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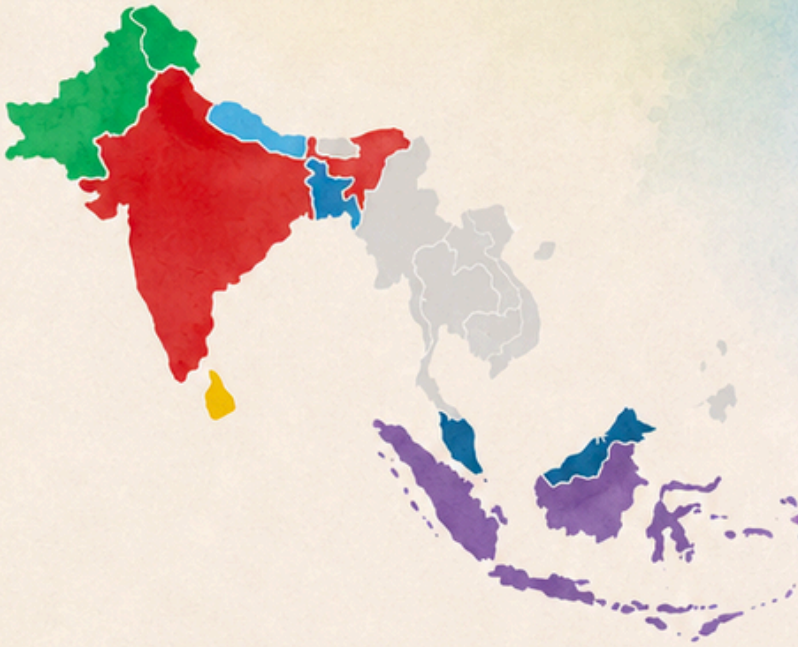

CLOSING THE GAP:
ACCELERATING MATERNAL AND CHILD HEALTH PROGRESS IN SOUTH AND SOUTHEAST ASIA

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Executive Summary

Countries across South and Southeast Asia have made remarkable progress in maternal, newborn, and child health (MNCH) over the past two decades, however, they have followed markedly different paths to achieve these gains. Through a comparative analysis of Bangladesh, India, Indonesia, Malaysia, Nepal, Pakistan, and Sri Lanka, this report finds that sustained improvements have not been driven by individual interventions, but by long-term investments in primary healthcare, institutional capacity, community-based service delivery, and adaptive governance. While each country's context is unique, their experiences demonstrate that durable progress depends on building resilient health systems capable of delivering continuous, equitable, and quality care.

Across the region, five common themes emerge. Countries are:

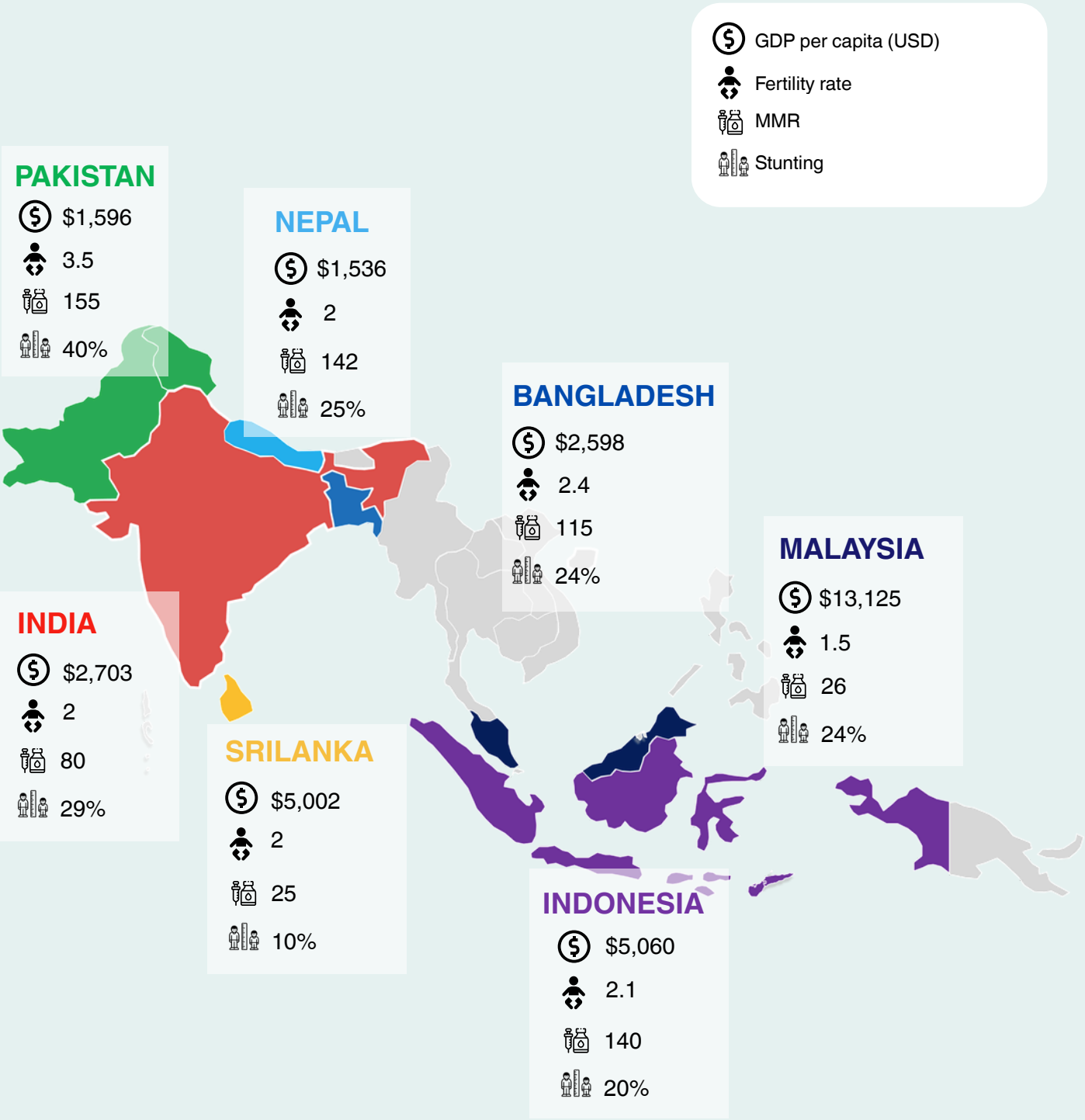
- Increasingly integrating maternal, newborn, child health, nutrition, and immunization within stronger primary healthcare systems
- Shifting from fragmented programs toward lifecycle approaches to care
- Leveraging digital technologies to improve service delivery and health information systems
- Strengthening community health workforces, and
- Recognizing that future gains will depend less on expanding coverage and more on improving the quality, coordination, and resilience of care.

Across these themes, strong institutions, sustained political commitment, and predictable financing consistently emerge as the foundations of successful reform. Building on these lessons, the report presents a Regional Action Agenda focused on strengthening integrated primary healthcare and improving quality of care, harnessing digital transformation, building resilient public institutions, investing in climate-resilient MNCH architecture, and expanding structured South-South collaboration. Rather than advocating a single model for replication, it argues that the region's greatest opportunity lies in adapting proven implementation approaches across comparable contexts, enabling countries to build on one another's experience, avoid costly duplication, and accelerate progress toward better maternal and child health outcomes.

List of Abbrevations

Antenatal Care (ANC)
Basic Health Units (BHUs)
Community Health Worker (CHW)
Community Skilled Birth Attendants (CSBA)
Confidential Enquiry into Maternal Deaths (CEMD)
Electronic Reproductive Health Management Information System (eRHMIS)
Emergency Obstetric and Newborn Care (EmONC)
Female Community Health Volunteer (FCHV)
Gross Domestic Product (GDP)
Infant Mortality Rate (IMR)
Integrasi Layanan Primer (ILP)
Integrated Reproductive, Maternal, Newborn, and Child Health (IRMNCH)
Jaminan Kesehatan Nasional (JKN)
Jaminan Persalinan (JAMPERSAL)
Lady Health Worker (LHW)
Maternal Death Surveillance and Response System (MDSR)
Maternal Mortality Ratio (MMR)
Maternal Voucher Health Scheme (MVHS)
Maternal, Newborn, and Child Health (MNCH)
Non-governmental Organization (NGO)
Postnatal Care (PNC)
Public Health Midwife (PHM)
Safe Delivery Incentive Program (SDIP)
Skilled Birth Attendance (SBA)
Sustainable Development Goals (SDG)
Under-five Mortality Rate (U5MR)
United Nations International Children's Emergency Fund (UNICEF)
Universal Health Coverage (UHC)
Water, Sanitation, and Hygiene (WASH)
World Health Organization (WHO)

