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Understanding the Impact of the Economic Crisis on Child and Maternal Health among the Poor: Opportunities for South Asia

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Abstract

The economic crisis hit many countries in 2007 and the effects are still being felt, especially in poorer developing nations. Much of the debate surrounding the economic crisis and its impacts has focused on the financial and economic aspects—import/export impacts, economic growth losses, labor force cutbacks, and fiscal imbalances. The social impact, especially on poor and vulnerable groups, has received less mention. Yet, if countries are to address the overall impacts of the economic crisis, it is vital that they also consider investing time and money to deal with social impacts more effectively. There are fears, however, that a reduction in spending on vital sectors (including the healthcare sector) to ensure economic recovery could affect poor and vulnerable populations and, in turn, erase the progress that has been made thus far. The decision to reduce such spending could also come from donors, who tend to favor a market-led recovery process in economic crises, thereby neglecting vital social service sectors that cater to the needs of poor populations. This spending can supplement government services or fill resource gaps and as a result reductions could have negative impacts on beneficiary populations, particularly the poor and vulnerable. Addressing child and maternal health issues within the context of the economic crisis is one key area to consider given its short, medium, and long-term effects on populations in developing countries. In South Asian countries, child and maternal health-related indicators tend to be disturbing despite the rapid growth rates in many of these countries. The number of infant deaths is still quite high, nutrition of children and women continues to be problematic, and maternal health and pre/post natal care remains poor. This paper presents an overview of child and maternal health in the South Asia region, but also recommends that interventions take into account a series of factors if the impacts of the economic crisis are to be minimized: There is a need for more information and research on the impacts of the crisis; Investing in social protection and safety nets is imperative; Food security should be integrated into social protection; Vulnerable households require support to cope with the crisis despite their own efforts and coping strategies; State investments that support vulnerable populations should be protected in times of crisis.

JEL Classification: I10, Y20

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1. INTRODUCTION: BACKGROUND AND OBJECTIVES OF THE PAPER

The effects of the economic crisis are no longer visible only in developed countries; they are becoming even more apparent in developing countries. Slower economic growth during this time is expected to trap 46 million more people in poverty (based on the United States dollar [US$]1.25-a-day poverty line), while 53 million more people will be pushed into US$2-a-day poverty. This is in addition to the number of people pushed into poverty globally as a result of food and fuel price rises in 2008, estimated to be between 130 and 155 million people[1] (Harper et al. 2009).

While developing countries try to address the effects of the crisis on their economies, there is also an urgent need to implement interventions that can mitigate the impacts on households—especially poorer households—and on vulnerable groups, including mothers and children. Macroeconomic changes do impact children, especially younger children, and it is premature to believe that the effects of the crisis in developing countries will have a minimal impact on its populations—including the poorer segments—if macroeconomic solutions are put in place.

Past crises have resulted in increased infant mortality; more young children dying of malnutrition; reductions in school enrolment; increased levels of child labor, including hazardous forms of labor (especially when the main income earner was unemployed); increased household labor, especially for girls; and vulnerability to trafficking and sexual exploitation; as well as service-side implications as a result of resource cuts in the health and education sectors. Household support networks that ensure the safety and security of children have also been affected. Parents have been required to work longer hours and have not been able to afford paid care for their children, reflecting structural failures to support households during these changing conditions and ensure greater child protection and wellbeing (Harper et al. 2009).

There are many examples[2] of the effects on child and maternal health of past crises. During the Asian financial crisis in 1997, some countries, such as Thailand, cut back on education and health spending by 6% and 9%, respectively, while Indonesia reduced its health spending by 7%. This resulted in significant declines in school enrolment, especially in primary schooling. During the 1989–1990 financial crisis in Peru, infant mortality increased. Similar increases were seen in under-five mortality in Mexico during the economic crisis in 1999 (UNICEF undated and Mendoza 2009).

Experts warn that the current global economic crisis could be the worst the world has ever faced. The crisis is different because it originated in financial markets in the developed world; although many high-income countries are in recession, the economies of low-income countries are still growing, albeit at a slower rate. Yet government revenues from imports, exports, and tourism are declining, foreign direct investment is falling, remittances have been affected, and the currencies of a number of countries have been devalued (Office of the Prime Minister of Norway 2009). The World Bank (World Bank 2008a in Mendoza 2009) has identified low and middle-income countries that have increased fiscal vulnerability due to the food and fuel crisis and which, as a result, are more vulnerable to the shocks posed by the economic crisis. These countries include Nepal, the Maldives, and Sri Lanka. Lower-income countries such as Nepal have preexisting vulnerabilities that could be exacerbated by the crisis as well as potentially give rise to new vulnerabilities.

[1] Based on World Bank estimates for 2009 as stated in Harper et al. (2009).

[2] See Harper et al. (2009) for multiple examples.

This paper was commissioned by the Asian Development Bank Institute in August 2009, and developed by the Centre for Poverty Analysis, based in Sri Lanka. Preliminary findings of the paper were presented at the 3rd People's Republic of China-Association of Southeast Asian Nations (ASEAN) Forum on Social Development and Poverty Reduction and the 4th ASEAN+3 Higher Level Seminar on Poverty Reduction. The paper focuses on countries in the South Asian region (i.e., Sri Lanka, India, Nepal, Bhutan, Pakistan, Afghanistan, and the Maldives) and aims to:

- understand if and how child and maternal health among the poor in the region has been impacted by the recent economic crisis;
- provide insights on the responses in dealing with these impacts; and
- provide recommendations that can help stakeholders mitigate the impacts of the crisis on child and maternal health in the region.

2. CONCEPTUAL FRAMEWORK AND METHODOLOGY

This paper attempts to present the impacts of the crisis on child and maternal health through a framework that seeks to show how effects from the macro levels can filter down to the more micro levels in terms of impacting households and communities.[3] The framework focuses on the following key elements:

The context within which the financial crisis is taking places is very different for each country in the region. This component introduces the crisis but also acknowledges that the crisis is taking place within a wider context that is affecting the groups in each country in various ways. It acknowledges that the disaggregated picture is important to note in terms of these factors and its impacts on creating and exacerbating vulnerabilities. This includes being faced with varying levels of poverty, income inequality, and exposure to conflicts, disasters, etc.

The macroeconomic context points to various levels of affectedness between various groups in a country, which can act as a way of identifying affected groups, working out characteristics of affectedness and sectoral variations. It is important to note that changes in the macroeconomic context do filter down to the micro level eventually.

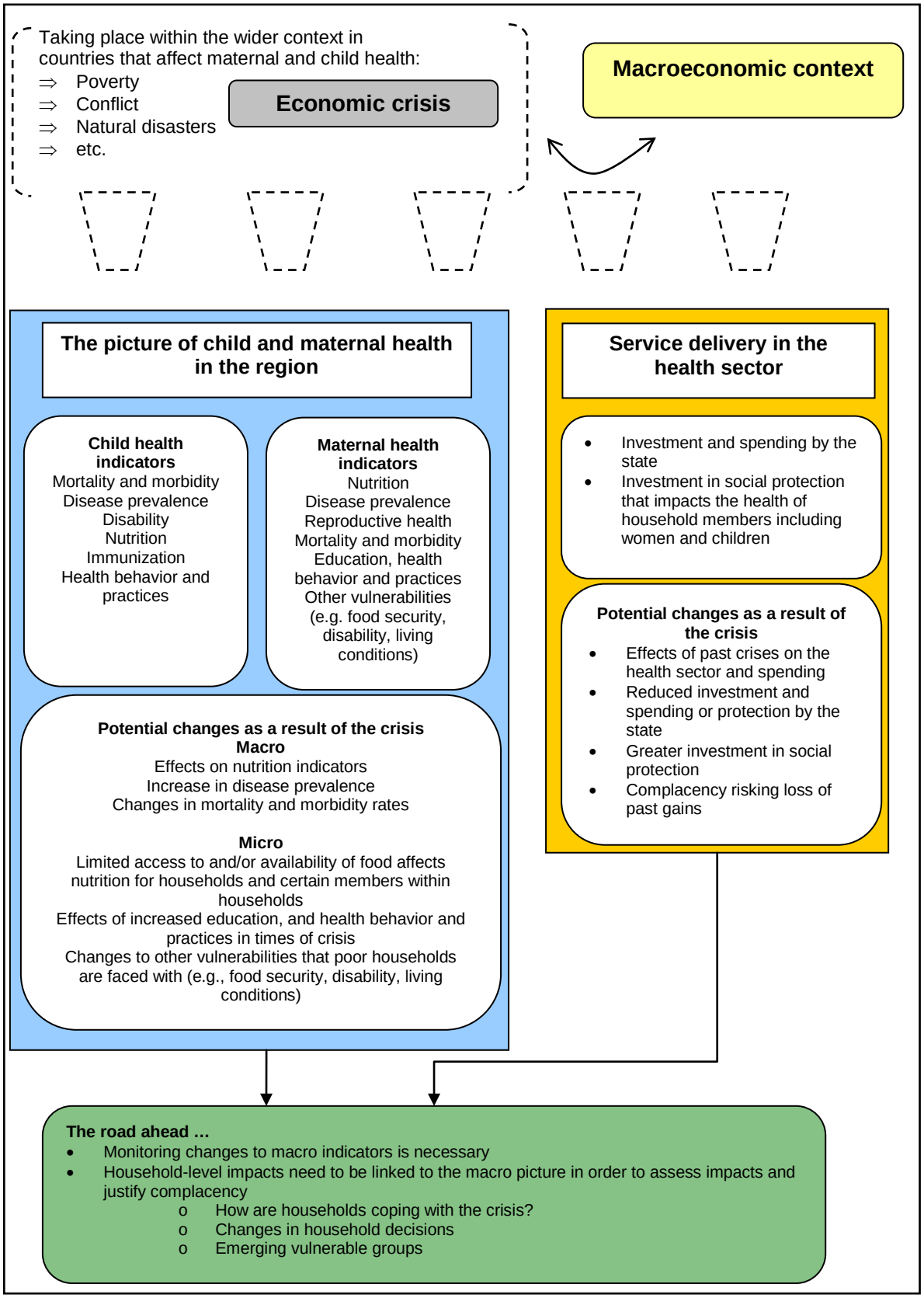
Macro health conditions in the region differ for each country. Key indicators will be described (where available) that focus on health outcomes and healthcare service delivery. These indicators could include rates of child and maternal mortality, nutrition, and immunization, prevalence of diseases, and indicators relating to fertility, pregnancy, and delivery, such as immunization, postnatal care, skilled birth attendance, contraceptive use, nutritional services, and improvements to health behavior practices.

