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Child and Maternal Health and Nutrition in South Asia - Lessons for India

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CHILD AND MATERNAL HEALTH AND NUTRITION IN SOUTH ASIA – LESSONS FOR INDIA

Pavithra Rajan, Jonathan Gangbar and K Gayathri*

Abstract

South Asia has been characterized by its minimal progress in the areas of child and maternal health and nutrition in comparison to other regions in the world. The case of India is especially enigmatic as there has been a lack of improvement in its performance in this area since the 1990s. Furthermore, compared to other countries in South Asia such as Sri Lanka, Bangladesh and Nepal, India's progress towards the achievement of its Millennium Development Goals (1, 4 and 5 specifically) is quite concerning. Despite having their own "local" problems, Bangladesh and Nepal have achieved or nearly achieved many of their MDG targets of optimal maternal and child health and nutrition and Sri Lanka is already in its post-MDG phase. However, as far as India is concerned, the achievement of MDGs seems way off target. The comparative performance of these countries relative to India is of particular interest because they have often been able to realize substantial improvements in the area of child and maternal health and nutrition with more pressing resource constraints. Hence it will be of interest to compare India to other countries in the South Asian region and examine the individual country experiences of addressing child and maternal health and nutrition. A major reason for the lack of progress in India could be attributed to issues of poor governance – lack of political will, divergence of effort, and the lack of a transparent dedicated health system that is pro-child and maternal health and nutrition. Further research is required to examine the state of child and maternal health and nutrition from a sub-national perspective in India and to examine how resources are being allocated and utilized to address the issues that persist in relation to this field.

INTRODUCTION

South Asia[1] is a region that has been characterized by the very minimal progress that it has made in the field of child and maternal health and nutrition as compared to other regions in the world, which is troubling since South Asia houses approximately 20% of the world's population (Human Development Report, 1999). Reasons including, but not limited to bad governance, inadequate monitoring, weaker health institutions, and poor accountability have been identified as factors inhibiting progress in the region. The case of India is quite enigmatic in the region because at the beginning of the 1990s, India was a top ranked country in South Asia as it came to particular Human Development Indicators (HDIs), but since then "India has started falling behind every other South Asian country (with the partial exception of Pakistan) in terms of social indicators" (Dréze and Sen, 2011). Within the region, India's performance in addressing its social challenges is often considered poor. In terms of its decrease in standing within the region, other countries in South Asia, as classified by Dréze & Sen (2011), namely, Bangladesh, Bhutan, Nepal, and Sri Lanka have been able to surpass India, which can likely be attributed to the manner in which these countries have attempted to address their nations' persistent challenges.

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[1] For the purposes of this paper South Asia refers to the following countries: Bangladesh, Bhutan, India, Nepal, Pakistan and Sri Lanka (Dréze and Sen, 2011)

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For the purposes of this comparative paper, Pakistan and Bhutan will not be included as countries of interest for the following reasons that will be explained presently. As noted earlier, Pakistan is the sole country in South Asia that has not surpassed India in its HDI performance for select indicators and hence will be excluded (Dréze and Sen, 2011). Given that India was the "lead" country in the early 1990s, it will be best to examine countries that have surpassed India, countries that have performed relative to India and/or countries that have improved substantially over time as it relates to child and maternal health and nutrition. Bhutan has been excluded because of its population size, which, as recorded by the World Bank in 2012, is 741 800. Given that India's population is 1.237 billion, the scope for comparison might become less significant if Bhutan were included. Thus, the countries of interest in this paper are India, Sri Lanka, Bangladesh and Nepal. The basis for comparison is the Millennium Development Goals pertaining to child and maternal health and nutrition. Having said that, it needs to be acknowledged that the MDGs are not an exclusive measure of the performance in child and maternal health and nutrition, but rather are being used as a common ground for comparison.

Millennium Development Goals (MDGs) Indicators

Despite the massive growth of the Indian economy and the substantial rise in its Gross Domestic Product per capita since the 1990s, India continues to struggle with improving the state of child and maternal health and nutrition as is reflected in their performance of Millennium Development Goals 1, 4 and 5[2]. Based on the situations in Sri Lanka, Bangladesh and Nepal, and their often renowned and/or substantially improved progress towards the achievement of their Millennium Development Goal targets, it raises the question as to how India's experience compares to other countries in Sub-Continent, and how India can benefit from the experiences of its regional neighbours.

