The Report describes the evaluation of WHO's contribution to the Maternal Health Program in South-East Asia Region. This was an independent evaluation conducted in 2015 by Amaltas, a Delhi based organization. The evaluation highlights the progress in five countries, namely Bangladesh, Indonesia, Myanmar, Nepal and Sri Lanka and provides specific recommendations for Organizational Learning and Development.

This report will be useful for all those interested in WHO's work on Maternal Health Program in the Region.

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Independent Evaluation

Evaluation of WHO's Contribution to Maternal Health in the South-East Asia Region

Saving Mothers' Lives

World Health Organization
Regional Office for South-East Asia

Independent Evaluation

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This report has been prepared by Amaltas Consulting Private Limited, New Delhi. Amaltas is a Delhi based organization with a mission to work within the broad scope of development to provide high quality consulting and research in support of accelerating improvements in the lives of people of the region. Amaltas has garnered a wide range of experience through its portfolio of prestigious projects with foundations such as the Bill and Melinda Gates Foundation, World Vision, Save the Children; research institutions such as Johns Hopkins University and IDRC, Canada; the UN including UN Women, UNDP, UNICEF, UNAIDS; bilateral and multilaterals such as DFID, the World Bank, USAID; and governments including Government of India, the Royal Government of Cambodia among others. It has core competencies in high quality research, documentation and evaluation. A detailed profile of Amaltas may be found on its website at www.amaltas.asia

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Annexes

Acronyms

ANC	antenatal care
ANC1	antenatal care with 1 visit
ANC4	antenatal care with at least 4 visits
AMW	auxiliary midwife
BAN	Bangladesh
BHU	Bhutan
BPJS	Badan Penyelenggara Jaminan Sosial
BMMS	Bangladesh Maternal Mortality and Health Care Survey
BDHS	Bangladesh Demographic and Health Survey
CCS	Country Cooperation Strategy
CPR	contraceptive prevalence rate
CSO	civil society organization
CSBA	community skilled birth attendants
DGHS	Directorate General of Health Services
DMR	Department of Medical Research
DNS	Directorate of Nursing Services
DoH	Department of Health
DoPH	Department of Public Health
DPRK	Democratic People's Republic of Korea
DFAT	Department of Foreign Affairs and Trade
EmOC	emergency obstetric care
EmONC	emergency obstetric and neonatal care
FHB	Family Health Bureau
GNI	gross national income
GDP	gross domestic product
GIS	geographical information system
HDI	human development index
HIV/AIDS	human immunodeficiency virus/acquired immune deficiency syndrome
HMIS	health management information system
HQ	headquarters
IDHS	Indonesia Demographic and Health Survey
IND	India
INO	Indonesia
KII	key informant interviews
MICS	Multiple Indicator Cluster Survey
MDG	Millennium Development Goal
MDR	Maternal Death Review
MAV	Maldives
MBBS	Bachelor of Medicine and Bachelor of Surgery
MMR	maternal mortality ratio

MMR	Myanmar
MDSR	Maternal Death Surveillance and Response System
MoHP	Ministry of Health and Population
MPDR	Maternal and Perinatal Death Review
MoH	Ministry of Health
MNCH	maternal, newborn and child health
MCH	maternal and child health
MIS	management information system
NEP	Nepal
NDHS	Nepal Demographic Health Survey
NPO	National Professional Officer
NGO	nongovernmental organization
PMTCT	preventing mother-to-child transmission
PPP	purchasing power parity
RH	reproductive health
RMNCAH	reproductive, maternal, newborn, child and adolescent health
SBA	skilled birth attendant
SEA Region	South-East Asia Region
SEARO	Regional Office for South-East Asia
SDG	Sustainable Development Goal
SRL	Sri Lanka
SLCOG	Sri Lanka College of Obstetricians and Gynaecologists
TB	tuberculosis
TFR	total fertility rate
TBA	traditional birth attendant
THA	Thailand
TLS	Timor-Leste
UHC	universal health coverage
UN	United Nations
UN-WB	United Nations-World Bank
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UHC	universal health coverage
WCO	World Health Organization Country Office
WHO	World Health Organization
WB	World Bank
3MDG	Three Millennium Development Goals Fund

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Executive Summary

(1) Maternal health is a pressing priority recognized by both the Millennium Development Goals (MDG) and the Sustainable Development Goals (SDG). New targets have been set to achieve a global maternal mortality ratio (MMR) of less than 70 per 100 000 live births by 2030. As the directing and coordinating authority for health within the United Nations (UN) system, the World Health Organization (WHO) is required to take a leadership position on addressing maternal health concerns.

(2) Responsibility for maternal health rests with the Department of Maternal, Newborn, Child and Adolescent Health at the WHO headquarters (HQ). In the Regional Office for South-East Asia (SEARO), this responsibility has been devolved to the Department of Family Health, Gender and Life Course. WHO proposes to achieve its goals through six core functions, which encompass the continuum between advice and effect.

(3) As a part of ongoing WHO reform processes, WHO has taken steps to introduce a culture of evaluation in the organization through an Evaluation Policy (2012) and establishment of an independent evaluation office. SEARO has commissioned the present evaluation as its first important exercise on its own, as also to help SEARO develop, on the basis of practical experience, a richer understanding of the principles and processes that will help WHO to build and nurture an evaluation culture in the Region. It is hoped that the evaluation will aid WHO to better target country needs in a manner that is both collaborative and timely, as well as for policy communities whose interests centre on supporting institutional capacity and knowledge transfer.

(4) Amaltas was invited to evaluate the contribution of WHO to improve maternal health in the South-East Asia (SEA) Region from 2010 to 2015. This evaluation reviewed progress particularly in five countries, namely Bangladesh, Indonesia, Myanmar, Nepal and Sri Lanka. Each country is at a different stage of the development trajectory and has quite different opportunities and challenges.

(5) The evaluation has the following objectives:

- understand the scope and diversity in maternal health responses by WHO;
- study the contribution of WHO to the policies, projects and practices in maternal health;
- ascertain strategies that yield good uptake by governments and local partners; and
- identify learning that can be applied to strengthen WHO's programme in the Region.

(6) Amaltas adopted a strengths-based evaluation approach to study the effectiveness of the WHO's contributions in the Region and ascertain the extent to which government policies/plans were influenced by the Organization. It assessed the contribution of WHO at the policy, programme and practices level in light of WHO's six core functions. In agreement with the WHO, Amaltas undertook a qualitative approach to data collection and analysis. Country-based consultants supported an intensive process that involved review of more than 300 documents and in-depth interviews, and discussions with more than 150 stakeholders in five countries. Likert scales were used to capture perceptions of stakeholders about the performance of core functions by WHO. A total of 99 responses were collected.

(7) Limitations of the methodology adopted for the evaluation include the post-hoc nature of the evaluation; difficulty in teasing out perception of WHO Country Office (WCO) staff on maternal health alone; and inability to capture long-term impact due to a focus on the period between 2010 and 2015.

Overall findings

(8) Progress in the past 15 years towards MDG 5 has been remarkable. Maternal deaths have fallen across the globe from more than half a million to 300 000. This has arguably been due to improvements in antenatal care (ANC) and skilled birth attendance (SBA). However, these are not yet universal. In addition, there is need to address considerable inequities in health care, malnourishment and maternal morbidity.

(9) The South-East Asia Region of WHO encompasses a population of 1.855 billion across 11 Member States. In 1990, the Region contributed more than 35% to the maternal mortality worldwide; today after engineering a reduction of more than 64%, its share of maternal mortality has fallen to about 23.5%. The Region has seen the greatest improvement in ANC4 and SBA coverage.

(10) Bangladesh, with a population of 160 million, has seen its MMR fall drastically by 70% between 1990 and 2010 despite deep poverty (30%). There is low use of SBA (42.0%) and ANC visits (ANC4=31.2%). A large proportion of pregnancies take place before the age of 18. Key priorities include encouraging use of SBA during delivery, addressing adolescent pregnancies, and ensuring better funding and management of the programme.

(11) Indonesia has a population of about 250 million. Decentralization has affected the functioning of central and peripheral levels of the health system evident in challenges to financial flows and health regulation. The country's health systems reforms aimed at achieving universal health coverage (UHC) by 2019 have contributed to high rates of SBA (83%) and ANC4 (88%). A key priority is ensuring a reduction in MMR, which continues to be high (190 per 100 000 live births) even by the most modest estimations. Other key areas include improving accountability of decentralized management, and ensuring availability of well-trained personnel at all levels of the health system.

(12) WHO has been a trusted partner in Myanmar with a population of 50 million. Although Myanmar has witnessed a steady decline in MMR (192), this statistic is disputed by the new Census 2014, which pegs it at 282. Key concerns include resolving the disparity in SBA across socioeconomic groups, addressing weak infrastructure and poor reach of health services, and limited implementation of evidence-based interventions for direct and indirect causes of mortality.

(13) Nepal, with a population of more than25 million, has witnessed a dramatic fall in MMR, from 850 in 1990 to 170 per 100 000 live births in 2011. But SBA attends only one in three deliveries, and half of all pregnant women receive ANC4. The focus areas identified by this study include expanding birthing care facilities, including all regions of Nepal, addressing nutritional problems typically associated with poor maternal outcomes and focusing on reproductive and maternity morbidities.

(14) Though Sri Lanka, with a population of 20 million, advanced to the MDG with an already low level of maternal mortality, the last five years have seen its MMR stagnate at 32 per 100 000 live births, which can be attributed to direct and indirect causes of mortality, unplanned pregnancies and high levels of caesarean section. Other key concerns include geographical, social and economic inequities in maternal health and nutritional problems among mothers.

(15) WHO has contributed substantively to improvements in maternal health in the Region through work executed jointly by HQ, SEARO and WCOs. Their assistance has sometimes been directed to the policy architecture of the countries, sometimes to programmes and at other times to practices adopted. Each level of the system has played a role and contributed to the perception held by countries, international and national development partners, and other stakeholders.

(16) Overall, it would be fair to say that WHO plays a critical role in setting norms and standards in the Region. Its leadership in health remains greatly anticipated, but sometimes unrealized. Still, great value is attached to its approval of policies, programmes and practices adopted in maternal health. The 2010–2015 period is short, especially to look for substantive influence in the maternal health area; nonetheless, instances were found where WHO had played a critical supporting role to each of the country governments.

Setting norms and standards

(17) WHO's work on setting norms and standards is widely valued by governments, development partners and other stakeholders in all the countries reviewed. WHO is seen to be the first point of reference in this regard.

(18) The efficiency of the process by which these norms and standards are produced and the time it takes to adapt global norms to regional and country specific contexts were seen as problematic in some settings. There was little evidence of systematic effort to track the extent and reach of dissemination of these important technical inputs. Country experience does not appear to inform the development of regional and global norms and guidance.

(19) Better tracking of the adoption of norms and standards by key target audiences is required to assess WHO's contribution to make real impact on the ground. This would also become a source of valuable feedback to governments, partners and other key stakeholders about the kinds of factors that inhibit or constrain adoption of sound public health policies.

(20) Recommendations are to put a system in place a system to track efficiency of adaptation, dissemination and pace and extent of adoption of norms and standards; and pursue opportunities to feed country experience into development of regional and global norms and guidance.

Providing technical support and building institutional capacity

(21) Ministries of Health in the countries continue to value and trust WHO's high quality technical advice and support from all levels of the Organization. The quality of technical support is dependent on staff's ability, availability and credibility. When suitable staff is not present, other partners fill the vacuum, creating the risks for the introduction of inconsistent or inappropriate advice.

(22) The time taken to respond to requests for advice is long and complex, may involve multiple directorates/categories and advice or input from all the three levels within WHO. The Organization is seen as being very closely embedded within the government and is a strong comparative advantage but it may constrain WCO's willingness to speak truth to power.

(23) WHO's support to building institutional capacity on the other hand, is less visible than it used to be. Supporting institutional capacity is different from supporting participation in national and international meetings, and exposing ministries of health officials to trends and issues in international health. In the past five years in these countries, capacity-building efforts have been sporadic; several training of trainers workshops have been supported through financial and/or technical assistance.

(24) Recommendations to WHO are to maintain the integrity and rigour of technical advice; pay the greatest attention to hiring and allocating its staff; and make expectations from WCO staff in the area of providing technical advice and building institutional capacity more explicit.

Shaping the research agenda

(25) To the extent that this role is played, it is carried out largely from WHO HQ and SEARO. There was no indication that global and regional research support is aligned with or informed by country needs/WCO's understanding.

(26) In some countries, some small-scale research studies are being financed including through resource mobilization. Several WCOs are supporting research studies, but not expressly shaping the country agenda on research in maternal health. Yet, there was no evidence of shaping a country level agenda of research; this is a missed opportunity.

(27) Recommendations include: make expectations of what WCOs are supposed to do on research more explicit; empower and animate WCO staff to inform global guidance through country-specific research; and ensure generation of country knowledge to concentrate global focus on overcoming implementation constraints.

Articulating policy options

(28) WHO's support on articulating ethical and evidence-based policy options is visible. SEARO is doing well in keeping WCO aware of latest policy trends, and communication between the Regional Office and WCOs in this regard seems up to date. The regional coordination mechanism enshrined in the memorandum of understanding between WHO, United Nations Children's Fund (UNICEF) and United Nations Population Fund (UNFPA) means that organizational cooperation at the country level is much smoother and less difficult to broker.

(29) Yet, the process of policy articulation is marked by inefficiency and delays. Sometimes the delay is in government processing, and sometimes governments and partners request a view on certain matters, but WHO response is not timely. The vacuum left by WHO is filled by other less technical partners, sometimes with risky results.

(30) Several examples of how evidence-based policies developed globally are being translated into country policies were identified. However, there were not many examples of these policies being validated through local experience or indeed, local experience being captured by the regional/global level to inform the global policy. WCOs are not being encouraged or facilitated to critically appraise and inform changes to global guidance.

(31) Recommendations are to: empower and encourage WCO staff to actively influence global guidance; and utilize the credibility and position of WHO to extend its support and reach to all actors in the health space.

Monitoring health situation and trends

(32) WHO supports efforts to harmonize core indicators at the global level. At the country level, staff participate in the design and discussions on the Demographic Health Survey and other critical health surveys. However, in several countries, this was felt to be mostly supportive rather than leading.

(33) Presently, the WCO's role is mostly as a consumer and not producer or synthesizer of data. This represents a missed opportunity as a number of country-based agencies are producing quite a large amount of relevant data. It was also not clear whether WCOs are staffed appropriately for data analysis, synthesis and visualization.

(34) Recommendations are to: ensure that the main messages of the Commission on Information and Accountability percolate to the country level with adequate attention to decreasing the load of data collection; utilize WHO's credibility and position to study the inputs of all actors in the health space; and to leverage their position to become an advisor on new ways of doing monitoring and new approaches to evaluate implementation.

Providing leadership on health

(35) Governments trust and value WHO as a neutral and evidence-based partner, which is likely to provide robust advice without meddlesome vested interests. Yet, WHO is not leveraging its technical capacity to lead partner efforts on health.

(36) It was quite evident that leadership is intimately connected to the availability of technically skilled, credible and experienced staff, and a few WCOs are perceived to have insufficiently experienced staff. Further, the absence of appropriate staff in position also has a debilitating effect on reputation.

(37) Recommendations include: leverage country knowledge and UN mandate to exert leadership of the health community; build common purpose with partners and ensure a coordinated approach; invest in country level relationships with a wide range of stakeholders; and ensure that country relationships are supported, to the extent possible, by global and regional dialogue.

Facilitators and challenges

(38) WHO's expertise and responsiveness to national level requests for technical support has built longstanding relationships and trust between WHO and its Member States. This strong reputation and credibility as an honest broker has clearly facilitated WHO's influence at the national and local levels. WHO's focus on its role as a generator and transmitter of knowledge is a strong advantage and it must think deeply about how to measure its achievements in this regard. WHO has the opportunity to use its strong country presence to sharpen the global focus on the gap between norms and standards and their application and use i.e. implementation.

(39) The main challenges to WHO's ability to deliver on its mandate are threefold:

- the number, technical skill and seniority of staff at the country level may constrain WHO's ability to cover all categories in all countries;
- the planning process tends to focus on listing activities in each category in each country, which leads to a diffusion of focus and perceptions of WHO being everywhere yet nowhere;
- supervisory and review mechanisms are multiple and primarily focused on completion of activities and expenditures, and lack a sharp focus of the contribution of sets of activities to a specific country level outcome or impact.

Recommendations

(40) Recommendations are presented keeping in mind the findings of the evaluation with regard to each core function in the maternal health space. It may be worthwhile for other departments of the Organization to consider these recommendations when carrying out a review of their own functioning:

- become more selective and pick the issues that will be the focus of efforts in select countries based on an analysis of the situation and opportunities that pertain;
- become the voice of the countries to support the articulation of an appropriate direction for domestic and international financing of health care;
- become the voice of country implementers to highlight constraints in country health systems and help to address them through collaboration between reproductive, maternal, newborn, child and adolescent health (RMNCAH) and health systems departments in WHO;
- become a source of feedback and become more deliberate in providing feedback from country to the global level.

Chapter I: Introduction

In the 21st century, health is a shared responsibility requiring equitable access to essential care and collective defence against transnational threats. The World Health Organization (WHO) is the directing and coordinating authority for health within the United Nations (UN) system. The Millennium Development Goals (MDGs) are a UN initiative ratified in 2000 to establish a blueprint for tackling the most pressing development challenges across the globe.[1] Maternal health finds a place in the list of most pressing problems: MDG 5 aims to improve maternal health with targets of reducing maternal mortality by 75% and achieving universal access to reproductive health by 2015. WHO supports countries to deliver integrated, evidence-based and cost-effective care for mothers and babies that begins before conception and goes through pregnancy, childbirth and the postpartum period.

More recently, in September 2010, the UN Secretary-General announced the Global Strategy for Women's and Children's Health, which aims to prevent 33 million unwanted pregnancies between 2011 and 2015 and save the lives of women who are at risk of dying of complications during pregnancy and childbirth, including unsafe abortion.[2] This Global Strategy calls on all stakeholders to work together to save the lives of 16 million women and children by 2015. The effort was created to spur commitments to policies and programmes that address major health issues facing women and children. Every Woman Every Child is an unprecedented global movement that mobilizes and intensifies international and national action by governments, multilaterals, the private sector and civil society to address the major health challenges facing women and children. In the words of the UN Secretary-General Ban Ki-moon,

> *"The global mobilization behind the Millennium Development Goals has produced the most successful anti-poverty movement in history. … By putting people and their immediate needs at the forefront, the MDGs [have] reshaped decision-making in developed and developing countries alike."*[3]

The Sustainable Development Goals (SDGs) adopted at the Special UN session on sustainable development in September 2015 propose a broad transformational development agenda. Maternal health continues to have a place in the new goals through SDG 3 with the target to reduce the global maternal mortality ratio (MMR) to less than 70 per 100 000 live births by 2030.[4] The Global Financing Facility, launched in 2015 brings together stakeholders under the leadership of national governments, to provide financing to accelerate such efforts to end preventable maternal, newborn, child and adolescent deaths by 2030.[5]

The South-East Asia Region

Home to a quarter of the world population, the South-East Asia (SEA) Region contributed to 35.5% of maternal mortality worldwide in 1990.[6] During the past 25 years, the SEA Region has experienced a remarkable decline in maternal mortality – a commitment made to achieve the MDG 5. Although some countries did not achieve their self-declared targets for MDG 5, all have shown considerable progress.

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1 United Nations.(2014). The Millennium Development Goals Report 2014. UN. Available at: http://www.who.int/topics/millennium_development_goals/maternal_health/en/ (Accessed on 2 November 2015).

2 World Health Organization.(2015). MDG-Improve Maternal Health. WHO. Available at: http://www.who.int/topics/millennium_development_goals/maternal_health/en/ (Accessed on 2 November 2015).

3 United Nations. (2015). The Millennium Development Goals Report 2015. United Nations. Available at: http://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20Summary%20web_english.pdf (Accessed on 2 November 2015).

4 United Nations.(2015). Goal 3: Ensure healthy lives and promote well-being for all at all ages. Available at: http://www.un.org/sustainabledevelopment/health/ (Accessed on 4 November 2015)

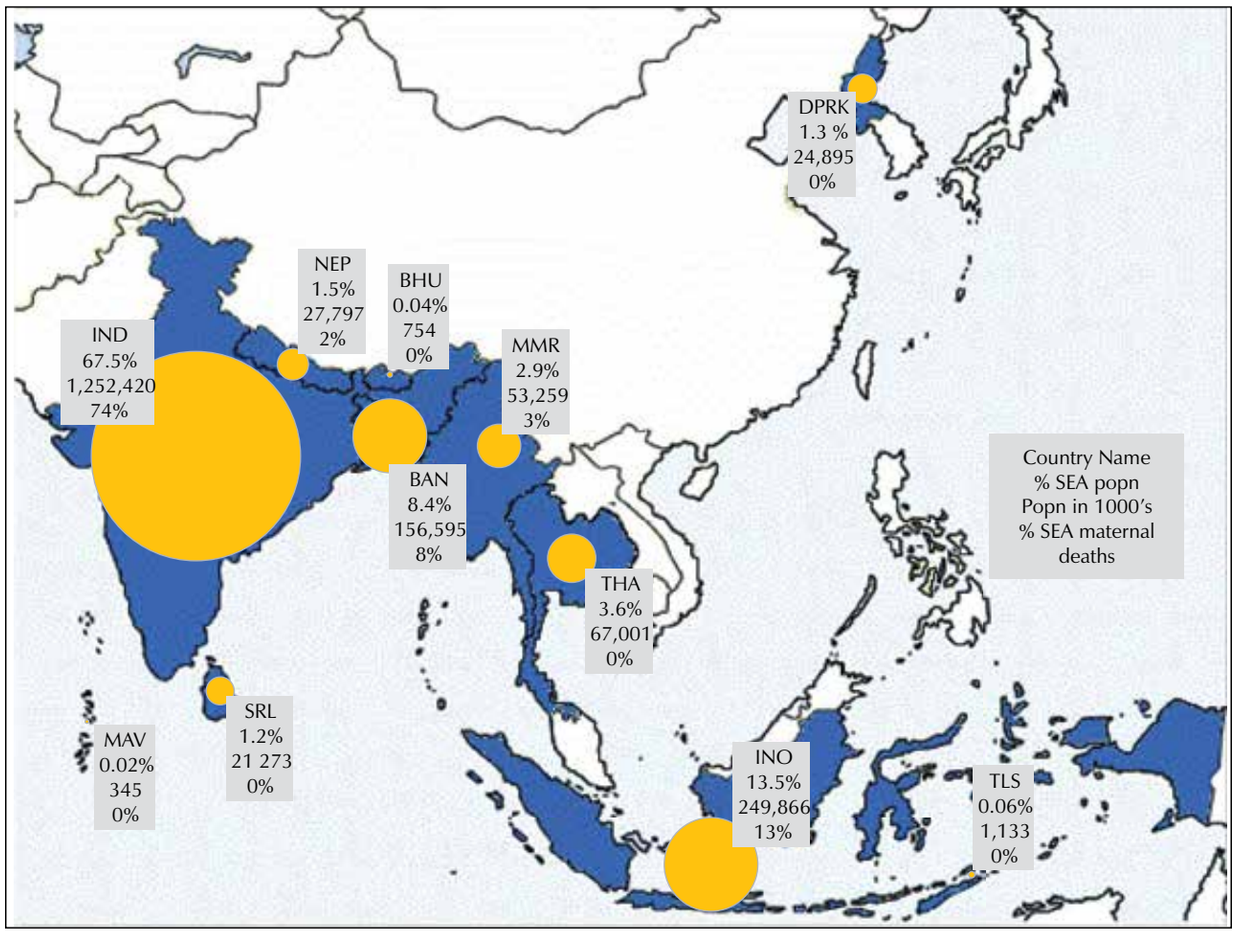
5 The World Bank. (2015). Global Financing Facility in Support of Every Woman Every Child. WB. Available at: http://www.worldbank.org/en/topic/health/brief/global-financing-facility-in-support-of-every-woman-every-child (Accessed on 5 November 2015)

6 WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division. (2015). Sexual and Reproductive Health: Trends in Maternal Mortality: 1990 to 2013, Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division. Available at: http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2013/en/ (Accessed on 6 November 2015).

Today, the Region contributes 23.5% of the globe's maternal mortality, a testimony to the remarkable rate of decline that the Region as a whole has been able to achieve.[7]

The term South-East Asia coined by the Indian historian K.M Pannikar was initially recognized as a separate geographical entity due to strategic and military considerations during the Second World War.[8] The SEA Region of WHO has 11 Member States spanning longitudes 68°7'E and 125°55'E. Member States include Bangladesh (BAN), Bhutan (BHU), Democratic People's Republic of Korea (DPRK), India (IND), Indonesia (INO), Maldives (MAV), Myanmar (MMR), Nepal (NEP), Sri Lanka (SRL), Thailand (THA) and Timor-Leste (TLS) (see exhibit 1). There is great variation among the countries with regard to degree of development, resources, burden of disease and health systems response.

Exhibit 1: *Population and maternal deaths, SEA Region*



Source: *From* Achieving the Health-related Millennium Development Goals in the South East Asia Region: Measuring Indicators 2014. Regional Office for South East Asia, World Health Organization. 2014.

The total population of the SEA Region is 1.855 billion, second only to the Western Pacific Region (1.857 billion), which includes China. There are three distinct categories of countries in the SEA Region with regard to population, namely large, medium and very small. Countries such as Bangladesh, India and Indonesia lie on one end of the spectrum with over 89% of the Region's population (see exhibit 1). At the other end, Bhutan, Maldives and Timor-Leste fall in the very small population category, accounting for less

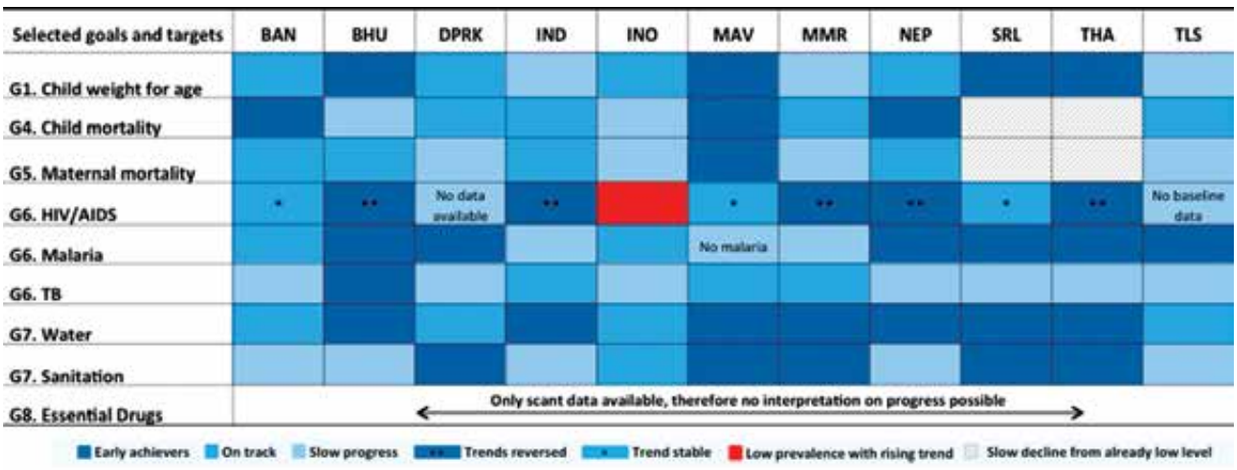
7 WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division. (2015). Sexual and Reproductive Health: Trends in Maternal Mortality: 1990 to 2013, Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division. Available at: http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2013/en/ (Accessed on 6 November 2015)

8 Regional Office for South-East Asia, World Health Organization. (2015). History of the WHO South-East Asia Region. SEARO. Available at: http://www.searo.who.int/about/history/en/ (Accessed on 9 September 2015).

than 1% of the total. The remaining 10% of population lives in medium category countries that include Democratic People's Republic of Korea, Myanmar, Nepal, Thailand and Sri Lanka. India is the Region's largest country and it disproportionately accounts for 67.5% of the Region's total population.[9]

Progress towards the MDGs in the Region has been mixed. That some countries have made faster progress than others can be seen from this scorecard from the 2014 WHO report on Achieving the Health-related Millennium Development Goals in the South-East Asia Region.[10]

Exhibit 2: *Scoreboard of progress towards health-related MDGs, SEA Region*



Source: From Achieving the Health-related Millennium Development Goals in the South-East Asia Region: Measuring Indicators 2014. Regional Office for South-East Asia, World Health Organization. 2014.

Maternal health in the SEA Region

Maternal health is ranked as the 21st highest cause of disease burden by the Global Burden of Disease study.[11] This seemingly low rank does not reflect the large impact of maternal mortality on the infant and family health and productivity.

Globally, progress towards reducing maternal deaths is substantial. According to the recently released Trends in Maternal Mortality: 1990–2015, global MMR has fallen from 385 in 1990 to 216 in 2015 and absolute maternal deaths from 532 000 in 1990 to 303 000 in 2015, falling by about 43%.[12] About two thirds of pregnant women (64%) had four or more visits for antenatal care, and the proportion of births attended by skilled personnel is above 90% in three of the six WHO regions.[13] An estimated global total of 13.6 million women have died in the past 25 years between 1990 and 2015 due to maternal causes. It is expected that in the next 15 years, maternal deaths will be less than half of this number.[14]

9 World Health Organization Regional Office for South-East Asia. Improving Maternal, Newborn and Child Health in the South-East Asia Region. SEARO. Available at: http://www.searo.who.int/entity/maternal_reproductive_health/documents/SEA-MCH-228/en/ (Accessed on 5 November 2015)

10 Regional Office for South-East Asia, World Health Organization. (2014). Achieving the Health-related Millennium Development Goals in the South-East Asia Region: Measuring Indicators 2014. Available at: http://www.searo.who.int/entity/health_situation_trends/data/mdg/mdg_2014_analytical_kit.pdf(Accessed on 08 November 2015)

11 Bulusawar et.al. (2014). R. 50 Breakthroughs: Critical scientific and technological advances needed for sustainable global development. Institute for Globally Transformative Technologies at the Lawrence Berkeley National Lab. Available at: https://ligtt.org/sites/all/files/page/50BTs-Consolidated.pdf (Accessed on 2 November 2015).

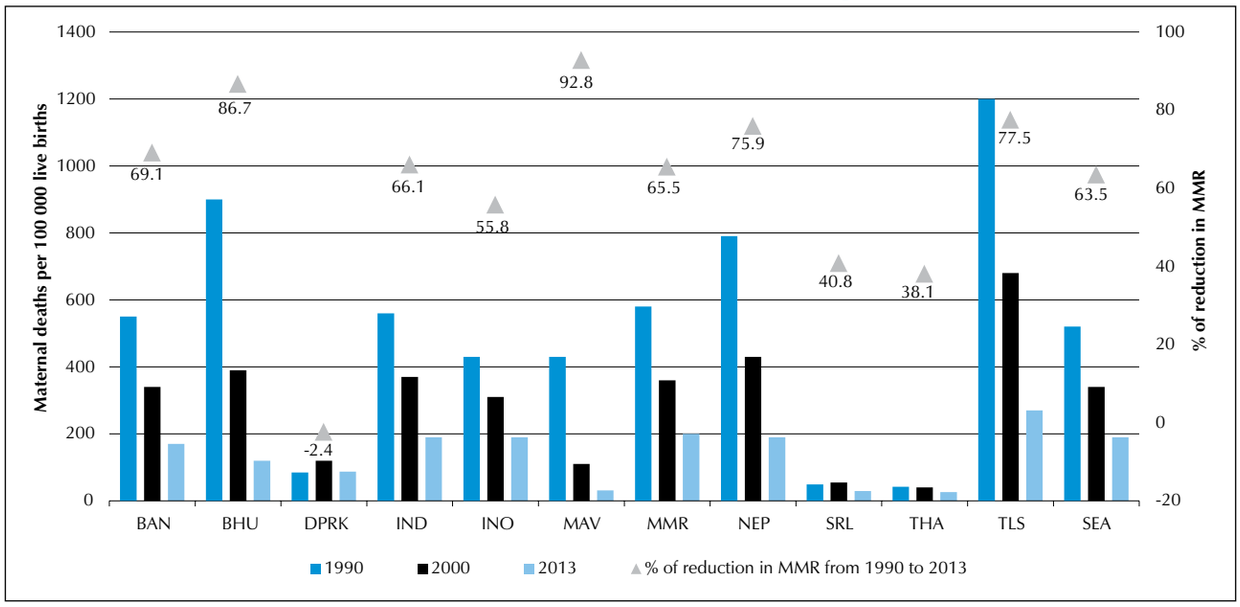
12 WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division. (2015). Trends in Maternal Mortality: 1990 to 2013, Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division. Available at: http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf?ua=1 (Accessed on 6 November 2015).

13 World Health Organization. (2015). Media Centre: Millennium Development Goals (MDGs). WHO. http://www.who.int/mediacentre/factsheets/fs290/en/ (Accessed on 2 November 2015).

14 World Health Organization. (2015). Sexual and reproductive health. WHO. Available at: http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2015/en/ (Accessed on 4 November 2015).

The SEA Region has a significant burden of maternal mortality and morbidity relative to the other five WHO regions. However, it has also experienced the greatest decline in MMR (64%) between 1990 and 2013, compared with the global decline of 45%.[15], [16] (See exhibit 3). While the progress is notable, the annual rate of decline is less than that needed to achieve the MDG target requiring an annual decline of 5.5%. At 4.4%, the SEA Region falls short of this goal.[17]

Exhibit 3: *Maternal mortality ratio, SEA Region*



Source: From MDG5 progress in the SEA Region. Presentation by Dr N Raina. Regional Meeting 01, SEARO. August 2015.

Discussing progress on maternal health through the lens of a single indicator provides only a one-dimensional view. For instance, MMR fails to capture reductions in maternal mortality attributable to declining fertility. In India, for example, declining fertility rates are expected to bring childbirth down from 27 million to 24 million, directly accounting for a 9% fall in maternal deaths.[18]

The six major causes of maternal deaths are haemorrhage, hypertensive disorders, sepsis, unsafe abortion, indirect causes and other direct causes are responsible for these deaths.[19] (See exhibit 4.) The SEA Region contributes approximately one third of an estimated 166 000 maternal deaths from haemorrhage each year.[20] Increasingly however, indirect medical conditions that exist before pregnancy and are exacerbated during pregnancy contribute to maternal deaths. In developing countries, these conditions are mostly unknown, partly due to large numbers of unreported pregnancies and partly because of inadequate diagnostic capabilities, and lack of data on vital events, including stillbirth and causes of death. Further, indirect causes such as Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome (HIV/ AIDS) are under-represented due to data constraints.[21]

15 World Health Organization. (2015). World Health Statistics 2015: Part I Health-related Millennium Development Goals. WHO. Available at: http://www.who.int/gho/publications/world_health_statistics/EN_WHS2015_Part1.pdf?ua=1(Accessed on 5 November 2015).

16 WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division.(2015). Sexual and Reproductive Health: Trends in Maternal Mortality: 1990 to 2013, Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division. Available at: http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2013/en/ (Accessed on 4 November 2015).

17 World Health Organization. (2015). World Health Statistics 2015: Part II Global health indicators. WHO. Available at: http://www.who.int/gho/publications/world_health_statistics/EN_WHS2015_Part2.pdf?ua=1 (Accessed on 5 November 2015).

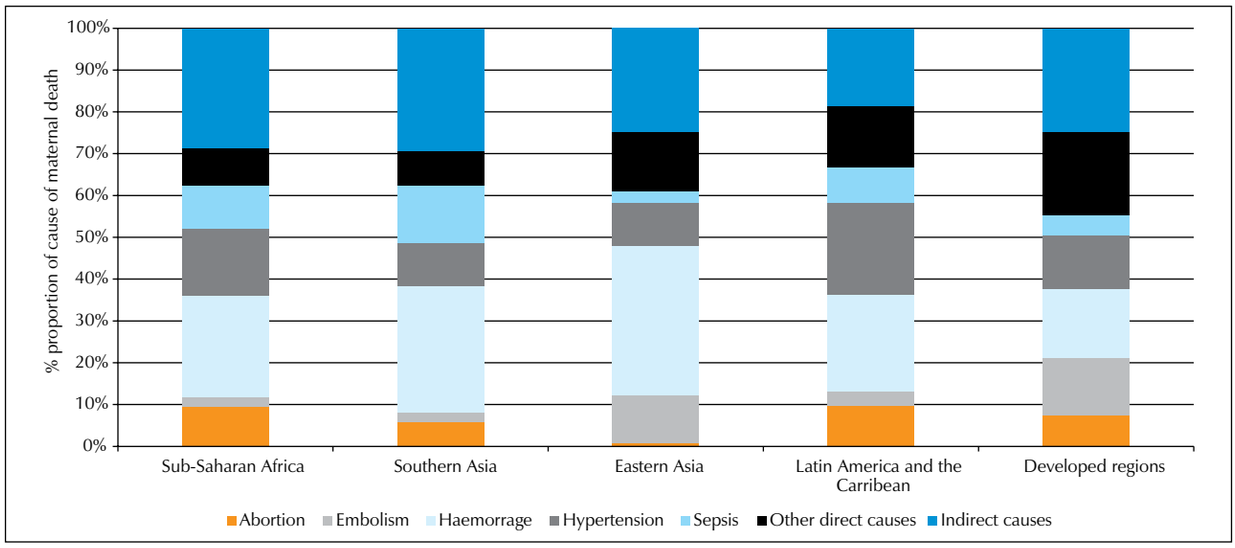
18 Ronsmans C, Graham J W. (2006). Maternal mortality: who, when, where, and why. Lancet. Available at: http://www.thelancet.com/journals/lancet/article/PIIS014067360669380X/fulltext (Accessed on 3 November 2015)

19 Bulusawar et.al. (2014). R. 50 Breakthroughs: Critical scientific and technological advances needed for sustainable global development. Institute for Globally Transformative Technologies at the Lawrence Berkeley National Lab. Available at: https://ligtt.org/sites/all/files/page/50BTs-Consolidated.pdf (Accessed on 2 November 2015).

20 Ronsmans C, Graham J W. (2006). Maternal mortality: who, when, where, and why. Lancet. Available at: http://www.thelancet.com/journals/lancet/article/PIIS014067360669380X/fulltext (Accessed on 3 November 2015)

21 Ronsmans C, Graham J W. (2006). Maternal mortality: who, when, where, and why. Lancet. Available at: http://www.thelancet.com/journals/lancet/article/PIIS014067360669380X/fulltext (Accessed on 3 November 2015)

Exhibit 4: *Causes of maternal deaths, SEA Region*



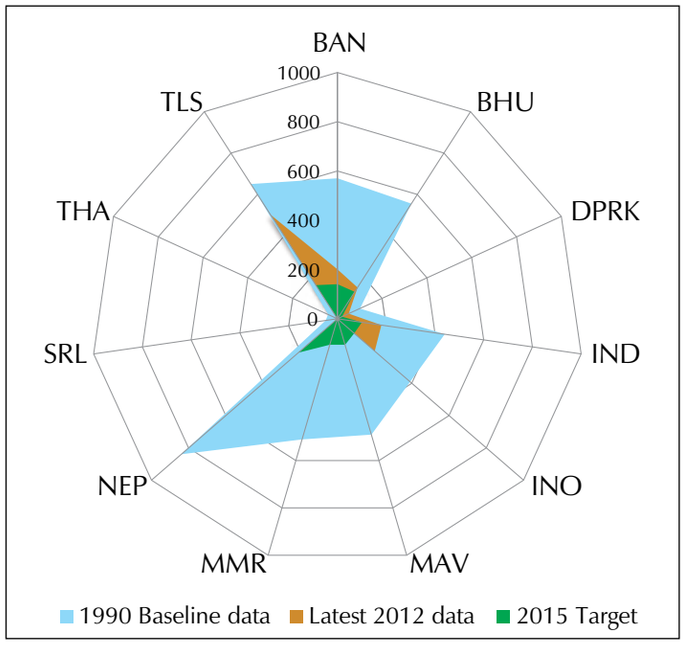
Source: Adapted from Maternal mortality: who, when, where, and why. Ronsmans C, Graham J W. Lancet. 2006.

Current challenges in maternal health

The unfinished agenda of MDG5 dominates much of the international literature on challenges to maternal health.[22] Provided below is a brief discussion of these challenges, as they have relevance to findings of this report.

Skilled birth attendance In developing countries, more than half of the childbirths take place at home with the assistance of traditional birth attendants (TBA). Early attempts to skill up TBAs did not yield the gains expected.[23] It is now postulated that if pregnant women had access to skilled birth attendants (SBA) during childbirth, such as a doctor, nurse or midwife, most obstetric complications could be prevented or managed. The positive impact of increasing SBA coverage is illustrated by the reciprocal relationship between MMR and SBA (see exhibit 6).

Exhibit 5: *Maternal mortality ratio, SEA Region*



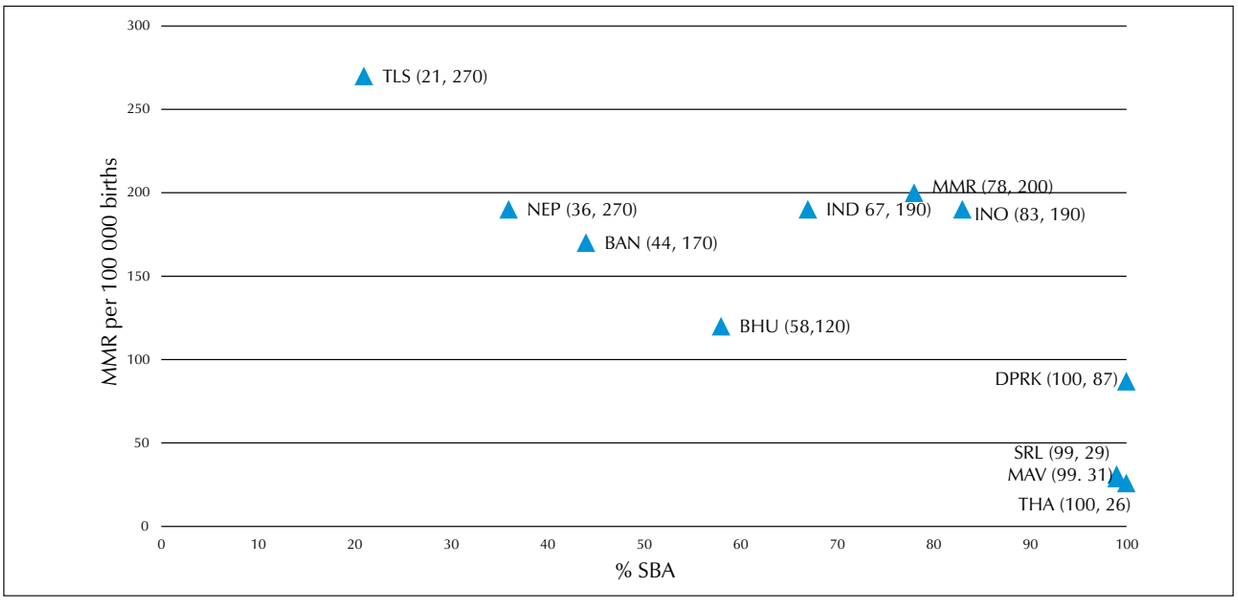
Source: World Health Organization. (2015). World Health Statistics 2015: Part II Global health indicators. WHO. Available at: http://www.who.int/gho/publications/world_health_statistics/EN_WHS2015_Part2.pdf?ua=1 (Accessed on 5 November 2015).

22 Regional Office for South-East Asia, World Health Organization. (2014). Achieving the Health-related Millennium Development Goals in the South-East Asia Region: Measuring Indicators 2014. Available at: http://www.searo.who.int/entity/health_situation_trends/data/mdg/mdg_2014_analytical_kit.pdf (Accessed on 8 November 2015)

23 Bulusawar et. all. (2014). R. 50 Breakthroughs: Critical scientific and technological advances needed for sustainable global development. Institute for Globally Transformative Technologies at the Lawrence Berkeley National Lab. Available at: https://ligtt.org/sites/all/files/page/50BTs-Consolidated.pdf (Accessed on 2 November 2015).