At a Glance: Key Indicators



Introduction and Regional Context

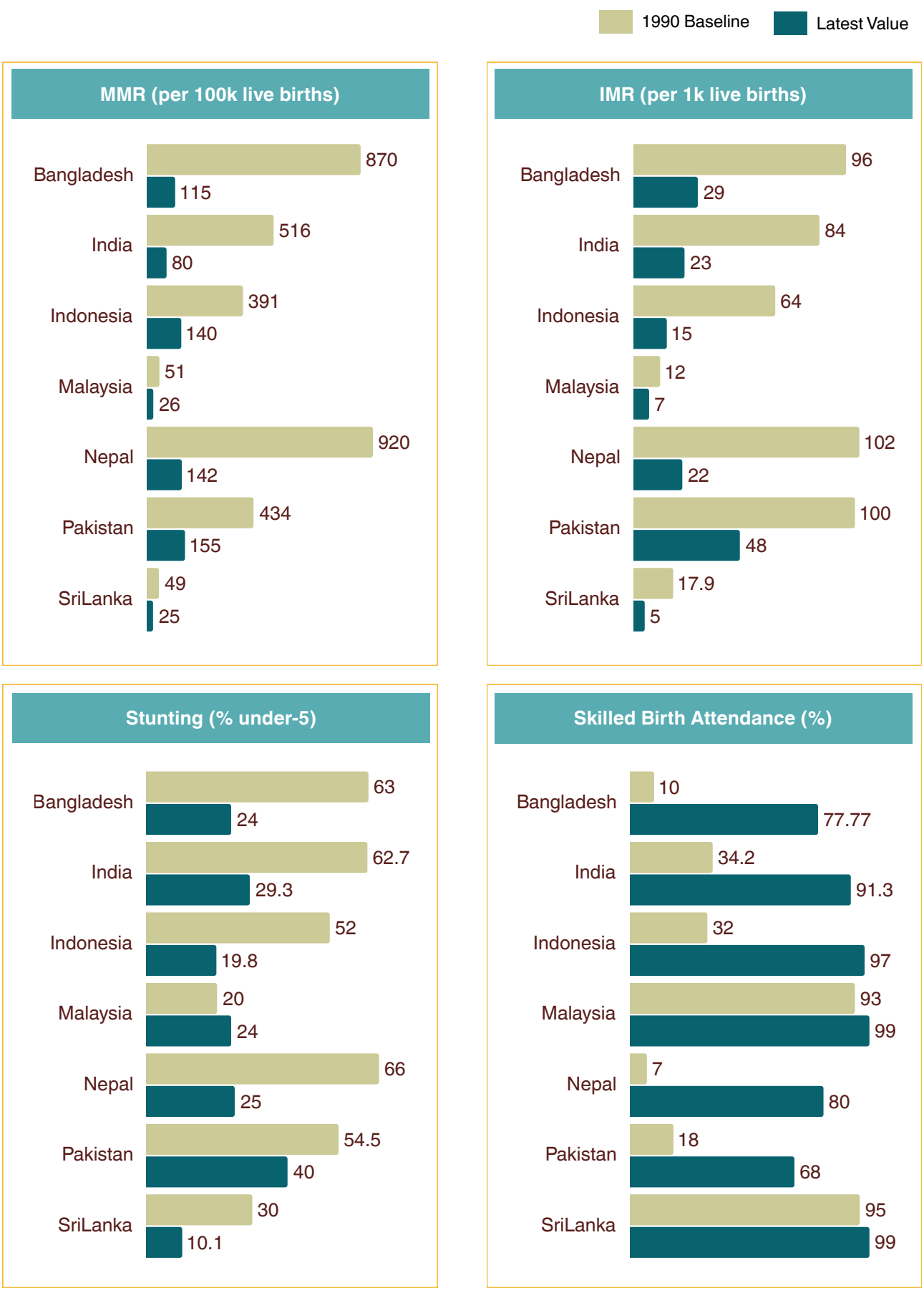
South and Southeast Asia is home to more than one-third of the world's population and has accounted for some of the most significant gains in maternal, newborn, and child health (MNCH) over the past two decades. Across the region, sustained investments in primary healthcare, immunization, skilled birth attendance, nutrition, and maternal health have contributed to substantial declines in maternal, infant, and under-five mortality. However, progress has been uneven. While several countries have approached upper-middle-income health outcomes, others continue to face persistent challenges driven by geographic disparities, unequal access to quality care, workforce constraints, and financing gaps. As countries move beyond expanding coverage toward improving quality and equity, understanding how these gains were achieved has become as important as measuring what was achieved.

This report examines the MNCH trajectories of **Bangladesh**, **India**, **Indonesia**, **Malaysia**, **Nepal**, **Pakistan**, and **Sri Lanka** to identify the policies, delivery models, and institutional reforms that have driven improvements over time. Together, these countries provide a representative cross-section of South and Southeast Asia, encompassing diverse political systems, health system models, and income levels, as well as a range of MNCH outcomes, from regional leaders to countries facing persistent challenges. Rather than identifying a single model for replication, the report seeks to understand the distinct pathways each country followed, the reforms they prioritized, and the implementation strategies that enabled progress under different political, fiscal, and health system contexts.

The analysis focuses on six core indicators: **maternal mortality ratio (MMR)**, measuring maternal deaths per 100,000 live births; **infant mortality rate (IMR)**, deaths before age one per 1,000 live births; **under-five mortality rate (U5MR)**, deaths before age five per 1,000 live births; **stunting**, the proportion of children under five with impaired linear growth; **skilled birth attendance (SBA)**, the proportion of births attended by skilled health personnel; and **institutional deliveries**, the proportion of births occurring in health facilities. These internationally recognized indicators are widely used to monitor MNCH performance and together provide a comprehensive picture of both health outcomes and the accessibility and utilization of essential maternal and child health services. They are examined alongside the major policies, governance reforms, financing mechanisms, community-based interventions, and digital innovations that shaped each country's trajectory, enabling a comparative understanding of how different policy choices, institutional arrangements, and implementation strategies influenced MNCH progress over time.

Drawing on these country analyses, the report identifies the cross-cutting factors that consistently underpin successful MNCH improvements across the region. It also highlights emerging trends, including integrated primary healthcare, digital health, lifecycle approaches to service delivery, community-centered care, and multisectoral coordination, that are reshaping maternal and child health systems and quality of care. Finally recognizing that each country offers distinct strengths and continues to face its own challenges, the report concludes with a regional action agenda that promotes structured knowledge exchange, adaptation of proven practices, and stronger South-South collaboration to accelerate progress in maternal and child health across the region.

MNCH Trajectory Comparison
1990 Baseline to Latest Available (2019-25)



I. Country Profiles

Bangladesh: A Success Story of Community-Based MNCH Architecture

Bangladesh is widely studied as a global success story in maternal mortality reduction. Its MNCH trajectory is anchored by a remarkable 86.7% cut in its MMR since 1990, outpacing its wealthier regional counterparts and representing one of the fastest MMR declines globally within that timeframe.[1] This was followed closely by a sharp 79% decline in U5MR, meeting the country's MDG target for child survival. Conversely, improvements in child nutrition proved more stubborn, with under-5 stunting decreasing by 32 percentage points since 1990. The country owes its successes to its vast and unique system of community-based service delivery, and a cross-sectoral approach cited by WHO, the World Bank, and UNICEF as a model for government-NGO collaboration and demand-side health financing.

A defining feature of Bangladesh's evolution was the gradual transition from task-specific community interventions to a **structured, sector-wide health delivery system**. In the late 1990s, the Government of Bangladesh revolutionized its health governance by adopting a Sector-Wide Approach (SWAp) through successive five-year plans. Prior to that, the country, in partnership with BRAC, pioneered community-based oral rehydration therapy (ORT) in the 1980s by training new mothers to manage childhood diarrheaat home. The initiative contributed to a sharp decline in diarrheal deaths, which at the time accounted for more than a quarter of all deaths among children under five; Bangladesh now has the world's highest ORT usage rate.[2] The strength of vernacular systems for healthcare delivery emerged as the country's biggest learning point in the process.

Launched in 1996, the government's **Community Clinic Program became the structural backbone of Bangladesh's MNCH architecture** thereafter. Reaching more than 50 million beneficiaries today, the program comprises more than 13,500 union-level facilities at walking distance in rural areas providing an integrated continuum of care - combining primary care, family planning, antenatal care (ANC) visits, and nutritional support within a single service platform.[3] The clinics function in close NGO partnership with BRAC's community health workers comprising volunteer Shasthya Shebika and salaried Shasthya Kormi for home visits and referrals. This network - the world's largest NGO-run health system consisting of 100,000 volunteers across 61 districts catering to nearly 80 million people - was key to extending last-mile care to women unlikely to seek formal natal services otherwise, serving as a model for grassroots health volunteerism globally.[4] To respond to a shortage of trained midwives, the government launched its Community Skilled Birth Attendants (CSBA) program in 2003, training up to 7,000 community health workers. However, the program was unable to scale coverage sufficiently due to monitoring limits, ultimately prompting a broader policy shift toward deploying university-certified professional midwives.[5]

> Bangladesh has achieved one of the fastest declines in MMR globally and has also met its U5MR MDG target.

A particularly notable aspect of Bangladesh's trajectory is that it achieved these major health gains under severe fiscal constraints. The country's public health budget has historically hovered around only 2-3% of GDP (**with public spending allocated to health at under 1% of GDP**), among the lowest in South Asia. Rather than relying on heavy capital expenditures, Bangladesh strategically maximized low-cost, high-impact frontline outreach and NGO partnerships to extend service delivery. These sustained investments also coincided with a significant demographic transition. Fertility fell from 4.5 births per woman in 1990 to 2.4 in 2025, while annual population growth declined from 2.0% to 1.2%, gradually reducing the number of pregnancies and births requiring care as service coverage expanded. This transition also reflects broader

1 Maternal mortality ratio (per 100 000 live births), WHO (1990, 2025)
2 Demystifying the Science of Delivery: Learning from how Bangladesh Reduced Child Mortality, World Bank (2015)
3 Community Clinics: Bangladesh Brings Health Care to Doorsteps of Rural People, World Bank (2018)
4 50 years of serving Bangladesh, BRAC (2022)
5 Community based skilled birth attendants programme in Bangladesh; intervention towards improving maternal health, Journal of Asian Midwives (2015)

gains in female education, family planning, and women's empowerment, complementing the country's community-based health system reforms.

Despite its achievements, **Bangladesh faces a new generation of structural challenges alongside disruptions to programmatic continuity caused by recent political upheaval and ongoing power transitions**. Following historic youth protests in 2024, the country experienced a deadly measles outbreak in 2026 due in large part to interruptions in vaccine procurement and routine immunization delivery under the interim government, resulting in nearly 800 mortalities and 120,000 total suspected cases.[6] More generally, **neonatal deaths continue to account for roughly 60% of remaining under-5 mortality**, marking a shift from preventable infections to clinically complex conditions, while under-5 stunting has plateaued since the mid-2010s.[7] Interventions for both lie beyond the scope of basic community-based tools, requiring specialized newborn and obstetric care - such as Special Care Newborn Units (SCANUs), reliable blood supplies, and round-the-clock clinical staffing - that primary clinics lack. Furthermore, complex social determinants like high rates of child marriage continue to weigh on outcomes, while wide geographic and wealth disparities persist; only 14.5% of rural women receive quality care, compared to 27.1% in urban areas, with coverage remaining lowest in the chars (flooded riverine islands), haor wetlands, and the Chittagong Hill Tracts.[8] NGOs have played a key role in expanding MNCH coverage in the chars region amid a worsening climate crisis, with the Friendship NGO operating floating hospitals and boat clinics in flood-affected areas to provide critical primary healthcare and gynecological services.[9]

In response to these obstacles, Bangladesh is pursuing a suite of health system reforms designed to modernize its primary and secondary delivery architecture. To address plateauing neonatal outcomes, the government is deepening its investment in tech-intensive clinical infrastructure by establishing Mother-Special Care Newborn Units (M-SCANUs) at sub-district hospitals, combining specialized clinical hardware with mother-led Kangaroo Mother Care to manage prematurity, asphyxia, and sepsis.[10] Concurrently, to close severe urban-slum infrastructure gaps, the country has been progressing the integration of its primary healthcare systems, such as via the World Bank-supported Urban Primary Health Care Services Project (UPHCSP) which has contracted private NGOs (such as BRAC and Marie Stopes) to operate urban health centers (Nagar Matrisadan) under results-based payment structures tied to verified targets for antenatal visits, skilled birth attendance, and immunizations. Responding to perennial climate shocks particularly in the chars region, Bangladesh has also begun to formalize anticipatory protection of pregnant women into its cyclone preparedness plans.

