National Research Journal of Social Sciences (NRJSS)
Volume-1, Issue-2, Year-2016 PP: 42-58 ISSN No: 2348-473X

Child and Maternal Health in South Asia: Achievements, Challenges and the Way Forward

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Abstract

Most South Asian countries made progress in child health. Except Afghanistan and Pakistan, the South Asian countries have either achieved the targeted gains in childhood mortality, i.e., MDG 4 (Sri Lanka, Maldives and Bangladesh) or are on track of achieving the target (India and Nepal). Also, several South Asian countries made progress in maternal health. Maldives and Sri Lanka have achieved the targeted gains in maternal mortality, i.e. MDG 5; and Bangladesh is on track, while India, Pakistan and Afghanistan are off track. There has been increase in contraceptive use and declines in unmet need and fertility. However, the gains in child and maternal health have not been uniform both within and among countries.

To achieve further gains in improving child and maternal health, especially insofar as the SDG 3 is concerned, South Asian countries must effectively address the challenges to make the gains in child and maternal health more inclusive. The political will and commitment for improving the health sector performance must be clearly reflected in policy documents and budgets; and must be effectively implemented.

Keywords: Child health; maternal health; MDG; SDG; South Asia

1. Introduction

The health of women and children is critical to creating a healthy world. However, despite great progress, there are still too many mothers and children dying mostly from preventable causes. Every day, around 800 women die from preventable causes related to pregnancy and childbirth, 99% of these deaths occurring in developing countries. In 2012, 6.6 million children died before reaching age 5, and 5 million of them in the first year of life. Newborn, or neonatal, deaths account for 40

percent of all deaths among children under five[1]. Therefore, the major international conferences on population and health attached high priority to reduction in child and maternal mortality.

Every year, over 9 million children in the world die before reaching their fifth birthday, and so do more than half a million pregnant women. The situation is particularly acute in Asia and the Pacific, whose share of the global total is nearly 41% of the under-fives, more than 44% of the mothers and 56% of the newborn babies.

The 1994 International Conference on Population and Development (ICPD) in Cairo is an important landmark in redefining and addressing the issues of population and reproductive health (RH) within a holistic and human-rights based perspective[2].This international consensus was reaffirmed at a number of international conferences, including the Fourth World Conference on Women held in Beijing in September 1995 (UN 1995). One of the major landmarks influencing policies globally since the ICPD was the introduction of the Millennium Development Goals (MDGs) in 2000 and the subsequent inclusion of MDG target 5.B on universal access to reproductive health. The three health-related MDGs, to be achieved by 2015, are to: (i) reduce child mortality; (ii) improve maternal health; and (iii) combat HIV/AIDS, malaria and other diseases. MDG 4 was to reduce by two-thirds, between 1990 and 2015, the under-five mortality rate; and the indicators are: (i) under-five mortality rate, (ii) infant mortality rate, and (iii) proportion of 1 year-old children immunized against measles. MDG 5 was to reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio; and the indicators were: (i) maternal mortality ratio, (ii) proportion of births attended by skilled health personnel, (iii) contraceptive prevalence rate, (iv) adolescent birth rate, (v) antenatal care coverage (at least one visit and at least 4 visits), and (vi) unmet need for family planning[3].

In September 2015, the United Nations General Assembly adopted "Transforming our World: The 2030 Agenda for Sustainable Development". The 2030 Agenda outlined a new framework to form the cornerstone of the sustainable development agenda for the period leading up to 2030, replacing the Millennium Development Goal (MDG) framework that expired in 2015. The SDG set 17 universal goals and 169 targets referred to as the Sustainable Development Goals (SDGs). The SDGs substantially broaden the development agenda beyond the MDGs. Health is a core dimension of the SDGs. Goal 3 aims to "ensure healthy lives and promote wellbeing for all at all ages". [4] *Target 3.1 is to, by 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births*-- indicators: Maternal mortality ratio (3.1.1) and skilled birth attendance (3.1.2); *Target 3.2 is to, by 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births*--Indicators: Under-5 mortality (3.2.1) and Neonatal mortality (3.2.2); and *Target 3.7 is to, 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 programmes*-- indicators: Family planning need met, modern contraception (3.7.1) and Adolescent birth rate (3.7.2.).

The objectives of this paper are to briefly review the achievements and challenges in child health and maternal health in South Asian countries; and then, propose measures to move forward in achieving further gains in child and maternal health in South Asia. .

[1] For more detail information, see WHO 2014 and 2015; UNICEF, WHO World Bank Group and UN Population Division; IHME and World Bank 2013; Bhutta et.al., 2015

[2] See, e.g. UN 1994; McIntosh and Finkle 1995.

[3] For more detail information, see UNICEF 2008; Rajan et.al, 2014; WHO 2009.

