborn Action Plan • National Plan on prevention & Control of Birth Defects	• National Action Plan on School-aged Child and Adolescent health 2016–2019**
Maldives	• National Reproductive Health Strategy 2014–2018 • National Guideline on Health Sector Response to GBV 2014		• AYFHS standards 2014
Myanmar	• Five Year Reproductive Health Strategic Plan 2014–2018 • Strategic Plan for Ending Preventable Maternal Mortality 2017–2022**	• Five Year Newborn and Child Health Development Strategic Plan 2015–2018 • Myanmar Every Newborn Action Plan 2014–2020 • Five Year Strategic Plan for Prevention and Control of Birth Defects 2014–2018	• Five Year Strategic Plan for Young People's Health 2016–2020
Nepal	• Safe motherhood, National Reproductive Health Research Strategy • National policy on Skilled Birth Attendants 2006, • MPDSR Guidelines 2014	• Nepal Newborn Action Plan • National Birth Defect Surveillance, prevention and control implementation plan 2015–2019	• National Adolescent Health and Development Strategy* • Implementation Guide on Adolescent Sexual and Reproductive Health*
Sri Lanka	• Maternal Newborn Health Strategy 2012–2016; MNH strategic plan for 2017–2020*	• Child Health Strategy • Every Newborn Action plan	• Adolescent Health strategy: 2013–2017
Thailand	Each programme has an individual action plan under the overall national plan cycles		
Timor-Leste	• National strategy on RMNCAH 2015–2019 • Road map for prevention of GBV and IPV** • EmONC assessment conducted and costed Action Plan of action	• National strategy on RMNCAH 2015–2019	• National strategy on RMNCAH 2015–2019

*Being Updated ** Being Developed/Finalized

Strategic planning and costing

Evidence-based strategic planning and costing is essential to the implementation of national RMNACH programmes. The Regional Office provided support to Member States to update their national plans and guidelines for newborn, child and adolescent health, and assisted in updating its IMCI guidelines in 2014–2015. SEARO also assisted Bangladesh and India in developing integrated approaches to prevent childhood pneumonia and diarrohea.

A regional workshop on the use of the computer-based planning and costing tool, OneHealth, was organized by WHO and UNICEF in April 2015 to train selected resource persons from the Region on its use. This set of resource persons would be available to assist the countries in the Region to undertake strategic planning and costing of RMNCAH plans. WHO provided follow-up support in the use of the OneHealth Tool for planning and estimating the cost of national newborn action plans to Bangladesh, Indonesia and Myanmar.

Capacity-building/training

WHO-SEARO provides opportunities to countries to build capacity of national experts in the key technical areas under the RMNCAH continuum through regional and national training workshops and by providing training packages and tools. During 2014–2015, e-learning courses on newborn care and training on newborn-birth defects database have been supported. A Pocket Book for maternal health care in small hospitals was finalized this past year in consultation with regional experts. Moving forward, the judicious adoption of standard treatment guidelines contained in this handbook, developed by the WHO will help to improve the quality of obstetric care.

1.2 The MDGs 4 and 5 Journey: Taking stock, looking back

MDG 5: Reducing maternal mortality by three fourths between 1990 and 2015

In 1990, the South-East Asia Region had a very high MMR of 525 per 100 000 live births, well above the global average of 385 and second only to the Africa Region.[2] By 2015, the Region had attained an MMR of 164 which was well below the global average of 216 (Table 3). Despite the sharp reduction in MMR at 69% reduction, SEAR fell short of the MDG 5 mark.[2]

> The region had 149 000 fewer maternal deaths in 2015 in comparison to 1990

It is however noteworthy, that SEAR registered the best progress made in MMR reduction among all the Regions in the MDGs era. Compared to a total of 210 000 maternal deaths in the 11 countries of the region in 1990, the region had 149 000 fewer maternal deaths in 2015 in comparison to 1990. The burden of maternal deaths in 2015 had plummeted to 61 000 – an unprecedented accomplishment in maternal survival in the history of South-East Asian countries.[2]

Table 3: Maternal mortality ratio (MMR) change in the MDG era (1990–2015)

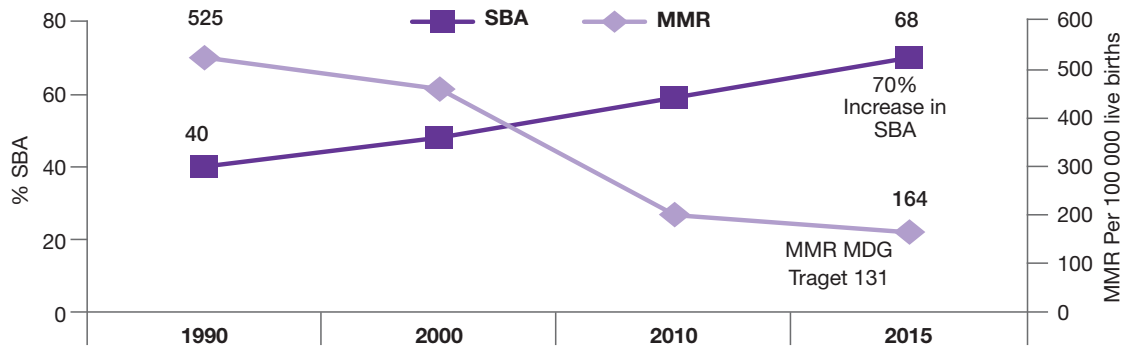
WHO Region	MMR		% Decline in MMR between 1990 and 2015
	1990	2015	
Africa	965	542	44%
Americas	102	52	49%
South-East Asia	525	164	69%
Europe	44	16	64%
Eastern Mediterranean	362	166	54%
Western Pacific	114	41	64%
World	385	216	44%

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

Maternal deaths result mainly from hemorrhage (postpartum and antepartum), hypertensive disorders, puerperal sepsis and unsafe abortion.[2] Indirect causes (that include non-obstetric medical and surgical conditions) also contribute toward maternal mortality burden. Interventions to prevent maternal deaths include antenatal care, care during labour and childbirth provided by skilled birth attendants (doctors, midwives and nurses), emergency obstetric care (including cesarean section, manual removal of placenta, and blood transfusion), safe abortion, antibiotic and supportive treatment for sepsis, and treatment of indirect medical and surgical conditions.

The decline in MMR in the Region has occurred in consonance with a surge in the proportion of deliveries attended by skilled birth attendants. It is worth noting that between 1990 and 2015, the increase was an impressive 70%[5] (from 40% in 1990[4] to 68% in 2015) (Graph 2). Facility births have increased substantially with three Member States (Maldives, Sri Lanka and Thailand) having nearly 100% institutional deliveries.[5]

Graph 2: Trends in reducing maternal mortality (MMR) and increasing delivery by skilled health personnel (SBA) in South-East Asia Region (1990–2015)

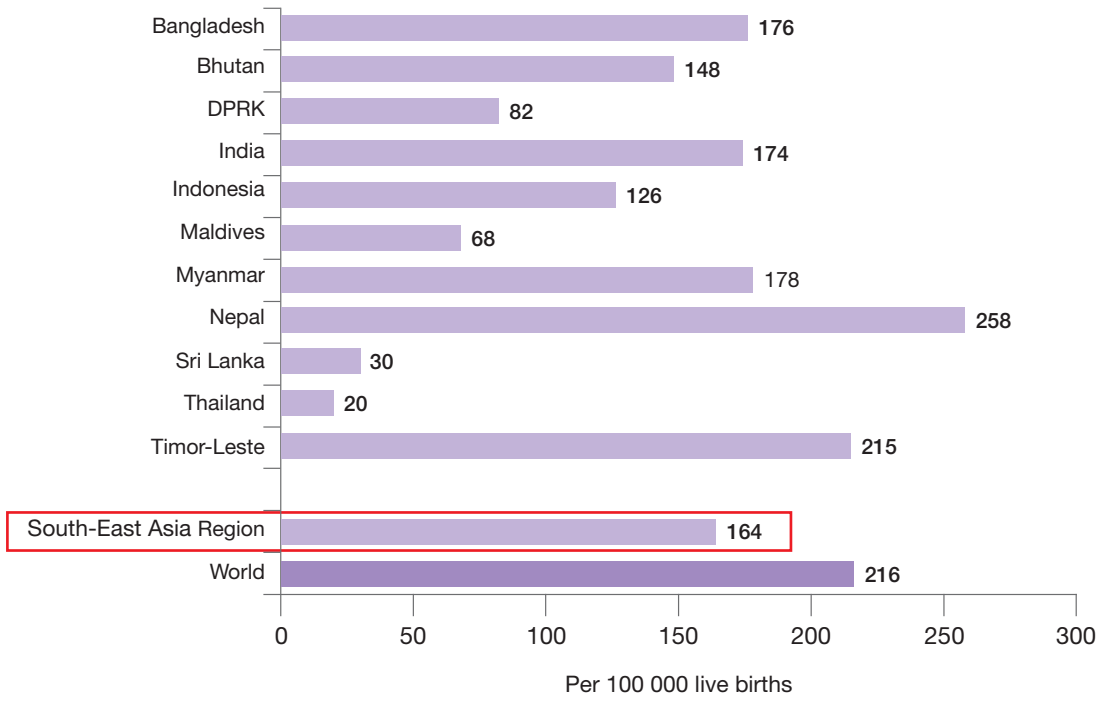


Source: *WHS 2006, WHS 2012, WHS 2016*

Attaining universal access to reproductive health was an integral part of the MDG 5 strategy. It is known that fertility control measures lead to fewer maternal deaths[6] and fulfilling unmet contraceptive need can prevent an additional 150 000 maternal deaths annually worldwide.[7]

In the Region, contraception prevalence rate (CPR) rose from 57% in 2000 to 60% in 2015; with an unmet need for contraception of 13% (2015).[4,5] These are significant achievements. Despite the progress, profound disparities in maternal mortality still exist within and across the countries of the Region. The present MMR varies from 20 in Thailand and 30 in Sri Lanka to 215 in Timor-Leste and 258 in Nepal (Graph 3).

Graph 3: Maternal mortality ratio (per 100 000 live births): Wide variations among SEAR Countries

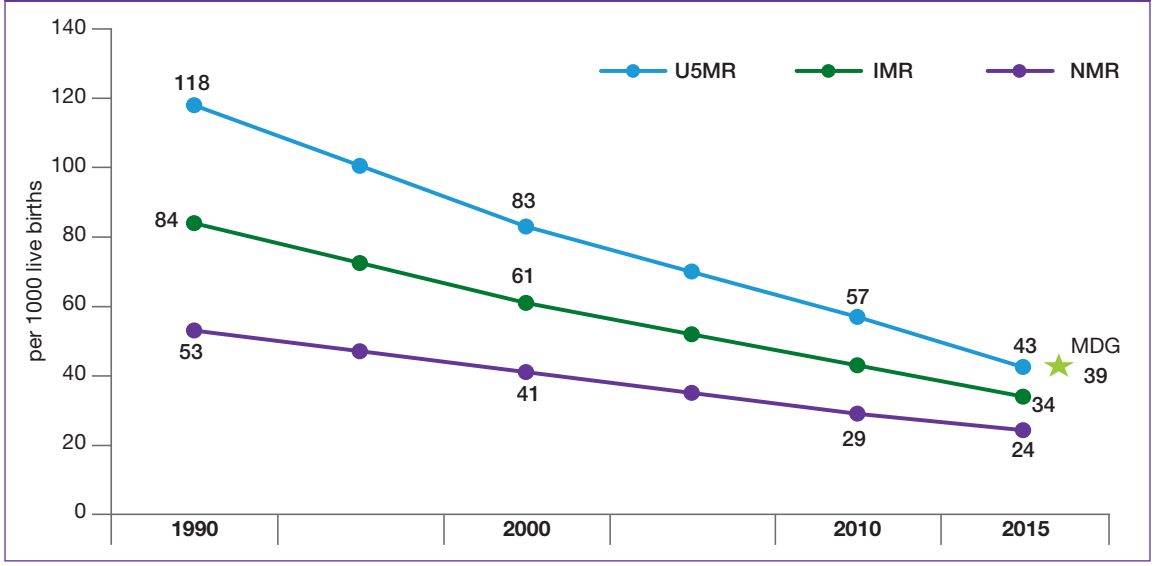


Source: *Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division*

MDG 4: Reducing child mortality by two thirds between 1990 and 2015

The progress in child survival has been a remarkable achievement of the Region. With a 64% decline in child mortality in the South-East Asia Region from 118 per 1000 live births in 1990 to 43 per 1000 live births in 2015 the reduction in U5MR exceeds the global rate of decline of 53% (Graph 4 and Table 4).[3]

Graph 4: Trends in reducing child mortality in South-East Asia Region (1990–2015)



Source: *UN Interagency Group for child mortality estimates: 2015 and WHS 2012; Report. MDG target of 39 for reduction of child mortality.*

Compared to a total of 4 570 000 deaths among under-five children in the Region in1990, the toll in 2015 was estimated to be 1 558 000, a dramatic saving of child lives, achieved by the Member Countries.[3]

With a 64% reduction in Under 5 child mortality, the Region missed the MDG 4 target (of 67% decline) narrowly.

Notably, in 2015 the Region had 3 million less child deaths compared to 1990.

Table 4: Under-five child mortality rate (U5MR) change in MDGs era (1990–2015): Global and WHO Regions

WHO Region	U5MR		% decline in U5MR between 1990 and 2015
	1990	2015	
Africa	176	81	54%
Americas	42	15	65%
South-East Asia	118	43	64%
Europe	32	11	65%
Eastern Mediterranean	101	52	49%
Western Pacific	52	14	74%
World	90	43	53%

Source: *Levels & Trends in Child mortality - Report 2015: Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation*

Neonatal mortality has been the more difficult part of the child mortality challenge. The progress in neonatal mortality reduction was less impressive. The Regional NMR declined by 54% (from 53/1000 live births in 1990 to 24/1000 live births in 2015) in the MDGs era.[3] Even though gains are better than the global decline of 47%, slow progress on newborn survival has hampered attainment of MDG 4 in the Region and the world (Table 5).

Table 5: Neonatal mortality rate (NMR) change in MDGs era (1990–2015): Global and WHO Regions

WHO Region	NMR		% change in NMR between 1990 and 2015
	1990	2015	
Africa	45	28	38%
Americas	18	7.7	57%
South-East Asia	53	24.3	54%
Europe	15	6	60%
Eastern Mediterranean	43	26.6	38%
Western Pacific	27	6.7	75%
World	36	19.2	47%

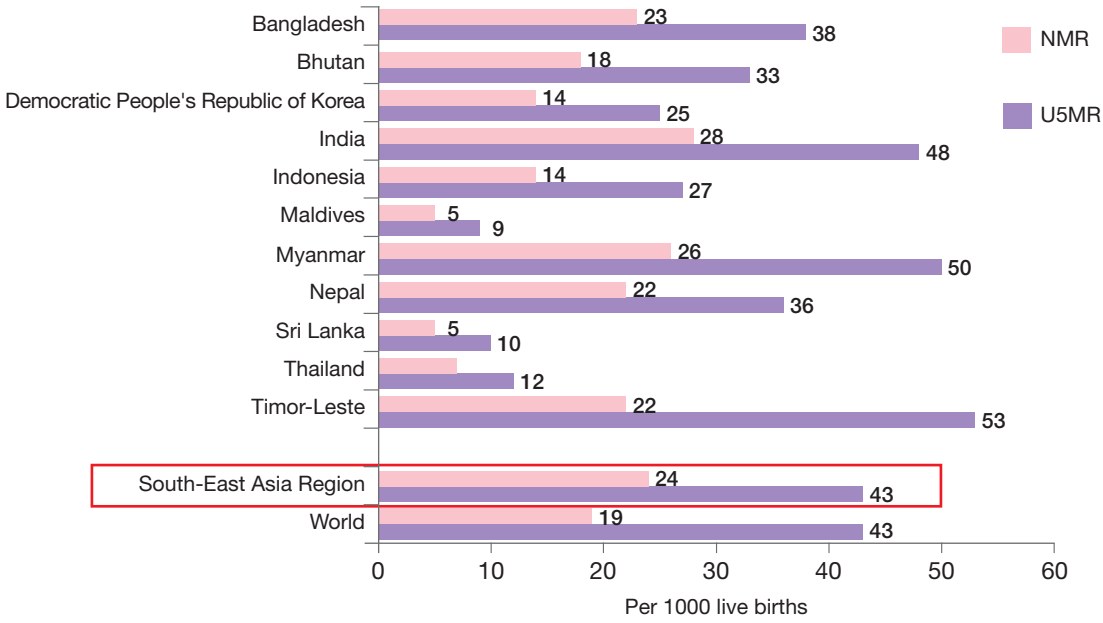
Source: *Levels & Trends in Child mortality - Report 2015: Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation*

In 1990, the Region had 2 037 000 neonatal deaths.[3] At the end of 2015, the annual burden of neonatal deaths had declined to 894 000.[3] Since post-neonatal child mortality has declined faster than neonatal mortality; NMR now constitutes 56% of under-five mortality rate in the Region.[3]

Notably, three countries in the Region (Maldives, Sri Lanka and Thailand) have already attained the SDG indicator 3.2 (U5MR 25 per 1000 live births or less, and NMR 12 per 1000 live births or less); and Indonesia is also quite close to it although it still accounts for 74 000 neonatal deaths per year.[3]

Hence, further progress in child survival is even more dependent on neonatal mortality reduction.

Graph 5: Neonatal and Under 5 Mortality: Wide variations among countries in South-East Asia Region



Source: *Levels & Trends in Child mortality - Report 2015: Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation*

SEAR is characterized by a heterogeneous population and contexts, and disparate progress in maternal and child health in Member States. U5MR (per 1000 live births) ranges from low levels of 9 in Maldives and 10 in Sri Lanka to high levels of 50 in Myanmar and 48 in India (Graph 5). Likewise, NMR (per 1000 live births) currently ranges from being as low as 5 in Sri Lanka and Maldives and 7 in Thailand to as high as 28 in India and 26 in Myanmar.[5]

As per the global evidence, when we disaggregate neonatal deaths by age, neonatal mortality is concentrated in the first week of life.[8] Around three fourths of neonatal deaths occur within the first week of life, and roughly half of that burden (i.e. 36%) occurs on the very first day of life.[8] Early neonatal deaths are largely attributable to preterm birth complications and intrapartum related complications (birth asphyxia). Bacterial infections also play some role in the early neonatal period, but they are the dominant cause of mortality after the first week of life.

Soon after polio-free certification, the South-East Asia Region achieved yet another public health milestone, eliminating maternal and neonatal tetanus across all 11 countries, when India and Indonesia achieved the elimination status in 2015. Persistent efforts and innovative approaches to enhance tetanus vaccination coverage of pregnant women and children, increased skilled birth attendance and promoting clean cord practices has made this possible.

Key to achieving neonatal and child health targets is good maternal health. The time period of labour and the day of birth accounts for 46% of maternal deaths and 40% of all stillbirths.[8] Antenatal care, skilled birth attendance and emergency obstetric care not only save mothers, but constitute the trinity of essential high impact interventions that improve perinatal-neonatal survival.

Lifesaving interventions include: care at birth comprising of appropriate resuscitation, thermal protection, and early initiation of breastfeeding, extra care of the low birth weight baby including "kangaroo mother care", and detection and treatment of sepsis incorporated in the newborn survival package. Furthermore, pregnancies and childbirth after 20 years of maternal age and adequate birth spacing, enhance birth weight and reduce neonatal deaths.[9]

Post-neonatal child deaths are still largely due to pneumonia, diarrhoea and malaria, with under-nutrition being as high as 60% in some South-East Asian countries, and contributing significantly to mortality.[5] Early and exclusive breastfeeding (EBF), vaccination, timely treatment of pneumonia, diarrhoea and malaria, as well as prevention and management of under nutrition are all critical for child survival.[8]

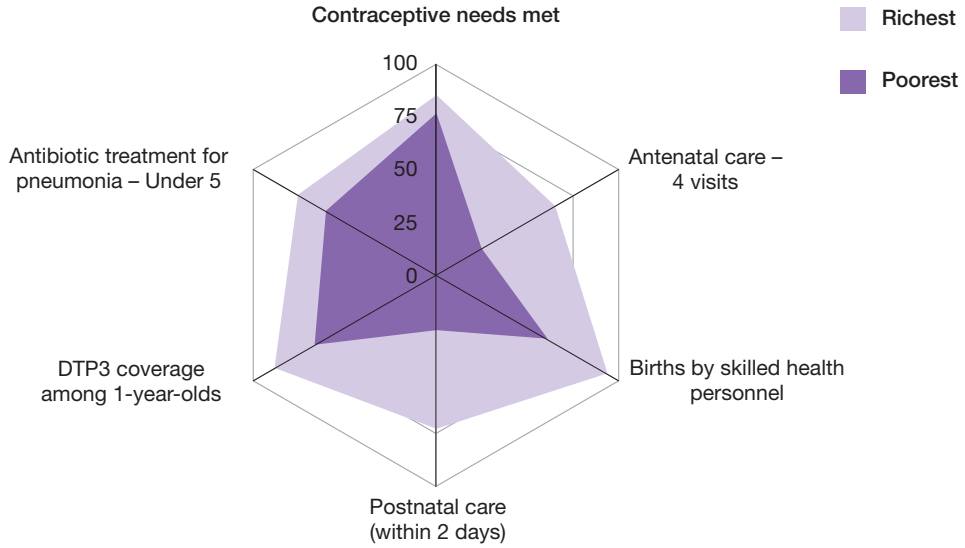
Countries in the Region are at the forefront of implementing Integrated Management of Newborn and Childhood Illness (IMNCI) both at facility and community levels. Furthermore, investment in expanding IMNCI is required to ensure that every child gets the care needed. As under five mortality reduces, paying greater attention to early childhood development becomes critical in ensuring that the child has the best start in life.

Intervention coverages need to be better and equitable: No one should be left behind

Priority interventions across the continuum of maternal–newborn–child care includes access to contraception, prevention of adolescent pregnancy and adequate birth spacing, minimum four antenatal care visits (ANC4), skilled attendance at birth (SBA), post-natal care (PNC), early and exclusive breastfeeding (EBF), measles vaccination, and appropriate management of diarrhoea and timely treatment of pneumonia with appropriate antibiotics among others.

Coverages of these interventions have increased, although there is a considerable variation between and within countries (Graph 6,7,8). Country-wise coverages of key interventions are also depicted in the country fact sheets in this monograph.

Graph 6: Wealth inequity in maternal and child health services among richest and poorest income quintiles in South-East Asia Region (2010–2015)

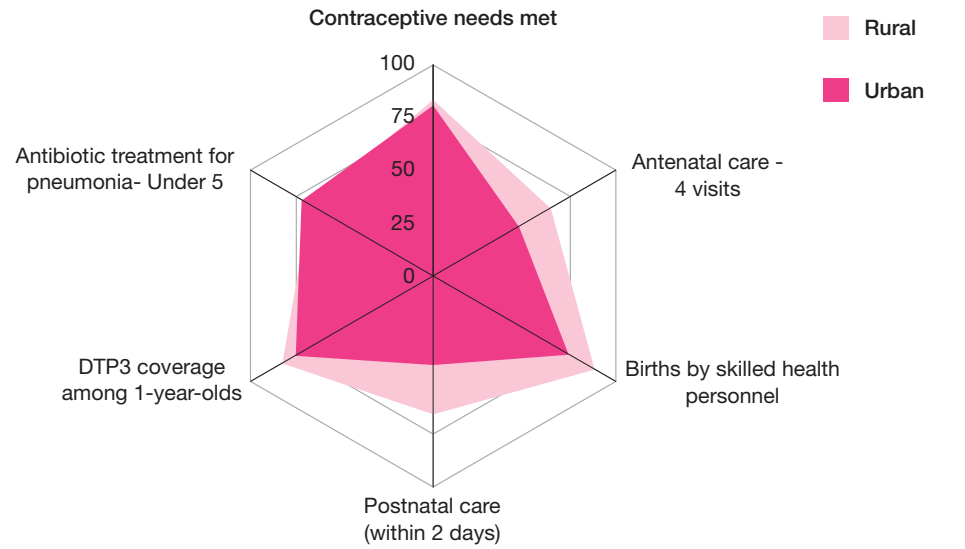


Source: *DHS/ MICS 20007-2014 (Bangladesh-DHS 2014, Bhutan-MICS 2010, India-NFHS3, Indonesia-DHS 2012, Maldives-DHS 2009, Nepal-DHS 2011, Thailand-MICS 2005, Timor-Leste-DHS 2009–2010); World Health Statistics, 2015 and Country Reports 2010-2015*

Immunization coverage is the most widely scaled-up intervention in the Region, while contraceptive needs met is the most equitable indicator across different wealth quintiles, with nearly equal coverages between the richest and poorest.

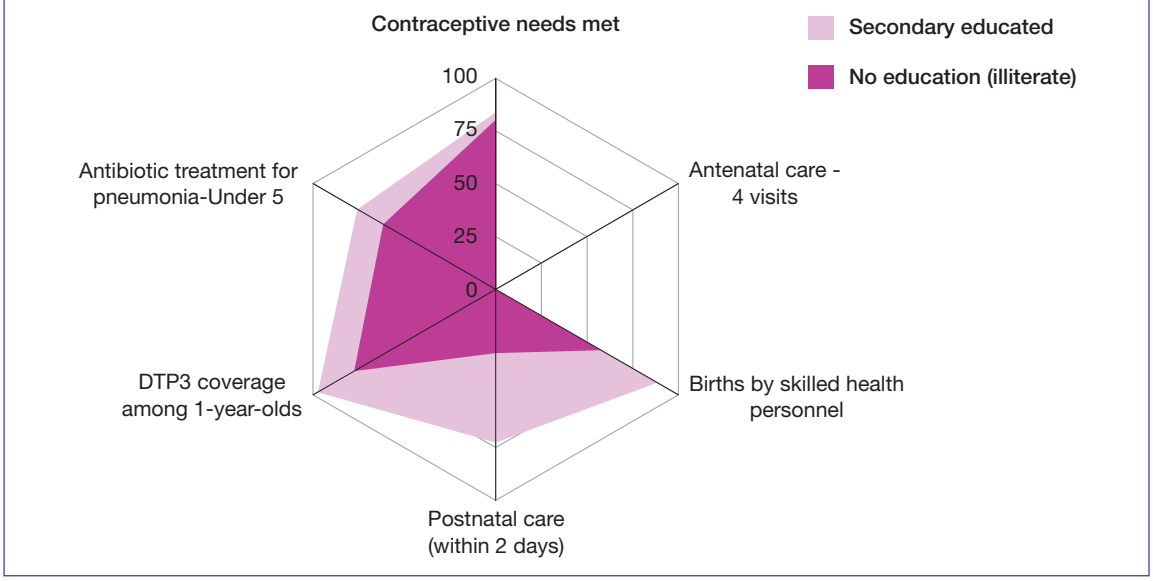
DTP3 coverage is also relatively equal with high coverage in Bangladesh and Indonesia, and relatively high coverages but moderate equity differential in India and Nepal.[10]

Graph 7: Geographic inequity in maternal and child health services between urban and rural areas in South-East Asia Region (2010–2015)



Source: *DHS/ MICS 20007-2014 (Bangladesh-DHS 2014, Bhutan-MICS 2010, India-NFHS3, Indonesia-DHS 2012, Maldives-DHS 2009, Nepal-DHS 2011, Thailand-MICS 2005, Timor-Leste-DHS 2009–2010); World Health Statistics, 2015 and Country Reports 2010-2015*

Graph 8: Education inequity in maternal and child health services among those with no education and secondary or higher education in South-East Asia Region (2010-2015)



Source: *DHS/ MICS 20007-2014 (Bangladesh-DHS 2014, Bhutan-MICS 2010, India-NFHS3, Indonesia-DHS 2012, Maldives-DHS 2009, Nepal-DHS 2011, Thailand-MICS 2005, Timor-Leste-DHS 2009–2010); World Health Statistics, 2015 and Country Reports 2010-2015 Ante-natal Care -4 visits—Data unavailable*

Inequities in coverage of health services, in addition to wealth quintiles, also occur across geographical terrain, urban–rural locations and based on the education status primarily of women. In the South-East Asia Region, for instance women with secondary education are twice more likely to get post-natal care for the mother and child as compared with those who are illiterate.[10] In summary, it is the poor, those in rural areas and the uneducated who are being left behind.

1.3 The MDGs 4 and 5 journey: Country initiatives and achievements worth admiration and emulation

Undoubtedly, the MDGs galvanized countries into action. Leadership in each country of the South-East Asia Region deserves to be congratulated for leveraging resources, orchestrating innovations and steering implementation of programmes have dramatically improved maternal, newborn and child survival in the recent past. WHO has pro-actively collaborated with Member States to provide technical assistance and also engaged with partners and relevant stakeholders to partner in this extraordinary endeavor.

The lives of millions have improved in the Region during the MDGs phase in the last two decades. One way to accelerate progress and deliver a healthier, more equitable and sustainable future moving into the SDG era is to share innovations, learn from each other's experiences and cultivate cross-sectoral partnerships. The next section summarizes selected country initiatives, achievements and innovations. These stories have lessons for other countries, within and outside the Region.

Increasing access to facility care through conditional cash transfer and financial protection

Accessing facilities for childbirth and other care imposes financial hardship on the poor. The facilities are far away in many countries, and there are heavy direct and indirect costs. Programmes in the Region show how this barrier can be overcome.

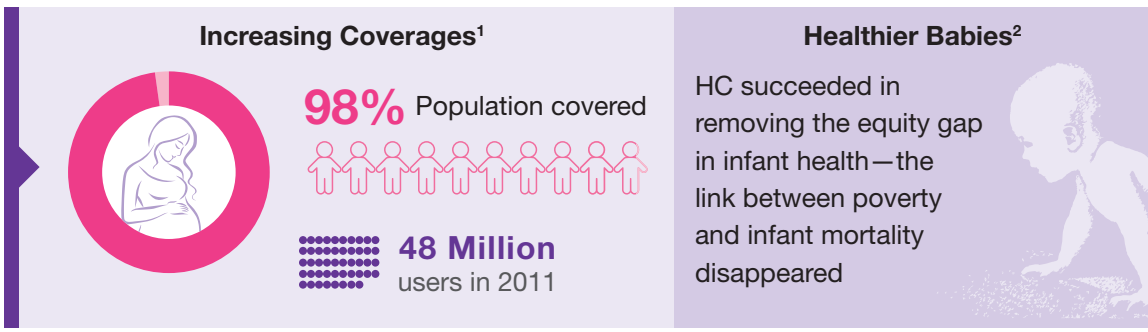
Janani Suraksha Yojana (JSY) in India provides a cash incentive to the woman who delivers in a health facility, and to the community health volunteers (ASHA) who facilitates this. From less than a million in 2005, the number of beneficiaries reached over 11 million in 2015. With 26 million births each year, this means 50% of all women delivering babies are now covered by this demand-side financing mechanism.