Prioritizing funding for healthcare service delivery is key under normal circumstances, but is even more crucial in times of crisis as it can provide for services that the poor find difficult to access. These services could be sensitive to changes associated with the crisis including changes in fiscal budgets and state investments in health. This has been noted in the light of past crises that have resulted in reductions in investment or cutbacks that have affected child and maternal health. This aspect cannot ignore the important role that social protection programs could play in protecting the poor and vulnerable. Social protection has a long history in the region in trying to impact poverty reduction efforts and strengthening these efforts could help mitigate negative impacts of the crisis.

[3] The authors gratefully acknowledge the feedback from Professor Alejandro N. Herrin used in developing the conceptual framework for this paper.

Households have their own responses when faced with crisis situations. Changes in intra-household distribution of workloads, food consumption, and investment in human capital, household decision making, and resource allocations can affect household members, including women and children, in various ways.

Figure 1: Conceptual Framework



Source: Developed by the authors.

This paper was developed using a review of secondary literature and data, as well as "key person interviews." Secondary literature and data were accessed from printed and online data resources that informed the country comparison for the region. This analysis was supplemented by a series of key informant interviews in Sri Lanka[4] with state and non-state stakeholders working in the health sector in order to ascertain the immediate impacts of the crisis despite the lack of data to show local level impacts. The interviews were also conducted to obtain information on potential interventions being implemented to address child and maternal health in general that could provide valuable lessons on how to mitigate the impacts of the crisis.[5]

Due to time and resource limitations, the paper is not based on household-level primary data collection. The secondary review, however, highlights the dearth of information needed to understand the impacts of the crisis on child and maternal health and the need for more research at the micro level to capture dynamic, local-level affectedness that can be used to supplement macro health indicators.

As the paper also reveals that there is a sense of complacency among policymakers and civil society organisations regarding local-level impacts. There is an urgent need to support work that documents how families are coping with the effects of the crisis in their daily lives and ways in which their experiences can be used to inform more policy-level discussions that attempt to capture the dynamism of the situation.

3. CHANNELS OF THE GLOBAL ECONOMIC CRISIS

Overall, it seemed at the time of writing that the economies of Asia may not have been affected by the crisis, but the export sector, which is key to many economies, collapsed as a result of shrinking demand in industrial economies that affected value chains, and reduced demand for services (including tourism and migrant labor). However, despite this, most Asian economies are recovering. Developing Asia is leading the global economic recovery with a strong rebound in gross domestic product (GDP) growth that began in the second quarter of 2009 (Asian Development Bank [ADB] 2009).

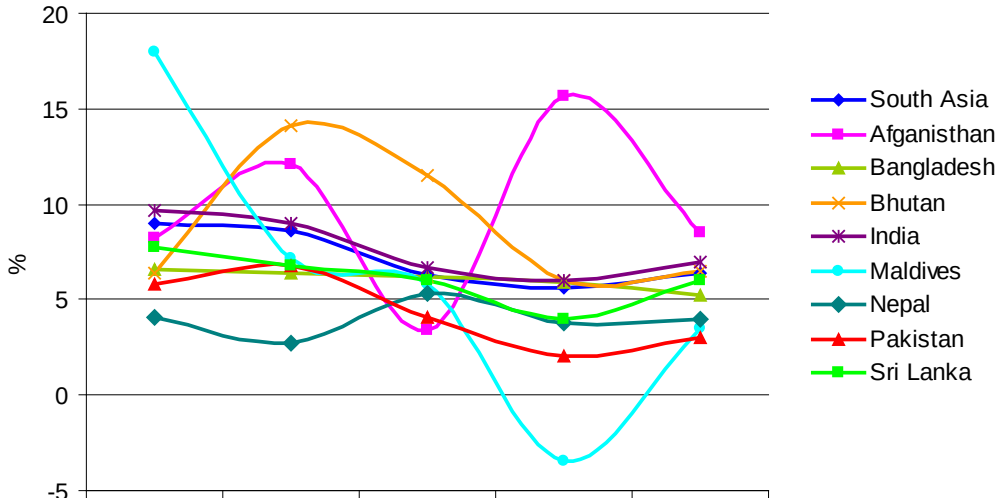
South Asia was initially considered to have a deteriorating growth rate, but the region is showing signs of improvement in economic growth, due mainly to the growth of the Indian economy, one of the world's largest growing economies. Individual country performance in 2009 varied within the region (ADB 2009).

Sri Lanka's GDP growth slowed to 2.5% in early 2009 as a result of reductions in industrial production, while India maintained 5.8% growth that increased later in the year, though private consumption and investment seemed to be slowing. All other countries, except for Afghanistan (for which data is limited), displayed a decline in economic activity (ADB 2009).

[4] See list of key person interviews in Appendix 1.

[5] This is not an exhaustive list but an illustration of the types of interventions that could be considered for expansion or implementation in the light of the economic crisis.

Figure 2: Growth Rate of GDP (% per year) in South Asia



	2006	2007	2008	2009 (forecast)	2010 (forecast)
South Asia	9.0	8.6	6.3	5.6	6.4
Afganisthan	8.2	12.1	3.4	15.7	8.5
Bangladesh	6.6	6.4	6.2	5.9	5.2
Bhutan	6.4	14.1	11.5	6.0	6.5
India	9.7	9.0	6.7	6.0	7.0
Maldives	18.0	7.2	5.8	-3.5	3.5
Nepal	4.1	2.7	5.3	3.8	4.0
Pakistan	5.8	6.8	4.1	2.0	3.0
Sri Lanka	7.7	6.8	6.0	4.0	6.0

Source: ADB 2009.

3.1 Impacts on the South Asian Economies

Migration and migrant remittances have been hit to some extent by the economic crisis. Workers have been laid off, and migrant-receiving countries have implemented protectionist policies that favor the employment of locals over foreigners in order to protect jobs for their nationals.

The growth of workers' remittances has slowed in the region, but a slower pace does not appear to have negatively impacted economies during the crisis. Remittances, which play a major role in the macro- and microeconomic contexts in Nepal, Bangladesh, Sri Lanka, and Pakistan (accounting for 20%, 11%, 7%, and 5% of GDP, respectively), have shown considerable resilience in early 2009 compared with exports, and continue to support domestic consumption demand and the current account. Remittance growth has slowed, but has maintained double-digit growth in Bangladesh and Nepal, although in Sri Lanka, remittances expanded only by approximately 5% (ADB 2009).

Drops in external demand for exports have impacted countries whose economies heavily depend on export revenues. Merchandise exports contracted in India, Nepal, Pakistan, and Sri Lanka. In Bangladesh, export growth slowed substantially over the year to June 2009, and the Maldives is experiencing a drop in tourism (ADB 2009).

While key economic indicators seem to show resilience amongst South Asian countries to the economic crisis, Bauer (2009) identifies the main impact channels to be through the labor markets within countries. He notes that an export sector analysis is limiting and could mask the effects within the backward linkages of value chain-related labor markets and the informal sector.