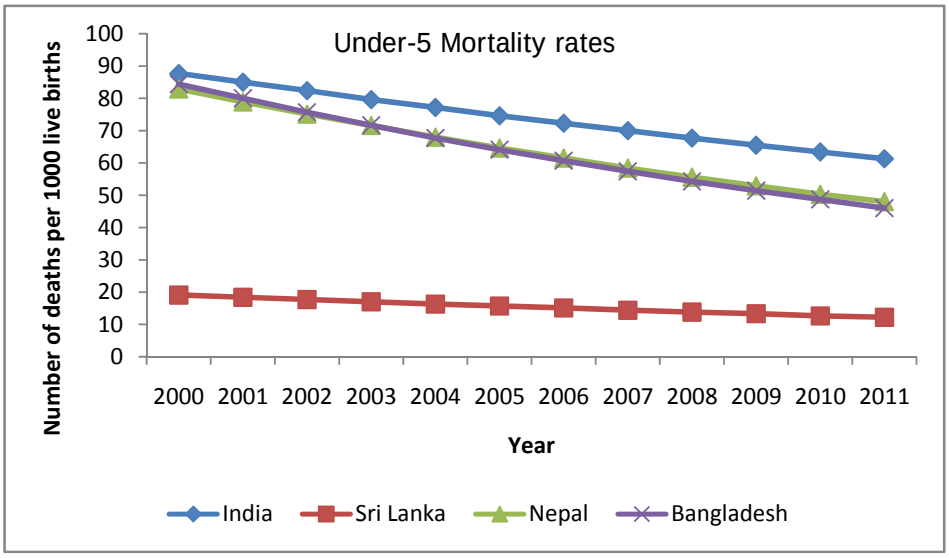
Some of the major indicators for child and maternal health and nutrition are Under-5 years Mortality Rate, Infant Mortality Rate and Maternal Mortality Rate. It has been seen that for the indicator of Under-5 years Mortality Rate, there is a decline for all the four countries. However, among the four countries, India had the highest Under-5 years Mortality Rate (U5MR) at 87.7, almost close to Nepal (82.9) and Bangladesh (84.4) in 2000. Despite this, after almost a decade, while the rates have gone down for Nepal (48.0) and Bangladesh (46.0), India still continues to have the highest Under-5 mortality rates at 61.3 (please refer to Figure 1). Sri Lanka has not shown drastic decline in the rates, but its Under-5 mortality rate was already quite low to begin with. The second important indicator of progress in child and maternal health and nutrition is the Infant Mortality Rate (IMR). The picture is very similar to the earlier one, with India not progressing at the same rate as the other countries in the region, despite having a similar starting point (please refer to Figure 2).

IMR is a major component affecting India's child mortality rate, specifically because of its high levels of neonatal mortality. Certain factors have been identified by Mundle (2011) for this high child mortality rate, namely, a lack of adequate medical facilities and health infrastructure, as well as insufficient transportation infrastructure for quick access to health care facilities. What can be inferred from these issues is that the state of India's health system is not necessarily a top-priority at the policy

[2] Millennium Development Goals 1, 4 and 5: Eradicate Extreme Poverty and Hunger; Reduce Child Mortality; Improve Maternal Health

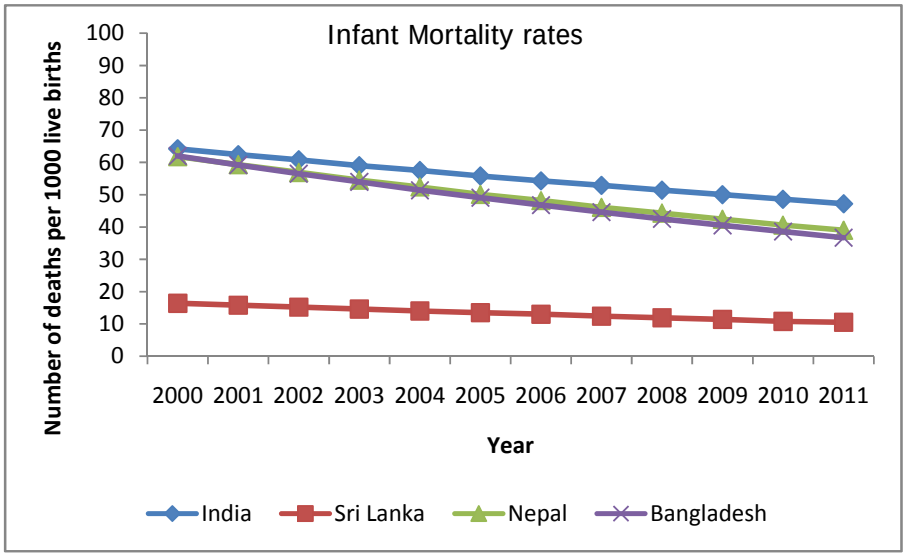
level. However, in Sri Lanka the health of its citizens has been a major priority for many decades, having put in place mechanisms to deliver a universal health care system (Björkman, 1985). As well, in Bangladesh, the efforts to address child mortality have gained substantial importance on the health policy agenda of the Government of Bangladesh since the start of the MDG period (Shiffman and Sultana, 2013). However, despite experiencing both financial and human resource constraints, Nepal is on track to achieve its MDG targets for child and maternal health and nutrition. This is partially attributed to decentralized financial planning and better implementation (Campbell et al, 2003).

Figure 1: The Under-5 Mortality Rate in Select South Asian Countries



Data Source: http://mdgs.un.org/unsd/mdg/data.aspx

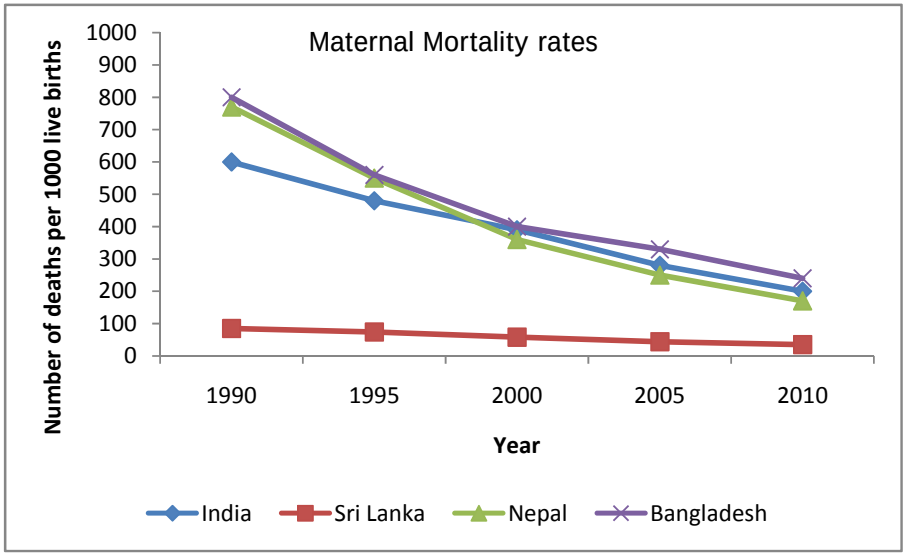
Figure 2: The Infant Mortality Rate in select South Asian countries