In the SEA Region between 2007 and 2014, 68% of births were attended by skilled health personnel compared with 74% globally. The Region has however, the highest improvements in SBA coverage among all regions. Improvements in MMR between 1990 and 2013 can therefore be partially attributed to improvements in the coverage of SBA.

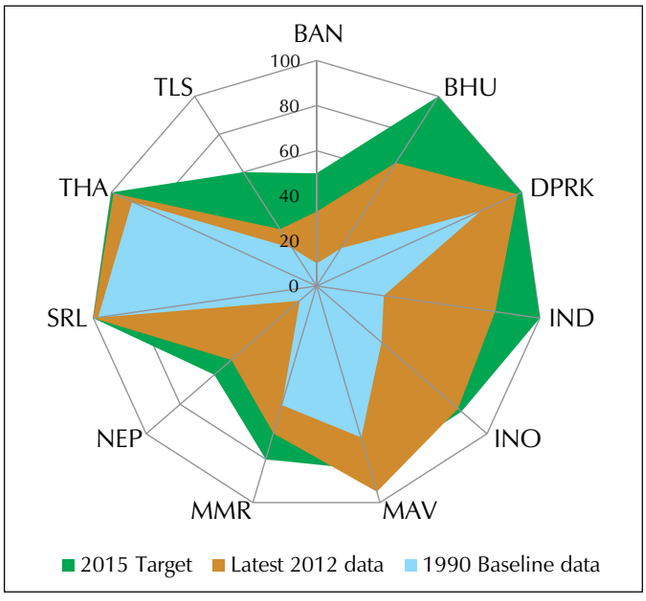
Exhibit 6: *Correlation between MMR and SBA, SEA Region*



Source: From MDG5 progress in SEA Region. Presentation by Dr N Raina. Regional Meeting 01, SEARO. August 2015.

At the country level, Maldives is the only country in the Region to achieve and exceed its 2015 target before time (see exhibit 7). Five other countries in the Region namely the Democratic People's Republic of Korea, India, Indonesia, Sri Lanka and Thailand are on track to achieve their country set targets by 2015, provided that they continue to progress at their current rates. The remaining five countries (Bangladesh, Bhutan, Myanmar, Nepal and Timor-Leste) have made slow progress with respect to improving the coverage of skilled health personnel at birth. To ensure that these countries achieve their set targets, they need to strengthen efforts to accelerate the progress and close the gaps between the 2015 targets and the anticipated progress at the current rate.[24]

Exhibit 7: *Births attended by skilled health personnel, SEA Region*



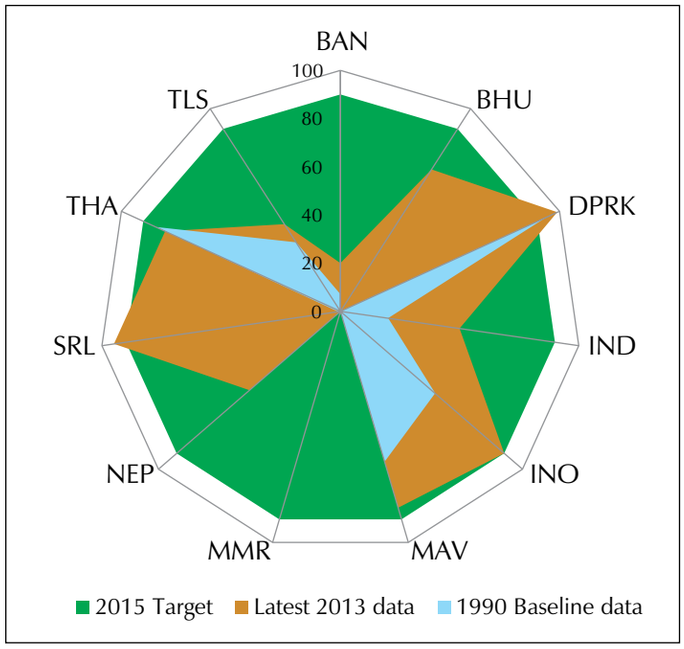
Source: World Health Organization. (2015). World Health Statistics 2015: Part II Global health indicators. WHO. Available at: http://www.who.int/gho/publications/world_health_statistics/EN_WHS2015_Part2.pdf?ua=1 (Accessed on 5 November 2015).

24 Regional Office for South-East Asia, World Health Organization. (2015). Health Situation and Trend Assessment: MDG 5: maternal and reproductive health. SEARO. Available at: http://www.searo.who.int/entity/health_situation_trends/data/mdg/anc_1/en/ (Accessed on 9 September 2015).

Antenatal care (ANC) Coverage with ANC is another important progress marker of maternal health care. Two countries (Sri Lanka and Democratic People's Republic of Korea) have already achieved and exceeded their 2015 antenatal care with at least four visits (ANC4) target of 90%.[25] Additionally, six others have made substantial progress i.e. they are at least halfway to achieving the ANC4 target. These countries include Bhutan, India, Indonesia, Maldives, Nepal and Thailand. Bangladesh and Timor-Leste are the remaining two countries that have made slow progress and are still below 50% coverage of ANC4.[26] Little information is available on the quality of ANC.

Interestingly, coverage with one antenatal care visit (ANC1:77%, 2007–2014) in the SEA Region was below the global average of 83%.[27],[28] However, the coverage with four antenatal care visits (ANC4: 70%, 2007–2014) was ahead of the 64% global average.[29],[30]

Exhibit 8: *Antenatal care coverage with at least four visits, SEA Region*



Source: World Health Organization. (2015). World Health Statistics 2015: Part II Global health indicators. WHO. Available at: http://www.who.int/gho/publications/world_health_statistics/EN_WHS2015_Part2.pdf?ua=1 (Accessed on 5 November 2015).

Three new areas of concern are gradually emerging; one relating to maternal morbidity, another to maternal nutrition and the third to inequities across social groups, geographies and other key demographic factors. A common view is that much of the remaining agenda requires multisectoral action and cannot be effectively addressed by the health sector alone. The importance of including the private sector is also becoming more apparent as the last mile approaches.

25 Regional Office for South-East Asia, World Health Organization. (2015). Health Situation and Trend Assessment: MDG 5: maternal and reproductive health. SEARO. Available at: http://www.searo.who.int/entity/health_situation_trends/data/mdg/anc_1/en/ (Accessed on 9 September 2015).

26 Regional Office for South-East Asia, World Health Organization. (2015). Health Situation and Trend Assessment: MDG 5: maternal and reproductive health. SEARO. Available at: http://www.searo.who.int/entity/health_situation_trends/data/mdg/anc_1/en/ (Accessed on 9 September 2015).

27 World Health Organization. (2015). World Health Statistics 2015: Part II Global health indicators. WHO. Available at: http://www.who.int/gho/publications/world_health_statistics/EN_WHS2015_Part2.pdf?ua=1 (Accessed on 5 November 2015).

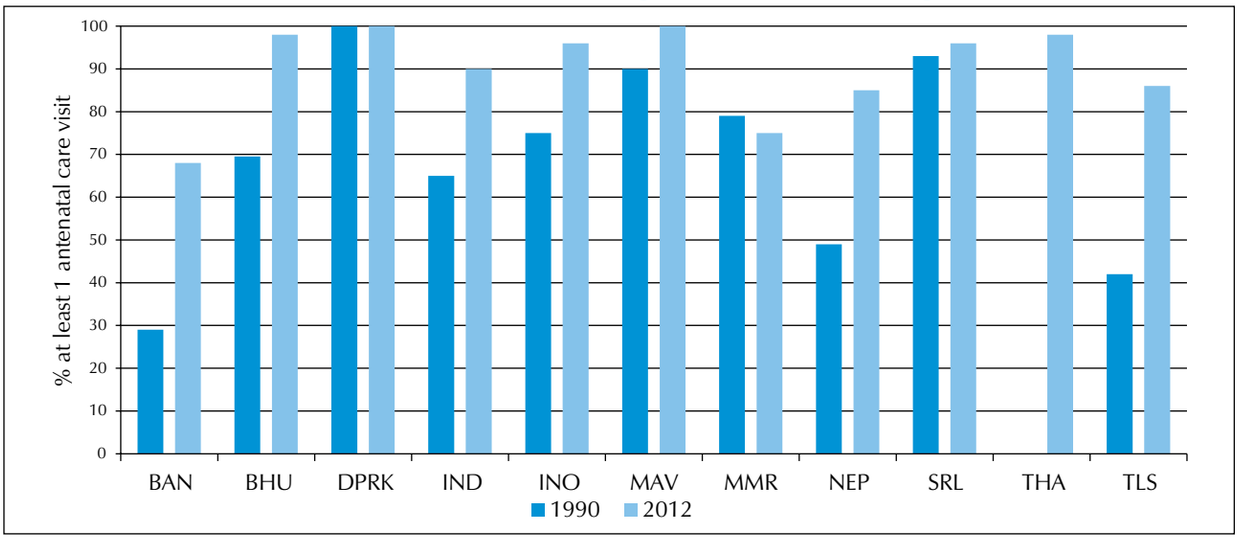
28 World Health Organization. (2015). World Health Statistics 2015: Part II Global health indicators. WHO. Available at: http://www.who.int/gho/publications/world_health_statistics/EN_WHS2015_Part2.pdf?ua=1 (Accessed on 5 November 2015).

29 World Health Organization. (2015). World Health Statistics 2015: Part II Global health indicators. WHO. Available at: http://www.who.int/gho/publications/world_health_statistics/EN_WHS2015_Part2.pdf?ua=1 (Accessed on 5 November 2015).

30 World Health Organization. (2015). World Health Statistics 2015: Part II Global health indicators. WHO. Available at: http://www.who.int/gho/publications/world_health_statistics/EN_WHS2015_Part2.pdf?ua=1 (Accessed on 5 November 2015).

Maternal morbidity It is increasingly been recognized that maternal mortality represents only a small proportion of the burden of ill-health that women carry due to pregnancy and delivery. Each maternal death overshadows the burden of chronic morbidity and disability that women aged 20–30 years will carry the rest of their lives. This burden disproportionately affects women living in low- and middle-income countries. In 2011, the WHO published guidelines to record the most severe forms of such morbidity in the form of a maternal near miss, defined as "the near death of a woman who has survived a complication occurring during pregnancy or childbirth or within 42 days of the termination of pregnancy".[31,32]

Exhibit 9: *Antenatal care coverage with one visit, SEA Region*



Source: From Health Situation and Trend Assessment: Antenatal care coverage (at least one visit). World Health Organization Regional Office of South-East Asia. 2015.

Malnourishment Malnutrition in expectant mothers is another challenge in improving maternal health and can result in severe delivery complications and preterm births. It is estimated that a significant proportion of pregnant women in developing countries are undernourished or stunted, with approximately 50% of pregnant women in developing countries suffering from anaemia.[33] Further, the SEA Region has the highest prevalence (42%) of anaemia among women aged 15–49 years compared with 17% in the Region of the Americas and 29% globally.[34]

31 World Health Organization. (2015). Bulletin of the World Health Organization: Measuring Maternal Health, focus on maternal morbidity. WHO. Available at: http://www.who.int/bulletin/volumes/91/10/13-117564/en/ (Accessed on 3 November 2015).

32 Koblinsky et al. (2012). Maternal Morbidity and Disability and Their Consequences: Neglected Agenda in Maternal Health. JHPN, ICDDR,B. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3397324/ (Accessed on 3 November 2015).

33 Bulusawar et. al. (2014). R. 50 Breakthroughs: Critical scientific and technological advances needed for sustainable global development. Institute for Globally Transformative Technologies at the Lawrence Berkeley National Lab. Available at: https://ligtt.org/sites/all/files/page/50BTs-Consolidated.pdf (Accessed on 2 November 2015).

34 World Health Organization. (2015). World Health Statistics 2015: Part II Global health indicators. WHO. Available at: http://www.who.int/gho/publications/world_health_statistics/EN_WHS2015_Part2.pdf?ua=1 (Accessed on 5 November 2015).

Health inequity Health inequities between population subgroups and within countries are apparent through key maternal health indicators.[35,36] Strikingly, WHO has reported that the MMR in developing regions was 14 times higher than that in developed regions, and that the risk of a woman in a developing country dying from a maternal-related cause during her lifetime is about 23 times higher compared with a woman living in a developed country. [37,38] Of all the maternal deaths, the vast majority (99%) occur in low-resource settings and most could have been prevented.[39] Data on process indicators such as SBA, ANC1 and ANC4 confirm the alarming disparities between social groups within countries.

As the world moves beyond the MDGs, Secretary-General Ban Ki-moon reminds us that

> *"… inequalities persist and that progress has been uneven. The world's poor remain overwhelmingly concentrated in some parts of the world. … Too many women continue to die during pregnancy or from childbirth-related complications. Progress tends to bypass women and those who are lowest on the economic ladder or are disadvantaged because of their age, disability or ethnicity. Disparities between rural and urban areas remain pronounced".*[40]

Addressing these disparities is the unfinished agenda for the post-2015 period.

35 WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division.(2015). Sexual and Reproductive Health: Trends in Maternal Mortality: 1990 to 2013, Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division. Available at: http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2013/en/ (Accessed on on 3 November 2015)

36 World Health Organization. (2015). World Health Statistics 2015: Part II Global health indicators. WHO. Available at: http://www.who.int/gho/publications/world_health_statistics/EN_WHS2015_Part2.pdf?ua=1 (Accessed on 5 November 2015).

37 WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division.(2015). Sexual and Reproductive Health: Trends in Maternal Mortality: 1990 to 2013, Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division. Available at: http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2013/en/ (Accessed on 2 November 2015).

38 WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division.(2015). Sexual and Reproductive Health: Trends in Maternal Mortality: 1990 to 2013, Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division. Available at: http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2013/en/ (Accessed on 2 November 2015).

39 World Health Organization. (2015). Media centre: Maternal Mortality. WHO. Available at: http://www.who.int/mediacentre/factsheets/fs348/en/ (Accessed on 9 September 2015).

40 United Nations. (2015). The Millennium Development Goals Report 2015. UN. Available at: http://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20Summary%20web_english.pdf (Accessed on 4 November 2015).

Chapter II: The evaluation process

The Executive Board of WHO has recently taken steps to introduce a culture of evaluation in the organization. In May 2012, WHO approved an evaluation policy and established an independent evaluation office to frame and support evaluation work. The office's aim is to strengthen evaluation and organizational learning in support of ongoing WHO reform processes.[41]

In her vision statement for the SEA Region, Regional Director, Dr Poonam Khetrapal Singh, emphasized the need to "… augment the capacities of all Member States so that our Region is recognized for its intellectual vigour and evidence-based decision-making".[42] This regional focus further complements the salience of the evaluation effort in the SEA Region. Evaluation work in WHO Regional Office for South-East Asia (SEARO) is housed in Programme, Planning and Coordination unit under the office of the Director Programme Management.

SEARO's work towards building an evaluation culture started with the implementation of several preparatory activities. These include the development of a biennial workplan for evaluation 2014–2015 and a survey of senior staff on various aspects of evaluation. In addition, SEARO commissioned the present evaluation, an important first exercise on its own account, as also to help SEARO develop a richer understanding of the principles and processes that will help to build and nurture an evaluation culture in the Region. Maternal health was selected as the subject of inquiry because of the salience of the topic to development of the Region's flagship focus on maternal health and its potential contribution to regional impact. Measurability of the topics and potential utility of the evaluation to inform course corrections were also considered in selecting the topic.

Purpose of the evaluation

The overall objective of this evaluation is to understand the contribution of WHO to maternal health improvements in the SEA Region from 2010 to 2015. In particular, this evaluation reviews the progress in five countries: Bangladesh, Indonesia, Myanmar, Nepal and Sri Lanka to understand the scope and diversity in maternal health responses by WHO in the Region.[43]

Each of the countries has followed a different path to improving maternal health, and has faced different challenges in their trajectories. An independent examination of their efforts may therefore provide lessons applicable to other countries in the Region, and indeed, to other efforts within the Organization. In light of the mixed results for MDG5 across the Region, the evaluation seeks to identify the actions required for accelerated and sustained reduction in maternal mortality in the future. The evaluation will aid WHO to better target country needs in a manner that is both collaborative and timely.

The evaluation assesses the contribution of WHO at the policy, programme and practices levels in light of WHO's six core functions (See exhibit 10).[44] The evaluation uses a strengths-based approach to study the effectiveness of the WHO's contributions in the Region and ascertain the extent to which government policies/plans were influenced by the Organization. Based on learning from the evaluation, recommendations that are practical and aligned to the WHO's overall maternal health goals have been made.

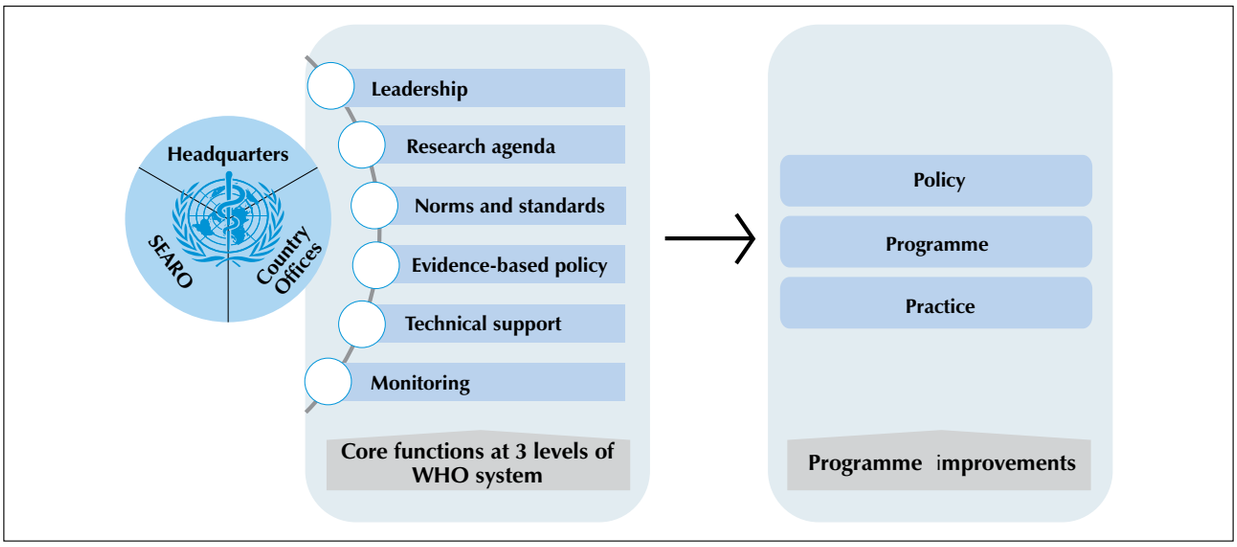
41 World Health Organization. (2015). About WHO: Achievements of WHO reform. WHO. Available at: http://www.who.int/about/who_reform/achievements/en/ (Accessed on 3 November 2015).

42 Regional Office for South-East Asia. World Health Organization. (2015). Healthier WHO South-East Asia Region; responsive Regional Office. SEARO. Available at: http://www.searo.who.int/mediacentre/features/2014/rd-singh-vision/en/ (Accessed on 4 November 2015).

43 World Health Organization. (2015). Agreement of Performance of Work between WHO/SEARO and Amaltas Consulting Private Limited . Document shared by Dr Tawhid Nawaz, Director Department of Programme Management on 8 May 2015.

44 World Health Organization. (2013).Report of the Taskforce on the roles and functions of the three levels of WHO. Available at: http://www.who.int/about/who_reform/task_force_report_three_levels_who_2013.pdf (Accessed on 5 November 2015).

Exhibit 10: *Evaluation Framework*



Evaluation methodology

The mandate of this evaluation is to understand how and what WHO has contributed to the maternal health trajectory in the Region; it does not aim to describe the trajectory itself. Unlike research, which often relies on repeated observations and where comparability of responses is an important marker, this evaluation followed a more evolutionary approach to data collection. An Information Needs Matrix was developed to guide the work of the evaluators and can be found at Annex I. For the purpose of this evaluation, the scope of maternal health is limited to a woman's pregnancy, childbirth and post-childbirth care of the mother up to 42 days after birth.

The work involved was person-intensive, involving country visits, discussions and interviews with a range of stakeholders at practice, programme and policy levels, as well as extensive document collection, analysis and review. The evaluation design recognizes that multiple stakeholders are involved in the advancement of maternal health in the SEA Region. Therefore, primary qualitative data was collected through in-depth interviews with a variety of interlocutors such as government officials, staff of government and nongovernment institutions, WHO and development partners. To sift the differing points of view, data collected through in-depth interviews was triangulated and cross-validated with other stakeholders, as well as with any relevant quantitative data. Preliminary information was collected through a questionnaire, which allowed WHO Country Office (WCO) focal points on maternal health to provide information on the scope and nature of interventions in their respective countries of the Region.

Extensive documentation was collected through the course of the evaluation. To understand the situation of maternal health in the Region, documents were systematically reviewed to further analyse secondary quantitative and qualitative data. In addition, each country study included quantitative analysis of secondary data.

Quantification of qualitative perceptions by various stakeholders regarding WHO's work is captured through the use of Likert scales. The Likert Scale ranged from 1 (does not perform the function) through 5 (exceeds expectations). A score of 3 on the Likert Scale indicates that the function was performed to expectations. Likert scores were sought from WHO staff and other stakeholders. Except for where indicated, scores provided by WHO staff have not been included in the analysis.

Target audience and use

The results of the evaluation identify gaps and opportunities in the performance of the six core functions in WHO as a way to build upon knowledge, relationships and capacities built by the Organization and inform its priorities and strategies. The primary users of this evaluation will be the three levels of the WHO system:

WHO country offices of the five countries included in this evaluation; Regional Office for South-East Asia; and WHO headquarters. In addition, the evaluation findings may also be of relevance to other country offices and regions of WHO, and policy communities whose interests centre on supporting institutional capacity and knowledge transfer.

The evaluators

The external evaluation was carried out by Amaltas, a research and consulting organization based in India. The Amaltas team was led by Dr Suneeta Singh, a development professional with over 30 years of experience and Mr J.S Kang, a seasoned public administrator. The team also had the advice from Dr Susan Stout, an evaluation expert with several years of experience as the manager for the Results Secretariat at the World Bank and as the leader of the Bank's first independent evaluation of its work in the health sector. They were assisted by Mr Ujjwal Gupta, Project Analyst at Amaltas and Christopher Dee (Intern). Ms Manavi Jain, Ms Akhiljeet Kaur and other staff of the organization also provided assistance.

To ensure that the team had enough local knowledge and sensitivity to the context of the five countries, the core team included independent evaluators for each of the countries. Each evaluator was chosen keeping their familiarity with the development priorities of the country and previous experience in conducting country evaluations. These senior consultants were: Dr Syed Jahangeer Haider, Bangladesh; Dr Aang Sutrisna, Indonesia; Dr Katherine Ba-Thike, Myanmar; Dr Archana Amatya, Nepal; and Dr Suneeta Mukherjee, Sri Lanka. Short biographies of the evaluators and organization may be found at Annex II. The evaluators would like to acknowledge the support and effort of the WCO staff in making the country visits and meetings possible.

Quantitative and qualitative data for the study were collected between August–October 2015. During the course of the evaluation, WHO staff, policy-makers, national and international partners were interviewed for their opinions and inputs. A total of 152 interviewees were contacted; 23 WHO staff from HQ, SEARO and WCOs, 58 government interviewees and 46 development partners working in maternal health. Another 25 were from other partners such as national research institutes, technical partners and nongovernmental organizations (NGOs). During the course of the evaluation, 99 completed Likert scores were obtained. A detailed list of interviewees is available at Annex III. Over 300 documents were reviewed by the team.

Limitations

As with all evaluations that seek to assess contribution or impact, a post-hoc approach is not able to compare experience relative to an explicit or measured counterfactual. The evaluation was informed by detailed consultation with WHO staff at the country level through several means such as emailed questionnaire, in-country meetings and discussions, and a regional meeting at SEARO. WCO staff also had the chance to go over the country briefs for each country that were developed by the senior consultants.

It is important to recognize that WHO has a remarkable span of responsibility in health. The maternal health function is carried out by WCO staff who are also responsible for work on the reproductive, maternal, newborn, child and adolescent health (RMNCAH) spectrum. Hence there is some bleed in assessing the performance of core functions for maternal health alone.

While every attempt was made to capture the widest set of stakeholder opinions, availability was sometimes not possible. Time and resources that could be applied to this task were limited and the evaluators would like to acknowledge that the materials they have reviewed may not be complete. They were as provided by the WHO offices at the three levels and those that could be accessed through an intensive web search.

Finally, the evaluation assesses the contribution of WHO to maternal health in the SEA Region for the limited period from 2010 to 2015. It therefore does not capture the long-term impact that WHO's contribution may have in the Region. While the evaluation may offer important lessons for reflection, it may not be applicable without modification to other aspects of the work of WHO.

Chapter III: Maternal health in the SEA Region

WHO is the technical agency of the UN that concerns itself with global health. The Organization has a staff of over 7000 people who work at three levels of the system: the HQ based in Geneva, Switzerland; six regional offices; and WCO in 150 countries, territories and areas. Responsibility for maternal health rests with the Department of Maternal, Newborn, Child and Adolescent Health. The vision statement of the Department reads, "A world where every pregnant woman, newborn, child and adolescent enjoys the highest attainable standard of health and development", thus marking the placement of maternal health within the continuum of family life. The Department makes the following four mission statements:[45]

- generate and synthesize evidence and define norms and standards for maternal, newborn, child and adolescent health;
- support the adoption of evidence-based policies and strategies, which conform to international human rights standards, including universal access to health care;
- build capacity for high quality, integrated health services for pregnant women, newborns, children and adolescents; and
- monitor and measure progress in implementation and the impact of those strategies on survival, health, growth and development.
- The Department proposes to achieve them through the three strategic directions:
- develop evidence-based norms and standards to support policies and strategies, for maternal, newborn, child and adolescent health;
- support action to achieve universal access to quality, integrated health services for women, children and adolescents; and
- monitor and evaluate progress to inform planning and implementation, and promote accountability.

At SEARO, responsibility for maternal health is housed in the Department of Family Health, Gender and Life Course. The focus of the Department is to bring attention to three main issues that have an important bearing on further gains in maternal health, namely equity in reach, quality of services and human resources for health.

This evaluation assesses the contribution of WHO to maternal health improvements through the lens of the six core functions that it uses to organize its work. These core functions are:[46]

Function 1. Setting norms and standards and promoting and monitoring their implementation.

Function 2. Providing technical support, catalysing change, and building sustainable institutional capacity.

Function 3. Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge.

Function 4. Articulating ethical and evidence-based policy options.

Function 5. Monitoring the health situation and assessing health trends.

Function 6. Providing leadership on matters critical to health and engaging in partnerships where joint action is needed.

45 World Health Organization. (2011). Strategic Directions of the Department of Maternal, Newborn, Child and Adolescent Health. Available at: http://www.who.int/maternal_child_adolescent/about/Aboutus.thedepartment.strategicdirections.pdf?ua=1 (Accessed on 4 November 2015).

46 World Health Organization. (2015). About WHO: What we do. Available at: http://www.who.int/about/what-we-do/en/ (Accessed on 5 November 2015).

WHO is currently undertaking a reform process driven by three fundamental challenges: the need to reflect its comparative advantage through selective and strategically focused priorities; the need for greater clarity on its role in global health governance and relationship to other actors in international health; and the need to become more nimble and agile in responding to new challenges and a rapidly changing environment.[47]

Guidance on responsibilities with respect to core functions at each level of the system is set out in the March 2013 report of the 'Taskforce on the Roles and Functions of the Three Levels of WHO'.[48] See Annex IV for details.

The five countries included in the evaluation (Bangladesh, Indonesia, Myanmar, Nepal and Sri Lanka) and maternal health were selected as the subject of inquiry because of their potential contribution to regional impact and the salience of the topic to development of the Region's flagship focus on maternal health. Each country brief offers the opportunity to learn important lessons for what and how WHO was able to contribute to the country's health situation. Country also discusses the interaction of various environmental, organizational and individual that appears to influence WHO's performance. Country briefs are available in section II of the report.

Provided in the following sections are the principal findings of the evaluation, focusing first on critical challenges at the country level, the contribution to policy, programme and practice levels and lastly on the performance of the six core functions.

Each of the five countries is at a different stage of development trajectory. Maternal health indicators follow quite diverse pattern and the countries face distinct maternal health challenges. Population size varies from 20 million in the island state of Sri Lanka to the archipelago of Indonesia with more than 250 million. Several, including Myanmar and Nepal experience significant political change and new elections in the immediate past.

Although among the five countries, Sri Lanka shows the fastest and most extensive improvement in growth. Even conditions in Indonesia and Bangladesh have also propelled a growing prosperity. Among these countries, Bangladesh and Myanmar have been reclassified to lower middle income status during 2010–2015, and hold human development index (HDI) ranks of 142 and 150 respectively. Nepal, with an HDI rank of 145, remains in the low income category. Sri Lanka and Indonesia have maintained their lower middle income category per the World Bank classification in both 2010 and 2015.

At one end of the MMR spectrum is a country such as Sri Lanka, which advanced to the MDG with an already low level of MMR while countries such as Nepal had levels of MMR approaching 450 per 100 000 live births. However, MMR is not the only indicator of interest; SBA and ANC4 are also remarkably different for each of these countries. In some, the rate of SBA appears incongruous with the level of MMR achieved as in Bangladesh; while in others the rate of SBA achieved is incongruous with the MMR, as in the case of Indonesia. Some countries are beginning to experience that indirect causes are a great proportion of the maternal mortality seen as in Sri Lanka.

Given significant dissimilarities in their topography, demographic make up and choice of service delivery alternatives, these distinctions translate to quite different challenges in the path to tackling maternal mortality.

Bangladesh

Bangladesh is one of the world's most populated countries. It has a population of more than 160 million, most still living in rural areas. Poverty is common; over 30% of the population lives below the poverty line. Over 30% of girls marry before the age of 15 years, and by 18 years, the proportion goes up to 60%. Bangladesh has an HDI rank of 142, and is now classified as a lower middle income country as per the

47 World Health Organization. (2015). About WHO: WHO reform. Available at: http://www.who.int/about/who_reform/en/ (Accessed on 3 November 2015).

48 World Health Organization. (2013).Report of the Taskforce on the roles and functions of the three levels of WHO. Available at: http://www.who.int/about/who_reform/task_force_report_three_levels_who_2013.pdf (Accessed on 5 November 2015).

World Bank's classification 2015. Bangladesh is on a development trajectory, which is expected to have far-reaching effects on the demographics of the country.

Bangladesh has achieved a remarkable fall in MMR, which has gone down by about 70% between 1990 and 2010. SBA is 42.1% and ANC4 is 31.2%. Much work remains to be done, and key priorities in maternal health identified during the course of this study include: improving use of ANC services; awareness on delivery by SBA; address adolescent pregnancies which pose additional risks to the young mother; and improve funding and management of the programme.

Indonesia

Indonesia is an archipelago of about 18 000 islands with very densely and very sparsely populated regions. The country has a population of more than 250 million. In the last 25 years, Indonesia has seen economic prosperity, rising in HDI rank to 108. It has maintained its lower middle income category from 2010 to 2015 using the World Bank classification. Estimates are that if the maternal mortality indicators could be improved, the country could soon enter the high income category.

The country is in the midst of implementing a series of health systems reforms aimed at attaining universal health coverage by 2019. MMR has shown a continuing downward trend and is currently estimated to be 190 per 100 000 live births. There is some uncertainty about the prevailing MMR due to recent estimates by the 2012 Indonesia Demographic and Health Survey (IDHS) estimates based on sibling-survival data which indicates an MMR of 359 per 100 000 live births. Yet the country has high SBA which is 83% and ANC4 is 88%. Key priorities in maternal health identified in Indonesia include: ensure reduction in MMR; improve accountability of the decentralized management; and build availability of well trained personnel at appropriate levels of the health system.

Myanmar

Myanmar is only just emerging from a long period of political isolation and is beginning to take its place in the world community. During its seclusion, the main development partners operating in the country have included WHO, which is seen as a trusted partner. The country has a population of more than 50 million comprising many races and speaking more than 100 languages and dialects. The population remains largely rural in character with more than 70% living in rural areas of the country. The country has moved from the low income category to the lower middle income category as per the World Bank income classification in the reference period. Myanmar's HDI rank is 150.

The country has seen a steady decline in MMR and is presently estimated to be 192 per 100 000 live births. New Census (2014) data puts this level into question and estimates a much higher 282 per 100 000 live births. SBA is 67% and ANC4 is 71%. Concerns in maternal health include an MMR that is still quite high; a SBA that requires improvement and is quite variable by factors such as area and ethnic group; weak infrastructure and poor reach of health services; and limited implementation of evidence-based interventions for postpartum haemorrhage, eclampsia and abortion-related mortality.

Nepal

Nepal has seen a decade of volatility and armed internal conflict. A new peace is promised with the promulgation of a new Constitution in September 2015, but the country remains politically fragile. The population of Nepal is just under 25 million. The country has continued to be in the low income category using the World Bank classification and has an HDI of 145. The population growth of Nepal is higher at an annual rate of 1.35 than any of the other four countries.

MMR in Nepal has fallen from 850 in 1990 to 170 per 100 000 live births in 2011, a fall even more dramatic than that of Bangladesh. SBA leaves room for improvement, with only one in three deliveries being attended by a skilled attendant. ANC4 has risen to 50%. Issues in maternal health that were identified

during the course of this study are: expanding birthing care facilities; intensifying the reach of services to all regions; increasing choice for family planning services; addressing nutritional problems associated with poor maternal outcomes; and focusing on reproductive and maternity morbidities, including mental health.

Sri Lanka

Sri Lanka is an island state with a population of about 20 million. It achieved middle income status in 2010 and is expected to transition to the high income group. It has remained a frontrunner in South Asia with respect to most development indicators, in particular those relating to maternal health. It enjoys a high HDI rank (73) and a high Gender Inequality Index rank (75).

MMR in Sri Lanka has been low since the 1970s, having already fallen below triple digit levels; this is generally credited to the use of village midwives. The trajectory has continued downwards until recently when it has, for the last five years, hit a phase of stagnation at around 32 per 100 000 live births. SBA is 99.8% and ANC4 is 100%. Key priorities identified during this study were: addressing the stagnant MMR, including direct and indirect causes of mortality, unplanned pregnancies and high levels of caesarean section; addressing geographical, social and economic inequities in maternal health; and dealing with nutritional problems among mothers.

Contribution of WHO to policy, programme and practices

WHO has contributed substantively to improvements in maternal health in the Region through work executed jointly by headquarters, SEARO and WCOs. Their assistance has sometimes been directed to the policy architecture of the countries, sometimes to programmes and at other times to practices adopted. Each level of the system has played a role and contributed to the perception held by countries, international and national partners, and other stakeholders.

Overall, it would be fair to say that WHO plays a critical role in setting norms and standards in the Region. WHO's leadership in health remains greatly anticipated, but sometimes unrealized. Still, great value is attached to its approval of policies, programmes and practices adopted in maternal health. The period 2010–2015 is short, especially to look for substantive influence in the maternal health area; nonetheless, instances were found where WHO had played a critical supporting role to each of the country governments. Some examples of these instances are presented here.

Policy

In Myanmar, WHO has developed and disseminated international guidance on life-saving interventions. Implementation is however, affected by health system level factors, including health workforce shortages and need for strengthened drug and equipment procurement, distribution and management systems. Incorporation of evidence-based practice in clinical management is in place at teaching hospitals and promoted at public sector facilities.

In Indonesia, evidence from at least two research studies led by WHO, contributed to the Ministry of Health (MoH) Action Plan for accelerating maternal mortality reduction.

In Nepal, WHO has played a role on the Technical Advisory Committees on Maternal Health and Family Planning; provided technical support for intensified action to ensure skilled care based on continuum of care model from adolescents through pregnancy, delivery and postnatal period and from community to facility; helped to strengthen the quality of medical and nursing education; and assisted in the establishment of midwifery education and the midwifery workforce in Nepal.

WHO's work in Sri Lanka is also played through the Technical Advisory Committee on Maternal Health and Family Planning and the Technical Advisory Committee on Newborn and Child Health and provides inputs which guide the National Committee on Family Health where policy decisions are taken. Within the

life-cycle approach, WHO has contributed towards formulation of adolescent health strategy. They have also supported the Government in addressing the preconception stage i.e. among newly married couples.

In Bangladesh, WHO has supported Short Programme Reviews for maternal and reproductive health. WHO played a significant role in developing the 3-year midwifery and 6-month postbasic nurses' midwifery training. WHO also helped to design the Demand Side Financing Scheme for Pregnant Mothers and finalizing and getting endorsement of a Strategic Action Plan on Birth Defects. It is supporting the development of a national strategy on Support to Individual, Family and Community for Maternal and Neonatal Health.

Programme

Through WHO support, Indonesia has taken key steps in the improvement in quality of care of health facilities which has been brought upon the national radar. This has been translated into programme at the ground level. In Myanmar, incorporation of evidence-based practice in clinical management is in place at teaching hospitals and promoted at public sector facilities.

In Nepal, WHO works closely with government bodies to assess and monitor the maternal health situation and trends in the country; likewise it has a strong role in monitoring maternal and perinatal deaths and carrying out maternal and perinatal death surveillance and reporting. In the area of family planning, it has supported the implementation of interventions to improve quality of services and increase service accessibility.

WHO has played a strong role in strengthening institutional capacities through technical assistance in Bangladesh. WHO provided support to develop the clinical management protocol for the management of emergency obstetric care (EmOC) facilities. It has also supported the development of quality improvement tools for health facilities to improve maternal and neonatal services. It supports training of programme management to contribute to strengthening of service delivery.

In Sri Lanka, there has been a very strong partnership by WHO in maternal mortality and morbidity surveillance where the Organization now proposes to introduce confidential enquiry. WHO has worked for neonatal health through the newborn unit and has now supported the introduction of a neonatal retrieval system. It is noteworthy that with WHO's efforts the National Institutes of Health, Sri Lanka, have been developed into a WHO Collaborative Centre.

Practices

Sri Lanka has led the way in supporting the national neonatal and maternal health strategy planning, the maternal care package, the management guidelines for obstetric emergencies and strengthening basic midwifery training.

In Nepal, basic midwifery training was introduced and strengthened with WHO support; and they have contributed to practice through development and support for various guidelines. In Indonesia, WHO has helped to put in place standardized maternal health services in health facilities.

In Myanmar, the WCO has supported Department of Health (DoH) to adapt Pregnancy, Childbirth, Postpartum and Newborn Care developed by WHO and its partners and subsequently to conduct a post-training assessment on maternal and newborn health.

Practice norms and standards developed by WHO with regard to quality of care and ANC visits are applied in Bangladesh. WHO has helped to design the accreditation mechanism for SBAs and the standards they must abide by, as well as, in 2010, standard for health services aimed at adolescents. WHO also developed guidelines on Nursing and Midwifery Workforce Planning and Quality Assurance and Accreditation of Nursing and Midwifery Educational Institutions.

Performance of core functions

It is also useful to consider the evaluation findings as they relate to how various stakeholders perceive how WHO's performance relative to the six core functions contribute to or influence changes in maternal health policies and programmes. The following sections discuss each of the core functions in turn, starting with those where perceived contribution is the highest through to functions which are perceived to be going less well.

Function 1: Setting norms and standards
Setting norms and standards and promoting and monitoring their implementation

WHO's work on setting norms and standards is widely valued by governments, partners and other stakeholders in all the countries reviewed. It is a general expectation that norms and standards will be set for health activities by WHO. The Organization is seen to be the first point of reference in this regard. In some cases, WHO is helping governments to monitor that these standards are being met such as in Indonesia on the quality of care being provided by health facilities. The Likert score averaged 3.6 across stakeholders, well above the meets expectations score of 3.

However, the efficiency of the process by which these norms and standards are produced in the first place, and the time that it takes to adapt global norms to regional and country specific contexts were seen as problematic in some settings. Respondents felt that these took too long to produce and adapt. Moreover, country interviews and document that there was little evidence of systematic effort to track the extent and reach of dissemination of these important technical inputs. The evaluators note that assessing WHO's contribution to real impact on the ground, i.e. effectiveness, would require assessment of the adoption of norms and standards by key target audiences such as implementers and local decision-makers. Better tracking of reach (i.e. did norms and guidance get to the right audience) and adoption would be necessary for more robust evaluation of WHO's influence, but, crucially, would also become valuable feedback to governments, partners and others about the kinds of factors that inhibit or constrain adoption of sound public health policies.

Evaluators also observed that country experience does not appear to inform the development of regional and global norms and guidance as much as they might and that there is scope to ensure that opportunities to do this are both frequent and effectual. For instance, does the fact that MMR declined in Bangladesh despite low institutional deliveries, have lessons for how best to train and deploy community skilled birth attendants (CSBAs)?

Core function recommendations

- Put a system in place to track efficiency of adaptation (time to adapt), dissemination (type of target audience) and pace and extent of adoption of norms and standards.
- Pursue opportunities to feed country experience into development of regional and global norms and guidance.

Function 2: Providing technical support and building institutional capacity
Providing technical support, catalysing change, and building sustainable institutional capacity

Ministries of Health in the countries continue to value and trust WHO's technical advice and support. WHO's support from all levels taken together is seen to be of high quality. WHO is catalysing change in countries; the Maternal Death Surveillance and Response System (MDSR) in several countries and the Pocketbook on Midwifery in Indonesia are examples of technical inputs that have been widely employed. The development of the Country Cooperation Strategy (CCS) is also a crucial opportunity to undertake an analysis of the country's health situation. The average Likert score for this function was 3.2, also above the meets expectations score of 3.

The quality of technical support is dependent on staff's ability, availability and credibility. When suitable staff is not present, other partners fill the vacuum, creating the risks for the introduction of inconsistent or inappropriate advice. Many interviewees further noted that the time taken to respond to requests for advice is long and complex, may involve multiple directorates/categories and advice or inputs from all three levels within WHO. For example, in Nepal several interviewees noted long delays in receiving information due to the time taken in getting the requested information from HQ or SEARO.

Selectivity needs to be applied if change is to be catalysed. WHO is seen as being very closely embedded within the government in all these countries. While this is a strong comparative advantage, it may constrain WCO's willingness to speak truth to power. The question that arises is whether there is a trade-off between closeness and maintenance of professional rigour and independence. A case in point is the need to highlight the importance of abortions in maternal health and advocacy towards a policy response in Sri Lanka, where current political sensitivities may make it challenging to remind policy-makers of this unfortunate but important scientific reality.

WHO's support to building institutional capacity is less visible or apparent than it used to be. Supporting institutional capacity is different from supporting participation in national, international meetings, and exposing ministries of health officials to trends and issues in international health. In the past five years in these countries, capacity-building efforts have been sporadic; several training of trainers workshops have been supported through financial and/or technical assistance. The review did not suggest a very clear statement about the role of WCOs in strengthening institutional capacity.

Core function recommendations

- Maintain the integrity and rigour of technical advice.
- WHO is a knowledge organization. It rests on the technical and relationship skills of its staff. Ergo, it must pay the highest attention to the hiring and distribution of its staff.
- Make expectations of what WCO should do more explicit. Perhaps this should be to reduce the constraints to implementation/adoption of norms and standards.

Function 3: Shaping the research agenda

Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge

To the degree that this role is played, it is carried out largely from HQ and SEARO. In some countries, some small-scale research is being financed including through resource mobilization. Several WCOs are supporting research studies, but not apparently shaping the country agenda on research in maternal health. The Likert score on this function averaged 2.5 across the five countries, below the meets expectations level.

Small and disconnected support is provided for discrete research studies in the countries studied. WHO had not supported any real ground-breaking studies except for Indonesia on the quality of care. There was also no indication that global and regional research support is aligned with or informed by country needs/WCO's understanding. For example in most of the countries, the informal private sector plays an important role in the delivery of health care; yet little effort is made to better understand the sector and devise strategies to bring it onto the agenda of government.