Employment growth rates between 1991 and 2006 have been marginal in South Asia as a whole (i.e., 2–2.4%), as well as in each country. The employment rate in the region has remained relatively stagnant from the 1990s to 2006 (at 55%, with Sri Lanka having the lowest rate at 51%). Unemployment in the region has grown from 3.7% in 1991 to 5.7% in 2007, and in 2007 was highest in the Maldives (14.4%), Afghanistan (8.5%), and Sri Lanka (6%) (United Nations Economic and Social Commission for Asia and the Pacific [UNESCAP] 2009). These rates are only indicative of the problems related to job losses and do not capture the full extent of the impact of the crisis on increasing unemployment.[6]

Box 1: The Global Recession and Economies in South Asia

- Afghanistan: Although the impact of the economic crisis on the Afghan economy is said to be minor because its financial system and economy are relatively small and weakly integrated with global markets, the amount of donor assistance available to the country may be affected by recessionary conditions in donor countries (ADB 2009). The country continues to be affected by political uncertainty and conflict that places its own constraints on the health conditions of its population.
- Bangladesh: GDP growth was estimated to be 5.2% in 2009, but the growth rates of industry, services, and remittances is expected to slow, which could contain consumer spending (ABD 2009). Bangladesh was forced to import 300% more rice in 2007 (Food and Agriculture Organization/World Food Programme data) due to cyclones and flooding at a time of rising food and fuel prices. At the same time, its exports, especially from the garment sector, could be affected due to weak global demand in 2009. Migrant remittances supported the current account balance in 2008 (United Nations Children's Fund [UNICEF] 2009).
- Bhutan: Bhutan's economy is largely driven by the construction of hydropower stations (specifically the Tala Hydroelectric Project) and power production exported to India, which grew by 9% in one year (2008–2009). Experts suggest that this activity is not likely to be affected in the context of the crisis as regional demand will continue, but Bhutan is heavily dependent on its exports to India. The country's budget for 2010 also has a large poverty reduction orientation that could cushion the effects of the crisis. GDP growth was estimated at 6% in 2009 (ADB 2009). The tourism sector could be under threat as global tourism demand drops (UNICEF 2009).
- India: A public expenditure-led growth strategy is resulting in signs of recovery, despite exports that are lower than expected. India's exports plunged by 15% in October 2008 and by another 19% in

[6] Also noted by Bauer (2009).

February 2009, as a direct result of the global economic crisis. Labor-intensive sectors such as the garment industry, leather, gems, and jewelry were the worst affected (UNICEF 2009).

- Maldives: The economy is particularly vulnerable to the crisis because tourism accounts for more than a quarter of the country's GDP. The government plans to introduce new taxes, such as an airport tax and a green tax, as well as to start privatizing state enterprises to offset some of its revenue shortfalls while curtailing state expenditure. The country is dependent on food and fuel imports and thus has faced a large increase in its import costs (ADB 2009 and UNICEF 2009).
- Nepal: Nepal, emerging from a decade of conflict and low growth, imports a large share of its goods and services through India, including fuel and food. However, strong flows of migrant remittances propped up falling current account balances in 2008, though this effect appeared to be waning in 2009. Tourism may decline as a result of contracting incomes in tourist origin countries (UNICEF 2009).
- Pakistan: Pakistan's economy is extremely fragile and is among the most vulnerable in the region due to high fiscal and current account deficits, runaway inflation that is depleting foreign exchange reserves, a weak currency, and considerable internal security issues. Pakistan has been forced to ask for financial assistance to cover its short-term debt and stabilize its economy. In November 2008, the International Monetary Fund approved a US$7.6 billion loan package for Pakistan (UNICEF 2009).
- Sri Lanka: Its economy remains under severe strain and, with the end of the civil war in 2009, the country must deal with the heavy costs of post-conflict reconstruction efforts. Following a fall in foreign exchange reserves, the International Monetary Fund approved a US$2.6 billion standby loan in support of the government's ambitious program of fiscal, monetary, and exchange rate reforms (ADB 2009). Sri Lanka is dependent on food and fuel imports (UNICEF 2009).

3.2 Persisting Poverty and Economic Inequality in the Region

Poverty, defined as US$1.25 per day (which enables extreme poverty comparisons across countries), has been declining since 1990 in the region. Some countries, such as Bangladesh and Pakistan, have shown significant declines in the proportion of people living in extreme poverty between 1990 and 2005. However, data gaps in countries like Afghanistan, Bhutan, Maldives, and Nepal do exist to some extent. Poverty line information may also not provide a complete picture of people who have fallen into poverty as a result of the crisis as it does not map vulnerabilities and the dynamics of poverty. Acknowledging the data's limitations, it is used here to highlight the potential impacts on the absolute number of poor.

Table 1: Percentage of the Population below the Poverty Line (US$1.25) in South Asia

Region and Country	Population Living on Less Than US$1.25 (2005PPP) a Day				Population Living Below the National Poverty Line	
	1990	1996	2002	2005	Earliest	Latest
South Asia (including South and South West Asia)	47.0	42.3	38.7	35.5	-	-
Afghanistan	-	-	-	-	-	-
Bangladesh	66.8 (91)	59.4 (95)	57.8 (00)	49.6	58.8 (92)	40.0 (05)
Bhutan	-	-	-	26.2 (03)	-	-
India	51.3	46.6	43.9	41.6	36.0 (94)	27.5 (05)
Maldives	-	-	-	-	-	-
Nepal	-	68.4 (95)	-	55.1 (03)	41.8 (96)	30.9 (04)
Pakistan	64.7	48.1	35.9 (01)	22.6 (04)	28.6 (93)	22.3 (06)
Sri Lanka	15.0	16.3 (95)	14.0	-	20.0 (91)	15.2 (07)

- = data unavailable, PPP = purchasing power parity, US$ = United States dollar.

Notes: Numbers in brackets indicate data source year.

National Poverty Line: This refers to a monetary allocation (income or expenditure) that stipulates a standard amount of goods and services (food and non-food) which a household requires to meet a set of defined needs.

Source: UNESCAP 2008a.

The share of total income earned by the poorest has remained low despite growth; this is indicative of limited pro-poor growth in the region. In some countries, their share has decreased even further, which is indicative of worsening conditions in terms of income.

Table 2: Share of the Poorest Quintile in Income or Consumption (%) in South Asia

Country	Earliest year available	Latest year available
Afghanistan	-	-
Bangladesh	9.4 (02)	8.8 (05)
Bhutan	-	-
India	-	8.1 (04)
Maldives	-	-
Nepal	7.5 (96)	6.0 (04)
Pakistan	8.1 (91)	9.1 (05)
Sri Lanka	9.0 (90)	7.0 (02)

- = data unavailable.

Notes: Numbers in brackets indicate data source year.

Source: UNESCAP 2008a.

3.1. Emerging Vulnerable Groups in the Crisis

"I was so embarrassed [that] I had no savings. My children expected me to give them at least one gift when I came back from Malaysia. But I haven't even bought a single piece of new clothing for anybody in the family and I had to take my daughter out of school."

Bangladesh (March 2009), UNICEF 2009:6

Hasan, Magsombol, and Cain (2009) predict an increase in the number of people living in extreme poverty and vulnerable to falling into poverty based on four scenarios that calculate the number of people who could fall into poverty as the result of reductions in economic growth rates. In their analysis, they note that some population groups have become vulnerable as a result of the crisis, including groups who are in danger of falling into poverty or, in the case of the already poor, of experiencing greater deprivation.

Within the eight countries of South Asia,[7] more than 1.18 billion people (three quarters of the population) live on less than US$2 a day (World Bank in UNICEF Regional Office South Asia [ROSA] 2009).

Hasan, Magsombol, and Cain (2009) also note that households that depend on income from export sectors, as well as households that rely on remittances as a main form of income, are likely to be the most affected.

Small and medium enterprises (SMEs) are another group that may be vulnerable to a decline in funding due to their generally higher risk profiles and lower levels of internal funds. Here too, export-oriented SMEs, including those in the textile, footwear, and toy industries, could be affected (UNESCAP 2009).

Other groups likely to be impacted include semi-skilled and wage labor within export-oriented sectors such as gem mining, tea, and garments, and migrant labor (lower-skilled returnees especially and their reduced remittance earnings as a result of job loss).

Job losses in key industries and the informal sector are also making certain groups vulnerable. UNICEF (2009) notes that pressure on the informal sector will intensify, leading to many becoming vulnerable to hunger and nutritional deprivation given the large numbers that work in the sector, especially in South Asia (estimated at 90% of the population).

There is some evidence that this may be starting to happen. In Sri Lanka, the proportion of people under the poverty line has decreased (as of 2006/2007) since 2002, but this figure does not take into account the effects of the economic crisis that started much later as the crisis hit after this data was collected. It is important for policymakers to take note of this limitation when considering the implications of the crisis for the poor. The official poverty line shows a marginal increase in poverty in 2009,[8] despite a slight dip in late 2008 (Department of Census and Statistics [DCS] undated). Although this is a slight change, it could be indicative of changes in the absolute number of people who are vulnerable to moving into income poverty because they lack sufficient income to meet the basic needs of household members.

The jobs of informal laborers in India's labor-intensive cotton textile and leather sectors have become vulnerable. Job losses in the information technology and automobile sectors are also mounting. In January 2009, a survey conducted by the Indian Central Employment Ministry estimated that total job losses since October 2008 came to over half a million. The garment industries in Bangladesh, Sri Lanka, and Nepal are under threat from falling demand in the markets of the North, as well as from increased competition (UNICEF ROSA 2009).

These trends point to certain groups emerging as more vulnerable than others in the crisis climate, and highlight the need for those vulnerabilities to be identified and addressed more specifically. Within these groups, marginalized groups, women, and children could be more affected than others because they are already compromised as

[7] India, Sri Lanka, Pakistan, Nepal, Bhutan, Bangladesh, Maldives, and Afghanistan.

[8] From Sri Lanka rupee (SLR)2890 (US$25.1) in January 2009 to SLR2970 (US$25.3) in July 2009.

a result of socio-cultural marginalization and inequalities. At the same time, the fact that the numbers do not definitively reveal the magnitude of current problem has to be acknowledged.