Creation of demand and financial protection through JSY has contributed to an unprecedented increase in institutional deliveries from 39 % in 2005-2006 to 79% in 2013-14. Most significantly, the increase in facility births jumped from 29% (2005-06) to 75% (2013-2014) in rural areas. JSY had a significant effect on increasing antenatal care and in-facility births. In the matching analysis, JSY payments were associated with a reduction of 3.7 (95% CI 2.2–5.2) perinatal deaths per 1000 pregnancies and 2.3 (0.9–3.7) neonatal deaths per 1000 live births.[11]

A similar initiative, **Demand-side Financing Programme** for maternal health has been **successfully implemented in Bangladesh.** It was initiated in 2007 as a voucher scheme for poor women to encourage them to accept skilled care at birth. The scheme includes: "three antenatal check-ups; safe delivery care in a health facility or at home with a skilled birth attendant; emergency care for obstetric complications, including caesarean sections; and one postnatal care check-up within six weeks of delivery. Cash incentives are provided to cover routine and emergency transport, some food and medicine costs for the family; and a small gift box".[12] An evaluation found the programme to be 'strongly and significantly' associated with higher rates of skilled birth attendance, institutional deliveries and postnatal care visits, particularly among the poor.[13]

Conditional Cash Transfer (CCT) programmes in Sri Lanka serve as safety nets in keeping children at school and have been effective in increasing educational achievements.[14] This is an example of addressing a pivotal social determinant of health, development and well-being.

The Universal Health Coverage programme in Thailand ensures that women who would not be able to otherwise afford it are able to access essential antenatal, perinatal and postpartum care (see box). Using the district and sub-district healthcare system as a foundation, the "30 baht programme" was introduced in 2001. Today, this programme delivers universal health coverage and ensures that every individual in Thailand can access registered health services. This also ensures that skilled attendants are available at all births In Thailand. Universal health coverage has ensured that nearly 100% of Thai babies are born in hospitals. With its focus on protecting and improving the availability, accessibility and acceptability of maternal and child health services within the framework of primary health care and UHC, Thailand serves as a role model in Asia.



Source: [1]*Patcharanarumol et al. Universal Health Coverage for Inclusive and Sustainable Development: Country Summary Report for Thailand, September 2014*
[3]*Gruber, Jonathan, Nathaniel Hendren, and Robert M. Townsend. 2014. "The Great Equalizer: Health Care Access and Infant Mortality in Thailand." American Economic Journal: Applied Economics 6 (1): 91–107. doi:10.1257/app.6.1.91.*

Indonesia's National Health Insurance system financed by premiums, aims to reduce out of pocket spending. A National Health Insurance system (JKN) that includes maternal care and delivery services has been implemented to achieve Universal Health Coverage by 2019. This scheme has become the world's largest single-payer health insurance system, under which the poor and near poor are fully subsidized.

Similarly, **Nepal's Safe Delivery Incentive Programme (SDIP)** which specifically targets improvements in maternal and newborn health had a positive effect on the utilization of maternity services by providing cash incentives to women conditional on them giving birth in a health facility.[15]

April 2016-- 166 million people were covered, including 94 million poor

20,000 primary health facilities and 1900 referral hospitals have contracts with the NHI to provide services.

Progress greater in registering in low-income groups

These success stories from Member States provide significant opportunities for learning and to undertake programming within the countries based on their specific contexts and needs. Country contexts may differ; nonetheless, there is significant scope for impact both through programming within the countries, and through wider sharing and dialogue.

Reaching neonates and mothers at home

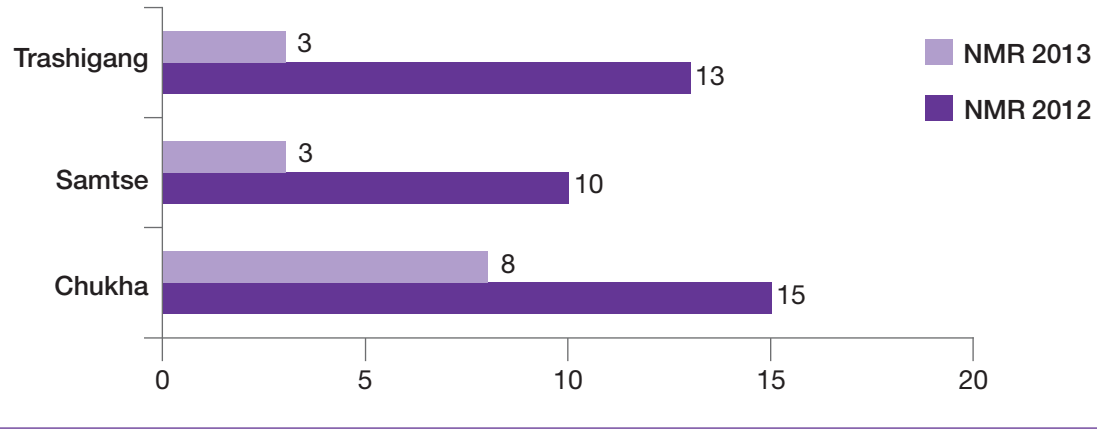
In 2009, WHO and UNICEF issued a joint statement recommending home visits by health workers for newborn and maternal care and counseling.[16] The statement acknowledged the studies conducted in Bangladesh and India that have shown that home visits can reduce deaths of newborns by 30% to 61% in high mortality, developing country settings.

The visits improve coverage of key newborn care practices such as early initiation of breastfeeding, exclusive breastfeeding, skin-to-skin contact, delayed bathing and attention to hygiene, such as hand washing with soap and water, and clean umbilical cord care. It has been estimated that universal scale up of home–based newborn care could save 367 000 neonatal deaths each year by 2025.[16]

India launched the Home-Based Newborn Care programme in 2011, under which essential newborn care is to be provided to all newborns, along with early detection of illness followed by referral; and support to family for adoption of healthy practices by ASHA worker. By 2013, ASHAs had visited more than 1.2 million newborns.[17]

Postnatal home-visiting programme in Bhutan is another great example. Given the significant proportion of home deliveries, the Ministry of Health decided in 2013 to pilot a programme for home visits for PNC in three districts with support from UNICEF. The home visits pilot was based on the evidence from WHO studies[18] in India, Bangladesh and Pakistan which showed a significant reduction in mortality rates in the three districts in Bhutan as well. In 2014, when the pilot was evaluated; results showed PNC visits increased from 83% to 93% in Chukha, from 62% to 83% in Samtse, and from 49% to 86% in Trashigang (Graph 9). No maternal deaths were reported in the three districts, and newborn mortality was halved. In 2015, the PNC home visit service was scaled up to cover all 20 districts.

Graph 9: Postnatal visits decrease NMR in three districts in Bhutan



Source: *Ministry of Health, Royal Government of Bhutan (2013) Postnatal Care Home Visit Pilot Review. Thimphu.*

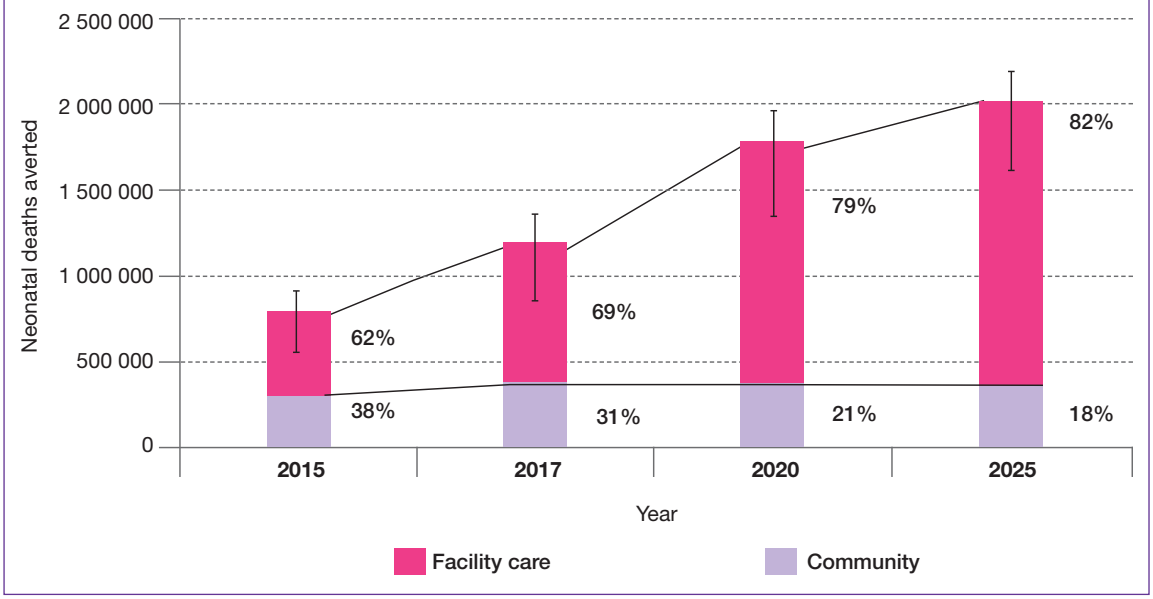
The current PNC policy encompasses both institutional and home-based approaches. The Ministry of Health is piloting an online mother and child health (MCH) tracking system, which is expected to contribute to closer and more accurate monitoring, and to improve PNC coverage further.

Facility-based neonatal care for high risk small and sick neonates

All neonates are not the same. Full term healthy newborns need maternal care and thrive well, while preterm neonates (<34 weeks of gestation) and those with significant intrauterine growth restriction require extra care that includes thermal protection (using radiant warmers/incubators), assisted feeding, parenteral fluids and when settled “Kangaroo Mother Care”. Similarly, neonates who develop complications such as birth asphyxia, respiratory distress, sepsis/pneumonia, and/or severe jaundice require treatment (e.g. antibiotics, anticonvulsants), oxygen and other supportive care. Such a package of neonatal special care is provided in neonatal units or ‘nurseries’ by nurses and doctors.

The Lancet Every Newborn series concluded that facility-based neonatal care will be increasingly important to make an incremental impact on neonatal mortality (Graph 10). As the newborn mortality declines, access to facility based care incorporating care of the small and the sick neonate becomes mandatory. This becomes more apparent when NMR declines below 25 per 1000 live births. If scaled up universally facility based care could save 1.6 million neonates by 2025 (Graph 10).[19]

Graph 10: Estimated impact on neonatal deaths by the year 2025 by community and for facility care assuming increasing coverage of facility care



Source: *Bhutta ZA, Das JK, Bahl R, Lawn JE, Salam RA, Paul VK, et al. Can available interventions end preventable deaths in mothers, newborn babies, and stillbirths, and at what cost? Lancet. 2014 Jul 26;384(9940):347-70.*

All countries in the Region have augmented facility-based care in the last decade. India has succeeded in establishing over 660 Special Care Newborn Units at district and sub-district hospitals throughout the nation. This is a stellar example that successful strengthening of public facilities for sophisticated newborn care on a large scale over a relatively short span of time can be achieved.

Reducing maternal, newborn and child mortality is a major challenge in the **Democratic People's Republic of Korea,** because of high number of cases of postpartum hemorrhage, unsafe abortion, post-abortion and puerperal complications and malnutrition, due to inadequate and delayed health care services. In response, WHO has provided substantial support, by the introduction of evidence-based practices in the areas of basic and comprehensive obstetric care and essential newborn care. Since 2006, more than US$ 66 million have been contributed for improving women's and children's health in the country. Capacity of health staff has increased through provided training on EmOC, ENC and IMCI. Evaluation has shown that at the end of the Programme 93-95% of staff were capable in managing dangerous pregnancy complications, such as eclampsia, hemorrhages and puerperal infections in women and neonatal resuscitation in newborns. Capacity of health staff has increased through provided training on EmOC, ENC and IMCI.

Integrated management of newborn and childhood illness

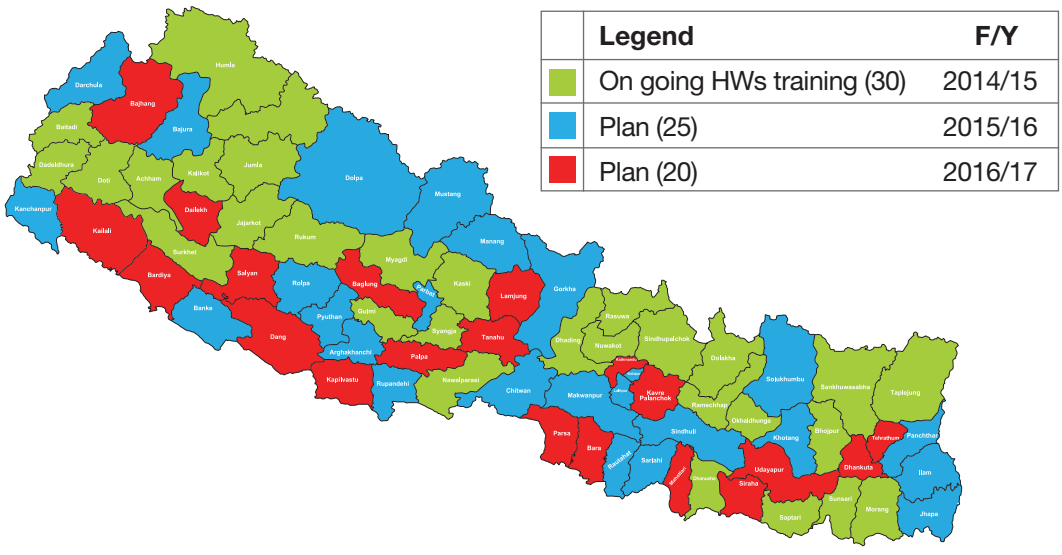
The Integrated Management of Childhood Illness (IMCI) strategy has been a flagship initiative of WHO and UNICEF worldwide. WHO-SEARO has supported country efforts to scale up IMNCI. Neonatal health component was added to the strategy at the initiative of countries of this Region to develop Integrated Management of Neonatal and Childhood Illness (IMNCI) package with community and facility components. A recent systematic review on IMCI/IMNCI has concluded that this strategy reduces child mortality by 15%.[20]

A very recent survey on IMCI/IMNCI programmes administered through questionnaire was carried out by WHO in nine countries of the Region (except Thailand and Democratic People's Republic of Korea) presents an impressive success story. Nine countries have scaled up implementation of IMCI/IMNCI in 90% or more districts. The strategy has led to community health workers being allowed to dispense ORS, zinc and antibiotics for pneumonia in most countries. Six countries have adopted the WHO Pocket Book for hospital care of children.

No surveys, however, reflect the full scale of public health action on scale as much as country-level scale-up experience in IMCI/IMNCI are show-cased by accounts from **Myanmar and Nepal as examples**. Nepal was one of the first countries in the Region to adopt the IMCI strategy with support from WHO and UNICEF in the late nineties. The new CB-IMNCI package was developed in 2014-15 and is currently being implemented. CB-IMCI implementation leads to improved provider skills, community practices and health system strengthening. The training is ongoing in a phase-wise manner and it is planned to cover the entire country by 2017. In collaboration with WHO and UNICEF, scaling up of IMCI has become the main approach and cost-effective strategy to address the major causes of mortality among under-five children.

After it was expanded to include the neonatal component in 2011, the strategy is being implemented as IMNCI (Integrated Management of Neonatal and Childhood Illness) covering pneumonia, diarrhoea and malnutrition along with essential newborn care, both at the facility and community levels as Facility-based integrated Management of Neonatal and Childhood illness (F-IMNCI) and Community based integrated Management of Neonatal and Childhood illness (CB-IMNCI), etc. (Graph 11).

Graph 11: Implementation status of CBIMNCI in Nepal

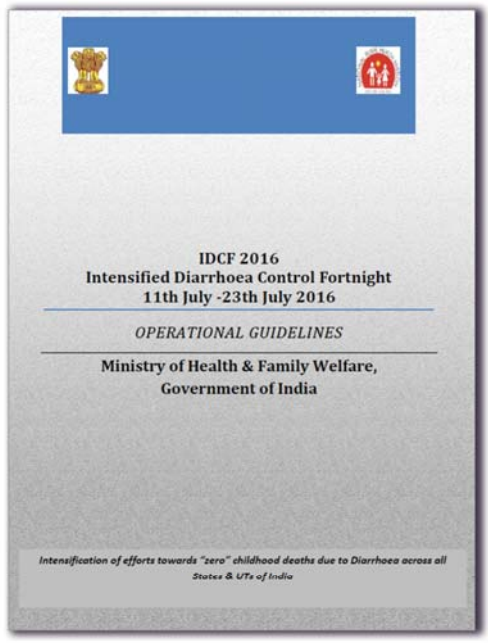


Therefore, while designing strategies, it is important for countries to examine "missed opportunities" where maternal and child service coverage is either lacking along the continuum of care, and/or to identify access points and linkages where interventions can strengthen multiple points along the continuum. Home-based antenatal, postnatal and newborn care interventions are not just important for saving the lives of mothers and newborns but they can also establish key behaviours such as early and exclusive breastfeeding, safe disposal of child faeces and hand-washing with soap, which are important foundations for child nutrition and the prevention of childhood illness later in life.[21]

Campaigning for child survival

In addition to sustained, round-the-year implementation of the programmes 'top up' campaigns, if conducted effectively, can raise coverage to a whole new level. Campaigns raise public awareness, enhance visibility of the cause among political leadership and energize the health system. For a seasonally-linked issue (e.g. diarrhoea, malaria), well-timed campaigns can make a defining difference.

Started in 2014, an annual campaign to reach the unreached with routine immunization in India, **Mission Indradhanush**, has succeeded in increasing coverage of childhood vaccines to an unprecedented level.[22] In another highly successful campaign, the Indian government has championed the cause of preventing and treating diarrhea particularly, boosting ORS and zinc usage, by conducting the highly successful nation-wide Intensified Diarrhea Control Fortnight (IDCF) campaigns in the month of July since 2014. In October 2014, Ministry of Health and Family Welfare (MOHFW) with WHO and UNICEF launched the integrated Global Action Plan for Pneumonia and Diarrhoea. The goal of this plan is to end preventable childhood deaths by reducing mortality from diarrhoea to less than 1 per 1000 live births. Currently, diarrhoea accounts for 10% under-five deaths (as many as 1.4 million deaths) each year in the country.



The 1st **Intensified Diarrhoea Control Fortnight (IDCF)** was organized in July 2014. Branding of the campaign using the IEC material such as TV spots, audio jingles, print inserts along with flip charts for health education is used by all states

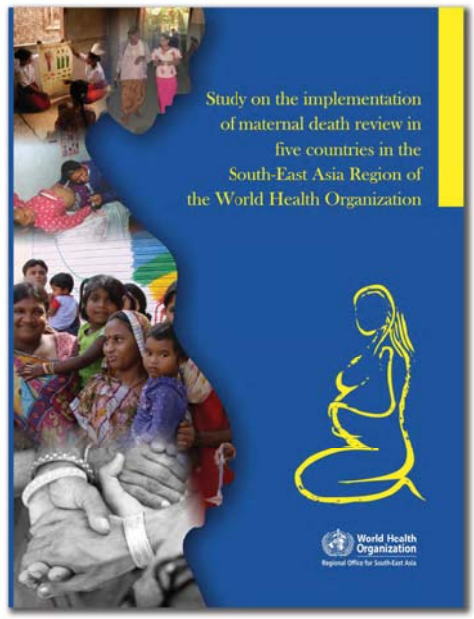
Table 6: Reported national coverage of IDCF

	IDCF 2014	IDCF 2015
No. of under-five children given ORS	19 million	63 million
No. of children treated with both zinc and ORS during the fortnight	0.96 million	2.15 million
No. of ORS and zinc corners established at public health facilities, etc.	0.19 million	0.34 million
No. of schools participating in IDCF activities	0.11 million	0.54 million
PRI meetings held (Village Health, Sanitation and Nutrition committee (VHSNC).)	49 932	0.32 million

and districts in the country; and shared with all states for replication and dissemination. During IDCF 2015, 44 million additional children were reached with ORS packets, 2.2 million children having diarrhoea were treated with ORS and zinc as compared to about a million children in 2014. An additional 1.5 million ORS-Zinc corners were established at public health facilities, and 0.32 million Village Health, Sanitation & Nutrition Committee (VHSNC) meetings were conducted in IDCF 2015 to raise public awareness about diarrhoea, ORS use and feeding during diarrhoea.

One important outreach is targeted to schools. In 2015, 0.54 million schools participated in the campaign when messages and demonstration on hand washing were provided. The IDCF campaigns have succeeded in galvanizing diarrhoea prevention and treatment activities in all states.

Maternal death reviews: A pathway to improving maternal healthcare quality



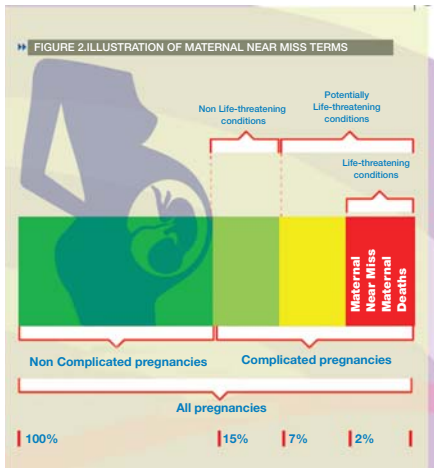
WHO SEAR has been leading the initiative on promoting maternal death reviews, since 2003. All countries of the Region are currently implementing this measure as a policy, with varying degrees of success. There are important lessons that surface through such surveillance. MDSR provides data that is critical to policy, such as timing of maternal deaths. In Bangladesh, for instance, review data from 10 districts in 2013–2015, 1309 maternal deaths showed that almost half died within six hours after delivery. This was a call for policy shift to 100% facility delivery. Maternal Death Review and Response in India is included in the national RCH II Programme. Since 2012, the approach has evolved to Maternal and Perinatal Death Surveillance and Response (MPDSR). The approach includes surveillance of maternal deaths and now, perinatal deaths with timely notification and an action/response to the aggregated death review information. There is a continuous action cycle linking surveillance, the health information system and quality improvement processes from local to national levels. It includes the routine identification, notification, quantification and determination of causes of all maternal deaths so that future preventable deaths can be averted through adequate and judicious response.

Nepal presents an excellent example of implementing MPDSR that holds useful lessons for other countries to follow. In 2003, the perinatal death review (PDR) was integrated in hospitals implementing MDR. The maternal and perinatal death review (MPDR) was further expanded to cover 42 hospitals in 23 districts of the country by 2013. After 2013 the focus was on writing MPDSR guidelines, planning to cover five districts in both facilities based and community based maternal deaths and no hospital expansion was made.

In Maldives, formal Maternal Death Review System introduced as early as 1997 resulted in identification of causes, circumstances and factors for maternal deaths and identification of actions to address these. With timely implementation and scaling up of evidence based quality interventions; Maldives witnessed a rapid decline in maternal mortality ratio which made it an early achiever of MDG 4 and 5 and have already achieved SDG target for maternal and child mortality.

The quest to continually improve called for a review of the maternal death review process itself which was assessed in 2000 which broaden the scope and functions of the review through the Maternal and Perinatal Morbidity and Mortality Committee (MPMMRC). The main aim of the MPMMRC is to help the Ministry of Health to sustain gain and maintain progress in reducing preventable maternal deaths by analyzing all the factors surrounding maternal deaths and make recommendations for ensuring corrective measures. This is to ensure:

- A 'Birth Plan' for every pregnant woman;
- Better communication and referral through the use of the SBAR (Situation-Background-Assessment-Recommendation) form;
- Use of Partogram with timely recognition and management of obstetric emergencies with improved knowledge and skills of health care providers.



Considering that there are very few maternal deaths, a 'Maternal death near Miss Review' has been initiated but the area needs further strengthening. The maternal death and near miss review mechanism has ensured that each death and potential threat to life has been investigated and national accountability strengthened. WHO is presently supporting Maldives to adopt 'maternal and perinatal death surveillance and response' to further ensure better reporting of maternal and perinatal deaths and health system wide actions to improve quality of care, sustain gains in maternal and newborn health and prevention of avoidable deaths in future.

Nothing succeeds like success

Timor-Leste and Maldives both started with very high maternal and child mortality, which many thought was impossible to tackle. But a high degree of political will, initiatives to strengthen the health system and evidence-based interventions taken to scale, to reach every woman ever child, have led to dramatic reductions in maternal and child mortality, and ultimately helping them achieve MDGs 4 and 5.

In Timor-Leste, the policy environment concerning MNH is very enabling: Since 2000 the Government has publicized its commitment to the MDGs 4 and 5, and demonstrated very positive improvements.

Emergency Obstetric and Newborn Care (EmONC) Improvement Plan of Action Timor-Leste 2016–2019

Goal

To sustain and contribute to improvement of maternal and newborn health in Timor-Leste towards the SDGs

Guiding Principles

- ✓ Evidence base
- ✓ Health system integration
- ✓ Partnership
- ✓ Clear definition of roles and responsibilities
- ✓ Transparency and accountability
- ✓ Equity
- ✓ Permanent monitoring and periodic evaluation

The National Health Sector Strategic Plan covering 2011 to 2030 has been augmented by the National RMNCAH Strategy 2015-2019, encouraging institutional delivery, guaranteeing free services for all at the point of delivery, and offering a reasonable standard of staffing for Referral Hospitals, Community Health Centres, CSIs and Health Posts with teams of midwives and medical doctors. The development of EmONC Improvement Plan of Action 2016-2019 in Timor-Leste was done with strategic support from WHO and partner agencies.






New horizons

Toward a more ambitious vision of the SDGs for women, children and adolescents

2.1 Unfinished task of MDGs 4 and 5 remains a high priority in the SDGs era

The extraordinary momentum acquired in the final years of the MDGs phase era promises even more impressive outcomes in coming years. As we enter the post-2015 era, it is time not only to end all preventable deaths of women and children, but also avert morbidity that hinders quality and productivity of lives.

The global development endeavor in the post-2015 phase is shaped by the Sustainable Development Goals (SDGs) to be attained by 2030. Equity, universality and sustainability are the most critical underpinnings of the SDGs. The 17 SDGs cover the world's most pressing economic, social and environmental challenges. The SDG 3 is devoted to health and is framed in an inclusive statement, specifically, 'Ensure healthy lives and promote well-being for all at all ages'.

Table 7: The 13 Targets in the Health SDG 3

3.1	By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births
3.2	By 2030, end preventable deaths of newborns and children under five years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-five mortality to at least as low as 25 per 1000 live births
3.3	By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, waterborne diseases and other communicable diseases
3.4	By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being
3.5	Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
3.6	By 2020, halve the number of global deaths and injuries from road traffic accidents
3.7	By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and program
3.8	Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
3.9	By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination
3.a	Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate
3.b	Support the research and development of vaccines and medicines for the Communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines
3.c	Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least-developed countries and small island developing States
3.d	Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks

The health SDG has 13 targets. These include targets 3.1, 3.2 and 3.7 that are directly related to the unfinished MDGs 4 and 5 flagship agenda (Table7). The present MMR in the Region is 164 per 100 000 live births. The SDG 3.1 target is to reduce it to 70 per 100 000 live births. The present neonatal and under-five mortality rates (per 1000 live births) in the Region are 24.3 and 43, respectively. SDG target 3.2 mandates their reduction to at least as low as 12 and 25, respectively by 2030. The SDGs impart a decisive impetus to reproductive health. In addition to target 3.7 under the health SDG, another target, namely, 'Ensure universal access to sexual and reproductive health and reproductive rights'. is included in SDG 5 on gender equality and empowerment of women and girls.

Thus, even though the unfinished task of the MDGs 4 and 5, form an integral part of the SDGs agenda, an *even more aspirational expectation* is to be realized in the next decade and a half. This will require not only a renewed commitment, but also new approaches and invigorated investments. More of the same will not be enough.

The Region is currently faced with 61 000 maternal deaths, 789 200 stillbirths and 1 558 000 under 5 child deaths (including 894 000 neonatal deaths).[23] Over half of the total child deaths in the Region are neonates, representing about 30% of the global burden of neonatal mortality[3]; while, one-third children under 5 years are stunted, 13.5% wasted and 5.1% are overweight.[5] All-cause mortality rates (per 100 000) among adolescents 15-19 years was 184 each year[24] and as many 6 million adolescent girls give birth each year. While, 20% of the mortality rate can be attributed to exposure to unsafe WASH services 5 ; the probability of dying from any cardiovascular disease, diabetes, chronic respiratory disease between ages 30 and 70 years is still the highest for any Region at 24.5%[5] and there are 175 000 new cases of carcinoma cervix.[25]

Photo courtesy: SWACH, Haryana, India

To achieve a further reduction in maternal mortality and universal access to quality care at birth and emergency obstetric care coupled with elimination of the 'three delays' is the prime need. For the residual child mortality, neonatal mortality reduction (addressing deaths due to preterm birth complications, sepsis, intra-partum related conditions and birth defects) in addition to nearly eliminating deaths due to diarrhea, measles and pneumonia is the key.

A strong health system is a necessary pre-condition to achieve SDGs. A well-functioning continuum of care enabled by a balanced mix of health personnel (community health workers, midwives, nurses, physicians, obstetricians, anesthesiologists and pediatricians) would be required to achieve the health SDG.

Some countries in the Region have already attained the SDG level maternal, neonatal child health outcomes, and have done so by building on the platform of strong health systems. Health systems should also be resilient to be able to respond to health emergencies resulting from natural and man-made calamities, and disease epidemiology shifts.

The interventions to save maternal and child lives are the same for all settings. It is the strength and resilience of the health system that determines the coverage, equity and quality of service delivery, which may be different in different settings with its own unique characteristics and challenges. Each one of the building blocks of the health system (namely, infrastructure, human resources, service delivery, commodities, finances, governance and information system) has to be in place to make an impact. It is possible that less demanding strategies, such as vertical approaches, may have succeeded in the past in our quest for the MDGs. But as maternal, newborn and child mortality declines to progressively lower levels, the pace could slow down because of the increasing demand for an even stronger health system needed to make an incremental difference required to achieve the SDGs.

For instance, if Bangladesh, a country that achieved MDG 4 with effective community-based approaches, has to reduce the neonatal mortality rate (per 1000 live births) from the present level of 23 to 12 as mandated in the SDGs, it would require care of small and sick neonates in resource-intensive special care newborn units with highly trained nurses and doctors. Likewise, for MMR to reach 70 per 100 000 live births, countries would need to ensure access to efficient transportation and facilities with C-section and blood transfusion. A high coverage of deliveries by skilled birth attendants alone will not be enough to achieve the SDG MMR target. Given the renewed, comprehensive and, more importantly, a rights-based emphasis to reproductive health in the SDGs, a new orientation and energy would be needed for this health and gender-linked priority.