[4] For more detail information, see WHO 2009; Gao 2015; GBD 2015 SDG Collaborators; WHO 2016; UN 2015

The paper is based on an extensive review of relevant documents and data sources; meaningful insights gained from discussions with key stakeholders; and from the first author's in-depth understanding of the health sector programmes in several South Asian countries.

2. SOUTH ASIA--BACKGROUND

South Asia is the home of one-quarter of the world's population, with a population of 1.86 billion out of the world's population of 7.42 billion as of mid-2016 (PRB 2016; Khuda, Barkat and Roy 2015)[5]. It is a densely populated region, with a population density of 266 persons per square kilometer in 2014, though there are large variations across countries.

South Asia has a youthful population age structure. Those under 15 years of age account for 31 percent of the total population. About half of the population in Afghanistan is under 15 years of age, followed by Pakistan and other countries (UN 2014 a).

South Asia has been experiencing rapid urbanization, with one-third of the population living in urban areas. Maldives and Sri Lanka respectively have the highest and lowest percentages of their populations living in urban areas.

The female age at marriage continues to be low, though there has been some increase (Raj 2012). In 2010, about half of the women aged 20-24 years reported being married before reaching 18 years (UNFPA 2012). Bangladesh has the lowest female median age at marriage, while Sri Lanka has the highest (NIPORT et.al. 2013; Government of Afghanistan and UNICEF 2012; IIPS and Macro International 2005-06; Government of Nepal et.al.2012; ICRW 2012). Two-thirds of the adolescents in Nepal and Bangladesh initiated childbearing.

Enrollment rates for girls and boys at primary school are highest in India and lowest in Pakistan; and at secondary school they are highest in Sri Lanka and lowest in Pakistan. Gender parity has been achieved in the Maldives, Sri Lanka, Bhutan, Bangladesh and India at the primary school level; and at the secondary level in Bangladesh, Sri Lanka and the Maldives (UNICEF 2013; Government of Bangladesh 2014 a).

Economic growth averaged around 6 percent annually over the past two decades, resulting in considerable decline in poverty. The GDP per capita at Purchasing Power Parity (PPP) in 2015 in South Asian countries was highest in Sri Lanka ($11,480), closely followed by Maldives ($11,310), Bhutan ($7,610), India ($6,020), Pakistan ($5,360), Bangladesh ($3,550), Nepal ($2,500) and Afghanistan (($1,990) (World Bank 2016).There is considerable inequity in income distribution across the South Asian countries, and a significant percentage of the population lives below the poverty line (UN 2013; World Bank 2014).

The health sector programmes suffer from various challenges[6]: (i) lack of adequate coordination between the health and family planning departments, (ii) weak monitoring and supervision, (iii) gaps in commodity security, (iv)lack of adequate support for behaviour change communication, (v) gaps in programme efficiency, and (vi) limited funding.

[5] See Appendix Table 1 for data on selected characteristics of the South Asian countries.
[6] A detail discussion is given in Zaman, Masnin and Loftus (eds.) 2012; Zaman and Masnin (eds.) 2012; Khuda and Barkat 2012 a and b; 2015 a.

3. ACHIEVEMENTS[7]

3.1.1 Child Health

Nutrition

There has been some improvement in the nutritional level of children[8]. Stunting is lowest in Sri Lanka and highest in Afghanistan. Wasting is lowest in Bhutan and highest in Sri Lanka. Underweight is lowest in Bhutan and highest in Pakistan (Table 1; Govt. of Afghanistan 2011; NIPORT et.al. 2013; Khuda and Barkat 2015 b; Royal Govt. of Bhutan et.al. 2011; IIPS and Macro International 2007; Govt. of Maldives and ICF Macro 2010; Government of Nepal and ICF International 2012; NIPS and ICF International 2013; Government of Sri Lanka 2009).

Immunization

Immunization coverage (BCG, DPT 3, Polio 3 and measles) for children increased. It is highest in Sri Lanka, while it is lowest in Afghanistan and Pakistan. BCG coverage is almost universal in Sri Lanka, Maldives and Bangladesh. It is lowest in Afghanistan (75%). DPT 3 coverage is near universal in Sri Lanka, Maldives and Bhutan and 93 percent in Bangladesh. It is lowest in Pakistan (65%), followed by Afghanistan (71%). Polio 3 coverage is almost universal in Sri Lanka, Maldives and Bhutan, and 93 percent in Bangladesh. It is lowest in Afghanistan and India (around 70%). Measles coverage is near universal in Sri Lanka, and around 95 percent each in Bhutan and Maldives and 88 percent each in Bangladesh and Nepal. It is lowest in Pakistan (61%), followed by India and Afghanistan (around 75%) each (Table 2; Govt. of Afghanistan 2011 and 2013; NIPORT et.al. 2013; Royal Govt. of Bhutan et.al. 2011; Govt. of Maldives and ICF Macro 2010; Government of Nepal and ICF International 2012; NIPS and ICF International 2013; Government of Sri Lanka 2009).