There is a difference between shaping and supporting, a research agenda. However, it must be remarked that there seems to be some ambiguity as to the role of WCOs in carrying out this function. There was no evidence of shaping country level agenda of research; this is a missed opportunity. As an example, in Myanmar, WHO is not a member of the on Evaluation and Research Technical Strategy Group under the Myanmar Health Sector Coordination Committee.

Core function recommendations

- Make expectations of what WCOs are supposed to do on research more explicit.
- Empower and animate WCO staff to inform global guidance through country specific research.
- Ensure generation of country knowledge to concentrate global focus on overcoming implementation constraints.

Function 4: Articulating policy options

Articulating ethical and evidence-based policy options

The support by WHO on articulating ethical and evidence-based policy options is visible. Examples include the work done in the introduction of misoprostol for postpartum haemorrhage and basic emergency obstetric and newborn care in all five countries included in the evaluation. SEARO is doing well in keeping WCO aware of latest policy trends, and communication between the Regional Office and WCOs in this regard seems up to date. There is a long list of evidence-based policy examples from SEA countries provided in this chapter. The regional coordination mechanism enshrined in the memorandum of understanding between WHO, United Nations Children's Fund and United Nations Population Fund means that organizational cooperation at the country level is much smoother and less difficult to broker. Further, the three organizations subscribe to common policy frameworks on maternal and child health. Average Likert score on this function was 3.1 across the countries, approximating the meets expectations level of 3.0.

Nonetheless, the process of policy articulation is marked by inefficiency and delays. Sometimes the delay is in government processing; e.g. in Indonesia while the Pocket Book for Maternal, Newborn, Reproductive Health in Primary Health Care and Referral Hospitals, 2013 is accepted, the MoH is yet to issue the Ministry Decree, which will oblige funding for the same. In some cases, governments and partners request guidance on technical matters, but the response is not very timely. So others step in to fill the vacuum, sometimes with risky results. An example from Nepal is when WHO did not engage effectively in a dialogue on the use of misoprostol when the Government of Nepal and Unites States Agency for International Development (USAID) proposed it.

The evaluation also identified several examples of how evidence-based policies developed globally are being translated into country policies. However, there were not many examples of these policies being validated through local experience or indeed, local experience being captured by regional/global level to inform the global policy. WCOs are not being encouraged or facilitated to critically appraise and inform changes to global guidance.

Core function recommendations

- Empower and encourage WCO staff to actively influence global guidance. This would ensure that global thinking includes evidence drawn from local reality.
- Utilize its credibility and position to extend its support and reach to all actors in the health space.

Function 5: Monitoring health situation and trends

Monitoring the health situation and assessing health trends

WHO supports efforts to harmonize core indicators at the global level. WCO staff participate in the design and discussions on the Demographic Health Survey and other critical health surveys at the country level. There were also sporadic efforts to study particular aspects of the health system data. The Likert score averaged 2.8 for this function.

WCO role is presently mostly as consumers and not producers or synthesizers of data. This represents a missed opportunity as a number of country-based agencies are producing quite a large amount of relevant

data. These could be synthesized by WHO in a way that informs all agencies as well as informs the needs of government. There is also an opportunity for SEARO and WCOs to become the voice of countries in reducing the burden of data extraction. In some cases, data is used narrowly. Governments often give access only to data that has already been analysed; many times, WCOs are not able to identify or address them to key data messages. It was also not clear whether WCOs are staffed appropriately for data analysis, synthesis and visualization.

Core function recommendations

- Utilize WHO's credibility and position to study the inputs of all actors in the health space.
- Ensure that the main messages of the Commission on Information and Accountability percolate to the country level with adequate attention to decreasing the load of data collection.
- Become an advisor on new ways of doing monitoring and new approaches to evaluate implementation.

Function 6: Providing leadership on health
Providing leadership on matters critical to health and engaging in partnerships where joint action is needed

Governments trust and value WHO. The Organization is seen to be a neutral and evidence-based partner, which is likely to provide robust advice without meddlesome vested interests. The Likert score averaged across the five countries was 2.8, short of the meets expectation level.

However, a few WCOs are perceived to be having insufficiently experienced staff. Only in one out of the five SEA countries included in the study, namely Bangladesh, was WHO anchoring donor coordination efforts. It was quite evident that leadership is intimately connected to the availability of technically skilled, credible and experienced staff.

The absence of a WHO representative over an extended period of time as in Myanmar, had led to serious erosion to the quality of the long-standing relationships of WHO in the country. It is well known that it is much easier to lose leadership than to build it. And leadership is a function of staffing – which leads to the larger question of selectivity – and our general recommendations.

Core function recommendations

- Leverage country knowledge and the UN mandate to exert leadership of the health community.
- Build common purpose with partners and ensure a coordinated approach.
- Invest in country level relationships with a wide range of stakeholders. Ensure that country relationships are supported, to the extent possible, by global and regional dialogue.

Facilitators and challenges

Long-standing relationships and trust between WHO and its Member States clearly facilitate the Organization's influence at the national and local levels. Government values WHO's expertise and responsiveness to national level requests for technical support. WHO has a solid reputation, credibility and neutrality as an honest broker. WHO is not a funding agency, so there is no perverse incentive to spend the money. HQ and SEARO willing and able to try to help get the right person to the right place on time. This enables it to focus on its role as a generator and transmitter of knowledge; this is a strong advantage. However, it might be noted that evaluating transfer of knowledge is much harder than evaluating transfer of funds, so while WHO does and should continue to focus on ensuring knowledge transfer, it must also think deeply about how to measure its achievements in this regard.

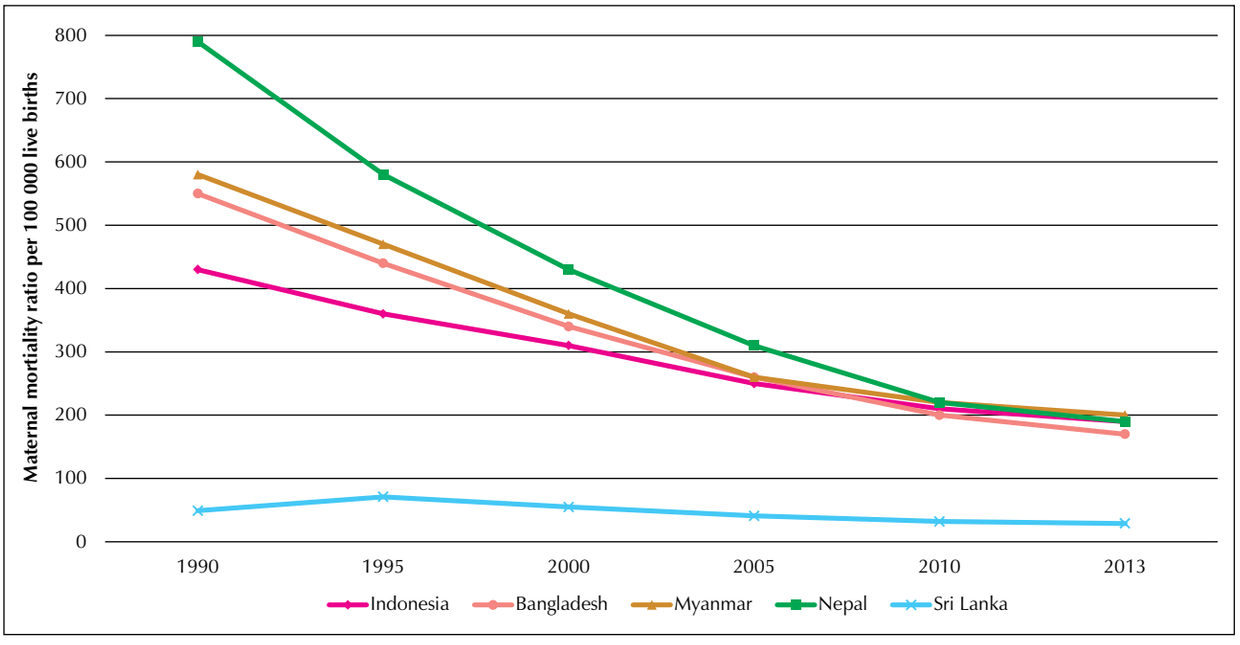
Its country presence puts WHO in a strong position to help give countries voice in shaping the global policy. As a local player, with national and international staff on hand, it has the opportunity to use this voice/feedback to sharpen the global focus on the gap between norms and standards and their application and use, i.e. implementation.

The main challenges to WHO's ability to deliver on its mandate are threefold: (i) The number, technical skill and seniority of staff at the country level may constrain WHO's ability to cover all categories in all countries. The national staff may face travel constraints, limiting their access to and capacity to transmit regional and global lessons; (ii) The planning process tends to focus on listing activities in each category in each country leading to a diffusion of focus. This results in a perception of WHO being everywhere yet nowhere. The same process tends to lead to a diffusion of focus with multiple meetings, and lack of time to reflect and be strategic. It spreads available staff time too thinly across multiple small-scale activities. A high administrative workload and high transaction cost makes it challenging to put the right expertise in the right place at the right time; and (iii) Supervisory and review mechanisms are multiple. They are primarily focused on completion of activities and expenditures, and lack a sharp focus of the contribution of sets of activities to a specific country level outcome or impact. The absence of a clear evaluation framework amplifies the problem, as it means that neither staff nor management have a good idea of what is working and what is not.

Recommendations

Countries of the SEA Region have steered a remarkable decline in their MMR since 1990. Trends in countries included in this study indicate a convergence towards the MDG targets, with improvements suggesting over 60% reduction since 1990 and about 50% since 2000. Sri Lanka was already well ahead of others at the start of the countdown to 2015.

Exhibit 11: *Maternal mortality ratio from 1990 to 2013, SEA Region*



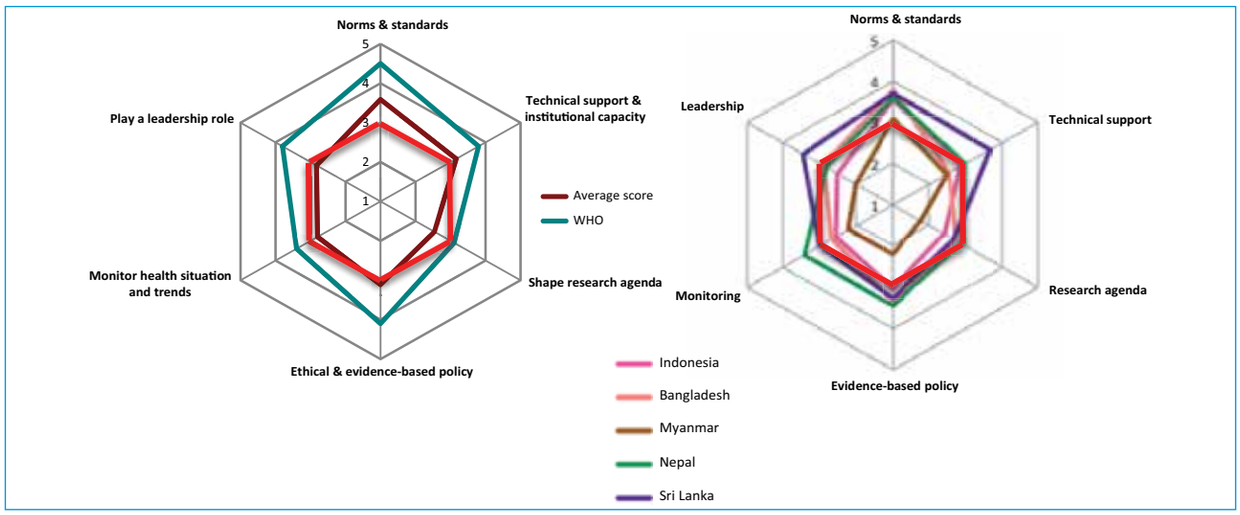
Source: Global Health Observatory Data Repository, Maternal Mortality Ratio: Data by Country. World Health Organization. 2015.

Exhibit 12 summarizes the perceptions of WHO's stakeholders across each of the core functions, compared with WHO's own self-assessments of its performance on the same dimensions. Not surprisingly, and typical of evaluations of this type,[49] WHO rates its performance on average higher than that of its

49 That is, self-assessments in many organizations tend to trend higher than do assessments of outside respondents, which is among the many reasons that organizational effectiveness is usually best served through a combination of self and independent evaluations.

stakeholders. At the same time, there is evident agreement across groups that WHO's performance on setting norms and standards, leadership and in the promotion of evidence-based policies is generally more highly valued than are its roles in technical support and strengthening institutional capacity, monitoring health trends and shaping the research agenda. Exhibit 13 provides the summary Likert scores by country. These scores do not use the ratings that WHO staff provided.

Exhibit 12: *Core functions: Average 5 SEA countries and WHO staff Likert Scores*



Source: Amaltas, 2015

The evaluation has provided useful findings and specific recommendation with regard to each core function in the maternal health space. The overall guidance suggested for the maternal health area, but may be worthwhile for other departments of the Organization to consider when carrying out a review of their own functioning. In sum, the overall recommendations emerging from the evaluation are:

(1) **Become more selective**. Pick the issues that will be the focus of efforts in select countries based on an analysis of the situation and opportunities that pertain. Where responsible partners are already focusing on important issues, it may not be necessary for WHO to also play a similar role or perform a similar activity.

(2) **Become the voice of the countries**. The Global Financing Facility provides an opportunity to support the articulation of an appropriate direction for domestic and international financing of health care.

(3) **Become the voice of country implementers**. Highlight constraints in country health systems and help to address them through collaboration between RMNCAH and Health Systems Departments in WHO.

(4) **Become a source of feedback**. Its unique positioning in the countries and the trust that it enjoys, WHO could play a critical role in ensuring that country voices are heard. WHO could become more deliberate in providing feedback from country to the global level.

Country briefs

Capital:	Dhaka*	Life expectancy at birth m/f:	70/72*
Population:	156 595 000*	Infant mortality rate:	33.2*
Rank in HDI:	142#	Neonatal mortality rate:	24.2*
World Bank income classification:	Low#	Under 5 mortality rate:	41.1*
GNI per capita (PPP):	USD 2810*	Maternal mortality rate:	170*
Expenditure on health per capita	USD 85*		

*WHO 2015#UNDP 2013

Bangladesh

The country context

Bangladesh is a fertile alluvial plain in the delta of three main rivers; the Ganges, the Brahmaputra and the Meghna. It covers an area of 147 000 square km and has a population of approximately 160 million, which makes it one of the world's most densely populated countries. More than 85% of Bangladeshis are Muslims. Hindus make up 8.5% of the population, and other religion includes Buddhists and Christians.[50] About one third (29.6%) of Bangladeshis live in urban areas including Dhaka, the capital and largest city. Bangladesh is one of the world's poorest countries – 31.5% of the population lives below the poverty line. The population has also to face severe weather in the monsoon season, when heavy summer rains are commonly accompanied by cyclones and floods.

Despite these challenges, the country is generally considered to be a frontrunner in respect of health status. As described in Exhibit 13, the country had made significant progress on all major health indicators by 2014 and looks likely to meet its 2016 targets.

Exhibit 13: *Health, Population and Nutrition Sector Development Programme priority indicators with benchmarks and targets*

1.	**Health service delivery (district level or below, excluding metro areas)**	**Index**
	Number and distribution of health facilities per 10 000 population	1.17
	Number of health facilities on the average within 2 km radius	1.33
	Number and distribution of inpatient beds per 10 000 population	2.62
	Number of outpatient department visits per 10 000 population per year	11 530
Proportion of health facilities offering		
	• Expanded Programme on Immunization services	77%
	• ANC services	55%
	• Inpatient services	5%
2.	**Health workforce: number of health workers per 10 000 population**	5.58

50 Department of foreign affairs and trade, Australian Government. Bangladesh Country Brief. Department of foreign affairs and trade. Available at: http://dfat.gov.au/geo/bangladesh/pages/bangladesh-country-brief.aspx (Accessed on 2 November 2015).

3. Health financing	
Total expenditure on health per year (2010 estimate)	US$ 23/capita
General government expenditure on health as a proportion of general government expenditure	6.5%
The ratio of household out-of-pocket payments for health to total expenditure on health	0.64

Exhibit 14: *Block indicators: Bangladesh Health Facility Survey 2011*[51]

Indicators	Achievement 2014	Target 2016
Infant mortality rate	38 (Bangladesh Demographic and Health Survey, BDHS 2014)	31
Under 5 mortality rate	46 (BDHS 2014)	48
Neonatal mortality rate	28 (BDHS 2014)	21
Maternal mortality ratio	194 (Bangladesh Maternal Mortality and Healthcare Survey BMMS 2010) Estimate by Expert Group: 170 (2014)	<143
Total fertility rate (TFR)	2.3 (BDHS 2014)	2.00
Prevalence of stunting among children under 5 years of age	36% (BDHS 2014)	38%
Prevalence of underweight among children under 5 years of age	33% (BDHS 2014)	33%
Prevalence of HIV/AIDS in most-at-risk populations	<1% (Serological Surveillance, 2007)	<1%

The Bangladesh public sector health programme is the responsibility of the Ministry of Health and Family Welfare, which is headed by the Minister of Health with Secretary of Health as the executive head. At the implementation level, there are two technical directorates, the Directorate General of Health Services (DGHS) and the Directorate of Family Planning. Implementation of the maternal health programme is a function shared by these two directorates with some overlap of responsibilities.

The national health programme includes activities implemented by the public sector, the private sector including NGOs, and the community with a large number of volunteers and community level service providers. The predominance of the traditional dais is a vital factor in maternal health, as they assist with 66% of the total deliveries performed in the country, in which 76% of the deliveries are performed at home. Exhibit 14 below broadly indicates availability of health facilities, services and expenditure:

The contribution of the government to health expenditure is low at US$ 27 per capita.[52] The contribution of the government to health expenditure is low at US$ 3 per capita. Seeking traditional medicine services is common practice among the population in the rural areas. Persons in rural areas generally seek modern medical services only for severe illnesses. The country has more physicians than nurses. A little over half the physicians (52%) and 7% of non-physician health-care providers are involved in private practice. At the field level (Upazila Health Centres), absenteeism among physicians is double of the absenteeism among non-physicians (e.g. nurses and technicians). The absenteeism rate is 7.4% overall; about 10% for physicians and about 5% for non-physicians.[53] Shortages of critical human resource and absenteeism adversely impact the performance in the health sector.

51 University of South Carolina,Tulane University, New Orleans,USA: ACPR, Dhaka. (2012). Bangladesh Health Facility Survey- Revised Final Report. Available at: http://hpnconsortium.org/admin/essential/Bangladesh_Health_Facility_report_2011_Feb_12_V2.pdf (Accessed on 3 November 2015).

52 World Health Organization. (2015). Global Health Observatory (GHO) data: World Health Statistics 2015. WHO. Available at: http://www.who.int/gho/publications/world_health_statistics/EN_WHS2015_Part2.pdf?ua=1(Accessed on 2 November 2015).

53 U University of South Carolina,Tulane University, New Orleans,USA: ACPR, Dhaka. (2012). Bangladesh Health Facility Survey- Revised Final Report. Available at: http://hpnconsortium.org/admin/essential/Bangladesh_Health_Facility_report_2011_Feb_12_V2.pdf (Accessed on 3 November 2015).

Maternal health in Bangladesh

In 1990, the MMR in Bangladesh was 574 per 100 000 live births. By 2001, the MMR had fallen to 322 from which it fell dramatically to 194 in 2010. This represents a 40% decline in nine years. The rate of decline has averaged about 5.5% per year, above the 5.4% targeted to achieve MDG5. [54] The overall proportion of births attended by skilled health personnel increased by more than eightfold in the last two and a half decades, from 5.0% in 1991 to 42.1%% in 2014. During the same period, ANC1 has also increased about two times from 27.5% in 1993 to59% in 2007–2014. [55] Institutional deliveries increased from 9% to 23% and use of facilities for maternal complication went up from 16% to 29% between the Bangladesh Maternal Mortality and Health Care Survey (BMMS) 2001 and BMMS 2010. Substantial decline in all causes of direct obstetric deaths has been observed in the 2001 and 2010 surveys. In BMMS 2010, haemorrhage and eclampsia were the dominant direct obstetric causes of deaths, and were together responsible for more than half of the MMR. The risk of a maternal death is now down to 1 in 500 births. Abortion-related deaths declined from 5% of MMR in 2001 to about 1% of MMR in 2010. Indirect obstetric causes of deaths accounted for about one third (35%) of maternal deaths.[56]

Exhibit 15: *Health indicators (human resources), Bangladesh*[57]

Health services provision	Existing	Source
Registered nurses	38 950	BNC2015
Nurses in public sector	17 907	DNS 2015
Government nursing institutes	43	BNC 2015
Private nursing institutions	107	BNC 2015
Registered midwives	1407	BNC 2015
Trained SBA	8777	WHO, 2014
Population per physician	2785	
Population per nurse	5782	
Physician to nurse ratio	2.07:1	
Population per bed (beds of health sector + registered private hospital)	1860	DGHS 2010

The Government has framed the National Health Policy, 2011 and the National Population Policy 2012. It has launched 12 979 community clinics (1 per 6000 rural population). Government and nongovernment collaboration has played a significant role in the health sector development in Bangladesh. Non-health activities such as poverty reduction initiatives have also contributed to Bangladesh's progress on maternal health. Participation in microcredit programmes has been connected to better child survival. An increase in net primary education enrolment has resulted in improved literacy rates. The economic and social position of women has gradually improved in line with education, income-generating activities, access to microfinance and employment in the garment industry.[58] Programmes such as the Maternal Health Voucher Scheme and Emergency Obstetric Care services, and the rapid development of the private sector have also contributed to reducing maternal mortality.[59]

54 National Institute of Population Research and Training, MEASURE Evaluation, UNC-CH, USA ICDDR,B. (2012). Bangladesh Maternal Mortality and Health Care Survey 2010. NIPORT, MEASURE Evaluation, and ICDDR,B. Available at: file:///C:/Users/HP/Downloads/tr-12-87-en.pdf (Accessed on 2 November 2015).

55 Millennium Development Goals: Bangladesh Progress Report 2015 General Economics Division (GED), Bangladesh Planning Commission Government of the People's Republic of Bangladesh, September 2015, Dhaka. Published by: General Economics Division (GED), Planning Commission Government of the People's Republic of Bangladesh With the assistance from Support to Sustainable and Inclusive Planning (SSIP) Project, UNDP Bangladesh.

56 General Economics Division (GED) Bangladesh Plannning Commission Government of the People's Republic of Bangladesh. (2015). Millennium Development Goals: Bangladesh Progress Report 2015. Government of Bangladesh. Available at: http://www.plancomm.gov.bd/wp-content/uploads/2015/09/MDGs-Bangladeh-Progress-Report_-PDF_Final_September-2015.pdf (Accessed on 5 November 2015).

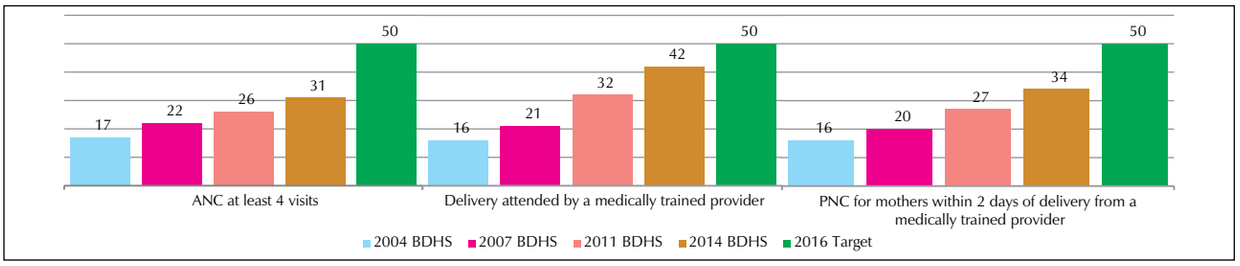
57 Bangladesh Bureau of Statistics, Statistics and Informatics Division, Ministry of Planning, Government of the people's republic of Bangladesh. (2012). Statistical Yearbook of Bangladesh-2011. Government of Bangladesh. Available at: http://www.bbs.gov.bd/WebTestApplication/userfiles/Image/LatestReports/YB2011.pdf (Accessed on 2 November 2015).

58 General Economics Division (GED) Bangladesh Plannning Commission Government of the People's Republic of Bangladesh. (2015). Millennium Development Goals: Bangladesh Progress Report 2015. Government of Bangladesh. Available at: http://www.plancomm.gov.bd/wp-content/uploads/2015/09/MDGs-Bangladeh-Progress-Report_-PDF_Final_September-2015.pdf (Accessed on 5 November 2015).

59 PMNCH, WHO, World Bank and AHPSR. (2014). Success Factors for Women's and Children's Health: Policy and programme highlights from 10 fast-track countries. WHO. Available at: http://www.who.int/pmnch/knowledge/publications/success_factors_highlights.pdf (Accessed on 5 November 2015).

With the support of partners, the Government of Bangladesh has invested substantially in maternal health programmes. Its target is to reduce MMR to 143 per 100 000 live births by 2015, and to increase skilled attendance at birth to 50% by 2016. In 2008, a review of the then ongoing health sector programme stated that, "MDG targets seem well on track, but areas of concern relate in particular to maternal and newborn care, where progress is too slow". The review called for midwifery services through a midwifery workforce.[60], [61]In the 1990s, to ensure skilled birth attendance at the community level, the Government had initiated the trained traditional birth attendant programme. In view of the limited success of the programme, as a further initiative, CSBAs programme was launched with the support of UNFPA, WHO and Obstetrical and Gynaecological Society of Bangladesh; with present day numbers of CSBAs being about 10 000.[62]

Exhibit 16: *Trends in maternal health, Bangladesh*



Source: Bangladesh Demographic and Health Survey 2014. NIPORT, MOHFW, Mitra Associates, ICF International RockvilleNational Institute of Population Research and Training, Ministry of Health and Family Welfare, Government of Bangladesh. 2011.

Current priority areas in maternal health

The priorities identified by interviewees from across the sectors were much the same as those mentioned in the National Maternal Health Strategy, namely**:**[63]

- improve quality of maternal and neonatal health services from preconception to the postnatal period in health facilities;
- increase coverage of ANC and increase the number of quality ANCs at facilities;
- strengthen 24/7 Emergency Obstetric and Neonatal Care (EmONC) services;
- train 3000 midwives by 2015 as part of the scalingup of skilled health workers to accelerate achievement of the MDG 5;
- expand SBA presence at the institutional level;
- strengthen newborn care services at all levels with rapid referral mechanisms; and
- address inequities in maternal health services through equity-promoting measures within the health sector and intersectorally.

60 PMNCH, WHO, World Bank and AHPSR. (2014). Success Factors for Women's and Children's Health: Policy and programme highlights from 10 fast-track countries. WHO. Available at: http://www.who.int/pmnch/knowledge/publications/success_factors_highlights.pdf (Accessed on 5 November 2015).

61 Directorate of the Nursing Services, Government of People's Republic of Bangladesh. (2013). Available at: http://www.dns.gov.bd/ (Accessed on 4 November 2015).

62 Roskamm et. all. (2011). Midwifery Workforce Management and Innovation. Available at: http://www.who.int/workforcealliance/media/Alliance_backgrd_SWMR.pdf (Accessed on 5 november 2015).

63 Ministry of Health and Family Welfare, Government of People's Republic of Bangladesh. (2014). Bangladesh National Strategy for Maternal Health, 2014-2024. Government of people's republic of Bangladesh. Available at: https://drive.google.com/file/d/0B4bW0fmAqJeHRFl0QnVacHpyZ00/edit (Accessed on 5 November 2015).

Current challenges in maternal health

There are three major issues facing the country insofar as maternal health is concerned. The first is to address the issue of adolescent pregnancies. Adolescents constitute nearly one fourth (23%) of the population in Bangladesh. Early marriage and pregnancy, under nutrition, poor knowledge about reproductive health and illiteracy are common problems in this age group. Child marriage is the norm; about 30% girls marry by the age of 15 years and by the legal age of marriage of 18 years of age, 60% of girls are married. Neonatal, post-neonatal and infant mortality rates are higher among the adolescent mothers than older age groups.[64]

Efforts to address maternal and neonatal mortality require a combination of access to SBAs, EmOC services, functional health facilities and strong involvement of the community. Secondly, the recent growth of the private sector with about 1500 private facilities has accelerated caesarean section deliveries (19% in 2007–2014). Despite the awareness of majority (82.9 %), the median coverage for ANC4 is only 31.2%. The critical threshold level of a team of 23 doctors, nurses and midwives per 10 000 people is generally considered necessary to deliver essential health services. Bangladesh remains much below this level at 5.58.[65]

The shortage of staff is compounded by uneven geographical distribution within the country. Poverty and inequity are underlying contributors to many maternal, newborn and child deaths, and evidence shows that poor households have more than twice the risk of mortality compared with wealthy households.[66] Preventing maternal mortality and reducing morbidities calls for concentrated efforts to improve comprehensive coverage and access to family planning programmes and antenatal, childbirth, emergency obstetric and postnatal care across geographical (underserved areas) and Socioeconomic (poor and marginalized) barriers.[67] The higher proportion of maternal deaths is now contributed by postpartum deaths (73% in 2010; up from 67% in 2001) suggesting the need to prioritize the strengthening of access to treatment and improve quality assurance monitoring, referral systems and referral level care. Finally, access for the poor is essential, and as relatively expensive interventions become more widely available, some kind of health insurance (like Demand Side Financing or another model) may be needed to overcome the fear of heavy costs of lifesaving obstetric procedures.[68]

The maternal health function

WHO has envisioned a SEA Region in 2015 that is safer for each mother and her child and it aimed to mould a world where pregnancy, childbirth and care for mother and child are highly valued; where every birth benefited from skilled care; where UHC accounts for the social determinants of health and maintains high quality of care; where health systems are strengthened; and where cooperation among civil societies and partners facilitates skilled care for all mothers. Bangladesh is a story of success that had gripped the imagination of the RMNCAH world. Its outstanding success in meeting contraceptive needs in the 1980s made it the poster child of the development world.

As estimated by the Ministry of Health and Family Welfare, only 38.8% of the total budget of the Health, Population and Nutrition Sector Development Programme (2011–2016) can be met by the Government funds; the remaining 61.2% are expected to be mobilized from the 16 development partners. Of the

64 Ministry of Health and Family Welfare, Government of People's Republic of Bangladesh. (2014). Bangladesh National Strategy for Maternal Health, 2014-2024. Government of people's republic of Bangladesh. Available at: https://drive.google.com/file/d/0B4bW0fmAqJeHRFl0QnVacHpyZ00/edit (Accessed on 5 November 2015).

65 Ministry of Health and Family Welfare, Government of People's Republic of Bangladesh. (2014). Bangladesh National Strategy for Maternal Health, 2014-2024. Government of people's republic of Bangladesh. Available at: https://drive.google.com/file/d/0B4bW0fmAqJeHRFl0QnVacHpyZ00/edit (Accessed on 5 November 2015

66 World Health Organization, Unicef. (2010). Countdown to 2015 Decade Report (2000-2010): Taking Stock of maternal, newborn and child survival. WHO, Unicef. Available at: http://www.who.int/pmnch/topics/child/CountdownReportOnly.pdf (Accessed on 4 november 2015).

67 World Health Organization, Unicef. (2010). Countdown to 2015 Decade Report (2000-2010): Taking Stock of maternal, newborn and child survival. WHO, Unicef. Available at: http://www.who.int/pmnch/topics/child/CountdownReportOnly.pdf (Accessed on 4 November 2015).

68 National Institute of Population Research and Training, MEASURE Evaluation, UNC-CH, USA ICDDR,B. (2012). Bangladesh Maternal Mortality and Health Care Survey 2010. NIPORT, MEASURE Evaluation, and ICDDR,B. Available at: file:///C:/Users/HP/Downloads/tr-12-87-en.pdf (Accessed on 2 November 2015).

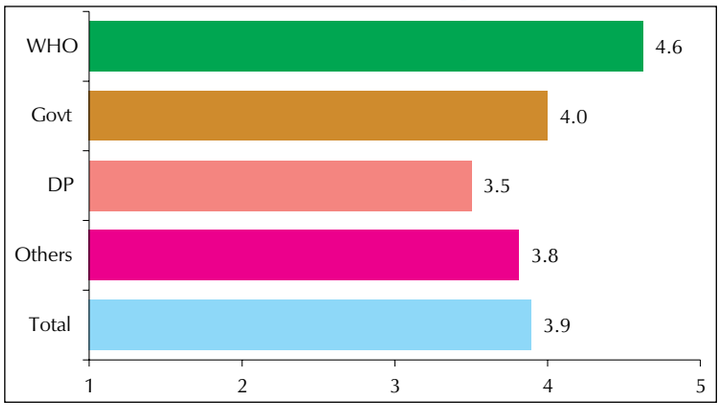
expected contributions by partners, 4.8% is to be contributed by WHO.[69] In total, 30 to 32 different health activities are being supported by WHO and maternal health is only one of these. WHO itself suffers from constraints of resources, both human resource and funds.

Contribution to maternal health

WHO has spearheaded actions that seek to improve maternal health in Bangladesh. Both regional and local activities during 2010–2015 are summarized and assessed here.

Function 1: Setting norms and standards
Setting norms and standards and promoting and monitoring their implementation

Exhibit 17: *Norms and standards, Bangladesh. Likert Scores*



Source: Amaltas, 2015

WHO's norms and standards for maternal care are applied in Bangladesh both with regard to quality of care and in terms of protocols for treatment/care. The Organization has helped to design the accreditation mechanism for SBAs and the standards they must abide by, as well as, in 2010, standards for health services aimed at adolescents. WHO also developed guidelines on Nursing and Midwifery Workforce Planning and Quality Assurance and Accreditation of Nursing and Midwifery Educational Institutions.

WHO Country Office for Bangladesh assistance on setting norms and standards includes maternal complications treatment and prevention; ANC care and visits; standard operating procedures; CSBA manual; and midwifery manual. Although the WCO assists in adapting protocols, it does not follow-up on the compliance of the norms and standards nor does it assess the performance on these protocols. For example, climate change has affected women's health particularly in the Aila (cyclone) affected areas; hence compliance to ANC4 is very low.

> WHO has set the norms and standards for midwifery training and their accreditation; the curricula and training programmes are designed, developed and implemented following the norms and standards of WHO for maternal health in Bangladesh. However, when it comes to monitoring implementation, WHO has no role. Interviewees

Function 2: Providing technical support and building institutional capacity
Providing technical support, catalysing change, and building sustainable institutional capacity

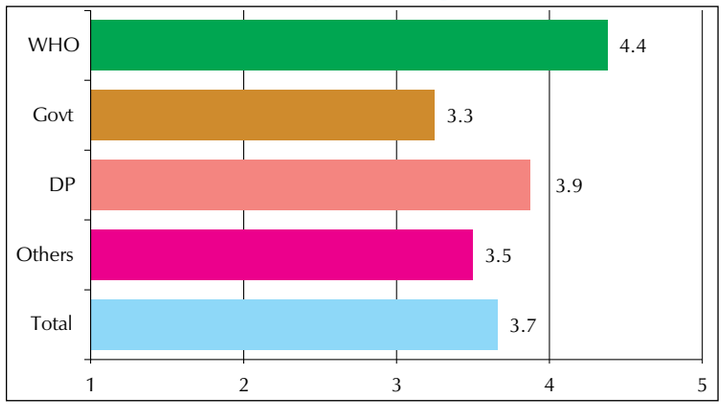
WHO provided technical support for a mid-term review of the menstrual regulation project in December 2010. It also supported, through advocacy, technical advice, capacity-building, improved infrastructure and guideline development, the improvement of midwifery and nursing as well as deployment and retention of public health nurses. Jointly, WHO and UNFPA have supported capacity-building workshops on quality and counselling for family planning, as well as distribution of WHO guidelines and tools. Substantial work has been done in capacity-building across different areas of maternal health.

69 Planning Wing Ministry of Health and Family Welfare Government of the People's Republic of Bangladesh. (2011). HPNSDP Health, Population and Nutrition Sector Development Program (2011-2016). Government of the People's Republic of Bangladesh. Available at: file:///C:/Users/HP/Downloads/PIP_HPNSDP_2011-16_Signed.pdf (Accessed on 2 November 2015).

> WHO is a very sound and esteemed organization, which provides important technical assistance. It provides capacity development particularly of government-run service institutions. Interviewees

WHO has played a strong role in strengthening institutional capacities through technical assistance on developing programme strategies on training, accreditation and services of the midwives; extending EmONC services to the health facilities up to the subdistrict and the union levels; and designing and supporting Demand Side Financing through the Maternal Health Voucher Scheme. WHO provided support to develop the clinical management protocol for management of EmOC for EmONC health facilities. It also supported the development of quality improvement tools for health facilities to improve maternal and neonatal services. Similar support was extended to RMNCAH workforce assessment in March 2014. Further, WHO provided technical support in finalizing and endorsing a Strategic Action Plan on Birth Defects. It supports training of programme management to contribute to strengthening of service delivery. It is also supporting the development of a national strategy on Support to Individual, Family and Community for Maternal and Neonatal Health. Yet WHO's technical assistance has not proved effective in improving the quality of services in maternal health. An area where WHO has not provided support in maternal health is on indirect causes of maternal death (which form 35% of the causes of maternal deaths) such as jaundice, anaemia, pneumonia, heart disease, etc.

Exhibit 18: *Technical support, Bangladesh. Likert Scores*



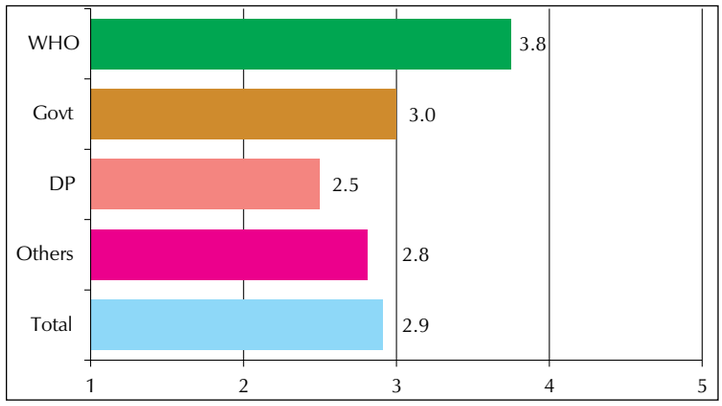
Source: Amaltas, 2015

Function 3: Shaping the research agenda

Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge

WHO has supported research in Bangladesh by disseminating knowledge and guidelines, preparing maternal health intervention frameworks, and spearheading data collection. In 2010, WHO compiled data on adolescent pregnancy and prepared regional and country fact sheets on HIV/AIDS and young people. Specifically in Bangladesh, the areas of research covered by WHO are: Survey of Adolescent Health and Assessment/Evaluation of CSBA performance. WHO has been coordinating with International Centre for Diarrhoeal Disease Research, Bangladesh and other agencies to conduct research. An important contribution has been its support to the Health Facilities Survey 2014. However, WHO's role on shaping the research agenda of the country through relevant discussion forums is limited.

Exhibit 19: *Research agenda, Bangladesh. Likert Scores*



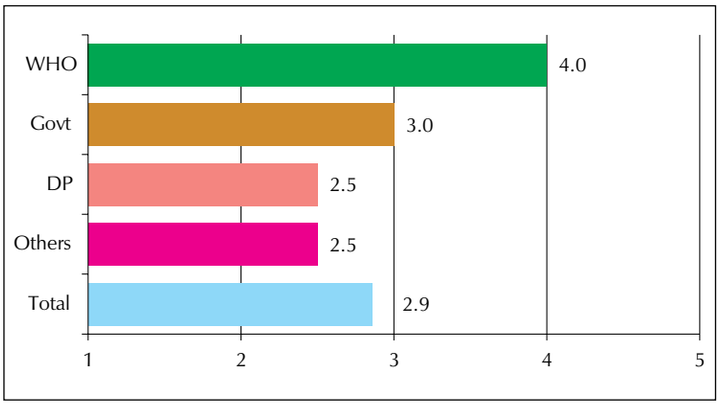
Source: Amaltas, 2015

> WHO's role in Bangladesh is not very strong and I do not know who is in charge of maternal health in WHO in Bangladesh. Rather, UNFPA's role is more visible. Interviewee

Function 4: Articulating policy options
Articulating ethical and evidence-based policy options

In conjunction with research and standard-setting efforts, WHO articulates evidence- and ethical policy options. WHO supported short programme reviews for maternal and reproductive health. It also provided support to update and revise the National Maternal Health Strategy of 2001. National standards on adolescent-friendly health services were scaled up in 2012–2013 underscoring the application of standards of care.

Exhibit 20: *Evidence-based policy, Bangladesh. Likert Scores*



Source: Amaltas, 2015

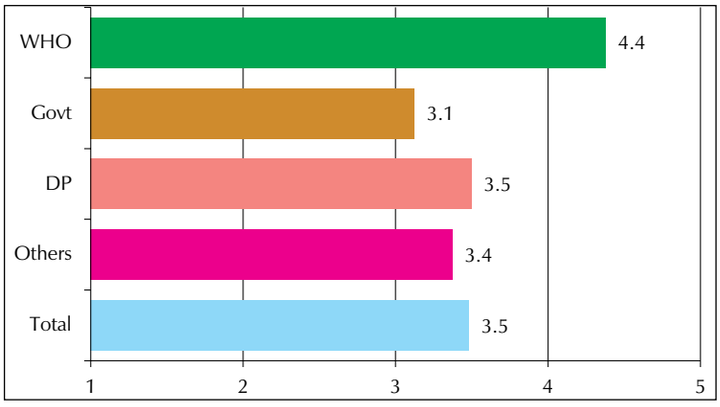
WHO's role in Bangladesh on developing evidence-based policies is strong. WHO played a distinct role in developing policies and strategies on 3-year midwifery and 6-month post-basic nurses' midwifery training. It also supported designing of policies, strategies and programmes on Demand Side Financing providing allowances on delivery and treatment of complications. It has been highlighting the role of midwives, and the fact that midwifery care can be effective in addressing maternal, newborn and infant mortality. It has accordingly been working with the Government to enhance the access of mothers and children to quality midwifery services. Similarly, WHO has also been advocating for safe blood transfusion as a key life-saving intervention to save mothers and neonates are bleeding during or after childbirth is a common cause of maternal mortality.

> WHO assists with the development of protocols. But on policy formulation, WHO has little contributions at the country level. Other players see WHO as a source of essential clearance on ethical standards and policies; particularly in this regard, the contributions of SEARO and HQ are prominent. Interviewee

Function 5: Monitoring health situation and trends
Monitoring the health situation and assessing health trends

Monitoring the health situation, assessing trends, and using these findings to inform health activities are other critical functions of the Organization. WHO coordinated efforts to review contemporary estimates of MMR data. Bangladesh received support from WHO in a mid-term review of the menstrual regulation project in December 2010; the data were used to mobilize resources from other donors. WHO has also been supporting a project on Strengthening and Expansion of Newborn Birth Defect Surveillance in Bangladesh in five tertiary and three district and Upazila facilities.

Exhibit 21: *Monitoring Health, Bangladesh. Likert Scores*



Source: Amaltas, 2015

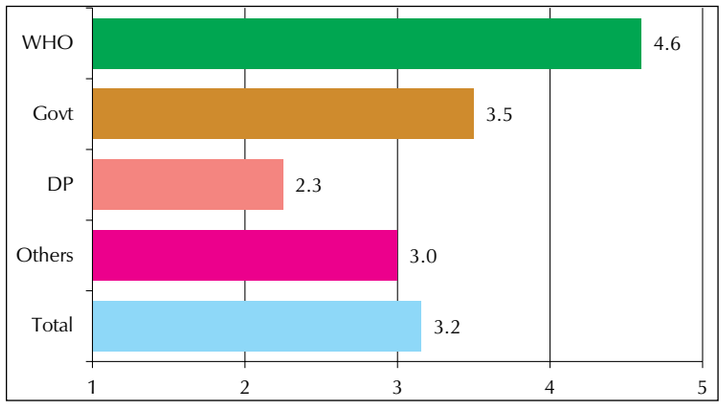
However, WHO's role is limited with respect to strengthening monitoring information systems (MIS), although it has assisted the development of the MIS system for the Demand Side Financing scheme and District Health Information System.