2.2 SDGs envisage women's, children's and adolescents' health and well-being beyond survival

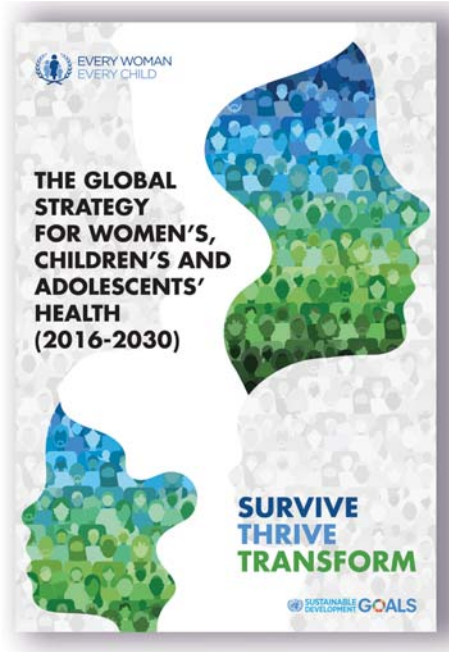
The SDGs set a vision for women's, children's and adolescents' health that is well beyond reproductive health, maternal mortality, and child nutrition and survival. There is a new focus on mortality due to chronic diseases (cardiovascular, cancer, diabetes and chronic respiratory disease), suicide, traffic accidents and household pollution. Childhood stunting and wasting remain a priority, but overweight is also on the agenda. Child development, violence against women and girls, genital mutilation and mental health figure prominently in the SDGs frame.

The defining principle of the SDGs is equity, and the core doctrine is to leave no one behind. Towards that end, the universal health coverage target 3.8 (of achieving 'universal health coverage, including financial risk protection, access to quality essential health-care services, medicines and vaccines for all) is an overarching target that underpins equity, and is key to the achievement of all others[26]. This target provides a commitment to ensure health-care without financial hardship for all - including all women, children and adolescents.

Health is dependent on many economic, social and environmental factors. SDGs encompass several such determinants including gender equality, empowerment of women and girls, education, water, sanitation, employment, adverse climate effect mitigation, and elimination of exploitation of children. Progress on these vital determinants would have a decisive impact on the health of women, children and adolescents. These targets, scattered in other SDGs [such as poverty reduction (SDG 1), education (SDG 4), gender equality (SDG 5), water and sanitation (SDG 6) and inclusive societies (SDG 16), among others], would be vital levers for improving healthy lives.

2.3 Global Strategy for Women's, Children's and Adolescents' Health is the new framework in the SDGs era

In 2015, UN Secretary General unveiled the Global Strategy (GS) for Women's, Children's and Adolescents' Health (2016-2030) as a successor to the Global Strategy for Women's and Children's Health launched in the thick of the MDGs era in 2010.[27]



The vision statement of the Strategy affirms: 'By 2030, a world in which every woman, child and adolescent in every setting realizes their rights to physical, and mental health and wellbeing, has social and economic opportunities, and is able to participate fully in shaping sustainable and prosperous societies'.

The World Health Assembly endorsed the Strategy and its operational framework in May 2016.[27] With that, the Strategy, incorporating and aligned to SDGs, has become the globally agreed upon guiding precept for the advancing health of women, children and adolescents in the next 15 years.

The Strategy is guided by country-led, universal, sustainable, human rights-based, equity-driven, gender-responsive,evidence-informed, partnership-driven, people-centred, community-owned and accountable approaches that epitomize the high principles of global health and development.

The Global Strategy draws its purpose and power from the SDGs (Table 8). The three cardinal objectives of the Strategy, namely, *Survive, Thrive and Transform,* portray the aspiration to not only end preventable mortality, but also to avert illnesses, ensure wellbeing, as well as usher in a productive and empowered future.

Table 8: Objectives and core targets of the Global Strategy for Women's, Children's and Adolescents' Health (SDG targets in parentheses)

SURVIVE

- Reduce global maternal mortality to less than 70 per 100 000 live births (SDG 3.1)
- Reduce newborn mortality to at least as low as 12 per 1000 live births in every country (SDG 3.2)
- Reduce under-5 mortality to at least as low as 25 per 1000 live births in every country (SDG 3.2)
- End epidemics of HIV, tuberculosis, malaria, neglected tropical diseases and other communicable diseases (SDG 3.3)
- Reduce by 1/3 premature mortality from non-communicable diseases and promote mental health and well-being (SDG 3.4)

THRIVE

- End all forms of malnutrition and address the nutritional needs of adolescent girls, pregnant and lactating women and children (SDG 2.2)
- Ensure universal access to sexual and reproductive health-care services (including for family planning) and rights (SDG 3.7 and 5.6)
- Ensure that all girls and boys have access to good-quality early childhood development (SDG 4.2)
- Substantially reduce pollution-related deaths and illnesses (SDG 3.9)
- Achieve universal health coverage, including financial risk protection and access to quality essential services, medicines and vaccines (SDG 3.8)

TRANSFORM

- Eradicate extreme poverty (SDG 1.1)
- Ensure that all girls and boys complete free, equitable and good-quality secondary education (SDG 4.1)
- Eliminate all harmful practices and all discrimination and violence against women and girls (SDG 5.2 and 5.3)
- Achieve universal and equitable access to safe and affordable drinking water and to adequate sanitation and hygiene (SDG 6.1 and 6.2)
- Enhance scientific research, upgrade technological capabilities and encourage innovation (SDG 8.2)
- Provide legal identity for all, including birth registration (SDG 16.9)
- Enhance the global partnership for sustainable development (17.16)

The **'Survive'** theme targets are the SDGs 3 targets. These include 2030 targets for global maternal mortality ratio (less than 70 per 100 000 live births), neonatal mortality rate (at least as low as 12 per 1000 live births), under-5 mortality (at least as low as 25 per 1000 live births, and reducing mortality due to non-communicable disease as well as targets for HIV, TB and malaria etc (Table 8).[27]

The **'Thrive'** agenda is centered around promoting health and well- being and covers nutrition, sexual and reproductive health, early childhood development and pollution related health loss (Table 8).[27]

The **'Transform'** priorities of the Global Strategy aim at universal health coverage and creating enabling environments by addressing social determinates of health (Table 8).[27]

The Strategy is imbued with recommendations of the 'Every Newborn Action Plan'[28] and 'Strategies toward Ending Preventable Maternal Mortality (EPMM)'.[29] The recommended interventions are based on the life-course approach (Annex 3). Thus, the Strategy underscores a renewed and more ambitious agenda on maternal, newborn, child survival and nutrition, reproductive health, and HIV. But notably, the Strategy envisages 'new' priorities as listed below (Table 9).

Table 9: The 'new' priorities in the Global Strategy for Women's, Children's and Adolescents' Health

- Stillbirths
- Adolescent child birth
- Adolescent health
- Congenital anomalies and childhood disabilities
- Child development
- Overweight in childhood
- Cardiovascular disease, diabetes, chronic respiratory disease in women
- Cervical and breast cancers
- Gender-based violence

The Global Strategy takes into account the need to invest in health system enablers, namely, policies for universal coverage, health workforce, commodity supply, health infrastructure, community engagement, emergency preparedness, human rights and accountability. Implementing the Strategy worldwide would yield tremendous returns (Table 10) including:

- an end to preventable maternal, newborn, child and adolescent deaths and stillbirths;
- At least a 10-fold return on investments in the health and nutrition of women, children and adolescents through better educational attainments, workforce participation and social contributions;
- at least US$100 billion in demographic dividends from investments in early childhood and adolescent health and development;
- a "grand convergence" in health, giving all women, children and adolescents an equal chance to survive and thrive.

Table 10: Action areas for operationalizing the Global Strategy

Source: *Every woman every child. The Global Strategy (GS) for Women's, Children's and Adolescents' Health (2016-2030), 2015. everywomaneverychild.org*

The Strategy also recognizes the multisector enablers such as education, agriculture, legislation and technologies, among others. An 'Indicators and monitoring framework' has been developed, and indicators compiled (Annex 2).[27] Accountability is an intrinsic component of the Strategy. An Independent Accountability Panel (IAP) has been tasked to report annually on progress and provide recommendations and guidance to all stakeholders on how to accelerate implementation.

WHO is committed to assist Member States in implementing the Strategy thereby ensuring that the momentum built by the MDGs is accelerated further to transform lives of women, children and adolescents and attain the SDGs.

Renewed commitment

On the move for ambitious gains in women's, children's and adolescents' health and well being

3.1 Ample preparedness for the unfinished agenda

The new vision of the SDGs and the new framework of the Global Strategy for Women's, Children's and Adolescents' Health demand new thinking, new strategies and new tools to assist Member States. Although a great deal more will need to be done in coming years, our team at the Department of Family Health, Gender and Life Course has already made ample progress in this direction. Some of the activities that have given WHO SEARO a head start in the new era are summarized next.

Cementing partnerships for the Global Strategy for Women's, Children's and Adolescents' Health

The Regional Director convened a Regional Summit of "H6 agencies" (WHO, UNICEF, UNFPA, World Bank, UNAIDS and UN WOMEN) in December 2015 to develop a consensus on joint commitment and to articulate a harmonized strategy to support Member States in implementing the U.N. Secretary General's Global Strategy for Women's, Children's and Adolescents' Health. A joint Regional H6 statement on Ending Preventable Maternal, Newborn and Child Mortality was released with a pledge to work with the governments to help strengthen their leadership and capacity to undertake time-bound actions to end preventable mortality in the Member States.

Release of the joint statement at the Regional H6 Summit on Ending Preventable Maternal, Newborn and Child Mortality

Joint Statement on Ending Preventable Maternal, Newborn and Child Mortality

New Delhi, India - 16 December 2015

We, the representatives of the H4+ agencies in South and East Asia, jointly commit our continuing support to the governments across our regions towards ending preventable maternal, newborn and child deaths by 2030. We are also committed to help our regions progress toward meeting the global targets as adopted in the Sustainable Development Goals (SDGs) and proposed in the second Global Strategy for Women's, Children's and Adolescents' Health.

We acknowledge that there has been significant progress in reducing maternal and child mortality in the South and East Asia Regions in pursuit of the Millennium Development Goals (MDGs). However, newborn mortality and stillbirths still remain high in many countries while in some these are under-reported. In addition, there is significant inequity between and within countries and quality of care remains a concern. We recognize that much morbidity and mortality among women, newborns and children is preventable using well-known, evidence-based solutions, several of which are not associated with high cost or technology. Likewise, we recognize the importance of empowerment of women, the attainment of gender equality and promoting adolescent health to ensure the sustainable future of all countries.

The regional H4+ leadership urges Member States to prioritize universal coverage of essential interventions and high-quality care urgently around the time of childbirth and the first days of life because of the dangerous implications during this period for women, their unborn babies and newborns. Evidence suggests that this strategy will accelerate reduction in newborn mortality and, at the same time, help reduce stillbirths and maternal mortality.

We pledge to work with governments to help strengthen their leadership and capacity to undertake time-bound actions to:

- Mobilize sufficient, sustainable and equity-focused financing, adequate and skilled human resources, and essential commodities and equipment for maternal and newborn health care.
- Improve management capacity to sustain strong health systems for high-quality service delivery, community participation to reach the unreached, and preparedness to maintain services in humanitarian emergencies and fragile settings.
- Assume national accountability for results and resources through harmonized monitoring, reporting and use of relevant disaggregated health data, indicators and information; and upholding rights of women and children.
- Enhance collaboration and coordination with donors and partners including civil society and the private sector.
- Expand coverage of services for family planning, preventing adolescent pregnancies, prevention of mother-to-child transmission of HIV and syphilis, prevention of birth defects; and enhance investment in early childhood development and adolescent health to ensure better chances of survival, good health and overall well-being.
- Address, over time, the wider determinants of health, including but not limited to socioeconomic status; education, especially for girls; nutrition; water, sanitation and hygiene; the empowerment of women and gender equality through a multi-sectoral approach.

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SEAR Technical Advisory Group on Women's And Children's Health

The South-East Asia Region Technical Advisory Group on Women's And Children's Health, comprising twelve eminent global and regional experts, was constituted in 2015 by the Regional director to provide guidance on how best to accelerate the implementation of high impact strategies to reduce newborn, child and maternal mortality in the Region. Its first meeting was held with a focus on neonatal health in December 2015 with the participation of all Member States, partner agencies, professional associations and academia. Recommendations have been received and actions initiated in coordination with H6 agencies. The key recommendations of the TAG would pave way for accelerating the decline in difficult-to-address neonatal mortality (Table 11). The next phase of the TAG's work would focus on women's and adolescents' health this year.

Table 11: Key recommendations of the Technical Advisory Group on Women's and Children's Health for neonatal health

- Assist high priority countries to develop **national newborn action plans** (drawing upon the global Every Newborn Action Plan) with budgets, targets and milestones, and accountability commitments
- Scale up **facility-based newborn care** for small and sick neonates – develop demonstration sites in countries with no models thereof
- Scale up home-visiting based postnatal care
- Using the Regional Framework for **Improving Quality of Care** in RMNCAH and WHO standards, build capacity to improve quality of care at childbirth in facilities
- **Incorporate WASH** as an integral part of the standards of facilities
- Develop a Regional Monitoring Framework for RMNCAH incorporating **equity-sensitive indicators, and expand MPDSR** (maternal perinatal death surveillance and response) uptake
- Undertake a landscape review of **private sector newborn care** services and explore approaches to engage it for services for the poor without financial hardship
- Support countries to launch multisectoral initiatives to reduce **adolescent pregnancies**

3.2 Preparing for the agenda beyond survival across the life course

Adolescent health

With over 350 million adolescents in the South-East Asia Region (SEAR), our Member States have the largest adolescent population in the history of mankind. Bearing the changing global health agenda in mind, holistic and effective interventions during adolescence can protect long-term public health investments- both by rectifying gaps from the first decade of life and optimizing potential future gains in health and welfare.

Adolescent health challenges

1.3 million adolescents globally, died in 2012 from preventable or treatable causes. with road injuries, HIV, suicides, lower respiratory infections and interpersonal violence as leading causes

6 million girls in SEAR between 15 and 19 years give birth each year mostly within marriage.

70% of adult deaths from non-comunicable diseases are linked to risk factors that start in adolescence

25–50% of adolescent girls in SEAR are reported to be anaemic

Rise of substance use, tobacco & alcohol use along with mental health problems like loneliness, suicide, violence

In the Region, at 33.9%, although the adolescent birth rate is less than the global average, it remains to be alarmingly high. It is disconcerting to know that in some countries in the Region, a large proportion of girls are married before 18 years of age (59% in Bangladesh[30], 47% in India[30] and nearly 41% in Nepal[30]). About six million girls between 15 and 19 years of age give birth each year in SEAR mostly within marriage. Early pregnancy has higher adverse reproductive health outcomes like high maternal mortality and high infant mortality.

Neonatal mortality rate (per 100 live births) is nearly 2 times in mothers under 20 years as compared to 20-24 year olds in Indonesia at 34 and 18 and Maldives at 25 and 13.[32] Similar trends are observed in infant mortality rates (per 100 live births) at 82 and 64 in mothers under 20 years as compared to 20-24 year olds in Myanmar. Additionally, nearly 2/3rd of premature deaths and 1/3rd of the total disease burden in adults is associated with conditions or behaviours that are initiated during adolescence.[32]

In South-East Asia, the focus on adolescent health is rapidly moving beyond the traditional sexual and reproductive health agenda. For a healthy transition from childhood to adulthood other parameters like nutrition and physical activity, mental health and well-being, risk-taking, violence and injuries, and habits that form the basis of life-style diseases must be addressed.

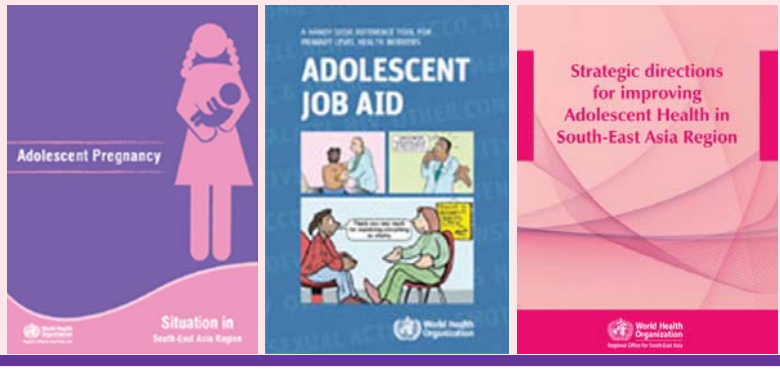
- More than 25% of adolescent girls in the Region are reported to be anemic; in some countries the prevalence is as high as 50%
- There is increasing emphasis on physical activity in our Region, but it varies- with 30% of students in India, 20% in Myanmar to only 14% students in Sri Lanka that were physically active for a total of at least 60 minutes per day and boys are mostly more active than girls
- Education, particularly with regard to access to education by girls is an important social determinant of health
- Tobacco, alcohol and substance abuse has been reported in 13-15 year old adolescents. Mental health problems like loneliness, suicide and violence are increasing during the last one decade
- Issues like violence, accidents and injuries are the leading cause of mortality in adolescent boys

Prioritizing adolescent health

Despite these challenges, compared to 20 years ago, adolescents today are healthier, more likely to be in school, delay marriage and childbearing, and the momentum is building up. WHO-SEARO has provided substantial technical and strategic support to the Member States to address the determinants underlying poor health and health-compromising behaviours in adolescents. The Regional Office has provided technical support to Member States in developing their national strategies on adolescent health and development in line with the Regional Strategic Framework on Adolescent health (Table 12).

Table 12: Adolescent health and development initiatives in SEAR

Regional programme manager meetings and inter-agency collaboration
• Gender, Equity, Rights & Social Determinant of Adolescent Health – June 2016
• Strengthening intersectoral collaboration for adolescent health – December 2015
• Regional expert group consultation on pre-conception care – December 2014
• Adolescent Pregnancy Situation in South-East Asia Region – November 2014
• Scaling up adolescent health in South-East Asia – October 2012
• Strategic directions for improving adolescent health in South-East Asia Region – October 2011
• Prevention of iron deficiency anemia in adolescents – October 2011
• Modules on adolescent mental health promotion



Adolescents are a great human resource that could become the engine of national growth and prosperity. This potential can only be realized if society can ensure that they remain healthy. WHO has been playing a leadership role to strengthen the health sector response to the health needs of these adolescents. WHO has provided technical assistance to Member States in the Region and supported country adaptation of tools for planning, capacity-building, monitoring and supervision (Table13).

Table 13: Progress in implementation of adolescent health programmes in SEAR

	National adolescent health	National adolescent health programme		National standards and implementation guidelines on AFHS	Training package for adolescent health care providers	Adolescent Friendly Health Services (AFHS)	
		Budget allotted	Currently implemented (2015)			Public health facilities with AFHS	Quality & coverage assessed
Bangladesh	✓	✓	✓	✓	✓	✓	✓
Bhutan	✓	✓	✓	✓	✓	✓	✓
DPR Korea	–	–	–	–	–	–	–
India	✓	✓	✓	✓	✓	✓	✓
Indonesia	✓	✓	✓	✓	✓	✓	–
Maldives	✓	✓	✓	✓	✓	✓	–
Myanmar	✓	✓	✓	✓	✓	✓	✓
Nepal	✓	✓	✓	✓	✓	✓	✓
Sri Lanka	✓	✓	✓	✓	✓	✓	–
Thailand	✓	✓	✓	✓	✓	✓	✓
Timor-Leste	✓	✓	✓	✓	✓	✓	–

Preventing stillbirths

Stillbirths are a hidden calamity. The global burden of stillbirths is estimated to be 2.5 million each year.[10] Of these, about 0.8 million occur in the South-East Asia Region (Table 14). Around half of stillbirths are intrapartum (fetal deaths which occurs after the onset of labour but before birth); stillbirths prior to onset of labor are termed antepartum stillbirths. Maternal pre-eclampsia/ eclampsia, infections (syphilis, malaria, HIV), maternal smoking, congenital anomalies and elderly mother are important risk factors of stillbirths. Skilled birth attendance and emergency obstetric care can avert a large proportion of intrapartum stillbirths. Every Newborn Action Plan aims to reduce stillbirth rate to 10 per 1000 total births by 2035. One of the indicators for the 'Survive' component of the Global Strategy for Women's, Children's and Adolescents' Health will be stillbirth rate.

Table 14: Stillbirth burden in SEAR countries

	Stillbirth rate per 1000 total births 2015	Number of stillbirths 2015
Bangladesh	25.4	83 100
Bhutan	16.0	200
Democratic People's Republic of Korea	13.5	5200
India	23.0	592 100
Indonesia	13.2	73 400
Maldives	7.7	100
Myanmar	20.0	18 700
Nepal	18.4	10 300
Sri Lanka	4.9	1500
Thailand	5.0	3700
Timor-Leste	17.8	900
South-Asia Region		789 200

Source: *Stillbirths: rates, risk factors, and acceleration towards 2030. Lancet 2016; published online Jan 18. http://dx.doi.org/10.1016/S0140-6736(15)00837-5*

WHO-SEARO has supported the development of **hospital based surveillance for stillbirths.** This online system for surveillance of stillbirths is fully operational for uploading the data on the SEAR-NBBD database. Fourteen hospitals in India are uploading the data on stillbirths (including birth defects) regularly. This will contribute towards improvement in maternal health care during pregnancy and childbirth as well as surveillance of birth defects and maternal risk factors. This prototype has been adapted by MOH in India for preparing national guidelines for stillbirths surveillance.

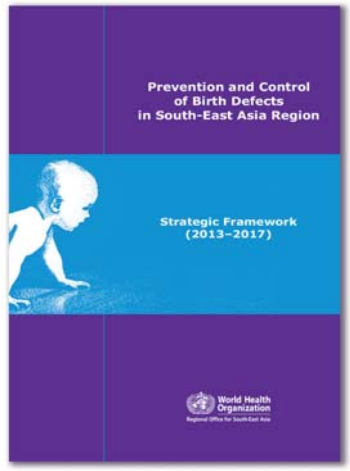
Preventing birth defects

Congenital anomalies or birth defects contribute to 10% neonatal deaths worldwide.10 As the NMR declines consequent to reductions in sepsis, prematurity and birth asphyxia mortality, the relative proportion of deaths due to birth defects rises as has happened in Sri Lanka and Thailand.

Attaining the SDG (and Global Strategy) target of neonatal mortality rate (NMR) of 12 per 1000 live births by 2030, as well the Global Strategy target of reducing stillbirths, would require significant progress toward preventing and treating birth defects.

Birth defects are also a leading cause of long term morbidity resulting from organ system dysfunction and disability, compromising quality of life as well as a high social and economic burden on the families as well as society at large. The World Health Assembly Resolution WHA 63.17, adopted in May 2010, recognizes the significant contribution of birth defects to neonatal mortality and stillbirths, and recommends implementation of prevention programmes within the existing health and related programmes, using a primary health care approach.

The WHO-South-East Asia Regional Office has led a comprehensive and successful collaborative Regional initiative with the National Center for Birth Defects and Developmental Disabilities at Centers for Disease Control and Prevention, (CDC USA), since 2011.

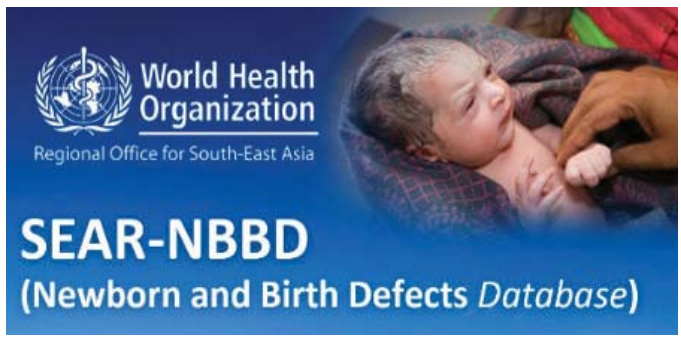


Following the development of the Regional Strategic Framework for prevention and control of birth defects nine countries have prepared national plans for surveillance and prevention of birth defects by adopting integrated approaches to embed the prevention and care interventions in the existing RMNCAH and related programmes like immunization, nutrition and environmental health.

At the same time capacity building support is being provided to set up birth defects surveillance mechanisms in the countries to understand the disease burden and know the trends over time to understand if preventive interventions have been effective. An online integrated database for newborn health, stillbirths and birth defects has been established and more than 150 hospitals from Member States have been enrolled to collect data and information on birth defects and perinatal health.

Networking among institutions and experts – Linkages with newborn health

The Regional Office has supported establishment of Regional and National Networks for newborn health and birth defects. WHO-SEARO convened a regional network meeting to review newborn-birth defects database.

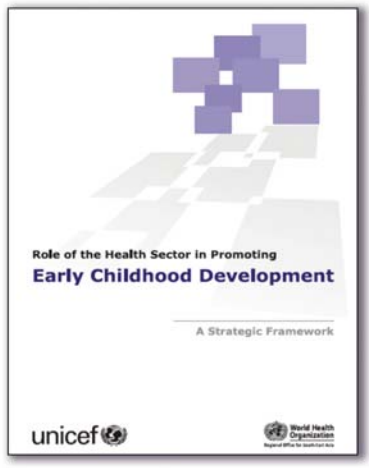


In 2014, WHO-SEARO along with support from CDC-USA created an online system of newborn-birth defects (SEAR-NBBD) database. The system was designed to support data management for newborn health, birth defects and stillbirths. Standardized forms for data collection are available online as well as through a mobile app, for submission to the system. This system is to develop capacity and establish a robust online database that can subsequently be migrated to national systems in the SEAR Member countries in the Region.

About 150 hospitals from 8 countries are currently registered as a part of the NBBD Surveillance network and 110 hospitals from 7 countries are reporting data on birth defects since 2014. The aim is to establish a baseline assessment and monitor the occurrence of birth defects in the Region, so that appropriate measures can be taken. A new online system has been added to the NBBD Surveillance network to report on 'Head Circumference' in all births among the registered hospitals in the network in response to the public health emergency of Zika Virus. This is to monitor the occurrence of microcephaly in the Region.

Promoting early childhood development

Globally over 200 million children under the age of 5 years are not developing their full potential. Of these, about 89 million are in South Asia. From conception through the first few years of a child's life is the period of greatest risk as well as greatest opportunity for providing the best start for children as well as long term benefits through adulthood.



The health sector has a unique role in young children's growth and development. WHO and UNICEF have developed a package "Care for Child Development" that can be used by primary health care and community health workers to assist individuals and families in promoting good nutrition and development, and preventing risks.

WHO-SEARO in collaboration with UNICEF has developed a strategic framework – Role of Health Sector in promoting Early Childhood Development to guide countries in the South-East Asia Region for developing programmes for children's growth and development as well as policies and plans to support such programmes that can be implemented through the health sector in collaboration with other sectors. It outlines evidence-based, effective age-appropriate interventions that health facilities, communities and families can use to ensure optimal early child development through the health system.

The Framework recommends that countries incorporate early child development into integrated primary health care. WHO supported pilot projects on implementation of WHO-UNICEF Care for Child Development package in India to examine the feasibility and effectiveness of the package through different delivery channels.

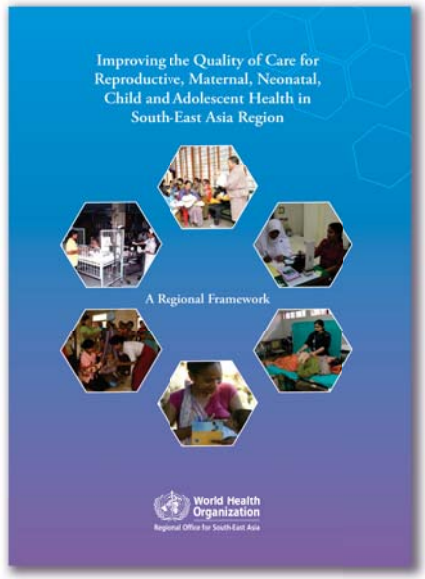
The intervention was undertaken in 100 villages at two sites. ASHAs (village level health volunteers), AWWs (Anganwadi Worker – the nutrition and child development workers) and mother groups were trained to deliver the intervention on Early Childhood Development (ECD) in the form of advice on age-appropriate advice on play and communication to the primary caregivers of 0–3 year old children.

Photo courtesy: SWACH, Haryana, India

The intervention was delivered during home visits, group sessions organized at the AWW centre or in the community. Following the intervention, there was a significant quantitative and qualitative improvement in the interaction between the primary caregivers in the family and the child as well as better nutritional outcomes (increase in weight for age) in the children. This experience is in line with a recent report of a cluster-randomized effectiveness trial in Pakistan[33] which demonstrated higher cognition, language and motor skills in children at 4 years of age who received responsive stimulation in a community health before 2 years of age.

Early childhood development is an essential element for the 'Thrive' objective of the Global Strategy for Women's Children's and Adolescents' Health. WHO-SEARO will build on this work and assist Member States in scaling up effective interventions that will help every child in the Region reach her maximum development potential.

Improving the quality of RMNCAH care



For reducing maternal, newborn and child mortality the focus has been on reaching higher coverage with key RMNCH interventions.[34] It has been observed that the evidence-based interventions are often delivered with insufficient quality.[35] A number of studies over the past years have documented poor quality of care provided to neonates and children.[36, 37, 38] Similarly, deficiencies in maternal health care, for both routine and emergency care, have also been described.[39]

This may even be harmful for the health of the individual as well as leading to adverse effects on future health-seeking behaviour by communities.[40] Low utilization of health care services by the population and lack of progress towards achieving MDG 4 and 5 can be partially attributed to the poor quality of the services. Universal coverage of health care services, as promoted by the World Health Organization (WHO), lays strong emphasis on good quality of care. The Global Strategy strategy for women's children's and adolescents' health (2016–2030) and SDG framework provide further impetus towards ending preventable mortality among mothers, newborns and children.

Universal health care is a centre piece for SDG3 wherein the quality of health care is a crucial element. Quality of care is embedded in the recently developed global frameworks like ENAP (Every Newborn Action Plan) and EPMM (Strategies for preventable maternal mortality). WHO-SEARO developed A Regional Framework for improving the quality of care for RMNCAH in consultation with Member States and partner agencies in 2015. WHO will support the Member States to adapt the guidance to prepare national framework for improving quality of care for RMNCAH.

Within the overall national framework, improving quality of services at the point of care at the health facility/hospital level will be the critical factor to ensure desirable improvement in health care outcomes like reduction in case fatality rate, reduction in hospitalization days and cost of care etc. Accordingly, it is important to build the capacity at the point of care (health facility level) among the teams of health care providers (Obstetrician, Pediatrician, Nurse-Midwife for improving at-birth

care) at the hospitals/health facilities for initiating and sustaining the improvement process that can cumulatively improve the outcomes of care. A Regional workshop on Quality Improvement for maternal and newborn health was organized in May 2016 to introduce a model of quality improvement for the care of mothers and newborns at the time of childbirth.

Training was undertaken for the invited teams of health care providers from hospitals from the Member States. WHO will support Member States to adopt this quality improvement model and in rolling out at scale implementation as well as creating a regional learning platform to support the hospital teams.

New impetus to Maternal and Perinatal Death Surveillance and Response

The Commission on Information and Accountability (CoIA) was established under the Global Strategy for Women's and Children's Health 2010–2015 to develop a framework to ensure global reporting, oversight and accountability for the Global Strategy. One of the 10 recommendations of the CoIA in 2011 was to take significant steps to establish national systems for registration of vital events, such as births, deaths and causes of death. In line with the recommendations WHO with partners launched the Maternal Death Surveillance and Response (MDSR) technical guide in 2013.