Underpinning these structural shifts is a sweeping digital transformation mandate, prioritizing unified electronic Shared Health Records (SHR) across rural clinics with a national digital Health card currently being piloted for nation-wide deployment. However, with out-of-pocket health expenditure remaining near 79%[11], sustaining these tech-intensive, hybrid, and digital reforms while bridging geographic quality gaps will require higher public financial commitments and resilient institutional governance.

6 Bangladesh records over 800 confirmed and suspected measles deaths, The Daily Star (2026)
7 Prevalence of stunting (% of children under 5), World Bank (1990-2022)
8 Association of rural-urban place of residence with adequate antenatal care visit in Bangladesh, PLOS Global Public Health (2023)
9 Floating Hospitals Treat Those Impacted by Rising Seas, (National Geographic, 2017)
10 Implementation research to understand the relevance, appropriateness, effectiveness for Mother- Special Care Newborn Unit in Bangladesh, UNICEF (2024)
11 Out-of-pocket expenditure (% of current health expenditure) Bangladesh, World Bank (2023)

Spotlight: Maternal Health Voucher Scheme (MHVS)

Introduced in 2007 as Bangladesh's flagship demand-side financing (DSF) initiative, the Maternal Health Voucher Scheme altered the economics of childbirth for poor rural families. Funded through a hybrid model combining public budget lines with multi-donor basket funds (World Bank, KfW, FCDO), the program established a dual-incentive mechanism: it provided low-income pregnant women with free coverage for antenatal checkups, facility deliveries, emergency C-sections, and transit stipends, while directly reimbursing health facilities and clinicians for each voucher-backed service delivered.

This dual approach successfully drove service utilization, acting as a key catalyst for the country's multi-decade 52 percentage point surge in institutional deliveries and shielding ultra-poor households from catastrophic out-of-pocket health expenditure. However, due to fiscal and administrative constraints, it was never scaled nationally, remaining restricted to 53 out of 492 sub-districts. Furthermore, while the scheme successfully generated high service volume at low-income levels, primary facilities were often overwhelmed and lacked the specialized clinical equipment to handle complex neonatal crises, resulting in more limited direct impact on neonatal mortality rates. Despite these limitations, the scheme serves as an instructive model for low-income countries shifting to demand-side health financing. Under the current 5th HPNSP (2024-2029), the government is addressing these administrative gaps by digitizing the framework into biometric national e-health cards and mobile health wallets.

India: Transforming Maternal and Child Health at Scale

India has made substantial progress in MNCH over the past three decades, transforming from one of the world's highest-burden countries into a lower-middle-income country with steadily improving MNCH outcomes. The country's MMR declined by approximately 85%, while IMR and U5MR fell by roughly 73% and 79%, respectively. Child nutrition also improved considerably, with stunting declining from more than half of children under five in the early 1990s to 29.3% in 2024, although India continues to carry one of the world's largest burdens of child malnutrition. Over the same period, SBA and institutional deliveries rose from ~30% to ~90%, reflecting a fundamental shift toward skilled and facility-based childbirth, drastically reducing home-based deliveries.

India's progress was driven by successive nationwide reforms rather than a single flagship intervention. In the 90s, the government introduced two key programs, Child Survival and Safe Motherhood (CSSM) Programme (1992), and Phase I of the Reproductive and Child Health (RCH) Programme (1997), moving from target-driven demographic metrics to a client-centered, holistic reproductive health framework. These programs **laid the foundation of integrated family welfare and built the early infrastructure of the deployment of the National Rural Health Mission (NRHM)** in 2005, which became a turning point for India's health system. NHRM was later integrated into the broader National Health Mission (NHM) in 2013 with an urban component to extend healthcare facilities to people living in urban slums, along with rural areas. A key defining feature of the NHM was the Accredited Social Health Activist (ASHA) program. Launched in 2006 across 18 priority states, the program expanded nationwide by 2009. ASHAs are an all-female cadre of community health workers who serve as a bridge between households and the formal health system. While classified as volunteers, they receive performance-based incentives and support communities through health awareness, counseling on family planning and safe pregnancy practices, promoting ANC, facilitating institutional deliveries, supporting immunization, and connecting women and children to essential health services. With nearly one million workers, ASHA is the largest government-run CHW program around the world.[1] Alongside ASHAs, Auxiliary Nurse Midwives at facilities and Anganwadi workers at village-level childcare centers, form the backbone of India's community-based MNCH platform, helping extend essential services to rural and marginalized populations.

> India's decline in MMR represents a significant public health success story, alongside its emergence as a global leader in child survival.

India complemented supply-side investments with one of the world's largest demand-side financing initiatives to increase utilization of maternal health services. Through conditional cash transfers under the Janani Suraksha Yojana (JSY) in 2005 and the subsequent expansion of free maternal and newborn care under the Janani Shishu Suraksha Karyakram (JSSK) in 2011, the government sought to reduce financial barriers and encourage women, particularly those from poorer households and high-focus states, to deliver in health facilities.[2] These reforms played a central role in rapidly increasing institutional deliveries and SBA. However, they also exposed longstanding weaknesses on the supply side. As utilization increased, many public facilities struggled with overcrowding, workforce shortages, inconsistent availability of medicines and diagnostics, poor infection control, and variable quality of care, highlighting that **expanding access alone was insufficient to improve maternal and newborn outcomes**.[3]

Nutrition became an increasingly important national priority alongside maternal health. Building on the long-standing Integrated Child Development Services (ICDS) program, India launched POSHAN Abhiyaan in 2018 to improve coordination across nutrition, health, sanitation, and social protection while strengthening growth monitoring, behavior change communication, and digital monitoring systems. More recently, POSHAN 2.0 has sought to further integrate maternal and child nutrition services within the broader primary healthcare system.[4]

1 The Impact of India's ASHA Program on the Utilization of Maternity Services, Human Resources for Health (2019)
2 India's Janani Suraksha Yojana, a Conditional Cash Transfer Programme to Increase Births in Health Facilities: an Impact Evaluation, The Lancet (2010), Janani Shishu Suraksha Karyakaram (JSSK), National Health Mission (2026)
3 Women's experiences of giving birth in healthcare facilities in India -A systematic literature review of qualitative research, Sexual & Reproductive Healthcare (2025)
4 Mission Poshan 2.0 Strengthening India's Nutrition Ecosystem, PIB (2026)

Unlike several neighboring countries, **India's MNCH transition has been financed primarily through domestic public investment rather than external assistance.** Over time, government health expenditure has gradually increased from historically low levels, reaching ~1.5-1.8% of GDP in recent years, with major platforms such as the NHM financed largely through central and state government resources.[5] These sustained investments have coincided with a significant demographic transition, with fertility declining from 4.0 births per woman in 1990 to 2.0 in 2024, while annual population growth more than halved from 2.2% to 0.9%. Together, these trends have eased the pace of growth in demand for MNCH services, although India's sheer population means the health system continues to manage millions of births each year. Large interstate and inter-district differences in fertility also mean that demographic pressures remain concentrated in several higher-burden states. While expanded public programs and financial protection initiatives such as Ayushman Bharat have sought to reduce household costs, out-of-pocket expenditure remains a significant share of total health spending, highlighting continued gaps in financial protection and the need for sustained public investment.

Despite its achievements, **India continues to face significant MNCH challenges, particularly around spatial inequality, quality of care, and health system capacity**.[6] Progress varies substantially across states, with Kerala and Tamil Nadu achieving outcomes comparable to upper-middle-income countries, while several poorer states continue to experience significantly higher maternal mortality, child mortality, and malnutrition. Workforce shortages remain particularly acute in rural areas, where limited availability of physicians, specialists, and female healthcare providers constrains the management of high-risk pregnancies and delivery of comprehensive maternal care. These disparities reflect differences in state-level governance capacity, health financing, infrastructure, and workforce availability. Inequities also persist within states, with poorer households, less educated women, and marginalized communities facing greater barriers to accessing services.

Recognizing these challenges, India is increasingly shifting its focus from expanding service coverage to improving the quality, continuity, and equity of care. Through Ayushman Bharat, the government is transforming existing primary care facilities into Health and Wellness Centres (now Ayushman Arogya Mandirs) that provide a broader package of comprehensive primary healthcare, including MNCH services, while strengthening referral pathways between community, primary, and higher levels of care.[7] This reflects a strategic shift away from vertical disease-specific programs toward more integrated, people-centered service delivery. Alongside these reforms, greater emphasis has been placed on quality assurance, standardized clinical protocols, and strengthening primary care as a means of reducing longstanding disparities in access and outcomes across underserved rural, tribal, and remote areas. At the same time, the Ayushman Bharat Digital Mission (ABDM) is building an interoperable digital health ecosystem centered on digital health IDs and electronic health records, enabling better continuity of care, improved pregnancy tracking, and more timely use of health data for service delivery and program management.[8]

These reforms recognize that India's remaining MNCH challenges are increasingly concentrated on the supply side of the health system. While digital tools, telemedicine, and stronger primary healthcare can improve access and coordination, they cannot fully overcome persistent shortages and uneven distribution of skilled health workers, particularly in rural and high-burden states, nor can they alone address variations in facility readiness and quality of care. Differences in governance capacity across states and health system performance also continue to limit the pace of progress. Going forward, sustaining India's MNCH gains will depend on narrowing geographic inequalities, strengthening the rural health workforce, improving the quality and responsiveness of facility-based care, and ensuring that digital transformation complements, not substitutes for, continued investment in frontline services and health system capacity.

5 Decentralisation and Public Expenditure on Health in India: Learnings from the Fourteenth Finance Commission, Journal of Health Management (2025)
6 Maternal and Reproductive Health in India: Challenges and the Road Ahead, Munich Personal RePEc Archive (2024)
7 Ayushman Arogya Mandir and India's Progress toward Universal Health Coverage: A Narrative Review, Journal of Family Medicine and Primary Care (2026)
8 The Ayushman Bharat Digital Mission (ABDM): making of India's Digital Health Story, CSIT (2023)

Spotlight: Scaling Frontline Health Through the ASHA Program

Launched in 2005 under the National Rural Health Mission, India's Accredited Social Health Activist (ASHA) program exemplifies the country's ability to implement health interventions at extraordinary scale. Today, nearly one million female community health workers serve as the vital link between households and the public health system, making it the world's largest government-led community health worker program. By embedding trusted local women within their own communities, the program has played a pivotal role in expanding utilization of maternal and child health services across a country of more than 1.4 billion people.