Data Source: http://mdgs.un.org/unsd/mdg/data.aspx

The Maternal Mortality Rates (MMR) show a declining trend. In the year 1990, India was placed between the countries of Nepal-Bangladesh and Sri Lanka. It is of interest to note that while Nepal has surpassed India in reducing its Maternal Mortality Rates, Bangladesh has a comparable MMR, almost close to India. Sri Lanka has maintained its MMR at less than 100 deaths per 1000 live births since the year 1990 (please refer to Figure 3). This is mainly due to its policies that support maternal health and education (Björkman, 1985), as well as the influence of the social and economic reform in Sri Lanka, which supported free education until University and free access to health care (Herring, 1987). Similar is the case in Nepal, where reduction in MMR could be attributed to improved maternal education (Tsai, 2009). Looking at India, it appears that one of the major factors contributing to the lack of progress in its MMR is the lack of adequate number of trained medical personnel for institutional deliveries (Mundle, 2011). This can be seen in the case of Bangladesh as well. Although maternal mortality rates have decreased, there are still limitations to the delivery of appropriate health services for pregnant women and improvements are often attributed to better family planning and social changes in the society. However, that being said, the Ministry of Health and Family Welfare in Bangladesh is committed to improving maternal mortality and increasing the number of trained skilled attendance (Sack, 2008).

Figure 3: The Maternal Mortality Rate in select South Asian countries



Data Source: http://mdgs.un.org/unsd/mdg/data.aspx

Looking at the status of India and its slow progress in achieving certain health related outcomes, it is clear that the state of the health system is greatly affected by a lack of quality governance. As a result, the health system is plagued by shortages in human capital and an inefficient delivery system (Mundle, 2011). This suggests that despite the constraints experienced by the Government of India that governance and the will to improve the state of the country's health system is an overarching factor that can drive change and lead to its improvement.

It can be inferred from the above graphs that over the past decade, South-Asian countries that are less developed than India, namely, Nepal and Bangladesh have performed on par or outperformed India. These countries have met many of the same challenges experienced by India such as cultural/political conflicts and difficult geographic terrain (which can create issues of accessibility). India has not shown considerable progress in improving the state of child and maternal health and nutrition, despite having large scale flagship programmes like Intergrated Child Development Services (ICDS) and active participation by the Government and international donors. This paper will further explore the cases of India, Sri Lanka, Bangladesh and Nepal and their respective efforts to improve the state of child and maternal health and nutrition. There will be special emphasis given to the issue of governance as it relates to political will and the influence of the international community in improving the state of child and maternal health and nutrition in these respective countries.

Governance in South Asia

Governance is fundamental to the smooth functioning of any country (Arnwine, 2001). Governance is also important for the economic development of the country. Over time, the governance in South Asia has changed from the conventional outlook to a more western methodology, with more focus on economic growth as opposed to overall development, and support to service delivery rather than leading it (Haque, 2001). The study by Bhutta et al in 2004 found that South Asia still needs to work on improving the child and maternal health and nutrition and one of the reasons for this lack in achieving success was attributed to the bad governance in this region. At times, South Asia has been exposed to tremendous political instability. There is inherent political instability in many countries in the region, a factor, amongst others, such as susceptibility to natural calamities can affect the steady progress of child and maternal health and nutrition. (Safaei, 2006; Nataraj, 2007). The paper by Abdulraheem (2009) has brought to light the rampant corruption and lack of good governance in the different sectors in India, including the health-care sector. Political instability can be considered one of the reasons for the delay in anticipated achievements in the field of child and maternal health and nutrition. As well, political will and consistency in policy over time can do much to improve the situation of a country's children and their mothers.

Political Will

Competing priorities often make it difficult for certain issues to be viewed as a political priority and thus placed on the political agenda (Shiffman and Sultana, 2013). In India, issues relating to child and maternal health and nutrition have received attention in recent years following pressure from civil society and the involvement of the Supreme Court, which has resulted in a greater emphasis on expanding interventions like the ICDS programme; however, nutrition is still not viewed as a political issue in the country. In fact, a common sentiment that is echoed across much of the available research regarding this issue is that the failure of such flagship programmes is partially attributable to a lack of political will (Gragnoloti et al, 2006; Maiorano, 2013; Mohmand, 2012). As can be seen throughout South Asia, political will is a factor that can place a pertinent issue on the agenda or keep it off, an issue to be discussed presently.

The lack of political will is evident in the nutrition interventions in Bangladesh, which do not appear to be a key priority at the National level. They have been limited in receiving attention because strategies are not effective; there is an absence of evidence-based decision making and because particular interventions are not perceived as visible from an electoral standpoint (Taylor, 2012). This is contrary to the experience in Sri Lanka where changes in policy are made following the input from technical and research experts, as well as feedback from stakeholders and policy makers. An evidence-based approach has consequently enabled Sri Lanka and its political representatives to take a very proactive stance as far as national health and nutrition programmes are concerned. Compared to India, Sri Lanka has been able to design interventions that emphasize behaviour change and lifestyle modification (de Silva et al, 2009). More importantly, Sri Lanka's consistent policy environment has been complimented by its willingness to engage its citizen and consequently involve them in effective participatory planning; thereby contributing to the creation of interventions that work at the grassroots level. What the situation boils down to is incentive to change the status quo. As can be seen in both Bangladesh and India, since malnutrition is such a common phenomenon to the extent that is normalized, it is often not perceived to be an issue by the masses. Therefore, there is a lack of incentive for politicians to change the status quo, by for example introducing a programme that focuses on behaviour change versus direct provision of food, and deviating from a situation that is already politically favourable (Taylor, 2012).