4. UNDERSTANDING CHILD AND MATERNAL HEALTH IN THE REGION

This section will provide an overview of child and maternal health in the region, focusing on the region's achievements and persisting problems, as well as providing a cross-country comparison.

The number of people who are unable to consume the minimum required amount of calories per day has increased since the onset of the economic crisis—by at least 100 million. The greatest increases have been in India, Pakistan, and Bangladesh. According to UNICEF ROSA (2009), this represents the largest increase within the region in 40 years.

Even before the economic crisis shook the world in 2007, South Asia had high levels of hunger and malnutrition. The economic crisis compounds an already precarious situation in which one-fifth of the population in South Asia lives under conditions of hunger and malnutrition caused by high income inequality, rapidly increasing urbanization, social polarization, increasing food prices, and limited agricultural and rural development (UNICEF ROSA 2009).

Table 3: Number of Hungry People in South Asia (millions)

Country	1970	1990	2001/03	2004/06	2007/08
Afghanistan	-	-	-	-	7.8
Bangladesh	20.3	33.3	43.1	44	65.3
India	218.3	261.3	212	209.5	230
Nepal	6.7	7.7	4.1	4.4	8.5
Pakistan	16.9	23.6	35.2	37.5	84
Sri Lanka	2.7	3	4.1	4.2	10
South Asia	265	328.9	298.5	300.6	405.6

- = data unavailable.

Note: Hunger is defined as consuming less than the minimum recommended energy intake. In South Asia, this averages 2100 calories per day per person, with slight differences within countries and sectors.

Source: Compiled from Food and Agriculture Organization database 1970–2003, and country-level rapid assessments and nutrition surveys for 2005/2006–2007/2008 in UNICEF ROSA (2009).

4.1 The Regional Picture of Child and Maternal Health

4.1.1 Comparisons of Child Health Indicators in South Asia

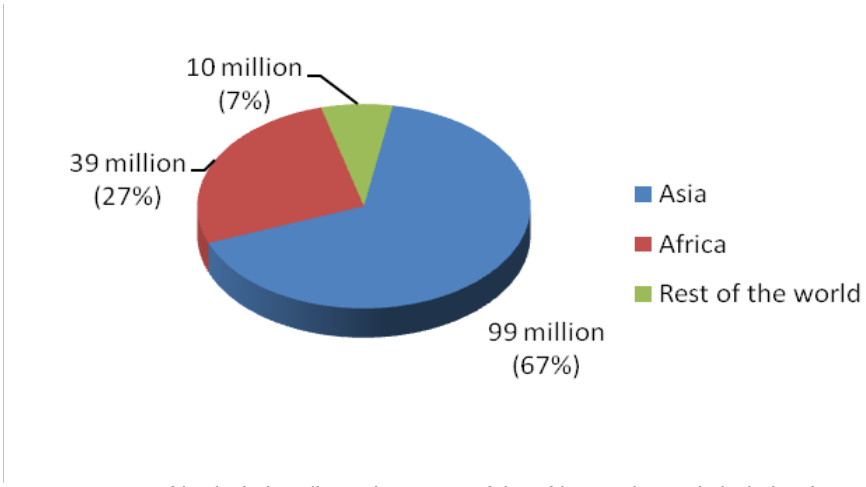
Even when using the most basic definition of child poverty (i.e., the inability to meet basic needs), conditions in South Asia are grim. 300 million children in South Asia are deprived of two or more of the basic needs, which include food, healthcare services, education, and shelter (according to UNICEF data as quoted by UNICEF ROSA [2009]). This accounts for 54% of the regional child population. Almost 345 million children—more than 60%—are at risk of sickness and disease caused by poor or

complete lack of sanitation (Regional Study on Child Poverty and Disparities, UNICEF ROSA forthcoming quoted in UNICEF ROSA 2009).

4.1.1.1 Birth Weight

Although South Asia boasts higher GDP growth than Africa, the number of underweight children in South Asia is more than double that in Africa (UNICEF ROSA 2009). World Bank sources (2009) estimate that about one-third of South Asian children are born with a low birth weight. In sub-Saharan Africa, 15% of children suffer from low birth weight, indicating that the prevalence of children born with low birth weight is higher in South Asia than anywhere else in the world. This trend is pervasive throughout the region, but particularly in India, Sri Lanka, Bangladesh, Maldives, and Nepal.

Figure 3: Underweight Children Under Five in Africa and Asia, 2007



Note: Africa includes all member states of the African Union. Asia includes the countries in the UNICEF regions of East Asia and the Pacific and South Asia. Numbers may not always add up due to rounding.

Source: UNICEF 2008b.

Table 4: % of Infants with Low Birth Weight, 2000–2007

Country	2000–2007
Afghanistan	-
Pakistan	19
Bangladesh	22
Bhutan	15
India	28
Maldives	22
Nepal	21
Sri Lanka	22

- = data unavailable.

Note: Data for Bhutan and Pakistan refer to years or periods other than those specified in the table heading. The specific year is not available.

Source: UNICEF 2008b.

4.1.1.2 Child Mortality

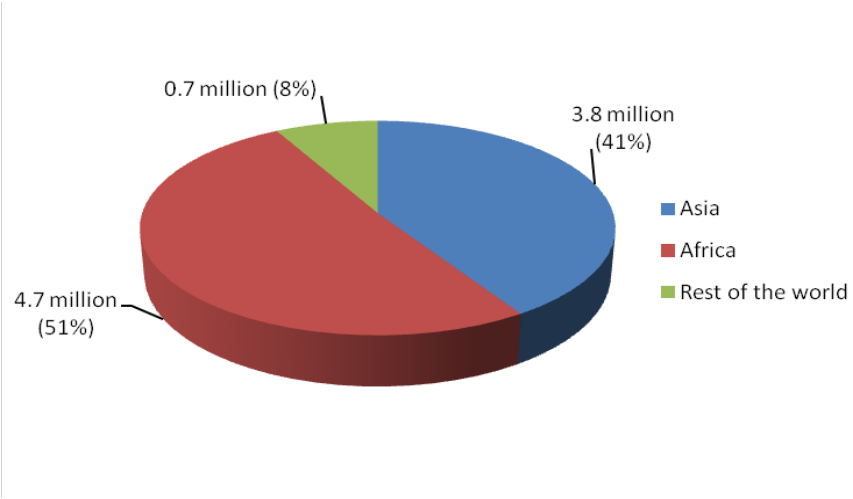
Table 5 presents data on infant mortality, which refers to the probability of a child dying between birth and exactly one year of age. It shows that Afghanistan has the highest levels of infant mortality (per 1,000 births), with more boys dying than girls. The gender disparity in child mortality can be observed in all countries in the region, except in India and Nepal where more girls die at birth.

Table 5: Infant Mortality Rate (per 1,000 live births), 2006, Overall and by Sex

Country	Both Sexes, 2006	Female, 2006	Male, 2006
Afghanistan	165	154	176
Pakistan	78	71	85
Bangladesh	52	46	57
Bhutan	63	58	68
India	57	58	57
Maldives	26	23	29
Nepal	46	46	46
Sri Lanka	11	9	14

Source: World Health Organization (WHO) Statistical Information System (WHOSIS) database. http://apps.who.int/whosis/data/Search.jsp (accessed November 2009).

Figure 4: Deaths of Children under Five in Africa and Asia, 2007



Note: Africa includes all member states of the African Union. Asia includes the countries in the UNICEF regions of East Asia and the Pacific and South Asia. Numbers may not always add up due to rounding.

Source: UNICEF 2008b.

In a ranking developed by UNICEF (2008b) that lists countries according to rates of under-five mortality (which refers to the probability of dying between birth and exactly five years of age, considered to be a critical indicator of child wellbeing), the countries in the region are ranked accordingly in descending order (from worst to best): Afghanistan 2, Pakistan 43, Bhutan 45, India 49, Bangladesh 58, Nepal 62, Maldives 88, and Sri Lanka 110 from a list of 189 countries.

The rate of under-five mortality has decreased sharply since 1990 for most countries in the region, especially in Bangladesh, Maldives, and Nepal, but less so in Afghanistan and Sri Lanka, where the decline has been less dramatic.

Sri Lanka has the lowest rate of neonatal mortality—the probability of dying during the first 28 completed days of life—in the region: 8 deaths per 1,000 births in 2005. In Afghanistan and Pakistan, on the other hand, more than 50 infants die per 1,000 live births.

Table 6: Under-Five Mortality Rate per 1,000 Live Births, 1990 and 2007

Country	Under-Five Mortality Rate 1990	Under-Five Mortality Rate 2007
Afghanistan	260	257
Pakistan	132	90
Bangladesh	151	61
Bhutan	148	84
India	117	72
Maldives	111	30
Nepal	142	55
Sri Lanka	32	21

Source: UNICEF 2008b.