The ASHA program demonstrates both the opportunities and trade-offs of delivering health reforms at scale. It has been widely credited with increasing institutional deliveries, ANC, and childhood immunization, particularly among rural and marginalized communities, while providing a scalable model for strengthening community-based primary healthcare.

However, the large-scale implementation of such a program has also exposed systemic weaknesses within the broader health infrastructure. Many public health facilities continue to grapple with workforce shortages, overcrowding, inconsistent quality of care and limited referral capacity. Furthermore, ASHAs face expanding responsibilities, variable training quality and performance-based incentives, which can impact motivation and effectiveness. India’s experience shows that while scaling community-based interventions can rapidly improve access, sustaining these gains necessitates concurrent investments in enhancing the quality, capacity and resilience of the entire health system.

The ASHA program demonstrates the potential of community-based health initiatives, however, sustained impact requires continued system strengthening and improvements in service quality across all levels of care.

Indonesia: Bridging the Gap Between MNCH Access and Outcomes

Indonesia's MNCH story since the 1990s is one of significant but uneven progress relative to its income level. As the largest economy in ASEAN, Indonesia has achieved its child survival goals and built the world's largest single-payer health insurance scheme, however, it consistently underperforms on maternal mortality and nutrition indicators compared to other middle income countries. Since 1990, IMR was cut by 77% to nearly 15 deaths per 1000 births,[1] with a similar 79% decrease in under-5 stunting. However, Indonesia's MMR has lagged behind its broader economic performance, sitting at roughly 140 deaths per 100,000 live births - a figure substantially higher than lower-income regional peers like Bangladesh. This divergence highlights a **persistent "quality-coverage gap," where high institutional birth rates have not fully translated into reduced maternal mortality**.

The modern foundation of Indonesia's maternal care was laid in the early 1990s through a series of dramatic supply-side interventions. At the time, Indonesia relied heavily on the Puskesmas network for primary healthcare - a system of more than 10,300 community health centres established in the 1960s that remains the backbone of service delivery today. Facing an acute deficit of formal care providers in more rural territories, the central government initiated the Bidan di Desa (village midwife) campaign in 1989, which rapidly trained and stationed over 50,000 midwives in remote communities. While this program has since been deprioritized by the government, its massive deployment systematically disassembled the historical reliance on traditional home birth attendants (dukun bayi), successfully shifting the default toward skilled medical personnel. As a cumulative result of several such initiatives, Indonesia made skyrocketing progress on SBA, growing from a mere 32% in 1990 to approximately 97% in 2024.[2] On nutrition, the 2018 National Stunting Convergence Program integrated health, WASH, food security, and social protection across 23 ministries, with district-level convergence targets to combat and reduce child stunting.

Financing reforms played a pivotal role in removing economic barriers to facility-based care. In one of Indonesia's most critical health financing innovations, the government introduced the Jaminan Persalinan (JAMPERSAL) scheme in 2011. The program was designed to eliminate out-of-pocket childbirth costs by offering a completely free package of maternal and neonatal services to any pregnant woman lacking insurance. To ensure safe delivery and avoid bottlenecks, JAMPERSAL leveraged existing health infrastructure and made its funding conditional on mothers giving birth at public health facilities (Puskesmas) or with accredited village midwives (Bidan di Desa).

This initiative served as a pivotal step towards Indonesia's major health system transformation: the 2014 launch of Jaminan Kesehatan Nasional (JKN), a single-payer national health insurance scheme covering up to 98.6% of the population.[3] JKN absorbed JAMPERSAL into its framework, removing upfront fees for prenatal checks, facility deliveries, and emergency C-sections for low-income families. However, despite total health spending rising toward 2.7% of GDP as of 2023,[4] **public health expenditure remains constrained, leaving operational and staffing gaps across primary health centers.** These reforms have also coincided with a gradual demographic transition, with fertility declining from 3.1 births per woman in 1990 to 2.1 in 2024 and annual population growth slowing from 1.8% to 0.8%. Together, these trends have moderated the pace of growth in demand for MNCH services, although Indonesia's vast population and dispersed geography continue to place considerable pressure on the health system.

Despite these gains, Indonesia's central challenge is increasingly one of quality rather than coverage. Like many peers that have adopted community-based health models, the country has largely solved the access challenge with nearly 90% of births now occurring in facilities,[5] yet 140 women still die per 100,000 live births, well above the upper-middle-income country average of approximately 43-56. Although highly accessible, only 65% of the Puskesmas have the required clinical workforce to deliver the full spectrum of MNCH services needed to address these issues.[6]

1 Levels and trends in child mortality, UNICEF (1990-2024)
2 Proportion of births attended by skilled health personnel (%), WHO, (1990-2024)
3 BPJS Kesehatan: 98,62 Persen Penduduk Telah Terdaftar JKN, Kompas (July 2026)
4 Current health expenditure (% of GDP) - Indonesia, World Bank (2023)
5 Hasil Utama SKI 2023 - Badan Kebijakan Pembangunan Kesehatan | BKPK Kemenkes, Kemenkes (2023)
6 Indonesia strengthens health workforce planning through labour market analysis, WHO (2026)

While a centralized national stunting strategy successfully forced under-five stunting rates down to 19.8% by 2024, the country continues to struggle with high rates of child malnutrition. Most recently in 2025, the country introduced an ambitious $15 billion Free Nutritious Meals (Makan Bergizi Gratis, MBG) program for schoolchildren in 26 provinces, reaching up to 41 million of its planned 83 million beneficiaries. However, MBG's rapid scale-up has faced food safety incidents, logistical constraints, uneven delivery capacity and challenges in maintaining consistent nutritional and quality standards.

> Indonesia has recorded the slowest MMR decline relative to its income level, but has still achieved its U5MR SDG target.

The country's archipelagic geography is a key compounding factor for this quality-coverage gap: 17,000 islands, 38 provinces, and 514 districts create enormous variation in service quality, and eastern provinces such as Papua, East Nusa Tenggara, and Maluku record maternal and child mortality several times higher than Java and Bali. These access gaps are exacerbated by disruptions and displacement caused by perennial flooding across islands. Decentralization has deepened variations by creating hundreds of local health authorities with widely differing fiscal capacity, technical expertise, and political commitment to MNCH investment. The rapid expansion of private facilities has further added a governance gap as they handle a large share of institutional deliveries while remaining poorly regulated.

To resolve these governance and operational fragmentation challenges, Indonesia is implementing several structural, digital, and cross-sectoral reforms across its primary health network. Under its newly institutionalized Integrasi Layanan Primer (ILP) framework, the government is adopting a life-cycle approach by reorganizing primary health centers into age-based clinical clusters. **Cluster 2, dedicated to Maternal and Child Health, synchronizes sub-district clinics (Puskesmas), village clinics (Pustu), and neighborhood outposts (Posyandu) into a single continuum tracking mothers and infants from preconception through early childhood**. On stunting, the National Strategy to Accelerate Stunting Prevention (Stranas Stunting) operates multi-sectoral Stunting Reduction Acceleration Teams (TPPS) that coordinate local health, sanitation, and social welfare budgets through mandatory 8 Convergence Actions at the district level,[7] mandating local district heads (Bupati) to lock budgets into specific nutrition targets and driving stunting down from 30% in 2018 to 22% by 2023.[8] This is reinforced by the Program Keluarga Harapan (PKH) conditional cash transfer scheme, which ties monthly payouts for poor mothers to mandatory attendance at Posyandu for growth tracking. Underpinning these service shifts is a digital health transition featuring the ASIK app for frontline health worker reporting and the SatuSehat citizen health dashboard. This digital public infrastructure is paired with an innovative results-based financing approach under the Asian Development Bank's $350 million SEHAT Program, which unlocks loan disbursements against verified antenatal and stunting reduction metrics. Shifting the national focus from expanding insurance coverage toward enforcing strict clinical standards across every island and more targeted maternal and neonatal interventions remains the critical next frontier for Indonesia's MNCH policy.

Spotlight: The Village Midwife Campaign (Bedan di Desa)

In 1989, Indonesia initiated the Bidan di Desa (Village Midwife) Campaign in a bid to urgently reduce maternal mortality in rural areas - a then-unprecedented health-related human resource mobilization in the region. Fifty-thousand registered nurses were selected for an accelerated, intensive 1-year midwifery certification program, with at least one deployed per village nationwide. Prior to that, rural Indonesian women relied almost exclusively on traditional, untrained birth healers (dukun bayi) for home deliveries.

The campaign supported Indonesia in boosting skilled birth attendance from a mere 32% in 1990 to approximately 97% in 2024. In addition to deliveries, midwives were able to identify complications, make timely referrals, and facilitate access to hospitals for obstetric emergencies. This massive deployment systematically and successfully shifted the cultural default toward skilled medical personnel and encouraging health-seeking attitudes among rural families.

While the program has been deprioritized by recent government, what makes its achievements most notable is its ability to leverage vernacular systems of care already existent and embedded within the archipelago. Though successful, the campaign remains limited in connecting midwife referrals to specialized care that can further mitigate Indonesia's persistently high MMR.

7 A Policy Paper on Integrated Nutrition Strategies for Stunting Reduction, Save The Children (2024)
8 Prevalence of stunting, height for age (% of children under 5) - Indonesia, World Bank (2018-2023)

Malaysia: Driving MNCH Gains Through Systemic Change

Malaysia is widely cited as an MNCH success story in Asia, demonstrating how sustained investments in primary healthcare can produce lasting improvements in health outcomes. Since its independence in 1957, the country has reduced its MMR from approximately 540 deaths per 100,000 live births to around 24 by 2023, while IMR and U5MR have fallen to single-digit levels. Over the same period, SBA and institutional deliveries expanded to ~99%, reflecting the successful transition from home-based to facility-based care. Unlike most other MNCH indicators, however, stunting has remained persistently high at around ~24%, highlighting enduring challenges related to nutrition and inequitable access to services.