The key point to highlight is that in India, using the example of the ICDS programme, the Government of India's flagship programme for addressing the area of child and maternal health and nutrition, has continued to expand based upon an inefficient model that emphasizes political returns over beneficiary impact; whereas Sri Lanka has been able to create a political environment where beneficiary improvement breeds political returns. This is the result of bottom-up demand for quality service provision and top-down accountability for effective implementation. The implication for India, using the ICDS programme as the primary example, is that without governmental support, issues related to child and maternal health and nutrition will persist because there is no incentive to improve existing strategies, resource allocation, monitoring and evaluation and coordination across implementing bodies. The challenge for improving child and maternal health and nutrition interventions in India is remedying the persistent policy-implementation gaps that are all too prevalent and creating a platform for effective participatory planning, which will not only improve the quality of interventions, but also foster a demand for quality services (Dréze and Sen, 2011). However, beyond the national political environment, the international community has a great deal of influence in low-middle income countries and how policies and interventions are designed and implemented. The influence of the international community and its impact on the governance of child and maternal health and nutrition interventions in India, Sri Lanka, Nepal and Bangladesh is not commonly explored.

The International Community and its Influence

International organizations are highly influential in low-middle income countries because of opportunities for receiving financial and technical assistance at the expense of adopting priorities that are important to the international community, for example, the Millennium Development Goals

(Shiffman and Sultana, 2013). A common challenge of these engagements is to maximize the effectiveness of scarce resources to achieve conflicting goals such as working with weak health systems to achieve MDGs 4 and 5, while at the same time trying to strengthen that health system (Michaud, 2005).

The issue faced by recipient countries is that financial assistance often changes the scope of accountability to be donor-driven, and based on the above example, it can be inferred that the priority of the international donor community is with the achievement of MDGs 4 and 5 as opposed to strengthening the health system. This has been experienced by India, Bangladesh and Nepal where health and nutrition policies have often been weak and inconsistent over time and health systems continue to experience challenges in terms of (1) Insufficient Infrastructure (2) Lack of Adequate Personnel and (3) Limited Accessibility and (4) Low Utilization of Health Services (Mundle, 2011; Ministry of Health and Family Welfare, Strategic Plan for HPNSDP, 2011). The exception is Sri Lanka, where decades of consistent policy and a well established health system has enabled the Government to utilize international funds effectively and achieve donor priorities without having to compromise its own national goals.

However, as can be seen in Bangladesh, the World Bank, which is the largest funding partner of nutrition, has significant influence over the Government of Bangladesh (GOB). As a result of the GOB's dependability on the financial resources provided by the World Bank and its development partners, there are high levels of accountability over policy formation, but not in terms of implementation for nutrition interventions in Bangladesh (Taylor, 2012). Implementation is made difficult because of financial constraints and poor coordination. Since financial assistance from the international community is linked to performance, there is little incentive to coordinate inter-sectorally, but rather with the donors. In fact, this is well recognized by the international donors and has resulted in projects being run parallel to national interventions (Taylor, 2012). Similar is the case in Nepal where previous research has noted that the Government has tried to tailor its policies to appease international donors and receive funding (Lawoti, 2010). Funding is often contingent upon matching donor priorities, which can inhibit taking appropriate action to address the real needs of intervention benefactors. Consequently, international assistance can wind up shifting the accountability of a programme from its benefactors and ultimately detract from the implementation of meaningful interventions. Regardless of funds provided by the international community, those funds need to be used efficiently.

World Bank in India

- Have supported nutrition efforts since 1980
- Overall investment of US $712.3 M in sector
- Current Project: ICDS System Strengthening and Nutrition Improvement Program
- Objective: Improve nutritional outcomes of children and their mothers in India
- Focus:
  - Systems Strengthening Communication
  - Behaviour Change
  - Convergent Nutrition Action
  - Monitoring and Evaluation

Data Source: World Bank website

Looking at the case of India, the World Bank, who has supported nutrition efforts in India since the 1980s has recently approved USD $106 million that will be used to implement the ICDS System Strengthening and Nutrition Improvement Program, which has the objective of improving nutritional

outcomes of children and their mothers in the country (The World Bank Group, 2012). The per capita foreign aid towards maternal and child health could better explain the reasons for differences in performance for these countries; however the absolute funding has been used for comparison due to data availability constraints. The longstanding assistance of the World Bank, the sub-par performance of India's nutrition indicators and deep-rooted issues affecting the ICDS programme breeds the question as to whether international funds have been used efficiently and whether the influence of the international community in the area of child and maternal health and nutrition has been effective in this instance. This should be a top of mind concern for the Government of India in seeking to improve the design and implementation of child and maternal health and nutrition interventions in the country. There is definitely a need for further research to be conducted as to whether the international community and its current efforts to improve the state of child and maternal health and nutrition in South Asia is being undertaken in a long-term and sustainable manner.