Function 6: Providing leadership on health

Providing leadership on matters critical to health and engaging in partnerships where joint action is needed

WHO plays an active role in convening, communicating, path lighting and coordinating efforts towards improved maternal health in the Region. In 2014, it was the Chair, and is now the permanent Co-Chair of the Donor Consortium. WHO has been a vocal advocate increased maternal health resources and improved collaboration among society's various sectors in addressing problems of access.

Exhibit 22: *Leadership in health, Bangladesh. Likert Scores*



Source: Amaltas, 2015

> WHO is doing a lot to develop partnerships on maternal health, particularly among the donors. Interviewee

Yet some interviewees felt that WHO is not as much a leader as a partner in the development process. Other criticisms were that WHO does not support the country's maternal health programme as much as it supports the DGHS' public sector programme. Sometimes, WHO publications and reports are not available to stakeholders. A general feeling in many interviews was that WHO needs to forge more effective partnerships with a wider set of stakeholders, including civil society, professional organizations and institutions to be effective in this core function.

Conclusion

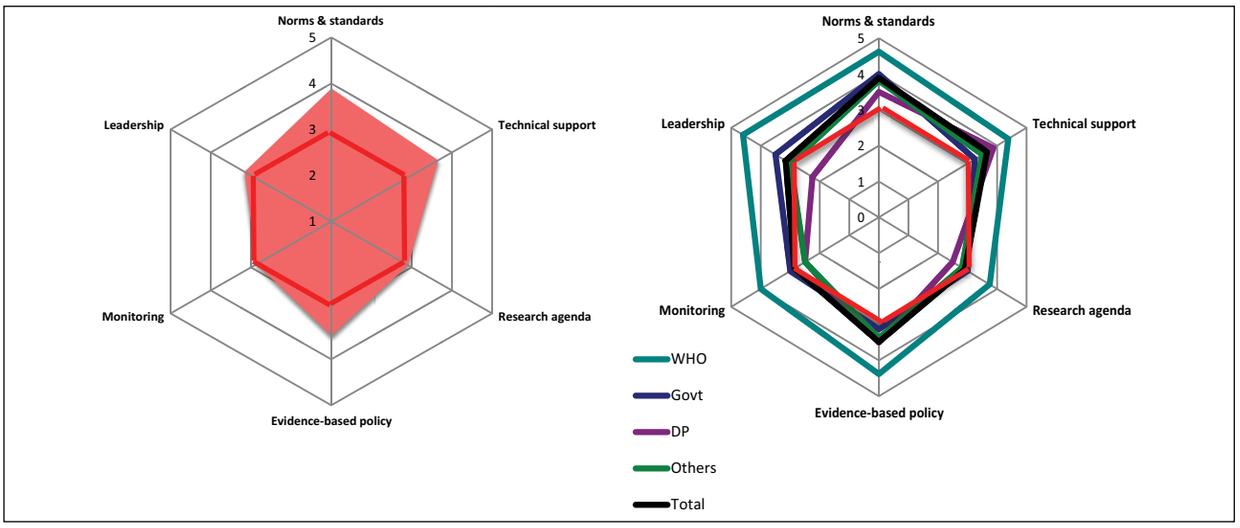
MMR in Bangladesh has declined by about 70% since the 1990s. ANC visits have increased by 51%; the overall proportion of births attended by skilled health personnel increased by more than eightfold and there is significant increase in the rates of institutional deliveries. All these indicators presage an achievement of the maternal mortality targets soon.

WHO has a well-established role in the health sector in Bangladesh. All stakeholders are keen to see an expansion of WHO assistance in the sector and feel that their contribution could be even more valuable than it presently is. Analyses of the six critical roles show that overall WHO in Bangladesh is performing generally at a satisfactory level. However, WHO itself feels that it could, if resources allow, perform more proactively in the areas of research, monitoring and leadership.

However, WHO must have more technically qualified staff in WCO; the present resourcing may be linked to the budgets available for what is a very wide range of subjects on which WHO is to provide its expertise. The role of staff in WCOs must be enhanced to approximate the role played by HQ in terms of professional quality. Demands for WHO's technical services is very large, but the WCO is already overstretched. This is a systemic issue that must receive attention from WHO as part of its reform thinking.

There is also an incomplete and sometimes erroneous understanding of the role of WHO. This adds to a sense of frustration with the seeming lack of action on the part of WCO. To redress this, WHO needs not only to understand what others understand about the Organization but also what others expect from WHO.

Exhibit 23: *Core functions: average and by type of interviewee, Bangladesh. Likert Scores*



Major challenges that WHO faces in its work on maternal health are to strike the balance between demands for technical assistance between and among public (DGHS and Directorate of Family Planning) and non-public sector programmes (NGOs, Civil Society Organizations or CSOs, Private Sector and the Local Government). This will require improvement in the technical and communication skills of WCO staff. It will need more funds to be able to do so. In select cases, it must make the shift from being a good partner to being an effective leader. One step to do this will be to deliberately increase the WHO role in assessing programme gaps by using reliable and objective data; and pursuing affirmative action to ensure quality of services and strengthened monitoring.

Key recommendations arising out of this study include:

- continue with both midwifery and CSBA training until community and facility demands are met;
- strengthen advocacy programmes at the community level to demand skilled attendance at birth, reduce child marriage and adolescent pregnancies, and violence against women;
- promote the image of nursing services at the policy (within the Government of Bangladesh and DGHS), planning, implementation levels to reach the communities: this is a serious gender issue too;
- address inequities in maternal health services across sociocultural class, economic and geographies.

Data sources: Primary qualitative data for the case study was collected through interviews with government officials, staff of government and nongovernment institutions, WHO and partners. Twenty two key informants from seven government units, 10partners and five CSOs were interviewed, and 14 Likert Scale scores obtained. In addition, more than 21 papers, reports, guidelines, presentations, and online statistics on maternal health in Bangladesh and the Region were consulted to triangulate information received from KII and Likert Scale.

Limitations:

- Several key informants were not familiar with the WHO contribution across all six functions, or judged WHO's performance based on their own organizational expectations.
- Data on WHO performance in maternal health was sparsely represented, including on resources available and utilized by WHO.

Capital:	Jakarta*	Life expectancy at birth m/f:	69/73*
Population:	249 866 000*	Infant mortality rate:	24.5*
Rank in HDI:	108#	Neonatal mortality rate:	14.4*
World Bank income classification:	Lower middle#	Under 5 mortality rate:	29.3*
GNI per capita (PPP):	US$ 9260*	Maternal mortality rate:	190*
Expenditure on health per capita:	US$ 273*		

*WHO 2015 #UNDP 2013

Indonesia

The country context

The Republic of Indonesia is an archipelago of almost 18 000 islands encompassing 34 provinces and special administrative regions with more than 240 million people. There are hundreds of distinct ethno-linguistic groups, which reside in areas as diverse as densely populated Java to sparsely populated regions in Kalimantan and Papua. Indonesia's HDI rank of 108 is above the average for countries in the medium human development group and below the average for countries in East Asia and the Pacific. Between 1980 and 2013, Indonesia's HDI value increased by 45% from 0.471 to 0.684; gross national income (GNI) per capita by about 306%; mean years of schooling by 4.4 years; and life expectancy at birth increased by 12.4 years to 71 years.[70]

Indonesia is in the midst of implementing a series of health system reforms aimed at attaining universal health coverage by 2019. The universal right to health care was included as an amendment to Indonesia's constitution in 1999. However, the impetus for UHC came a few years later, in 2004 landmark legislation—the Sistem Jaminan Sosial Nasional Law—which formed the legal basis for attaining several social protection objectives in the country. In 2011, the government passed a ground-breaking follow-up law that defined its

Key developments in maternal health

1988:	First national seminar for Safe Motherhood held in Indonesia with support from WHO. Safe Motherhood programme adopted.
1989:	Commenced *Bidan di Desa* to train village midwives for increased maternal health access.
2000:	Signed Millennium Declaration with commitment to reach MMR of 102 per 100 000 live births by 2015.
2000:	Adopted WHO global strategy –Making Pregnancy Safer–as the fundamental approach to maternal health.
2001:	Shifted responsibility of maternal health to district level via decentralization and devolution of authority to districts.
2004:	Began the National Health Insurance Plan for the Poor – *Askeskin*– thatincludes maternity care.
2010:	National Medium Term Development Plan set MMR target at 118 per 100 000 births by 2014.
2011-2013:	Began *Jampersal*programme to accelerate maternal and newborn deaths reductions through free and comprehensive care with an emphasis on promoting institutional deliveries.
2012:	Launched the National Action Plan 2012–2015for accelerating reductions in maternal mortality ratio.
2014:	Began implementation of universal health coverage through the National Health Insurance System and dismantled *Jampersal*.

70 World Health Organization. (2015). Global Health Observatory (GHO) data: World Health Statistics 2015. WHO. Available at: http://www.who.int/gho/publications/world_health_statistics/EN_WHS2015_Part2.pdf?ua=1(Accessed on 2 November 2015).

administrative and implementation arrangements—the Badan Penyelenggara Jaminan Sosial or BPJS Law—which stipulated that several existing contributory and noncontributory social health insurance schemes would be merged to provide streamlined uniform benefits under a single-payer umbrella beginning from 2014. Following institutionalization of the single payer insurance administration (BPJS Kesehatan) in 2014, the government plans to incrementally extend coverage to the entire population by 2019. BPJS Kesehatan has started to contract with both public and private providers for delivery of the benefit package.

In some ways, the country is an under-performer given its economic status and health expenditure per capita. A component used to estimate the life expectancy is the maternal mortality rate. If appropriate policies and programmes were undertaken to achieve the maternal mortality targets of the MDG 2015 (102 per 100 000 live births) or even the National Medium–Term Development Plan 2010–2014 (118 per 100 000 live births), the HDI score would increase about 0.024 value points jumping to a rank of 99, and placing Indonesia in the high human development group.[71]

Maternal health in Indonesia

Current priority areas in maternal health

Utilization of most key maternal health services is relatively high in Indonesia. Latest data from the 2012 IDHS and 2013 Basic Health Research indicate that 96% of mothers received ANC from skilled providers, with 88% of all pregnant women receiving the WHO recommended four or more ANC visits during their last pregnancy.[72] In addition, 83% of all births occurred with the SBA and 80% of mothers received postnatal care within two days following delivery. However, facility-based deliveries remain relatively low: only about 63% of all deliveries occur at a health facility in Indonesia; 13% are assisted by traditional birth attendants TBA.[73] Several studies have reported that possible reasons for maternal deaths include unskilled attendant during delivery, lack of knowledge of danger signs, and delayed referral. In addition, horizontal referrals have contributed to the delay in proper management of birth delivery complications.[74]

Although the achievement of the main indicators of maternal health services in Indonesia is quite high, the MMR is surprisingly much higher than in neighbouring countries such as Cambodia, Pakistan, Nepal, and Bangladesh. Sri Lanka for example, has similar gross domestic product (GDP) and health expenditure per capita as Indonesia, but has a substantially lower MMR. Indonesia has a higher GDP per capita and health expenditure per capita than India, but has a similar MMR. This suggests that the high MMR in Indonesia cannot solely be attributed to the economic status of the country nor its health expenditure. Previous assessments indicate that continued use of TBAs, poor access to emergency obstetric services, and poor quality of health care have contributed to high levels of maternal mortality.[75]

There is also some uncertainty about the exact level of Indonesia's MMR. Joint United Nations-World Bank (UN-WB) model-based estimates report an MMR of 190 per 100 000 live births in 2013. The Institute for Health Metrics and Evaluation model estimated an MMR of 189 in 2011. The 2012 IDHS estimates based on sibling-survival data indicate an MMR of 359, although it is important to note that this latter estimate is derived from a sample of only 92 maternal deaths over a five-year period. Despite the uncertainty in the estimates of the exact level of MMR in Indonesia, it remains clear that it is high and especially so for a country in which the population has ostensibly had access to universal maternal health coverage.

71 United Nations Development Project. (2014). Human Development Report 2014: Explanatory note on the 2014 Human Development Report composite indices, Indonesia. UNDP. Available at: http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/IDN.pdf (Accessed on 3 November 2015).

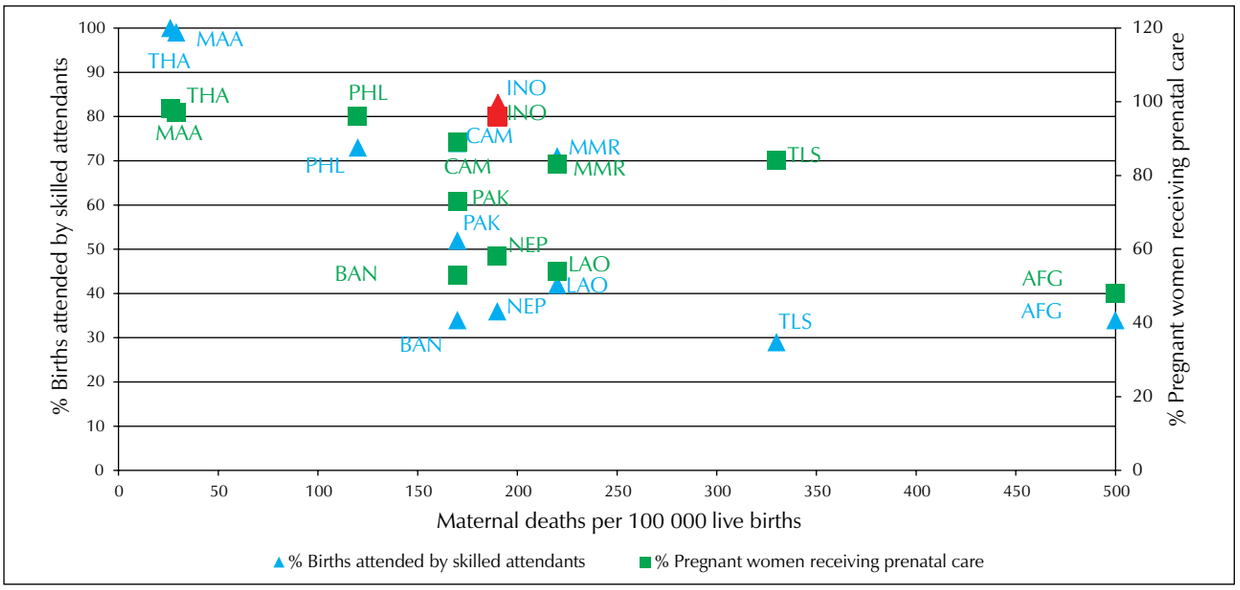
72 Statistics Indonesia , National Population and Family Planning Board , and Kementerian Kesehatan , and ICF International. 2013. Indonesia Demographic and Health Survey 2012. BPS, BKKBN, Kemenkes, and ICF International. Available at: https://dhsprogram.com/pubs/pdf/FR275/FR275.pdf (Accessed on 4 November 2015).

73 Ministry of Health and National institute of health Research and Development. (2014) National Report on Basic Health Research, RISKESDAS, 2013, Jakarta, Indonesia.

74 Joint Committee on Reducing Maternal and Neonatal Mortality in Indonesia; Development, Security, and Cooperation; Policy and Global Affairs; National Research Council; Indonesian Academy of Sciences. (2015). Reducing Maternal and Neonatal Mortality in Indonesia: Saving Lives, Saving the Future (2013). Available at: http://www.nap.edu/catalog/18437/reducing-maternal-and-neonatal-mortality-in-indonesia-saving-lives-saving (Accessed on 2 November 2015).

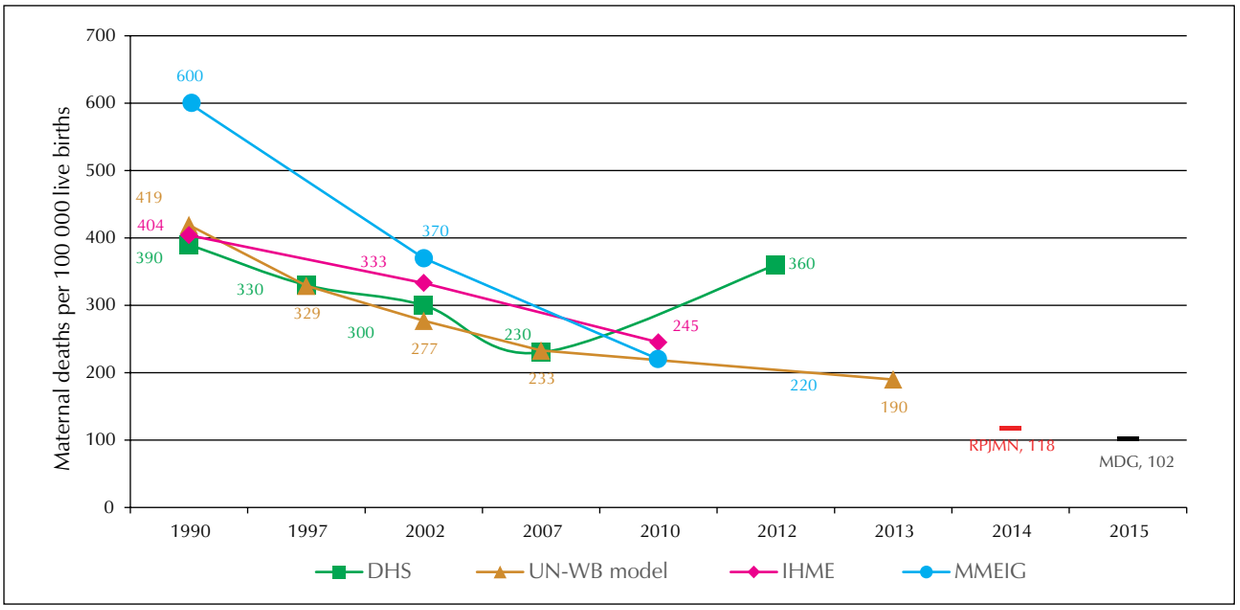
75 World Bank. 2010. "…and then she died': Indonesia maternal health assessment Report. World Bank. Available at: http://documents.worldbank.org/curated/en/2010/02/12023273/died-indonesia-maternal-health-assessment (Accessed on 5 November 2015).

Exhibit 24: *Correlation between maternal mortality ratio, skilled birth attendants and prenatal care coverage*



Source: Trends in Maternal Mortality: 1990 to 2015. WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division. 2015.

Exhibit 25: *Maternal mortality ratio trends by various sources, Indonesia*



Source: Progress towards Millennium Development Goals 4 and 5 on maternal and child mortality: an updated systematic analysis. Lozano et. al. The Lancet Volume 378, No. 9797, p1139–1165. 2011.

There is also considerable variation in the MMR across various geographies of Indonesia and social groups, especially in some of the poorer and more remote regions of the country. Despite the relatively high utilization rates for most key maternal health services, the level of maternal mortality remains unequal, especially in provinces such as West Papua, North Maluku, Papua, Gorontalo, West Sulawesi, Maluku, and South Kalimantan. For a variety of reasons, the high utilization of maternal health services does not translate into improvements in maternal health outcomes.[76]

76 Souza, JP et al. 2013. "Moving beyond essential interventions for reduction of maternal mortality (the WHO multi country survey on maternal and newborn health): a cross-sectional study." Lancet 381: 1747-55. Available at: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60686-8/abstract (Accessed on 5 November 2015).

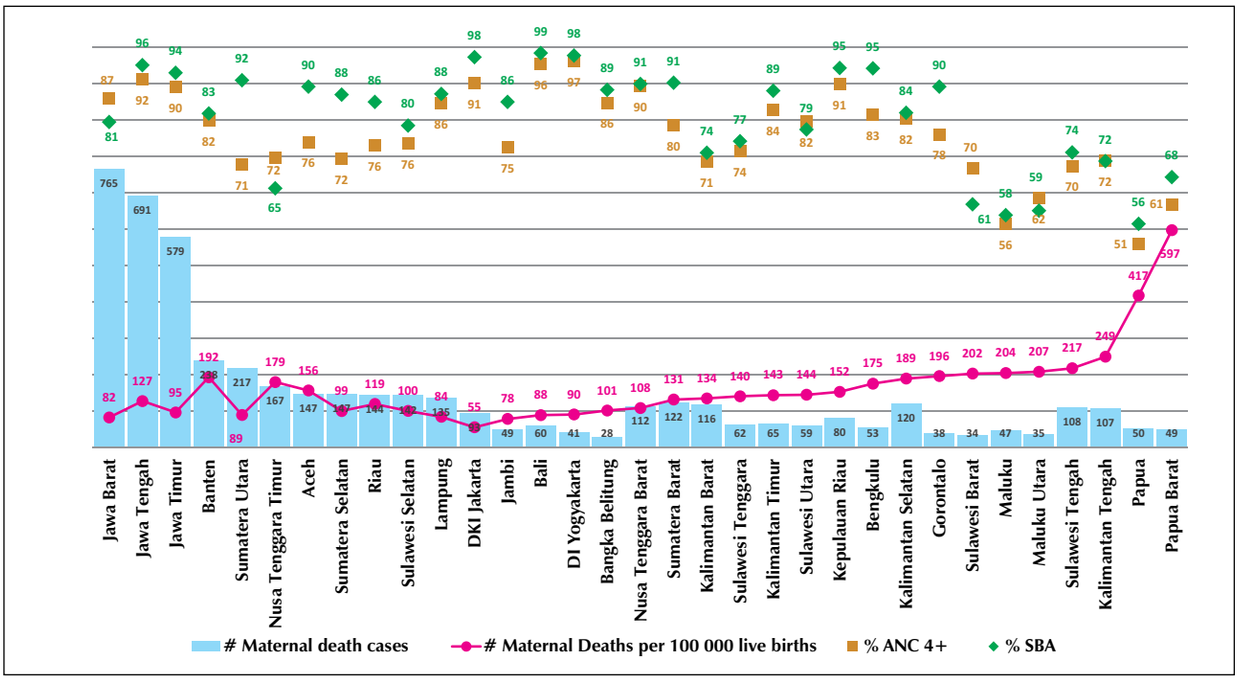
By most estimates, Indonesia has made steady and significant progress in attaining reductions in maternal mortality in the past few decades. Analyses of the MMR profile of Indonesia (such as Institute for Health Metrics and Evaluation model, the joint UN-WB data and IDHS) indicates an annual decline ranging between 1.9% and 3.5% depending on the years included and the methodology adopted. By comparison, in order for Indonesia to meet the MDG 5 target of reducing MMR by 75% over 25 years, a 5.4% reduction in the MMR per year is needed.

The decline in maternal mortality in the past few decades is likely the result of improvements in general socioeconomic conditions, as well as government initiatives specifically targeting maternal health. In addition to improving financial access via the expansion of social health insurance coverage, Indonesia has implemented several programmes that include improving access to family planning services, overhauling the national midwifery programme, the introduction of special waiting rooms for supervised deliveries in remote villages, and additional financing for puskesmas in regions with the poorest maternal health indicators.[77]

Current challenges in maternal health

The issue of high maternal mortality remains at the top of the health care agenda in Indonesia. The National Action Plan for Accelerating Reductions in Maternal Mortality Ratio 2012–2015 presents three major strategies: (i) improving coverage and quality of maternal health services; (ii) improving local government and private partnerships; and (iii) empowering families and communities. It outlines seven core programmes: (i) ensuring that village midwives work properly; (ii) ensuring that basic EmONC functions 24/7; (iii) ensuring that comprehensive EmONC functions 24/7; (iv) ensuring that the referral system works effectively; (v) strengthening the district for good governance; (vi) intersectoral and private partnership; and (vii) improving birth preparedness and complication readiness in family and community. The Directorate of Maternal Health of the Ministry of Health is responsible to make sure that implementation of these core programmes are financially and technically supported. According to the Annual Report of the Directorate, all targets in key programme indicators for the year 2013 have been achieved.[78]

Exhibit 26: *Maternal deaths and key maternal service indicators by province, Indonesia*



Source: Data Communications Integrated Nutrition and KIA. Directorate General of Nutrition and KIA. Bhaktihusada. 2015.

77 Webster, P. 2012. "Indonesia makes maternal health a national priority." *Lancet* 380: 1981-1982. Available at: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)62141-2/abstract (Accessed on 3 November 2015).

78 Direktorat Bina Kesehatan Kerja Dan Olahraga Direktorat Jenderal Bina Gizi Dan Kia Kementerian Kesehatan. (2013). Laporan Akuntabilitas Kinerja Direktorat Bina Kesehatan Kerja Dan Olahraga. Bakti Husada. Available at: http://www.gizikia.depkes.go.id/wp-content/uploads/downloads/2014/05/LAKIP-2013.pdf (Accessed on 4 November 2015).

Key issues identified by key informant interviews (KII) interviewees include: effective decentralization of health management and financing; improving compliance of service providers to standards set by MoH through an effective monitoring system; reducing the number of midwifery schools and improvement in midwifery through pre- and in-service training; improving regulation and accountability of the private sector in urban areas; and better distribution of related specialists in the country.

The maternal health function

WHO opened its office in Indonesia in 1950 with the overall goal to improve the health of the people of Indonesia by supporting health development and an effective response to urgent needs, advocating health promoting policies, raising awareness of neglected public health priorities and providing technical leadership in collaboration with the government, donor partners and other actors in health. WHO introduced the formulation of CCS in 1999 as part of the Organization's new corporate strategy. In 2000, a WHO CCS for Indonesia was among the first to be developed covering the period 2001–2005. To address the purpose of this evaluation, i.e. assessing the contribution of WHO to maternal health in Indonesia through 2010–2015, two CCSs are used as a reference; CCS 2007–2011 and CCS 2013–2017. In general, maternal health was included as the strategic priority number 3 in both the CCSs, which is to "promote policies and strengthen programmes to improve child, adolescent and reproductive health", with some differences in strategic action or focus area.

The CCS 2014–2019 has a significantly different cooperation framework from the previous CCS. The overall UN agencies Cooperation Framework with the Government of Indonesia changed from the UN Development Assistance Framework to the UN Partnership Development Framework. This is associated with the change in Indonesia's status as a middle income country, which has made the Government's position stronger. The Government is now more assertive about its own strategies and abilities, obliging a change in the manner in which WHO has traditionally provided its support to the country. This situation poses a challenge for WHO to remain relevant, perform its functions while providing the maximum benefit to the health of the people of Indonesia.

There does not appear to be much correlation between the priority issues raised by interviewees, issue of high MMR identified by the MoH and its response and the areas of concentration of the CCSs. Linked to this, is the very small allocation of WHO funds to support maternal health programmes in Indonesia, representing 1.9% (US$ 926 000) of funds for biennium 2012–2013 and 1.7% (US$ 524 000) of funds for biennium 2014–2015. It is also relevant that WHO funds made up only 1.2% (US$ 83 000) of the overall funds managed by the Directorate of Maternal Health (US$ 6.9 million) in 2013, and only half of the contributions of UNICEF (US$ 157 000) and UNFPA (US$ 180 000).[79] Nonetheless, there appeared to be the impression within the WHO that its support was instrumental in improving the quality of maternal health programmes in Indonesia through its strategic activities.

79 Country Office for Indonesia, World Health Organization. (2008). WHO Country Cooperation Strategy 2007-2011. Available at: http://www.who.int/countryfocus/cooperation_strategy/ccs_indonesia_2007_2011_en.pdf (Accessed on 2 November 2015).

Exhibit 27: *Maternal health strategic priorities in Indonesia*

Strategic priority 3 in CSS 2007– 20111	Main focus area 3 in CSS 2013– 20171
3.1 Provide technical support and promote the scaling-up of priority interventions;	3.1 Support improvement of access to quality maternal, neonatal, child and adolescent health services;
3.2 Promote increased access for all to good quality preventive and curative services by public and private providers;	3.2 Promote diversification of reproductive and sexual health services, including adolescent health, reproductive tract infection and cancers, and healthy ageing;
3.3 Advocate strengthening of national capacity to integrate gender equity and human rights approach into policies and programs;	3.3 Advocate strengthening of national capacity to integrate gender equity and a human rights approach into policies and programmes;
3.4 Support coordination of stakeholders and resource mobilization to facilitate implementation research (or essential national health research); and	3.4 Promote gender equity and quality and actions against violence against women.
3.5 Support implementation of nutrition interventions – and their integration – in all related programmes.	

Human resources allocations have seen several changes in the last 5 years making it difficult for the government and partners to establish steady relationship with the Organization. Presently, the Team Leader position is filled by an acting Team Leader who leads the Health Systems Development unit. Meanwhile, the National Professional Officer (NPO) for RMNCAH is also responsible as Equity, Gender and Human Rights Focal Point, with an estimated 70– 80% time available for maternal health.

Exhibit 28: *WHO staff working time for maternal health in Indonesia 2010–2015*

Position	2010	2011	2012	2013	2014	2015
NPO Maternal & Reproductive Health, and also responsible for Equity, Gender and Human Right	80%	80%	80%	80%	80%	80%
Team Leader for Health Systems Development and acting for RMNCAH					10%	10%
Team Leader for Reproductive, RMNCAH				30%	30%	30%
Team Leader for RMNCAH, and also responsible for Health Human Resources, Hospital Accreditation and Nutrition	20%	20%	20%			

WHO, jointly with UNICEF, UNFPA, the World Bank , United Nations Development Programme (UNDP) and the Joint United Nations Programme on HIV and AIDS, has established mechanisms of communication and coordination in the maternal and child health (MCH) programmes in Indonesia through the umbrella of the H4+ (UN Programme on HIV and AIDS, UNFPA, UNICEF, UN Women and WHO) partnership. When it began, partnership coordination meetings took place on a regular basis at the level of country representatives, team leaders, and national professional officers . Gradually these have dwindled, and currently only the meetings of the NPOs survive. In addition, WHO has also established cooperation with several professional organizations related to maternal health such as Indonesia Social Obstetrics and Gynaecology Association and Indonesian Midwifery Association; research and educational institutions such as the National Institutes of Health and Research Development, Public Health Faculty of the University of Indonesia, and the Indonesian Centre for Medical Student Activities; and development agencies such as USAID and Department of Foreign Affairs and Trade (DFAT Australia). Development partners are also sometimes a source of funding for such activities as research on quality of care and to provide technical assistance for the development of MoH National Action Plan for accelerating reductions in maternal mortality ratio.

Contribution to maternal health

Function 1: Setting norms and standards

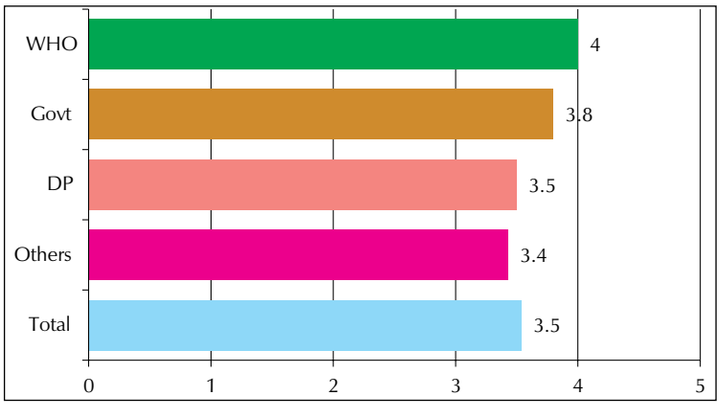
Setting norms and standards and promoting and monitoring their implementation

WHO has the unique mandate to generate evidence, and to lead processes to synthesize and interpret evidence to develop norms, standards, policies, guidelines and tools. During 2010–2015, there are several standards for maternal health developed and or adopted by the Ministry of Health in which the country office played a significant role in promoting and facilitating the process. These include:

- Pocket Book for Maternal, Newborn, and Reproductive Health in Primary Health Care and Referral Hospitals, 2013. MoH has adopted, published and disseminated the standard but has not yet issued the Ministry Decree, which will lead to an obligation of the government to fund the achievement of the standard at the service provider level.
- Standard assessment tools for improvement of quality of care on maternal and neonatal health, 2013.
- Adaptation of medical and eligibility criteria wheel for contraceptive use in collaboration with obstetrics and gynaecology organization and decision-making tool for family planning clients and providers, 2011.
- Revision of maternal perinatal audit tools, 2011. The revision was undertaken following training of trainers for reviewers and manager, socialization of the revision of maternal perinatal audit to 33 provinces, and piloting of the documentation of maternal death review (MDR) in several districts.
- Standard for integrated data driven District Planning for Maternal, Newborn, and Reproductive Health, 2015.
- Adoption of universal access to sexual and reproductive health indicators in collaboration with UNFPA, 2011.

Interviewees agreed that WHO has met their expectation in setting norms and standard functions. This function received an overall score of 3.6, above the meets expectations level. Most interviewees noted that they refer to norms and standards from the WHO website. Several remarked that they would like to receive these more proactively from the WCO; however, even the availability on the WHO website is already a great assistance.

Exhibit 29: *Norms and standards, Indonesia. Likert Scores*

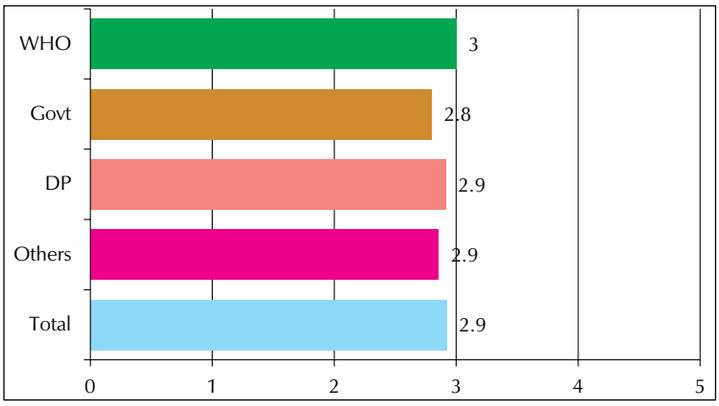


Source: Amaltas, 2015

> WHO is well acknowledged in adapting global standards to local context. Interviewee

Function 2: Providing technical support and building institutional capacity
Providing technical support, catalysing change, and building sustainable institutional capacity

Exhibit 30: *Technical support, Indonesia. Likert Scores*



Source: Amaltas, 2015

WHO's intention in providing such support is to help countries to implement contextually relevant and technically sound programmes. By being present and available in the country, WHO is in a good position to contribute to catalysing change and building sustainable institutional capacity. A critical area identified by some was to build capacity in maternal health policy analysis and management; however, the interviewees also noted that WHO itself needs greater capacity in these areas. Policy analysis ideally involves analysing problems from several standpoints: the problem, and who is affected; possible solutions; and the political and institutional feasibility as well as technical desirability of implementing any of them. This view is particularly relevant because of the unwieldy list of WHO programmes between 2010 and 2015 ranging from training of trainers on operational research in reproductive health, workshop on the review process to strengthen the focus on equity, determinants of health, gender, and human rights in Indonesia's Newborn and Maternal Health Action Plan; development of equity for maternal and newborn health module and link with District Team Problem Solving; to orientation of the maternal and child health household survey tools and adaptation and field testing. The visible impact of the WHO's contribution is limited to certain technical areas such as improved knowledge and awareness of service providers on maternal health care standards, and improved capacity of district health offices for integrated equity and right based planning for maternal health programme. However, partners pointed to a significant reduction of WHO initiatives in supporting MoH to be more adaptive to the lessons from the field in the last few years.

On average, interviewees from UN agencies, MoH, and Civil Society Organizations believe that WHO has provided technical support and institutional capacity to MoH as expected with an overall score of 2.9.

Function 3: Shaping the research agenda
Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge

WHO Country Office for Indonesia has been quite active with respect to shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge function. Among these are:

- In 2012 MoH, WHO, and relevant professional associations undertook a maternal health services quality assessment in 100 health facilities all over Indonesia. The study identified major gaps, including lack of knowledge and skills to manage normal deliveries and recognize obstetric and neonatal complications and perform life-saving procedures, and shortages of equipment and supplies. It concluded that greater efforts are needed to standardize quality of care throughout the health system, improve supervision and monitoring and strengthen accreditation and regulation of public and private providers, some of which have become the core of National Action Plan to accelerate MMR reduction.

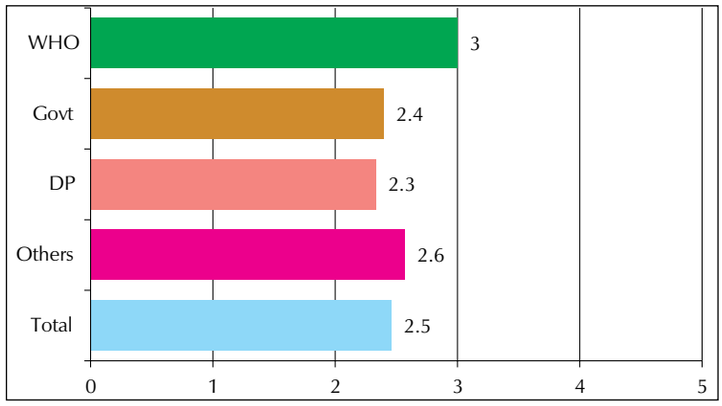
> We used the services quality assessment tool developed by WHO in our recent study. The NPO was very kind and supportive in sharing the lessons learnt, and presenting the assessment process and result. Interviewee

- In 2012, WHO with a consultant from School of Public Health, University of Indonesia piloted community-based MDR in several districts. This has led to new knowledge in shaping the surveillance curriculum and may be adopted as an intervention to reduce maternal mortality. The project has yet to follow through on this innovation.
- In 2013, WHO led and facilitated MoH and development agencies to conduct short programme review for maternal, newborn, and reproductive health in Nusa Tenggara Timur and West Java where many of the development agencies fund programmes. Yet, only a fraction of lessons learnt from subnational programmes supported by development agencies, which show promising results have been adopted in the Ministry of Health Action Plan.

> Gaps are expected to be filled by WHO in translating operational research findings from development agencies into the measurable policy and programme of MoH. Interviewee

- In 2013–2014, WHO with funding from The Global Fund to fight AIDS, Tuberculosis and Malaria, led operational research and demonstration sites of integrated preventing mother-to-child transmission (PMTCT) into ANC programmes in five selected provinces. The result of this research was then adopted in PMTCT National Action Plan and scaled-up across the country with support from the Global Fund to fight AIDS, Tuberculosis and Malaria.

Exhibit 31: *Research agenda, Indonesia. Likert Scores*



Source: Amaltas, 2015

The findings for the contribution of WHO in shaping the research agenda indicates that WHO does not yet meet the expectation of interviewees. Nevertheless, there were 8 out of 26 interviewees who felt that WHO has met their expectation. These are mostly from other UN agencies and CSO, which were to some degree, involved in research led by WHO. The lowest average Likert Scale score is from partners, which expect WHO to help adoption of the lessons learnt from their subnational funded programme to the national level policy.

Function 4: Articulating policy options

Articulating ethical and evidence-based policy options

Evidence is best put in practice when it is generated as part of a cycle that links research and development of policies, norms, standards and tools with implementation, monitoring and evaluation. Such an approach ensures that research and development are focused and relevant; and that countries are supported in their efforts to implement evidence-based and pragmatic policies and strategies. WHO in Indonesia has been leading several studies, as described in the shaping research agenda section, to gather evidence for informing policy formulation at the national level.

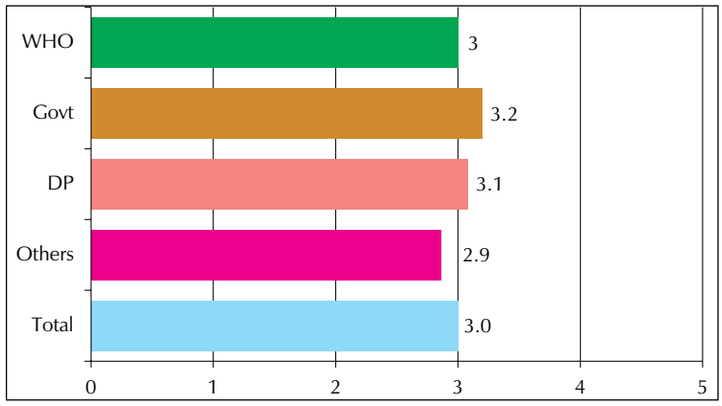
> Lately WHO has provided evidence on quality of care issues, which led to awareness in MoH that the problem is not merely the physical access, but also quality of care. Interviewee

In addition to such research, WHO Indonesia has also regularly supported secondary data analysis on MMR from the National Basic Health Research 2010 and 2013, IDHS 2012, Health Facility Based Survey 2011 and several ad hoc studies to generate evidence on the causes of maternal death. This is to support better policy and strategy at all levels of government as well as for other stakeholders that support or implement maternal health programme. However, most of evidence generated by WHO is limited in its scope, such as quality of health workers and care, referral and response time, and community awareness on complication signs in pregnancy. Such evidence would clearly not be sufficient to respond to worsening maternal health status in Indonesia since it does not discuss the root of the problem, which is poor health governance due to decentralization and weak intra and intersectoral coordination and collaboration.[80]

> Governmentwide decentralization in Indonesia shifted responsibility for financing, planning and delivering health care to the district level. However, many districts have not yet developed the capacity to plan and manage their health budgets, identify local health needs and set targets and monitor progress – this reality never been considered in policy. Interviewee

The average Likert Scale score is 3.0, which indicates that WHO in Indonesia has met expectations in the ethical and evidence-based policy option function. Yet there are 6 of 26 KII interviewees who do not think that WHO is meeting their expectations, mostly due, in their perception, to the limited WHO support to MoH to accelerate MMR reduction in Indonesia. According to these interviewees, WHO has not taken up the cause of better health governance that is not the exclusive preserve of MoH. Actors such as civil society networks, individual NGOs at the international and community levels, professional groups, philanthropic foundations, trade associations, the media, national and transnational corporations, and individuals and informal diffuse communities that have found a new voice and influence have an influence on decision-making that affects maternal health and need to be considered in developing evidence-based policy options.

Exhibit 32: *Evidence-based policy, Indonesia. Likert Scores*

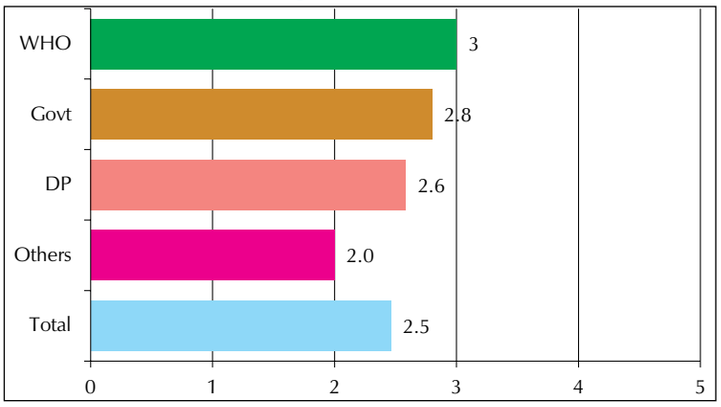


Source: Amaltas, 2015

Function 5: Articulating policy options
Monitoring the health situation and assessing health trends

WHO carries out its monitoring responsibilities in countries in collaboration with MoH and national statistical institutions. The Health Metrics Network, hosted by WHO, is a global initiative involving collaboration in strengthening country health information systems to generate sound data for decision-making in countries and internationally. However, the recently released joint UN-WB data published by WHO on Indonesia's MMR (190/100 000 live births) is not acknowledged by the

Exhibit 33: *Monitoring health, Indonesia. Likert Scores*



Source: Amaltas, 2015

80 Amaltas, 2015.

Government of Indonesia, which uses the much higher MMR from IDHS 2012 (359/100 000 live births) as the most recent result. This estimate is also being used by MoH as a baseline to set targets in its Strategic Plan for 2019 at 306//100 000 live births, which is well above the MMR estimate of the joint UN-WB group published by WHO.[81]

> WHO is supposed to facilitate the Government of Indonesia and all key stakeholders to reach a consensus on MMR as main indicator of maternal health status, not create confusion by publishing significantly different MMR. Interviewees

WHO Indonesia regularly leads secondary data analysis on MMR from the National Basic Health Research 2010 and 2013, IDHS 2012, and Health Facility Based Survey 2011 to learn about factors related to maternal mortality. Unfortunately, the WHO Maternal Health unit does not provide technical assistance to the MoH unit, which maintains the maternal death cases reported by provincial health offices.