Table 7: Neonatal Mortality Rate per 1,000 Live Births, 2004

Country	2004
Afghanistan	60
Pakistan	53
Bangladesh	36
Bhutan	30
India	39
Maldives	24
Nepal	32
Sri Lanka	8

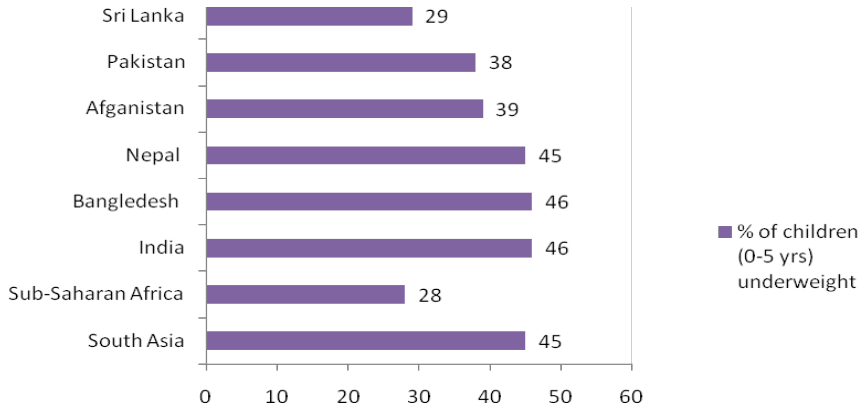
Source: UNICEF 2008b.

Major causes of neonatal mortality in the region include birth asphyxia, low birth weight, and the high prevalence of serious infections, such as neonatal tetanus, sepsis, and pneumonia (Bhutta et al. 2004).

4.1.1.3 Nutrition among Children

There are 175 million children under the age of five in the region and 45% are undernourished—the highest rate of malnutrition in the world (higher even than that in sub-Saharan Africa) (UNICEF ROSA 2009).

Figure 5: Malnutrition in South Asia



Note: Data does not include the Maldives.

Source: UNICEF 2009, quoted in World Bank (2009).

Malnutrition is caused by a lack of adequate nutritious foods and micronutrient deficiencies, including iron and iodine deficiencies, that can affect immunity as well as long-term mental and physical development (Bhutta et al. 2004).

Table 8: Percentage of Children Under Five who are Malnourished, 2000–2007*

Country	Underweight (WHO ref. pop.)	Underweight (NCHS/WHO)		Wasting (NCHS/ WHO)	Stunting (NCHS/ WHO)
	Moderate and Severe	Moderate and Severe	Severe	Moderate and Severe	Moderate and Severe
Afghanistan	33	39	12	7	54
Pakistan	31	38	13	13	37
Bangladesh	41	46	-	16	36
Bhutan	14	19	3	3	40
India	43	45	-	19	38
Maldives	-	30	7	13	25
Nepal	39	45	10	12	43
Sri Lanka	23	29	-	14	14

NCHS = National Center for Health Statistics, WHO = World Health Organization.

Notes: Data for Afghanistan, Bhutan, and Sri Lanka refer to years or periods other than those specified in the table heading. The specific year is not available. The "underweight" statistics apply the same indicators to two different reference populations. Due to this difference, the data presented here are not strictly comparable with each other or with previous editions of this report. The WHO Child Growth Standards are gradually replacing the widely used NCHS/WHO reference population.

Source: UNICEF 2008b.

Afghanistan has one of the highest child malnutrition rates in South Asia, with 54% of children under five suffering from stunting due to malnutrition. Nepal and Bhutan follow, with over 40% of children being stunted. In comparison, only 14% of children suffer from this type of malnutrition in Sri Lanka, where children tend to be moderately to severely underweight.

Children who are moderately to severely underweight are a greater problem in Bangladesh, Nepal, and India, where 45% of children are affected. Nearly the same proportion of children are affected in Afghanistan and Pakistan: 39% and 38%, respectively.

In addition, UNICEF ROSA (2009) notes that 12% of Afghan children suffer from acute malnutrition and more than 70% of the country's children suffer from micronutrient

deficiencies. UNICEF ROSA (2009) estimates the absolute number of children affected to likely be greater than 2.75 million.

4.1.2 Comparisons of Maternal Health Indicators in South Asia

4.1.2.1 Prevalence of Contraception Usage

The percentage of married women aged 15–49 currently using contraception is lowest in Afghanistan, where as few as 10% of women use contraception. These figures do not corroborate with fertility and population growth rates in the region, which are decreasing and slowing, respectively.

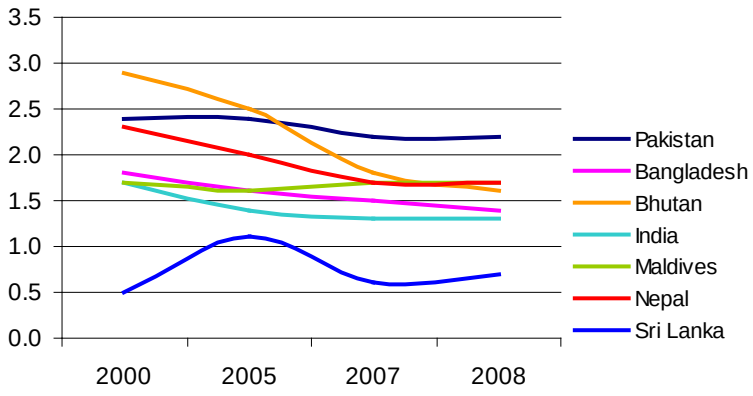
Table 9: Prevalence of Contraception Usage, 2000–2007 (% of the population)

Country	2000–2007
Afghanistan	10
Pakistan	30
Bangladesh	56
Bhutan	35
India	56
Maldives	39
Nepal	48
Sri Lanka	68

Note: Data refer to the most recent year available during the period specified in the column heading. Data for Bhutan refer to years or periods other than those specified in the column heading, differ from the standard definition, or refer to only part of the country.

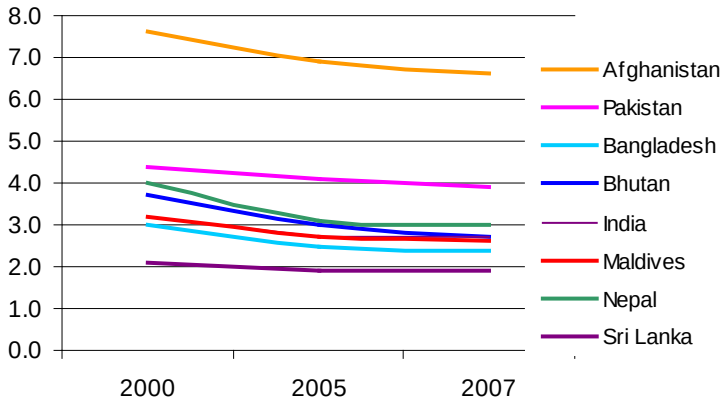
Source: UNICEF 2008b.

Figure 6: Population Growth in South Asia (% annual growth)



Source: World Bank, World Development Indicators database, April 2009. http://data.worldbank.org/data-catalog/world-development-indicators

Figure 7: Fertility Rate, Total (births per woman)



Source: World Bank, World Development Indicators database, April 2009. http://data.worldbank.org/data-catalog/world-development-indicators

4.1.2.2 Nutrition among Women

South Asia's problem of undernutrition affects not only children, but also women of reproductive age. World Health Organization (WHO) estimates[9] show this to be a grave problem among adult women in Bangladesh, India, and Pakistan, where more than one-third have a lower body mass index than is healthy.

Adding to the problem is the high prevalence of iron deficiency anemia across the region, ranging from 55%–81%. Undernourished pregnant mothers perpetuate the cycle of undernutrition as the chances of them giving birth to undernourished babies with low birth weight is high, and this can lead to stunting during childhood and adolescence (World Bank 2009).

There is evidence of nutritional deprivation among pregnant woman in South Asia at the household level—women tend to eat fewer meals per day than men and eat last in their households, resulting in weight gains of only five kilograms (of the recommended 10kg) during pregnancy (World Bank 2009). Maternal undernutrition, while common in South Asia, is seen as having reached critical levels, especially in countries like Bangladesh and India (UNICEF 2008c and Black et.al 2008).

4.1.2.3 Prenatal Care

Prenatal care refers to the extent to which women, usually of childbearing age (15–49 years old), are attended to by skilled health personnel (doctors, nurses, or midwives) at least once during pregnancy, and the extent to which they are attended to by any provider at least four times while pregnant (UNICEF 2008b).

During the 1990s, 46% of women in South Asia received one prenatal visit. In 2005, this figure had risen to 65%. The widest coverage (of at least one visit) is found in countries including Bhutan, Maldives, and Sri Lanka (at over 80% and, in the case of Sri Lanka, 99%). Afghanistan, in contrast, has less than 20% of pregnant women receiving any form of prenatal care (UNICEF 2008b).

[9] See the WHO's global database on Body Mass Indices. http://apps.who.int/bmi/index.jsp

Table 10: Prenatal Care Coverage (%), 2000–2007

Country	At Least Once	At Least Four Times
Afghanistan	16	-
Pakistan	61	28
Bangladesh	51	21
Bhutan	88	-
India	74	37
Maldives	81	-
Nepal	44	29
Sri Lanka	99	-

- = data unavailable.

Note: Data refer to the most recent year available during the period specified in the table heading.

Source: UNICEF 2008b.

Progress made by countries such as Bangladesh, India, and Nepal is significant and encouraging, with all three increasing prenatal care by 20% or more, and with rural improvements eclipsing those in urban areas (UNICEF 2008b).