A defining feature of Malaysia's success was the **gradual development of a professional midwifery system alongside a government-led expansion of the MNCH program**. The first phase (1945-1956), beginning in the late colonial period, focused on establishing the legal and institutional foundations of the profession through the Midwives Act, certification requirements, and the expansion of urban MNCH clinics. Following independence, the second phase (1957-1975) shifted attention to rural populations, where maternal and child mortality was highest. The government rapidly expanded a network of midwifery clinics, supported by health centers and sub-centers, while providing free antenatal, delivery, and postnatal care. Government midwives attended home births, conducted community outreach, and helped bring essential maternal and child health services closer to underserved communities. The third phase (1976-1989) focused on strengthening quality and professional standards through the certification of nurse-midwives and public health nurses, alongside the introduction of standardized clinical protocols. By the end of this period, SBA had exceeded 90%, laying the foundation for near-universal institutional deliveries and sustained reductions in maternal mortality.[1]

Malaysia also adopted an integrated primary healthcare model that combined maternal health, child health, nutrition, immunization, disease control, and family planning services within a single service delivery platform.[2] Family planning was incorporated into maternal and child health programming, helping reduce high-risk pregnancies and improve birth spacing. At the same time, strong investments in immunization, communicable disease control, and child health services contributed to substantial reductions in infant and under-five mortality. Rather than relying on isolated interventions, Malaysia pursued a continuum-of-care approach that linked services across the life cycle and reinforced gains across multiple health indicators.

A particularly notable feature of Malaysia's journey is that it **achieved these gains without exceptionally high levels of health expenditure.** Healthcare was financed primarily through general taxation - a mechanism heavily fortified by the nation's mid-century economic transition from primary commodity reliance to an export-driven industrial powerhouse, which vastly expanded the government's fiscal capacity. Public resources derived from this broadened tax base were strategically directed toward primary healthcare rural outreach, and MNCH services in underserved communities. By reducing financial barriers to care and expanding access to frontline services, Malaysia was able to achieve substantial reductions in maternal and child mortality despite total health expenditure remaining at approximately 2-3% of GDP throughout much of its MNCH transition, well below the average for upper-middle-income countries. This experience underscores the importance of strategic resource allocation and strong service delivery systems in improving health outcomes.

Broader socioeconomic development reinforced these health sector interventions. Rising female educational attainment, declining fertility rates, improvements in transport infrastructure, and expanded access to water and sanitation created an enabling environment that amplified the impact of health policies. Fertility fell from 3.3 births per woman in 1990 to 1.5 in 2024, while annual population growth slowed from 2.9% to 1.2%, reducing the number of pregnancies and births requiring care over time. Together with sustained investments in the health system, this enabled Malaysia to progressively shift its focus from expanding coverage toward improving the quality of care and responding to the needs of an ageing population.

1 Missing Midwifery: Relevance for Contemporary Challenges in Maternal Health, Indian Journal of Community Medicine (2013)
2 40 years of Alma Ata Malaysia, Primary Healthcare Research and Development (2020)

Malaysia has achieved near-universal skilled birth attendance and its U5MR SDG target, but continues to struggle with child stunting.

Despite its achievements, Malaysia faces a new generation of challenges. While maternal and child mortality has declined substantially, progress has slowed in recent decades and significant disparities persist across states and population groups. Underserved states such as Sabah continue to record poorer outcomes than the national average, highlighting the need to improve the quality, equity, and responsiveness of care rather than simply expand coverage. In response, Malaysia is pursuing several next-generation health system reforms. To improve outcomes for high-risk mothers and newborns, it has expanded technology-intensive clinical infrastructure, including specialized Level III Neonatal Intensive Care Units (NICUs), advanced neonatal equipment, and tele-NICU consultations linking district hospitals with tertiary specialists. At the same time, persistent child stunting, rising from 20% in 2000 to 24% in 2025 despite broader improvements in maternal and child health, has prompted a whole-of-government response through the National Strategic Plan to Address the Problem of Stunting in Children, bringing together the health, education, women, and family sectors to deliver coordinated nutrition and community interventions and reducing stunting to 14.2% by 2030.

Digital transformation has also emerged as a central pillar of Malaysia's health system strategy, driven by the need to improve efficiency and contain rising healthcare costs amid growing fiscal pressures. Through its "One Citizen, One Record" initiative, the government aims to establish a unified national electronic medical record system by 2029, expanding cloud-based digital infrastructure across more than 2,000 primary healthcare facilities and adopting international interoperability standards. By enabling providers to access a patient's complete medical history across the public health system, the reform seeks to reduce unnecessary duplication of tests, referrals, and treatments, optimize resource allocation, and improve continuity of care. However, with public health spending remaining at around 4% of GDP, below the WHO-recommended 7%, sustaining these reforms will require continued investment alongside stronger institutional capacity. As Malaysia's population ages and the burden of non-communicable diseases grows, the country's next phase of health reform will increasingly focus on sustaining high-quality, equitable, and financially resilient health systems.

Spotlight: Confidential Enquiry into Maternal Deaths (CEMD)

The CEMD is a non-punitive review mechanism established by the Malaysian government to systematically analyze all maternal deaths and identify avoidable factors contributing to mortality. Introduced in 1991, it is an example of Malaysia’s strong political commitment to reducing maternal mortality through audits, alongside a growing emphasis on system-wide quality improvement in MNCH services.

It identifies gaps in maternal care and translates its findings into actionable recommendations to improve health services. It is embedded within the existing health system, strengthening rather than replacing existing structures. Its success has been driven by multi-sectoral engagement in maternal health, continuous professional development of health personnel, sustained investment in health facilities and workforce capacity, and a systems-based approach to patient safety. CEMD findings are integrated into national key performance indicators and clinical targets, ensuring that lessons from maternal deaths directly inform policy, practice, and service delivery improvements. Over the years, these lessons have contributed to the introduction of targeted training programs, improved access to essential medicines, strengthened clinical protocols, and other structural reforms.

Nepal: From High-Burden Outlier to MNCH Reform Leader

Nepal is widely regarded as one of the strongest MNCH success stories among low-income countries. Despite challenging geography, prolonged political instability, and relatively low health spending, the country achieved some of the world's fastest improvements in maternal and child survival. MMR, IMR, and U5MR declined by ~80% from 1990 to 2024, while stunting fell from ~66% in 1996 to 25% in 2022, making Nepal a globally recognized nutrition success story. Over the same period, SBA and institutional delivery increased from 7% in 1990 to ~80% by 2022, reflecting a dramatic shift from home births to attended and facility-based deliveries.

Nepal has achieved the fastest reduction in MMR in South Asia and is a globally cited exemplar. It also achieved its U5MR MDG target ahead of schedule

A defining feature of Nepal's success was the 1991 **National Health Policy that identified maternal health as a national priority** and was followed by a series of reforms focused on expanding access to emergency obstetric care and skilled delivery services. Following that, the National Safe Motherhood and Newborn Health Long-Term Plan (2002-2017) sought to establish basic and comprehensive emergency obstetric care services across all districts, while the National Policy on Skilled Birth Attendants (2006) accelerated the training and deployment of skilled personnel.[1] Together, these reforms significantly expanded access to quality maternal healthcare, particularly in rural areas where mortality burdens were the highest.

The Female Community Health Volunteer (FCHV) program formed the core of Nepal's progress. Introduced in the late 1980s and scaled nationally by the early 1990s, the program grew to more than 50,000 volunteers covering communities across the country with remuneration in allowances and in-kind support instead of fixed salaries. Initially focused on family planning, FCHVs gradually assumed a broader MNCH role, conducting mothers' group meetings, promoting ANC and immunization, supporting nutrition interventions, identifying high-risk pregnancies, and referring women to health facilities.[2] By embedding trusted female volunteers within communities, Nepal sought to address social, geographic, and informational barriers that often prevent women from accessing maternal and child health services.

Nepal particularly focused on introducing evidence-based reforms. **Research had shown that transportation costs and financial barriers were major reasons women continued to deliver at home**. Therefore, the government introduced the Safe Delivery Incentive Program (SDIP) (now known as Aama Program) in 2005 to provide cash incentives for facility-based deliveries. The program, funded by both the government and international donors, aimed to increase demand for institutional childbirth while simultaneously expanding the availability of birthing services. While the program generated greater benefits for women living in geographically accessible areas compared to mountainous regions, this combination of demand-side financing and rapid facility expansion widely contributed to revamping Nepal's MNCH landscape.[3] Building on the Aama Program, Nepal also introduced the National Health Insurance Program in 2016 to expand financial protection and reduce out-of-pocket spending through a government-financed insurance scheme. Although the program represents an important step toward universal health coverage, implementation has been constrained by low enrollment, poor renewal rates, and financing challenges.[4]

While Nepal's MNCH trajectory is a celebrated success story of low-cost primary healthcare delivery, the macroeconomic picture reveals a complex funding structure. Government public health expenditure was severely limited, lingering between ~0.5% and ~1.5% of GDP from 2000 to 2020. The gap left by low state investment was bridged by a unified framework of international development partners and, heavily, by out-of-pocket spending from households. Therefore, Nepal's breakthrough was not achieved in a funding vacuum, but rather by precisely steering available donor resources toward exceptionally cost-effective programs like FCHVs and free delivery schemes. These investments unfolded alongside the region's fastest demographic

1 Nepal's Story: Understanding Improvements in Maternal Health, ODI (2013)
2 Female Health Volunteers of Nepal: The Backbone of Health Care, The Lancet (2019)
3 Incentivizing universal safe delivery in Nepal: 10 years of experience, Health Policy and Planning (2017)
4 Nepal's Health Insurance Program: Challenges and Early Impacts, CUNY (2025)

transition, with fertility falling by over 60% from 5.2 births per woman in 1990 to 2.0 in 2024, while annual population growth declined from 2.4% to slight population decline (-0.1%). Together, these trends reduced the number of pregnancies and births requiring care over time, reinforcing Nepal's community-based approach to expanding MNCH services.

Despite its remarkable achievements, Nepal faces a new generation of MNCH challenges. **Maternal mortality remains well above the SDG target**, and progress has slowed compared to earlier decades, with newborn survival emerging as a persistent concern. Geographic inequities also remain pronounced, as remote mountain districts and poorer provinces continue to record worse outcomes than more accessible urban and hill regions. Out-of-pocket expenditure still accounts for more than half of total health spending, while the National Health Insurance Program faces challenges related to low enrollment, poor renewal rates, and long-term financial sustainability. At the same time, the FCHV program is under increasing strain as volunteers shoulder expanding responsibilities with limited incentives and support, while health budget utilization remains weak.

However, alongside these challenges, Nepal is increasingly prioritizing quality of care, digital health, and continuity of service delivery. The Ministry of Health is rolling out the Integrated Maternal and Child Health Handbook, creating a unified lifecycle record that links maternal and child health information across community and facility levels while strengthening continuity of care. Nepal is also investing in the quality of emergency obstetric and newborn care, expanding digital health information systems, and continuing to leverage partnerships with development organizations to strengthen service delivery in underserved areas.