WHO contribution is not seen yet in providing significant technical support and building capacity to monitor maternal health trends. Most of the interviewees agree that WHO is not meeting their expectation in providing updates or progress of the maternal health programme in Indonesia. Twelve out of 26 Likert Scale interviewees felt that WHO does not meet their expectations. Other UN agencies are perceived to be playing a more significant role and taking the initiative in monitoring and disseminating the maternal health situation. The overall Likert Scale Score is only 2.4.

Function 6: Providing leadership on health

Providing leadership on matters critical to health and engaging in partnerships where joint action is needed

The leadership function of WCO is manifest as a vision of what could be achieved, and then to communicate this to others and evolve strategies for realizing the vision. It is also manifest by the ability to motivate key stakeholders and negotiate for resources and other support to achieve the country goal, which is reducing MMR to 102 per 100 000 live births by 2015.

> "Future developments will shift the focus to the leadership role of heads of WHO offices. In particular, enabling heads of WHO offices to play a more authoritative role in facilitating policy dialogue: across different parts of governments, with civil society and nongovernmental organizations, and with all other in-country health partners"[82]

The fact that Indonesia will not achieve its goal on MMR has been acknowledged since the IDHS 2012 result was published in 2013. It had actually strongly previously been indicated by the unpublished population Census 2010 result. WHO has taken the lead on the development of National Actions Plan 2013–2015 to accelerate MMR reduction as a short-term action plan in response to IDHS 2012 result. Furthermore, with funding support from DFAT, Australia, WHO also facilitated a wide range of key stakeholders including subnational health offices to develop a Costed National Action Plan on Maternal, Newborn, and Reproductive Health 2016–2030 for long-term maternal health programme framework. Unfortunately, the Strategic Plan is not published by MoH until now and it is not used as a framework to develop new government target on MMR in mid-term National Development Plan 2015–2019.

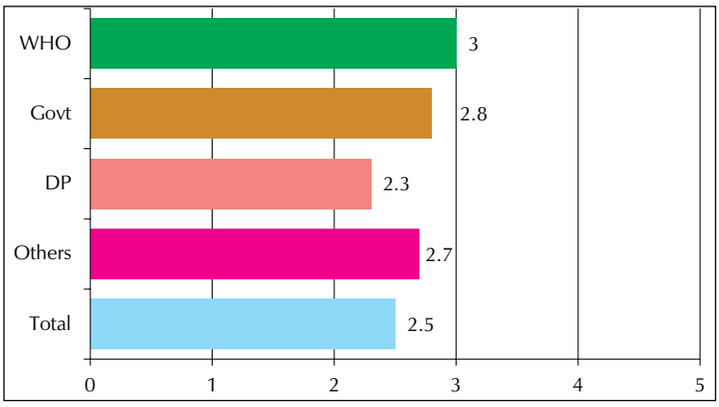
> WHO's role is not visible enough in reviewing the important information and data concerning maternal health programme and using it to make decisions about how the programme can be modified and improved. Interviewees

81 Ministry of Health, Indonesia. (2015). Strategic Plan 2015 – 2019 . Available at: http://www.depkes.go.id/resources/download/info-publik/Renstra-2015.pdf. (Accessed on 2 November 2015).

82 Clift Charles. (2013). The Role of the World Health Organization in the International System. The Royal Institute of International Affairs. Available at: https://www.chathamhouse.org/sites/files/chathamhouse/public/Research/Global%20Health/0213_who.pdf (Accessed on 3 November 2015).

> WHO is seen by government to be a neutral in its advice. Yet, it has not been able to create bridges between development partners and is seen by many to be a suboffice of the maternal health directorate. Interviewees

Exhibit 34: *Leadership in health, Indonesia. Likert Scores*



Source: Amaltas, 2015

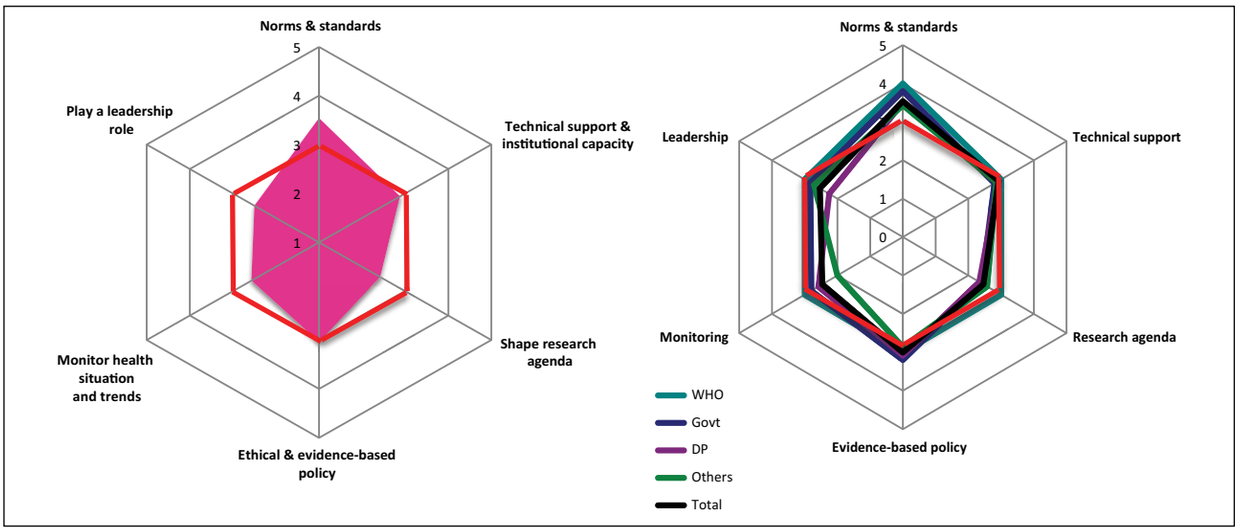
WHO has fulfilled expectations in leadership function especially in the technical area, although contribution in recent years has been declining according to members of the UN H4+ (Joint UN Programme on HIV/AIDS, UNFPA, UNICEF, UN Women, WHO). It was widely felt that this is very dependent on the capacity and performance of WHO staff in maternal health. Nevertheless, none of the interviewees from development agencies and most of KIIs interviewees consider WHO has not met their expectations in performing leadership function. The average Likert Scale score (2.4) all 26 interviewees indicates that WHO has not met expectations in providing leadership and engaging in partnerships function. Most interviewees (15 out of 26 interviewees) seem to describe their frustration with the stagnant maternal health programme in Indonesia through their score. As a multilateral organization, they feel that WHO is the closest to the Ministry of Health and considered to be more neutral, has not been able to influence government policies in maternal health. They feel that policies are fragmented, do not build upon proven approaches, and do not target the root of the problem of a high MMR in Indonesia.

This is probably also related with the positioning of WHO, which has still to come to grips with the new framework of cooperation between UN agencies and the Government of Indonesia. Hence several interviewees felt that WHO is a suboffice of the Directorate of Maternal Health, is not visible in promoting dialogue for intersectoral and multistakeholder collaboration, leading interagency work in integrating maternal health priorities, or convening the comprehensive and collaborative responses to accelerate the reduction of MMR.

Conclusion

WHO's contribution in maternal health in Indonesia has met or exceeded expectations of the interviewees of this study in three core functions, namely setting norms and standards, articulating evidence-based policy options, and providing technical support. The other three core functions where performance is below respondent expectations are, providing leadership, shaping the research agenda, and monitoring the health situation. WHO core function with the highest number of interviewees who perceived WHO as having met expectations, is setting norms and standards (100%) followed by core function in articulating evidence-based policy option (73%) and providing technical support (69%). Core functions of monitoring health status (46%), providing leadership role (42%), and shaping research agenda (38%) did much worse. Development partners' interviewees provided the lowest average Likert Scale score in all six core functions (overall average 2.7), though they provide significant amount of funds for WHO to carry out several strategic activities in maternal health during 2010–2015.

Exhibit 35: *Core functions: average and by type of interviewee, Indonesia. Likert Scores*



Source: Amaltas, 2015

Overall, the study found that WHO influence on maternal health had been positive. The area of influence in the reference period has been in providing evidence-based interventions for MoH Action Plan to accelerate maternal mortality reductions in Indonesia; prioritizing the quality of care improvement to become a national priority programme; and standardizing maternal services through development and dissemination of guidelines. The concerns were:

- As Indonesia has graduated into middle income country status, it is asserting its technical capabilities. It is now looking to WHO for a different form of engagement to improve its health systems' performance.
- Many of the problems relating to maternal health are located in the health systems. Limited government mechanism of regulation, policy implementation and performance monitoring are hampering gains. Maternal health problems need be seen not merely technical health issues, and may require quite different staff skills sets.
- An effective mechanism to promote and advocate new norms and standards – a well respected responsibility of WHO – with all key stakeholders is urgently required, and to bring findings from the field to inform national policy.
- Internal coordination within the WHO system with effective technical and financial support to WCO would greatly enhance the effectiveness of WHO.

Certain aspects facilitate WHO's performance of its roles and responsibilities in maternal health. These include having the WCO office in the same building as the Maternal Health Directorate of the MoH and having little bureaucracy in their communication and relationship with them. WHO has an unique mandate, acknowledgment and comparative advantage in: (a) capacity to develop evidence in response to current and emerging maternal health issues; (b) ability to contribute to capacity-building; (c) capacity to respond to changing needs based on current assessments of performance; and (d) potential to work with other sectors, organizations and stakeholders to have a significant impact on maternal health.

A difficulty faced by this evaluation was to assess the contribution of an international technical body with a mandate as broad as the one WHO by focusing on only a small area (maternal health) of its roles and responsibilities. Yet, as was discovered, maternal health is an important indicator of overall development. More importantly, maternal health is a multifaceted idea, taking in physical, mental and emotional health and is complicated by a great many issues linked into larger questions of development. This means that WHO's operations are by necessity complex, with additional layers of complexity being added by the many stakeholders who are present in the health area.

The study suggests that WHO in Indonesia take a more coordinated approach to a well defined multisectoral maternal health agenda, reflected in better alignment of financial and technical support to country health policies and strategies. It has the following broad recommendations:

- The health governance challenges in Indonesia give renewed emphasis to the need for WHO to engage with a range of other stakeholders since many of the areas in which change can have a positive impact on maternal health are those in which existing efforts are supported by various international institutions.
- There is need to adjust WHO personnel's skills sets according to the challenges faced by the country. WHO must leverage its convening power which, combined with the scientific credibility of the staff, can enable it to exercise a more visible leadership and better communicate the WHO brand and impact.

Data sources: Primary qualitative data for the case study was collected through interviews with government officials, staff of government and nongovernment institutions, WHO and partners. Thirty-one key informants from five government units, five UN agencies, three partners, and four CSOs were interviewed, and 25 Likert Scale scores obtained. In addition, more than 50 papers, reports, guidelines, presentations, and online statistics on maternal health in Indonesia both in Bahasa and English were consulted to triangulate information received from KII and Likert Scale.

Limitations:

- A description of WHO programme achievements and budget allocation were not available until the end of the data collection. Consequently, most of WHO contributions were identified through a list of activities only, and validated by the interviews.
- Several key informants were not familiar with the WHO contribution across all six functions or judged WHO performance based on their own organizational expectations.
- Some key informants arranged by WCO were consultants to WHO or received funding from WHO to conduct activities, which may have led to bias.

Capital:	Nay Pyi Taw*	Life expectancy at birth m/f:	64/68*
Population:	53 259 000*	Infant mortality rate:	39.8*
Rank in HDI:	150#	Neonatal mortality rate:	25.5 *
World Bank income classification:	Low#	Under 5 mortality rate:	50.5*
GNI per capita:	not available*	Maternal mortality rate:	200*
Expenditure on health per capita:	US$ 35*		

*WHO 2015 #UNDP 2013

Myanmar

The country context

Myanmar has been an independent nation since 1948 when it achieved independence from the British Commonwealth.[83] Myanmar covers an area of 676 578 square km, sharing borders with the People's Republic of China on the north and north-east; with Lao People's Democratic Republic and the Kingdom of Thailand on the east and south-east, the People's Republic of Bangladesh and the Republic of India on the west. Its 1930 km long coastline is bounded on the west by the Bay of Bengal and on the south by the Andaman Sea.[84]

The Republic of the Union of Myanmar is divided administratively into *Nay Pyi Taw*union territory and 14 states and regions. These are further organized into 74 districts, 330 townships, 3065 wards and 64 134 villages.[85] The country is made up of 135 national races speaking over 100 languages and dialects. The major ethnic groups are Bamar, Chin, Kachin, Kayah, Kayin, Mon, Rakkhine and Shan. The large majority of the population is Buddhists, while the rest are Christians, Hindus and Muslims.[86]

In 2014, the population of Myanmar was estimated to be 53.26 million with a growth rate of 1.01. About 70% of the population resides in the rural areas, whereas the remaining are urban dwellers. The population density for the whole country is 76 per square km.[87] In 2009, the Central Statistical Organization had estimated that half of the population is aged 15–49 years and women of reproductive age constituted approximately 30%.[88] Latest estimates are that the largest proportion of the population is aged 15–59 years (62%); 29.2% are aged0–14 years; and those 60 years and above form 8.8% of the population.[89] The

83 Central Intelligence Agency, United States of America. (2015). The World Fact Book:: East and South Esat Asia: Burma. CIA. Available at: https://www.cia.gov/library/publications/resources/the-world-factbook/geos/bm.html (Accessed on 5 November 2015).

84 Central Intelligence Agency, United States of America. (2015). The World Fact Book:: East and South East Asia: Burma. CIA. Available at: https://www.cia.gov/library/publications/resources/the-world-factbook/geos/bm.html (Accessed on 5 November 2015).

85 Ministry of Health, The Republic of the Union of Myanmar. (2014). Health in Myanmar: Country Profile. Republic of the Union of Myanmar. Available at: http://www.moh.gov.mm/file/COUNTRY%20PROFILE.pdf (Accessed on 5 November 2015).

86 Ministry of Health, The Republic of the Union of Myanmar. (2014). Health in Myanmar: Country Profile. Republic of the Union of Myanmar. Available at: http://www.moh.gov.mm/file/COUNTRY%20PROFILE.pdf (Accessed on 5 November 2015).

87 Department of Population, Ministry of Immigration and Population, Republic of the Union of Myanmar. (2015). Union: (Main Report) List of Tables: Series A- Demographic Characteristics. Available at: http://www.dop.gov.mm/moip/index.php?route=census/state&path=21 (Accessed on 5 November 2015).

88 Central Statistical Organization, Ministry of National Planning and Economic Development. (2009). Statistical Yearbook 2009.

89 Department of Population, Ministry of Immigration and Population, Republic of the Union of Myanmar. (2015). Union: (Main Report) List of Tables: Series A- Demographic Characteristics. Available at: http://www.dop.gov.mm/moip/index.php?route=census/state&path=21 (Accessed on 5 November 2015).

absolute number of women of reproductive age (15–49 years) is estimated to be 13 161 284.[90] The total fertility rate is estimated to be 1.9.[91]

The Department of Public Health (DoPH) is responsible for providing comprehensive health care services to the entire population in the country and among other responsibilities, is responsible for primary health care and basic health services. The Department of Medical Care is responsible for setting specific goals for hospitals and management of hospital services. The Department of Health Professional Resource Development and Management is responsible for training of all categories of health personnel to have an appropriate mix of competent human resources for delivering health services. The Department of Traditional Medicine provides traditional medicine services through the existing health care and explores means to develop safe and efficacious therapeutic agents and medicine.[92]

The Township Health System is the backbone of the Myanmar Health System. The Township Health Department provides primary and secondary health-care services down to the grassroots level for approximately 100 000–200 000 population. At the Rural Health Subcentre, Rural Health Centre and Maternal and Child Health Centre, midwives provide antenatal, delivery and postnatal care as per national standards. These services are also provided during outreach visits. Midwives are responsible for recording and reporting throughout pregnancy, delivery and postnatal period (mother and newborn) care. [93]At the village level, voluntary health workers provide delivery of and linkages to health services. At the community level, the auxiliary midwife (AMW) provides health education on self-care, nutrition, breastfeeding, care during pregnancy, labour and postnatal period and danger signs during the same periods, birth plans, and emergency preparedness. The Township Hospital provides comprehensive emergency obstetric and newborn care, which includes performing a caesarean section and giving blood transfusions and resuscitation of the newborn. Referral hospitals at the district level are staffed by medical specialists including an obstetrician/ gynaecologist and a paediatrician provide specialized services to townships under the jurisdiction of the district[94].

Maternal health in Myanmar

Current priority areas in maternal health

Maternal health is an important focus of Myanmar's health policies, programmes and services. A Midwifery Law was promulgated as early as in 1927. The Rural Health System was established under the Directorate of Health Services in 1950. In 1974, the Township Health System was restructured to be in line with government administrative set-up. In the same year, the MCH Society was formed at each township to encourage the participation of civil society. The Society was registered with MoH and in urban areas, midwives and doctors were deployed to provide MCH services. In 1989, the MCH Society became an NGO i.e. the Myanmar Maternal and Child Welfare Association and in 1990, the Myanmar Maternal and Child Welfare Association Law was promulgated. In 1996, the Family Health Care Programme was reinstituted as the Reproductive Health Care Programme using the life-cycle approach, in which safe motherhood was incorporated as one of the major elements.

Programmes on pregnancy, delivery, postnatal and newborn care are the cornerstone of the strategic plans on reproductive health (2004–2008, 2009–2013 and 2014–2018). The interventions in the Strategic Plan are in accordance with the WHO Global Reproductive Health Strategy. The strategic plans are a national

90 Ministry of Health.(2014). Health Management Information System.

91 World Health Organization. (2015). Global Health Observatory (GHO) data: World Health Statistics 2015. WHO. Available at: http://www.who.int/gho/publications/world_health_statistics/EN_WHS2015_Part2.pdf?ua=1(Accessed on 2 November 2015).

92 Ministry of Health, The Republic of the Union of Myanmar. (2014). Health in Myanmar: Myanmar Health Care System. Republic of the Union of Myanmar. Available at: http://www.moh.gov.mm/file/MYANMAR%20HEALTH%20CARE%20SYSTEM.pdf (Accessed on 5 November 2015).

93 Ministry of Health, The Republic of the Union of Myanmar. (2014). Health in Myanmar: Myanmar Health Care System. Republic of the Union of Myanmar. Available at: http://www.moh.gov.mm/file/MYANMAR%20HEALTH%20CARE%20SYSTEM.pdf (Accessed on 5 November 2015).

94 Ministry of Health, The Republic of the Union of Myanmar. (2014). Health in Myanmar: Myanmar Health Care System. Republic of the Union of Myanmar. Available at: http://www.moh.gov.mm/file/MYANMAR%20HEALTH%20CARE%20SYSTEM.pdf (Accessed on 5 November 2015).

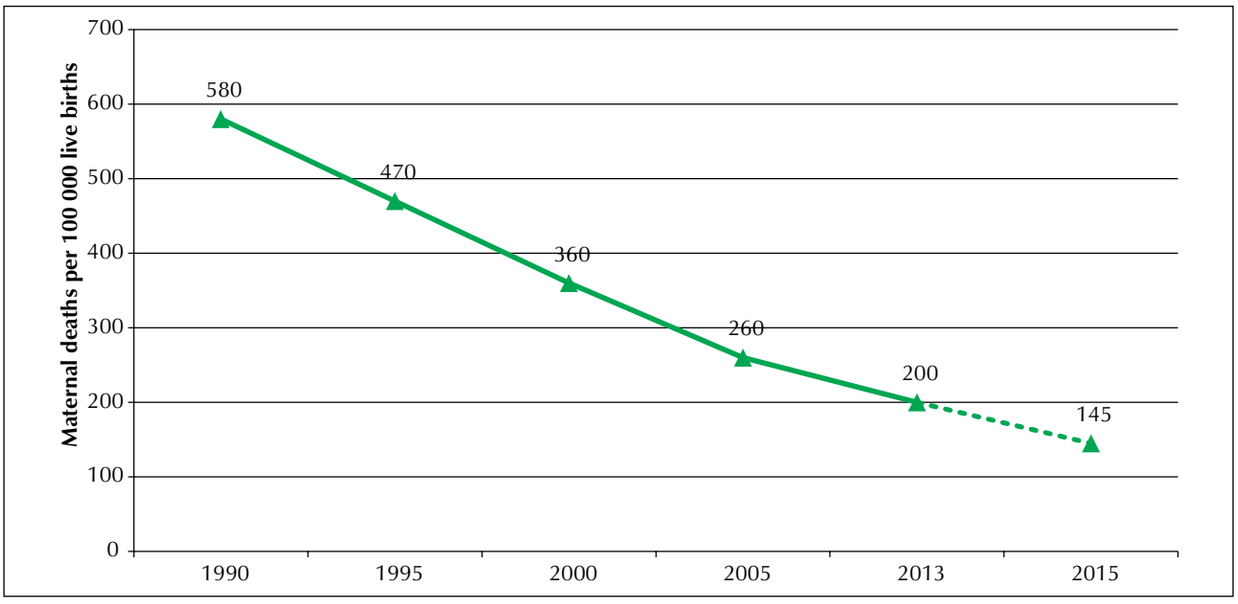
response to the Programme of Action of the International Conference on Population and Development, the UN MDG and the UN Secretary-General's Global Strategy for Women's and Children's Health (2010). WHO has defined the core elements of reproductive health as listed below:

- pregnancy, delivery, postpartum and newborn care;
- birth spacing/family planning;
- prevention of unsafe abortion and post-abortion care;
- reproductive tract infections/sexually transmitted infections/HIV/AIDS, cervical cancer and other gynaecological morbidities;
- sexual health including adolescent reproductive health.

Myanmar's MMR has declined steadily over the last 25 years. According to estimates of the Maternal Mortality Estimation Inter-Agency Group, MMR was 580 per 100 000 live births in 1990 and has decreased to 200 per 100 000 live births in 2013.[95] (See exhibit 36) These trends are validated by the government's health management information system (HMIS) according to which the country's MMR fell to 192 in 2011. However, the Population and Housing Census (2014) has indicated that the MMR may be much higher at 282 per 100 000 live births. Methodologically, the Census is designed to measure pregnancy-related deaths rather than maternal deaths. Therefore, the actual figure could be lower. On the other hand, since the Census covers a larger geographical area, it could be reflecting the MMR more accurately than the estimates. The finding of the Census was of concern that certain areas in the Ayeyawaddy and Magway regions and Chin and Shan states have a much higher maternal and infant mortality.

According to the government's Public Health Statistics Report 2011, the proportion of SBA has increased only marginally from 52% in 1990 to 67% in 2011 (Exhibit 37). The 2009–2010 Multiple Indicator Cluster Survey (MICS) corroborates these estimates. In the two years preceding the MICS, a skilled attendant, namely a doctor, nurse or midwife, attended nearly 71% of births. Midwives (36%) and doctors (28%) attend most of the births in Myanmar, with TBAs (18%), AMWs (8%), and lady health visitor/nurses (6%) attending the rest. The proportion of skilled attendance at birth was considerably higher (90%) in urban than in rural areas (63%). Adolescent girls have the least skilled attendance at birth (59%). The 2009–2010 MICS also revealed differentials across states and regions.

Exhibit 36: *Maternal mortality ratio from 1990 to 2015, Myanmar*



Source: From Trends in Maternal Mortality: 1990 to 2013. WHO, UNICEF, UNFPA, WB, UN. 2014.

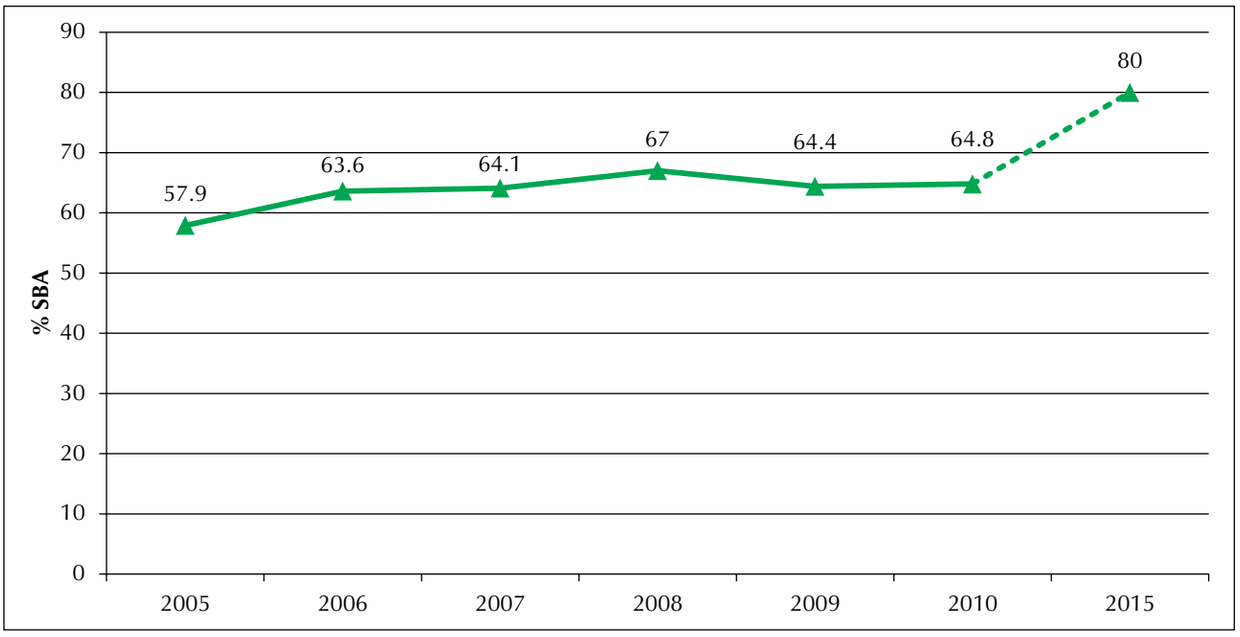
95 World Health Organization. (2015). Global Health Observatory (GHO) data: World Health Statistics 2015. WHO. Available at: http://www.who.int/gho/publications/world_health_statistics/EN_WHS2015_Part2.pdf?ua=1(Accessed on 2 November 2015).

Current challenges in maternal health

Postpartum haemorrhage, eclampsia and abortion-related mortality remain the major causes of maternal deaths in Myanmar.[96] An analysis of maternal deaths in 2011–2012 by first provider of care indicates that these causes are still prevalent. [97]Three quarters of all maternal deaths occur during delivery and the immediate postpartum period.

Further contributing to maternal mortality are weak infrastructure, poor reach of health services and limited access to information. The budget for health has increased but is still approximately 1% of the total government budget. There is high out-of-pocket expenditure and financial barriers limit access to services. For the health workforce in addition to competency-based training, attention to deployment, retention and remuneration is necessary to ensure there is equitable distribution of service providers between urban and rural areas. While a health information system is in place, coverage and quality data from hard-to-reach areas is a considerable challenge. Procurement, distribution and management need to be further improved to ensure equitable access to medical products. In rural areas, up-to-date technologies are lacking, and leadership, good governance need strengthening for accountability.[98] In addition to these direct causes of maternal mortality, a number of household and community level factors and social factors such as the nutrition of girls and women and their educational levels underpin the high levels of maternal mortality.[99]

Exhibit 37: *Births attended by skilled health personnel, Myanmar*



Source: World Health Statistics 2011. World Health Organization. 2014.

ANC is provided at all levels of the health-care system, specifically by midwives at the primary health care level while health promotion for maternal and newborn health is also carried out by the public sector and NGOs. The coverage for ANC was estimated as 74% in 2011, although there are regional disparities. Many initiatives by the Red Cross and NGOs are in place to increase referrals for EmOC, which range from awareness raising on danger signs; these are reinforced by community support groups and assistance provided during emergencies. In some townships where funds to cover costs for emergency referrals are

96 UNICEF, Department of Health, Republic of Myanmar. (2005). Nationwide cause specific maternal mortality survey (2004-2005).

97 Maternal and Reproductive Health Division, Department of Health. (2013). Maternal Death Review in Myanmar. 3 Millennium Development Goal Fund. . Available at: file:///C:/Users/HP/Downloads/MDR_Outline.pdf (Accessed on 5 November 2015).

98 3 Millennium Development Goal Fund. (2014). Annual Report January to December 2014. Available at: file:///C:/Users/HP/Downloads/3MDG_Annual_Report_Web_2015.06.03.pdf (Accessed on 5 November 2015).

99 United Nations Development Programme. (2012). Improve Maternal Health: Where we are? UNDP. Available at: http://www.mm.undp.org/content/myanmar/en/home/mdgoverview/overview/mdg5/ (Accessed on 5 November 2015).

provided by NGOs through assistance from the 3MDG Fund, the referral rate increased dramatically, indicating that cost of transportation is a major barrier to access to health-care services.

The development of information, education and communication materials and the conduct of behavioural change communications activities are carried out by a range of stakeholders: DoH, NGOs and community-based organizations. Although the programmes are conducted nationwide by DoH, improved outcomes are more evident where there are focused programmes. Traditional beliefs still prevail in remote and rural areas.

Birth spacing/family planning is recognized as an important intervention for improved maternal health through healthy timing and spacing of pregnancies. Information and services for birth spacing/family planning are provided both in the public and private sectors and at NGO clinics. The contraceptive prevalence rate (CPR) is 38.4% and the unmet need for family planning is 17.7%.[100] Management of miscarriage and post-abortion complications is provided at health facilities and project support is provided in approximately one-third of the townships by multilateral agencies such as UNFPA and UNICEF and NGOs. Manual Vacuum Aspiration, which is associated with fewer complications than traditional curettage, has been introduced in only a few township hospitals. Interventions to reduce maternal mortality and morbidity caused by unsafe abortion comprise of providing effective contraceptive methods and early diagnosis of post-abortion complications and timely and appropriate treatment.[101]

Contribution to maternal health

The WHO CCS for Myanmar (2014–2018) was formulated in line with the Myanmar National Health Plan (2012–2016) and harmonized with the UN Strategic Framework (2012–2015). The main focus areas in regard to maternal health are: developing integrated package of interventions for birth spacing and maternal newborn and child health (MNCH); and improving sexual and reproductive health, including adolescent and women's health. The role of WHO in the context of Maternal Health in the country are to: [102]

- provide technical and policy support for comprehensive MNCH, through predictable and sustainable investment to ensure availability and accessibility of quality MNCH service-based technologies, integrated delivery of health service and life-saving interventions;
- increase the knowledge of families, communities, decision- and policy-makers and target groups on MNCH to ensure a favourable social, economic and political environment, and community mobilization;
- provide technical assistance to strengthen community-based nutrition programmes for women and children.

Other related areas in which WHO plays a role are as follows:

- improve reproductive health programme implementation, including adolescent reproductive health, and strengthen the capacity of adolescent and youth-friendly confidential services and education;
- strengthen capacity of management for gynaecological conditions such as severe menstrual problems, obstetric fistulae, uterine prolapse, pregnancy loss, sexual dysfunction and cancer screening (cervical and breast).

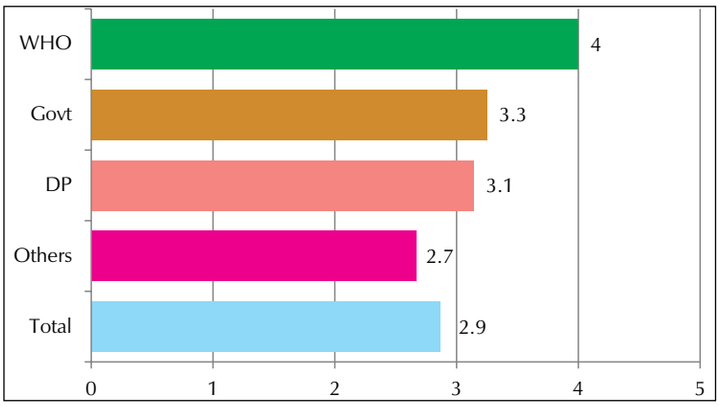
100 Department of Population, Ministry of Immigration and Population, Union of Myanmar. (2009). Country Report on 2007 Fertility and Reproductive Health Survey. UNFPA. Available at: http://countryoffice.unfpa.org/myanmar/drive/2007_FRHS.pdf (Accessed on 5 November 2015).

101 Department of Health, Department of Health Ministry of Health, Myanmar.(2014). Five-Year Strategic Plan for Reproductive Health (2014-2018). Available at: file:///C:/Users/HP/Downloads/RHSP%20with%20Foreword%2021June%202014.pdf (Accessed on 10 November 2015).

102 Amaltas, 2015.

Function 1: Setting norms and standards
Setting norms and standards and promoting and monitoring their implementation

Exhibit 39: *Norms and standards, Myanmar. Likert Scores*



Source: Amaltas, 2015

The evidence-based guidelines on maternal health developed by HQ e.g. IMPACT guidelines, recommendations for postpartum haemorrhage, postnatal care, 'Beyond the Numbers - Reviewing Maternal Deaths and Complications To Make Pregnancy Safer and Maternal Death Surveillance and Response' are referred to, and have been adapted and translated into Burmese.[103] WHO guidance is a key reference for the 'Guidelines for Post-abortion Care and Family Planning' developed by DoPH and 'Guidelines in Obstetrics and Gynaecology' developed by the obstetrics and gynaecology professional society.[104],[105]

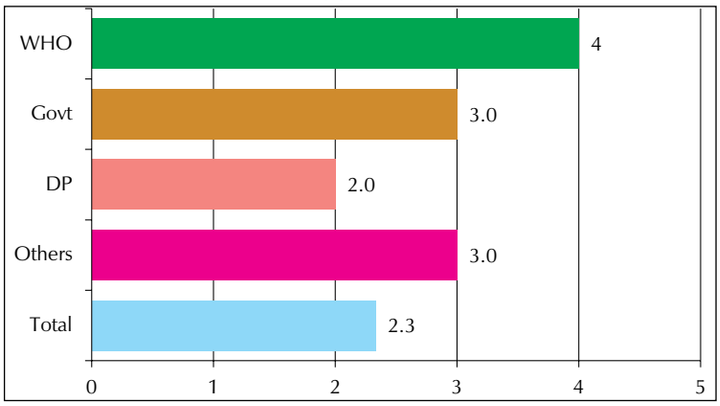
The WHO guidelines are usually obtained either at the regional technical meetings or downloaded when needed, directly from the website. However, active dissemination of guidelines could be more systematic. Various partners support adaptation and translation, but there is neither a mechanism to ensure that the guidance is in accordance with the WHO recommendations nor whether there is adherence in the field. For midwifery training, an area where WHO has been traditionally a key player, UNFPA and Johns Hopkins Program for International Education in Gynaecology and Obstetrics (JHPIEGO) are establishing norms based on the guidelines developed by the International Confederation of Midwives or the Association of Southeast Asian Nations Guidelines for Skilled Birth Attendants.

> WHO HQ develops evidence-based guidance. However, a good process for ensuring that knowledge is well translated to the local context into ethically sound systems is not there. There is also little follow-up of guidelines introduction and monitoring of implementation. Interviewees

Function 2: Providing technical support and building institutional capacity
Providing technical support, catalysing change, and building sustainable institutional capacity

The added value of facilitation at the national workshops and meetings by resource persons from all levels of the organization and the technical inputs are appreciated. In addition, WCO provides financial support to MoH for organizing these national events and covers the participation at the regional meetings on EmOC. However, in the past few years there has been less assistance from WHO for participation at the regional meetings.

Exhibit 40: *Technical support, Myanmar. Likert Scores*



Source: Amaltas, 2015

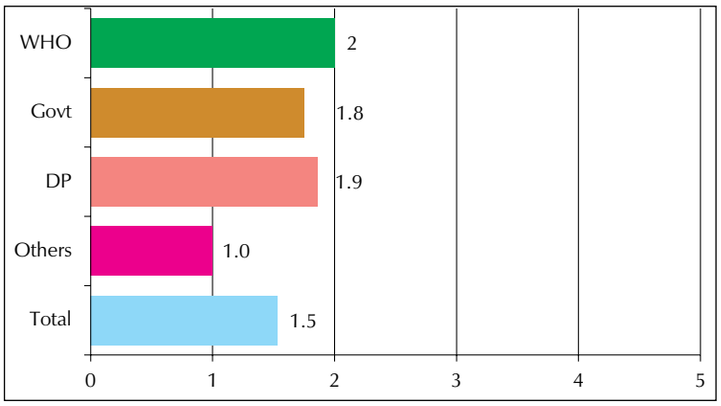
103 Department of Obstetrics, Gynaecology and Child Health, University of Medicine 1, MCH, Ministry of Health, Republic of Myanmar. (2011). Postnatal Care Guidelines in Hospital Settings.

104 Maternal and Reproductive Health Section, Ministry of Health. (2014). Guidelines on Post-abortion Care for Public Sector Health Facilities.

105 Obstetrical and Gynaecological Society. (2015). Guidelines in Obstetrics and Gynecology.

Sister UN agencies and partners would like to have WHO continue in its time-honoured role of providing cutting edge technical expertise. However, interviewees reported that technical assistance for MCH fell short of their expectations. Placing international staff in the Country Office for short periods ranging from 2 months to 4 months was not regarded as very helpful as there is an initial period of adaptation to the environment and no continuity of support. The scenario and modus operandi for providing technical assistance is evolving and currently there are other national and international institutions/agencies or individuals either in country or external who have the required expertise and have filled the gap.

Exhibit 41: *Research agenda, Myanmar. Likert Scores*



Source: Amaltas, 2015

> There should be greater clarity about the role of WHO as the leading technical advisory body rather than an implementing agency. Interviewees

While it was acknowledged that WHO introduced certain global concepts and methodologies at the regional meetings, assistance for in country follow-up remained weak. Interviewees noted the need for better collaboration among technical units within the Country Office and with other departments responsible for related work in MoH e.g. it would be in the interests of all concerned that the Department of Health Professional Resource Management and Development and Human Resources for Health team in WCO work collaboratively with MCH team when the midwifery task force is being reviewed.

Function 3: Shaping the research agenda

Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge

Research on MCH has been conducted by researchers from institutions such as the Department of Medical Research (DMR), Universities of Medicine and Public Health in collaboration with the DoPH. The Independent Evaluation Services of the 3MDG Fund/Euro Health Group conducted a desk review of MCH research from 2011 to quarter1 of 2015. There are limited studies available on quality of MCH services; health system strengthening and evaluation of AMWs' performance in MCH care and referral.[106] There are several sources of updated data such as the Population and Housing Census, which was conducted in 2014. The DMR has conducted surveys on Reproductive Health Commodity Security (in collaboration with UNFPA) and the Service Availability and Readiness Assessment (in collaboration with WHO) in 2014–2015.

The upper Myanmar branch of DMR is receiving a second long-term institutional development grant from the World Bank, UNDP, UNFPA, UNICEF, WHO cosponsored Special Programme of Research, Development and Research Training in Human Reproduction. The 5-year grant (2012–2016) covers infrastructure development, short course and masters training, and support for research projects. Studies on maternal health include: Field evaluation of haemoglobin colour scale in improving the treatment and referral of anaemic pregnant women; Promoting ANC services in urban health centres of Mandalay to improve early detection of pre-eclampsia; and male involvement in reproductive health matters of women at the rural settings.

A specific research agenda for MCH has not been shaped although investigators conduct studies on priority issues identified in the 5-year National Reproductive Health Strategic plans. WCO plays more of a

106 Euro Health Group A/S, The Department of Medical Research – Lower Myanmar, ITAD, UK. (2014). Myanmar Independent Evaluation Services of the 3MDG Fund : Final Inception Report. Available at: file:///C:/Users/HP/Downloads/3MDG_IEG_Final_Inception_Report_280515_1432805062.pdf (Accessed on 4 November 2015).

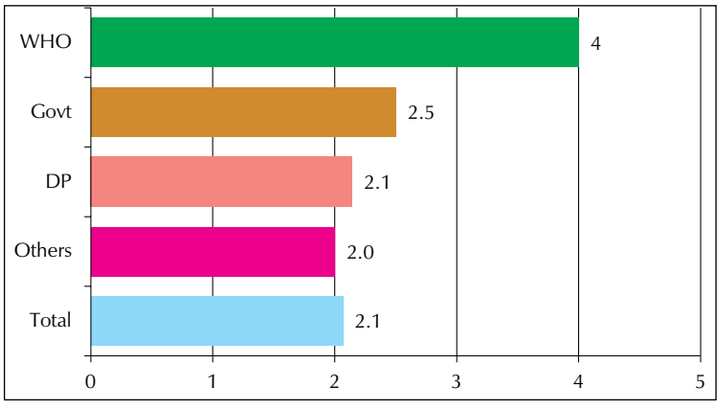
supportive role through funding assessments and studies conducted by the MCH/RH Programme and the DMR. The studies cover access to quality maternal health care in remote areas and anaemia in pregnancy. Other research studies related to maternal health include:

- comparative access to antenatal care services among migrant mothers in Bogale and Mawlamyinegyun Townships in the Ayeyawaddy Region (DMR - supported by the Three Millennium Development Goal Fund, 3MDG/International Organization for Migration)
- expecting the unexpected: role of community health workers in maternal and child health in the Ayeyarwaddy Region, Myanmar (DMR - supported by the 3MDG/International Organization for Migration)
- malaria and HIV in pregnant women, helminthic coinfection in pregnant women (supported by the University of Maryland)
- how women are treated during facility-based childbirth: development and validation of measurement tools in four countries – a qualitative study. (DMR supported by UNDP/UNFPA/UNICEF/WHO/the World Bank Special Programme on Research, Development and Research Training in Human Reproduction).

> WHO should have a stronger stance on the issues of reproductive health and rights in policy. Interviewees

WCO supported an analysis of reproductive health stakeholders in Myanmar by geographical area and by thematic area, which includes an analysis of maternal health stakeholders.[107] WCO has also supported DoH to conduct a post-training assessment on maternal and newborn health using the adapted pregnancy, childbirth, postpartum and newborn care developed by WHO and its partners. However, it is not clear what follow-up action has been taken on deficiencies identified. Assistance was provided to conduct a Reproductive Health Programme Review in 2013, which contributed to the development of the National Reproductive Health Strategic Plan (2014–2018).[108]

Exhibit 42: *Evidence-based policy, Myanmar. Likert Scores*



Source: Amaltas, 2015

Function 4: Articulating policy options

Articulating ethical and evidence-based policy options

As evidence provides the foundation for setting priorities, defining strategies and measuring results, WHO develops evidence-based recommendations, which are a combination of technical and policy considerations. However, there is not a good process for knowledge translation, defined by Straus et al. as "a dynamic and iterative process that includes the synthesis, dissemination, exchange and ethically sound application of knowledge to improve health, provide more effective health services and products, and strengthen the health-care system"; or for taking advances in evidence-base practices forward in country.[109]

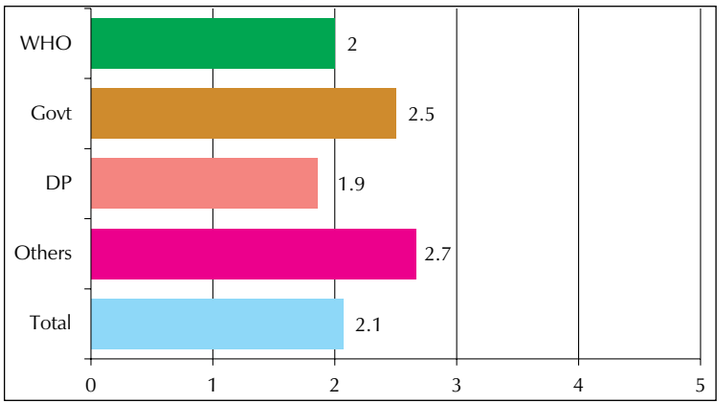
107 World Health Organization, Ministry of Health, Republic of Myanmar. (2013). Reproductive Health Programme Review Gynecology.