The Indian National Family Health Survey suggests that women are not often empowered to seek prenatal care. 40% of husbands whose wives did not receive prenatal care reported that they did not think it was necessary, or that they had refused to allow a visit, while an additional 15% said someone else in the family did not think it was necessary or had refused to allow a visit (UNICEF 2008b and International Institute for Population Sciences [IIPS] and Macro International [MI]. 2007).

Table 11: Delivery Care Coverage (%), 2000–2007

Country	Skilled Attendant at Birth	Institutional Delivery
Afghanistan	14	13
Pakistan	39	34
Bangladesh	18	15
Bhutan	56	55
India	47	39
Maldives	84	-
Nepal	19	18
Sri Lanka	99	98

Note: Data refer to the most recent year available during the period specified in the table heading.

Source: UNICEF 2008b.

In the global context, women in South Asia are among the least likely to deliver in the presence of a skilled health attendant, with a mere 41% of all births being delivered by a health professional (UNICEF 2008b). Yet these figures are misleading when considering country-level delivery care coverage. Nepal, Bangladesh, and Afghanistan trail behind other countries in the region quite significantly. India and Pakistan have greater skilled attendance levels at birth but this availability is for less than 50% of births.

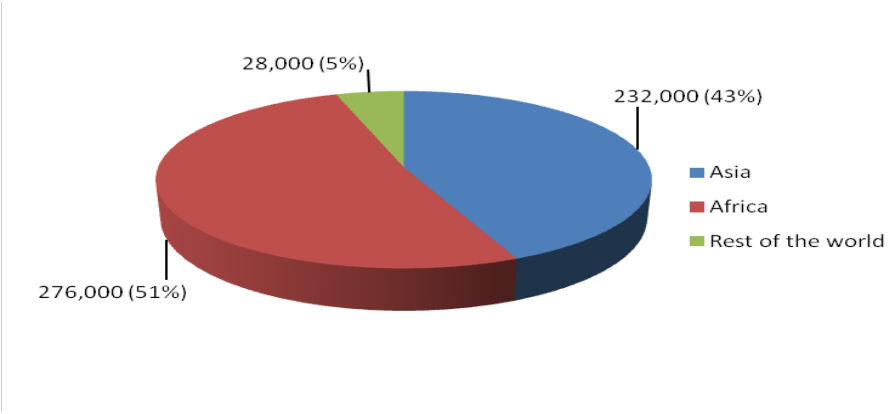
Between 1995 and 2005, regional coverage increased from 31% to 40%, showing a marked improvement with notable gains being seen in rural areas through the region. For example, in rural Nepal the proportion of births attended by a skilled health professional rose from 8% in 2001 to 14% in 2006. Data from rural India also suggest a slight increase in coverage between 1999 and 2006. However, overall, the likelihood of a rural woman's delivery being attended by a skilled health professional is still half that of an urban woman. In rural areas of Bangladesh, Nepal, and Pakistan, less than

5% of births are by Cesarean section, pointing to a serious lack of access to emergency obstetric care. Most countries in South Asia also face critical shortages of doctors, nurses, and midwives (UNICEF 2008b).

4.1.2.4 Maternal Mortality

The South Asian region accounted for 187,000 maternal deaths in 2005—a third of the estimated global figure of 536,000.

Figure 8: Maternal Deaths in Africa and Asia, 2005



Note: Africa includes all member states of the African Union. Asia includes the countries in the UNICEF regions of East Asia and the Pacific and South Asia. Numbers may not always add up due to rounding.

Source: UNICEF 2008b.

Maternal mortality refers to the annual number of pregnancy-related deaths of women per 100,000 live births. Despite the disparities in reporting figures on maternal mortality, it is a huge problem for most countries. Countries like Sri Lanka report substantially lower figures and seemed to have progressed much further than other countries in the region.

Table 12: Maternal Mortality Ratio (per 100,000 live births), 2000–2007

Country	Reported	Adjusted
Afghanistan	1600	1800
Pakistan	530	320
Bangladesh	320	570
Bhutan	240	440
India	300	450
Maldives	140	120
Nepal	280	830
Sri Lanka	43	58

Note: Data refer to the most recent year available during the period specified in the table heading. “Reported” refers to country-reported figures that are not adjusted for underreporting and misclassification. Periodically, UNICEF, WHO, the United Nations Population Fund, and the World Bank evaluate these data and make adjustments to account for the well-documented problems of underreporting and misclassification of maternal deaths and to develop estimates for countries with no data. “Adjusted” refers to estimates for 2005, reflecting the most recent of these reviews.

Source: UNICEF 2008b.

Data does show reduced levels of maternal mortality in South Asia since 1990. According to UNICEF, the best available estimates show the rate of maternal mortality in South Asia was 650 deaths per 100,000 live births in 1990 and 500 in 2005, showing a 22% reduction (UNICEF 2008b).

While the risk of maternal death is high in the region overall, regional variation of risk is considerable. Afghan women, for example, have a greater than average chance of dying during childbirth, while in Sri Lanka, the risk is lower.

The main causes of maternal mortality include hemorrhage, obstructed labor, and infectious disease (Bhutta et al. 2004).

4.2 Achievements on Millennium Development Goals Related to Health

According to available data for the Asian region (UNESCAP 2008b), many countries are not on track to meet the Millennium Development Goals (MDGs), which stipulate a minimum level of achievement in economic and non-economic development. Some countries will have achieved the goal relating to halving income poverty by 2015, but most will make limited progress in achieving a majority of the MDGs, particularly in terms of progress within countries at a disaggregated level. In the context of the economic crisis, achieving these targets will be much harder.

There are two goals that focus on child and maternal health within the MDGs: Goal 4 (reducing child mortality) and Goal 5 (improving maternal health). The table below outlines the targets that countries aim to achieve by 2015 and the indicators used to map their progress.

Table 13: Millennium Development Goals on Maternal and Child Health

Millennium Development Goal 4: Reduce Child Mortality	
Targets	**Indicators**
4.A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	4.1 Under-five mortality rate
	4.2 Infant mortality rate
	4.3 Proportion of one-year-old children immunized against measles
Millennium Development Goal 5: Improve Maternal Health*	
Targets	**Indicators**
5.A: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	5.1 Maternal mortality ratio
	5.2 Proportion of births attended by skilled health personnel
5.B Achieve, by 2015, universal access to reproductive health	5.3 Contraceptive prevalence rate
	5.4 Adolescent birth rate
	5.5 Prenatal care coverage (at least one visit and at least four visits)
	5.6 Unmet need for family planning

*The revised Millennium Development Goal (MDG) framework agreed by the United Nations General Assembly at the 2005 World Summit, with the new official list of indicators effective as of 15 January 2008, has added a new target (5.B) and four new indicators for monitoring MDG 5.

Source: United Nations MDG Indicators: The official site for MDG Indicators as quoted in UNICEF 2009

http://ddp-ext.worldbank.org/ext/GMIS/gdmis.do?siteId=2&menuId=LNAV01HOME3

In terms of maternal health performance in Asia, the data provides a pessimistic picture. Although the situation differs from country to country, maternal health is affected by issues relating to gender discrimination in access to health services, poor quality of services, lack of emergency obstetric care, and shortage of skilled health personnel and community-level field workers. Another major factor is that many pregnant women in poor health are malnourished (UNESCAP 2008b).

Where data is available for countries in South Asia, Bangladesh, Pakistan, Sri Lanka, India, and Nepal feature on the list of countries with the highest rates of malnutrition (in 2008).

A growing trend in relation to women's health is the increasing number of people who are infected with HIV/AIDS.[10] UNESCAP (2008b) notes that India, Bangladesh, and Pakistan have rising numbers of infected people and a growing trend of women being infected by their husbands. Other communicable diseases include malaria and tuberculosis, but the number of cases has decreased since the 1990s.

[10] Human immunodeficiency virus/ acquired immunodeficiency syndrome.

5. IMPACTS OF THE ECONOMIC CRISIS ON CHILD AND MATERNAL HEALTH

5.1 Warning Signs from Past Crises

As noted earlier, previous crises provide lessons on how to minimize the effects of the present crisis, including by protecting budgets for the most basic and cost-effective services delivered to the poor, and by making provisions for social protection and safety nets.

According to the East Asian experience during the 1997–1998 Asian Financial Crisis, at least a 1% increase in spending on safety nets is required to protect the poor. Reducing financial barriers to accessing healthcare has been shown to have a positive impact (e.g., bringing in specific interventions that protect access while assuring adequate quality) (Office of the Prime Minister of Norway 2009).

At the same time, the availability of timely information and monitoring systems is crucial for contingency planning in case of economic deterioration. As people's incomes decline, labor programs—such as unemployment benefits, retraining, job clubs, and labor-intensive public works—can serve to cushion against shock. Countries can also focus on becoming more efficient in their health spending, using this as an opportunity to focus on results (Office of the Prime Minister of Norway 2009).

5.2 Adequate Nutrition is a Lingering Problem for All Countries in the Region

The impact of the global crisis has spared no South Asian country. India has the worst statistics for food insecurity in the world with more than 230 million hungry. More than 20% of the Indian population suffers from chronic food deprivation. India is also home to a little less than 40% of the world's hungry children, a figure that is higher than that in sub-Saharan Africa and significantly higher than the global hunger and nutrition figures.