The approach includes surveillance of maternal deaths with timely notification and an action/response to the death review information. MDSR is a form of continuous action cycle from surveillance linking the health information system and quality improvement processes from local to national levels. It includes the routine identification, notification, quantification and determination of causes and avoidability of all maternal deaths. This information is then used for responding by actions that will prevent future deaths.

Besides the issue of maternal deaths, perinatal deaths pose a great challenge for the low and middle-income countries. Perinatal deaths include stillbirths and early neonatal deaths. WHO and partners have recently develop technical guideline on MPDSR. This is an important step towards counting every newborn besides maternal deaths, are included in surveillance and response. WHO-SEARO organized Regional meeting on MPDSR in February 2016.

The progress in implementation of maternal death surveillance and response in the Member States was reviewed and new guidelines of perinatal death surveillance and response were introduced to the programme managers. WHO-SEARO will provide assistance for building capacity to introduce and scale up implementation of MPDSR to strengthen accountability and improve quality of care.

Cervical Cancer

The Global Strategy for Women's, Children's and Adolescents' Health encompasses preventing and managing non-communicable diseases. In particular, there is focus on cervical cancer. Second commonest cancer among women, cancer cervix is both preventable and largely treatable. Globally each year, about half a million women develop cervical cancer, and about 275 000 women die of the disease. In terms of prevalence, an estimated 1.4 million women worldwide are living with cervical cancer. In 2008, there were almost 200 000 new cases of cervical cancer in Member States of the World Health Organization (WHO) South-East Asia Region, giving an incidence of almost 25 per 100 000 and mortality rate of almost 14 per 100 000 (Table 15).

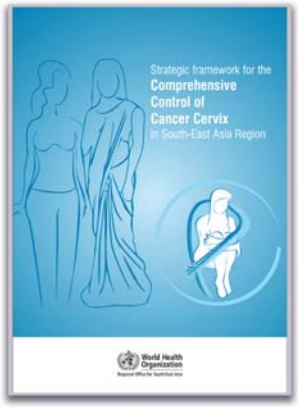
Table 15: Burden of cervical cancer in the South- East Asia Region

Country	Cancer Cervix incidence		Cancer Cervix mortality	
	No. of cases per year	ASR* (per 100 000)	No. of deaths per year	ASR (per 100 000)
Bangladesh	11 956	19.2	6 582	11.5
Bhutan	37	12.8	19	7.0
DPR-Korea	1 881	12.4	1 119	7.2
India	122 844	22.0	67 477	12.4
Indonesia	20 928	17.3	9 498	8.1
Maldives	14	11.0	7	6.3
Myanmar	5 286	20.6	2 998	12.3
Sri Lanka	1 721	13.1	690	5.0
Thailand	8 184	17.8	4 513	9.7
Timor-Leste	-	-	-	-

*ASR – age standardized rates; PBCR – population-based cancer registry

Source: *Strategic Framework for comprehensive control of Cancer Cervix*

The vast majority of cases and deaths from cervical cancer are unnecessary, because efficacious and potentially effective modalities exist for its prevention and management by a three-pronged intervention. These include:



a. primary prevention by human papillomavirus (HPV) vaccination for girls 9-13 years of age;

b. secondary prevention by timely screening and treatment of precancerous lesions in 30-49 years old women; and

c. early detection and treatment of invasive cancer, and palliative care.

The WHO Regional Office for South-East Asia has facilitated the development of the Strategic framework for the comprehensive control of cervical cancer in South-East Asia.[25] The framework is based on a situational analysis of Member States regarding their preparedness and capacity to introduce new cervical cancer control measures, and has taken into account the emerging scientific evidence related to new technologies and novel paradigms in cervical cancer screening, as well as the safety and efficacy of HPV vaccine. In addition, a training package on Cervical Cancer Screening and Management of Cervical Pre-cancers has been developed and is ready for dissemination.

3.3 Inclusive, more robust Flagship Action for Women's, Children's and Adolescents' Health – Guided by the SDGs and the Global Strategy

The health and well-being of women, children and adolescents is the key to sustainable development and a prosperous future for all in the SDGs era. UN Secretary General's Global Strategy for Women's, Children's and Adolescents' Health, endorsed by the Member States, provides the vision and framework, *a new paradigm,* for this renewed mission.

The new paradigm extends beyond the unfinished survival agenda of maternal, fetal, neonatal, and child survival to the aspirational holistic goals of 2030. The bar has been raised much higher. The focus on ending maternal deaths due to hemorrhage, eclampsia, obstructed labor, infection and unsafe abortion will be intensified, along with emphasis on the coverage and quality of skilled care at birth and of emergency obstetric care. Newborn and child deaths due to measles, diarrhea, pneumonia, sepsis, prematurity and perinatal asphyxia will be prevented, and further action will be targeted to reach children in homes, communities and facilities.

Given the momentum on maternal and child survival in our Member States, it is expected that the MDG 4 and MDG 5 targets will be achieved soon. The post-2015 paradigm is also about concentrating on adolescent health as the window to adulthood, and to the future. Adolescent health is no more just sexual and reproductive health (as has been the case), but must also encompass promotion of positive lifestyles, low risk behaviors, mental well being, optimum nutrition, and empowerment. The new paradigm calls for addressing birth defects, child development and over-nutrition. In addition, women's cancers (cervix and breast) and cardiovascular diseases are clear priorities the progress on which will be essential.

Equity is the principal tenet in the SDGs. The women's, children's and adolescents' heath will be achieved within the charter of universal health coverage which is the overarching frame of SDG 3. We shall endeavor together to ensure that no one will be left behind - the poor, the marginalized, the young urban slum dweller, the old woman in the remote mountain village, the family facing a natural calamity or the child held up in a conflict zone. Girls and boys alike must survive, thrive and attain the best physical, mental and cognitive potential.

WHO SEARO has demonstrated early preparedness to accelerate progress on the unfinished agenda, as well as for most of the new focus areas. These efforts will be intensified as guided by the Member States. The Regional office is developing a Regional Framework for RMNCAH that will set interim targets for 2020 and 2025 towards the 2030 global targets, and accompanying accountability framework. Strengthened and resilient health systems are an essential pre-requisite for SDG 3. WHO-SEARO would therefore create enabling mechanisms for integration of strategies and action spanning across various departments.

The ultimate success of SDG3 and Global Strategy will depend also on coordinated action across sectors, particularly nutrition (Goal 2), education (Goal 4), gender equality and empowerment of all women and girls (Goal 5) and water and sanitation (Goal 6). WHO-SEARO will reorient its approach to create connections, pathways and synergies with these sectors as never before.

The Regional Director reaffirms her and her team's unstinting determination to strive for the highest attainable standard of health for women, children and adolescents in the South-East Asia Region. Women, children and adolescents shall always remain WHO-SEARO's core priority. In the post-2015 era, Regional Director's flagship action will be guided by the SDGs and the Global Strategy. The WHO SEARO shall support Member States to not only strive to end all preventable maternal, newborn and child deaths, but also embrace the expanded 'thrive' and 'transform' vision and action areas of the Global Strategy.

A more inclusive and more dynamic action for women's, children's and adolescents' health and development is indeed the way forward for WHO, development partners and the Member States.

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Annex – 4.1

Country Factsheets

Bangladesh

Bhutan

Democratic People's Republic of Korea

India

Indonesia

Maldives

Myanmar

Nepal

Sri Lanka

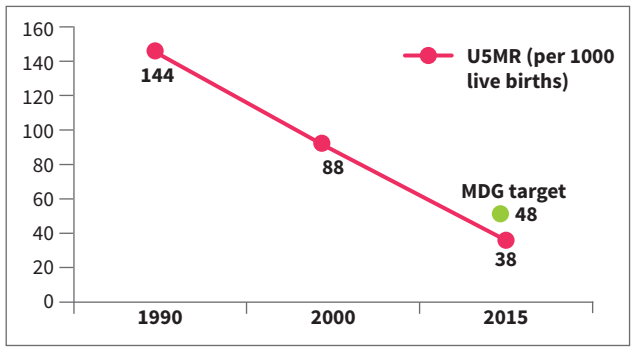
Thailand

Timor-Leste

BANGLADESH

ACHIEVED MDG 4

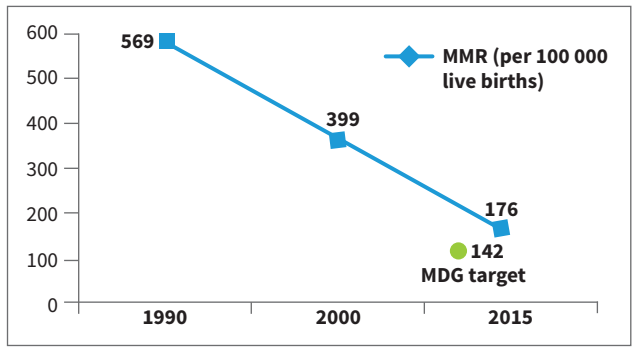
74% reduction in under 5 mortality since 1990



Source: *UNICEF, World Health Organization, The World Bank, United Nations Department of Economic and Social Affairs, Population Division. Levels & trends in child mortality - report 2015: estimates developed by the UN inter-agency group for child mortality estimation. New York, 2015.*

SIGNIFICANT PROGRESS FOR MDG 5

69% reduction in maternal mortality since 1990



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Total population	160 996 000 (2015)	Population under 5 (%)	10	Maternal mortality ratio (per 100 000 live births)	176 (2015)
Neonatal mortality rate (per 1000 live births)	23 (2015)	Prevalence of stunting in children under 5 (%)	36.1 (2015)	Adolescents 10-19 years (%)	20
Under-five mortality rate (per 1000 live births)	38 (2015)	Prevalence of wasting in children under 5 (%)	14.3 (2015)	Adolescent Birth Rate (births 1000 women 15-19 years)	113
Infant mortality rate (deaths per 1000 live births)	31 (2015)	Prevalence of overweight in children under 5 (%)	1.4 (2015)	Unmet need for family planning*(%)	14 (2014)

Source: *World Health Organization. World health statistics 2016. Geneva, 2016. http://apps.who.int/iris/bitstream/10665/170250/1/9789240694439_eng.pdf - accessed 9 August 2016.*
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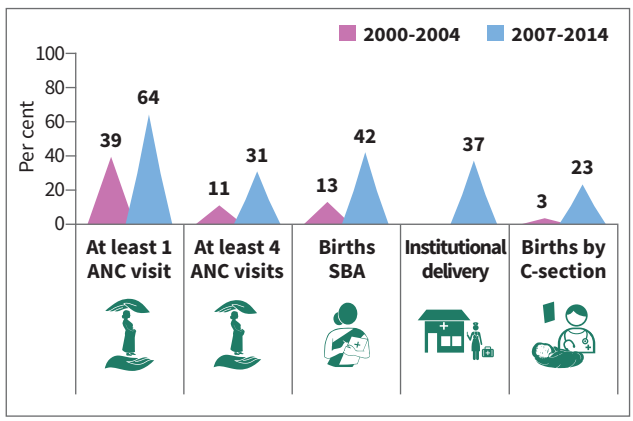
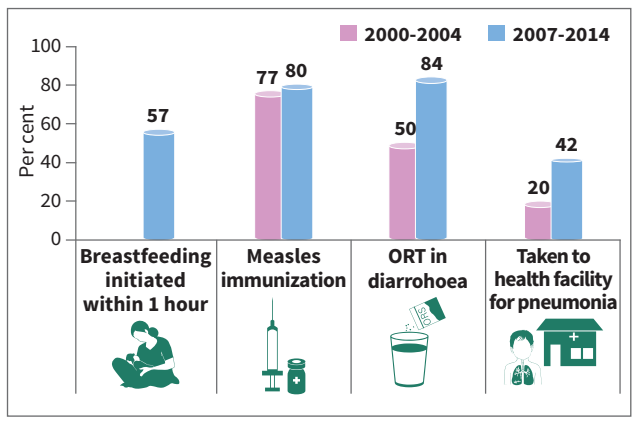
COVERAGE OF LIFE-SAVING INTERVENTIONS INCREASED

Maternal interventions



Source: *World Health Organization. World health statistics 2006. Geneva, 2006. http://www.who.int/gho/publications/world_health_statistics/whostat2006_erratareduce.pdf- accessed 9 August 2016*

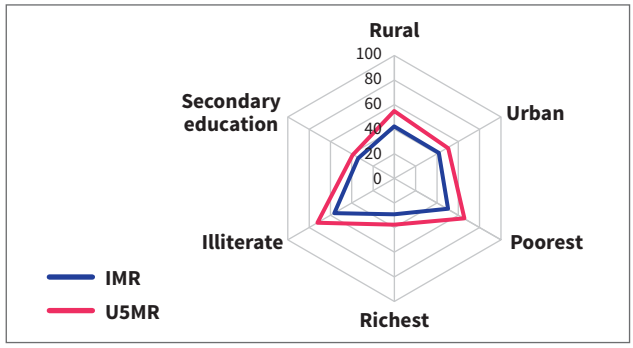
Immunization and illness treatment in children



Source: *World Health Organization. World health statistics 2006. Geneva, 2006. http://www.who.int/gho/publications/world_health_statistics/whostat2006_erratareduce.pdf- accessed 9 August 2016*

DO INEQUITIES PERSIST?

In mortality



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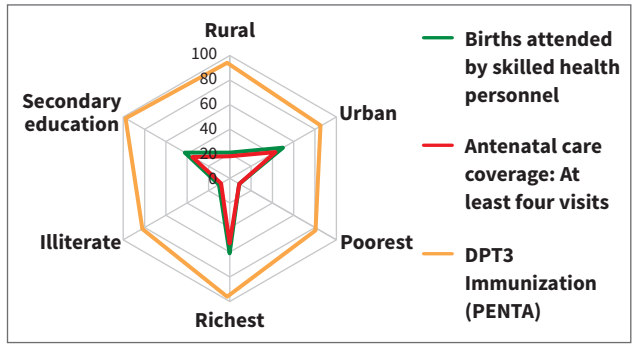
In life-saving interventions

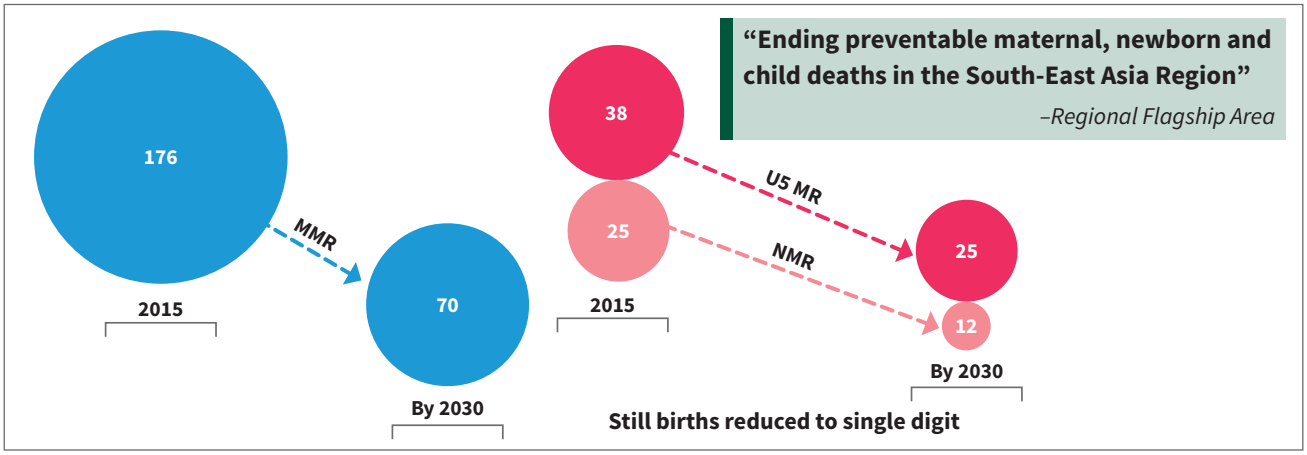


Source: *Bangladesh Demographic and Health Survey 2014*

SUSTAINABLE DEVELOPMENT GOALS

NEW HORIZONS

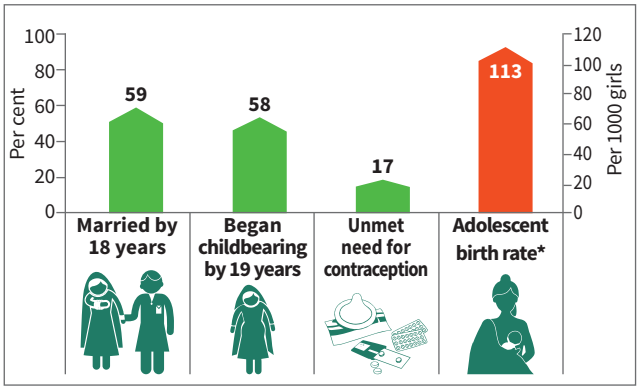
SDG targets



Source: World Health Organization, United Nations Children's Fund, United Nations Population Fund, the World Bank, United Nations. Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf - accessed 9 August 2016.

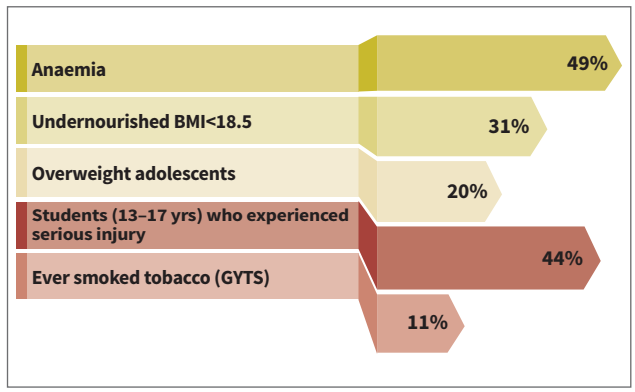
ADOLESCENTS: TOWARDS HEALTHY TRANSITIONS

Adolescent marriage and childbearing (15–19 years)



Source: Bangladesh Demographic and health Survey 2014; *World Health Statistics, WHO Publication. 2016. Available from: http://www.who.int/gho/publications/world_health_statistics/2016/en/

Diet, physical activity and tobacco use



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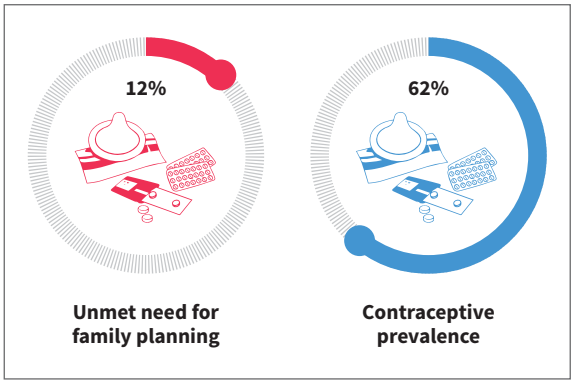
REPRODUCTIVE HEALTH

Access to reproductive health-care services



Source: Bangladesh Demographic and Health Survey 2014

Cervical cancer

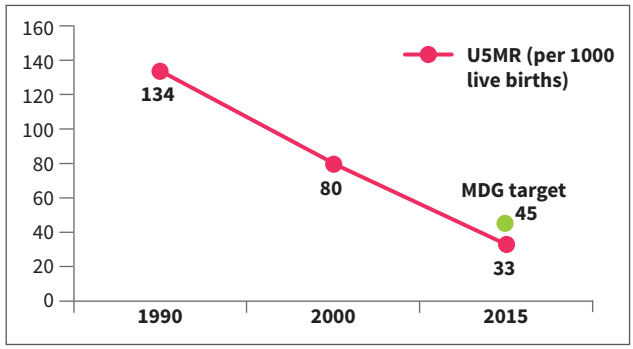
Number of girls between 9–13 years (eligible for HPV vaccination)	7 751 000
Opportunity for HPV vaccination	
National Cervical Cancer Screening Programme (Launched in 2005)	
Cancer Cervix Incidence (per 100 000)	19.2
Cancer Cervix Mortality (per 100 000)	11.5
Need for population-based cancer registry	

Source: Strategic framework for the Comprehensive Control of Cancer Cervix in South-East Asia; http://apps.who.int/iris/bitstream/10665/152098/1/9789290224723-MRH.pdfRegion,http://apps.who.int/iris/bitstream/10665/152098/1/9789290224723-MRH.pdf

BHUTAN

ACHIEVED MDG 4

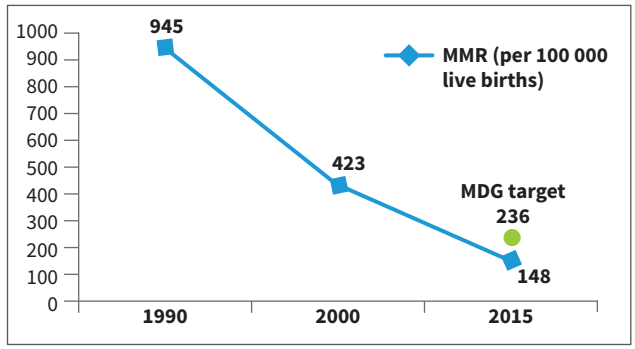
75% reduction in under 5 mortality since 1990



Source: *UNICEF, World Health Organization, The World Bank, United Nations Department of Economic and Social Affairs, Population Division. Levels & trends in child mortality - report 2015: estimates developed by the UN inter-agency group for child mortality estimation. New York, 2015.*

ACHIEVED MDG 5

84% reduction in maternal mortality since 1990



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

Total population	775 000 (2015)
Neonatal mortality rate (per 1000 live births)	18 (2015)
Under-five mortality rate (per 1000 live births)	33 (2015)
Infant mortality rate (deaths per 1000 live births)	27 (2015)

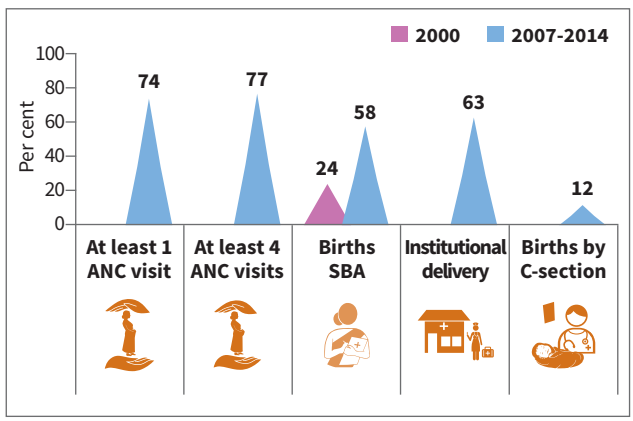
Population under 5 (%)	9 (2015)
Prevalence of stunting in children under 5(%)	33.6 (2015)
Prevalence of wasting in children under 5(%)	5.9 (2015)
Prevalence of overweight in children under 5 (%)	7.6 (2015)

Maternal mortality ratio (per 100 000 live births)	148 (2015)
Adolescent 10-19 years (%)	18.4 (2015)
Adolescent Birth Rate (per 1000 women 15-19 years)	28.4 (2015)
Unmet need for family planning*(%)	12 (2015)

Source: *World Health Statistics [Internet]. WHO Publication. 2016.*
**World Health Statistics [Internet]. WHO Publication. 2015.*

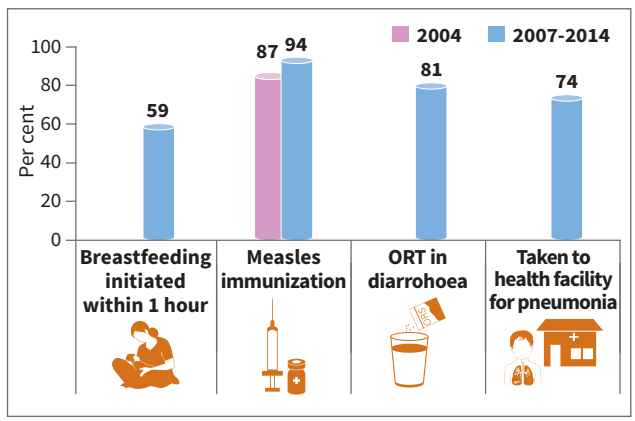
COVERAGE OF LIFE-SAVING INTERVENTIONS INCREASED

Maternal interventions



Source: *Situation of Newborn and Child Health in South-East Asia: Progress towards MDG4; World Health Organization. World health statistics 2006. Geneva, 2006. World Health Organization. World health statistics 2015. Geneva, 2015.*

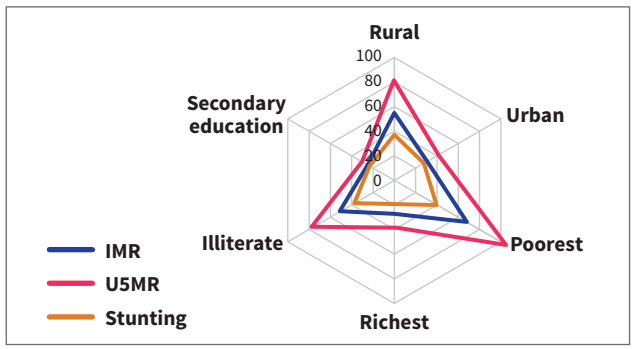
Immunization and illness treatment in children



Source: *Situation of Newborn and Child Health in South-East Asia: Progress towards MDG4; World Health Organization. World health statistics 2006, World Health Organization. World health statistics 2015*

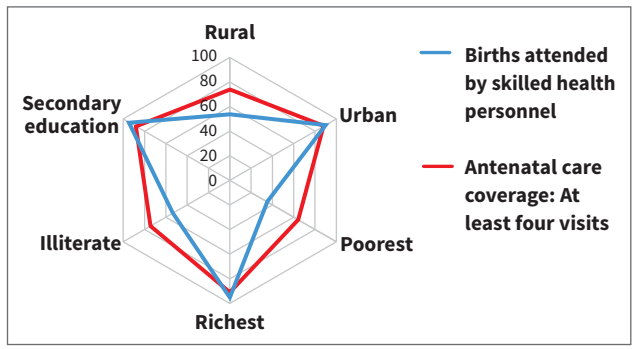
BUT INEQUITIES PERSIST

In mortality



Source: *Situation of Newborn and Child Health in South-East Asia: Progress towards MDG4-National Statistics Bureau, Royal Government of Bhutan(Bhutan) Multiple Indicator Survey 2010.Thimphu, Bhutan: National Statistics Bureau, 2011.*

In life-saving interventions



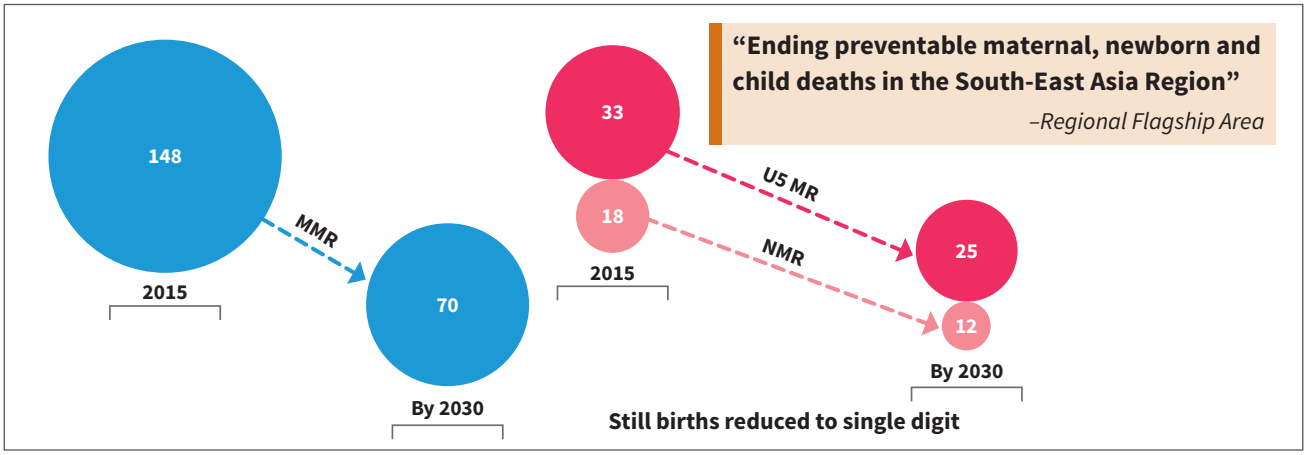
Source: *Situation of Newborn and Child Health in South-East Asia: Progress towards MDG4-National Statistics Bureau, Royal Government of Bhutan(Bhutan) Multiple Indicator Survey 2010.Thimphu, Bhutan: National Statistics Bureau, 2011.*

BHUTAN

SUSTAINABLE DEVELOPMENT GOALS

NEW HORIZONS

SDG targets

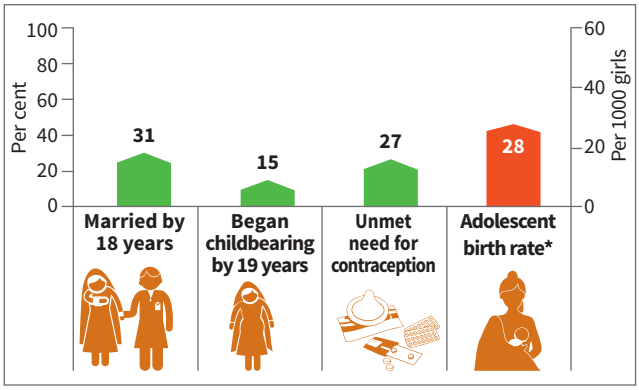


> **"Ending preventable maternal, newborn and child deaths in the South-East Asia Region"**
> *–Regional Flagship Area*

Source: *Levels & Trends in Child mortality - Report 2015: Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation*
Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division.