108 World Health Organization, Ministry of Health, Republic of Myanmar. (2014). Reproductive Health Stakeholder Analysis in Myanmar 2007-2012.

109 Straus SE, Tetroe J, Graham I. Defining knowledge translation. CMAJ. 181(3-4):165–8 Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2717660/ (Accessed on 5 November 2015).

HQ develops and disseminates evidence-based, clinical-practice guidelines based on high-quality systematic review of the literature. HQ and WCO had collaborated with the DoPH in 2014 to review and consider certain tasks to be shared between midwife and AMW to optimize their respective scope of practice and improve the maternal and child health outcomes. Currently, attempts are being made to expand the limited scope of the midwifery practice in order that the midwife, who is a frontline health worker, is able to manage maternal and newborn complications more effectively and efficiently. Certain tasks such as administration of misoprostol for prevention of postpartum haemorrhage and distribution of oral contraceptive pills can now be carried out by AMWs.

Exhibit 43: *Monitoring health, Myanmar. Likert Scores*



Source: Amaltas, 2015

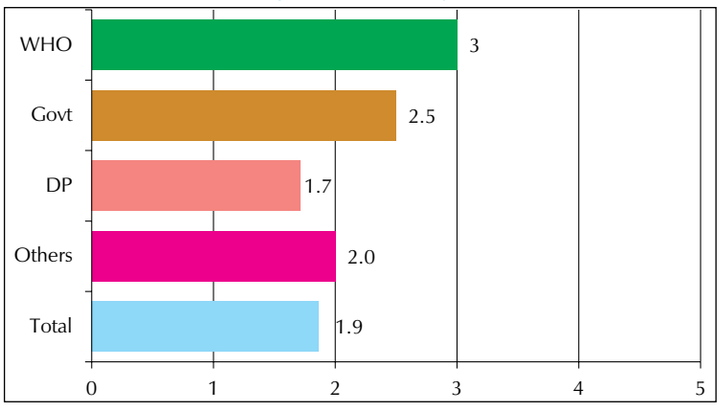
Uptake for research-based evidence that can contribute to policies that have a profound impact on mothers and babies lives is limited. There are no institutional arrangements designed to encourage transparent and balanced use of evidence from well designed research conducted internationally or nationally in public policy-making.

Function 5: Monitoring health situation and trends

Monitoring the health situation and assessing health trends

The public health information system under DoPH is standardized by the use of a minimum essential data sets and data dictionary for all basic health staff. Data collection, analysis and dissemination are undertaken through the HMIS of DoPH. WHO and other partners cannot access MNCH data until analysis is completed and a report has been prepared. While there are concerns over the validity of data, HMIS data is referred to in programme planning. It was also noted that HIV, tuberculosis (TB) and Malaria have focal persons placed at the state/regional level, which ensures better reporting whereas MCH does not have a similar set-up.

Exhibit 44: *Leadership in health, Myanmar. Likert Scores*



Source: Amaltas, 2015

As follow-up to the recommendation of the Commission on Information and Accountability for Women's and Children's Health, 'Better information for better results', SEARO has supported MDR in Myanmar over the past 10 years. The data collection follows the methodology described in the WHO guide 'Beyond The Numbers- Reviewing Maternal Deaths and Complications To Make Pregnancy Safer'. A community-based MDR through verbal autopsy was conducted initially in 30 pilot townships and in 2013 data was collected from more than 50 townships, and a facility-based MDR from major teaching hospitals.[110] The review validated the major causes of maternal mortality from a national survey conducted 10 years ago. However, it is not clear what follow-up actions have been taken on findings from the reports and the realization of the accountability framework's three interconnected processes – monitor, review and act; as well as the utilization of findings and corrective action.

110 Maternal and Reproductive Health Division, Department of Health. (2013). Maternal Death Review in Myanmar. 3 Millinnium Development Goal Fund. . Available at: file:///C:/Users/HP/Downloads/MDR_Outline.pdf (Accessed on 5 November 2015).

Function 6: Providing leadership on health
Providing leadership on matters critical to health and engaging in partnerships where joint action is needed

The absence of a definitive WHO Representative for 18 months and limitations to the support from SEARO led to a perception of "being abandoned by WHO", and affected WHO's ability to provide strategic advice and contribute to technical programmes. In this perceived leadership vacuum, other agencies stepped in and took the lead on areas traditionally led by WHO.

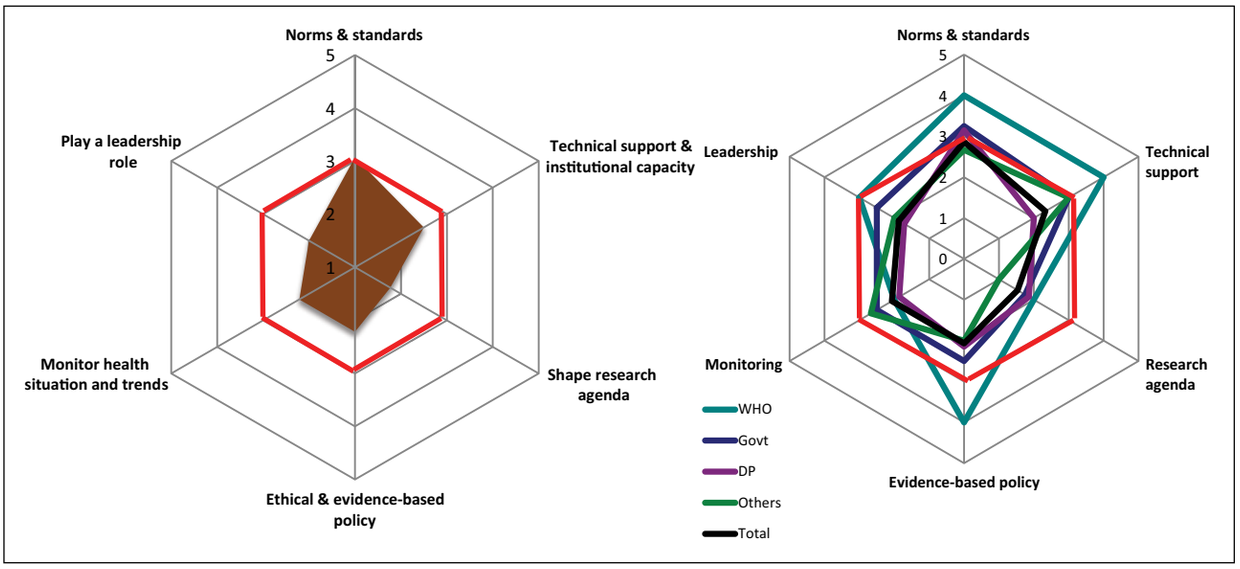
WHO's leadership role as the directing and coordinating authority for health within the UN system has to be reviewed against a backdrop of an increasingly complex and rapidly changing landscape within the country. The relationship of WHO with other UN agencies was seen as more of partnership rather than leadership. There is also some uncertainty among partners of the role of WHO: whether it is a leading technical body or an implementing agency. While WHO enjoys and nurtures a good relationship with DoPH, the association with other partners such as UN agencies, international nongovernmental organizations and professional organizations is not on the same level. The TB, HIV, malaria units of WCO have a stronger presence, visibility and voice, compared with MCH. In addition, the situation is compounded by limited human resources and funds compared with funds such as UNFPA, UNICEF and 3MDG Fund.

For the biennium 2012–2013, the budget allocation for maternal health was US$ 509 400, which is approximately 52% of the total budget of US$ 985 320 for Strategic Objective 4 (SO4): To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals. Funds allocated/received for maternal health for the biennium 2014–2015 was US$ 237 400, which is approximately 41% of the total budget of US$ 584 867 for Category 3: Promoting Health through Life-course. Thus, although the overall envelope remains the same, the allocation for maternal health has diminished over time. In both biennia, WCO has mobilized resources, from DFAT (AusAID) in 2012–2013 and from 3MDG Fund in 2014–2015.

Conclusion

Perceptions of government counterparts, UN agencies, development funders and international NGOs with respect to WHO fulfilling its priorities through its six core functions are summarized below. The Likert scores are a cumulative figure of the various interviewees.

Exhibit 45: *Core functions: Average and by type of interviewee, Myanmar. Likert Scores*



Source: Amaltas, 2015

Interviewees agreed unanimously and gave high scores to WHO on 'Setting norms and standards'. However, promoting and monitoring of their implementation was found to be deficient (Likert score 3.1). WHO's expertise and providing technical support was acknowledged although the technical assistance was less prominent in catalysing change and building sustainable institutional capacity (Likert score 2.5). Technical assistance ranged from institutional research capacity strengthening to supporting regional and national workshops. The translation of state-of-the art technical guidance to ethical and evidence-based policy options received a score of 2.2. This is the core function that partners wished to see WHO play a dominant role; together with providing leadership on matters critical to health, i.e. as leading the maternal health dimension rather than simply active participation or contributing.

At the policy level, WHO has developed and disseminated international guidance on life-saving interventions. There has been some influence of key recommendations on shaping the policy but there is weakness in taking policy to action. While there is awareness of WHO guidelines and the specific recommended interventions, implementation was affected by the health system level factors, including health workforce shortages and need for strengthened drug and equipment procurement, distribution and management systems, which limit the capacity of providers to deliver high-quality care, despite their willingness to do so. The need for health policies to support these implementation efforts has been reiterated.

Incorporation of evidence-based practice in clinical management is in place at the teaching hospitals and promoted at the public sector facilities. There is a gap in promotion of interventions that reduce preventable maternal mortality at the community level, which is partly due to the health system factors.

The greatest challenge is at the practice level – adaptation of WHO recommendations to the national context often leads to guidance that can lead to substandard care. As the lead international agency setting norms and standards and promoting and monitoring their implementation, WHO should not be seen to be complicit with or accepting of policies and care that is not aligned with international standards. While government and partners acknowledge the strong leadership from WHO on HIV, TB and malaria on shaping policies and implementing programmes, the same cannot be said of the maternal health agenda.

There is great expectation from government and partners from WHO as being the directing and coordinating authority on health. In the past years however, the lack of human resources has affected WHO fulfilling their expectations, primarily the absence of WHO Representative and limited numbers of national staff covering responsibilities for an area that generates interest from several development funders.

Due to sanctions and various restrictions imposed over the past two decades, apart from humanitarian assistance, Myanmar received a very low level of development aid; what was available was mainly from UN agencies. With the gradual lifting of sanctions, the role of WHO became less clear to partners on whether it is an agency that helps to set the health agenda or an implementing agency. By directly implementing activities, WHO staff are burdened with bureaucratic processes namely, managing contracts and reporting.

In maternal health in particular, WHO is seen as a partner rather than as a leader against a backdrop of an evolving scene with new agencies and other sources of technical assistance. The main collaborating partner is the MoH and partnerships with a different range of stakeholders: academia, sister UN agencies, donors, international NGOs, professional organizations, civil society and the private sector was not as strong. Collaboration with relevant stakeholders will ensure that WHO is able to fulfil its core functions effectively.

There was general agreement on maternal health priorities that attention needs to be focused on ending preventable maternal mortality and morbidity. Due consideration needs to be given to the six building blocks of the health system. Health policies in favour of equitable access and responsiveness to the needs of the marginalized populations – the rural and urban poor, those living in hard-to-reach areas and states and regions where reproductive, maternal and infant indicators are below the national averages –were highlighted. WHO and partners will need to address contextual issues and social determinants of health to the extent possible for improving the overall maternal health status.

Broadly speaking, WHO continues to enjoy a high status in terms of its role as the UN agency responsible to address maternal health along with UNFPA. There is expectation that WHO will play a

stronger role in coordination of the RMNCAH programmes and re-establish its position as the turn-to Organization for maternal health.

A key challenge for health systems stakeholders is the need to identify and apply effective strategies to promote the use of evidence-based practices in the provision of maternal and newborn care. By setting and clarifying its priorities in supporting maternal health work, WHO can coordinate with other UN bodies and development funders to provide the country with the support it needs to address its maternal health priorities. WHO has been thinly stretched at the country level, and fulfilment of its mandate and core functions has not been equal across the board. An agreed programme of work between WCO Myanmar, SEARO and HQ would ensure that the country can access the international expertise it requires. Comparisons were made with the good business model of the TB, HIV, Malaria teams in the country office and their convening power, diverse partnerships, bringing global knowledge to the local level and cutting edge technical expertise were lauded by partners.

To meet the expectations of stakeholders in maternal health, WHO will need to:

- Devote sufficient organizational priority, commitment and human and financial resources to support effective promotion and implementation of maternal health within the broader framework of RMNCAH. This will entail setting policies and high-level strategic work rather than managing projects and contracts. WHO will need to prioritize, among the core functions, those in which it has a comparative advantage, and focus on these areas.
- Build upon its comparative advantage, neutral status and impartiality, and its strong convening power for the UN system to work together. More importantly, partnerships with government and other actors will need to be built or strengthened to advocate and implement cost-effective interventions.
- Capitalize on WHO's strengths in developing norms and standards, the Organization should use the strategic power of evidence to influence policies and encourage partners implementing programmes to align their activities with best technical guidelines and practices with the priorities established by countries.

Owing to its long-standing support for research capacity strengthening in Myanmar, there is an unprecedented opportunity to shape the research agenda, interventions and policy in the direction of the most vulnerable and link that to poverty reduction.

Data sources: Primary qualitative data for the case study was collected through interviews with government officials, staff of government and nongovernment institutions, WHO and partners. Thirty-one key informants from the government (12), UN bodies, including WHO (10), partners (4), international NGO (3) and NGO (1) were interviewed and 15 Likert Scale scores obtained. In addition, more than 30 papers, reports, guidelines, presentations, and online statistics on maternal health in Myanmar and the Region were consulted to triangulate information received from KII and Likert Scale.

Limitations:

- Several key informants were not familiar with the WHO's contribution across all six functions or judged WHO's performance based on their own organizational expectations.

Capital:	Kathmandu*	Life expectancy at birth m/f:	67/70*
Population:	27 797 000*	Infant mortality rate:	32.2*
Rank in HDI:	145#	Neonatal mortality rate: 23*Under 5 mortality rate:	39.7*
World Bank income classification:	Low#	Maternal mortality rate:	190*
GNI per capita (PPP):	US$ 2260*		
Expenditure on health per capita:	US$ 118*		

*WHO 2015 #UNDP 2013

Nepal

The Country context

Nepal is a landlocked country, with a total area of 147 181 square km. The size of population of Nepal according to the latest population census (2011) is 23 693 378. The sex ratio is 94.16 males per 100 females. The population growth rate is 1.35%.[111]

The country of Nepal was founded in the 18th century, and enjoyed relative stability under a succession of monarchs until the country underwent a violent struggle for democracy in the 20th century. Nepal has experienced considerable political instability since democracy was introduced in 1990. In 1996, a Maoist revolution broke out leading to a decade long-armed conflict, which ended in 2006 when Nepal was declared a federal democratic republic. An Interim Constitution was formed in 2007, but the country remains politically unstable. In September 2015, the country adopted a new constitution.[112]

There are significant disparities in health, education, wealth and access to care between Nepal's 125 distinct ethnic/caste groups, and between people living in different regions. A low-income country, Nepal had a GDP per capita (purchasing power parity (PPP), international $) of US$ 1279 in 2012. The poverty rate has declined from 42% to 25% in the past 15 years, partly owing to the inflow of remittances. [113]Total health expenditure per capita increased from US$ 35 in1995 to US$ 118 in 2012 (PPP, international $).[114,115] Although there was ambitious target to increase the proportion of total government allocation on health to 10% by 2014 from 7% in 2011, however the total allocated budget for health remains at about 5% of the total budget.[116,117]

111 Central Bureau of Statistics, National Planning commission secretariat, Government of Nepal. (2014). Population Monograph of Nepal. Volume 1. Population Dynamics. Available at: http://cbs.gov.np/image/data/Population/Population%20Monograph%20of%20Nepal%202014/Population%20Monograph%20of%20Nepal%202014%20Volume%20I%20FinalPrintReady1.pdf (Accessed on 4 November 2015).

112 Ministry of Health and Population Nepal, Partnership for Maternal, Newborn & Child Health, WHO, World Bank and Alliance for Health Policy and Systems Research. (2014) Success Factors for Women's and Children's Health: Nepal. Available at: http://www.who.int/pmnch/knowledge/publications/nepal_country_report.pdf?ua=1 (Accessed on 4 November 2015).

113 The World Bank. (2013). World Development Indicators. WB. Available at: http://databank.worldbank.org/data/download/WDI-2013-ebook.pdf (Accessed on 30 August 2015).

114 The World Bank. (2013). World Development Indicators. WB. Available at: http://databank.worldbank.org/data/download/WDI-2013-ebook.pdf (Accessed on 30 August 2015).

115 World Health Organization. (2015). Global Health Observatory (GHO) data: World Health Statistics 2015. WHO. Available at: http://www.who.int/gho/publications/world_health_statistics/EN_WHS2015_Part2.pdf?ua=1(Accessed on 2 November 2015).

116 Ministry of Health & Population,Government of Nepal (2010). Nepal health sector programme – implementation plan II (NHSP–IP 2) 2010-2015. Government of Nepal. Available at: http://www.nhssp.org.np/health_policy/Consolidated%20NHSP-2%20IP%20092812%20QA.pdf (Accessed on 5 November 2015).

117 iwari S et al. NHSSP Budget Analysis 2011/12. Ministry of Health and Population and Nepal Health Sector Support Programme. Ministry of Health and Population. Available at: http://www.nhssp.org.np/health_financing/Budget%20Analysis%202011-12.pdf (Accessed on 5 November 2015).

There are three ecological zones: mountain, hill and Terai (plains). Nepal is predominantly rural despite an increasingly rapid rate of urbanization from 14% in 2001 to 17% in 2011.[118] Life expectancy at birth continues to increase for both males and females; increasing from 55 years for males and 53.5 years for females in 1991 to 67 years and 70 years for males and females, respectively, in 2013.[119], [120]As per the 2011 census, 37.2% of population was below 15 years, 54.4% between 15–59 years, and 8.4% was 60 years and above. The population living below the national poverty line has declined from 42% in 1996 to 25% in 2010. Poverty remains predominantly a rural phenomenon with 96% of the poor living in rural areas; 29% of the rural population fall below the poverty line versus 8% of the urban population. The HDI continues to improve increasing from 0.398 in 2000 to 0.54 in 2013 although wide disparities persist across districts.

Maternal health in Nepal

Nepal has seen a significant decline in MMR since 1996 and is currently on track to achieve MDG 5A. The reduction in Nepal's MMR has been driven partly by a fall in the total fertility rate (TFR), from 4.8 (Nepal Family Health Survey 1991) to 2.3 in 2013.[121] TFR fell between 2006 and 2011despite stagnation in the CPR, and has been partly attributed to spousal separation caused by migration. Family planning programmes have contributed to increased CPR, which has been an important contributory factor to fertility decline and thus MMR. The government has focused on making contraceptives available at all levels of health facilities, and through female community health volunteers. Prior to the legalization and roll-out of safe abortion services, deaths from unsafe abortions were on the increase. The use of maternal health services has improved since 1996, with increase in ANC visits, rate of institutional deliveries and deliveries attended by a SBA.

The under-five mortality rate has decreased significantly in recent years. The prevalence of HIV/AIDS among adults aged 15 - 49 years appears to have stabilized at 0.23 in 2014 and the MDG target for reversal of HIV/AIDS and other diseases is likely to be met. [122] Nepal is also on track to achieve MDG4; however, in the past few years, the neonatal mortality rate has remained stagnant at around 23 deaths per 1000 live births.[123] This compares to a rate of 32 in India (2011) and 36 in Pakistan (2011). Neonatal mortality is a serious concern in Nepal, accounting for 72% of the infant mortality rate and 61% of the under 5 mortality rate in 2011.

Current priority areas in maternal health

Areas such as maternal nutrition, safe delivery, abortion services are among the ones prioritized in Nepal. As per the National Safe Motherhood Programme, priority areas in maternal health include the promotion of birth preparedness, encouragement for institutional delivery, expansion of 24 hour EmOC services. The revised Safe Motherhood and Neonatal Health Long-Term Plan (2006–2017) includes recent developments not adequately covered in the original plan. These include: recognition of the importance of addressing neonatal health as an integral part of safe motherhood programming; the policy for SBAs; health sector

118 Ministry of Health & Population. (2004). Nepal health sector programme – implementation plan (NHSP-IP) 2004-2009. Ministry of Health & Population. Available at: http://www.nhssp.org.np/health_policy/Consolidated%20NHSP-2%20IP%20092812%20QA.pdf (Accessed on 5 November 2015).

119 Central Bureau of Statistics, National Planning commission secretariat, Government of Nepal(2014). Population Monograph of Nepal. Volume 1. Population Dynamics. Available at: http://cbs.gov.np/image/data/Population/Population%20Monograph%20of%20Nepal%20 2014/Population%20Monograph%20of%20Nepal%202014%20Volume%20I%20FinalPrintReady1.pdf (Accessed on 4 November 2015).

120 World Health Organization. (2015). Global Health Observatory (GHO) data: World Health Statistics 2015. WHO. Available at: http://www.who.int/gho/publications/world_health_statistics/EN_WHS2015_Part2.pdf?ua=1(Accessed on 2 November 2015).

121 World Health Organization. (2015). Global Health Observatory (GHO) data: World Health Statistics 2015. WHO. Available at: http://www.who.int/gho/publications/world_health_statistics/EN_WHS2015_Part2.pdf?ua=1(Accessed on 2 November 2015).

122 Department of Health Services, Ministry of Health and Population, Government of Nepal Annual Report. Available at: http://dohs.gov.np/wp-content/uploads/2014/04/Annual_Report_2070_71.pdf (Accessed on 5 November 2015).

123 World Health Organization. (2015). Global Health Observatory (GHO) data: World Health Statistics 2015. WHO. Available at: http://www.who.int/gho/publications/world_health_statistics/EN_WHS2015_Part2.pdf?ua=1(Accessed on 2 November 2015).

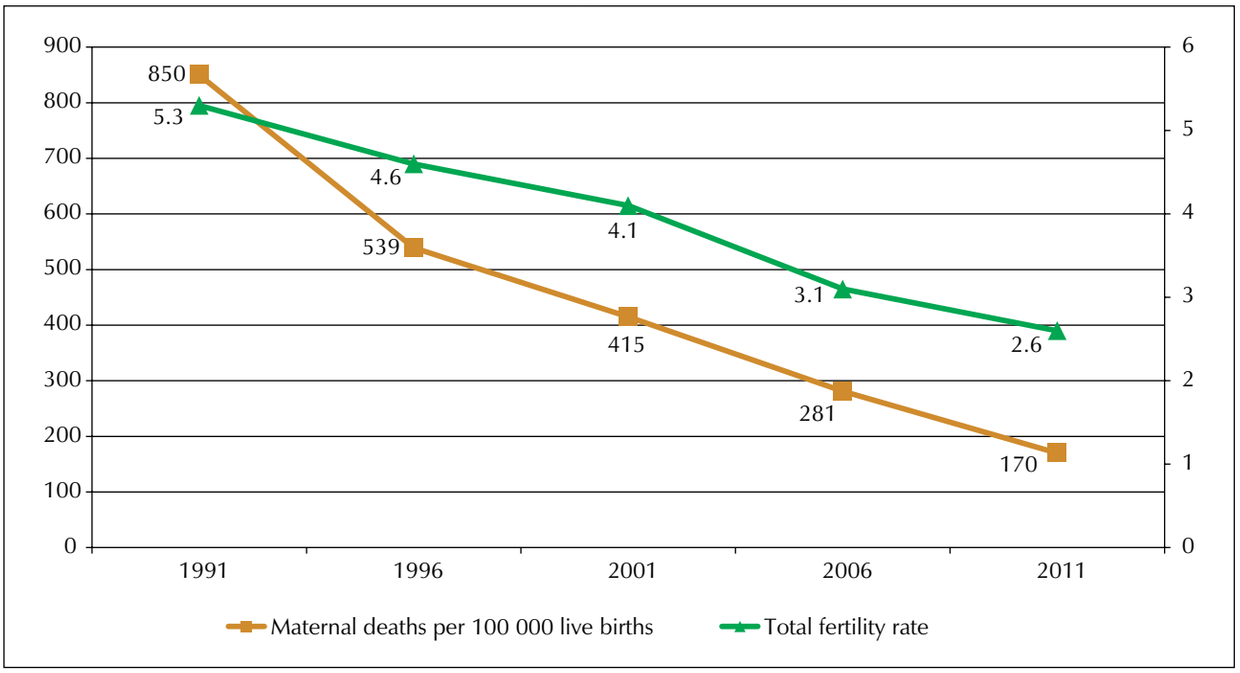
reform initiatives; legalization of abortion and the integration of safe abortion services under the safe motherhood umbrella; addressing the increasing problem of mother to child transmission of HIV/AIDS; and recognition of the importance of equity and access efforts to ensure that most needy women can access the services they need.[124]

Current challenges in maternal health

Including the low service availability to the general population, the main challenge to maternal health in Nepal is the differential among different ecological zones, ethnicity, wealth and educational status that contribute towards maternal morbidity and mortality.

The total fertility rate for women aged 15–49 years is 2.6 births per woman in 2011. The level of fertility is found to be inversely related with women's educational attainment with 3.7 births per women with women with no education to 1.7 births per women with women with a school-leaving certificate or above. The fertility was also found to be inversely associated with wealth quintile as the women in the lowest wealth quintile had an average of 4.1 births per women while the women in the highest wealth quintile had 1.5 births. One in six women (12%) is shorter than 145 cm and about one fifth (18%) women of reproductive age are thin or undernourished. On the other hand, 11% of women are overweight and 2% are obese. Anaemia is found in 35% of women of reproductive age. Pregnant women are more anaemic (48%) than breastfeeding women (39%) and neither pregnant nor breastfeeding (33%).[125]

Exhibit 46: *Maternal mortality ratio and total fertility rate, Nepal*



Source: Success Factors for Women's and Children's Health. World Health Organization. 2015.

According to World Health Statistics 2015, only 50% of the mothers made four or more antenatal care visits with a skilled provider. However, Nepal has targeted an ANC4 rate of 80% of women during their last pregnancy by 2015.[126] Deliveries in health facilities are still low in the country. Most (63%) of the

124 Department of Health Services, Ministry of Health and Population, Government of Nepal Annual Report. Available at: http://dohs.gov.np/wp-content/uploads/2014/04/Annual_Report_2070_71.pdf (Accessed on 5 November 2015).

125 Population Division, Ministry of Health and Population (MoHP), New ERA and ICF International. (2012). Nepal Demographic and Health Survey 2011. Available at: http://dhsprogram.com/pubs/pdf/FR257/FR257%5B13April2012%5D.pdf (Accessed on 5 November 2015).

126 Population Division, Ministry of Health and Population (MoHP), New ERA and ICF International. (2012). Nepal Demographic and Health Survey 2011. Available at: http://dhsprogram.com/pubs/pdf/FR257/FR257%5B13April2012%5D.pdf (Accessed on 5 November 2015).

deliveries take place at home and only 35% of the deliveries take place in a health facility. Only 36% of births take place with the assistance of a SBA. Institutional delivery is more than twice as likely in urban area (71%) than in rural area (32%). Health facility delivery is strongly associated with mother's education and wealth quintile. Nepal has aimed at raising the institutional delivery to 60% by 2015.[127] MICS indicates that institutional deliveries are 55.2% of the total while the deliveries by SBA are 55.6%. This means that other SBAs are not carrying our many deliveries. The postnatal care was received by 59% of the mothers. However, only 44% of them received all threePNC visits.[128]

The contraceptive prevalence rate for currently married women is 50% of which 43.2% are using modern methods.[129] Contraceptive methods are used more by urban women than by the rural women. Also, the use of modern contraceptive increased as household wealth increases. The unmet need for family planning among married women is 28%.[130] Nepal has a target to increase the CPR to 67% by 2015.[131]

The maternal health function

Nepal became a member of WHO on 2 September 1953, and a cooperation agreement was signed the following year. WHO's main focus is to provide technical assistance to the Ministry of Health and Population. WHO works to achieve agreements reached in the shape of the CCS, which provide a coherent medium-term vision for WHO's technical cooperation and defines its strategic framework for working in and with Nepal. The current CCS (2013–2017) has six priority areas, of which one is "Promoting health over the life-cycle, focusing on interventions for under privileged and vulnerable population." Beyond the six strategic priorities, WHO continues to address other important public health challenges in Nepal that do not fall within the priority areas as part of WHO's collaboration. Collaborative work in these areas will be planned in a biennium to biennium mode through negotiation between WHO, national authorities and relevant stakeholders.[132] The budget for RMNCAH has been declining, with biennial allocations falling from a high of USç 465 000 in 2010 to US$ 375 000 and in the current biennium (2014–2015) to US$ 214 392.

Contribution to maternal health

Function 1: Setting norms and standards
Setting norms and standards and promoting and monitoring their implementation

The WHO guidelines are routinely referred to and the Government of Nepal relies on the WHO standards. Yet challenges persist in the implementation of national standards and guidelines insofar as maternal and newborn care is concerned. Areas, important for the country, in which guidelines have been supported/developed by WHO are:

- The District Family Planning Strengthening Guideline (2011), followed by support to strengthen the District level Family Planning services through micro planning (2013). An evaluation of the programme was conducted in 2014 and results showed increase in CPR in the intervention districts.

127 Population Division, Ministry of Health and Population (MoHP), New ERA and ICF International. (2012). Nepal Demographic and Health Survey 2011. Available at: http://dhsprogram.com/pubs/pdf/FR257/FR257%5B13April2012%5D.pdf (Accessed on 5 November 2015).

128 Department of Health Services, Ministry of Health and Population, Government of Nepal Annual Report. Available at: http://dohs.gov.np/wp-content/uploads/2014/04/Annual_Report_2070_71.pdf (Accessed on 5 November 2015).

129 World Health Organization. (2015). Global Health Observatory (GHO) data: World Health Statistics 2015. WHO. Available at: http://www.who.int/gho/publications/world_health_statistics/EN_WHS2015_Part2.pdf?ua=1(Accessed on 2 November 2015).

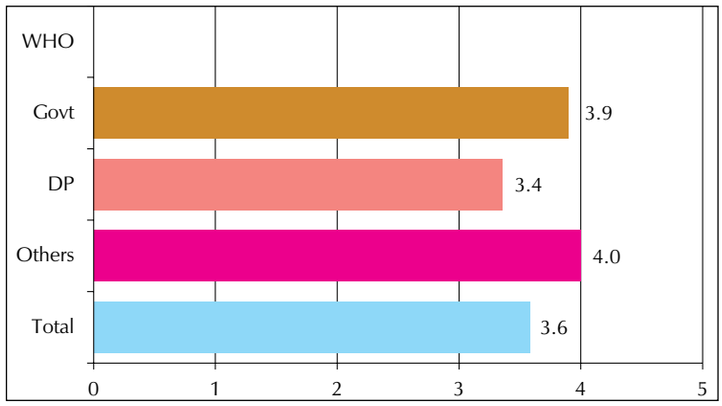
130 World Health Organization. (2015). Global Health Observatory (GHO) data: World Health Statistics 2015. WHO. Available at: http://www.who.int/gho/publications/world_health_statistics/EN_WHS2015_Part2.pdf?ua=1(Accessed on 2 November 2015).

131 Population Division, Ministry of Health and Population (MoHP), New ERA and ICF International. (2012). Nepal Demographic and Health Survey 2011. Available at: http://dhsprogram.com/pubs/pdf/FR257/FR257%5B13April2012%5D.pdf (Accessed on 5 November 2015).

132 World Health Organization. (2013). WHO country cooperation strategy Nepal:2013-2017. Available at: http://www.who.int/countryfocus/cooperation_strategy/ccs_npl_en.pdf (Accessed on 5 November 2015).

- The WHO Decision-making Tool for Family Planning 2014 has been adapted and translated into Nepalese by UNFPA and is being implemented by partners and government.
- The National Cervical Cancer Guidelines in 2010 and a National Training Package for Cervical Cancer screening, prevention and management.
- The Reference Manual and Training Materials for prevention and treatment of cervical cancer 2011 to complement the existing training package.

Exhibit 47: *Norms and standards, Nepal. Likert Scores*



Source: Amaltas, 2015

- The National Training Package for Prevention and management of Gender Based Violence 2011 and review in 2014.
- The National implementation plan for Birth Defect surveillance, prevention and control has been developed, and endorsed in early 2015.
- Assistance for the development of the Reproductive Health Monitoring and Evaluation Guideline, and training of trainers based on the guideline.
- Assistance for development of the National Guidelines and standard operating procedures on minimum initiation service package for sexual and reproductive health.
- Adaptation of the Medical Abortion Guidelines per WHO protocols.
- The National Postnatal and Kangaroo Mother Care Guidelines presently being developed in 2015.

The expectation is that WHO will identify gaps in respect of country norms and standards and be able to focus on those gap areas. The development community expects WHO to take the leadership and facilitate policy dialogue when it comes to setting norms and standards. As an example, the US Agency for International Development and the Government of Nepal promoted the introduction of Misoprostol in remote areas through female community health volunteers in the country. The process of distribution using non-medical volunteers is strongly opposed by WHO. WHO also strongly opposed the application of chlorhexidine on the umbilical stump in facility settings; yet the government introduced this in both facility and community settings where neonatal mortality rate is low. In both cases, the role of WHO in the dialogue on the subjects was not very effective.

> Heavily engaged but not actually leading. KII Respondents

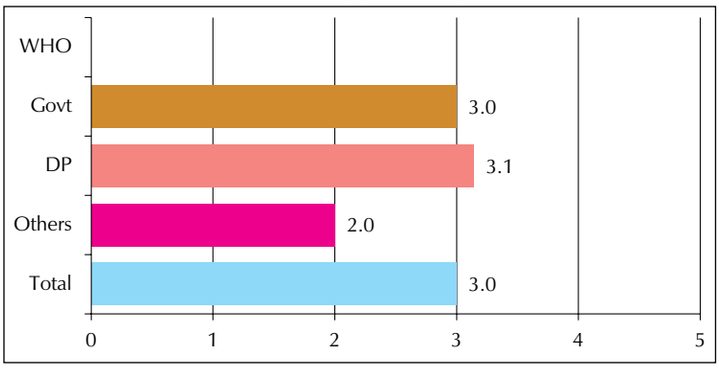
Function 2: Providing technical support and building institutional capacity

Providing technical support, catalysing change, and building sustainable institutional capacity

WHO has played a very strong role in the country for monitoring causes of maternal and perinatal deaths with the MDRs initiated since 1990 and has begun to support Perinatal Death Reviews. Maternal Perinatal Death Review (MPDR) began with implementation in 6 hospitals and since 2014, 42 hospitals have adopted MPDR processes. Last year, the Maternal Perinatal Death Surveillance and Response guidelines developed

with WHO´s support, and have received endorsement in early 2015. WHO has supported the revision of the National Safe Motherhood Policy to incorporate MDSR provisions and other emerging issues.

Exhibit 48: *Technical Support, Nepal. Likert Scores*



Source: Amaltas, 2015

Reproductive morbidity has been among the Government of Nepal's priority programmes. WHO has given strong support in capacity-building through training of trainers on cervical cancer screening, support for training of trainers and training for service providers at the district level in visual inspection with acetic acid/cryotherapy/colposcopy. In 2014–2015, WHO has supported development of training materials for prevention and treatment of cervical cancer to complement the existing training package. Gender based violence is one of the priorities of the country at this time, and WHO has provided training on frontline health workers and community-based social workers on prevention and management of gender based violence. Additionally, support has been provided for training of trainers on gender equity and social inclusion to national health training centre trainers and Regional Health Directorate officials. Although supporting sustainable multisectoral approaches to improve nutrition throughout the life-cycle by addressing social and economic determinants of all forms of malnutrition is an important strategic approach, little has been done on this account.

Keeping in mind the challenges of human resources in health in Nepal, WHO has shown strong leadership and commitment. There are many examples such as to help to strengthen the quality of Bachelor of Medicine and Bachelor of Surgery (MBBS) and nursing education in Nepal over the years, it has assisted the revision of pre-service and in-service curriculum for senior a nurse midwives, review of minimum requirements for the auxiliary nurse midwives programme and also in the revision of the curriculum of mid-level nurses with a focus on proficiency certificate level nursing curriculum. Similarly support in other trainings include: training of trainers conducted on SBA competencies for pre-service nursing, for in-service SBAs and supervision, monitoring and skill update was provided at different level of health facilities. As envisioned by the national SBA Policy 2006 to establish a professional midwifery cadre, WHO supported a National Consultative meeting to discuss the need for a midwifery programme in the country. WHO is a part of the midwifery taskforce in the Ministry of Health and Population (MoHP) and provides technical assistance to MoHP for establishment of midwifery education and workforce. A draft of strategic document was developed to outline the need for a bachelor midwifery degree, which is yet to be finalized. It has also contributed to the MBBS programme by supporting the training of master trainers on communication curriculum in the MBBS programme and teachers' training on improving teaching competency. Recently, it has supported the development of a curriculum for a two years master programme in health promotion and education.

WHO is engaged in advocacy for the Every Newborn Action Plan process in Nepal through technical advice. WHO has also been advocating for strengthening national data on birth defects and supported the national implementation plan for Birth Defect Surveillance, Prevention and Control, which was endorsed in early 2015.

> WHO has a big name in Nepal. But it has done many things in little bits and pieces but not enough on a larger scale. Interviewees

Criticisms include, inability to coordinate effectively on the right persons for trainings and meetings; doing things in "little bits" but not on a large enough scale; and efficiency and technical leadership being less than the expectations thereof.

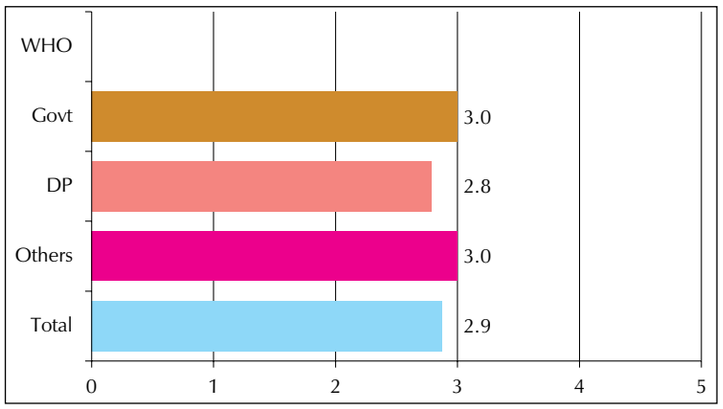
Function 3: Shaping the research agenda

Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge

WHO is doing its part, but there is room for improvement. Interviewees

WHO is involved in shaping the research agenda as a member of the Family Health Technical Working Group. It coordinated these meetings for the Family Health Division and has also been involved in all other technical working groups. Support was also provided on cross-cutting areas. Both the Government of Nepal and external partners rely on WHO for the necessary hardcore technical inputs for various programmes. Recently however, lack of staff has meant that such support is either missing or greatly delayed.

Exhibit 49: *Research Agenda, Nepal. Likert Scores*



Source: Amaltas, 2015

Nepal requires strengthening of research institutions and linkage of research institutions with policy- makers to strengthen information management and accountability to country commitments. WHO has contributed on this account; in 2013, a national workshop on networking meeting was organized with this objective. WHO supported the development of a country accountability roadmap to translate the global Commission on Information and Accountability recommendations for women´s and children´s health. It has assisted with strengthening the Nepal Medical Council on Governance and Quality Assurance in 2012, and advocacy followed in subsequent years.

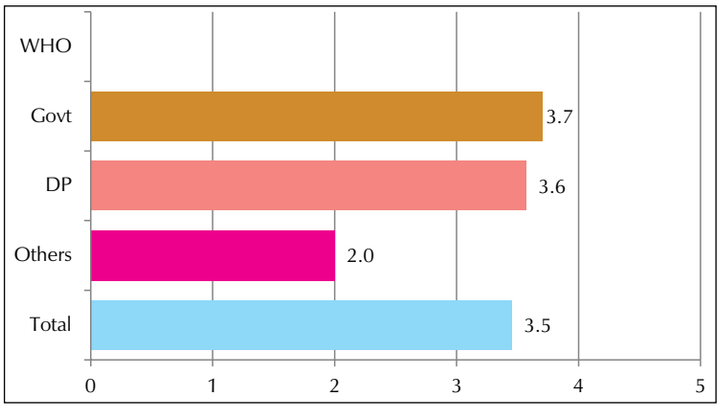
WHO has contributed in the development of National Demographic Health Survey (NDHS), MICS and has worked very closely with the Government of Nepal in developing strategies and policies. It has helped to identify the needs and ways of conducting research and supports Nepal Health Research Council in identifying priorities. They have been the key technical advisors for providing information on maternal health agenda. Studies being conducted with the technical assistance of WHO are as follows:

- two studies have been conducted on menopausal health;
- factors associated with abnormal birth outcomes, looking at the relationship with exposure to pesticides;
- WHO also supported a study on success factors for Nepal´s progress in MDG 4 and 5 through a national consultative process, desk review and analyses of secondary data (2014);
- technical support has also been extended for developing the report on the SDGs (2015);
- Maternal and Perinatal Death Surveillance and Response Guidelines 2015.

To improve the quality of research, WHO has been supporting and contributing in the trainings of different health cadres. For example, it has supported trainings for doctors, nurses and medical recorders in research methodology and proposal writing and to develop a manual for trainers in health research for health-care professionals. WHO has been strongly supporting the Family Health Division plenary sessions on MPDR and MDSR at the 2015 conference of the Nepal Society of Obstetricians and Gynaecologists.

Function 4: Articulating policy options
Articulating ethical and evidence-based policy options

Exhibit 50: *Evidence-based policy, Nepal. Likert Scores*



Source: Amaltas, 2015

Nepal has large gaps in the health work force and to meet these gaps the 2006 National Policy for Skilled Birth Attendants was endorsed to improve and build on the skills of existing health workers to fill the gaps in provision of antenatal, delivery and postnatal care. The long-term goal of the 2006 SBA Policy was to establish a professional midwifery cadre and the National Heath Policy clearly emphasizes the need for professional midwives. WHO advocated with the Ministry of Health and Population to sign a memorandum of understanding with four universities to start midwifery education. An assessment was also conducted to identify availability of doctors and nurses in Nepal with projection scenarios. This gave needed evidence on the requirements for skilled human resources in Nepal. Examples of the work carried out by WHO to generate evidence on human resource needs for maternal and newborn health are:

- in depth country assessment of nursing and midwifery education in Nepal to develop regional strategic directions for nursing and midwifery development;
- survey was conducted on community health nursing.

WHO participates in the midwifery taskforce in MoHP and provides technical assistance to MoHP for establishment of midwifery education and workforce. A draft strategic document has been developed to outline the need for a bachelor midwifery degree, which however, is yet to be finalized. Postpartum haemorrhage management and postnatal care guidelines are also being developed as per WHO protocols.

> The name WHO stands out but it needs to do more.Interviewees

Yet WHO is not seen by stakeholders to be doing enough on this area. As an example, there is a strong debate on the use of antenatal corticosteroids. Opinions are informed by a strongly positive Cochrane Review, yet doubters persist. It was expected that WHO would provide its own opinion and expert advice, but this has so far, not been forthcoming. Several interviewees feel that while WHO is quite independent, its advice is generally not clear enough.

Nonetheless, WHO was able to bring evidence to bear and convince the Government of Nepal to work on universal health care and quality of care as part of Nepal Health Sector Strategy discussions. WHO has also taken the lead role in sharing new materials and evidences among the external partners and other stakeholders.