India and Its Standing in South Asia

A detailed evaluation of India, Sri Lanka, Bangaldesh and Nepal is essential to identify the successes and failures, which is a formidable task for individual research. Hence, the current paper uses the existing research evidence for undertaking a comparison of child and maternal health and nutrition within the context of South Asia. However, certain points need to be considered prior to making the comparisons. First, a direct comparison from one country to another is not appropriate without taking into consideration the unique cultural and political contexts of these countries. Second, although Sri Lanka, Bangladesh and Nepal have made substantial progress relative to India in terms of improving their HDIs and achieving certain MDG targets, this does not imply that policies, strategic interventions and programmatic implementation are more effective in these countries than in India. Lastly, although India has experienced massive economic growth since the 1990s especially when compared with the other countries, it cannot be implied that economic growth is an exclusive factor that drives social development, and that consequently India should be in a better position than Sri Lanka, Bangladesh and Nepal. The goal is to highlight key takeaways and/or valuable lessons (whether from positive or negative experiences) from Sri Lanka, Bangladesh and Nepal that might be of use for India in strengthening its policies as they relate to child and maternal health and nutrition and improving the implementation of these interventions.

It is necessary to examine the individual country contexts of India, Sri Lanka, Bangladesh and Nepal to better understand the landscape by which these countries are addressing the issue of child and maternal health and nutrition (please refer to Table 1 for a snapshot of child and maternal health in nutrition in South Asia over time). From there, a comparison of the challenges and triumphs of the respective countries will be undertaken in order to understand how to better bridge the gap between policy and implementation.

Table 1: Child and Maternal Health in South Asia – A Snapshot

Countries	*2000*				*Health system*	*2010*			
	U5MR	**IMR**	**MMR**	**Health Care Exp. (% GDP)[3]**		**U5MR**	**IMR**	**MMR**	**Health Care Exp. (% GDP)**
India	87.7	64.2	390	4.3	• Low levels of public expenditure on health care (as % of GDP)[4] • Lack of investment in health infrastructure & inadequate human resources (Planning Commission, 2011). • Lack of citizen engagement and participation in design and implementation of services	63.4	48.6	200	3.7
Sri Lanka	19.1	16.4	58	3.7	• Long history of a progressive health care system • Sound governmental policies • Universal education and universal health as top priorities of the Government since 1970s • Citizen empowerment by decentralization through convergence of Government activities with private sector, NGOs, community based organizations, donors and other stakeholders • Integration of health research into health care system • Increased accountability and transparency	12.6	10.8	35	3.5
Bangladesh	84.4	62.0	400	2.8	• Policies framed to ensure basic health services to all • Integration of NGO services into the health system to reach the difficult areas	48.7	38.6	240	3.7
Nepal	82.9	61.8	360	5.4	• Long history of extensive external aid (both financial and strategic) until 1990s • National Reproductive Health Program in early 1990s to strengthen the health care system • Lesser reliance currently on foreign bodies for finance • Better decentralization and financial planning • Better project implementation	50.3	40.6	170	5.1

Data source: http://mdgs.un.org/unsd/mdg/data.aspx &
http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS?page=2

Country Context

INDIA

India is not in a position to achieve many of its Millennium Development Goal (MDG) targets by 2015, despite having long term flagship programmes in place (please refer to Figure 4). With respect to the issue of child and maternal health and nutrition, the outlook is not particularly promising. Specifically, its efforts to address hunger (MDG 1), reduce child mortality (MDG 4) and improve maternal health (MDG 5) are not on track. It is projected that by 2015, the percentage of underweight children in India will be

[3] Total health expenditure is the sum of public and private health expenditure. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation.

[4] At the end of the XIth year plan, it was noted that the total public expenditure on health in Government of India was less than 1% of GDP. Reasons for the high levels of expenditure as per the chart are a result of the disproportionate spending on private health care, which usually is out of pocket expenditure. This speaks of the deficiencies of the healthcare system and the public sector's ability to deliver basic services (Planning Commission, 2011).

40.7% versus its 2015 target of 26.8% (Mundle, 2011) and that the majority of states will miss their U5MR and IMR targets by 2015 (as per the MDG India Country Report, 2011). As well, despite improvements in maternal health, the rate of decline is lower than its set targets (Planning Commission, 2011; Mundle, 2011). However, it needs to be kept in mind that India is diverse, with disparities in the performance of health outcomes across the different states in the country. Certain regions in the country like the South Region[5] have shown considerable progress in child and maternal health and nutrition, while certain states like Bihar and Jharkhand in the North have not shown much progress (Das Gupta et al, 2005). The performance in such poor states of the country tends to bring down India's overall performance, as they tend to suffer from substantial resource constraints (Mundle, 2011).

Factors that have inhibited improvements in the field of child and maternal health and nutrition include, but are not limited to: poor governance, poor resource allocation and a lack of accountability and transparency in the health care system. As well, Government of India (GOI) interventions targeting children ages 0-6, as well as pregnant and lactating mothers such as the ICDS programme (established in 1975) are experiencing similar issues. Policy feedback mechanisms are often not substantial. There is not much integration of research into policy making, due to which current policies are not very effective in producing outputs.

The issue of underfunding, as highlighted through research, has been identified as a major reason for the lack of progress made in regards to child and maternal health and nutrition in India. In fact, in regards to ICDS, it was recommended that both the GOI and international community substantially increase their financial support of the program (Gragnoloti et al, 2006). This recommendation has been heeded by both the GOI and the World Bank. The GOI has increased its expenditure on ICDS from INR 5396 crores in FY 2007-2008 to INR 16,058 crores in FY 2013-2014. As well, in 2012, the World Bank, a long time international supporter of the ICDS programme, approved USD $106 million to be used towards the improvement of nutrition among children in India under the ICDS programme (The World Bank Group, 2012). That being said, simply increasing the expenditure of the programme will not translate into an increase in effectiveness; rather, effective implementation of ICDS depends upon whether the resources provided are adequate and that they are used efficiently.