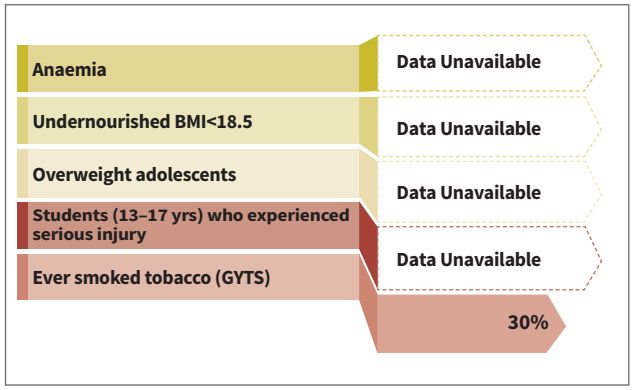
ADOLESCENTS: TOWARDS HEALTHY TRANSITIONS

Adolescent marriage and childbearing (15–19 years)



Source: *Adolescent Pregancy. Situation in South-East Asia Region. WHO Publication 2014 "World Health Organization. World health statistics 2016. Geneva, 2016.*

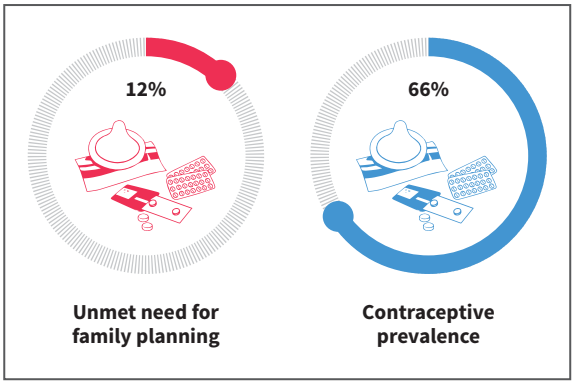
Diet, physical activity and tobacco use



Source: *Global Youth Tobacco Survey (GYTS)-, Bhutan-2013*

REPRODUCTIVE HEALTH

Access to reproductive health-care services



Source: *World Health Statistics, WHO Publication. 2015.*

Cervical cancer

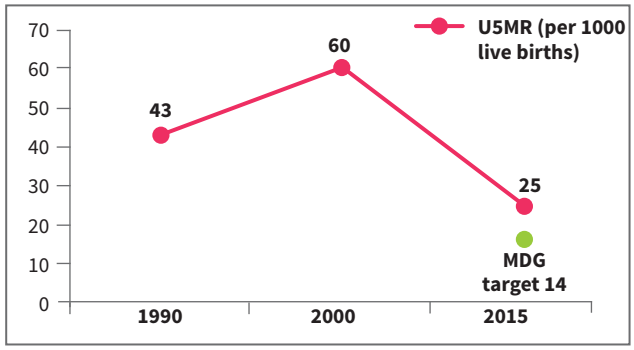
Number of girls between 9–13 years (eligible for HPV vaccination)	35 000
Opportunity for HPV vaccination	
2011, Quadrivalent vaccine introduced in National Immunization Program	
Reaching all girls up to 12 years through health facility	
Cancer Cervix Incidence (per 100 000)	12.8
Cancer Cervix Mortality (per 100 000)	7
Need for population-based cancer registry	

Source: *World Health Organization, Regional Office for South-East Asia. Strategic framework for the comprehensive control of cancer cervix. New Delhi, 2015.*

DPR KOREA

PROGRESS TOWARDS MDG 4

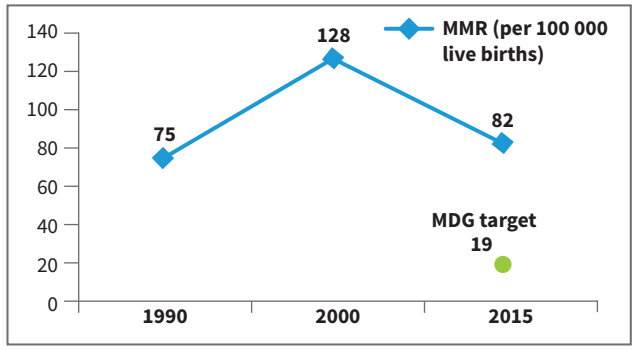
42% reduction in under 5 mortality since 1990



Source: *UNICEF, World Health Organization, The World Bank, United Nations Department of Economic and Social Affairs, Population Division. Levels & trends in child mortality - report 2015: estimates developed by the UN inter-agency group for child mortality estimation. New York, 2015*

SIGNIFICANT PROGRESS FOR MDG 5

Slow reduction in maternal mortality since 1990



Source: *World Health Organization, United Nations Children's Fund, United Nations Population Fund, the World Bank, United Nations. Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division.*

Total population	25 155 000 (2015)
Neonatal mortality rate (per 1000 live births)	14 (2015)
Under-five mortality rate (per 1000 live births)	25 (2015)
Infant mortality rate (deaths per 1000 live births)	20(2015)

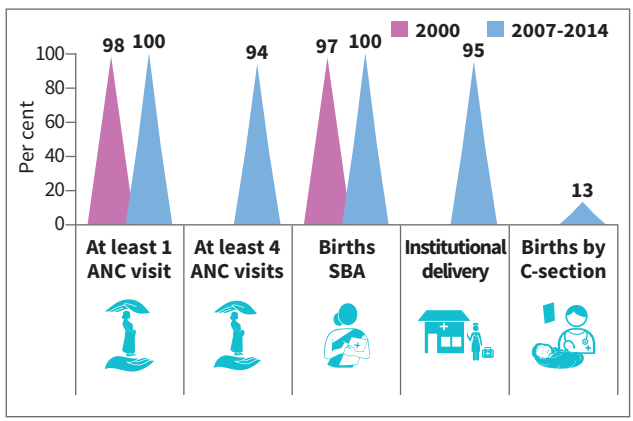
Population under 5 (%)	7 (2015)
Prevalence of stunting in children under 5 (%)	27.9 (2015)
Prevalence of wasting in children under 5 (%)	4.0 (2015)
Prevalence of overweight in children under 5 (%)	0.0 (2015)

Maternal mortality ratio (per 100 000 live births)	82 (2015)
Adolescent 10-19 years (%)	15.2 (2015)
Adolescent Birth Rate (per 1000 women 15-19 years)	0.7 (2015)
Unmet need for family planning*(%)	15 (2015)

Source: *World Health Organization. World health statistics 2016. Geneva, 2016.*
**World Health Organization. World health statistics 2015. Geneva, 2015.*

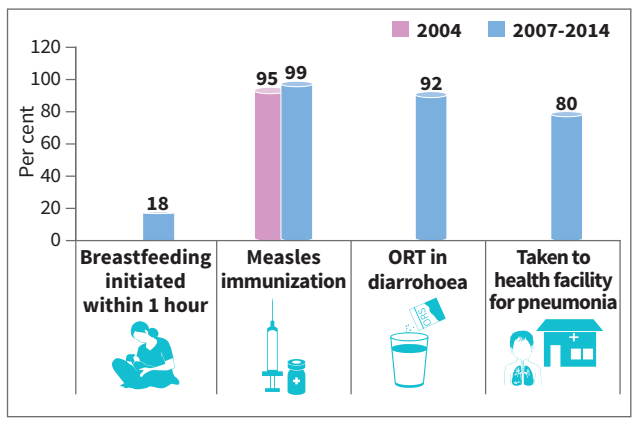
COVERAGE OF LIFE-SAVING INTERVENTIONS INCREASED

Maternal interventions



Source: *Situation of Newborn and Child Health in South-East Asia: Progress towards MDG4; World Health Organization. World health statistics 2006. Geneva, 2006. World Health Organization. World health statistics 2015. Geneva, 2015.*

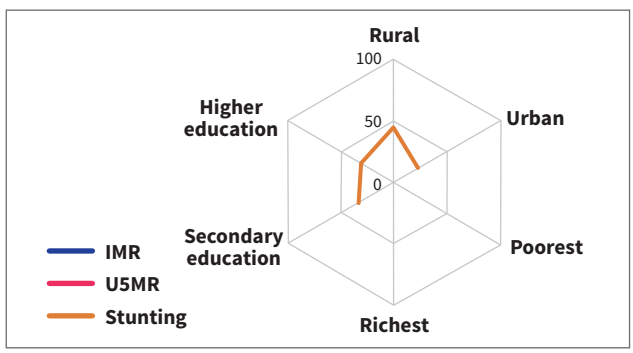
Immunization and illness treatment in children



Source: *Situation of Newborn and Child Health in South-East Asia: Progress towards MDG4; World Health Organization. World health statistics 2006. Geneva, 2006. World Health Organization. World health statistics 2015. Geneva, 2015.*

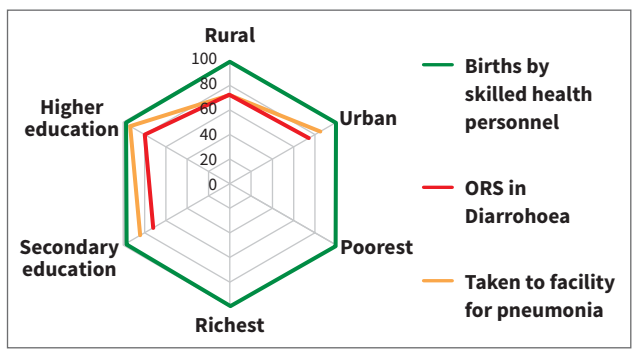
VERY FEWINEQUITIES

In mortality and nutritional status



Source: *Situation of Newborn and Child Health in South-East Asia: Progress towards MDG4; World Health Organization. World health statistics 2006. Geneva, 2006. World Health Organization. World health statistics 2015. Geneva, 2015.*

In coverage of interventions



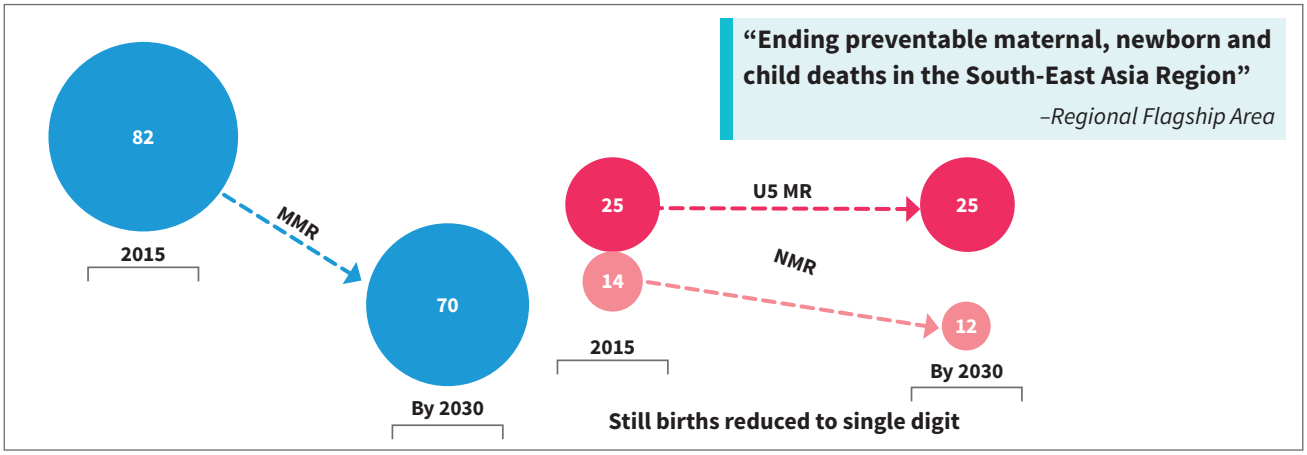
Source: *Situation of Newborn and Child Health in South-East Asia: Progress towards MDG4; World Health Organization. World health statistics 2006. Geneva, 2006. World Health Organization. World health statistics 2015. Geneva, 2015.*

DPR KOREA

SUSTAINABLE DEVELOPMENT GOALS

NEW HORIZONS

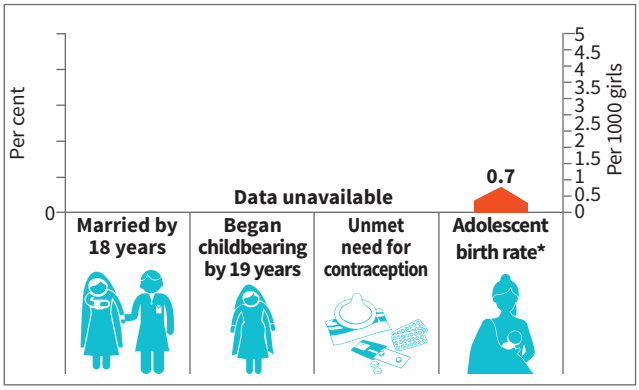
SDG targets



Source: *Levels & Trends in Child mortality - Report 2015: Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation*
Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division.

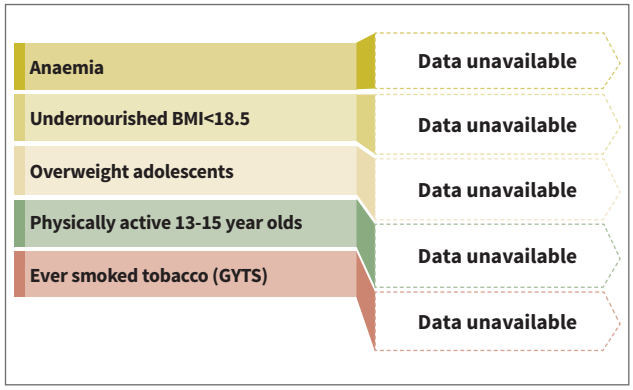
ADOLESCENTS: TOWARDS HEALTHY TRANSITIONS

Adolescent marriage and childbearing (15–19 years)



Source: **World Health Organization. World health statistics 2016*

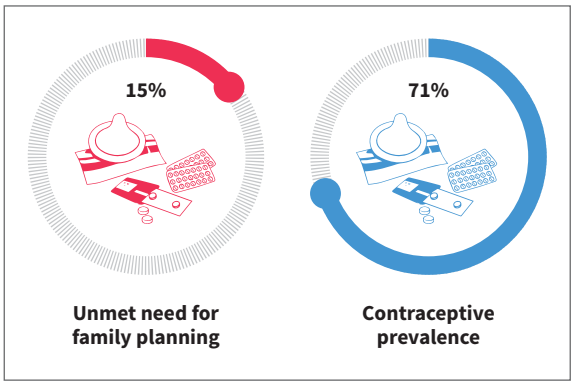
Diet, physical activity and tobacco use



Source: *Data Unavailable*

REPRODUCTIVE HEALTH

Access to reproductive health-care services



Source: *World Health Organization. World health statistics 2016. Geneva, 2016*

Cervical cancer

Number of girls between 9–13 years (eligible for HPV vaccination)	909 000
Opportunity for HPV vaccination	
Cancer Cervix Incidence (per 100 000)	12.4
Cancer Cervix Mortality (per 100 000)	7.2
No population-based cancer registry	

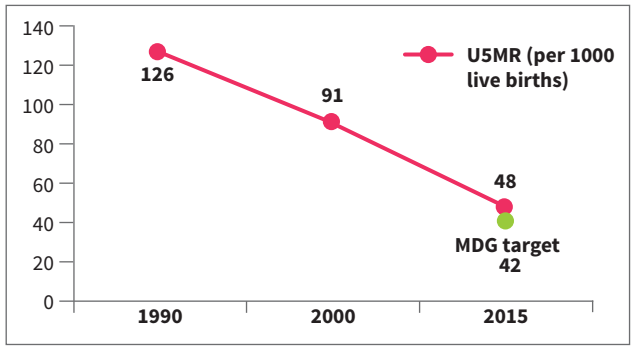
Source: *World Health Organization, Regional Office for South-East Asia. Strategic framework for the comprehensive control of cancer cervix. New Delhi, 2015.*

COVERAGE • EQUITY • QUALITY • ACCOUNTABILITY

INDIA

JUST MISSED MDG 4

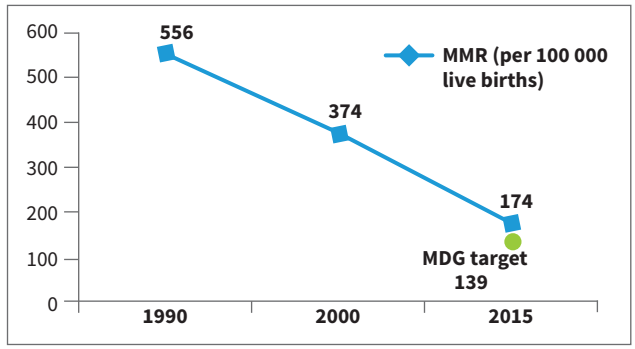
62 % reduction in under 5 mortality since 1990



Source: *UNICEF, World Health Organization, The World Bank, United Nations Department of Economic and Social Affairs, Population Division. Levels & trends in child mortality - report 2015: estimates developed by the UN inter-agency group for child mortality estimation. New York, 2015*

SIGNIFICANT PROGRESS TOWARD MDG 5

69% reduction in maternal mortality since 1990



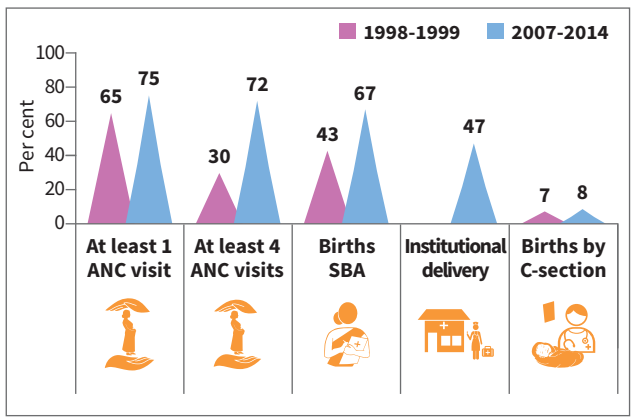
Source: *World Health Organization, United Nations Children's Fund, United Nations Population Fund, the World Bank, United Nations. Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division.*

Total population	1 311 051 000 (2015)	Population under 5 (%)	9 (2015)	Maternal mortality ratio (per 100 000 live births)	178 (2015)
Neonatal mortality rate (per 1000 live births)	28 (2015)	Prevalence of stunting in children under 5(%)	38.7(2015)	Adolescent 10-19 years (%)	18.8 (2015)
Under-five mortality rate (per 1000 live births)	48 (2015)	Prevalence of wasting in children under 5(%)	15.1(2015)	Adolescent Birth Rate (per 1000 women 15-19 years)	28.1 (2015)
Infant mortality rate (deaths per 1000 live births)	38 (2015)	Prevalence of overweight in children under 5 (%)	1.9(2015)	Unmet need for family planning*(%)	21 (2015)

Source: **World Health Organization. World health statistics 2015*
World Health Organization. World health statistics 2016

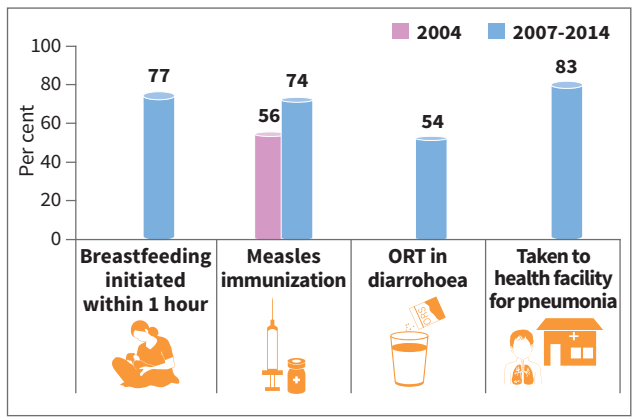
COVERAGE OF LIFE-SAVING INTERVENTIONS INCREASED

Maternal interventions



Source: *Situation of Newborn and Child Health in South-East Asia: Progress towards MDG4; World Health Organization. World health statistics 2006, World Health Organization. World health statistics 2015*

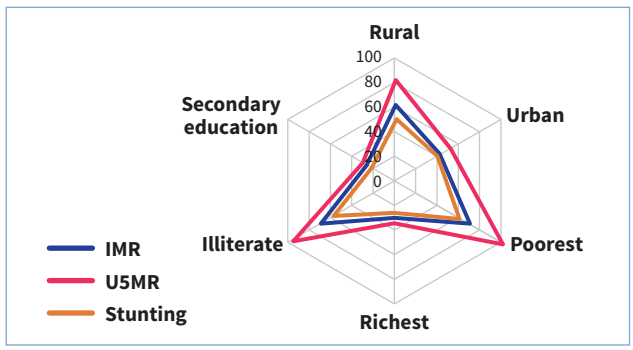
Immunization and illness treatment in children



Source: *Situation of Newborn and Child Health in South-East Asia: Progress towards MDG4; World Health Organization. World health statistics 2006, World Health Organization. World health statistics 2015*

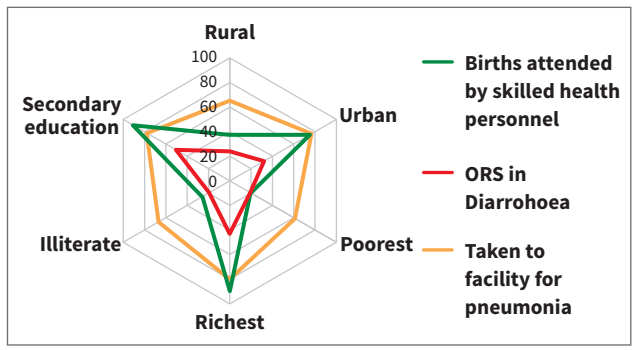
BUT INEQUITIES PERSIST

In mortality and nutritional status



Source: *International Institute for Population Sciences. National family health survey (NFHS-2) 1998-1999: India. 2 vols. Mumbai: IIPS, 2000*

In coverage of life-saving interventions

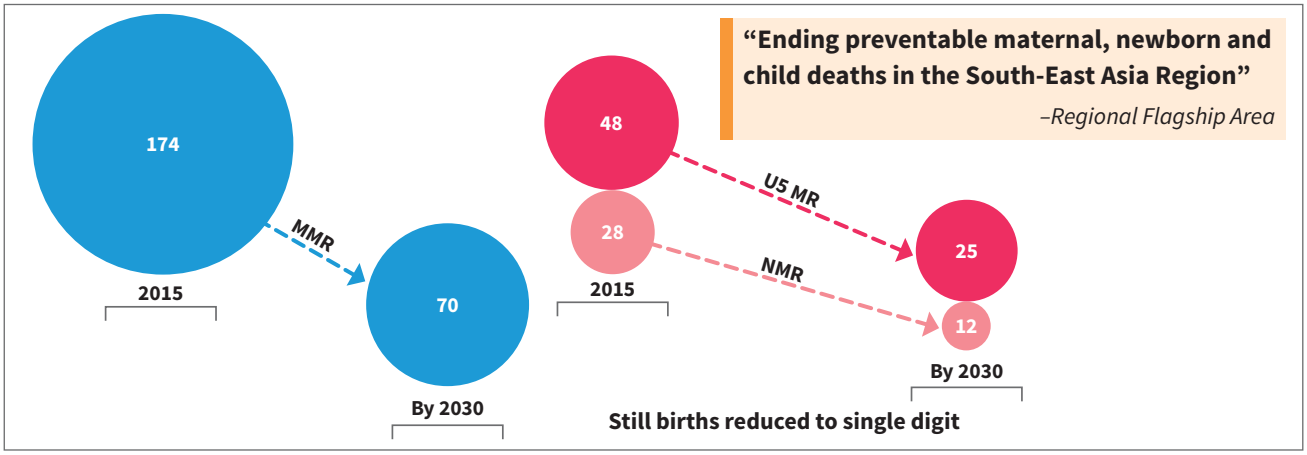


Source: *International Institute for Population Sciences. National family health survey (NFHS-2) 1998-1999: India. 2 vols. Mumbai: IIPS, 2000*

SUSTAINABLE DEVELOPMENT GOALS

NEW HORIZONS

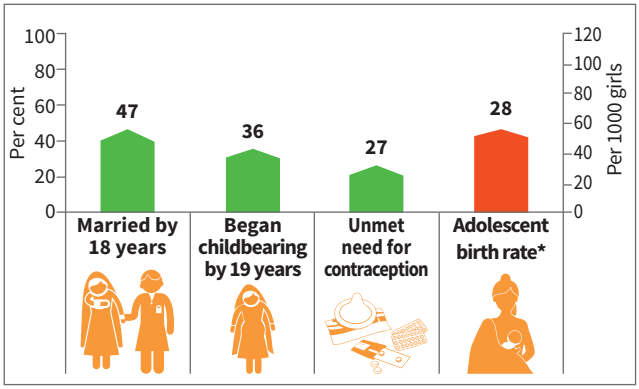
SDG targets



Source: *Levels & Trends in Child mortality - Report 2015: Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation*
Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division.

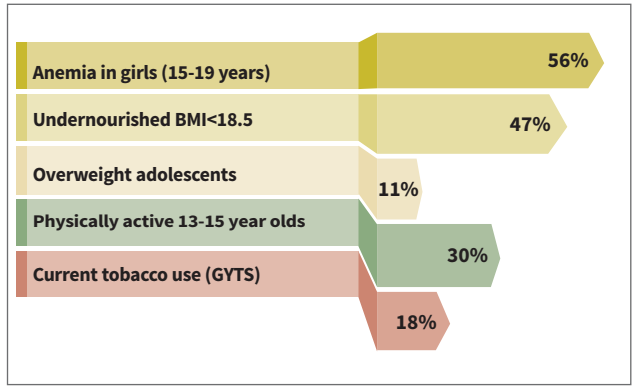
ADOLESCENTS: TOWARDS HEALTHY TRANSITIONS

Adolescent marriage and childbearing (15–19 years)



Source: *International Institute for Population Sciences. National family health survey (NFHS-2) 1998-1999: India. 2 vols. Mumbai: IIPS, 2000*
**World Health Organization. World health statistics 2016. Geneva, 2016.*

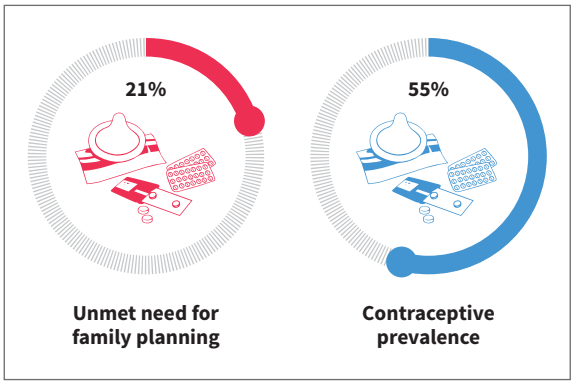
Nutrition, physical activity and tobacco use



Source: *International Institute for Population Sciences. National family health survey (NFHS-2) 1998-1999: India. 2 vols. Mumbai: IIPS, 2000.; Global school-based student health survey, India (CBSE), 2007 fact sheet.*

REPRODUCTIVE HEALTH

Access to reproductive health-care services



Source: *World Health Organization. World health statistics 2015: Geneva, 2015*

Cervical cancer

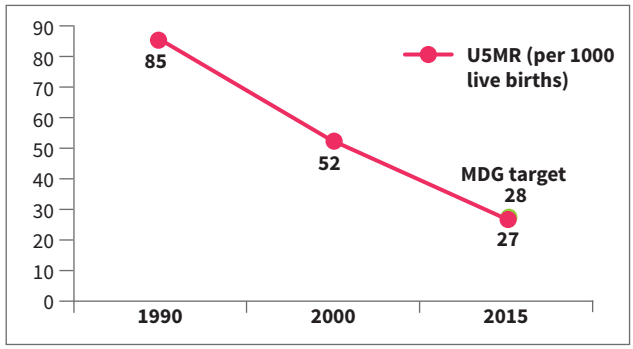
Number of girls between 9–13 years (eligible for HPV vaccination)	58 850 000
Opportunity for HPV vaccination	
Bivalent and Quadrivalent vaccine licensed	
Cancer Cervix Incidence (per 100 000)	22.0
Cancer Cervix Mortality (per 100 000)	12.4
Population-based cancer registry in select areas <5% population covered	

Source: *World Health Organization, Regional Office for South-East Asia. Strategic framework for the comprehensive control of cancer cervix. New Delhi, 2015.*

INDONESIA

ACHIEVED MDG 4

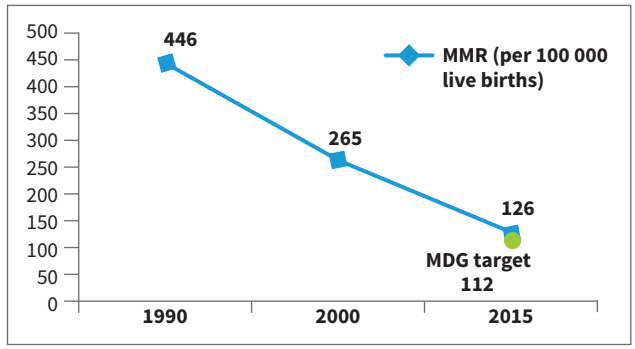
68% reduction in under 5 mortality since 1990



Source: *UNICEF, World Health Organization, The World Bank, United Nations Department of Economic and Social Affairs, Population Division. Levels & trends in child mortality - report 2015: estimates developed by the UN inter-agency group for child mortality estimation. New York, 2015*

SIGNIFICANT PROGRESS TOWARD MDG 5

72% reduction in maternal mortality since 1990



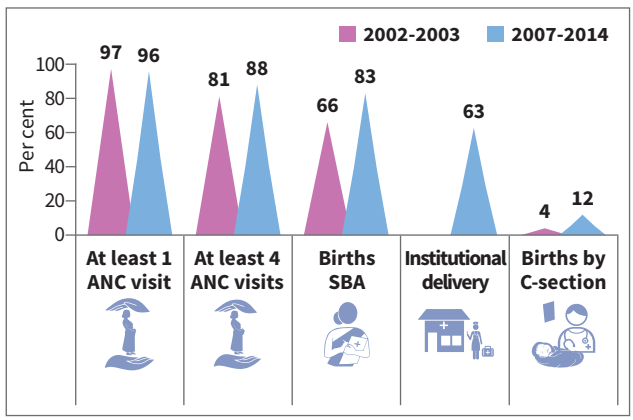
Source: *World Health Organization, United Nations Children's Fund, United Nations Population Fund, the World Bank, United Nations. Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division.*

Total Population	257 564 000 (2015)	Population under 5 (%)	10 (2015)	Maternal mortality ratio (per 100 000 live births)	126 (2015)
Neonatal mortality rate (per 1000 live births)	14 (2015)	Prevalence of stunting in children under 5(%)	36.4 (2015)	Adolescent 10-19 years (%)	18.2 (2015)
Under-five mortality rate (per 1000 live births)	27 (2015)	Prevalence of wasting in children under 5(%)	13.5 (2015)	Adolescent Birth Rate (per 1000 women 15-19 years)	47 (2015)
Infant mortality rate (deaths per 1000 live births)	23(2015)	Prevalence of overweight in children under 5 (%)	11.5(2015)	Unmet need for family planning*(%)	11 (2015)

Source: **World Health Organization. World health statistics 2015 World Health Organization. World health statistics 2016*

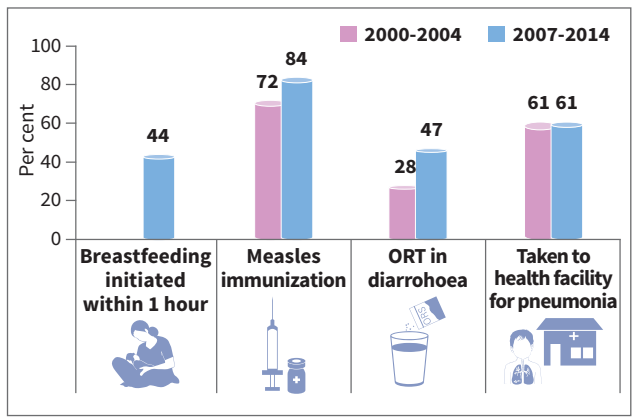
COVERAGE OF LIFE-SAVING INTERVENTIONS INCREASED

Maternal interventions



Source: *World Health Organization. World health statistics 2006, World Health Organization. World health statistics 2015*