Together, these reforms reflect a gradual shift from expanding service coverage toward strengthening quality, continuity of care, and health system resilience. Going forward, Nepal's challenge will be to translate these emerging reforms into sustained improvements by reducing geographic disparities, strengthening health financing, improving newborn survival, and preserving the community-based systems that have underpinned its remarkable MNCH progress.

Spotlight: Safe Delivery Incentive Program (Aama Program)

One of the most influential drivers of Nepal's MNCH success was the Aama Program, a maternal health initiative that combined cash incentives, free delivery services, and expanded access to birthing facilities. Introduced in 2005 as the Safe Delivery Incentive Program, it tackled one of the biggest barriers to safe childbirth in Nepal: the cost of reaching and delivering in a health facility.

The program provided financial incentives for women to give birth in health facilities while simultaneously expanding birthing centres and emergency obstetric care services nationwide. Its impact was amplified by Nepal's network of more than 50,000 FCHVs, who identified pregnant women, promoted antenatal care, and encouraged facility-based deliveries. As a result, skilled birth attendance increased from 26% in 2006 to ~77% by 2019, while institutional deliveries became the norm across much of the country.

Although implementation challenges remain, including funding delays, geographic inequities, and service quality gaps, the program demonstrates that targeted financial incentives are most effective when paired with strong community outreach and sustained investments in primary healthcare. The Aama Program is now widely regarded as one of South Asia's most successful maternal health interventions.

Pakistan: Advancing MNCH Access Amid Persistent Challenges

Over the past three decades, Pakistan's MNCH trajectory has transitioned from widespread crisis toward measurable progress, though its overall trajectory remains among the most constrained in South Asia. In the early 1990s, its MMR stood at ~434 per 100,000 live births and IMR at ~100 per 1,000, with SBA at just 18%. By the 2020s, these figures saw marked improvement: SBA increased to 69%, and institutional deliveries reached 74%. Despite this progress, Pakistan remains far from its SDG targets: stunting has declined only marginally over three decades while its MMR continues to sit at roughly 155 per 100,000 live births - more than double the SDG target of 70.

Pakistan entered the 1990s with an MNCH system defined by an absence of skilled care, widespread reliance on unattended home deliveries, and severe primary care deficits. Most births were managed by traditional birth attendants lacking the clinical training or equipment required to manage severe complications such as obstetric hemorrhage, eclampsia, sepsis, and obstructed labor. **The first major structural response came in 1994 with the launch of the Lady Health Worker (LHW) Program**, which recruited and trained local women to deliver essential antenatal advice, family planning, immunizations, and hospital referrals directly to underserved households. Building on this frontline foundation, the National MNCH Program introduced Community Midwives (CMWs) in the mid-2000s, standardized Emergency Obstetric and Newborn Care (EmONC) guidelines, and rolled out Integrated Management of Neonatal and Childhood Illness (IMNCI) protocols across basic health units.[1] After devolution, Punjab's IRMNCH Program became the strongest subnational model, integrating MNCH, nutrition, family planning, and 24/7 service provision into a single provincial framework.[2] Expanded immunization coverage - rising from approximately 35% in 1990-91 to nearly 77% by 2022 - further contributed to declining infant and child mortality.[3]

These service expansion efforts have operated within a highly constrained macro-fiscal environment and routinely shifting administrative structures. **Pakistan's public health spending has remained below 1% of GDP for much of the past decade**, placing severe financial limits on rural health infrastructure, frontline staffing, and essential medicine supplies. This persistent underfunding made Pakistan's MNCH architecture heavily reliant on external development donors, whose program-specific funding streams expanded access but often created vertical silos that were poorly integrated into routine government operations. The administrative landscape was further reshaped by the 18th Constitutional Amendment in 2010, which devolved healthcare management entirely to the provinces. While devolution enabled tailored subnational strategies, it also led to pronounced variations in planning capacity, resource allocation, and implementation across regional governments.

Socioeconomic barriers and clinical quality mismatches continue to impede faster reductions in mortality, worsened seasonally and subregionally by climate shocks like supercharged fooding. Broad geographic and wealth disparities mean that SBA has reached 84% in urban areas compared to 63% in rural communities, and stands at 94% among women with higher education versus 56% among those without formal schooling,[4] with provinces like Balochistan recording far higher maternal death rates than Punjab.[5] Cultural factors, including restrictions on female mobility and a low national contraceptive prevalence rate (~34%), perpetuate a cycle of high-risk, closely spaced pregnancies, while chronic child malnutrition - marked by stunting (40%), wasting (17.7%), and anemia (41%) - undermines early childhood survival.[6] Although fertility has declined substantially, from 6.4 births per woman in 1990 to 3.5 in 2024, **Pakistan still has the highest fertility rate and population growth among the countries examined**. Continued demographic momentum, with annual population growth remaining 1.6%, places sustained pressure on health financing, infrastructure, and the frontline workforce. Since primary facilities and referral hospitals frequently face shortages of emergency blood supplies, trained night-shift clinicians, and functional transport, increased facility deliveries have not consistently translated into lower neonatal mortality.

1 Reproductive, maternal, newborn, and child health in Pakistan, The Lancet (2013)
2 Punjab Integrated Reproductive, Maternal, Newborn, Child Health and Nutrition Programme, DG Health Services Punjab
3 Immunization for Pakistan's Healthy Future, World Bank (2021)
4 Pakistan Demographic and Health Survey 2017-2018, National Institute of Population Studies (2019)
5 Pakistan Maternal Mortality Survey 2019, National Institute of Population Studies (2020)
6 Pakistan Maternal Mortality Survey 2019, National Institute of Population Studies (2020)

Pakistan has made gains in maternal and child mortality, but preventable child mortality remains substantial. One in three children under five remains stunted.

To tackle these structural bottlenecks, provincial health authorities are implementing several updated service delivery, primary health care integrations, and technological investments. Under the provincial rollouts of the Universal Health Coverage (UHC) Benefit Package, rural Basic Health Units are being reorganized into 24/7 primary care hubs that integrate previously separate family planning, immunization, and prenatal services, linking community-based LHWs directly with clinical referral centers. The government is also working to strengthen nutrition-sensitive social protection by integrating maternal and child nutrition interventions into conditional cash transfer programs, reinforcing the role of social assistance in improving early-life health outcomes. Simultaneously, digitalization of health systems has emerged as a key government priority: public insurance initiatives like the Sehat Sahulat Program and private platforms like Sehat Kahani use biometric verification and electronic claims processing to lower financial barriers for low-income mothers, while the National Digital Health Framework is deploying electronic health records and mobile tracking tools to monitor high-risk pregnancies. In parallel, provincial health departments in Punjab and Sindh are leaning toward advanced clinical infrastructure, introducing portable AI-driven ultrasound devices into frontline clinics, bringing point-of-care diagnostic imaging closer to rural communities to accelerate the identification and referral of high-risk pregnancies.

Sustaining these integrated, digital, and diagnostic initiatives will require Pakistan to increase its domestic financial allocations for public health while strengthening coordination across devolved provincial structures. As the country works to bridge the divide between basic facility coverage and specialized clinical execution, improving the reliability and quality of emergency obstetric and newborn care will remain central to lowering preventable maternal and neonatal deaths.

Spotlight: Lady Health Worker Program

Launched in 1994, Pakistan's LHW Program was one of the first large-scale efforts in South Asia to bring maternal and child healthcare directly into communities. At a time when most births took place at home and many women had limited access to formal healthcare, the program recruited and trained local women to provide family planning counseling, maternal and child health education, immunization support, basic ANC, PNC, and referrals. The program was designed around a simple but important insight: women were more likely to access health services if those services were delivered by trusted female workers from within their own communities.

At its peak, the program deployed more than 100,000 women across the country, with each LHW typically responsible for a defined catchment population and serving as a bridge between households and the formal primary healthcare system. By bringing services and health information directly to women, particularly in rural and underserved communities, LHWs helped expand access to family planning, maternal and child health services, and preventive care. The program also demonstrated the broader value of community-based female health workers in settings where mobility constraints, gender norms, and distance continue to limit women's access to formal facilities.

Over time, the LHW program has come under strain as responsibilities expanded, training became increasingly uneven, and frontline workers were stretched across multiple health campaigns. The 18th Constitutional Amendment further fragmented service delivery, resulting in wide variations in provincial capacity, planning, financing, and implementation. Nonetheless, the program has remained the bedrock of Pakistan's community-based MNCH system and the target of new reforms, continuing to expand access to preventative health services for millions of women and children.

Sri Lanka: The Region's Foundational MNCH Exemplar

Sri Lanka's MNCH trajectory is one of South Asia's earliest and strongest public health success stories. Sri Lanka's progress was built early through sustained state investment in free healthcare, female education, trained midwives, and facility-based delivery. By the 1990s, Sri Lanka was already well ahead of most regional peers. Today, coverage is nearly universal: the Family Health Bureau reports SBA and institutional delivery both at 99.9% since 2019, while MMR stands at 25 deaths per 100,000 live births.[1] Overall, Sri Lanka is best understood not as a recent turnaround story, but as an early public-health state that translated preventive care, community outreach, and hospital delivery into sustained MNCH gains over more than a century.

Sri Lanka's success was rooted in early, deliberate investment in community and facility infrastructure. The Kalutara Health Unit, established in 1926, pioneered Sri Lanka's Public Health Midwife (PHM) model. PHMs were government-employed female health workers assigned to defined catchment areas to register pregnant women, conduct antenatal home visits, provide postnatal follow-up, and refer women to health facilities for delivery.[2] This community health platform was paired with targeted public investment in hospital infrastructure, allowing Sri Lanka to expand obstetric care nationwide and actively promote hospital-based childbirth from the 1950s onward. By the 1970s, institutional delivery had become nearly universal, reflecting a deliberate policy of investing simultaneously in preventive community services and curative facility-based care. The creation of the Family Health Bureau in 1968 institutionalized this dual model - community outreach through PHMs feeding into a well-resourced hospital system - as a nationally coordinated function.[3] Rather than relying on traditional birth attendants, Sri Lanka shifted deliveries to hospitals and maternity facilities while maintaining PHM-led community follow-ups before and after birth. **By 2016, nearly all births were attended by skilled providers in health facilities, and the country has since sustained high levels of antenatal home visits and clinic attendance**. Official data from 2023 indicate that this continuum of care, from the household to the health facility, remains a defining feature of Sri Lanka's MNCH system. This same community platform has been monumental in improving child health through routine immunization. PHMs have increasingly supported EPI coverage, contributing to Sri Lanka's elimination of polio (2014), measles (2019), and congenital rubella (2020).