Figure 4: Some of the Major Strategies Used by India to Address Child and Maternal Health and Nutrition

- Integrated Child Development Services in 1975 to address the holistic needs of the child (0-6 years and pregnant and lactating mothers)
- National Rural Health Mission in 2005 to provide accessible, affordable and quality health care to the rural population

In fact, increases in funding for child and maternal health and nutrition, specifically ICDS, come as the result of its mandated universalization in 2001. However, in undertaking the process of universalizing the programme, a quality-quantity gap has been identified; whereby efficient resource

[5] The South region consists of four states: Andhra Pradesh, Karnataka, Kerala and Tamil Nadu (Das Gupta et al, 2005).

allocation and emphasis on quality service provision has seemingly been neglected at the expense of achieving universalization targets. This is understandable given the fact that the programme is being universalized with a model that is not entirely efficient and that "implementation of such schemes remains highly siloed and has often been critiqued for being single mindedly concerned with providing inputs and monitoring outputs (number of centres established, number of staff trained, amount of money spent, number of village nutrition days organi[z]ed) rather than being focused on outcomes and objectives" (Page 14, Taylor, 2012). As well, there is a strong link between effective governance and the efficient allocation of resources, and as commonly pointed out by the available research, the poor performance of ICDS is very attributable to poor governance and a lack of political will (Gragnoloti et al, 2006). As Dréze highlights "it should be clear that the main challenge of "universali[z]ation with quality" is to make ICDS a lively political issue" (Page 3714, Dréze, 2006). There is a need to explore in depth the reasoning behind the failure of coordination at the National, State and Local levels, as well as the lack of convergence across implementing bodies.

India's attempts to address child and maternal health and malnutrition have been insufficient. Following the results of the Report of the Comptroller and Auditor General of India on Performance Audit of Integrated Child Development Services (ICDS) Scheme, which was published in January 2013, it is clear that much needs to be done to improve the state of child and maternal health and nutrition in India. The Infant Mortality Rate was reported at 48 per 1000 compared with the target of 30 per 1000 and the Child Mortality Rate was reported at 63 per 1000 compared with the target of 31 per 1000. As well, between 2006 to 2010, it has been reported that 43% of children in India were underweight and that 16% were severely underweight (as reported by the Ministry of Women and Child Development, 2012-2013).

The issues, as mentioned above, shed light on the necessity to look into the strategies and the policies for addressing child and maternal health and nutrition by other countries in South Asia and learn where India can draw key lessons for improvement. Therefore, it is important to look into the performance of Sri Lanka, Bangladesh and Nepal in this regard.

SRI LANKA

Sri Lanka, at the outset, is placed in an advantageous position in the field of child and maternal health and nutrition in South Asia and has made tremendous and laudable progress, which can be attributed mainly to its sound governmental policies for strengthening its public health care system, which in turn, has decreased the burden of diseases (Zaidi et al, 2004). Unlike India, Sri Lanka is recognized for its policies and interventions, which are evidence-based, encourage stakeholder participation and involve gradual change over time (please see Figure 5). British colonization and Sri Lanka's social and economic reform of the 1970s are key historical factors that have influenced practices of good governance at the political level and bottom-up demand for quality service delivery.

British Colonization

- The initial foundation of the public health system was established.
- Values of transparency, accountability and gender equality were ingrained into the Sri Lankan health system.

Social and Economic Reform (1970s)

- The policies favouring "social well being" especially for the poor families were introduced like free education until University, free food supplies, and subsidized or free medical care (Herring, 1987).
- Health policies have remained consistent over time - there has been only progressive changes in the health policies.
- Universal education and universal health have been top priorities for Sri Lanka since many decades now - improved maternal education helps reduce infant mortality rates (Björkman, 1985).

Figure 5: Some of the Major Strategies Used by Sri Lanka to Address Child and Maternal Health and Nutrition

- Breast feeding code established in 1983 to promote breast feeding
- Salt iodization program in 2001 to prevent goiter
- Poshana Malla Programme in 2006 ensuring free distribution of food to most needy pregnant mothers
- Integrated nutrition package in 2009 consisting of food fortification and behvaiour change communication training for pregnant mothers and children under 5 years
- National Nutrition Policy in 2009-2010 to ensure optimal nutrition throughout life cycle
- National Nutrition Surveillance System to enhance quality of service provision
- National Health Promotion Policy in 2006-07 to ensure monitoring and evaluation at implementation level

Non-Governmental Organizations (NGOs) in Sri Lanka have also been given their due place and importance in the field of poverty reduction. Sri Lanka is trying to work toward citizen empowerment by decentralization through convergence of Government activities with private sector, NGOs, community based organizations, donors and other stakeholders (Gunetilleke, 2001). This was done to increase the accountability and the transparency in the system. Over time, Sri Lanka has managed to achieve a high level of health status with less expenditure on health care (Jayasekara and Schultz, 2007). The country has decreased its expenditure on health care by 0.2% (expressed as a percentage of GDP) over time (please refer to Table 1). However, it is still striving to ensure high standards and better quality of health care services, especially post civil war (Bhutta et al, 2004). Thus, Sri Lanka is an example of good governance and sound policies, which have been instrumental in the progress of child and maternal health and nutrition over time.