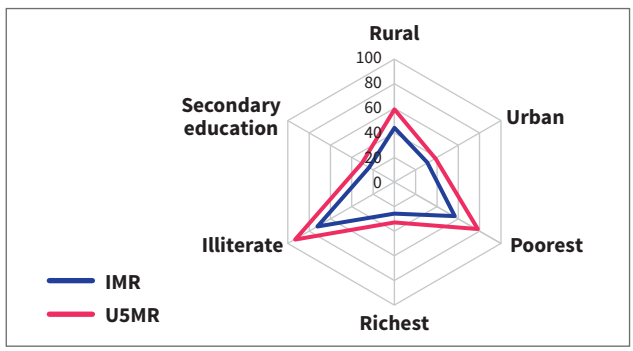
Immunization and illness treatment in children



Source: *Situation of Newborn and Child Health in South-East Asia: Progress towards MDG4; World Health Organization. World health statistics 2006, World Health Organization. World health statistics 2015*

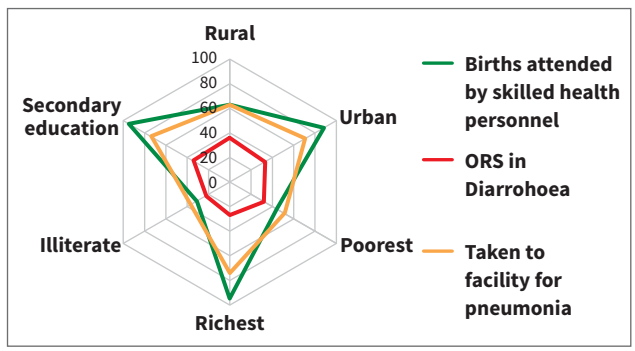
BUT INEQUITIES PERSIST

In mortality



Source: *Situation of Newborn and Child Health in South-East Asia: Progress towards MDG4, World Health Organization, 2014.*

In coverage of interventions

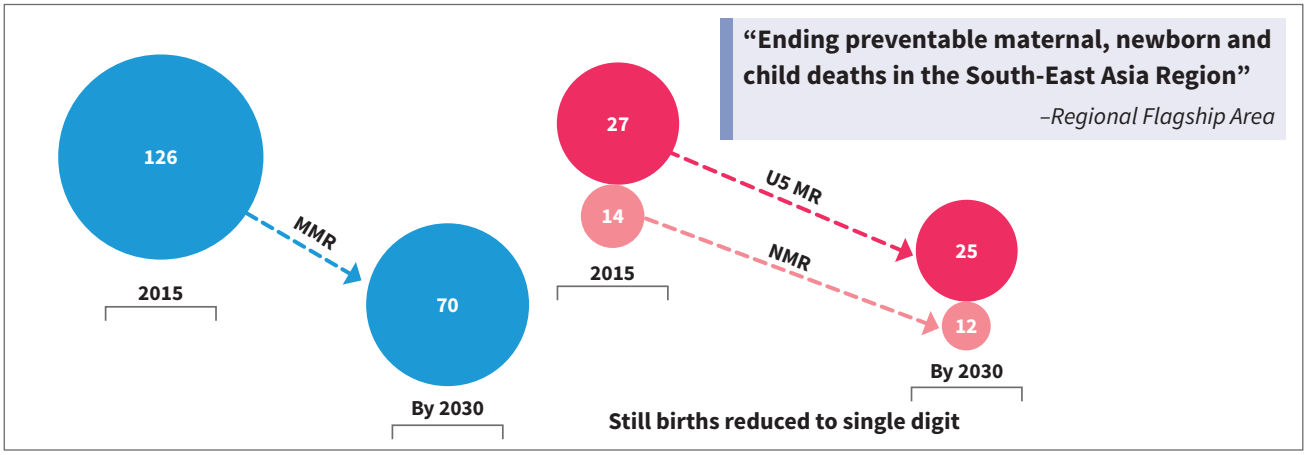


Source: *Situation of Newborn and Child Health in South-East Asia: Progress towards MDG4, World Health Organization, 2014.*

SUSTAINABLE DEVELOPMENT GOALS

NEW HORIZONS

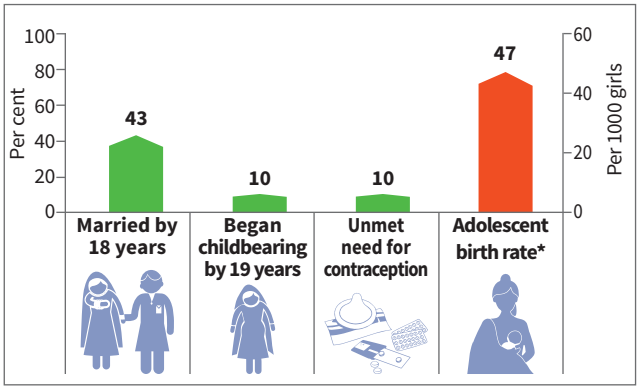
SDG targets



Source: UNICEF, World Health Organization, The World Bank, United Nations Department of Economic and Social Affairs, Population Division. Levels & trends in child mortality - report 2015: estimates developed by the UN inter-agency group for child mortality estimation. New York, 2015

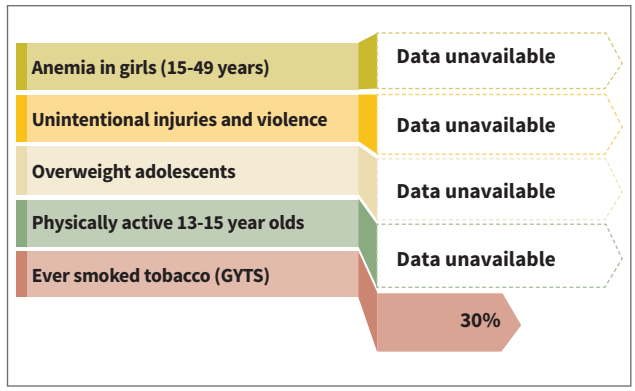
ADOLESCENTS: TOWARDS HEALTHY TRANSITIONS

Adolescent marriage and childbearing (15–19 years)



Source: * World Health Organization. World health statistics 2016. Geneva, 2016.

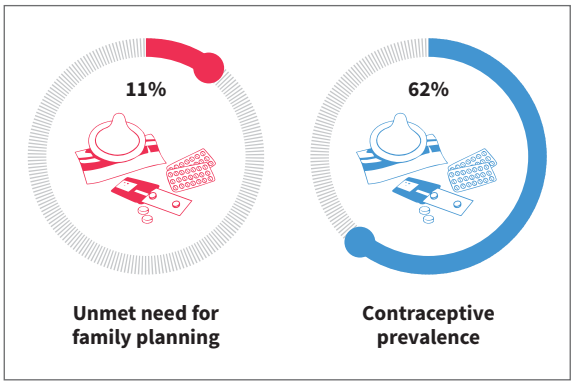
Diet, physical activity and tobacco use



Source: Global Touth Tobacco Survey, Indonesia 2011

REPRODUCTIVE HEALTH

Access to reproductive health-care services



Source: World Health Organization. World health statistics 2015. Geneva, 2015.

Cervical cancer

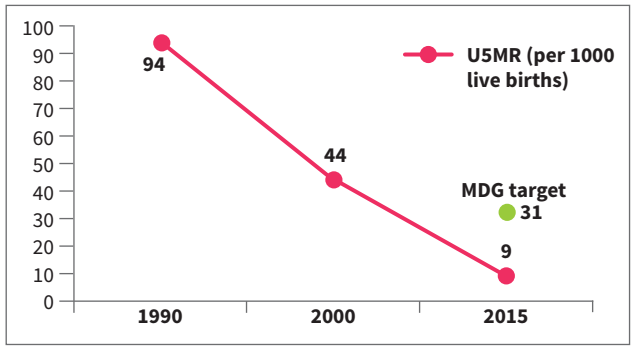
Number of girls between 9–13 years (eligible for HPV vaccination)	10 750 000
Opportunity for HPV vaccination	
HPV Vaccine available in private sector	
Cancer Cervix Incidence (per 100 000)	17.3
Cancer Cervix Mortality (per 100 000)	8.1
Hospital based registry in 23 teaching hospitals Need for population-based cancer registry	

Source: World Health Organization, Regional Office for South-East Asia. Strategic framework for the comprehensive control of cancer cervix. New Delhi, 2015.

MALDIVES

ACHIEVED MDG 4

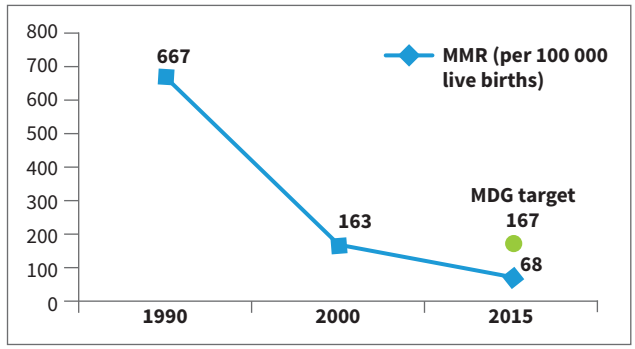
90% reduction in under 5 mortality since 1990



Source: *UNICEF, World Health Organization, The World Bank, United Nations Department of Economic and Social Affairs, Population Division. Levels & trends in child mortality - report 2015: estimates developed by the UN inter-agency group for child mortality estimation. New York, 2015*

ACHIEVED MDG 5

90% reduction in maternal mortality since 1990



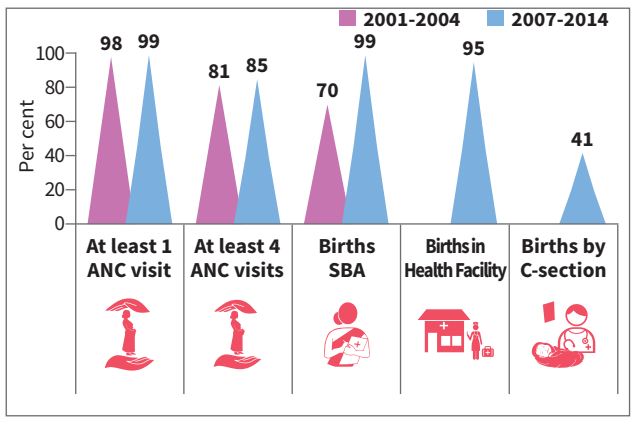
Source: *World Health Organization, United Nations Children's Fund, United Nations Population Fund, the World Bank, United Nations. Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division.*

Total population	364 000 (2015)	Population under 5 (%)	10 (2015)	Maternal mortality ratio (per 100 000 live births)	68 (2015)
Neonatal mortality rate (per 1000 live births)	5(2015)	Prevalence of stunting in children under 5(%)	20.3 (2015)	Adolescent 10-19 years (%)	17.8 (2015)
Under-five mortality rate (per 1000 live births)	9 (2015)	Prevalence of wasting in children under 5 (%)	10.2(2015)	Adolescent Birth Rate (per 1000 women 15-19 years)	13.7 (2015)
Infant mortality rate (deaths per 1000 live births)	7(2015)	Prevalence of overweight in children under 5 (%)	6.5 (2015)	Unmet need for family planning*(%)	29 (2015)

Source: **World Health Organization. World health statistics 2015*
World Health Organization. World health statistics 2016

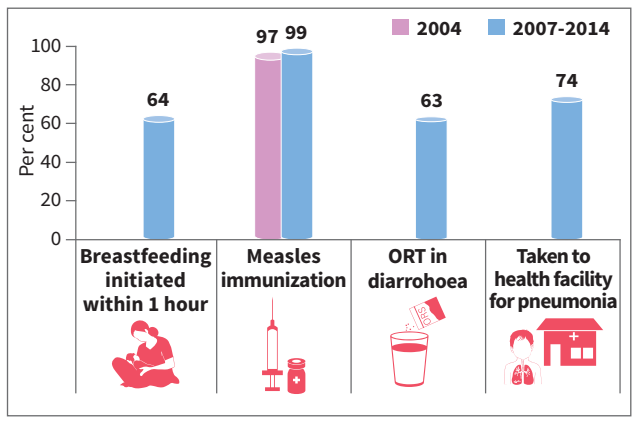
COVERAGE OF LIFE-SAVING INTERVENTIONS INCREASED

Maternal interventions



Source: *World Health Organization. World health statistics 2006, World Health Organization. World health statistics 2015*

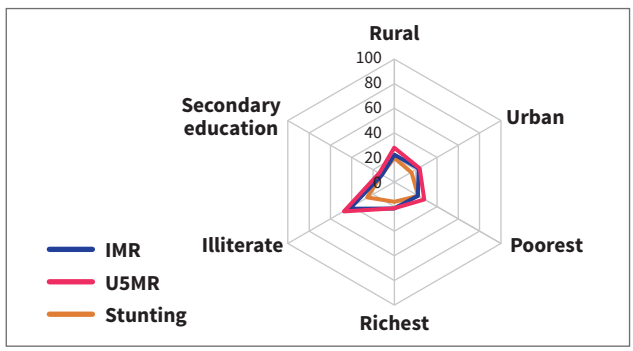
Immunization and illness treatment in children



Source: *World Health Organization. World health statistics 2006, World Health Organization. World health statistics 2015*

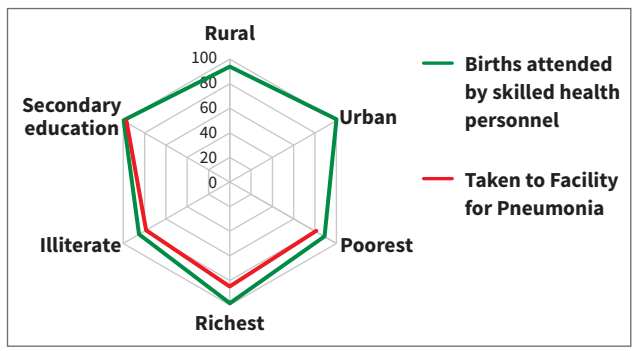
FEWINEQUITIES PERSIST

In mortality and nutritional status



Source: *Situation of Newborn and Child Health in South-East Asia: Progress towards MDG4, World Health Organization, 2014.*

In coverage of interventions



Source: *Situation of Newborn and Child Health in South-East Asia: Progress towards MDG4, World Health Organization, 2014.*

MALDIVES

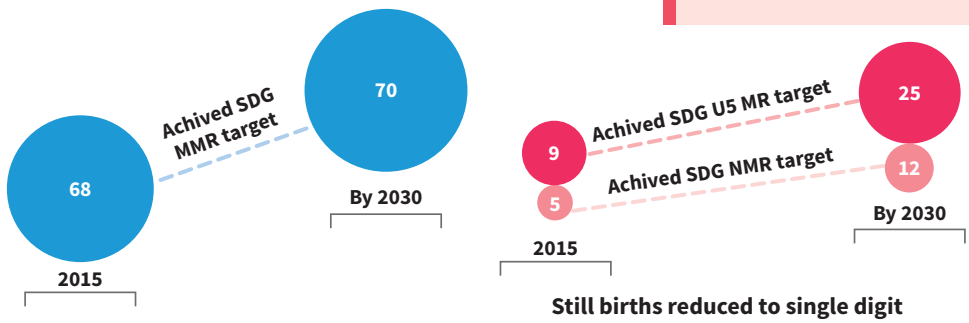
SUSTAINABLE DEVELOPMENT GOALS

NEW HORIZONS

SDG targets

"Ending preventable maternal, newborn and child deaths in the South-East Asia Region"

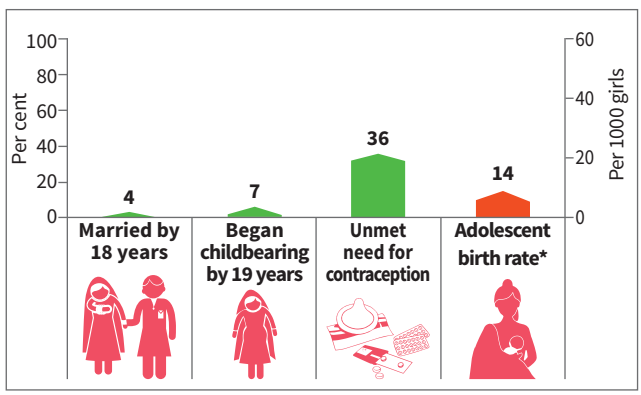
–Regional Flagship Area



Source: *UNICEF, World Health Organization, The World Bank, United Nations Department of Economic and Social Affairs, Population Division. Levels & trends in child mortality - report 2015: estimates developed by the UN inter-agency group for child mortality estimation. New York, 2015*

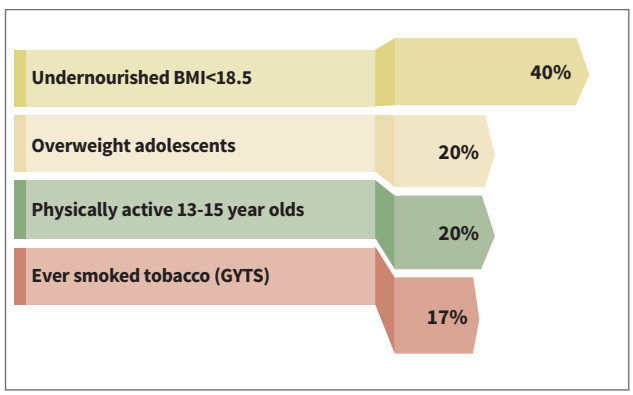
ADOLESCENTS: TOWARDS HEALTHY TRANSITIONS

Adolescent marriage and childbearing (15–19 years)



Source: *Adolescent Pregnancy - Fact sheet. Situation in South-East Asia Region 2014*
**World Health Organization. World health statistics 2016. Geneva, 2016.*

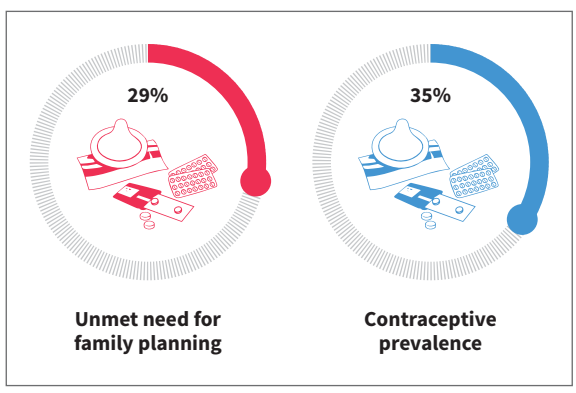
Diet, physical activity and tobacco use



Source: *Maldives demographic and health survey 2009; Republic of Maldives. Global school-based student health survey (GSHS). Male, 2009.*

REPRODUCTIVE HEALTH

Access to reproductive health-care services



Source: *World Health Organization. World health statistics 2015. Geneva, 2015.*

Cervical cancer

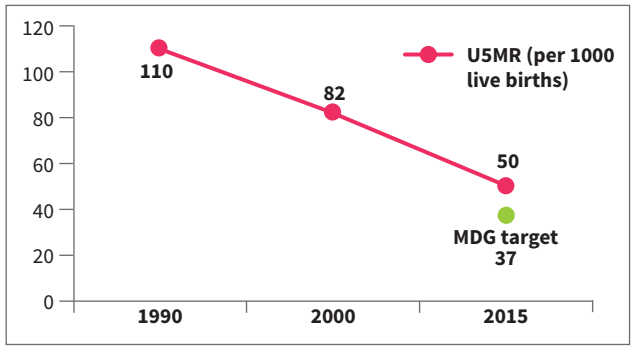
Number of girls between 9–13 years (eligible for HPV vaccination)	15 000
Opportunity for HPV vaccination	
Opportunity for HPV Vaccination	
Cancer Cervix Incidence (per 100 000)	11.0
Cancer Cervix Mortality (per 100 000)	6.3
Need for population-based cancer registry	

Source: *World Health Organization, Regional Office for South-East Asia. Strategic framework for the comprehensive control of cancer cervix. New Delhi, 2015.*

MYANMAR

PROGRESS TOWARD MDG 4

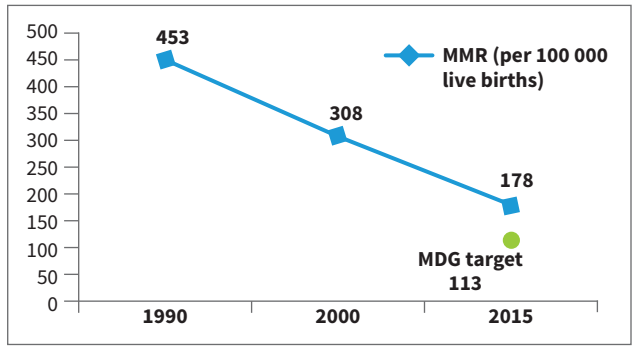
55% reduction in under 5 mortality since 1990



Source: *UNICEF, World Health Organization, The World Bank, United Nations Department of Economic and Social Affairs, Population Division. Levels & trends in child mortality - report 2015: estimates developed by the UN inter-agency group for child mortality estimation. New York, 2015*

SIGNIFICANT PROGRESS TOWARD MDG 5

61% reduction in maternal mortality since 1990



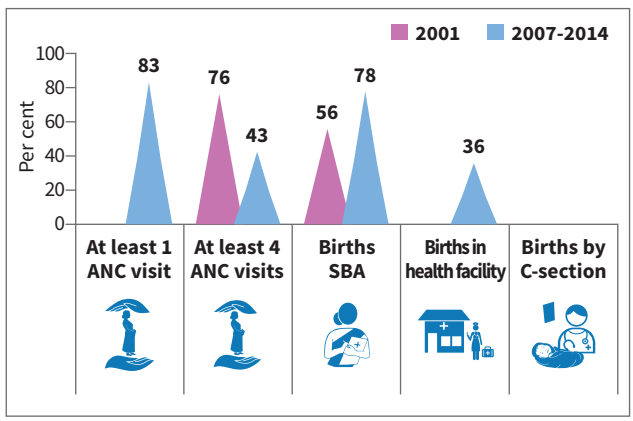
Source: *World Health Organization, United Nations Children's Fund, United Nations Population Fund, the World Bank, United Nations. Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division.*

Total Population	53 897 000 (2015)	Population under 5 (%)	8 (2015)	Maternal mortality ratio (per 100 000 live births)	178 (2015)
Neonatal mortality rate (per 1000 live births)	26 (2015)	Prevalence of stunting in children under 5(%)	35.1(2015)	Adolescent 10-19 years (%)	16.7 (2015)
Under-five mortality rate (per 1000 live births)	50 (2015)	Prevalence of wasting in children under 5(%)	7.9(2015)	Adolescent Birth Rate (per 1000 women 15-19 years)	30.3 (2015)
Infant mortality rate (deaths per 1000 live births)	40(2015)	Prevalence of overweight in children under 5 (%)	2.6(2015)	Unmet need for family planning (%)	na (2015)

Source: *World Health Organization. World health statistics 2016*

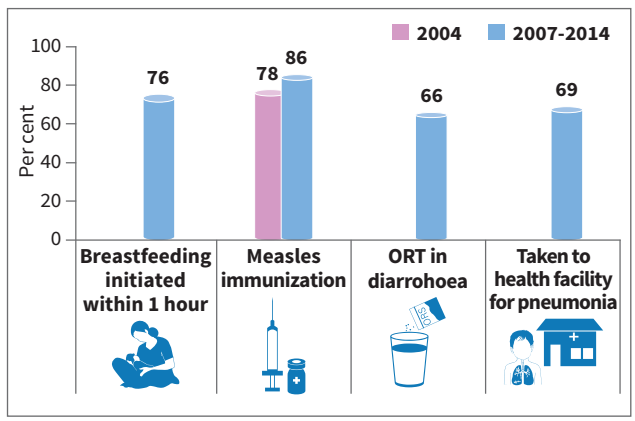
COVERAGE OF LIFE-SAVING INTERVENTIONS INCREASED

Maternal interventions



Source: *World Health Organization. World health statistics 2006, World Health Organization. World health statistics 2015*

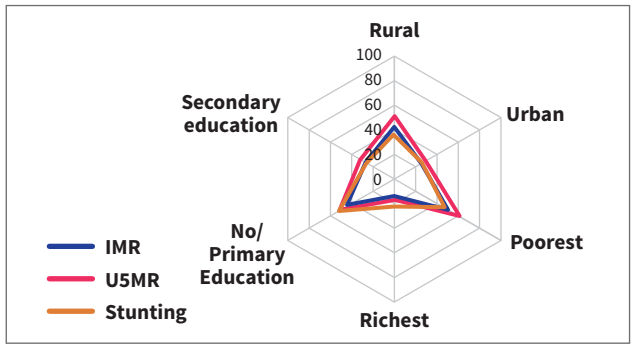
Immunization and illness treatment in children



Source: *World Health Organization. World health statistics 2006, World Health Organization. World health statistics 2015*

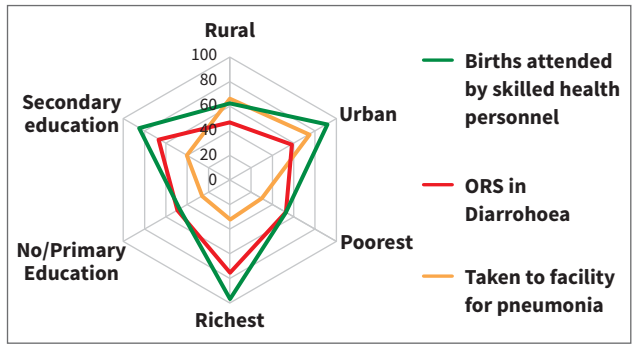
BUT INEQUITIES PERSIST

In mortality and nutritional status



Source: *Situation of Newborn and Child Health in South-East Asia: Progress towards MDG4, World Health Organization, 2014.*

In coverage of life-saving interventions



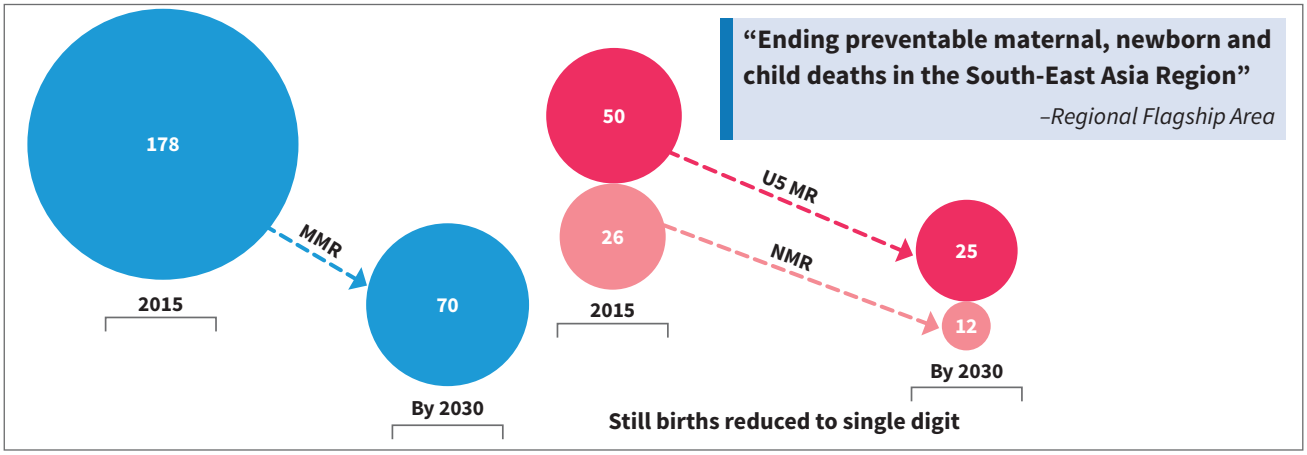
Source: *Situation of Newborn and Child Health in South-East Asia: Progress towards MDG4, World Health Organization, 2014.*

MYANMAR

SUSTAINABLE DEVELOPMENT GOALS

NEW HORIZONS

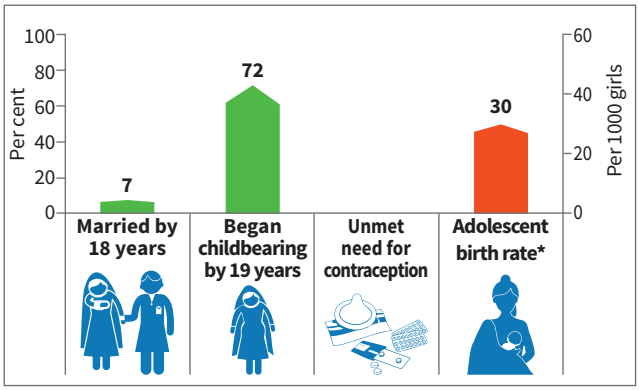
SDG targets



Source: UNICEF, World Health Organization, The World Bank, United Nations Department of Economic and Social Affairs, Population Division. Levels & trends in child mortality - report 2015: estimates developed by the UN inter-agency group for child mortality estimation. New York, 2015

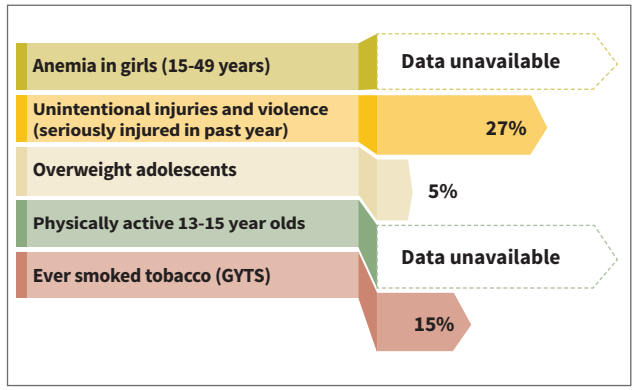
ADOLESCENTS: TOWARDS HEALTHY TRANSITIONS

Adolescent marriage and childbearing (15–19 years)



Source: Union of Myanmar, Ministry of Immigration and Population, UNFPA. Country report on 2007:fertility and reproductive health survey. Yangon: Department of Population and UNFPA, 2007. Multiple indicator cluster survey 2009-2010
*World Health Organization. World health statistics 2016. Geneva, 2016.

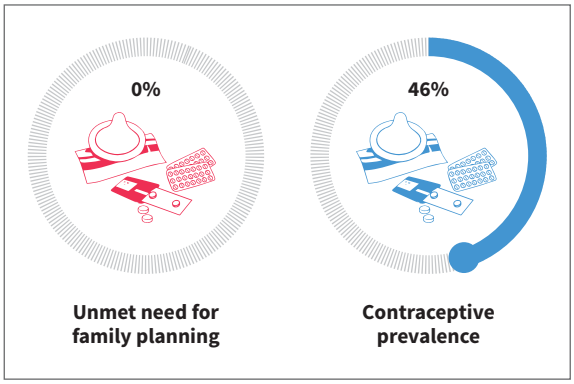
Nutrition, Physical Activity and Tobacco Use



Source: Union of Myanmar, Ministry of Health. Global school-based student health survey. Yangon: MOH,2007. Global school-based student health survey. 2007.

REPRODUCTIVE HEALTH

Access to reproductive health-care services



Source: World Health Organization. World health statistics 2015. Geneva, 2015.