Child Mortality

The MDG targeted that child mortality rate should be reduced by two-thirds by 2015[9]. In South Asia, neonatal mortality, infant mortality rate (IMR) and under-5 mortality rates have declined. They are lowest in Maldives and Sri Lanka, although quite high in Afghanistan and Pakistan. Neonatal mortality is lowest in Sri Lanka and Maldives (6). It is highest in Pakistan (42), followed by Afghanistan (36), India (29) and Bangladesh (24). The infant mortality rate (IMR) is lowest in Bhutan and Sri Lanka (8). It is highest in Afghanistan (70), followed closely by Pakistan (69), India (41), Bangladesh (33) and Nepal (32). The under-5 mortality rate is lowest in Maldives and Sri Lanka (10). It is highest in Afghanistan (97), followed closely by Pakistan (86), India (53) and Bangladesh and Nepal with around 40 each (Table 1; Govt. of Afghanistan 2011 and 2013; NIPORT et.al. 2013; Khuda and Barkat 2015 b; Royal Govt. of Bhutan et.al. 2011; Govt. of Maldives and ICF Macro 2010; Government of Nepal and ICF International 2012; NIPS and ICF International 2013; Government of Sri Lanka 2009).

3.1.2 Maternal Health

Nutrition

There has been some improvement in the nutritional level of mothers (Table 3; Govt. of Afghanistan 2011; NIPORT et.al. 2013; Khuda and Barkat 2015 b; Royal Govt. of Bhutan et.al. 2011; IIPS and Macro

[7] A more elaborate discussion is given in Khuda, Barkat and Hassan 2015.

[8] Around 101 million under-5 children (16% of all under-5 children), worldwide, were underweight in 2011; however, the prevalence of underweight in 2011 was highest in Southern Asia (57 million or 31%) (UN 2013; UNICEF 2013).

[9] Globally, the under-5 mortality rate declined by 41% during the last two decades (from 87 deaths per 1,000 live births in 1990 to 51 in 2011).However, more rapid progress is needed to meet the MDG4 target, especially in Southern Asia (UN 2013).

International 2007; Govt. of Maldives and ICF Macro 2010; Government of Nepal and ICF International 2012; NIPS and ICF International 2013; Government of Sri Lanka 2009).

Antenatal Care (ANC)

The percentage of women receiving ANC increased, except in Afghanistan. It ranges from less than half in Afghanistan to almost universal level in Bhutan, Maldives and Sri Lanka. Also, the percentage of women receiving 4+ ANC visits increased. It is highest in Bhutan (77%), and lowest in Afghanistan (16%) (Table 3; Govt. of Afghanistan 2011 and 2013; NIPORT et.al. 2012 and 2013; Khuda and Barkat 2015 b; Royal Govt. of Bhutan et.al. 2011; Govt. of Maldives and ICF Macro 2010; Government of Nepal and ICF International 2012; NIPS and ICF International 2013; Government of Sri Lanka 2009 and 2015).

Delivery Care

The percentage of births delivered by skilled personnel increased, ranging from almost universal levels in Maldives and Sri Lanka to around one-third in Bangladesh. Also, the percentage of births delivered at health facility increased, ranging from almost universal level in Sri Lanka to one-third in Afghanistan and Bangladesh (Table 3; Govt. of Afghanistan 2011 and 2013; NIPORT et.al. 2012 and 2013; Khuda and Barkat 2015 b; Royal Govt. of Bhutan et.al. 2011; Govt. of Maldives and ICF Macro 2010; Government of Nepal and ICF International 2012; NIPS and ICF International 2013; Government of Sri Lanka 2009 and 2015).

Maternal Mortality Ratio (MMR)

Globally, the MMR declined from 380 in 1980 to 210 in 2013 (45% decline). In Southern Asia, the decline was 64 percent. In South Asia, the MMR ranges from 29 in Sri Lanka to 400 in Afghanistan. Afghanistan recorded the sharpest decline in MMR from 1000 in 2000 to 400 in 2013, followed by Bhutan from 430 in 2000 to 120 in 2013, India from 390 in 2000 to 190 in 2013, and Bangladesh from 322 in 2001 to 170 in 2013 (Table 3; Govt. of Afghanistan 2011 and 2013; NIPORT et.al. 2013; Khuda and Barkat 2015 b; Royal Govt. of Bhutan et.al. 2011; Govt. of Maldives and ICF Macro 2010; Government of Nepal and ICF International 2012; NIPS and ICF International 2013; Government of Sri Lanka 2009 and 2015).