Malnutrition continues to be a leading cause of child deaths, especially among younger children. This is of particular concern in light of the fact that food price increases and shortages could worsen if not adequately addressed. A United Nations World Food Programme report (quoted in UNICEF ROSA 2009) estimates that 1.5 million children in India could become malnourished due to the food price crisis in 2008. The Maldives and Sri Lanka albeit to a lesser extent (as malnutrition continues to be one of the biggest problems Sri Lanka struggles with) are having the most success in the region in reducing malnutrition. Child mortality in the Maldives is low and life expectancy there is the highest in the South Asian region. However, malnutrition continues to be an ongoing problem, despite substantial improvement; almost one in four still remain underweight (WHO SEARO).

Despite Sri Lanka's low child mortality rates, some conditions in the country should be noted, especially its nutritional indicators. According to the Demographic and Health Survey 2007, 22% (nearly a quarter) of Sri Lankan children are underweight, with 4% classified as severely underweight; 15% of children suffer from wasting, with 3% showing signs of severe wasting; and 18% of children are stunted, with 4% suffering from severe stunting. The incidence of underweight, wasting, and stunting rises with the age of the child and peaks at 18–23 months. The prevalence of underweight is

higher for boys than for girls, with the children of estate/plantation sector workers showing higher levels of underweight than those living in urban or rural areas. Almost a third of pregnant women in Sri Lanka suffer from anemia. An emerging problem that also points to inadequate nutrition is overweight, especially in segments of the population with higher incomes (UNICEF ROSA 2009).

Bangladesh is home to some of the most malnourished children in South Asia, with a little less than half of Bangladeshi children being moderately or severely underweight. Bangladesh relies on rice imports to compensate for food crops destroyed due to cyclones and flooding. These conditions are compounded by the constant battering the country receives from flooding and related incidents, and are taking a toll on child and maternal health. The effects of the economic crisis will come on top of these and could worsen conditions. Acute malnutrition affects almost one in every five children in some areas of Nepal and 33 out of 75 districts in the country suffer from chronic food insecurity (UNICEF ROSA 2009).

5.3 Household-Level Impacts on the Crisis

> *"It hurts my heart that we cannot provide the things my children need. To earn enough money to feed the family for one day we have to work for two days. We have sold two of our bulls and most of my rings and necklaces. The only assets we have left are this house and three small bulls but we cannot get them good fodder."*
>
> Nepal (April 2009), UNICEF ROSA (2009:1)

With families struggling against unexpected challenges, women and children may see a change in the resources that are usually allocated to them for food and education. Children face higher chances of being drawn into work, both paid and unpaid, which adversely affects playtime and education. This is especially true for older children.

UNICEF also points out the emerging risks of early marriage and human trafficking, especially when families struggle with lower incomes, less food, and restricted living conditions (UNICEF ROSA 2009).

Households are facing reductions in their consumption and spending (e.g., on the quantity and quality of food, healthcare, and investment in their children's education). Drawing on household savings and selling assets, such as livestock, are common responses to economic shocks (Harper et al. 2009).

Changes in income and household consumption are likely to affect the quantity and quality of children's food intake and their access to medicine, healthcare, and education. These and other basic needs may be affected in the long term, even if parents—especially mothers—seek to minimize the impacts of economic shocks by taking on additional income-generating activities and altering their own food consumption. Choices about how or whether allocations of household resources to child wellbeing are changed or reduced—in particular, if specific resources should go to girls or boys, or to older or younger siblings—will depend on a number of factors: (i) the level of education of family decision makers and the locus of power (with child wellbeing being correlated with women's bargaining power); (ii) household wealth and asset base; (iii) household composition; and (iv) family eligibility for governmental or non-governmental social protection (Harper et al. 2009).

In terms of household labor supply, past crises have often had a disproportionately negative effect on women's employment, frequently leading to longer working hours and a move to riskier and lower status forms of employment, including commercial sex work. Declining household employment options also frequently result in increased child labor, either paid (especially for boys) or unpaid domestic work (especially for girls) (Harper et al. 2009).

Mendoza (2009) suggests that coping strategies also affect individuals within households. Studies indicate that poor households are often unable to share the risk effectively, leading to some individuals—often women and children—bearing most of the impact and facing more of the negative consequences.

5.4 Health Spending

Globally, during 2004–2005, official development assistance for child, newborn, and maternal health increased by 28%. This included a 49% increase in spending for child health and a 21% increase for maternal and newborn health. This increase was seen in most *Countdown* priority countries,[11] but a decrease was seen in others. While the benefits of the increased aid have resulted in improvements in the areas of child, maternal, and newborn health, UNICEF (2008c) notes that the programs focusing on these areas are still underfunded, with much more needing to be done to rectify the situation.

Table 14: External Resources for Health as a Percentage of Total Expenditure on Health, 2004–2006

Country	2004	2005	2006
Afghanistan	5.9	13.1	20.1
Pakistan	2.5	3.6	3.2
Bangladesh	14.9	12.2	14.6
Bhutan	15.7	37.1	48.2
India	0.5	0.4	0.7
Maldives	1.5	0.9	0.3
Nepal	17.3	16.4	15.7
Sri Lanka	1.3	1.2	1.2

Source: WHO Statistical Information System (WHOSIS) database. http://apps.who.int/whosis/data/Search.jsp (accessed November 2009).

Table 15, below, reflects this to some extent. Countries that have shown steady improvements over the years in some areas of child and maternal health, such as the Maldives and Sri Lanka, have significantly fewer resources for health. Despite India's need to address many health disparities, external resources for health remain quite low.

The following tables note indicate, however, that state expenditure is the driving force behind making resources available for health services for some countries in the region. In some instances these expenditures can be strained (such as in countries like Afghanistan) or limited (such as in Pakistan, India, Nepal, and Bangladesh), despite the fact that steady increases can be observed in all these countries except Pakistan.

[11] Bolivia, Eritrea, Guatemala, Democratic People's Republic of Korea, Lao People's Democratic Republic, Lesotho, Morocco, Peru, Brazil, Haiti, Mexico, Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Congo, Democratic Republic of the Congo, Côte d'Ivoire, Equatorial Guinea, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Togo, Djibouti, Egypt, Iraq, Sudan, Yemen, Azerbaijan, Tajikistan, Turkmenistan, Angola, Botswana, Burundi, Ethiopia, Kenya, Madagascar, Malawi, Mozambique, Rwanda, Somalia, South Africa, Swaziland, United Republic of Tanzania, Uganda, Zambia, Zimbabwe, Afghanistan, Bangladesh, India, Nepal, Pakistan, Cambodia, People's Republic of China, Indonesia, Myanmar, Papua New Guinea, Philippines.

Table 15: General Government Expenditure on Health as a Percentage of Total Expenditure on Health, 2004–2006

Country	2004	2005	2006
Afghanistan	16.2	20	27.5
Pakistan	18.5	17.5	16.4
Bangladesh	29	29.1	36.8
Bhutan	70.3	71	68.6
India	17.7	19	19.6
Maldives	78.1	85.6	84.1
Nepal	27.5	28.1	30.5
Sri Lanka	45.7	46.2	49.2

Source: WHO Statistical Information System (WHOSIS) database. http://apps.who.int/whosis/data/Search.jsp (accessed November 2009).

Table 16: General Government Expenditure on Health as a Percentage of Total Government Expenditure, 2004–2006

Country	2004	2005	2006
Afghanistan	2.1	3.3	4.4
Pakistan	1.6	1.5	1.3
Bangladesh	6.2	5.5	7.4
Bhutan	6.1	6.5	7.3
India	3.1	3.5	3.4
Maldives	16	17.7	14
Nepal	8.7	8.4	9.2
Sri Lanka	8.2	7.8	8.3

Source: WHO Statistical Information System (WHOSIS) database. http://apps.who.int/whosis/data/Search.jsp (accessed November 2009).

The data shows that there is definitely room for improvement and that governments cannot cut back on health-related spending and resource allocations during this crisis. The indicators highlight the need for more investment in order to mitigate shocks, rather than complacency, as it is clear that the allocated resources are insufficient to meet current needs.

5.5 Perspectives on the Impacts of the Economic Crisis in Sri Lanka

In order to obtain some initial reactions to how households and populations in general could be coping with the current crisis, the authors of this paper conducted a series of key person interviews to ascertain professional views on the effects of the crisis on child and maternal health.[12] The interviews focused on: (i) child and maternal health trends in Sri Lanka and the potential impacts of the crisis on these trends; (ii) how affected households are by the crisis and how they are coping; and (iii) national-level mechanisms that have been implemented to address child and maternal health.

This section will present these findings as insights that will hopefully inform more micro-level research documenting how households are coping with the crisis.

Trends in Child and Maternal Health

All respondents noted that Sri Lanka has made significant gains in child and maternal health over the years as a result of its consistent social welfare policies that have ensured free access to healthcare and educational services throughout the country.

[12] See Appendix 1 for a list of interviews conducted.

While disparities exist due to differences in outreach and availability, Sri Lanka's approach has resulted in it being ahead of many countries in the region.

Experts noted, however, that nutrition—in terms of consuming the right types of food and knowledge of micronutrients—remains a stumbling block for Sri Lanka. This can partially be attributed to behavioral health practices rather than simply to the availability and accessibility of nutritious foods.