Cervical cancer

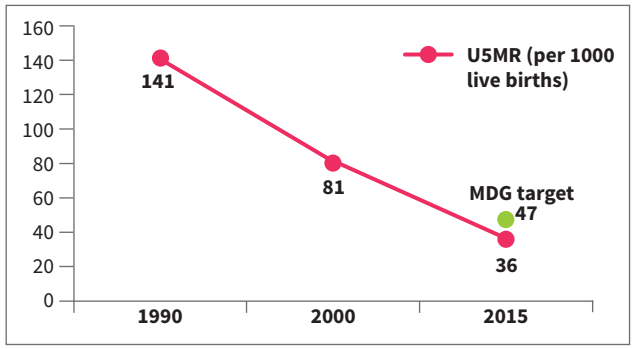
Number of girls between 9–13 years (eligible for HPV vaccination)	2 003 000
Opportunity for HPV vaccination	
Inclusion of HPV in National Immunization Program accepted by MoH	
Cancer Cervix Incidence (per 100 000)	20.6
Cancer Cervix Mortality (per 100 000)	12.3
High burden of cervical cancer	
No population-based cancer registry	

Source: World Health Organization, Regional Office for South-East Asia. Strategic framework for the comprehensive control of cancer cervix. New Delhi, 2015.

NEPAL

ACHIEVED MDG 4

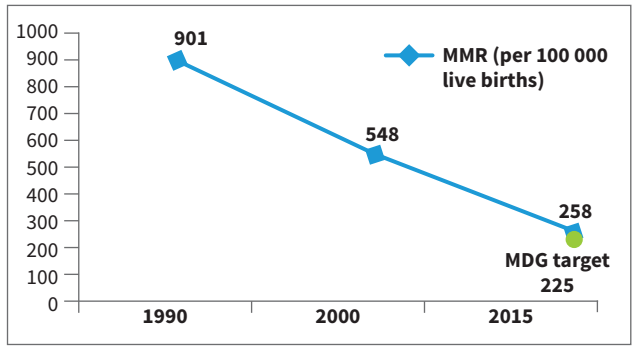
74% reduction in under 5 mortality since 1990



Source: *UNICEF, World Health Organization, The World Bank, United Nations Department of Economic and Social Affairs, Population Division. Levels & trends in child mortality - report 2015: estimates developed by the UN inter-agency group for child mortality estimation. New York, 2015*

JUST MISSED MDG 5

71% reduction in maternal mortality since 1990



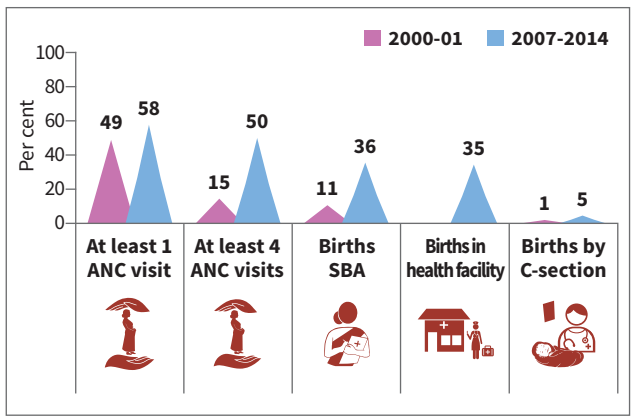
Source: *World Health Organization, United Nations Children's Fund, United Nations Population Fund, the World Bank, United Nations. Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division.*

Total population	28 514 000 (2015)	Population under 5 (%)	10 (2015)	Maternal mortality ratio (per 100 000 live births)	258 (2015)
Neonatal mortality rate (per 1000 live births)	22 (2015)	Prevalence of stunting in children under 5 (%)	37.4(2015)	Adolescent 10-19 years (%)	23.1 (2015)
Under-five mortality rate (per 1000 live births)	36 (2015)	Prevalence of wasting in children under 5 (%)	11.3(2015)	Adolescent Birth Rate (per 1000 women 15-19 years)	71 (2015)
Infant mortality rate (deaths per 1000 live births)	29(2015)	Prevalence of overweight in children under 5 (%)	2.1(2015)	Unmet need for family planning*(%)	28 (2015)

Source: **World Health Organization. World health statistics 2015*
World Health Organization. World health statistics 2016

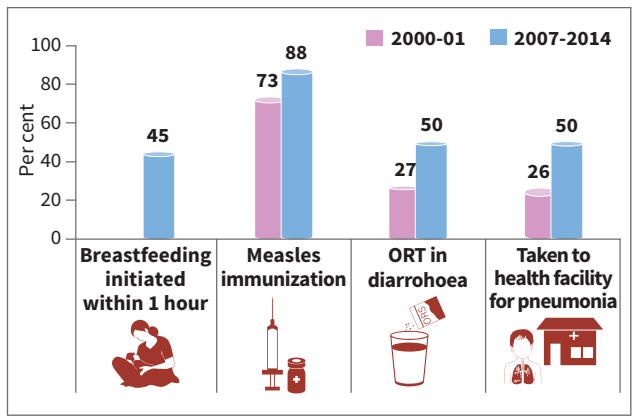
COVERAGE OF LIFE-SAVING INTERVENTIONS INCREASED

Maternal interventions



Source: *World Health Organization. World health statistics 2006, World Health Organization. World health statistics 2015*

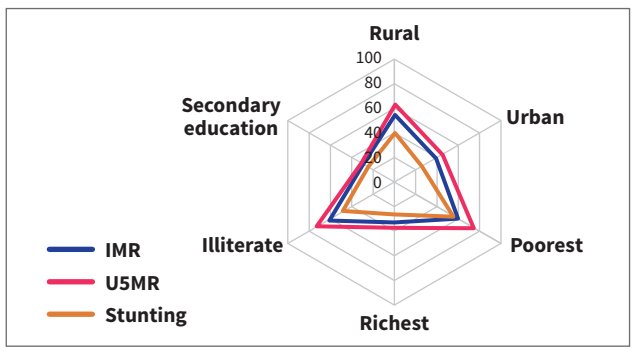
Immunization and illness treatment in children



Source: *World Health Organization. World health statistics 2006, World Health Organization. World health statistics 2015*

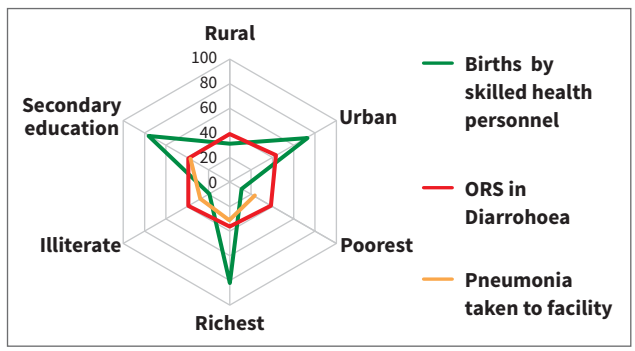
BUT INEQUITIES PERSIST

In mortality and nutritional status



Source: *Situation of Newborn and Child Health in South-East Asia: Progress towards MDG4, World Health Organization, 2014.*

In coverage of life-saving interventions

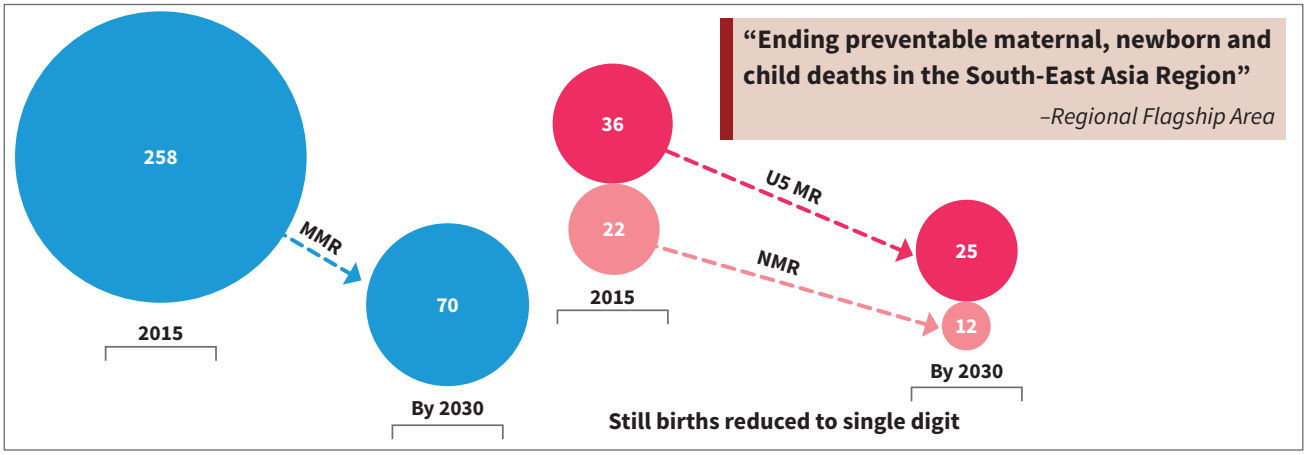


Source: *Situation of Newborn and Child Health in South-East Asia: Progress towards MDG4, World Health Organization, 2014.*

SUSTAINABLE DEVELOPMENT GOALS

NEW HORIZONS

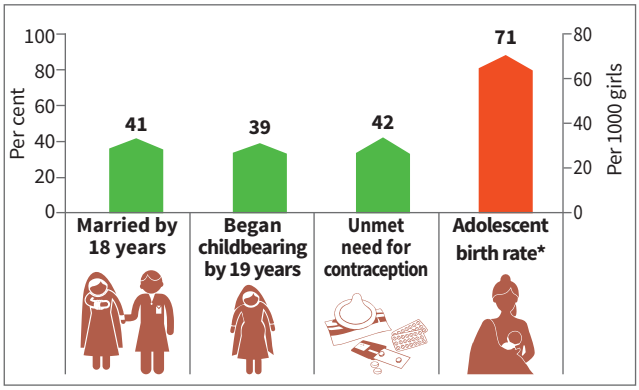
SDG targets



Source: *Same as Graph 1&2*

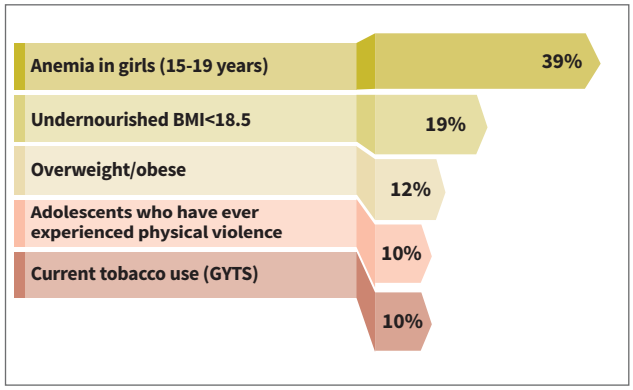
ADOLESCENTS: TOWARDS HEALTHY TRANSITIONS

Adolescent marriage and childbearing (15–19 years)



Source: *"Nepal demographic and health survey 2011; 5. World Health Organization. World health statistics 2016. Geneva, 2016*

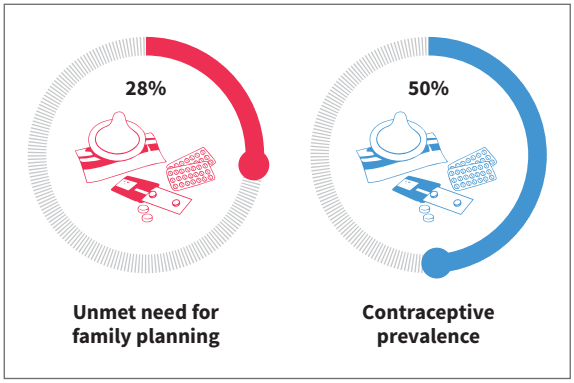
Nutrition, exposure to violence and tobacco use



Source: *"Nepal demographic and health survey 2011; World Health Organization. World health statistics 2016. Geneva, 2016;Nepal, Ministry of Health and Population. Nepal demographic and health survey 2011. Kathmandu: MOPH, New ERA, ICF International, 2012, Nepal, Ministry of Health and Population. Nepal Demographic and health survey 2011. Kathmandu: MOPH, New ERA, Macro International Inc., 2007. Statistical Yearbook for Asia and the Pacific 2013, United Nations Economic and Social Commission for Asia and the Pacific, Bangkok, Thailand. The World's Youth 2013 Data Sheet, Washington, DC: Population Reference Bureau, 2013.; Nepal GYTS 2011*

REPRODUCTIVE HEALTH

Access to reproductive health-care services



Source: *World Health Organization. World health statistics 2015. Geneva, 2015*

Cervical cancer

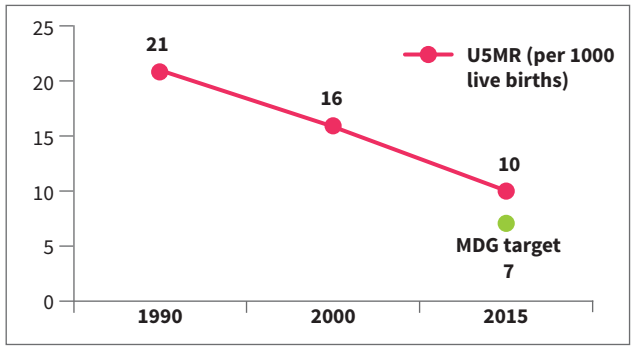
Number of girls between 9–13 years (eligible for HPV vaccination)	1 809 000
Opportunity for HPV vaccination	
Opportunity to include HPV in National Immunization Program	
Cancer Cervix Incidence (per 100 000)	19.0
Cancer Cervix Mortality (per 100 000)	12.0
No population-based cancer registry	
Select areas hospital based data	

Source: *World Health Organization, Regional Office for South-East Asia. Strategic framework for the comprehensive control of cancer cervix. New Delhi, 2015.*

SRI LANKA

PROGRESS MADE ON MDG 4

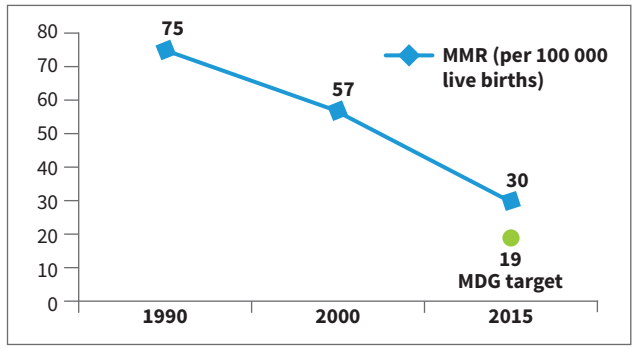
52% reduction in under 5 mortality since 1990



Source: *UNICEF, World Health Organization, The World Bank, United Nations Department of Economic and Social Affairs, Population Division. Levels & trends in child mortality - report 2015: estimates developed by the UN inter-agency group for child mortality estimation. New York, 2015*

PROGRESS MADE ON MDG 5

60% reduction in maternal mortality since 1990



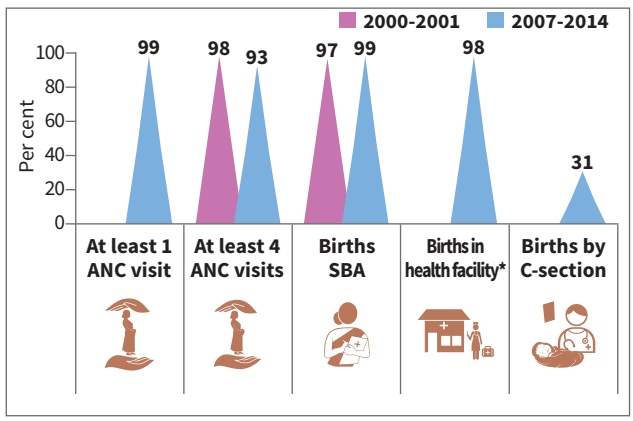
Source: *World Health Organization, United Nations Children's Fund, United Nations Population Fund, the World Bank, United Nations. Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division.*

Total population	20 715 000 (2015)	Population under 5 (%)	8 (2015)	Maternal mortality ratio (per 100 000 live births)	30 (2015)
Neonatal mortality rate (per 1000 live births)	5 (2015)	Prevalence of stunting in children under 5 (%)	14.7 (2015)	Adolescent 10-19 years (%)	15.2 (2015)
Under-five mortality rate (per 1000 live births)	10 (2015)	Prevalence of wasting in children under 5 (%)	21.4 (2015)	Adolescent Birth Rate (per 1000 women 15-19 years)	20.3 (2015)
Infant mortality rate (deaths per 1000 live births)	8 (2015)	Prevalence of overweight in children under 5 (%)	0.6 (2015)	Unmet need for family planning*(%)	7 (2013)

Source: **World Health Organization. World health statistics 2015*
World Health Organization. World health statistics 2016

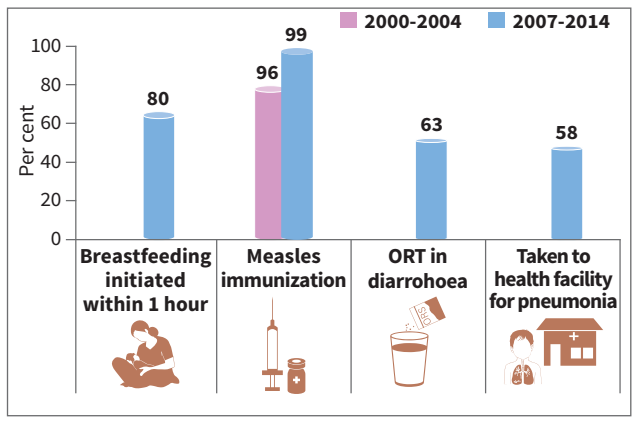
COVERAGE OF LIFE-SAVING INTERVENTIONS INCREASED

Maternal interventions



Source: *World Health Organization. World health statistics 2006. Geneva, 2006; 4. World Health Organization. World health statistics 2015. Geneva, 2015*

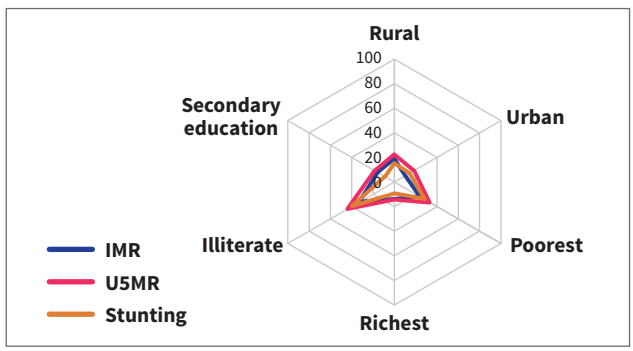
Immunization and illness treatment in children



Source: *World Health Organization. World health statistics 2006. Geneva, 2006; 4. World Health Organization. World health statistics 2015. Geneva, 2015*

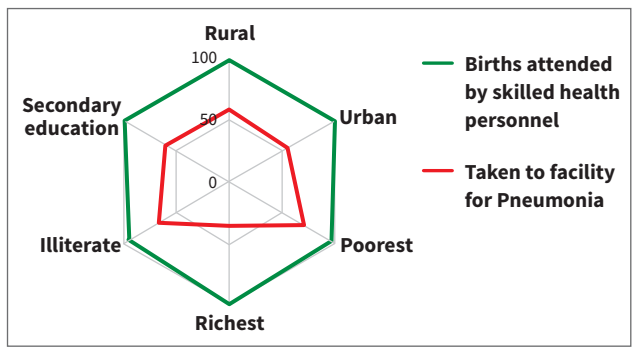
BUT INEQUITIES PERSIST

In mortality and nutritional status



Source: *Situation of Newborn and Child Health in South-East Asia: Progress towards MDG4, World Health Organization, 2014.*

In Coverage of interventions



Source: *Situation of Newborn and Child Health in South-East Asia: Progress towards MDG4, World Health Organization, 2014.*

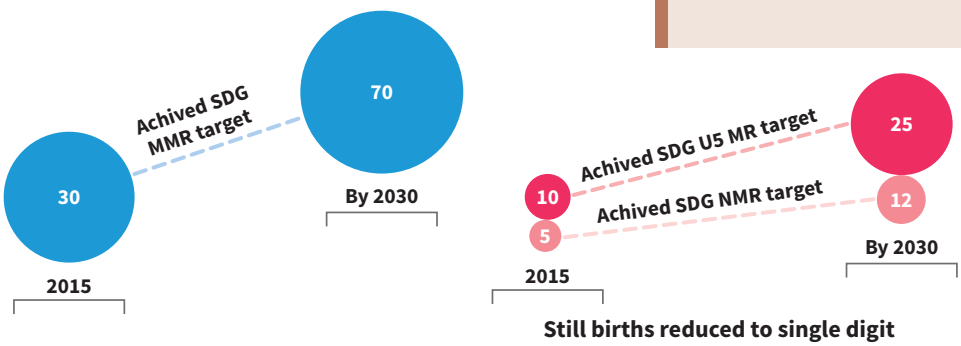
SUSTAINABLE DEVELOPMENT GOALS

NEW HORIZONS

SDG targets

"Ending preventable maternal, newborn and child deaths in the South-East Asia Region"

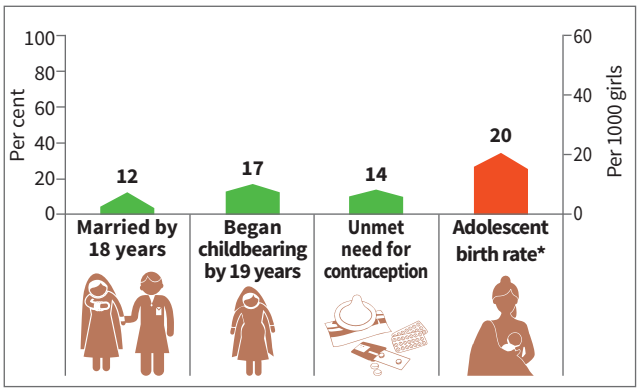
–Regional Flagship Area



Source: *UNICEF, World Health Organization, The World Bank, United Nations Department of Economic and Social Affairs, Population Division. Levels & trends in child mortality - report 2015: estimates developed by the UN inter-agency group for child mortality estimation. New York, 2015*

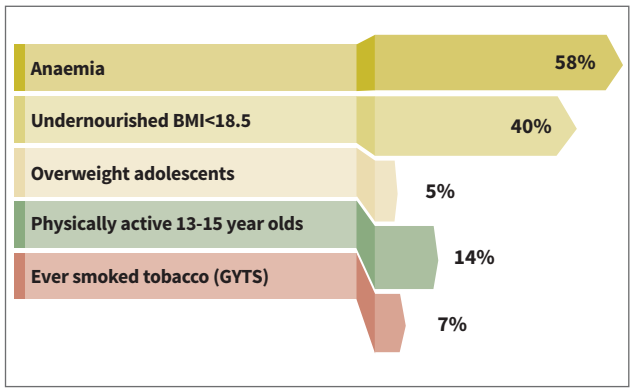
ADOLESCENTS: TOWARDS HEALTHY TRANSITIONS

Adolescent marriage and childbearing (15–19 years)



Source: *Sri Lanka demographic and health survey 2006/7*
**World Health Organization. World health statistics 2016. Geneva, 2016*

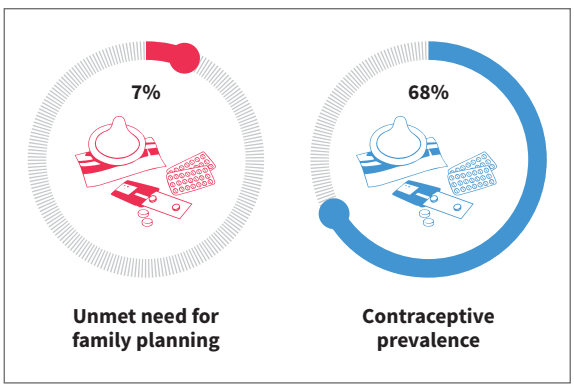
Diet, physical activity and tobacco use



Source: *Sri Lanka demographic and health survey 2006/7*

REPRODUCTIVE HEALTH

Access to reproductive health-care services



Source: *World Health Organization. World health statistics 2015. Geneva, 2015*

Cervical cancer

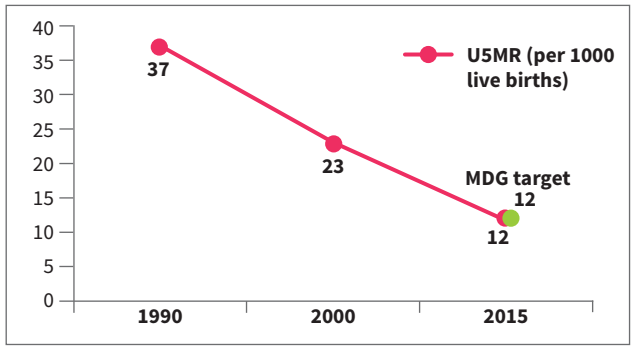
Number of girls between 9–13 years (eligible for HPV vaccination)	829 000
Opportunity for HPV vaccination	
2011, Quadrivalent vaccine introduced in National Immunization Program	
Reaching all girls up to 12 years through health facility	
Cancer Cervix Incidence (per 100 000)	13.1
Cancer Cervix Mortality (per 100 000)	5.0
Need for population-based cancer	

Source: *World Health Organization, Regional Office for South-East Asia. Strategic framework for the comprehensive control of cancer cervix. New Delhi, 2015.*

THAILAND

ACHIEVED MDG 4

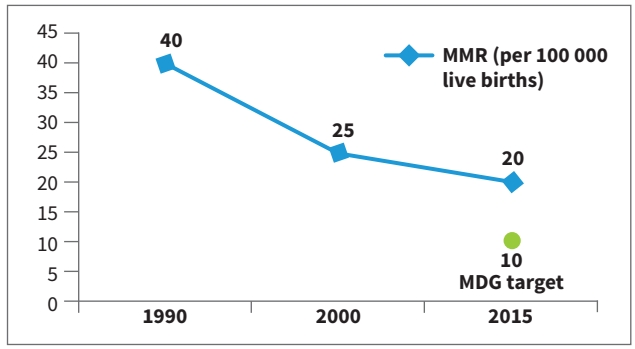
68% reduction in under 5 mortality since 1990



Source: *UNICEF, World Health Organization, The World Bank, United Nations Department of Economic and Social Affairs, Population Division. Levels & trends in child mortality - report 2015: estimates developed by the UN inter-agency group for child mortality estimation. New York, 2015*

SIGNIFICANT PROGRESS FOR MDG 5

50% reduction in maternal mortality since 1990



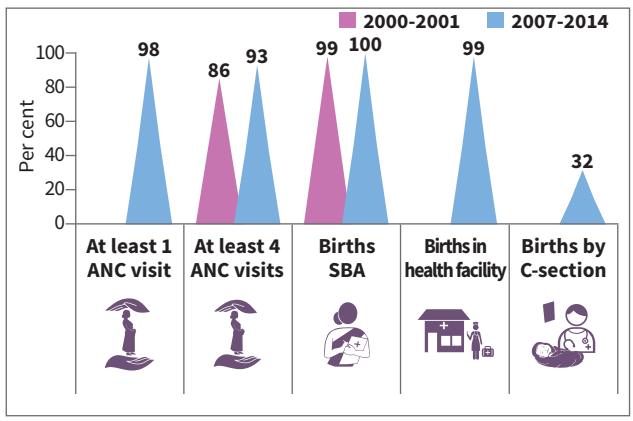
Source: *World Health Organization, United Nations Children's Fund, United Nations Population Fund, the World Bank, United Nations. Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division.*

Total population	67 959 000 (2015)	Population under 5 (%)	6 (2015)	Maternal mortality ratio (per 100 000 live births)	20 (2015)
Neonatal mortality rate (per 1000 live births)	7 (2015)	Prevalence of stunting in children under 5(%)	16.3 (2015)	Adolescent 10-19 years (%)	12.8 (2015)
Under-five mortality rate (per 1000 live births)	12 (2015)	Prevalence of wasting in children under 5 (%)	6.7 (2015)	Adolescent Birth Rate (per 1000 women 15-19 years)	60 (2015)
Infant mortality rate (deaths per 1000 live births)	11(2015)	Prevalence of overweight in children under 5 (%)	10.9 (2015)	Unmet need for family planning*(%)	7 (2013)

Source: **World Health Organization. World health statistics 2015*
World Health Organization. World health statistics 2016

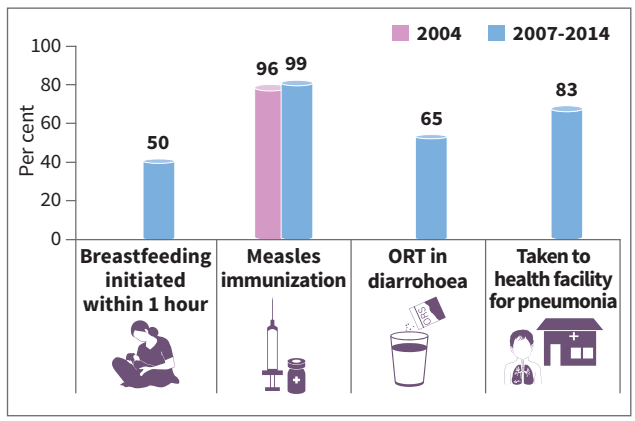
COVERAGE OF LIFE-SAVING INTERVENTIONS INCREASED

Maternal interventions



Source: *Thailand MICS 2012; World Health Organization. World health statistics 2006. Geneva, 2006; 4. World Health Organization. World health statistics 2015. Geneva, 2015*

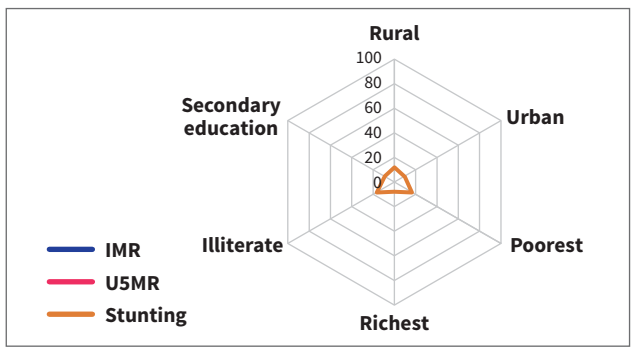
Immunization and illness treatment in children



Source: *World Health Organization. World health statistics 2006. Geneva, 2006; 4. World Health Organization. World health statistics 2015. Geneva, 2015*

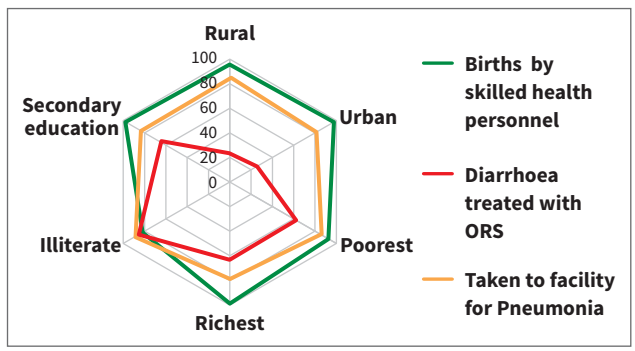
FEWINEQUITIES PERSIST

In mortality and nutritional status



Source: *Situation of Newborn and Child Health in South-East Asia: Progress towards MDG4, World Health Organization, 2014.*