Family Planning

Family Planning (FP) programmes in the different countries went through various phases[10].

The contraceptive prevalence rate (CPR) increased. It is highest in Sri Lanka (68%), closely followed by Bhutan (66%) and Bangladesh (62%). It is lowest in Afghanistan (21%), followed by Pakistan 35%) (Table 4; NIPORT et. al. 2013; Govt. of Afghanistan 2011; Royal Govt. of Bhutan, UNICEF and UNFPA 2011; Jain and Jain 2012; Niraula 2012; Government of Maldives and ICF Macro 2010; Ministry of Health and Population, Nepal, New ERA and ICF Macro 2012; Sathar and Zaidi 2012; Government of Sri Lanka 2009).

Unmet Contraceptive Need (UCN)

There has been a slight decline in UCN. It is lowest in Sri Lanka (7%), followed by Bangladesh and India (around 12%) and Maldives (15). It is highest in Nepal (28%), followed by Afghanistan (23%) and Pakistan (20%) (Table 4). Between 2000 and 2006, UCN declined in Pakistan from 33 percent to 25 percent; in Nepal from 28 percent to 25 percent; in India from 21 percent to 13 percent; and in Sri Lanka from 18 percent to 7 percent. Between 2007 and 2011, UCN declined in Bangladesh from 17 percent to 12 percent (Khuda and Barkat 2012 b).

[10] See, Khuda, 1981 and 1984; Khuda and Barkat 2012 a, 2015 a; Cleland et al 1994: Jain and Jain 2012; Nirmula 2012; Sathar and Zaidi 2012; Tamang et.al. 2012.

Fertility

Fertility declined. Afghanistan has the highest fertility (TFR of 4.9), followed by Pakistan, while the TFR ranges between 2.2 and 2.5 in other South Asian countries (Table 5; Govt. of Afghanistan 2011; NIPORT et.al. 2013; Khuda and Barkat 2015 b; Royal Govt. of Bhutan et.al. 2011; Govt. of Maldives and ICF Macro 2010; Government of Nepal and ICF International 2012; NIPS and ICF International 2013; Government of Sri Lanka 2009).

Adolescent fertility is high in South Asia. Bangladesh has the highest adolescent fertility (122), followed by Afghanistan (90), Nepal (87), Bhutan (59), Pakistan (48), India (39), Sri Lanka (24) and lowest in Maldives (16). (Table 5; Govt. of Afghanistan 2011; NIPORT et.al. 2013; Khuda and Barkat 2015 b; Royal Govt. of Bhutan et.al. 2011; Govt. of Maldives and ICF Macro 2010; Government of Nepal and ICF International 2012; NIPS and ICF International 2013; Government of Sri Lanka 2009).

4. CHALLENGES[11]

4.1 Child Health

Immunization

There are variations in immunization coverage by age, birth order, mother's education, household wealth, place of residence and certain regions within countries (Govt. of Afghanistan 2011; NIPORT et.al. 2012 and 2013; Royal Govt. of Bhutan et.al. 2011; IIPS and Macro International 2007; Govt. of Maldives and ICF Macro 2010; Government of Nepal and ICF International 2012; NIPS and ICF International 2013; Government of Sri Lanka 2009 and 2015; Khuda, Barkat and Hassan 2015).

Child Mortality

Progress in child health has not been uniform both within and among countries. There are differentials by mother's age, birth order, education, household wealth, place of residence and certain regions within countries (Govt. of Afghanistan 2011 and 2013; NIPORT et.al. 2012 and 2013; Royal Govt. of Bhutan et.al. 2011; IIPS and Macro International 2007; Govt. of Maldives and ICF Macro 2010; Government of Nepal and ICF International 2012; NIPS and ICF International 2013; Mahmood 2002; Government of Sri Lanka 2009; Khuda, Barkat and Hassan 2015).

4.2 Maternal Health

ANC

ANC coverage (1st and 4+) increased; however, there are differentials by age, birth order, education, household wealth, place of residence and certain regions within countries (Govt. of Afghanistan 2011 and 2013; NIPORT et.al. 2012;Government of Bangladesh 2013 b; Royal Govt. of Bhutan et.al. 2011; Government of India 2014; Govt. of Maldives and ICF Macro 2010; Government of Nepal and ICF International 2012; NIPS and ICF International 2013; Government of Sri Lanka 2009 and 2015; Khuda, Barkat and Hassan 2015).