> Sri Lanka has sustained near-universal coverage of skilled birth attendance and institutional delivery from an already high baseline, making it a regional benchmark.

On the demand side, Sri Lanka's near-universal female literacy rate reinforced these supply-side investments. High female literacy, combined with free public education and a culture of institutional delivery normalized well before most regional peers, created strong demand-side uptake for the services the state provided. Continuous incremental learning also played a role: Sri Lanka's approach has been characterized by iterative quality improvement - reviewing errors, particularly in maternal health, and adjusting systems accordingly - rather than episodic reform. This is also reflected in the low fertility rate, declining from 2.5 births per woman in 1990 to 2.0 in 2024, with the annual population growth shifting to -0.7%. With demographic pressures largely stabilized, Sri Lanka has increasingly been able to focus its MNCH agenda on improving the quality, integration, and resilience of care rather than expanding service coverage.

What makes these achievements particularly remarkable is that they were **sustained with relatively modest public health expenditure financed predominantly through domestic public revenues rather than external aid**. Government health spending has remained at ~1.5% of GDP for much of the past two decades, yet Sri Lanka has consistently delivered exceptional MNCH outcomes while maintaining comparatively low out-of-pocket spending and strong financial protection. Even compared with several

1 Annual Health Bulletin-RHMIS data (2022-2023), Ministry of Health, Sri Lanka, Sri Lanka Demographic and Health Survey 2016, Department of Census and Statistics Sri Lanka (2017)
2 PHM Training, Provincial Health Training Centre, Sri Lanka; Strengthening Primary Health Care Through Community Health Workers in South Asia, Lancet Regional Health - Southeast Asia (2024)
3 Maternal Health in Sri Lanka: 75 Years of National Commitment Towards Excellence, BJOG (2023)

higher-spending health systems, Sri Lanka has achieved comparable, or better, health outcomes at a fraction of the cost.[4] Equally notable, **these gains were largely sustained throughout the country's prolonged civil conflict (1983-2009), which placed significant strain on public resources and displaced large populations**, underscoring the resilience of Sri Lanka's public health institutions.

Building on decades of progress, Sri Lanka is increasingly shifting its focus from expanding access to strengthening the quality, integration, and resilience of its primary healthcare system. The country's 2026-2035 National Health Policy advances a state-led integrated primary healthcare model centered on family medicine.[5] This complements the National Nutrition Policy (2021-2030), which similarly frames nutrition as a life-cycle, multisectoral priority. Public Health Midwives remain the backbone of this integrated lifecycle approach, linking household registration, antenatal and postnatal care, institutional delivery, child health, nutrition, immunization, and family planning through continuous community-based follow-up. The country has also leveraged its Public Health Midwives network to achieve significant success in incorporating climate adaptation into its MNCH delivery systems in a way that is continuous instead of ad-hoc. In parallel, Sri Lanka has laid the groundwork for a National Electronic Health Record and Digital Health Exchange, building on established platforms such as the electronic Reproductive Health Management Information System (eRHMIS) and newer components including the Healthcare Facility Registry, Healthcare Professional Registry, and Digital Health Atlas. However, a comprehensive, interoperable EHR has not yet been fully rolled out and remains a key implementation opportunity. Rather than creating parallel digital systems, the government's stated approach is to strengthen interoperability and continuity of care by integrating digital tools into its long-established public health institutions, in support of lifelong, citizen-centered care once unified digital health records are fully implemented.[6]

Despite these reforms, **Sri Lanka's next challenge is improving quality and resilience rather than expanding access.** Nutrition has emerged as a growing concern over the last few years. Although stunting declined substantially over the past three decades, both stunting and underweight prevalence increased after 2021, reflecting the impact of the 2022 economic crisis on household food security, medical supply chains, and broader health system resilience. School closures and the loss of school meal programs during the crisis also contributed to rising child malnutrition, as documented in UNICEF's 2022 and 2023 Humanitarian Action for Children appeals for Sri Lanka.[7] Persistent inequities also remain across poorer districts, estate-sector communities, and vulnerable households. Sri Lanka's future challenge will be to sustain the institutional foundations that drove its success while improving quality of care, strengthening newborn survival, addressing nutritional setbacks, and protecting maternal and child health gains from future economic and fiscal shocks.

Spotlight: Maternal Death Surveillance and Response System (MDSR)

Established in 1981 and made mandatory in 1985, Sri Lanka's MDSR system is one of the longest-running and most comprehensive of its kind in the developing world. The system is designed around a simple principle: every maternal death must be identified, reviewed, and used to improve care. Through the Family Health Bureau, every maternal death in the country - in a facility or in the community - triggers a structured investigation: field staff conduct verbal autopsies within 14 days, facility-based multidisciplinary teams review clinical management, and findings are escalated to regional and national level for systemic action.

The system has been recognized globally as a model for turning maternal mortality from a statistic into a quality-improvement mechanism. Sri Lanka's MMR fell from 1,694 per 100,000 live births in 1947 to under 40 by the early 2000s - a reduction achieved in part because every death generated a lesson that fed back into the system.

4 Sri Lanka: Achieving Pro-Poor Universal Health Coverage Without Health Financing Reforms, World Bank (2018)
5 National Policy on Health and Wellbeing Sri Lanka, 2026-2035, Ministry of Health and Mass Media (2026)
6 Sri Lanka Digital Health Blueprint, Ministry of Health (2023)
7 Humanitarian Action for Children, UNICEF (2022), Humanitarian Action for Children, UNICEF (2023)

II. Cross-cutting Success Factors

The seven countries in this report arrived at their current MNCH positions through different political systems, income levels, and institutional histories. However, their trajectories collectively reveal a consistent pattern: the countries that improved fastest and most durably did not necessarily design better programs, but better institutions to carry those programs through political transitions, fiscal pressures, and the inevitable disruptions of governance over time. Six factors explain most of the variation.

1. Health Financing and Allocation to Primary Health Care

Cross-country evidence suggests that health spending alone does not determine MNCH outcomes. Countries such as Malaysia, Sri Lanka and Bangladesh achieved substantial reductions in MMR, IMR, and U5MR despite relatively modest levels of health expenditure. Their success was driven by sustained investments in primary healthcare, SBA, preventive services and community-based delivery. India similarly demonstrates how strategic investments in primary healthcare, community-based delivery, and domestic public systems can achieve substantial MNCH gains even without high levels of external financing. The evidence indicates that "where" countries spend is often more important than "how much" they spend.

However, the comparison also suggests that targeting cannot fully compensate for chronically inadequate financing. Pakistan, with government health expenditure remaining below 1% of GDP for much of the past decade, illustrates the limits of low spending: persistent resource constraints have weakened frontline services, workforce capacity, supply chains and program implementation, contributing to limited progress on MNCH outcomes. Nepal, meanwhile, demonstrates that sustaining earlier gains increasingly requires stronger domestic financing and financial protection alongside continued investments in primary care.

Taken together, the evidence points to two complementary lessons: health financing is most effective when resources are prioritized toward primary and preventive care, but countries must also maintain a minimum level of sustained public investment to ensure that essential health systems and frontline services can function reliably.

2. Institutionalization of Births and Skilled Birth Attendance

Across the seven countries, improvements in maternal health outcomes are broadly associated with a transition toward higher institutional delivery and SBA. While this does not establish a causal relationship, comparative patterns consistently show that countries with stronger gains in maternal outcomes have also expanded facility-based births as part of broader health system reforms. At the same time, the evidence reflects an important caveat: institutional delivery alone is not sufficient. Its effectiveness depends on the quality and readiness of care within facilities, including staffing, clinical capacity, and supply systems.

Sri Lanka and Malaysia both achieved near-universal institutional delivery and SBA earlier than their peers, sustaining MNCH improvement trajectories over subsequent decades. Nepal created a coordinated transition, where demand-side incentives under the Safe Delivery Incentive Program were matched with supply-side expansion of birthing centers. Bangladesh followed a different pathway, relying on community-based outreach and household engagement rather than financial incentives, while still achieving gradual increases in facility births.

India, Indonesia and Pakistan highlight the limits of access expansion without equivalent improvements in quality. India expanded institutional deliveries through large-scale demand-side financing, but the resulting rise in utilization exposed supply-side gaps and the need to balance access expansion with quality improvements. In Indonesia, institutional delivery rose sharply, however, reductions in MMR remained relatively modest, reflecting gaps in facility-level readiness under health insurance programs. Pakistan shows a similar pattern, with SBA increasing from 18% to 68%, but weaker-than-expected improvements in outcomes, pointing to persistent service delivery constraints. Overall, the comparative evidence suggests that institutional delivery is most effective when embedded within broader system strengthening, particularly improvements in quality of care at the point of service delivery.

3. Community Health Worker Programs

All seven countries have relied extensively on CHWs to expand access to primary healthcare, particularly for MNCH. However, regional experience suggests that effectiveness depends less on whether CHWs are volunteers or paid workers than on whether their responsibilities are matched by appropriate incentives, supervision, training, and institutional support.

India's ASHA and Nepal's FCHV networks demonstrate that volunteer models can be highly effective for community mobilization, health promotion, and referral, but can face growing sustainability concerns as workloads expand without proportional support. Bangladesh's hybrid community health system combines volunteer Shasthya Shebika with paid Shasthya Kormi, enabling broad community outreach while maintaining stronger technical supervision and continuity of service delivery. Indonesia's integrated model similarly pairs volunteer Posyandu cadres with salaried professionals at Puskesmas, successfully linking community engagement with facility-based care and supporting the national rollout of integrated primary healthcare.

At the other end of the spectrum, Sri Lanka's PHMs and Malaysia's community nursing workforce are fully salaried public employees, providing high levels of continuity, accountability, and clinical quality through strong government oversight. Pakistan's LHW Program, while one of the region's largest salaried CHW programs, demonstrates that remuneration alone is insufficient; delayed payments, increasing workloads, inconsistent supervision, and limited career progression have contributed to uneven performance across districts.

Across the countries examined in this report, the evidence suggests that volunteer models remain effective for prevention and community engagement, while expanded clinical responsibilities are increasingly associated with hybrid or professionalized cadres supported by predictable remuneration, structured supervision, and institutional integration. However, the appropriate division of responsibilities varies by country context, health system, and existing community health workforce model.