In coverage of interventions



Source: *Situation of Newborn and Child Health in South-East Asia: Progress towards MDG4, World Health Organization, 2014.*

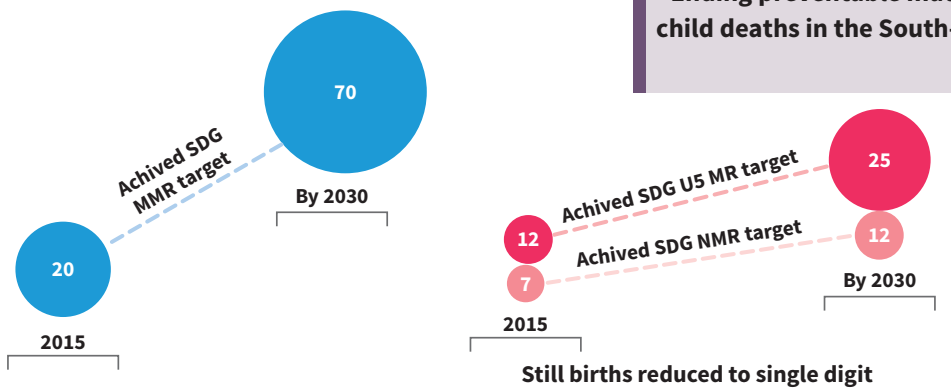
THAILAND

SUSTAINABLE DEVELOPMENT GOALS

NEW HORIZONS

SDG targets

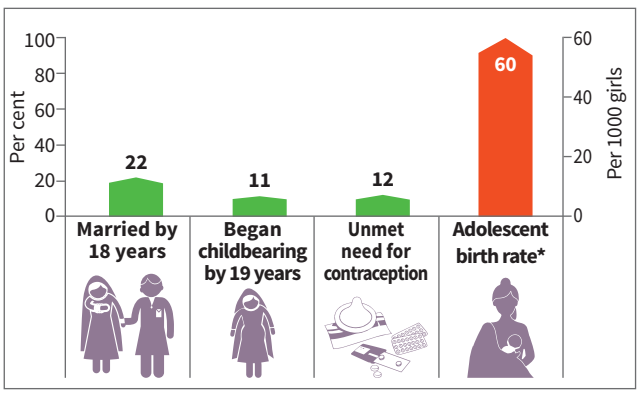
> **"Ending preventable maternal, newborn and child deaths in the South-East Asia Region"**
> *–Regional Flagship Area*



Source: *UNICEF, World Health Organization, The World Bank, United Nations Department of Economic and Social Affairs, Population Division. Levels & trends in child mortality - report 2015: estimates developed by the UN inter-agency group for child mortality estimation. New York, 2015*

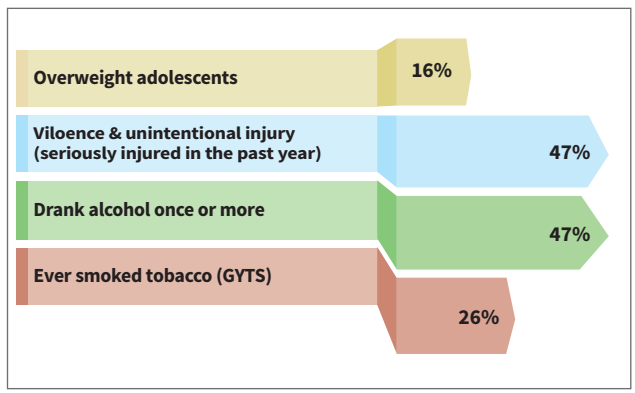
ADOLESCENTS: TOWARDS HEALTHY TRANSITIONS

Adolescent marriage and childbearing (15–19 years)



Source: *Thailand Multiple Indicator Cluster Survey 2012;*
** World Health Organization. World health statistics 2016. Geneva, 2016*

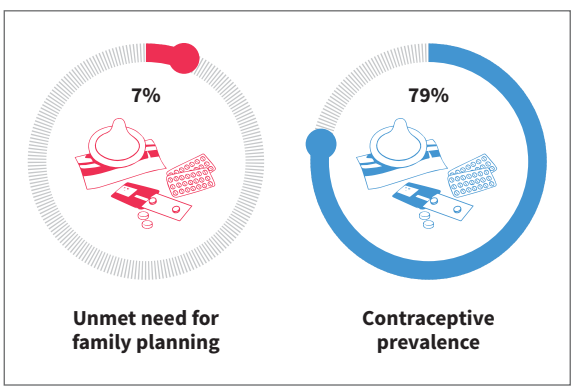
Diet, physical activity and tobacco use



Source: *"Thailand Multiple Indicator Cluster Survey 2012; The Global School-based Student Health Survey (GSHS) in Thailand, 2008"*

REPRODUCTIVE HEALTH

Access to reproductive health-care services



Source: *World Health Organization. World health statistics 2015. Geneva, 2015*

Cervical cancer

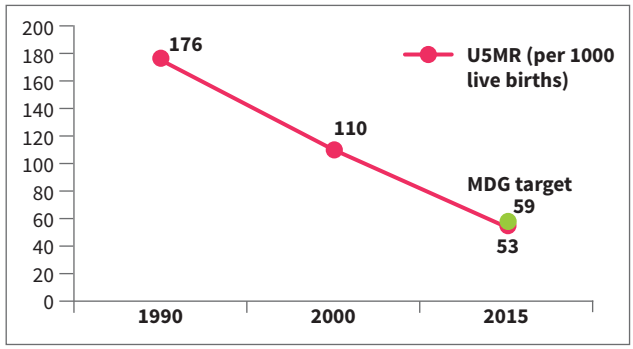
Number of girls between 9–13 years (eligible for HPV vaccination)	2 381 000
Opportunity for HPV vaccination	
National Cervical Cancer Screening Program since 2005	
Cancer Cervix Incidence (per 100 000)	17.8
Cancer Cervix Mortality (per 100 000)	9.7
Need for population-based cancer registry	

Source: *World Health Organization, Regional Office for South-East Asia. Strategic framework for the comprehensive control of cancer cervix. New Delhi, 2015.*

Timor-Leste

ACHIEVED MDG 4

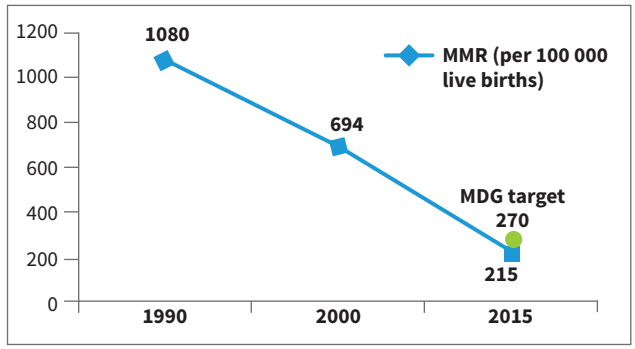
70% reduction in under 5 mortality since 1990



Source: *UNICEF, World Health Organization, The World Bank, United Nations Department of Economic and Social Affairs, Population Division. Levels & trends in child mortality - report 2015: estimates developed by the UN inter-agency group for child mortality estimation. New York, 2015*

SIGNIFICANT PROGRESS FOR MDG 5

80% reduction in maternal mortality since 1990



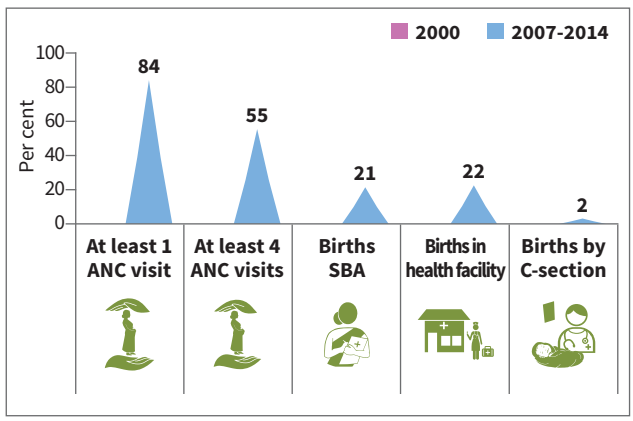
Source: *World Health Organization, United Nations Children's Fund, United Nations Population Fund, the World Bank, United Nations. Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division.*

Total population	1 185 000 (2015)	Population under 5 (%)	9 (2015)	Maternal mortality ratio (per 100 000 live births)	215 (2015)
Neonatal mortality rate (per 1000 live births)	22 (2015)	Prevalence of stunting in children under 5(%)	50.2 (2015)	Adolescent 10-19 years (%)	18.4 (2015)
Under-five mortality rate (per 1000 live births)	53 (2015)	Prevalence of wasting in children under 5(%)	11 (2015)	Adolescent Birth Rate (per 1000 women 15-19 years)	50 (2015)
Infant mortality rate (deaths per 1000 live births)	45 (2015)	Prevalence of overweight in children under 5 (%)	1.5 (2015)	Unmet need for family planning*(%)	32 (2015)

Source: **World Health Organization. World health statistics 2015 World Health Organization. World health statistics 2016*

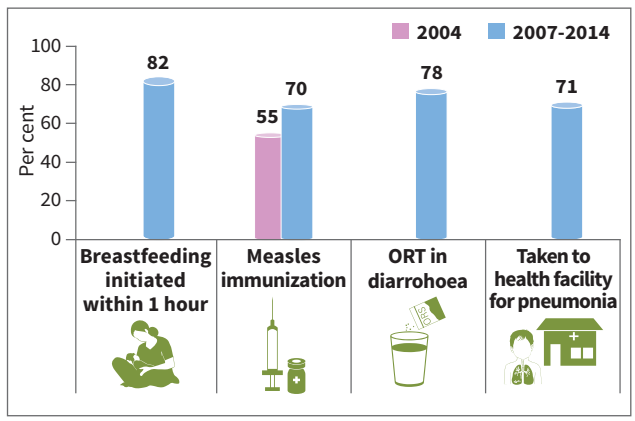
COVERAGE OF LIFE-SAVING INTERVENTIONS INCREASED

Maternal interventions



Source: *Timor-Leste Demographic and health survey 2009-2010; World Health Organization. World health statistics 2006. Geneva, 2006; 4. World Health Organization. World health statistics 2015. Geneva, 2015*

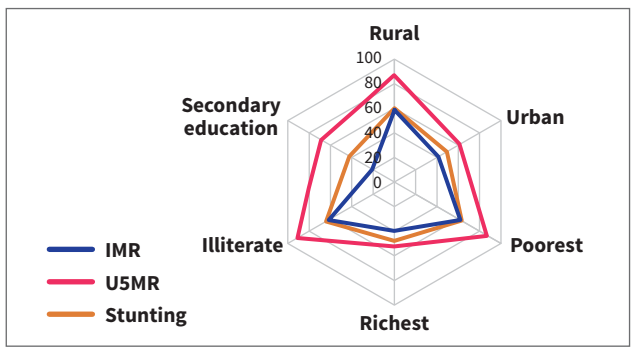
Immunization and illness treatment in children



Source: *Timor-Leste Demographic and Health survey 2012; World Health Organization. World health statistics 2006. Geneva, 2006; 4. World Health Organization. World health statistics 2015. Geneva, 2015*

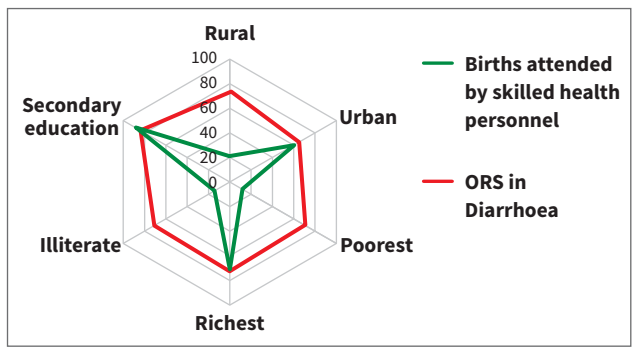
BUT INEQUITIES PERSIST

In mortality and nutritional status



Source: *Situation of Newborn and Child Health in South-East Asia: Progress towards MDG4, World Health Organization, 2014.*

In coverage of interventions



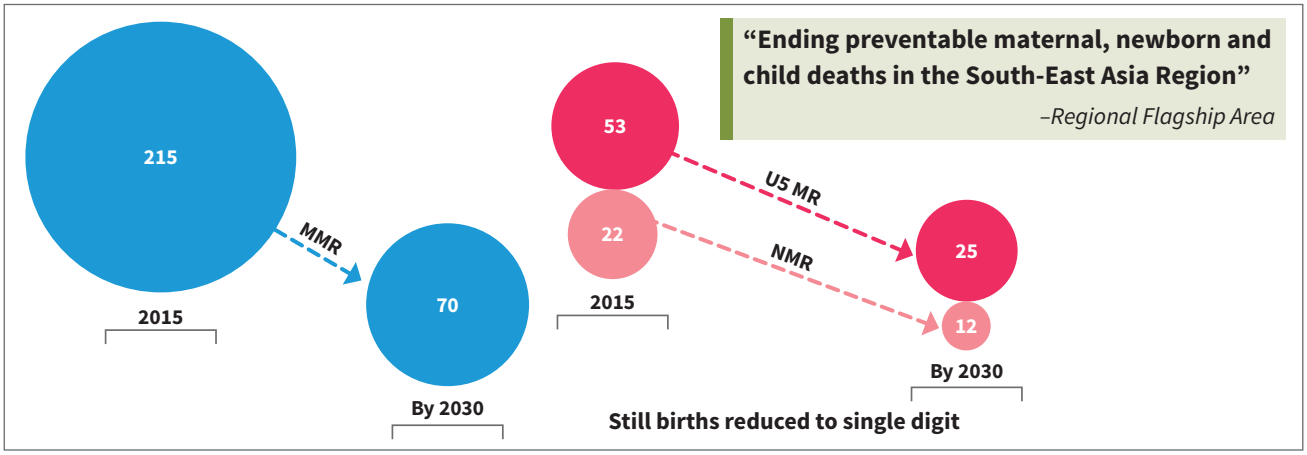
Source: *Situation of Newborn and Child Health in South-East Asia: Progress towards MDG4, World Health Organization, 2014.*

Timor-Leste

SUSTAINABLE DEVELOPMENT GOALS

NEW HORIZONS

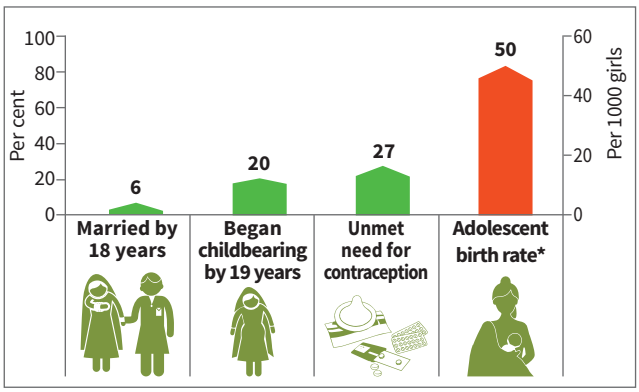
SDG targets



Source: *UNICEF, World Health Organization, The World Bank, United Nations Department of Economic and Social Affairs, Population Division. Levels & trends in child mortality - report 2015: estimates developed by the UN inter-agency group for child mortality estimation. New York, 2015*

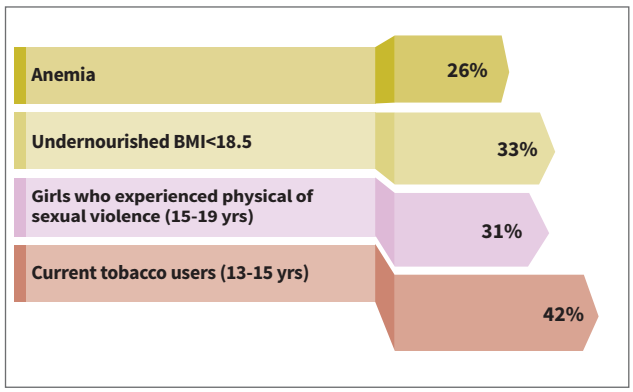
ADOLESCENTS: TOWARDS HEALTHY TRANSITIONS

Adolescent marriage and childbearing (15–19 years)



Source: *Timor-Leste Demographic and health survey 2009-2010*
**World Health Organization. World health statistics 2016. Geneva, 2016*

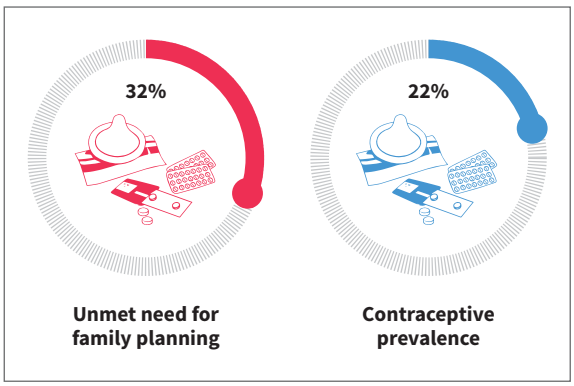
Nutrition, violence and tobacco use



Source: *Timor-Leste Demographic and health survey 2003, 2009-2010*

REPRODUCTIVE HEALTH

Access to reproductive health-care services



Source: *World Health Organization. World health statistics 2015. Geneva, 2015*

Cervical cancer

Number of girls between 9–13 years (eligible for HPV vaccination)	80 000
Opportunity for HPV vaccination	
Opportunity for vaccinatione	
PAP smear available for symptomatic patients	
Cancer Cervix Incidence (per 100 000)	Data NA
Cancer Cervix Mortality (per 100 000)	Data NA
No population-based cancer registry	

Source: *World Health Organization, Regional Office for South-East Asia. Strategic framework for the comprehensive control of cancer cervix. New Delhi, 2015.*

Annex – 4.2

SDG indicators and monitoring framework

Target	Included in SDGs	Additional
SURVIVE		
Reduce global maternal mortality to less than 70 per 100 000 live births (SDG 3.1)	Maternal mortality ratio (3.1.1 Proportion of births attended by skilled health personnel (3.1.2)	Proportion of women aged 15-49 who received 4 or more antenatal care visits Proportion of women who have postpartum contact with a health provider within 2 days of delivery
Reduce newborn mortality to at least as low as 12 per 1000 live births in every country (SDG 3.2)	Neonatal mortality rate (3.2.2)	Stillbirth rate Proportion of infants who were breastfed within the first hour of birth Proportion of newborns who have postnatal contact with a health provider within 2 days of delivery Proportion of women in antenatal care (ANC) who were screened for syphilis during pregnancy
Reduce under-5 mortality to at least as low as 25 per 1000 live births in every country (SDG 3.2)	Under-5 mortality rate (3.2.1)	Percentage of children with diarrhea receiving oral rehydration salts (ORS) Proportion of children with suspected pneumonia taken to an appropriate health provider Percentage of infants <6 months who are fed exclusively with breast milk Percentage of children fully immunized Use of insecticide-treated nets (ITNs) in children under 5 (% of children)
End epidemics of HIV, tuberculosis, malaria, neglected tropical diseases and other communicable diseases (SDG 3.3)	Number of new HIV infections per 1000 uninfected population, by age and sex (3.3.1) Malaria incident cases per 1000 persons per year (3.3.3)	Percentage of people living with HIV who are currently receiving antiretroviral therapy (ART), by age and sex Proportion of households with at least 1 ITN for every 2 people and/or sprayed by indoor residual spray (IRS) within the last 12 months
Reduce by 1/3 premature mortality from noncommunicable diseases and promote mental health and well- being (SDG 3.4)	Age-standardized prevalence of current tobacco use among persons 15 years and older, by age and sex (3.a.1) Mortality between ages 30 and 70 years from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases, by sex (3.4.1) Suicide mortality rate, by age and sex (3.4.2)	Adolescent mortality rate, by sex Proportion of women aged 30-49 who report they were screened for cervical cancer

Target	Included in SDGs	Additional
THRIVE		
End all forms of malnutrition and address the nutritional needs of adolescent girls, pregnant and lactating women and children (SDG 2.2)	Prevalence of stunting (height for age <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age (2.2.1) Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting and overweight) (2.2.2)	Proportion of women aged 15-49 who received 4 or more antenatal care visits revalence of insufficient physical activity among adolescents Prevalence of anaemia in women aged 15-49, disaggregated by age and pregnancy status Proportion of children aged 6-23 months who receive a minimum acceptable diet
Ensure universal access to sexual and reproductive health-care services (including for family planning) and rights (SDG 3.7 and 5.6)	Percentage of women of reproductive age (15-49) who have their need for family planning satisfied with modern methods (3.7.1) Adolescent birth rate (10-14, 15-19) per 1000 women in that age group (3.7.2) Proportion of women aged 15-49 who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care (5.6.1) Number of countries with laws and regulations that guarantee women aged 15- 49 access to sexual and reproductive health care, information and education (5.6.2)	Proportion of men and women aged 15-24 with basic knowledge about sexual and reproductive health services and rights
Ensure that all girls and boys have access to good-quality early childhood development (SDG 4.2)	Percentage of children under 5 years of age who are developmentally on track in health, learning and psychosocial wellbeing, by sex (4.2.1) Participation rate in organized learning (one year before the official primary entry age), by sex (4.2.2)	
Substantially reduce pollution-related deaths and illnesses (SDG 3.9)	Mortality rate attributed to household and ambient air pollution, by age and sex (3.9.1) Proportion of population with primary reliance on clean fuels and technology (7.1.2)	

Achieve universal health coverage, including financial risk protection and access to quality essential services, medicines and vaccines (SDG 3.8)	Coverage of essential health services (index based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non- communicable diseases and service capacity and access) (3.8.1) (including RMNCAH: family planning; pregnancy and childbirth care; breastfeeding; immunization; childhood illnesses treatment) [SDG 3.8.2 to be decided* * Indicator for SDG 3.8.2 proposed by the World Health Organization and the World Bank]	Current country health expenditure per capita (including specifically on RMNCAH) financed from domestic sources Out of-pocket health expenses as percentage of total health expenditure

Target	Included in SDGs	Additional
TRANSFORM		
Eradicate extreme poverty (SDG 1.1)	Proportion of population below the international poverty line, by sex, age, employment status and geographical location (1.1.1)	
Ensure that all girls and boys complete free, equitable and good-quality secondary education (SDG 4.1)	Proportion of children and young people: (a) in grades 2/3; (b) at the end of primary; and (c) at the end of lower secondary achieving at least a minimum proficiency	
Eliminate all harmful practices and all discrimination and violence against women and girls (SDG 5.2 and 5.3)	Percentage of women aged 20-24 who were married or in a union before age 15 and before age 18 (5.3.1) Proportion of ever-partnered women and girls aged 15 and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age (5.2.1)* Proportion of women and girls aged 15- 49 who have undergone female genital mutilation/cutting (FGM/C), by age (5.3.2)	Proportion of young women and men aged 18-29 who experienced sexual violence by age 18 (16.2.3) Proportion of rape survivors who received HIV post-exposure prophylaxis (PEP) within 72 hours of an incident occurring

Achieve universal and equitable access to safe and affordable drinking water and to adequate sanitation and hygiene (SDG 6.1 and 6.2)	Whether or not legal frameworks are in place to promote, enforce and monitor equality and nondiscrimination on the basis Percentage of population using safely managed drinking water services (6.1.1)	
Enhance scientific research, upgrade technological capabilities and encourage innovation (SDG 8.2)	Percentage of population using safely managed sanitation services including a hand-washing facility with soap and Research and development expenditure as a proportion of GDP (9.5.1) (disaggregated by health/ RMNCAH	
Provide legal identity for all, including birth registration (SDG 16.9)	Proportion of children under 5 years of age whose births have been registered with a civil authority, by age (16.9.1) Proportion of countries that (a) have conducted at least one population and housing census in the last 10 years; and (b) have achieved 100% birth registration and 80% death registration (17.19.2)	
Enhance the global partnership for sustainable development (17.16)	Number of countries reporting progress in multi stakeholder development effectiveness monitoring frameworks that support the achievement of the SDGs (17.16.1)	Governance index (voice, accountability, political stability and absence of violence, government effectiveness, regulatory quality, rule of law, control of corruption
Additional equity, humanitarian and human rights cross-cutting indicators	Proportion of indicators at the national level with full disaggregation when relevant to the target (17.18.1) (for indicators from the Global Strategy for Women's, Children's and Adolescents' Health, this indicator would be relevant at regional and global levels too).	Proportion of countries that have ratified human rights treaties related to women's, children's and adolescents' health

Annex – 4.3

Global Strategy recommended life-course interventions

Women (including pre-pregnancy interventions)

- Information, counselling and services for comprehensive sexual and reproductive health including contraception
- Prevention, detection and treatment of communicable and non- communicable disease and sexually transmitted and reproductive tract infections including HIV, TB and syphilis
- Iron/folic acid supplementation (pre-pregnancy)
- Screening for and management of cervical and breast cancer
- Safe abortion (wherever legal), post-abortion care
- Prevention of and response to sexual and other forms of gender-based violence
- Pre-pregnancy detection and management of risk factors (nutrition, obesity, tobacco, alcohol, mental health, environmental toxins) and genetic conditions

Pregnancy (antenatal care)

- Early and appropriate antenatal care (four visits), including identification and management of gender-based violence
- Accurate determination of gestational age
- Screening for maternal illness
- Screening for hypertensive disorders
- Iron and folic acid supplementation
- Tetanus immunization
- Counselling on family planning, birth and emergency preparedness
- Prevention of mother-to-child transmission of HIV, including with antiretrovirals
- Prevention and treatment of malaria including insecticide treated nets and intermittent preventive treatment in pregnancy
- Smoking cessation
- Screening for and prevention and management of sexually transmitted infections (syphilis and hepatitis B)
- Identification and response to intimate partner violence
- Dietary counselling for healthy weight gain and adequate nutrition
- Detection of risk factors for, and management of, genetic conditions
- Management of chronic medical conditions (e.g. hypertension, pre-existing diabetes mellitus)
- Prevention, screening and treatment of gestational diabetes, eclampsia and pre-eclampsia (including timely delivery)
- Management of obstetric complications (preterm premature rupture of membranes, macrosomia, etc.)
- Antenatal corticosteroids for women at risk of birth from 24-34 weeks of gestation when appropriate conditions are met
- Management of mal presentation at term

Childbirth

- Facility-based childbirth with a skilled birth attendant
- Routine monitoring with partograph with timely and appropriate care
- Active management of third stage of labour
- Management of prolonged or obstructed labour including instrumental delivery and caesarean section
- Caesarean section for maternal/ foetal indications
- Induction of labour with appropriate medical indications
- Management of post-partum haemorrhage
- Prevention and management of eclampsia (including with magnesium sulphate)
- Detection and management of women with or at risk of infections (including prophylactic use of antibiotics for caesarean section)
- Screening for HIV (if not already tested) and prevention of mother to child transmission
- Hygienic management of the cord at birth, including use of chlorhexidine where appropriate

Postnatal (mother)

- Care in the facility for at least 24 hours after an uncomplicated vaginal birth
- Promotion, protection and support of exclusive breastfeeding for 6 months
- Management of post-partum haemorrhage
- Prevention and management of eclampsia
- Prevention and treatment of maternal anaemia
- Detection and management of post-partum sepsis
- Family planning advice and contraceptives
- Routine post-partum examination and screening for cervical cancer in appropriate age group
- Screening for HIV and initiation or continuation of antiretroviral therapy
- Identification of and response to intimate partner violence
- Early detection of maternal morbidities (e.g. fistula)
- Screening and management for post-partum depression
- Nutrition and lifestyle counselling, management of inter-partum weight
- Postnatal contact with an appropriately skilled health-care provider, at home or in the health facility, around day 3, day 7 and at 6 weeks after birth

Postnatal (newborn)

- Care in the facility for at least 24 hours after an uncomplicated vaginal birth
- Immediate drying and thermal care
- Neonatal resuscitation with bag and mask
- Early initiation of breastfeeding (within the first hour)
- Hygienic cord and skin care
- Initiation of prophylactic antiretroviral therapy for babies exposed to HIV
- Kangaroo mother care for small babies
- Extra support for feeding small and preterm babies with breast milk
- Presumptive antibiotic therapy for newborns at risk of bacterial infection
- Continuous positive airway pressure (CPAP) to manage babies with respiratory distress syndrome
- Detection and case management of possible severe bacterial infection
- Management of newborns with jaundice
- Detection and management of genetic conditions
- Postnatal contact with a skilled health-care provider, at home or in the health facility, around day 3, day 7 and at 6 weeks after birth

Child Health and Development

- Exclusive breastfeeding for 6 months; continued breastfeeding and complementary feeding from 6 months
- Dietary counselling for prevention of undernutrition, overweight and obesity
- Responsive caregiving and stimulation
- Routine immunization (including *Haemophilus influenzae,* pneumococcal, meningococcal and rotavirus vaccines)
- Periodic vitamin A supplementation where appropriate
- Iron supplementation where appropriate
- Prevention and management of childhood illnesses including malaria, pneumonia, meningitis and diarrhoea
- Case management of severe acute malnutrition and treatment for wasting
- Management of moderate acute malnutrition (appropriate breastfeeding, complementary feeding; and supplementary feeding where necessary)
- Comprehensive care of children infected with, or exposed to, HIV

Child Health and Development *(Contd.)*

- Case management of meningitis
- Prevention and response to child maltreatment
- Prevention of harmful practices including female genital mutilation
- Care for children with developmental delays
- Treatment and rehabilitation of children with congenital abnormalities and disabilities

Adolescent health and development

- Routine vaccinations (e.g. human papillomavirus, hepatitis B, diphtheria-tetanus, rubella, measles)
- Promotion of healthy behaviour (e.g. nutrition, physical activity, no tobacco, alcohol or drugs)
- Prevention, detection and management of anaemia, especially for adolescent girls
- Comprehensive sexuality education
- Information, counselling and services for comprehensive sexual and reproductive health including contraception
- Psychosocial support and related services for adolescent mental health and well-being
- Prevention of and response to sexual and other forms of gender-based violence
- Prevention of and response to harmful practices such as female genital mutilation and early and forced marriage
- Prevention, detection and treatment of communicable and non- communicable diseases and sexually transmitted and reproductive tract infections, including HIV, TB and syphilis
- Voluntary medical male circumcision in countries with HIV generalized epidemics
- Detection and management of hazardous and harmful substance use
- Parent skill training, as appropriate, for managing behavioural disorders in adolescents
- Assessment and management of adolescents who present with unintentional injury, including alcohol-related injury
- Prevention of suicide and management of self-harm/ suicide risks

Humanitarian and fragile settings

- Develop and use a health and humanitarian risk assessments approach to identify priority needs and focus interventions
- In the event of humanitarian emergency, ensure deployment of essential health interventions (included above). Adapt, implement and co-ordinate use of the minimum initial service package. Pay specific attention to interventions such as:
  - Sexual and gender-based violence prevention, contraceptives (short-acting and long-acting emergency contraceptives), post- exposure prophylaxis
  - Ensuring that policies and practices in emergencies and humanitarian crises promote, protect and support breastfeeding and other essential interventions for women's, children's and adolescents' health, based on context and need

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