Delivery Care

Although the percentages of births attended by trained provider and delivered at facility increased, there are differentials by age, birth order, education, household wealth, place of residence and certain regions within countries (Govt. of Afghanistan 2011 and 2013; NIPORT et.al. 2012; Government of Bangladesh 2014 b; Royal Govt. of Bhutan et.al. 2011; Government of India 2014; Govt. of Maldives

[11] A more elaborate discussion is given in Khuda, Barkat and Hassan 2015.

and ICF Macro 2010; Ministry of Health, New ERA and Macro International 2007; Government of Nepal 2013; NIPS and ICF International 2013; Government of Sri Lanka 2009 and 2015; Khuda, Barkat and Hassan 2015).

MMR

Progress in maternal health has not been uniform both within and among countries. Although MMR declined, there are differentials by age, birth order, education, household wealth, place of residence and certain regions within countries (Govt. of Afghanistan 2011 and 2013; NIPORT et.al. 2012; Royal Govt. of Bhutan et.al. 2011; Government of India 2014; Govt. of Maldives and ICF Macro 2010; Government of Nepal 2013; Government of Pakistan, 2013; Government of Sri Lanka 2014 and 2015; Khuda, Barkat and Hassan 2015).

Family Planning

Use of contraception varies within and among countries and by characteristics of women. Further, the Family Planning Programmes are faced with a number of problems[12]: (i) slowing down in the rate of increase in CPR; (ii) regional variations in contraceptive; (iii) low contraceptive use among married adolescents; (iv) declining share of longer-acting and permanent methods (LAPM);[13] (v) high discontinuation rate -- dropping out on account of side effects and method failure indicates low quality of FP services[14], thereby contributing to huge system loss; and (vi) sizeable UCN.

Unmet Contraceptive Need

The extent of UCN declined slightly; and it varies within and among countries (Govt. of Afghanistan 2011; Khuda and Barkat 2012 b; NIPORT et.al. 2013; Royal Govt. of Bhutan et.al. 2011; IIPS and Macro International Inc. 2007; Govt. of Maldives and ICF Macro 2010; Aryal et. al. 2008; Ministry of Health and Population, Nepal, New ERA and ICF Macro 2012; Ministry of Health and Family, Maldives and ICF Macro 2010; NIPS and ICF International 2013; Government of Sri Lanka 2009).

Fertility

Fertility levels vary considerably both within and among countries by characteristics of women. Another major point of concern relates to the slowing down in the rate of fertility decline (Govt. of Afghanistan 2011; Khuda 2004; Khuda and Barkat 2012 b; Khuda et.al. 2015; NIPORT et.al. 2013; Royal Govt. of Bhutan et.al. 2011; Jain and Jain 2012; IIPS and Macro International 2007; Govt. of Maldives and ICF Macro 2010; Aryal et. al. 2008; Government of Nepal and ICF Macro 2011; Ministry of Health and Population, Nepal 2005; Pradhan and Pant 2007; Tamang et.al. 2012; Ministry of Health and Family, Maldives and ICF Macro 2010; NIPS and ICF International 2013; Sathar and Zaidi 2012; NIPS and Macro International Inc., 2008; Government of Sri Lanka 2009).

Although adolescent fertility declined[15], its prevalence varies both within and among the countries (Govt. of Afghanistan 2011; Khuda and Barkat 2012 a; NIPORT et.al. 2013; Royal Govt. of Bhutan et.al. 2011; IIPS and Macro International 2007; Govt. of Maldives and ICF Macro 2010; Government of

[12] See Zaman et.al. (eds) 2012; Zaman and Masnin (ed.) 2012; Khuda and Barkat 2015 a; Khuda and Barkat 2012 a and b

[13] Global experience shows that the most successful FP programmes include considerably high use of LAPM (see, e.g. UNFPA 2010).

[14] High discontinuation is due to poor quality of family planning services. Not surprisingly, therefore, there is high incidence of induced abortions (see, e.g. Singh et al 2012; Sedge et al 2012).

[15] Between 1990 and 2010, adolescent fertility declined globally, with the most pronounced decline in Southern Asia. Nevertheless, one in nine live births are among adolescent women worldwide, indicating relatively high adolescent fertility, especially in developing countries (UN 2013). An early transition to motherhood can not only reduce young women's opportunities for their schooling and future employment opportunities, but also, in turn, affect their children's schooling opportunities as well as their children's health and nutrition outcomes (World Bank 2010).

Nepal and ICF Macro 2011; Ministry of Health and Family, Maldives and ICF Macro 2010; NIPS and ICF International 2013; Government of Sri Lanka 2009; Khuda, Barkat and Hassan 2015).

4.3 Nutrition

South Asian countries continue to face high levels of malnutrition, both among children and mothers, with variations both within and among countries (Govt. of Afghanistan 2011 and 2013; NIPORT et.al. 2013; Royal Govt. of Bhutan et.al. 2011; IIPS and Macro International 2007; Govt. of Maldives and ICF Macro 2010; Government of Nepal and ICF International 2012; NIPS and ICF International 2013; Government of Sri Lanka 2009).