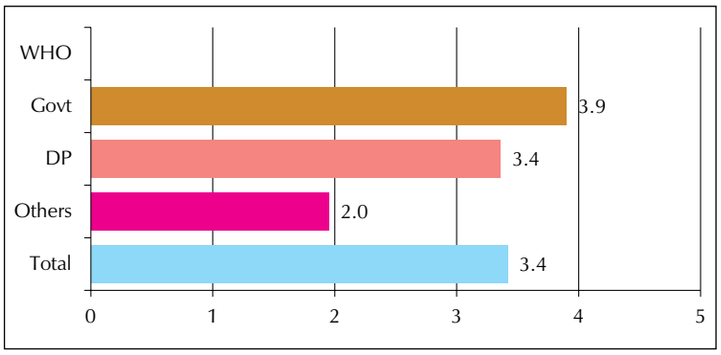
Function 5: Monitoring health situation and trends
Monitoring the health situation and assessing health trends

WHO participates in monitoring the health situation and health trends in the country. It contributes to the design of the MICS study and NDHS. It has a provided strong support in monitoring in maternal and perinatal deaths through the MDR, which have evolved into the more comprehensive Maternal Perinatal Death Surveillance and Response System.

That its role is vital is clear because the Government of Nepal consults WHO whenever they require technical advice. WHO estimates are used to feed into estimations of long-term trends. The Government

of Nepal supports evidence-based policies and has thus prioritised monitoring and evaluation processes through Census and survey data. Data is fed into the HMIS. WHO has been assisting with the HMIS through its role in the Technical Working Group. However, data analyses need to be disseminated properly by the country office.

Exhibit 51: *Monitoring health, Nepal. Likert Scores*



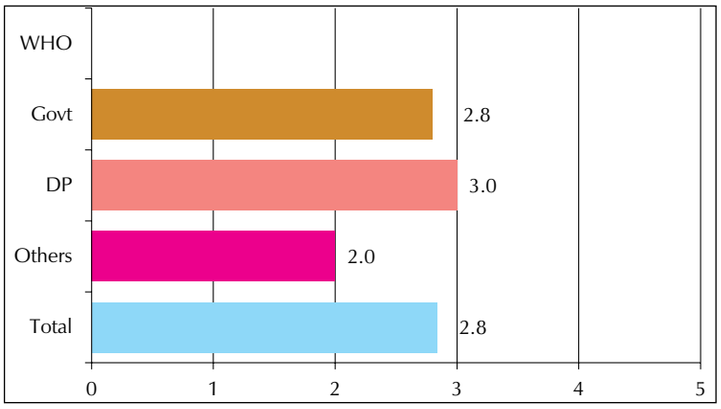
Source: Amaltas, 2015

Nepal lacks reliable national data on the prevalence of birth defects and how this is contributing to newborn mortality. There is a dire need to strengthen and expand neonatal and perinatal database in the existing network in the country. The National Implementation Plan for Birth Defect Surveillance, Prevention and Control Plan 2015–2019 needs to guide the multisectoral work required in this area where WHO is working intensively.

Function 6: Providing leadership on health
Providing leadership on matters critical to health and engaging in partnerships where joint action is needed

External partners have a vital role to play in a country like Nepal. The Government of Nepal has great expectations from all external partners specially WHO, which has taken up a crucial responsibility in initiating the MPDR. This is a vital area where WHO has taken the lead. It has also shown the way and support standardization of the birth and death registration in the country; establishment and expansion of the national network for neonatal and perinatal data; and piloting of the stillbirth surveillance protocol at the tertiary level health facilities. Although it has done well in terms of capacity-building for example trainings SBAs, developing trained cadre in public health; there are areas where it can perform better but is happening at a lesser calibre.

Exhibit 52: *Leadership in health, Nepal. Likert Scores*



Source: Amaltas, 2015

The Government of Nepal looks upon WHO as an organization to lead and show the right direction for issues in maternal health. Interviewees also view WHO inputs with anticipation and expect WHO to lead, not follow. They look to WHO to raise attention to one of Nepal's most pressing problems and spark some new change to address country concerns.

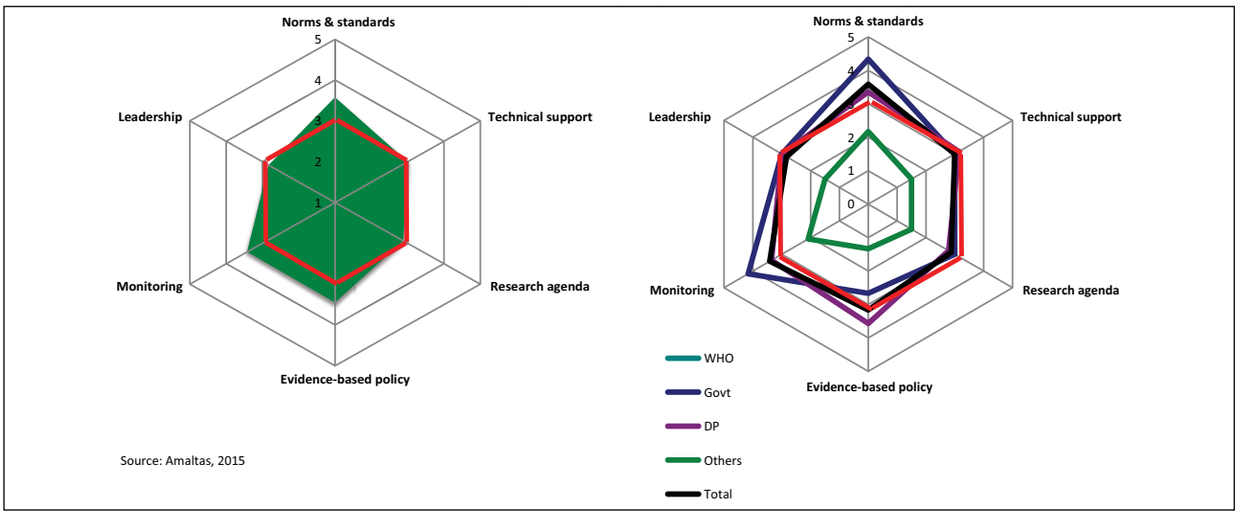
> They seem to be everywhere, but nowhere. Interviewee

Conclusion

As has been discussed in the preceding paragraphs, WHO has played an important role in the country's work on maternal health. Not only does it work closely with the Government of Nepal on key initiatives of the government, it helps to track the health situation and trends in maternal health in the country. It plays

an active role in the research agenda of the country, supporting research studies and participating in the research agenda setting through the Family Health Technical Working Group. It provides much needed technical and capacity-building support and generates evidence for policy setting.

Exhibit 53: *Core functions: Average and by type of interviewee, Nepal. Likert Scores*



Source: Amaltas, 2015

There are however, areas of concern. While there is no doubt that WHO has been sharing vital information for the Government of Nepal and external partners, the official process of acquiring documents and evidence seems to be quite long, there is a delay in getting the necessary documents when needed. In several instances, relevant and new guidance from WHO is first accessed by other partners through informal channels, rather than from WCO staff who often get documents later, through the Organization's website. There thus seems to be a gap in information sharing between the HQ, regional and WCO. WCO has little information available on what guidelines are currently under development and revision, which would be valuable knowledge when guiding the Ministry of Health and Population.

Being under-staffed and under-resourced is the biggest challenge at the moment; this has hampered functioning and could even lead to missing something vital. The single NPO position covers not only maternal health, including newborn and adolescent health but also child health covered by a different government division also with a need for strong technical assistance. Also gender, equity and human rights activities also fall into the responsibility basket of the same staff.

WHO is a well-respected organization, which is viewed with expectancy and hope for world-class guidance. Preserving their reputation is very important to its ability to exert influence over health outcomes in the country. WHO needs to foster their links with the Ministry of Health and Planning to prioritize their needs, and deliver more to the Government of Nepal expectations in respect of technical support and advice.

> WHO is one of the most trusted partners for the Government of Nepal. However, in the past few years, their performance has been mediocre and has not met expectations. Interviewees

In certain domains such as immunization and epidemic reporting and disaster preparedness, WCO is seen to be playing an extremely useful role. However, in maternal health, there appears to be a gap between HQ, SEARO and WCO in sharing and disseminating information.

The study yielded a number of useful lessons, which could be important for WCO as it moves forward.

- Maternal health continues to be a high priority domain for Nepal. There is great need for an organization to take a leadership role in coordinating a technical response to the needs of

the Government and other stakeholders in the country. A national level health forum for the country counterparts would be very helpful.

- WHO is involved in a very large number of initiatives in maternal health. With the result the technical accountability is spread thin. There is a dire need to prioritize its expertise and ensure focus to a few critical areas.
- The primary role of WHO is to provide technical guidance and support to country institutions working in the area of maternal health. Counter-intuitively, human resources are sparse at WCO and there is a great need for people with greater expertise. In a similar vein, it is important to maintain budget allocations for this domain despite organizational shifts to other issues of concern such as noncommunicable diseases.
- A stronger mechanism to facilitate relationships between HQ, SEARO and WCO needs to be put in place. There is an urgent requirement of an expert who can monitor and present key findings from data to the public health community. This role must be shared between the three levels of the organization.

Data sources: Primary qualitative data for the case study was collected through interviews with government officials, staff of government and nongovernment institutions, WHO and partners. Thirty one key informants from the Government (5), UN bodies including WHO (2), partners (5) and international NGOs (3) were interviewed and 12 Likert Scale scores obtained. In addition, more than 25 papers, reports, guidelines, presentations, and online statistics on maternal health in Nepal and the Region were consulted to triangulate information received from KII and Likert Scale.

Limitations:

- Due to the MOHP's regional reviews, which took place during the same period as the study data collection, some government officials that the team might have liked to meet were not available for interviews.

Capital:	Colombo*	Life expectancy at birth m/f:	72/78*
Population:	21 273 000*	Infant mortality rate:	8.2*
Rank in HDI:	73#	Neonatal mortality rate:	5.9*
World Bank income classification:	Lower middle#	Under 5 mortality rate:	9.6*
GNI per capita (PPP):	US$ 9470*	Maternal mortality rate:	29*
Expenditure on health per capita:	US$ 270*		

*WHO 2015 #UNDP 2013

Sri Lanka

The country context

The Democratic Socialist Republic of Sri Lanka is an island state situated in the Indian Ocean. It has an area of 65 610 sq km and houses a population of 20.7 million in 2014.[133] The country is a multi-religious, multi-ethnic, pluralistic society which has recently recovered from a civil conflict in its northern and eastern provinces. The development efforts of successive governments during the last 5 decades have enabled it to graduate to a lower middle income country status.

In 2012, Sri Lanka's HDI of 0.750 positioned the country at 73 out of 187 countries and the Gender Inequality Index was 0.383 placing it in the 75th rank in gender equity.[134] Sri Lanka's GDP per capita in 2014 was US$ 3608, which is ahead of most South Asian countries.[135] Investments made in human development especially education and health, have resulted in indicators such as life expectancy (75 years), mortality rate (Crude Death Rate: 6.2) and literacy rates (95.6%) to be ahead of most other developing countries, and are comparable with the developed world.[136],[137] Rapid declines in both Total Fertility Rate to 1.9 and crude death rate have led to an increase in ageing, side by side with the demographic bonus that the country collected. Issues facing the country include regional disparities, income inequities and an unexpected rise in the TFR (2.3 in 2013).[138],[139] Linked to these are social changes in respect of increasing women participation in the political sector and in wage employment in the nonagricultural sector, financing of health care, and overseas development assistance flows.

133 Statistics Department, Central Bank of Sri Lanka. (2015). Economic and Social Statistics of Sri Lanka 2015. Central Bank of Sri Lanka. Available at: http://www.cbsl.gov.lk/pics_n_docs/10_pub/_docs/statistics/other/econ_&_ss_2015_e.pdf (Accessed on 3 November 2015)

134 United Nations Development Programme. (2014). Human Development Report 2014 : Sustaining Human Progress: Reducing Vulnerabilities and Building Resilience. Available at: http://hdr.undp.org/sites/default/files/hdr14-report-en-1.pdf (Accessed on 4 November Statistics Department, Central Bank of Sri Lanka. (2015). Economic and Social Statistics of Sri Lanka 2015. Central Bank of Sri Lanka. Available at: http://www.cbsl.gov.lk/pics_n_docs/10_pub/_docs/statistics/other/econ_&_ss_2015_e.pdf (Accessed on 3 November 2015)2015)

135 Statistics Department, Central Bank of Sri Lanka. (2015). Economic and Social Statistics of Sri Lanka 2015. Central Bank of Sri Lanka. Available at: http://www.cbsl.gov.lk/pics_n_docs/10_pub/_docs/statistics/other/econ_&_ss_2015_e.pdf (Accessed on 3 November 2015)

136 Family Health Bureau (2014). Annual Report on Family Health 2013. Ministry of Health, Sri Lanka. Available at http://www.fhb.health.gov.lk/web/index.php?option=com_phocadownload&view=category&download=575:annual-report-2013&id=35:planning-monitoring-evaluation&Itemid=150&lang=en (Accessed on 5 November 2015)

137 World Health Organization. (2015). Global Health Observatory (GHO) data: World Health Statistics 2015. WHO. Available at: http://www.who.int/gho/publications/world_health_statistics/EN_WHS2015_Part2.pdf?ua=1(Accessed on 2 November 2015).

138 Department of Census and Statistics, Colombo, Sri Lanka. (2012). Census of Population and Housing - Key Findings. Available at http://countryoffice.unfpa.org/srilanka/drive/Census-2012.pdf (Accessed on 21 October 2015)

139 World Health Organization. (2015). Global Health Observatory (GHO) data: World Health Statistics 2015. WHO. Available at: http://www.who.int/gho/publications/world_health_statistics/EN_WHS2015_Part2.pdf?ua=1(Accessed on 2 November 2015).

Household out-of-pocket expenditure on health is estimated to be more than 50% of total expenditure.[140] Nevertheless maternal health is looked after mainly by the public sector, although there is increasing reliance on the private sector. While the public sector financing accounted for 84% of the total hospital expenditure in 1990, it has dropped to 76% in 2012 whereas the private sector financing has increased from 16% in 1990 to 24% in 2012. It is recognized that there is a need to revamp financial mechanisms so that effectiveness and equity is enhanced. The total health expenditure in Sri Lanka in 2012 was estimated at LKR 253 billion and per capita health expenditure was LKR 4392 in 2012.[141, 142] The Government expenditure on health was 1.4% of GDP and 4.1% of the national expenditure in 2012–13, lower than other countries with similar demographics.[143]

Maternal health in Sri Lanka

Sri Lanka has been held up as an example for the developing world, and some of its health indicators could be compared with developed countries. A strong health Infrastructure with trained human resource, and other development factors, have made it possible for Sri Lanka to be among the first developing countries to provide universal healthcare to its people along with free education while ensuring gender equality.

The decline of MMR has an interesting trajectory: while the decline from 1930 to 1950 can be related to disease control, especially malaria and the introduction of antibiotics, the next 50% reduction in the following 13 years was based on the government efforts to extend health services, including critical elements of maternal health care. In the decades that followed, the public sector systematically applied strategies to improve organizational and clinical management, and was able to reduce MMR by 50% every 6–12 years. Trained assistance during delivery, with a high percentage of institutional births, as the place of delivery shifted from home to maternity homes and institutions contributed greatly to the success of the programme. A range of primary, secondary and tertiary level institutions have been established with professionally trained human resource. However, the public health midwife who was trained to provide maternity care for uncomplicated pregnancies and began by doing home deliveries in 1926 still remains the cornerstone of the programme and is the first level of contact between the mother and the baby.[144]

The Family Health Bureau (FHB) was established to look after maternal and child health as well as family planning, and discharged its responsibilities for planning, coordination and monitoring the programme with information, education and communication support from the Health Education Bureau. The FHB is the technical arm of the Ministry of Health for MCH and WHO works closely with them. An enquiry into maternal deaths was started in 1985 where maternal deaths were reported to FHB. In 1995, the process was expanded nationwide and the system strengthened to immediately report a maternal death to FHB, and an investigation carried out at the facility and community levels. This has evolved over the years as a MDSR, which has been used to take corrective measures and guide the programme and not to fix individual responsibility. A MDR is conducted every 6 months at the district level where experts are sent from the district HQ and every year at the national level. It seems reasonable to suggest that this has contributed to the decline in maternal mortality. [145] In 2013, the MMR in Sri Lanka was at 29, while the

140 World Health Organization, Country Office of Sri Lanka. (2012). WHO Country Cooperation Strategy Sri Lanka, 2012–2017: Democratic Socialist Republic of Sri Lanka WHO. Available at: http://www.who.int/countryfocus/cooperation_strategy/ccs_lka_en.pdf?ua=1 (Accessed on 4 November 2015).

141 Amarasinghe, S. N. et al. (2014). Sri Lanka Health Accounts: National health Expenditure 1990-2012. Health Expenditure Series No. 3, Colombo, Institute for Health Policy. Available at : http://www.ihp.lk/publications/docs/HES1403.pdf (Accessed on 30 Oct, 2014).

142 Family Health Bureau, Ministry of Health, Government of Srilanka. (2014). Annual Report on Family Health 2013. Ministry of Health, Sri Lanka. Available at http://www.fhb.health.gov.lk/web/index.php?option=com_phocadownload&view=category&download=575:annual-report-2013&id=35:planning-monitoring-evaluation&Itemid=150&lang=en (Accessed on 5 November 2015)

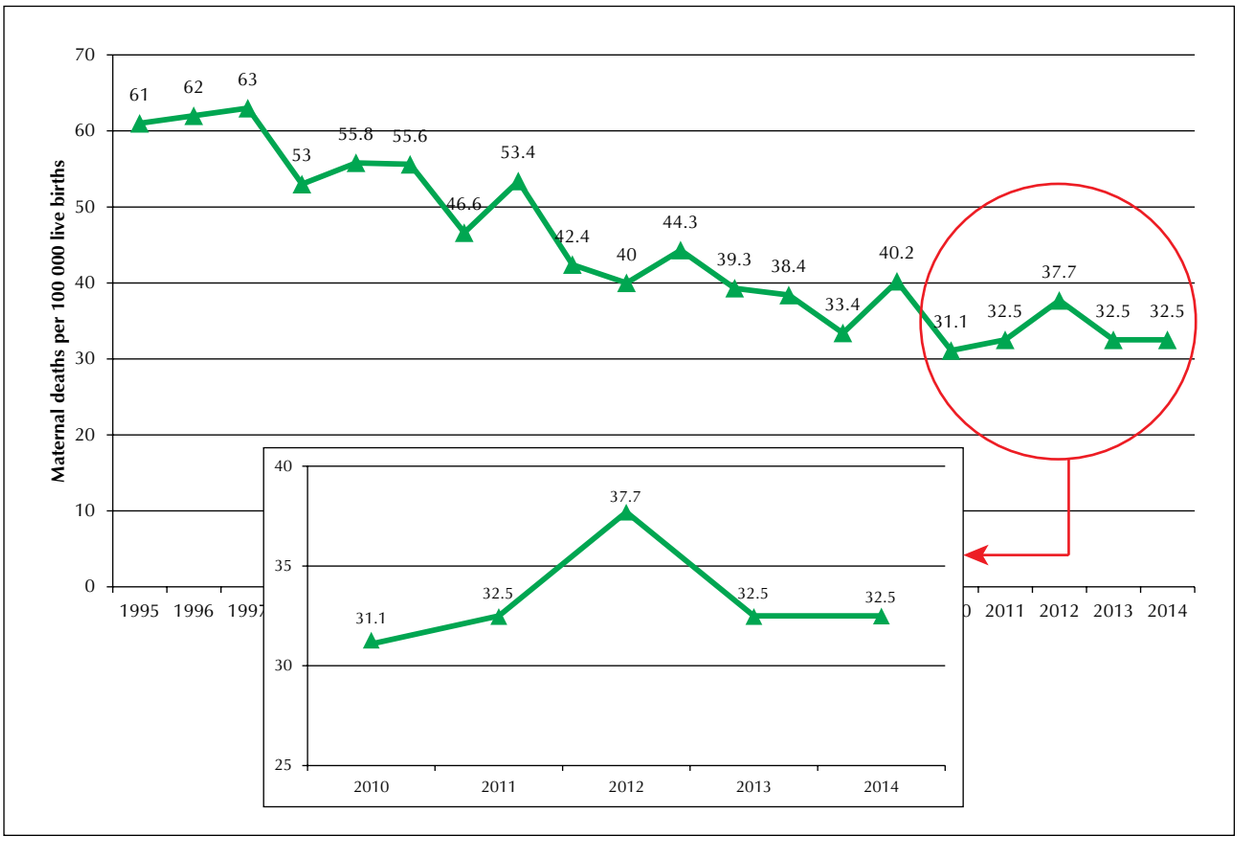
143 Family Health Bureau, Ministry of Health, Government of Srilanka. (2014). Annual Report on Family Health 2013. Ministry of Health, Sri Lanka. Available at http://www.fhb.health.gov.lk/web/index.php?option=com_phocadownload&view=category&download=575:annual-report-2013&id=35:planning-monitoring-evaluation&Itemid=150&lang=en (Accessed on 5 November 2015)

144 Dr. Vidyasagar WN. (2003). Maternal Mortality Reduction in Sri Lanka. Available at: file:///C:/Users/HP/Downloads/Maternal%20Mortality%20Reduction%20in%20Sri%20Lanka%20--.pdf (Accessed on 5 November 2015).

145 World Health Organization,Regional Office for South-East Asia.(2014). A study on the implementation on Maternal Death Review in five countries in South- East Asia region of the World Health Organization. WHO. Available at: http://apps.searo.who.int/PDS_DOCS/B5115.pdf (Accessed on 5 November 2015).

MDG 5 target was to achieve a ratio of 23 per 100 000 live births by 2015, a drop of 20%.[146] In 2011, MMR had risen to 32.5 and by the next year to 37.7. This last is now attributed to the H1N1 epidemic. But from there on, the MMR has continued to be about 32 per 100 000 live births, being 32.5 in 2013 and 32.03 (tentative) in 2014.

Exhibit 54: *MMR from 1995 to 2014, Sri Lanka*



Source: Adapted from findings of Maternal Death Reviews 2013. Presentation by Dr Anoma Jayathilaka, NPO, WCO-Sri Lanka. September 2015.

While MMR presented a clear declining trajectory from 1995 to 2010, after that date it seems to have plateaued barring a brief rise due to the H1N1 epidemic.

There has been an increase in the indirect causes for MMR (55% in 2013), especially cardiac and respiratory deaths in keeping with changing mortality patterns. Deaths due to cardiac causes include a substantial number of expectant mothers with congenital heart disease. Many deliveries now require specialized tertiary care. The Government is setting up three super speciality centres in Anuradhapura, Kandy and Colombo within or close to teaching hospitals to attend to these requirements.

146 World Health Organization. (2015). Global Health Observatory (GHO) data: World Health Statistics 2015. WHO. Available at: http://www.who.int/gho/publications/world_health_statistics/EN_WHS2015_Part2.pdf?ua=1(Accessed on 2 November 2015).

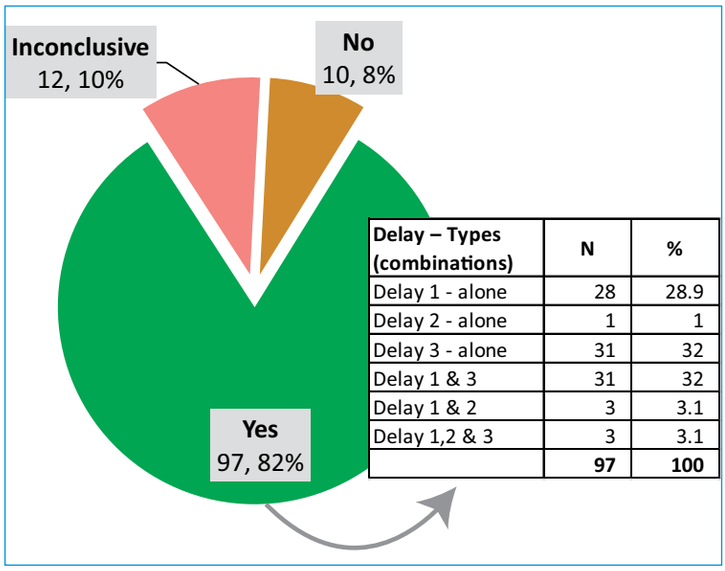
Exhibit 55: *Causes of maternal deaths, Sri Lanka*[147]

	2010	2011	2012	2013	2014
Total no. of maternal deaths	126	118	134	119	112
Obstetric haemorrhage	22	9	22	9	11
Heart disease	13	18	15	32	17
Hypertensive disorders	12	9	13	10	5
Septic abortion	17	11	13	3	14
Ectopic pregnancy	3	5	2	0	6
Pulmonary/Amniotic embolism	6	6	10	9	9
Respiratory diseases	8	4	12	22	18
MMR per 100 000 live births	31.1	32.5	37.7	32.5	32.03

In Sri Lanka pregnancies occur at a later age; of the 119 maternal deaths in 2013, 18% were among those above 36 years of age. Some of pregnancies occur among women for whom pregnancies are medically contraindicated e.g. congenital heart disease; others are socially stigmatized such as those among unmarried, widowed, divorced women and which resulted in nine (8%) maternal deaths in 2013. Addressing medical contraindicated pregnancies and socially stigmatised pregnancies could have been prevented if strong family planning services were available.[23]

Meanwhile, nearly half of the maternal deaths are still due to direct causes. In spite of near universal institutional delivery rates (99.9%) and 95% with comprehensive EmOC facilities, certain issues effective coverage of maternal care interventions arise. FHB along with WHO and other stakeholders is looking for patterns of the 3 delays in maternal deaths: the first indicating delay in seeking care; second indicating delay in reaching appropriate service facility; and the third, a delay in providing treatment and possible gap in quality of care.[148] However, the delays are classified through a local modification, which is far more strict than the traditional 3 delay method of Thaddeus and Maine (1994). Using this method, it is estimated that 71% of maternal deaths are preventable.[149]

Exhibit 56: *The three delays, Sri Lanka*



Delay – Types (combinations)	N	%
Delay 1 - alone	28	28.9
Delay 2 - alone	1	1
Delay 3 - alone	31	32
Delay 1 & 3	31	32
Delay 1 & 2	3	3.1
Delay 1,2 & 3	3	3.1
	97	**100**

Source: Amaltas, 2015

Comprehensive EmONC is available in 74 hospitals, managed by the Ministry of Health, and more than 95% of births take place in those institutions.[150] Nearly 400 secondary level institutions are available with labour room facilities with trained staff although less than 5% of deliveries take place in these institutions. Approximately 10 000 midwives serve in the country, 80% of whom work at the community level.[151]

147 Family Health Bureau, Ministry of Health, Government of Sri Lanka. (2014). Annual Report on Family Health 2013. Ministry of Health, Sri Lanka. Available at http://www.fhb.health.gov.lk/web/index.php?option=com_phocadownload&view=category&download=575:annual-report-2013&id=35:planning-monitoring-evaluation&Itemid=150&lang=en (Accessed on 5 November 2015)

148 Family Health Bureau, Ministry of Health, Government of Sri Lanka. (2014). Annual Report on Family Health 2013. Ministry of Health, Sri Lanka. Available at http://www.fhb.health.gov.lk/web/index.php?option=com_phocadownload&view=category&download=575:annual-report-2013&id=35:planning-monitoring-evaluation&Itemid=150&lang=en (Accessed on 5 November 2015)

149 Family Health Bureau, Ministry of Health, Government of Sri Lanka. (2014). Annual Report on Family Health 2013. Ministry of Health, Sri Lanka. Available at http://www.fhb.health.gov.lk/web/index.php?option=com_phocadownload&view=category&download=575:annual-report-2013&id=35:planning-monitoring-evaluation&Itemid=150&lang=en (Accessed on 5 November 2015)

150 World Health Organization, Country Office of Sri Lanka. (2012). WHO Country Cooperation Strategy Sri Lanka, 2012- 2017. WHO. Available at: http://www.who.int/countryfocus/cooperation_strategy/ccs_lka_en.pdf?ua=1 (Accessed on 5 November 2015).

151 Family Health Bureau, Ministry of Health. (2012). National emergency obstetric and neonatal care needs assessment: Provincial Report Southern Province 2012. Family Health Bureau, Ministry of Health. Available at: file:///C:/Users/HP/Downloads/southern_province_2012.pdf(Accessed on 5 November 2015).

Of the pregnant mothers who died in the year 2013, 90% died in hospitals; and of them 97% died at a base, general or teaching hospital where specialized facilities are available. This indicates that there might have been an adequate opportunity for interventions. One fourth of the maternal deaths in 2013 could have been prevented if unmet need for family planning had been addressed by relevant health-care personnel.[152]

Current priority areas and challenges in maternal health

At the base year of the MDGs, Sri Lanka was a clear frontrunner in comparison with other developing countries in the MDG 5 indicators. Above 94% of deliveries were already taking place with SBA; CPR was 66%; MMR was 92 per 100 000 live births; and infant mortality rate was 17.7 per 1000 live births. [153]

To meet the MDG target of reduction of MMR by 75% required very specific and critical interventions. These were embarked on, after a thorough analysis of the causes of maternal mortality. Increasing and improving comprehensive EmOC facilities, and paying attention to improving blood and blood products, improving transportation, enhancing maternal death surveillance and response by introducing a rapid communication system to facilitate links between hospital and field health-care workers were the main steps that were taken. By 2013, MMR had declined to 29 with deliveries by SBA at 99% (94% at a hospital with specialized obstetric facilities). Provision of ANC increased to 100%; 85% of women received at least one postnatal home visit by a well trained public health midwife; and more than 92% received more than four postnatal visits.[154], [155] Sri Lanka was on track to achieve the MDG 5.

However, there are challenges: (i) The level of births by caesarean sections are high at 30%, and in certain institutions much higher.[156] Maternal nutrition is a challenge as 20% of women begin pregnancy with low body mass index (18.5/kgm^2); low birth weight among newborns has also stagnated at about 15–20%.[157] Well Women's Clinics set up by the government in 1996, screen women for noncommunicable diseases such as cervical and breast cancers, diabetes and hypertension. The prevalence of HIV/AIDS is low and universal screening is done for prevention of mother to child transmission of HIV/AIDs and elimination of syphilis. Adolescent health has begun to be addressed in the life-cycle approach but unmarried women are not taken in account for CPR.

Abortion, which is restricted only to reason of saving the life of the mother, contributes to a large number of maternal deaths. There is lack of reliable data but various studies estimate the levels of illegal abortions to be between 150 000 and 175 000 a year.[158] A study undertaken in 1999 had the sobering finding that induced abortion was resorted to mainly among the urban and semi-urban married women in the age group 25–39 years with two or more children.[159] The fact is that septic abortion is a major cause of maternal deaths, and that there is evidence of a large number of maternal deaths in the older age group, indicates the lack of family planning services. TFR has increased as a result, and is corroborated by both

152 Family Health Bureau, Ministry of Health, Government of Sri Lanka. (2014). Annual Report on Family Health 2013. Ministry of Health, Sri Lanka. Available at http://www.fhb.health.gov.lk/web/index.php?option=com_phocadownload&view=category&download=575:annual-report-2013&id=35:planning-monitoring-evaluation&Itemid=150&lang=en (Accessed on 5 November 2015)

153 United Nations Fund for Population Activities.. (2015). Millennium Development Goals Country Report 2014. United Nations, Sri Lanka. Available at: www.un.lk (Accessed on 10 September 2015).

154 World Health Organization, Country Office of Sri Lanka. (2012). WHO Country Cooperation Strategy Sri Lanka, 2012- 2017. WHO. Available at: http://www.who.int/countryfocus/cooperation_strategy/ccs_lka_en.pdf?ua=1 (Accessed on 5 November 2015).

155 World Health Organization. (2015). Global Health Observatory (GHO) data: World Health Statistics 2015. WHO. Available at: http://www.who.int/gho/publications/world_health_statistics/EN_WHS2015_Part2.pdf?ua=1(Accessed on 2 November 2015).

156 World Health Organization, Country Office of Sri Lanka. (2012). WHO Country Cooperation Strategy Sri Lanka, 2012- 2017. WHO. Available at: http://www.who.int/countryfocus/cooperation_strategy/ccs_lka_en.pdf?ua=1 (Accessed on 5 November 2015).

157 Family Health Bureau, Ministry of Health. (2012). National emergency obstetric and neonatal care needs assessment: Provincial Report Southern Province 2012. Family Health Bureau, Ministry of Health. Available at: file:///C:/Users/HP/Downloads/southern_province_2012.pdf(Accessed on 5 November 2015).

158 World Health Organization, South East Asia Regional Office. (2014). Mapping abortion policies, programmes and services in the South-East Asia Region. WHO. Available at: http://apps.searo.who.int/PDS_DOCS/B5034.pdf (Accessed on 15 October 2015).

159 World Health Organization, South East Asia Regional Office. (2014). Mapping abortion policies, programmes and services in the South-East Asia Region. WHO. Available at: http://apps.searo.who.int/PDS_DOCS/B5034.pdf (Accessed on 15 October 2015).

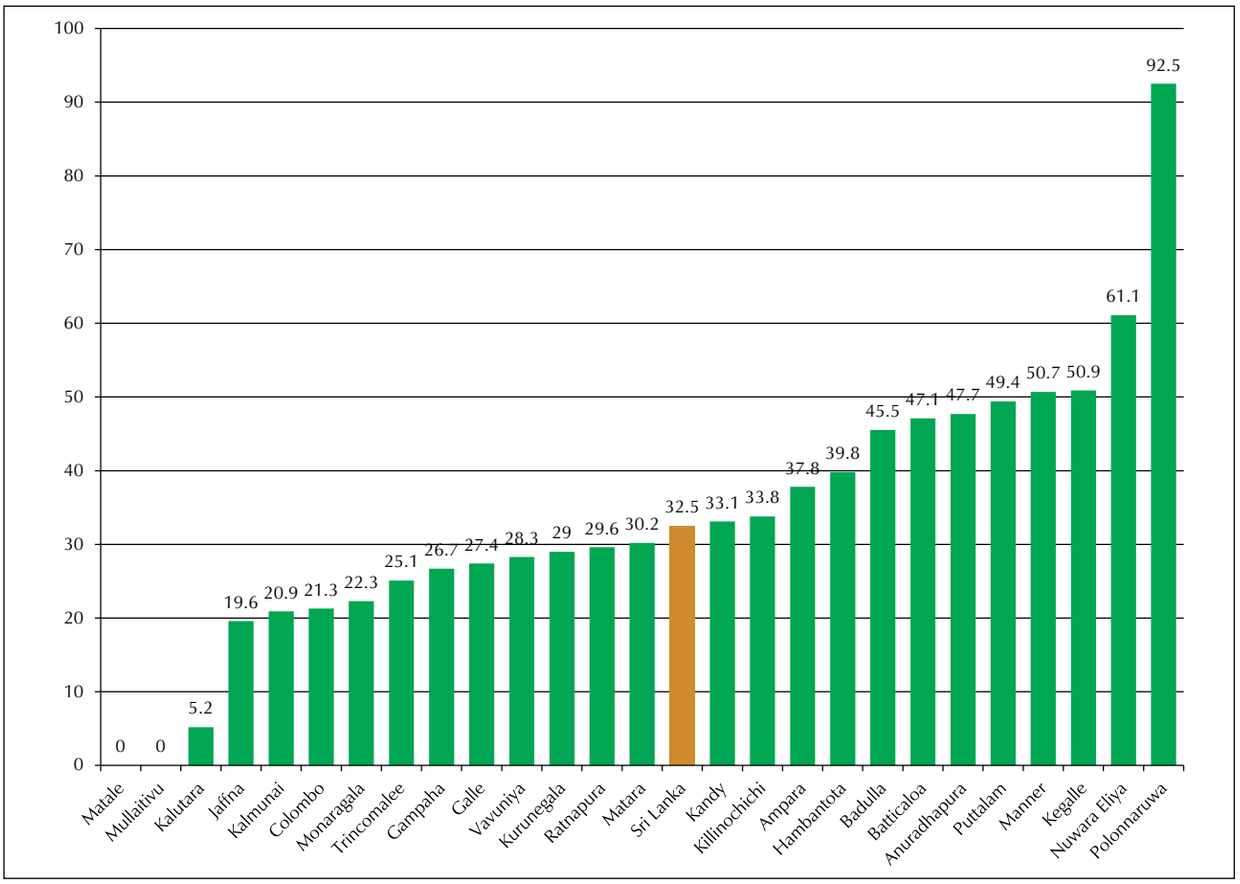
Demographic Health Survey (2.3) and the Census (2.4). [160]Family planning is thus a challenge and a priority in Sri Lanka.

Meanwhile the geographical as well as economic and social inequities remain, especially when viewed at district levels. The difference in MMR at the district level ranges from 92.5 in Polonaruwa to 5.2 in Kalutra and zero in Matale.[161]

The maternal health function

Sri Lanka became a member of WHO in 1948 with the country office opening in Colombo in 1952. This resulted in WHO being the first UN agency to be established in Sri Lanka, even before Sri Lanka gained membership to the UN in 1955.

Exhibit 57: *MMR by district, Sri Lanka*



Source: Adapted from findings of Maternal Death Reviews 2013. Presentation by Dr Anoma Jayathilaka, NPO, WCO-Sri Lanka. September 2015.

For close to 7 decades, WHO has collaborated with the Sri Lankan Government, Ministry of Health, other ministries, and UN agencies, partners and members of academia, the private sector and civil society. The cooperation of WHO with the government in maternal health has gone through a partnership of more than half a century and they accept and understand each other well. The cooperation of WHO and Sri Lanka is laid down in the CCS with the present CCS covering 2012–2017. To maximize its contribution to national health development, the CCS attempts to strike a balance between evidence-based country priorities and WHO's strategic priority areas. It takes note of the maternal and child health situation and

160 Department of Census and Statistics, Ministry of Finance and Planning,UNFPA, United Nations Population Fund. (2014). Census of Population and Housing 2012 Key Findings. Available at: http://countryoffice.unfpa.org/srilanka/drive/Census-2012.pdf (Accessed on 4 November 2015).

161 Presentation on findings of Maternal Death Reviews 2013 given to Amaltas by Dr Anoma Jayathilaka, National Professional Officer, WHO Sri Lanka Country Office on 22 September 2015.

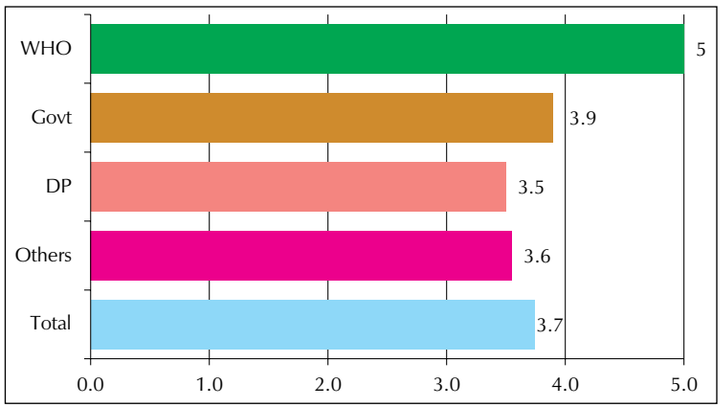
moves on to the noncommunicable diseases, which are the upcoming challenge. Maternal child and adolescent health including nutrition and food safety do remain a strategic priority though at number 4 out of the five priority areas. The focus here is to scale up evidence-based interventions and achieving universal coverage by addressing issues of quality and equity to accomplish effective coverage. WHO makes the best use of their resources and goes a long way in the programme with limited funds. Their contribution to maternal health in Sri Lanka has been US$ 231 478 for 2010–2011; US$ 245 030 in 2012–2013 and US$ 283 909 in 2014–2015, a gradually increasing allocation.[162]

Contribution to maternal health

WHO places a high priority on the health of mothers and has taken a leadership position worldwide by developing and disseminating information on evidence-based interventions that countries can make to improve and monitor maternal health, especially MMR which is the primary metric of maternal health and Goal 5 of the MDGs. Much work has been done by WHO headquarters in setting standards of care, generating more information through research and providing technical support to each country to help achieve improvements in maternal health and these are adapted by the country offices. SEARO facilitates regional coordination, surveys and knowledge sharing. Sri Lanka has been one of the flagship countries in the SEA Region and the contribution of WHO in the six functional areas are important.

Function 1: Setting norms and standards

Exhibit 58: *Norms and standards, Sri Lanka. Likert Scores*



Source: Amaltas, 2015

Setting norms and standards and promoting and monitoring their implementation

In keeping with their mandate, WCO Sri `Lanka has supported the development of norms and standards at the country level based on global norms and standards guidelines, tools and methodologies. Between 2009–2013, WHO, in cooperation with partner agencies, facilitated revision of the maternal care package to improve the quality of maternal care, reduce duplication of services and make it evidence based. Screening of diabetes and HIV, emergency preparedness plan and screening for postpartum depression were added to the essential package. This was pilot tested in a few districts and then scaled up along with training of staff. The package was designed by adapting various manuals and models of WHO, after studying a global review of the key interventions related to RMNCAH by HQ.

- Based on the WHO document on standards on maternal and newborn Care, standards for antenatal, intra-natal and postnatal care have been developed. The introduction of standards to the health system will be carried out with the establishment of quality of care assurance system.
- WCO along with UNFPA and UNICEF, and Sri Lanka College of Obstetricians and Gynaecologists (SLCOG) provided support to develop national guidelines for management of severe obstetric complications and management of normal labour using WHO guidelines published in 2014–15. National guidelines were also developed for Newborn Care and the Global Action Report on preterm birth was incorporated into relevant strategy and policy guidelines born too soon.

162 Communication between Dr D.K.Nilmini Nilangani Hemachandra, Ministry of Health, Sri Lanka and Dr Suneeta Mukherjee, Amaltas onon 15 Oct 2015.

- A pre-pregnancy package has been developed by the Family Health Bureau with the financial support of WHO. WHO's Wheel for Medical Eligibility for Contraception was adopted for the country in collaboration with UNFPA.

> WHO needs to look to its niche in the health sector given that other players are now playing a big role in this domain. KIIRespondents

In keeping with its role, WHO sets norms and standards for maternal care both with regard to quality of care and protocol. Those set before 2010 were updated during 2010–2015 to include latest protocols. Normally the norms and standards laid down by WHO HQ have been adapted in the country by adjusting them where necessary to the needs of the country. Sometimes these were also translated into the local languages of Sinhalese and Tamil when they were to be used by field workers. The challenge is of course to monitor their implementation. Several interviewees said that the mandate of monitoring rests with the government, specifically the Family Health Bureau (FHB). Nevertheless, it was generally felt that protocols needed to be fully and effectively followed; a strategy for this could be usefully designed by WCO.

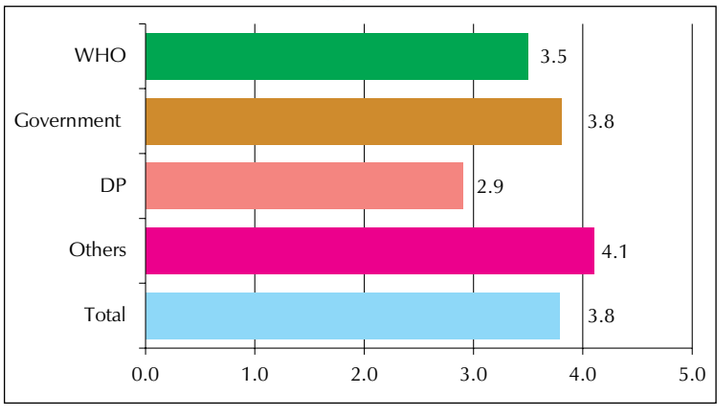
Function 2: Providing technical support and building institutional capacity

Providing technical support, catalysing change, and building sustainable institutional capacity

WHO provides technical support to the Government and other institutions and organizations and aims to build institutional capacity in the area. Some examples of capacity-building are:

- Technical support was given to introduce geographical information systems (GIS) mapping in the country and several capacity-building programmes were completed for FHB and district planning streams to introduce GIS mapping into the system.