BANGLADESH

Bangladesh has made commendable progress in reducing the Under-5 child mortality rates since early 1990s. This could be attributed to the various initiatives taken in the country. Bangladesh has a pro-health policy that ensures optimal health for all its citizens including the underprivileged in the remote areas (please refer to Figure 6). As well, Bangladesh has recently employed a strategy to mainstream nutrition services, which will fall under the National Nutrition Service and focus on the following interventions: "(i) facility based services, (ii) area based nutrition activities, (iii) capacity building through training of staff and development of relevant manuals etc, (iv) provision of micronutrient activities, and (v) research and surveillance" (Page 14, Ministry of Health and Family Welfare, Strategic Plan for HPNSDP, 2011). These services are integrated and available through agencies providing Maternal and Neonatal Child Services. This shift, at the instance of the World Bank, comes following

nutrition interventions that evolved from Bangladesh Integrated Nutrition Programme (BINP) to the National Nutrition Programme (between 1995 – 2011). The BINP focused on reducing malnutrition through three objectives, which consisted of institutional capacity building, community-level capacity building and improving nutritional status of children and pregnant and lactating mothers (The World Bank, 2005). Ultimately, a lack of reach, poor inter-sectoral coordination and poor governance were the major contributing factors to the ineffective performance of Bangladesh's earlier nutrition interventions.

Looking at the current state of child malnutrition in Bangladesh, the situation is not promising. Although a percentage decrease in underweight children between 2004 and 2009 was realized, going from 47.5% – 37.4% respectively, there have been increases in the percentage of underweight for height and stunting (Ministry of Health and Family Welfare, Strategic Plan for HPNSDP, 2011). Based on the available literature, it is clear that nutrition has not been a major political priority in Bangladesh (Taylor, 2012). Characteristically, nutrition policies and interventions since the 1990s have struggled and have been subject to (1) Resource Constraints (2) Poor Implementation – coordination and (3) Accountability Issues. The GOB's dependence on international development support appears to be a major contributing factor. In addition, lack of political will has been instrumental in delaying the progress of maternal and child nutrition in Bangladesh.

Figure 6: Some of the Major Strategies Used by Bangladesh to Address Child and Maternal Health and Nutrition

- Bangladesh Integrated Nutrition Programme & National Nutrition Programme (between 1995 – 2011) to reduce malnutrition
- Mainstreaming of Nutrition Services in 2011 to improve the child and maternal health and nutrition

Implementation of interventions is made difficult because of financial constraints and poor coordination. On average, the Government of Bangladesh spends approximately 3.2% of GDP on its Health Population and Nutrition sector, and due to tight budget constraints, it is only able to allocate 35% (USD $1,166.67 million) of the resources needed for the implementation of the current Health Nutrition and Population Sector Development Program, which means that the remaining 65% (USD $2,166.67 million) will be provided from external sources (Ministry of Health and Family Welfare, Strategic Plan for HPNSDP, 2011). Since financial assistance from the international community is linked to performance, there is little incentive to coordinate inter-sectorally, but rather with the donors (Taylor, 2012). In fact, this has resulted in policy level coordination, but poor implementation. This is well recognized by the international donors and has resulted in projects being run parallel to national interventions by international partners (Taylor, 2012). Thus, the situation in Bangladesh appears to be improving, but they are subject to many of the same constraints affecting other countries in the region such as India and Nepal, which include issues pertaining to good governance, resource constraints and effective implementation on the ground. Despite these constraints, Bangladesh has developed a highly accountable system for policy formation, which can be identified as one of the key reasons for its progress in this field.

NEPAL

Based on its 2010 MDG report, Nepal is on track to meet its MDG targets for child and maternal health and nutrition (please refer to Figure 7). However, Nepal has frequently looked to assistance from the international community due to the human and financial resource constraints that plague its health system (Campbell et al, 2003). The United Nations has been supporting Nepal to a very large extent, to accelerate the progress in achieving its MDG goals in relation to maternal and child health and nutrition. In fact, it has been noted in previous research that the Government of Nepal has a tendency to design its policies and implementation strategies in a manner conducive to the objectives of the international donor community as a means to attract funding (Lawoti, 2010). Regardless of the tremendous support for the international community, a comparison between projected cost and projected available financial resources (as per UNDP) shows that there are serious funding gaps in all years between 2011 and 2015. The funding gap for 2011 is NRs 40.7 billion, for 2012 is NRs. 58.4 billion, for 2013 is NRs. 87.5 billion, for 2014 is NRs.132.9 billion and for 2015 is NRs. 131.9 billion.

Figure 7: Some of the Major Strategies Used by Nepal to Address Child and Maternal Health and Nutrition

- National Reproductive Health Policy in 1990 to strengthen maternal and child health and nutrition
- Nepal Safer Motherhood Programme – 1997 to 2004 – to reduce maternal mortality rates
- Community Action for Nutrition Project – 2012 to 2017 – to enhance nutrition in women of reproductive age and children under two years of age

The lack of financial resources has always been a problem as far as child and maternal health and nutrition is concerned. As well, issues of convergence across and collaboration across NGOs and Government bodies present a continued challenge (Campbell et al, 2003). This can be partially linked to governance issues that persist in Nepal and are perpetuated by it unmotivated civil service. There are poor mechanisms in place to monitor accountability of the system and ensure transparency. “Unless civil society actors in Nepal mobilize to insert strong accountability mechanisms, in the new Constitution, the country may be plagued by gross abuses of power and corruption well into the foreseeable future” (Page 170, Lawoti, 2010).