5. The Way Forward

Except Afghanistan and Pakistan, the South Asian countries have either achieved MDG 4 (Sri Lanka, Maldives and Bangladesh) or are on track of achieving the target (India and Nepal). Maldives and Sri Lanka have achieved MDG 5, and Bangladesh is on track. India, Pakistan and Afghanistan are off track. However, the gains in both child and maternal health and contraceptive use and declines in fertility and unmet need have not been uniform within and among countries in the region.

To achieve further gains in improving child and maternal health, especially insofar as the SDG 3 is concerned, there is need for various measures to carry forward the 2030 Agenda.

Special consideration should be given to further strengthening and integration of newborn, child and maternal health interventions. Also, repositioning family planning as an essential element of reproductive health should be considered a priority task. There is often lack of integrated health plans and budgets that reflect all levels of care for maternal, newborn, and child health along the continuum of care. This often results in uncoordinated financing, and hinders a holistic and integrated approach to implementation and financing of maternal, newborn, and child health interventions.

Inequity in access to child and maternal health services, especially quality services, in South Asia is quite evident. Often, poor people have to pay for their own healthcare "out of pocket", implying that they sometimes cannot afford essential care and also becomes poorer in the process[16].

South Asian countries spend only around one-half of the WHO-recommended amount(US$ 54) per capita per year on health. Worse still, scarce resources are often not allocated where they have the biggest impact. Acute respiratory infection, the leading cause of child mortality, accounting for 25 percent of the burden of disease, attracts less than 3 percent of donor funding globally. Also, nutrition programmes remain considerably under-funded, although five of the ten most cost-effective interventions for helping the poor are related to nutrition. Furthermore, there has been a decline in donor funding for family planning programmes, although it is widely believed to be a cost-effective programme.

More specifically, the governments should: (i) improve access to quality services; (ii) strengthen overall supervision, monitoring and evaluation; (iii) address human resource issues; (iv) ensure commodity security and logistics; (v) implement a coherent BCC strategy; (vi) increase budgetary allocation; (vii) enhance implementation capacity; and (vii) improve programme efficiency.

To achieve SDG 3, South Asian countries must effectively address the challenges and ensure that the gains in child and maternal health become more inclusive. The political will and commitment for improving the health sector performance must be clearly reflected in policy documents and budgets; and must be effectively implemented.

[16] Out-of-pocket spending on health care by households and individuals generally increases inequity. Further, government spending on health often benefits the rich more than the poor.

Table 1. Child Mortality Rates and Child Nutrition Status in South Asian Countries

Country	Year	Mortality rates			Child Nutrition			Data Sources
		Neo-natal mortality (NN)	Infant mortality (1q0)	Under-5 mortality (5q0)	Height-for-age (stunting)	Weight-for-height (wasting)	Weight-for-age (underweight)	
Afghanistan	2013	36	70	97	59.0	9.0	33.0	The state of World's Children Report, 2015; National Nutrition Survey, 2013
	2010	25	55	71	na	na	na	Mortality Survey
	2004	-	-	-	-	-	-	National Nutrition Survey, 2004
	2003	na	na	na	na	na	na	Multiple Indicator Cluster Survey
Bangladesh	2013	24	33	41	41.0	16.0	37.0	The State of World's Children Report, 2015
	2011	32	43	53	41.3	15.6	36.4	Demographic and Health Survey
	2004	-	-	-	50.6	14.5	42.5	Demographic and Health Survey
	1999-00	42	66	94	na	na	na	Demographic and Health Survey
Bhutan	2013	18	30	36	34.0	6.0	13.0	The State of World's Children Report, 2015
	2010		47	69	33.5	5.9	12.7	Multiple Indicator Cluster Survey
India	2013	29	41	53	48.0	20.0	44.0	The state of World's Children Report, 2015
	2005-06	39	57	74	48.0	19.8	42.5	Demographic and Health Survey
	1998-99	43	68	95	na	na	na	Demographic and Health Survey
Maldives	2013	6	8	10	20.0	10.0	18.0	The State of World's Children Report, 2015
	2009	10	14	17	18.9	10.6	17.3	Demographic and Health Survey
Nepal	2013	23	32	40	41.0	11.0	29.0	The State of World's Children Report, 2015
	2011	33	46	54	40.5	10.9	28.8	Demographic and Health Survey
	2001	39	64	91	57.2	11.2	42.7	Demographic and Health Survey
Pakistan	2013	42	69	86	45.0	11.0	32.0	The State of World's Children Report, 2015
	2012-13	55	74	89	44.8	10.8	30.0	Demographic and Health Survey
	2006-07	54	78	94	na	na	na	Demographic and Health Survey
Sri Lanka	2013	6	8	10	15.0	21.0	26.0	The State of World's Children Report, 2015
	2006-07	11	15	21	17.3	14.7	21.1	Demographic and Health Survey
	1987	16	25	34	na	na	na	Demographic and Health Survey