Exhibit 59: *Technical support, Sri Lanka. Likert Scores*



Source: Amaltas, 2015

- WHO along with other stakeholders supported the formation of a National Maternal and Newborn Health Strategic Plan for 2012–2016. The WHO child health module was adapted for MCH and nutrition through a series of workshops and trainings at the district level.
- The National Institute for Health Sciences was evaluated and strengthened to make it a Centre of Excellence in primary health care training. Later it was developed as a WHO Collaborating Centre by the health systems unit in WCO. A large number of trainings are planned or technically assisted from National Institute for Health Sciences e.g. strengthened midwifery curriculum, conducting midwifery training and guiding midwifery competencies has been done.
- Capacity-building of middle level medical staff on intra-partum and EmOC was undertaken by SLCOG, financially supported by WHO. An In-Service Manual was also developed for field staff and trainings held.

- In addition, government staff has been trained in most of the relevant aspects in the country and overseas extensively to make the MNH programme a success. Regional meetings on maternal and newborn health programming, universal care, monitoring of MDGs and other related aspects have been organized and supported by WHO to strengthen capabilities.

Most interviewees rated WHO very high in providing technical support and also commended WHO in capacity-building.

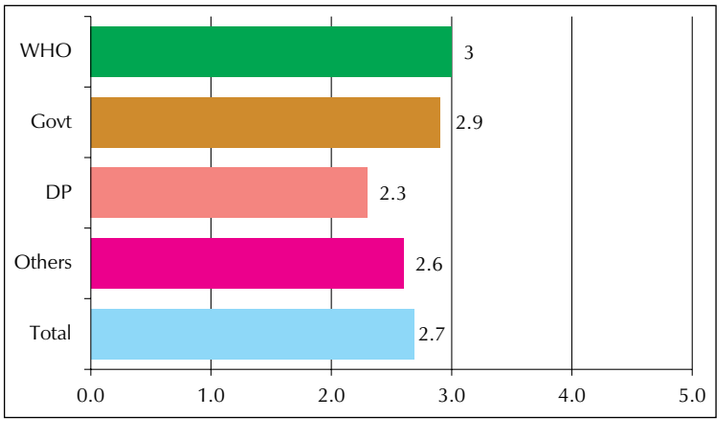
Function 3: Shaping the research agenda

Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge

WCO Sri Lanka advocated and supported the establishment of a research unit of FHB to coordinate and facilitate reproductive health research in 2012–2013. In addition, WCO coordinated with HQ to facilitate a reproductive health research unit to be set up in the University system. Some examples of research supported during 2010–2015 are:

- The review of national policies and laws were undertaken on adolescent, sexual and reproductive health with financial and technical assistance of WHO. The WHO tool Advancing Adolescent Sexual and Reproductive Health through human rights: strengthening laws, regulations and policies was adopted and used for this research.

Exhibit 60: *Research agenda, Sri Lanka. Likert Scores*



Source: Amaltas, 2015

- Evaluation was undertaken of the revised maternal care package through the research unit of FHB in 2014 to assess the adherence of clinical in-service delivery standards. This is under completion.
- Multicountry survey on maternal and neonatal health in 2012–2013 with the objective to study the relationship between mode of delivery, intra-partum care and pregnancy outcomes. The country reports near 1500 misses every year. This has led to the introduction of the concept of near-miss inquiry into the Sri Lankan health system.
- Research supported by the Faculty of Medicine Colombo enabled development of Symphisio fundal chart, which is now included in the national pregnancy record.
- Study on use of Misoprostol for abortion in Sri Lanka through Family Planning Association of Sri Lanka has now been included as a dangerous drug in the programme for postpartum haemorrhage.

While WHO has supported research in some relevant areas, and may be disseminating knowledge and guidelines, it has not shown direction to the research agenda. WCO facilitates research requests from the professional colleges but this seems to be individual-driven.

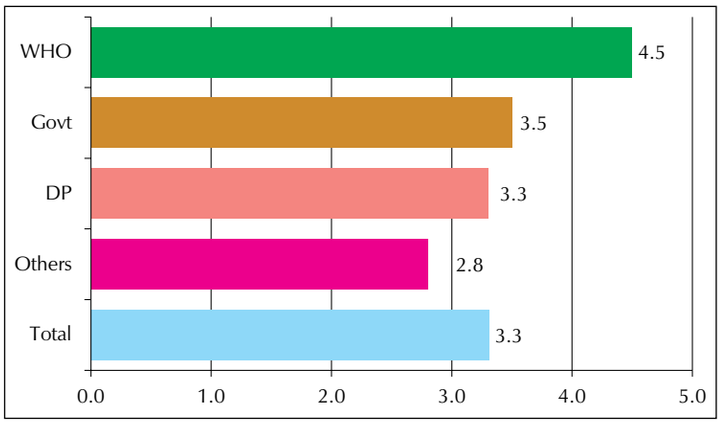
> Over 70% of deaths in Sri Lanka are preventable. We have it all: doctors, drugs, transportation, highly specialized super-centres for heart and respiratory diseases. We have to see what is missing through research. Interviewees

Function 4: Articulating policy options
Articulating ethical and evidence-based policy options

Along with research and standard-setting efforts, WHO articulates evidence and ethics-based policy options. Some examples of WHO promoting evidence-based policy options along with other stakeholders during this study period are:

- An adolescent health strategy was adopted in 2014 with the life-cycle approach to cover interventions to be done during the adolescent period.
- A service delivery package was introduced for the newly married couples (preconception stage) to deliver evidence-based interventions such as physical assessment, basic investigations, delaying first pregnancy when required, nutrition, male participation etc.

Exhibit 61: *Evidence-based policy, Sri Lanka. Likert Scores*



Source: Amaltas, 2015

- Along with UNICEF, WHO worked on adoption of Every New-born Action Plan (2014–15) after identifying gaps and using bottleneck analysis methodology. A neonatal retrieval system has been pilot tested by the College of Paediatricians in the western province and efforts are ongoing to introduce it in rest of the country.
- The adaption of WHO framework on quality of care assessment tools and the introduction of quality assurance system was initiated in 2012 along with UNICEF and UNFPA. WHO facilitated the development of maternal standards based on WHO standards for maternal care and newborn care 2007. Now WHO is assisting in adapting the tools to assess the quality of care in maternal and newborn care.
- WHO has provided technical and financial support to the training managers and district level planning teams in MCH/Family Planning and nutrition plans. In 2010, short programme review methodology was introduced for situational analysis of the National MCH/family planning programme.

It is clear that WHO Sri Lanka is consistently updating its guidelines in keeping with evidence-based policy generated from HQ and SEARO. However, the challenge is to work in areas where opinion is divided. FHB and SLCOG estimate that up to 70% of the maternal deaths could have been prevented in 2013.[163]

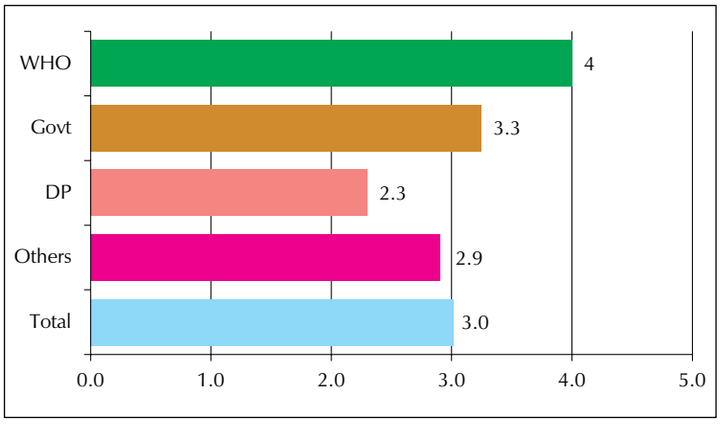
163 Family Health Bureau, Ministry of Health, Government of Sri Lanka. (2014). Annual Report on Family Health 2013. Ministry of Health, Government of Sri Lanka. Available at http://www.fhb.health.gov.lk/web/index.php?option=com_phocadownload&view=category&download=575:annual-report-2013&id=35:planning-monitoring-evaluation&Itemid=150&lang=en (Accessed on 5 November 2015).

Function 5: Monitoring health situation and trends
Monitoring the health situation and assessing health trends

WCO works with the government to monitor the health situation and trends on certain aspects of maternal health.

Sri Lanka is an example to other countries for their MDSR system. The system has indeed led to discussions and improvements not only in the country itself but also in the neighbouring countries. A mechanism to introduce confidential enquiry into maternal deaths is now proposed. This is been agreed to by the key players: MoH, SLCOG, Sri Lanka College of Forensic Pathologists. Required reporting formats and investigation reports have been developed and this is expected to be pilot tested in the last quarter of 2015; a countrywide investigation into near misses is also expected.

Exhibit 62: *Monitoring health, Sri Lanka. Likert Scores*



Source: Amaltas, 2015

- WCO along with the national maternal care programme and national sexually transmitted diseases AIDS control programme monitors congenital syphilis elimination and the PMTCT programme. Sri Lanka has been identified as a country where congenital syphilis and paediatric HIV can be eliminated.
- WHO assisted FHB along with other stakeholders in preparing the national and subnational level indicators, which could be monitored at policy and programme levels on MDG4 and MDG 5. Based on these, district level targets for impact indicators have been developed and communicated to the districts to enable FHB to monitor these better.
- WHO, in collaboration with professional bodies, developed a hospital-based MIS on strategic and newborn care, the electronic version of which will be introduced in the hospital based national MIS.

It is obvious the WHO has provided support to assess and monitor the maternal health situation in the country and often proposes preventive and corrective measures. An area that could be strengthened by WHO along with its partners is family planning, which could prevent up to a quarter of the maternal deaths. The results of the confidential enquiry into maternal deaths and near misses may well provide an answer.

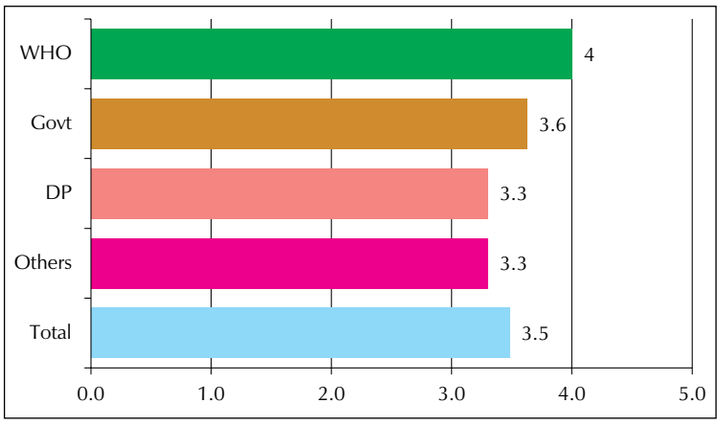
Function 6: Providing leadership on health
Providing leadership on matters critical to health and engaging in partnerships where joint action is needed

WHO Country Office for Sri Lanka plays an extensive role in convening, communicating, path lighting and coordinating efforts towards improvement of maternal health.

- On the recommendation of the External Review of Maternal Newborn Health programme 2007 –2008, WHO facilitated the establishment and functioning of the National Committee on Family Health in 2010. This committee is the highest forum for policy and is chaired by the Secretary to the Ministry of Health, with all stakeholders as members. It facilitates policy discussions on MNCH and considers the recommendations of technical advisory committees on Maternal Health and Family Planning and the technical advisory committee on Newborn

and Child Health. This body has provided a platform to have open discussions and take policy decisions. WHO convenes and facilitates the Committee.

Exhibit 63: *Leadership in health, Indonesia. Likert Scores*



Source: Amaltas, 2015

- WHO works very closely with the FHB, which is the focal point for maternal health programmes. Other stakeholders and partners are Sri Lanka College of Obstetricians and Gynaecologists, University of Colombo, Perinatal Society of Sri Lanka, Sri Lanka College of Paediatricians, and Sri Lanka College of Community Physicians. With these professional bodies WHO is able to use their unique blend of academics, current knowledge as well as practical experience, to act as a path lighter in difficult areas, such as adoption of misoprostol. Bilateral and multilateral partners in maternal health are UNICEF, UNFPA and the World Bank. WHO works in coordination with them in addressing MDG 5 and other areas related to maternal and newborn health.
- WHO convened partners on adoption of standards and norms and formulating guidelines or when undertaking surveys and planning and implementing programmes. For example, WHO along with UNFPA and UNICEF provided technical and financial assistance in developing national guidelines on Management of Severe Obstetric Complications (postpartum haemorrhage, pregnancy induced hypertension and Diabetes). Similarly WHO partnered with UNICEF while addressing newborn care and advocated adoption of every newborn plan after identifying gaps using bottleneck technology.
- The introduction of GIS mapping into the MCH programme and training district teams on GIS mapping to address issues of equity in planning was a welcome step, which was well coordinated with other agencies and stakeholders.
- WHO has also shown the way in introducing "one health costing tool" which was introduced for costing maternal and newborn health and nutritional plans by inviting resource personnel from WHO HQ, SEARO and the Fortune Institute of USA.

Interviewees left no doubt that WHO had played a leadership role under the stewardship of the Ministry of Health, along with the FHB in the field of maternal health. However, a challenge that WHO has faced in the reference period was the difficulty (with one exception) to work with NGO and civil society. At the programme level, in spite of indications of lack of choices and method mix in family planning services leading to unsafe abortions and maternal deaths, not much has been done to promote family planning.

It may well be that WHO works so closely with FHB that they are not able to voice controversial views which do not have the acquiescence of FHB. Yet interviewees noted that sometimes NGOs may be able to do what Government cannot, and suggested strengthening the partnership of WHO with NGOs. The possibility of working with opinion leaders such as Buddhist monks and other religious leaders, or community leaders may also be worthy of exploration.

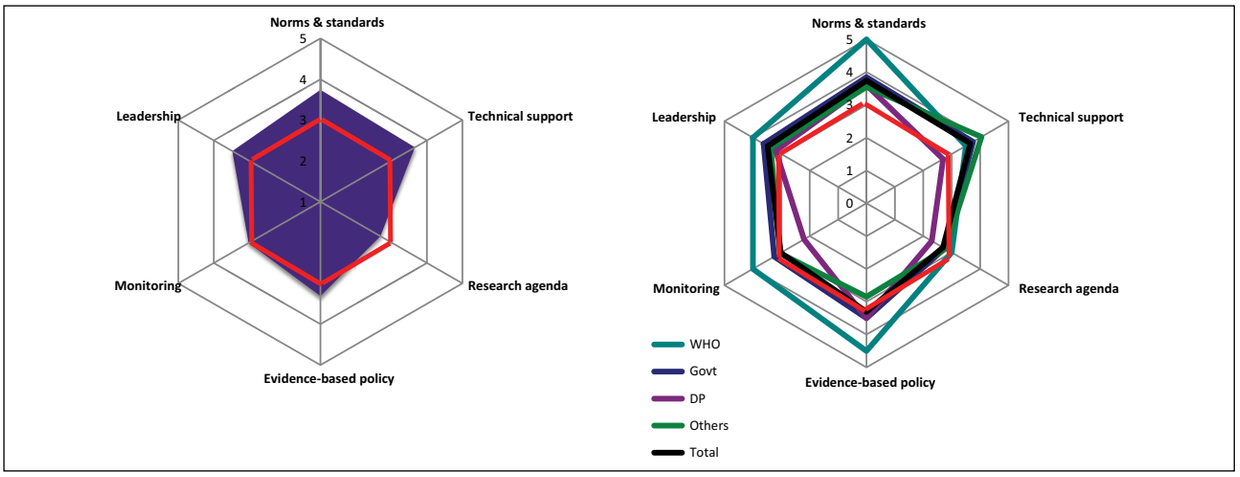
> It would be a good idea to ensure that there is enough consultation with all stakeholders: NGOs, religious groups, academic groups, private sector, and also at the provincial level. Interviewees

Conclusion

The influence of WHO's work in Sri Lanka is well recognized in policy, programmes and practices. WHO contributes to the maternal health policy by participating in the technical advisory committee on maternal health and family planning and the technical advisory committee on newborn and child health and provides inputs which guide the National Committee on Family Health where policy-decisions are taken. Within the life-cycle approach WHO contributed towards formulation of adolescent health strategy after supporting a review of national policies and laws on a sexual and reproductive health. They have also supported the government in addressing the preconception stage i.e. among newly married couples.

In Sri Lanka, some participation can be seen at the programme level, especially in their very strong partnership in maternal mortality and morbidity surveillance where WHO now proposes to introduce confidential enquiry. WHO has worked for neonatal health through the newborn unit and have now supported the introduction of a neonatal retrieval system. It is noteworthy that with WHO's efforts the National Institutes of Health have been developed into a WHO Collaborative Centre.

Exhibit 64: *Core functions: Average and by type of interviewee, Sri Lanka. Likert Scores*



Source: Amaltas, 2015

WHO is well known for leveraging expertise from all over the world through their global and regional offices, and adapting to the country's needs through different instruments such as protocols, norms and standards and guidelines and packages. The national newborn and maternal health strategy planning, the maternal care package, the management guidelines for obstetric emergencies and strengthening of basic midwifery training are some of the good practices that were followed.

WHO has faced many challenges in carrying out its role. The understanding between Government, FHB and WHO is very important and their commitment and harmonious functioning was the enabling factor, which propelled the programme forward. However, challenges such as the civil conflict, the rising noncommunicable diseases, and (now) the H1N1 epidemic confront them. Meanwhile there were some inhibitors to the family planning programme, which impacts maternal health and which WHO has not been able to address upfront. It is obvious that even in a country which is performing extremely well in its social and economic indicators, the last leg of the journey is not always easy. In spite of being on track in MDG 5, in the last decade, we find that Sri Lanka will not achieve an MMR of 23 in 2015.

Nonetheless, the Secretary-General's action plan of "Every Woman Every Child" and the Sri Lankan Public Investment Strategy where they propose to reach MMR of 20 by 2020 are indications of Sri Lanka's resolve to achieve their goal. With the large proportion of maternal deaths still preventable, and given the

available infrastructure, universal institutional delivery and universal coverage, this is certainly possible. Improving the capacity of the health system to respond effectively and in a timely manner to the obstetric emergencies and complications and complex indirect cases early enough, would ensure that the findings of cause specific mortality would continue to be a preventive tool.

However, changing patterns of morbidity need continuous analysis and immediate action. Some of these are life-style diseases, others are vulnerabilities that develop in childhood but the woman succumbs during pregnancy. The H1N1 took many lives, as did cardiac complications. The three superspeciality centres being developed by the government with support from WHO and other partners, will hopefully address these second generation problems.

In a country where the government is experienced and successful, the agencies support government's leadership and priorities as in Sri Lanka. However, there is sometimes need for out-of-the-box thinking, and with tacit concurrence of the government, WHO could do some path lighting.

- The plateauing of MMR in Sri Lanka is not an isolated phenomenon. WHO could collect, collate and disseminate relevant information to Sri Lanka so that the country could take steps to address this perilous situation. WHO could be the forum at which Sri Lanka could learn from European countries that have been through a similar situation.
- The disparities in MMR due to demographic or sociocultural factors must be addressed on priority basis for progress to be made. WHO should assist the government in strategizing and implementing the same in the interest of equity along with other agencies. For this WHO should consider partnerships also at the regional/district level.
- The implications of rise in TFR should be studied and publicized, along with other agencies. It should also be discussed in open forums so that public opinion can be voiced which will impact policies and programmes. WHO, along with other agencies, should examine through research, gaps in family planning services to suggest approaches so that women do not have unplanned pregnancies or resort to abortions which can lead to maternal deaths. A suggestion is to step up the family planning programme in the Well Women's clinics with a suitable mix of contraceptive choices to address unplanned pregnancies in the older age group.
- WHO could work with the government to address the difficult pregnancies early on e.g. those with congenital deformities. Setting up three superspecialty centres is a step in the right direction but their success will depend how well they function and how early the patient is brought in. A methodology for early detection and reference to superspecialty centres early may save maternal lives.
- WHO could strengthen some partnerships further and seek support of civil society and NGOs in their mandate. A dialogue could be established with opinion leaders and gate keepers of society such as Buddhist monks and other religious organizations or other opinion leaders, may be through partners. Advocacy needs to be strengthened for maternal health and all related areas including controversial ones.
- It is pointed out that many of the primary institutions and hospitals, though equipped, lie either completely or very partially utilized as most women go to hospitals which have EmOC facilities. WHO could advocate best alternate utilization of these to maximise resources.

It is clear that the government and the system which has done so well in the last decade needs to think differently and critically to address the fact that MMR, a critical indicator of women's health has become stagnant. Maternal health is a human right and accountability is central to the new development

agenda and central to Sri Lankan programmes for many decades. If WCO Sri Lanka were able to allocate greater resources to it, the institution is well placed to support Sri Lanka's ambitions outlined in the National strategic Plan on Maternal and Newborn Health.

Data sources: Primary qualitative data for the case study was collected through interviews with government officials, staff of government and non-government institutions, WHO and partners. Thirty one key informants from Government (21), UN bodies including WHO (7), partner (1) and international NGOs (1) were interviewed and 32 Likert Scale scores obtained. In addition, more than 36 papers, reports, guidelines, presentations, and online statistics on maternal health in Sri Lanka and the Region were consulted to triangulate information received from KII and Likert Scale.

Limitations:

- Elections took place in Sri Lanka in August 2015. This meant that the top level bureaucracy was quite new when data collection took place.
- A limited timeframe meant that repeat discussions could not be carried out. Further, a field visit may have added other dimensions.
- WCO Sri Lanka works very closely with the FHB and other partners. It was therefore difficult to assess their performance of the core functions isolated from the inputs and limitations of other players in maternal health in the country.

Annexes

Annex I: Information-needs matrix

	Information required	Study needed	Respondents for inputs/data
1	**Research agenda** ☐ How has WHO helped shape the research agenda, stimulated the generation of valuable knowledge, supported the translation of valuable knowledge? ☐ Has this been at the policy, programme and/or at the practices level? ☐ Can you provide examples? ☐ Can you describe WHO's initiative(s) wrt shaping the Research Agenda? ☐ Has the WHO been proactive in dissemination of valuable knowledge? ☐ Do you think that WHO faced challenges wrt shaping the Research Agenda? If so, which ones? ☐ Could you summarize the learning from the efforts by WHO for me? Do you think it could have been done differently? If so, how? ☐ How has WHO played a leadership role wrt the research agenda?	Document review IDIs Open-ended + Likert scale questionnaire	WHO HQ, regional and national level guidelines and vision documents Staff from WHO HQ, SEARO & country offices; Government officials and other stakeholders WHO Country Office Point Persons
2	**Norms and standards** ☐ How has WHO helped set norms and standards, promoted their implementation, monitored their implementation? ☐ Has this been at the programme and/or practices level? ☐ Can you give examples? ☐ Can you describe WHO's initiative(s) wrt setting norms and standards? ☐ Do you think that WHO faced challenges wrt setting norms and standards? If so, which ones? ☐ Could you summarize the learning from the efforts by WHO for me? Do you think it could have been done differently? If so, how? ☐ How has WHO played a leadership role wrt setting norms and standards?	Document review IDIs Open-ended + Likert scale questionnaire	WHO HQ, Regional and National level guidelines and vision documents Programme reports and documentation, conference level papers Staff from WHO HQ, SEARO & country offices; Government officials and other stakeholders WHO Country Office Point Persons
	Evidence-based policy ☐ How has WHO articulated ethical and evidence-based policy options? ☐ How has this influenced policy? ☐ Can you provide examples? ☐ Can you describe WHO's initiative(s) wrt articulating evidence-based policy options? ☐ Do you think that WHO faced challenges wrt articulating evidence-based policy options? If so, which ones? ☐ Could you summarize the learning from the efforts by WHO for me? Do you think it could have been done differently? If so, how? ☐ How has WHO played a leadership role wrt articulating evidence-based policy options?	Document review IDIs Open-ended + Likert scale questionnaire	WHO HQ, Regional and National level guidelines and vision documents Programme reports and documentation, conference level papers Staff from WHO HQ, SEARO & country offices; Government officials and other stakeholders WHO Country Office Point Persons

	Information required	Study needed	Respondents for inputs/data
4	Technical support □ How has WHO provided technical support and catalysed change? □ Has this been at the policy, programme or practices level? □ Can you give examples? □ Can you describe WHO's initiative(s) wrt providing technical support? □ How has WHO built sustainable institutional capacity? □ Do you think that WHO faced challenges wrt providing technical support? If so, which ones? □ Could you summarize the learning from the efforts by WHO for me? Do you think it could have been done differently? If so, how? □ How has WHO played a leadership role wrt building institutional technical capacity?	Document review IDIs Open-ended + Likert scale questionnaire	Technical guidelines from WHO SEARO and Country offices Staff from WHO HQ, SEARO & country offices; Government officials and other stakeholders WHO Country Office Point Persons
5	Monitoring □ How has WHO monitored the health situation and assessed health trends? □ How has it influenced policy, programme or practices? □ Can you provide examples? □ Do you think that WHO faced challenges wrt monitoring the health situation? If so, which ones? □ Could you summarize the learning from the efforts by WHO for me? Do you think it could have been done differently? If so, how? □ How has WHO played a leadership role wrt monitoring the health situation?	Document review IDIs Open-ended + Likert scale questionnaire	Programme reports and documentation, conference level papers Health monitoring reports and special reports if any Staff from WHO HQ, SEARO & country offices; Government officials and other stakeholders WHO Country Office Point Persons
6	Leadership role □ Would you say that WHO has taken a leadership role in addressing Maternal Health? Wrt: o Convening o Communicating o Path-lighting o Coordinating □ Can you provide examples? □ Has WHO taken the lead to build partnerships for joint action on Maternal Health? □ Can you provide examples?	IDIs Open-ended + Likert scale questionnaire IDI's	Staff from WHO HQ, SEARO & Country offices; Government officials and other stakeholders WHO Country Office Point Persons Staff from WHO HQ, SEARO & country offices; Government officials and other stakeholders

Annex II: Evaluators' biographies

Amaltas is a Delhi based organization with a mission to work within the broad scope of development to provide high quality consulting and research in support of accelerating improvements in the lives of people of the region. Amaltas has garnered a wide range of experience through its portfolio of prestigious projects with foundations such as the Bill and Melinda Gates Foundation, World Vision, Save the Children; research institutions such as Johns Hopkins University and IDRC, Canada; the UN including UN Women, UNDP, UNICEF, UNAIDS; bilateral and multilaterals such as DFID, the World Bank, USAID; and governments including Government of India, the Royal Government of Cambodia among others. It has core competencies in high quality research, documentation and evaluation. A detailed profile of Amaltas may be found on its website at www.amaltas.asia

Dr Suneeta Singh MD, DCH : Team Lead

Dr Singh is a development specialist with over 30 years of experience. She is involved in the review and evaluation of major programmes and policies internationally and in India. She is presently the Chief Executive Officer of Amaltas, a research and consulting organization based in Delhi. She has previously worked with the World Bank, DFID, DANIDA, Ministry of Health and Family Welfare GoI, St. John's National Academy of Health Sciences and the Lady Hardinge Medical College. At Amaltas, she has led several evaluation assignments including 'Evaluative Assessment of Avahan Transition' for the BMGF, 'A Strengths Based Evaluation of PLD' and 'Strategic Evaluation on Research Excellence' for IDRC. Trained as a medical doctor in India, Dr Singh has led work on a variety of World Bank supported projects supporting Government programs such as TB, HIV/AIDS, Leprosy, Cataract Blindness, and Health Systems Development.

Dr Susan Stout Dr PH: Evaluation Expert

Dr Stout is a world renowned Evaluation Expert with over 30 years of experience in development management and administration with a special focus on building and using monitoring and evaluation systems to improve efficiency and effectiveness of development policies and programs. Her key areas of focus include monitoring and evaluation of health programs, also experienced with large scale sectoral and country program evaluations. She has more than 25 years of experience working on population health and nutrition programs and policy at the World Bank, as well as evaluations in the health sector in the Bank's independent Evaluation Group. During those years, she worked to improve the effectiveness of maternal and child health programs in more than 20 countries, as well as on HIV/AIDS programs in at least 10 countries in Africa. She was also a champion of an improved focus results at the World Bank, leading the Bank's "Results Agenda' from 2004 – 2008.

Mr Jagmohan Singh Kang IAS (Rtd), MA: Evaluation Expert

Mr Kang is a seasoned public administrator with strong professional experience of over 35 years in Health, Population and Nutrition. He has served as international staff of the World Bank for over 16 years leading its work in Nepal, Bangladesh and in India. He has been with Amaltas for over five years. He has been the Project Director of the Evaluative Assessment of Phase 2 of the Gates Funded AVAHAN HIV-AIDS prevention program in India, M&E support to the Second Rural Water and Sanitation Project in Cambodia being carried out under the Ministry of Rural Development and Evaluation of Wellcome Trust support to

capacity building at the Public Health Foundation of India through a consortium of UK Universities. He is responsible for the overall oversight of the Amaltas project portfolio on quality and performance.

Dr Aang Sutrisna PhD: Senior Consultant for Indonesia

Dr Sutrisna is a highly experienced programme monitoring and evaluation professional. Over 10 years of experience in program monitoring and evaluation consultancies for programs funded by USAID, the World Bank, WHO, and other development agencies. He has led and managed several experimental, quasi-experimental, primary quantitative and impact evaluation study. He has extensive experience in managing nationwide integrated bio-behavioural survey as well as epidemic and socio-economic impact study and modelling at the country level.

Dr Archana Amatya MD: Senior Consultant for Nepal

Dr Amatya is an Obstetrician and Gynaecologist and a public health expert, who has an experience of more than 16 years. She is an Associate Professor at the Department of Community Medicine and Public Health, Tribhuvan University Teaching Hospital, Kathmandu. She took her training in medicine in Karnataka, India and has attended a large number of training courses since. She is a much sought after consultant in the areas of reproductive health and nutrition. Dr Amatya is a practising physician.

Dr Katherine Ba-Thike MBBS, FRCOG, MSc: Senior Consultant for Myanmar

Dr Ba-Thike has over 20 years of experience as an obstetrician and gynaecologist in Myanmar. She served as Area Manager for Asia and the Pacific for 8 years with the Department of Reproductive Health and Research, World Health Organization, Geneva, Switzerland to strengthen research capacity for institutions in low-income countries and to provide technical assistance to Reproductive Health Programmes. Since 2011, Dr Ba-Thike has worked as an independent consultant with UNFPA Asia and the Pacific Regional Office and WHO Department of Reproductive Health and Research.

Dr Suneeta Mukherjee IAS (Rtd), PhD: Senior Consultant for Sri Lanka

Dr. Mukherjee has over 22 years of experience in the Indian Administrative Services and 17 years in the International Civil Service as the UNFPA representative in several countries including Sri Lanka. After retiring from UNFPA, she has worked for MDGs through the millennium campaign. Subsequently she has developed the draft SAARC youth charter and the draft SAARC youth action plan. She is currently working as a part-time consultant with KPMG and ADB for skills development project for NSDA where I work is gender and affirmative action expert

Dr Syed Jahangeer Haider Dr PH: Senior Consultant for Bangladesh

Dr Haider completed his DrPH from the University of Texas, following which he worked at several international agencies, including USAID, the World Bank and others. Dr Haider has had over a decade of work experience as the Director of Family Planning in the Government of Bangladesh. Dr Haider has carried out a large number of research and consulting studies, including multi-country research in the field of maternal health in Bangladesh. He is currently the Managing Director of a private sector research firm that he set up in Dhaka.

Mr Ujjwal Gupta, BSc: Team Member

Mr Gupta has graduated from the University of Warwick, United Kingdom with a Bachelors of Science in Management. At Amaltas, he has been a key team member in a project commissioned by the Research Councils of UK to map the research landscape in India in the field of 'Public Health and Well Being' and 'Rapid Urbanisation and Sustainable Cities'. He also provided research support for the Nordic Trust Fund report titled 'Experienced discrimination and its relationship with socio-economic status and life chances of sexual minorities in India'.

Annex III: Interviewee list

BANGLADESH

Respondent name	Organization
Azizul Alim	Ministry of Health
Bilkis Akter	Ministry of Health
Bushra Binte Alam	World Bank
Farhana Dewan	Obstetric Gynecological Society of Bangladesh
Fatema Zahura	Ministry of Health
Ferdousi Begum	Sir Salimullah Medical College & Mitford Hospital
Halida H. Akhter	USAID/DFID
Jahir Uddin Ahmed	BRAC University
Kaosar Afasna	BRAC
Loshan N. Mona Singhe	UNFPA
Mahbuba Khan	WHO
Mamadou Hady Diallo	WHO
Mohammad Sharif	Ministry of Health
N. Paranietharan	WHO
Nelofar Farhad	Ministry of Health
Rabeya Kahtun	WHO
Rezaul Karim	Ministry of Health
Riad Mahmud	UNICEF
Rowshan Ara	Obstetric Gynecological Society of Bangladesh
S.A.J Musa	UNFPA
Samia Afrin	Women's Health & Rights Advocacy Partnership
Shamina Sharmin	UNFPA

INDONESIA

Respondent name	Organization
Anne Hyre	JHPIEGO
Apriati Kartini	Ministry of Health
Arum Atmawikarta	National Planning Bureau
Asri Adisasmito	University of Indonesia
Atmarita	National Institute for Health Research and Development
Azizah Noormala Dewi	Ministry of Health
Candra Wijaya	WahanaVisi Indonesia
Cho Kah Sin	UNAIDS
Devi Asmarani	UNICEF
Eko Pambudi	World Bank
Elvira Liyanto	UNFPA
Hadi Wibawa	AIPMNH
Ida Ayu Citarasmi	Ministry of Health
Imran Pambudi	Ministry of Health
Karina Hikmat	UNICEF
Lani Harijanti	UNDP
Lea Suganda	DFAT
Lely Wahyuniar	UNAIDS

Margaretha Sitanggang	UNFPA
Maya Gita	Ministry of Health
Melania Hidayat	UNFPA
Nadia Wiweko	Ministry of Health
Pancho Kaslam	Save The Children
Puti Marzoeki	World Bank
Robert Magnani	Future Institute
Rustini Floranita	WHO
Sabarinah	University of Indonesia
Siti Rahma	Muhamadiyah
Siti Romlah	Ministry of Health
Sri Poerwaningsih	Ministry of Health
Widya Setyowati	DFAT
Yustina Herlin	Ministry of Health

MYANMAR

Respondent name	Organization
Aye Sandar Aung	DFAT
Billy Stewart	UKAID (DfID)
Hla Hla Aye	UNFPA
Hnin Hnin Lwin	Ministry of Health
Hnin Hnin Pyne	World Bank
Hnin Wai Hlaing	JHPIEGO
Htay Htay Hlaing	Ministry of Health
Jorge Luna	WHO
Khin Lay Kywe	Ministry of Health
Khin Thet Wai	Ministry of Health
Ko Ko Zaw	Ministry of Health
Kyaw Nyunt Sein	3MDG Fund
Kyu Kyu Khin	WHO
Maung Maung Lin	WHO
Moe Moe Aung	Marie Stopes International
Mya Mya Nyo	Ministry of Health
Mya Thet Su Maw	UKAID (DFID)
Mya Thida	Obstetrics and Gyanecology Society
Nwe Ni Sein Myint	Ministry of Health
New New Khin	Ministry of Health
Panna Erasmus	3MDG Fund
Penelope Campbell	UNICEF
San San Myint	Ministry of Health
Sara Bibi Thuzar Win	UNICEF
Shwe Sin Yu	WHO
Sid Naing	Marie Stopes International
Theingi Myint	Ministry of Health
Tin Tin Lay	Ministry of Health
Wai Yee Khine	3MDG Fund
Yin Yin Soe	Ministry of Health

NEPAL

Respondent name	Organization
Asha Pun	UNICEF
Chandra Rai	JHPIEGO
Deepak Poudel	DFID
Laxmi Raj Pathak	Ex Ministry of Health and Population
Maureen Dariang	Nepal Health Sector Support Programme
Meera Upadhyay	Ministry of Health and Population
Nichola Cadge	DFID
Pawan Ghimire	Ministry of Health and Population
Preeti Kudesia	World Bank
Sagar Dahal	Ministry of Health and Population
Shilu Adhikari	UNFPA
Shilu Aryal	Ministry of Health and Population
Stuart King	Nepal Health Sector Support Programme
Tirtha Rana	Independent Expert
Tulasa Bharati	GIZ
Valerie Broch Alvarez	GIZ

SRI LANKA

Respondent name	Organization
AM Jayawickrama	Ministry of Health
Anoma Jayathilaka	WHO
ATPL Abeykoon	Institute for Health Policy
Ayesha Lokubalasooriya	Family Health Bureau
Chandana Wijesinghe	Ministry of Health
Chiranchika Vithana	Family Health Bureau
Chitramalee de Silva	College of Community Physicians Sri Lanka
Deepika Attygalle	UNICEF
Dhammica Rowel	Family Health Bureau
Hemantha Senanayake	University of Colombo
Jacob Kumarasen	WHO
Jayan Abewickrama	UNFPA
Kanishka Karunaratne	Sri Lanka College of Obstetricians & Gynaecologists
Kapila Gunawardhana	Sri Lanka College of Obstetricians & Gynaecologists
Kapila Jayaratne	Family Health Bureau
Kumari Vinodhani Navaratne	World Bank
Lacs Dahanayake	Ministry of Health
L. Siyambalagoda	Ministry of Health
Neelamani Hewageegana	Ministry of Health
Neil Thalagala	Family Health Bureau
Nethranjalee Mapitigama	Family Health Bureau
Nihal Jayathilaka	Ex Ministry of Health
Nilmini Hemachandra	Family Health Bureau
Palitha Abeykoon	Sri Lanka Medical Association
Paula Bulancea	UNICEF
PG Mahipala	Ministry of Health
Prasanna Gunasekera	Ex UNFPA

Ramya de Silva	Family Health Bureau
Ravindra Pathirathna	Ministry of Health
Renuka Jayatissa	UNICEF
RK Herath	Ministry of Health
Rohana Haththotuwa	Sri Lanka College of Obstetricians and Gynaecologists
Sanjeewa Godakandage	Family Health Bureau
Sanjeewani Karunaratne	Family Health Bureau
Sapumal Dhanapala	Family Health Bureau
Sujeewa Amarasena	Sri Lanka College of Paediatricians
Sunil Alwis	Ministry of Health
Thushara Agnes	Family Planning Association
Umanga Sooriyaouachchi	Family Health Bureau
Vineetha Karunaratne	Ex Family Health Bureau

WHO SEARO

Respondent name	Organization
Arun Thapa	WHO
Katayama Francisco	WHO
Kishori Mahat	WHO
Neena Raina	WHO
Phyllida Travis	WHO
Poonam Khetrapal Singh	WHO
Rajesh Mehta	WHO
Tawhid Nawaz	WHO
Thaksaphon Thamarangsi	WHO
Thushara Fernando	WHO

WHO HQ

Respondent name	Organization
Elil Renganathan	WHO
Metin Gulmezoglu	WHO

WCO Focal Points

Name	WCO
Mamadou Hady Diallo	Bangladesh
Rabeya Khatoon	Bangladesh
Mahabu Khan	Bangladesh
Rustini Floranita	Indonesia
Maung Maung Lin	Myanmar
Kyu Kyu Khin	Myanmar
Zainab Naimy	Nepal
Anoma Jayathilaka	Sri Lanka

Annex IV: Task force on roles and functions

World Health Organization

Report of the Taskforce on the roles and functions of the three levels of WHO

OVERARCHING ROLES and FUNCTIONS OF THE THREE LEVELS OF THE ORGANIZATION (ORF3L)

Function	Country Offices	Regional Offices	Headquarters
1. Providing technical support and building capacity	• Lead the development of a country cooperation strategy (CCS) and its implementation. • Lead and manage the provision and brokering of technical cooperation • Lead in the implementation and monitoring of international commitments, conventions and legal instruments • Lead emergency response/action during crisis and emergencies	• Contribute to the development of country cooperation strategies (CCS) • Backstop country offices in technical cooperation and in supporting the implementation of international commitments and legal instruments in collaboration with Headquarters • Lead technical collaboration in countries with no WHO presence • Backstop the strengthening of technical cooperation among countries, and among regions[1] • Provide surge capacity during crisis and emergencies	• Coordinate the development of corporate guidance for CCS and the strategic analysis of content and implementation • Promote of application of best practices in support of regional and country technical cooperation • Backstop regional offices by providing specialized technical assistance and mobilizing surge capacity in crisis and emergencies
2. Providing leadership	• Advocate for health in all policies and promote dialogue for intersectoral and multi-stakeholder collaboration • Lead WHO's UN interagency work in integrating national health priorities into the development agenda and UNDAF • Lead the convening and coordination of the health response in emergencies • Lead in strengthening country capacity in health diplomacy for better engagement in national and international processes, and global health governance	• Lead in supporting Member States for effective engagement in governing bodies • Convene regional intergovernmental meetings and working groups, and regional and inter-regional health platforms Lead in supporting Member States for effective engagement in governing bodies • Lead in supporting Member States' engagement in international initiatives and coordinate with regional and sub-regional entities, as well as their active participation in global health issues	• Lead in shaping the global health agenda and the development of international legal instruments, commitments and conventions • Convene global intergovernmental meetings and working groups and key stakeholders (including Member States) for global health initiatives

[1] Emerging initiatives requiring technical cooperation among countries across regions will be led and coordinated by Headquarters in collaboration with respective Regional Offices, unless decided otherwise through established managerial process.

World Health Organization

Report of the Taskforce on the roles and functions of the three levels of WHO

Function	Country Offices	Regional Offices	Headquarters
3. Setting norms and standards	• Support countries in the adaptation and implementation of guidelines, tools and methodologies • Contribute to setting global norms and standards by providing evidence from countries	• Adapt guidelines, when necessary, to apply norms and standards to regional context[2] • Backstop the implementation of norms, standards and guidelines, at country level • Monitor the implementation of norms and standards in countries of the region	• Lead in the formulation of technical norms and standards; develop methodologies, guidelines and tools • Lead global monitoring and reporting on the implementation of norms and standards
4. Shaping the research agenda	• Promote research and the strengthening of research capacity in countries • Support and, when appropriate, conduct operational research and use of results • Contribute to the body of knowledge on best practices	• Establish and coordinate the implementation of the regional research agenda • Lead in strengthening the regional research and innovation capacity in collaboration with Headquarters • Generate and disseminate body of regional knowledge on best practices	• Lead WHO's work in shaping and promoting the global research and innovation agenda • Support research and innovation on issues of global public health significance and broker inter-regional exchange of experience and lessons learnt • Generate and disseminate body of knowledge on best practices
5. Articulating policy options	• Lead health policy dialogue and provide policy advice to national counterparts and partners • Promote the engagement of countries in setting regional and global policies and strategies	• Adapt strategies or plans to apply policies to regional context • Lead development of regional policies and strategies as appropriate[3] • Backstop country offices on policy advice and dialogue	• Lead in the formulation of global public health policies, strategies and plans • Lead in establishing principles and rules for global public goods for health.
6. Monitoring and health trends	• Lead WHO's work in monitoring and evaluating national policies and programmes	• Monitor the regional health situation and trends by undertaking the aggregation, validation, analysis, dissemination and use	• Monitor the global health situation and trends by undertaking the aggregation, validation, analysis,

[2] Regional Offices contribute to the development of norms and standards, as well as develop guidelines, methodologies and tools whenever required, in agreement and coordination with HQ
[3] This is based on the WHO Constitution Article 50a. RO may develop regional policies and strategies where there are no global policies and strategies but this should be in agreement with HQ

World Health Organization

Report of the Taskforce on the roles and functions of the three levels of WHO

Function	Country Offices	Regional Offices	Headquarters
	• Support the collection, analysis, dissemination and use of data for monitoring the national health situation	of health-related data • Backstop country offices in the evaluation of national policies and programmes	dissemination and use of health-related data • Lead the development of guidelines and methodologies for national policy and programme evaluations • Lead in establishing standards and guidelines to strengthen health information systems
Corporate functions *(for further elaboration based on Category 6 discussions)*	• Leadership and governance (including Legal, IOS, GBS, …) • Governing bodies (WHA, EB, RC) • Strategic planning, resource mobilization, resource coordination and reporting • Strategic communications	• Transparency, accountability and risk management, including oversight, monitoring and reporting • Management and administration • Country Focus Policy	