4. Demand Generation and Fiscal Incentive Design

Financial barriers, social norms, and information gaps independently suppress MNCH service utilization. Comparative evidence suggests that countries addressing all three simultaneously achieved faster and more sustained shifts in demand than those relying on a single instrument.

Nepal's SDIP illustrates a layered approach to demand generation: cash transfers reduced direct and indirect costs, fee removal lowered user-cost barriers, and the FCHV network provided the trust and information channels necessary for uptake. Evidence from implementation suggests that in areas without active community mobilization, financial incentives alone were insufficient to shift skilled attendance, underscoring the importance of complementary demand-side systems.

India, Indonesia and Pakistan show the limits of demand-side expansion without adequate supply readiness: while financial protection increased utilization, shortages in staffing, equipment and service quality constrained gains in care. Sri Lanka represents a more integrated trajectory, pairing sustained investments in female education and human development with stronger primary healthcare systems. Overall, comparative evidence suggests that demand-side interventions are most effective when paired with affordable, trusted and supply-ready services.

5. Demographic Transition and MNCH Service Demand

Across South and Southeast Asia, declining fertility and slower population growth have both reflected and reinforced progress in MNCH. Sustained investments in primary healthcare, family planning, girls' education, child survival, and women's empowerment contributed to demographic transition across the region. In turn, lower fertility reduced the number of pregnancies, births, and newborns requiring care, allowing health systems to progressively shift from expanding coverage toward improving the quality, continuity, and equity of services.

The pace of transition has varied considerably. Nepal experienced the region's fastest decline in fertility, followed by Malaysia, Bangladesh, and India, all of which have now reached or approached replacement-level fertility. Indonesia has also undergone a steady transition, although its large population and dispersed geography continue to create significant delivery challenges. Pakistan remains the regional outlier, with fertility and population growth substantially higher than its peers despite considerable progress over the past three decades.

The evidence suggests that demographic transition should not be viewed as an independent driver of MNCH improvement, nor merely as its outcome. Rather, it is part of a mutually reinforcing process in which investments in health, education, family planning, and women's development contribute to declining fertility, while lower fertility creates a more manageable service delivery environment that enables countries to sustain further gains in maternal and child health.

6. Political Continuity and Institutional Memory

Across all seven countries, the most decisive factor is not technical design but institutional continuity. Programs that delivered sustained gains were embedded in institutions that survived political transitions. Sri Lanka's PHM system has operated continuously since 1926 as part of the civil service, Malaysia's CEMD audit system has generated continuous learning since 1991, Bangladesh's BRAC has sustained delivery through institutional independence from government, and successive Indian governments have enabled expansion of national MNCH programs.

By contrast, Nepal, Indonesia, and Pakistan illustrate how devolution can weaken program performance when institutional capacity does not transfer with devolved responsibilities. In Nepal, federalization fragmented accountability for the SDIP and FCHV programs, while decentralization in Indonesia and Pakistan devolved health functions without consistently preserving the coordination, management, and oversight needed to ensure equitable performance across subnational governments.

The cross-cutting implication is that institutional memory is a governance asset, not a technical one. It accumulates in civil service structures, recurrent budget lines, and professional culture, and it is destroyed by devolution without capacity transfer, project-financed delivery without absorption plans, and political transitions that treat health programs as patronage rather than public infrastructure.

III. Regional Action Agenda

Build Integrated, High-Quality Primary Healthcare Systems.

- **Connect** care across the lifecycle - maternal health, newborn care, nutrition, immunization, family planning, and child health within one continuum.
- **Shift** priority from expanded coverage toward improving the quality of care delivered.
- **Invest** in better-equipped facilities, stronger emergency obstetric and neonatal care, and effective referral networks.
- **Strengthen** links between community health workers, primary care facilities, and hospitals.

Harness Digital Transformation to Strengthen Health Systems

- **Build** interoperable, patient-centered health information systems.
- **Connect** electronic health records, civil registration, and routine health information systems with frontline providers.
- **Pair** investments with strong data governance, standardized data protocols, and cybersecurity safeguards.
- **Scale** up and support the uptake of innovations, including new products, service delivery models, and policy approaches.

Invest in Climate-Resilient MNCH and Primary Healthcare Architecture

- **Build** climate-resilient health infrastructure and continuity plans for essential MNCH services.
- **Integrate** climate risks into health planning and surveillance systems.
- **Link** early warning systems with frontline providers and communities.
- **Move** beyond emergency response toward systems that anticipate, withstand, and recover from climate shocks.

Strengthen Institutions That Can Outlast Political Change

- **Strengthen** institutional capacity at both national and subnational levels as countries decentralize and reform their health sectors.
- **Preserve** technical expertise and establish clear accountability for implementation.
- **Maintain** policy continuity and the ability to adapt to changing priorities.
- **Sustain** reforms beyond changes in political leadership.

Invest in Cross-Border Systems Learning

- **Leverage** country strengths by creating structured opportunities for countries to share and adapt proven approaches across MNCH - from Sri Lanka and Malaysia's strong primary healthcare systems and Bangladesh's community-based delivery to Nepal's demand-side financing, India's delivery at scale, Indonesia's digital health, and Pakistan's social protection and nutrition models.
- **Institutionalize** peer learning through regular policy dialogues, technical exchanges, and structured sharing of implementation experience across countries.
- **Build** regional platforms to strengthen South-South collaboration, accelerate adaptation of successful approaches, and reduce duplication of effort.

Annex: MNCH Trajectory Comparison
1990 Baseline to Latest Available (2019-25)

Bangladesh* | *Strong Trajectory

Indicator	1990 Baseline	Latest Value
GDP per capita (USD)	$283.10	$2,597.30 (2025)
Population growth rate (%)	2	1.2 (2025)
Fertility rate	4.5	2.4 (2025)
MMR (per 100k live births)	870	115 (2025)
IMR (per 1k live births)	96	29 (2025)
U5MR (per 1k live births)	~146	33 (2025)
Stunting (% under-5)	63	24 (2022)
Skilled birth attendance (%)	~10	77.7 (2025)
Institutional delivery (%)	~5	71 (2025)

India* | *Steady Performance

Indicator	1990 Baseline	Latest Value
GDP per capita (USD)	$371.10	$2,702.50 (2025)
Population growth rate (%)	2.2	0.9 (2025)
Fertility rate	4	2 (2024)
MMR (per 100k live births)	516	80 (2023)
IMR (per 1k live births)	84	23 (2024)
U5MR (per 1k live births)	127	26.6 (2024)
Stunting (% under-5)	62.7 (1989)	29.3 (2024)
Skilled birth attendance (%)	34.2. (1993)	91.3 (2024)
Institutional delivery (%)	26.1	90.6 (2024)

Annex: MNCH Trajectory Comparison
1990 Baseline to Latest Available (2019-25)

Indonesia | Moderate — Underperforms Income Level

Indicator	1990 Baseline	Latest Value
GDP per capita (USD)	$578.40	$5,059.60 (2025)
Population growth rate (%)	1.8	0.8 (2025)
Fertility rate	3.1	2.1 (2024)
MMR (per 100k live births)	~391	140 (2023)
IMR (per 1k live births)	~64	15 (2024)
U5MR (per 1k live births)	~83	18 (2024)
Stunting (% under-5)	~52	19.8 (2024)
Skilled birth attendance (%)	~32	97 (2024)
Institutional delivery (%)	~27	89.9 (2023)

Malaysia | Benchmark — High Baseline, Sustained Performance

Indicator	1990 Baseline	Latest Value
GDP per capita (USD)	$2,468.70	$13,124.60 (2025)
Population growth rate (%)	2.9	1.2 (2025)
Fertility rate	3.3	1.5 (2024)
MMR (per 100k live births)	51	26 (2023)
IMR (per 1k live births)	12	7 (2024)
U5MR (per 1k live births)	17	8 (2022)
Stunting (% under-5)	~20 (2000)	24 (2025)
Skilled birth attendance (%)	93	~99 (2019)
Institutional delivery (%)	75.6	~99 (2022)

Annex: MNCH Trajectory Comparison
1990 Baseline to Latest Available (2019-25)

Nepal* | *Strongest Trajectory

Indicator	1990 Baseline	Latest Value
GDP per capita (USD)	$185.80	$1,535.90 (2025)
Population growth rate (%)	2.4	-0.1 (2025)
Fertility rate	5.2	2 (2024)
MMR (per 100k live births)	920	142 (2023)
IMR (per 1k live births)	102	22 (2024)
U5MR (per 1k live births)	138	25 (2024)
Stunting (% under-5)	~66 (1996)	25 (2022)
Skilled birth attendance (%)	~7	80 (2022)
Institutional delivery (%)	~7	79 (2022)

Pakistan* | *Weakest Trajectory

Indicator	1990 Baseline	Latest Value
GDP per capita (USD)	$344.50	$1,595.90 (2025)
Population growth rate (%)	3.3	1.6 (2025)
Fertility rate	6.4	3.5 (2024)
MMR (per 100k live births)	~434	155 (2023)
IMR (per 1k live births)	~100	~48 (2024)
U5MR (per 1k live births)	140.4	~56 (2024)
Stunting (% under-5)	~54.5	40 (2018)
Skilled birth attendance (%)	~18	~68 (2020)
Institutional delivery (%)	~15	~74 (2019)

Annex: MNCH Trajectory Comparison
1990 Baseline to Latest Available (2019-25)

Sri Lanka* | *Benchmark — High Baseline, Model of Sustained Quality

Indicator	1990 Baseline	Latest Value
GDP per capita (USD)	$491.20	$5,002.10 (2025)
Population growth rate (%)	0.6	-0.7 (2025)
Fertility rate	2.5	2 (2024)
MMR (per 100k live births)	~49	25 (2024)
IMR (per 1k live births)	~17.9	5 (2025)
U5MR (per 1k live births)	~23.3	~6 (2025)
Stunting (% under-5)	~30	~10.1 (2024)
Skilled birth attendance (%)	~95	~99 (2022)
Institutional delivery (%)	~94	~99 (2022)

NOTES AND SOURCES

- pp = percentage points; the arithmetic difference between two percentages. A coverage rate rising from 18% to 69% is a 51 pp increase, distinct from a 283% relative increase.
- GDP per capita, Population growth rate, Fertility rate, MMR, IMR, U5MR, SBA, Stunting, Institutional Delivery — WHO/UNICEF/UNFPA/World Bank/WHO Global Nutrition Report/National DHS/Nutrition surveys. Year varies by most recent national survey.
- NFHS-6 - India-specific stats
- All figures are modelled estimates with associated uncertainty intervals.

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