Lastly, geographically speaking, Nepal is not uniformly accessible. Hence, achieving equitable health for all is difficult. Apart from difficult terrains and remote areas, certain socio-cultural factors hinder the progress of Nepal’s development, namely, traditions, gender inequity, lack of resources and poor infrastructure. It can be said that Nepal, although initially was very much reliant on international assistance, has recently taken up the issue of child and maternal health and nutrition at the national level by framing specific policies and ensuring better programme implementation.

Lessons for India

The key issues being faced by India that are hindering the performance in child and maternal health and nutrition are related to: 1. Governance 2. Resource Allocation 3. Policy weaknesses and 4. Regional disparity (please refer to Figure 8). As can be seen in Sri Lanka, Bangladesh and Nepal, the ability to

improve the state of child and maternal health and nutrition began with the issue receiving attention at the political level and being placed firmly on each country's respective national agenda. As has been already mentioned, Sri Lanka has historically been in a favourable position due to a long standing commitment to the state of its country's health system. In addition, the health policies and strategies have given special attention to child and maternal health and nutrition (Björkman, 1985). Bangladesh is still struggling with poor governance for nutrition, like India, however the situation of child and maternal health and nutrition is comparatively more improved than India. The GOB has placed special emphasis on reducing child mortality rates, with more trained personnel for skilled birth attendance. "New born survival in Bangladesh is a case of successful advocacy for the placement of a health issue on the policy agenda of a low income country" (Page 1, Shiffman and Sutlana, 2013). As well, Nepal has managed to improve its standing in maternal and child health and nutrition due to a firm commitment to strengthening the political process, in spite of the issues related to caste, rich-poor and urban-rural divide (Tsai, 2009).

It is evident that Sri Lanka, Bangladesh and Nepal seem to have a strong political will to strengthen the health system relating to child and maternal health and nutrition, which seems to be lacking in India. Looking specifically at Nepal (Campbell et al, 2003) and Bangladesh (Ministry of Health and Family Welfare, Strategic Plan for HPNSDP, 2011), there are serious resource constraints, plaguing their respective health systems. Although there is a heavy reliance on international community for funding and technical support, these countries have shown sincere will to address the challenges associated with child and maternal health and nutrition. In the case of India, efforts to enhance the scope of its interventions are not the result of political interest but rather top-down pressure from the higher authorities and/or bottom-up pressure from the civil society (Mohmand, 2012). Therefore, India's interventions have seen an increase in funding support; however resource utilization is dependent upon two factors: 1. Adequacy of resources and 2. Efficient utilization of those resources. This is beyond the scope of the current paper and needs further investigation. As well, looking at the disparities regionally in India, Nepal seems to have a similar regional distribution. Both countries account for these issues in their strategies; however Nepal seems to have implemented their strategies effectively when compared with India. India is often criticized for its ineffective policy implementation, which again points back to deficient governance. This is of concern since efficacy of a program largely depends on programme implementation, as pointed out by Das Gupta et al (2005). Nonetheless, disparity across the regions is bringing down India's national performance and need to be studied more carefully.

Figure 8: Lessons for India

- Strengthen the political commitment to ensure pro-child and maternal health and nutrition policy
- Better Governance to ensure the implementation of the policy
- Better startegies to tackle the issues of regional and state disparity
- Efficient resource allocation
- Establishment of a pro-child and maternal health environment which involves strong convergence (Governmental and non-Governmental), effective participatory planning, bottom-up demand for quality service provision and top-down accountability for effective implementation of government interventions

The state of child and maternal health and nutrition across India is not showing the results that it should be, given the time that has been invested in trying to address these problems. Therefore, it is necessary to undertake an examination of how funding patterns and expenditure have changed over time in relation to intended outcomes. This has been looked at from a sub-national perspective and the regional differences including the disparities in the literacy levels and functioning of the local governments are some of the deciding factors for the progress of the programme (Gangbar et al, 2014).However, an indepth state-wise analysis could yield more accurate information. In addition, a pro-child and maternal health environment needs to be established (as seen in the Sri Lankan case) which involves strong convergence (Governmental and non-Governmental), effective participatory planning, bottom-up demand for quality service provision and top-down accountability for effective implementation of government interventions. As well, exploring the performance of child and maternal health and nutrition in India at individual State level would also prove valuable, as it might help identify pockets that require greater attention. It would also be of interest to explore how well resources are being used to achieve intended outputs/outcomes as they relate to child and maternal health and nutrition at the individual State level.

Conclusion

The available research highlights that poor resource allocation and utilization as a contributing factor to the ineffectiveness of health and nutrition policies and systems in India as it relates child and maternal health and nutrition. Granted, inconsistent policies, weak infrastructure, governance issues and financial constraints do greatly affect countries such as Bangladesh and Nepal, but in lieu of these challenges, both countries have managed to make great strides in terms of MDG achievement relative to India's performance. Specifically looking at the issue of funding, it is evident that increasing funding will not ensure progress in this field, but rather, success is contingent upon whether the resources are adequate, and how well they are allocated and used. This issue of resources is compounded by the fact that such programmes in India have not been directly linked with improving malnutrition rates across the country (Das Gupta et al, 2005). A major reason for the lack of progress in India could be attributed to issues of poor governance – lack of political will, divergence of effort, and the lack of a transparent dedicated health system that is pro-child and maternal health and nutrition. Further research is required to examine the state of child and maternal health and nutrition from a sub-national perspective in India and to examine how resources are being allocated and utilized to address the issues that persist in relation to this field.

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