Table 2. Immunization coverage in South Asian Countries

Country	Year	BCG	DPT 3	Polio 3	Measles	Data Sources
Afghanistan	2013	75.0	71.0	71.0	75.0	WHO 2015
	2000	30.0	24.0	24.0	27.0	WHO 2015
Bangladesh	2011	97.8	93.4	93.4	87.5	DHS
	1999-00	91.0	72.1	70.8	70.8	DHS
Bhutan	2013	97.0	97.0	97.0	94.0	WHO 2015
	2000	97.0	92.0	98.0	78.0	WHO 2015
India	2013	87.0	72.0	70.0	74.0	WHO 2015
	2005-06	78.1	55.3	78.2	58.8	DHS
	1998-99	71.6	55.1	59.7	50.7	DHS
	2000	74.0	60.0	59.0	59.0	WHO 2015
Maldives	2009	99.4	97.9	97.0	94.5	DHS
	2000	99.0	98.0	98.0	99.0	WHO 2015
Nepal	2011	96.5	91.7	92.5	88.0	DHS
	2001	84.5	72.1	91.5	70.6	DHS
Pakistan	2012-13	85.2	65.2	85.3	61.4	DHS
	2006-07	80.3	58.5	83.1	59.9	DHS
	2000	85.0	62.0	65.0	59.0	WHO 2015
Sri Lanka	2013	99.0	99.0	99.0	99.0	WHO 2015
	2000	98.0	99.0	99.0	99.0	WHO 2015

Table 3. Maternal Mortality Ratio and Maternal Health Status in South Asian Countries

Country	Year	Maternal Mortality Ratio	Antenatal care (at least one by MTP)	ANC (4+)	Facility delivery	Assistance during delivery by MTP	Maternal Nutrition		Data Sources
							Height percent < 145 cm.	Height percent < 145 cm.	
Afghanistan	2013	400	48.0	-	33.0	39.0	na	9.2	The State of World's Children Report, 2015; National Nutrition Survey, 2013
	2010	327	63.8	16.1	32.4	34.5			Mortality Survey
	2004						na	20.9	National Nutrition Survey, 2004
	2000	1000	-	-	-	-			Trend in Maternal Mortality, 1990-2010
Bangladesh	2013	170	53.0	-	33.0	34.0			The State of World's Children Report, 2015
	2011	-	54.6	25.5	26.9	31.7	12.9	27.5	Demographic and Health Survey
	2010	194	-	-	-	-			Maternal Health Services and Maternal Mortality Survey
	2004	-	-	-	-	-			Demographic and Health Survey
	2001	322	-	-	-	-			Maternal Health Services and Maternal Mortality Survey
	1999-00	-	34.7	10.5	8.2	12.9	15.8	45.4	Demographic and Health Survey
Bhutan	2013	120	97.0	-	63.0	65.0			The State of World's Children Report, 2015
	2012	180	-	-	-	-			The State of World Population, 2012
	2010	-	97.3	77.3	63.1	64.5			Multiple Indicator Cluster Survey
	2000	430	-	-	-	-			Trend in Maternal Mortality, 1990-2010
India	2013	190	74.0	-	47.0	52.0			The State of World's Children Report, 2015
	2012	200	-	-	-	-			The State of World Population, 2012
	2005-06	-	75.7	37.0	40.4	48.9	11.9	39.9	Demographic and Health Survey
	2000	390	-	-	-	-			Trend in Maternal Mortality, 1990-2010

Table 4. Current use of contraception (any method) and unmet need for contraception in South Asian Countries						
		Current use of contraception	Unmet need			
Country	Year	Any method	Spacing	Limiting	Total	Data Sources
Afghanistan	2010-11	21.2	-	-	-	Multiple Indicator Cluster Survey
	2010	24.9	-	-	-	Mortality Survey
	2006	-	na	na	23.0	Govt. of Afghanistan 2006
	2000	4.9	-	-	-	Multiple Indicator Cluster Survey
Bangladesh	2013	62.0	-	-	-	Multiple Indicator Cluster Survey
	2011	61.2	4.4	7.3	11.7	Demographic and Health Survey
	1999-00	54.3	7.6	7.4	15.0	Demographic and Health Survey
Bhutan	2010	-	na	na	12.0	Govt. of Bhutan 2011
	2009	65.6	-	-	-	Multiple Indicator Cluster Survey
	2000	30.7	-	-	-	Bhutan 2000 National Health Survey
India	2013	55.0	-	-	-	India 2007-2008 District Level Household Survey
	2005-06	56.3	6.2	6.6	12.8	Demographic and Health Survey
	1998-99	48.2	8.3	7.5	15.8	Demographic and Health Survey
Maldives	2009	34.7	13.6	28.6	15.0	Demographic and Health Survey
	2006-07	-	14.9	13.2	28.1	Demographic and Health Survey
	2004	39.0	-	-	-	Maldives 2004 Reproductive Health Baseline Survey
Nepal	2011	49.7	9.9	17.6	27.5	Demographic and Health Survey
	2001	39.3	11.1	16.7	27.8	Demographic and Health Survey
Pakistan	2012-13	35.4	8.8	11.3	20.1	Demographic and Health Survey
	2006-07	29.6	10.8	14.4	25.2	Demographic and Health Survey
Sri Lanka	2006-07	68.4	3.5	3.8	7.3	Demographic and Health Survey
	2000	70.0	6.2	12.0	18.2	Demographic and Health Survey

Table 5. Adolescent Fertility and Total Fertility Rate in South Asian Countries				
Country	**Year**	**Adolescent fertility rate (15-19)**	**Total Fertility Rate**	**Data Sources**
Afghanistan	**2013**	**90**	**4.9**	**The State of World's Children Report, 2015**
	2010	**80**	**5.1**	**Mortality Survey**
	2003	**na**	**6.3**	**Multiple Indicator Cluster Survey**
Bangladesh	**2013**	**128**	**2.3**	**Demographic and Health Survey 2015**
	2011	**118**	**2.3**	**Demographic and Health Survey**
	1999-00	**144**	**3.3**	**Demographic and Health Survey**
Bhutan	**2013**	**59**	**2.2**	**The state of World's Children Report, 2015**
	2009	**59**	**2.2**	**Multiple Indicator Cluster Survey**
India	**2013**	**39**	**2.5**	**The state of World's Children Report, 2015**
	2005-06	**90**	**2.7**	**Demographic and Health Survey**
	1998-99	**107**	**2.8**	**Demographic and Health Survey**
Maldives	**2013**	**16**	**2.3**	**The state of World's Children Report, 2015**
	2009	**10**	**2.5**	**Demographic and Health Survey**
Nepal	**2013**	**87**	**2.3**	**The state of World's Children Report, 2015**
	2011	**81**	**2.6**	**Demographic and Health Survey**
	2001	**110**	**4.1**	**Demographic and Health Survey**
Pakistan	**2013**	**48**	**3.2**	**The state of World's Children Report, 2015**
	2012-13	**44**	**3.8**	**Demographic and Health Survey**
	2006-07	**51**	**4.1**	**Demographic and Health Survey**
Sri Lanka	**2013**	**24**	**2.3**	**The state of World's Children Report, 2015**
	2006-07	**28**	**2.3**	**Demographic and Health Survey**
	2000	**27**	**1.9**	**Demographic and Health Survey**

Appendix Table 1. Data on selected indicators in South Asian countries													
Country	Population (in millions)	Density (Per Sq. Km.)	Under 15 Population (%)	Elderly (65+) population (%)	Year	Median age at first marriage	Median age at first birth	Urban population (%)	Net primary school enrolment (%)		Net secondary school enrolment (%)		GDP per capita at PPP (USD)
						Age group: 25-49	Age group: 25-49		Girls	Boys	Girls	Boys	
Afghanistan	31.3	48	46	2	2010	17.7	20.0	24	na	na	na	na	2000
					2003 MICS	na	na						
Bangladesh	150.5	1101	29	5	2011	15.5	18.1	32	na	na	51	43	2810
					1999-00	14.7	17.8						
Bhutan	0.75	16	30	5	2009 MICS	na	na	36	91	88	57	50	7210
India	1730	394	31	5	2005-06	17.4	19.8	31	99	99	na	na	5350
					1998-99	17.1	19.4						
Maldives	0.4	1241	26	5	2009	19.0	21.2	41	95	94	na	na	9890
Nepal	27.1	184	34	5	2011	17.5	20.2	17	na	na	na	na	2260
					2001	16.7	19.9						
Pakistan	194	294	38	4	2012-13	19.5	22.2	35	66	79	29	40	4920
					2006-07	19.1	21.8						
Sri Lanka	20.7	315	26	8	2006-07	23.3	25.1	15	93	93	91	86	9470
					1987	24.6*	24.0						

Sources: Population Reference Bureau 2015; UN 2014 b; UNESCO 2012; UNICEF 2013; Afghanistan Mortality Survey; Bhutan MICS; Demographic and Health Surveys of Bangladesh, India, Maldives, Nepal, Pakistan and Sri Lanka.

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