"When we look at feeding practices, there are problems. Nutrition is closely related to poverty but poverty alone is not the factor. There are lots of behavioral elements. Children need only small amounts of food but they don't get the correct type at the correct time and the correct amount. Lot of behavioral changes need to take place, on caring practices and feeding practices."

Child Health Expert, Family Health Bureau

They also noted that there is an urgent need to look at nutrition more closely given the short, medium, and long-term impacts that it can have on a child's life and overall development.

"…So if they don't receive nutrients at the correct levels at the correct time, their brain development will be affected and as a result intelligence, memory power, [and] attention span decrease…productivity will reduce in the long term. Malnourished children are more susceptible to non-communicable diseases so the risk of diabetes, heart disease etc increase…"

Child Health Expert, Family Health Bureau

Sri Lanka has a relatively low rate of maternal deaths to live births. Every maternal death that occurs is investigated with the active participation of professional bodies such as the College of Obstetricians, the Ministry of Health, and the Family Health Bureau. This has helped identify and prevent some causes of death. However, it was noted that causal patterns are changing and issues not directly related to the management of labor are coming out as leading causes of maternal death. These include post partum hemorrhaging and septic abortion caused by illegal abortions performed by unskilled personnel.

"…Causes of maternal deaths have changed—the leading cause was post partum hemorrhage—as in developed countries. Now the numbers are coming down compared to other countries and other (previous) years because of the participation from professional bodies such as College of Obstetricians as well as Ministry of Health and the Family Health Bureau to investigate each and every maternal death in this country. Each maternal death is reported to the Maternal Health Unit of the FHB and there are inquiries conducted at every level to find out the causes of these deaths."

Nutrition Consultant, UNICEF

It was noted that some hurdles continue to persist in Sri Lanka. The country needs to improve screening facilities for women to test for conditions that will make pregnancy dangerous for the mother, have adequate awareness-raising campaigns about these conditions, and provide counseling and contraception for women and couples at risk.

"The second leading cause of maternal deaths is septic abortion…There are many who haven't succumbed but suffer from some other side effects. Out of these mothers who died, roughly 35–40% of them experience an unmet need in terms of contraception."

Nutrition Consultant, UNICEF

Impacts of the Crisis on Health

The impact of the economic crisis on child and maternal health is perceived to be minimal. The minimal impact is attributed to state policies that have been promoting local, household-level food production (through home gardens), as well as controls of some food prices (mainly rice), which have helped to maintain food availability. However, it is noted that the diversity of food consumed might have been affected and that families may be restricting their intake of certain types of nutritious food.

"The diversity of their food maybe affected. May restrict diversity especially when it comes to animal sources of protein more than calorie sources."

Child Health Expert, Family Health Bureau

While there is a certain level of complacency among officials, others warn that it may be too early to determine what the impacts may be as there is not yet adequate information. The available data on poverty and child wellbeing does not capture the dynamism of these conditions and, hence, is unable to fully assess the impacts of the economic crisis. At the same time, the economic crisis is not considered a priority in light of other emergencies, such as the civil conflict and its effects. As a result, there is a lack of perceived urgency to improve information among other mechanisms to address the health impacts of the crisis.

"We use different health indicators to measure maternal and child health. Information on some of these are collected only annually. The financial crisis happened recently so there might not be a lot of information."

Director, Ministry of Healthcare and Nutrition

Household-Level Coping

Discussion with health professionals further substantiated that the increase in prices of food could lead to families, especially those in the lower-income groups, buying cheaper food that is not of high nutritional value. Protein consumption, especially of animal protein, could be minimized in an effort to reduce cost, therefore exacerbating the problem of undernutrition in Sri Lanka.

"Yes, the cost of living has gone up. Whatever the thing, people are going to curtail expenses on food. In our country no matter what happens we don't curtail children's education. Ultimately they are going to restrict the purchasing power of the food they eat. Nutrition is directly affected. I think there will be reduced intake of food or they go for cheap food. They might reduce the amount or quality. They might have rice with one curry maybe, not having a balanced diet."

Nutrition Consultant, UNICEF

Women in lower-income groups are more at risk of being in situations where their health will be adversely affected than others in their households. Health professionals noted that the nutrition of the husband and children, especially in the lower-income groups, is put first because if the husband misses a day of work due to bad health, the household's income will dwindle, affecting everyone. Mothers may also reduce their food consumption in order to give priority to the education of their children.

Initiative to Address Child and Maternal Health

Sri Lanka's public healthcare system is noted as being a main driver of positive changes in the country and a cause of its being ahead of other countries in the region.

However, disparities in access and hidden costs are noted as factors that negatively affect health conditions.

"…even in the rural areas are reached by the public health system where they are delivered integrated interventions. Follow up is regular; there is regular monitoring both before and after childbirth. But our system did not reach them [those in the estate sector]. There are gaps, human resource gaps exist; their accessibility is poor; road networks are not adequate; people don't have adequate transport services to reach them. There are a lot of problems."

Child Health Expert, Family Health Bureau

"Improving the urban sectors, the estate sectors, vulnerable groups, disadvantaged populations are also very, very important—improve the facilities for them to get specialized care. 98% of mothers do deliver in a hospital. Only 2% deliver at home, so that 2% is whom you need to target. Those home deliveries provide the space for mothers to die or have morbidities. In Sri Lanka we advocate hospital deliveries and if you want home deliveries, to have a skilled attendant present."

Nutrition Consultant, UNICEF

"Healthcare in Sri Lanka is free but in most of the cases you get the prescription from the doctor but you get the medicine at a private pharmacy. So all these things are hidden factors that affect people."

Senior Advisor, Save the Children Sri Lanka

Initiatives to mitigate the effects of the crisis cannot be implemented by the state alone. There is a need for continued technical and financial assistance from other partners if current gains are to be maintained. It was also noted that in light of the economic crisis and the need to prioritize funds, donors might give priority to other countries as a result of Sri Lanka's current gains, potentially putting those gains in jeopardy.

"…especially at [the] provincial level, the donors play a large role. At this level funds are mainly used for activities like service development and capacity building so donor support is crucial [in improving]... nutrition [and] maternal and child health, [and reducing the incidence of] non-communicable diseases."

Director, Ministry of Healthcare and Nutrition

"There could be prioritization of other countries over Sri Lanka, yes that is a possibility, as Sri Lanka has achieved a lot of good indicators. There is a problem of getting funds compared to the others."

Nutrition Consultant, UNICEF

Addressing child and maternal nutrition issues—especially malnutrition—requires an integrated and mainstream approach that takes into account behavioral practices and household decision-making patterns. The issue of nutrition is currently only addressed by the Ministry of Healthcare and Nutrition and as such addressing it as an issue is centralized. Officials are of the view that it needs to also be included in development programs run by other ministries and institutions (with the involvement of the Ministry of Healthcare and Nutrition), in addition to ongoing programs.

"Today malnutrition is mostly due to poor childcare practices. To improve the situation, it has to be an integrated approach where other areas such as agriculture, education, and poverty alleviation must work with the health sector."

Professor of Medicine, University of Colombo

"The Ministry of Healthcare alone can't be responsible. I think nutrition has to be coordinated at a higher level and it must be integrated with other ministries such as trade, agriculture, livestock, fisheries etc because all these policies matter."

Child Health Expert, Family Health Bureau

6. SOLUTIONS TO CONSIDER WHEN TRYING TO MITIGATE SHOCKS

The literature notes a number of ways that shocks to the poor can be mitigated. This section aims to present some interventions that could be considered in order to mitigate the impact on child and maternal health. Social protection is identified as a key component that could help poor households, but it is also noted as usually being focused on the poor rather than on the vulnerable.

Table 17: Snapshot of Responses in the Region to Prevailing Vulnerabilities

Country	Vulnerabilities	State response
Afghanistan	• Conflict affectedness • Female-headed households • Displaced populations	• Removal of import tax on wheat and staples • Discussing strategic grain reserve system • Food imports • Joint appeals for food aid and agricultural recovery • Five-year social protection strategy integral in new development strategy
Bangladesh	• Natural disaster proneness • Lack of land • Low-income and rural households	• Public food distribution system • Open market sales • Food for work and cash for work programs • Fertilizer subsidy
India	• Rural sector (farmers are vulnerable, high suicides) • Availability of food against the population's needs	• Reserves of 31.6 million tons of food grain • Targeted public food distribution system • Export restrictions • Midday meal schemes • Wheat based nutrition program • National rural employment guarantee scheme • Food and fertilizer subsidies • 11th five-year plan nutrition security • Rural grain banks
Nepal	• Flood proneness • Decreased production of maize and local crops • Lack of market access • Poor and excluded groups (e.g., Dalits, indigenous groups, landless)	• Restrictions on food grain exports • Reduction in fuel prices (but still high) • Aid mobilization in venerable food districts • Social protection (considering introducing ration cards) • Targeted kerosene and LPG subsidy (planned)
Pakistan	• Female HH, rural HH, urban poor, border districts	• 2.5 million metric tons of wheat imported • 1 million metric tons of wheat maintained as strategic reserve • Removal of duty on wheat • Minimum export price on rice • Subsidized wheat distribution • Benazir credit card (for short term loans to small farmers and cash subsidies to five million poor HH)
Sri Lanka	• Conflict affected • IDP populations, female HH, disabilities	• Direct imports to meet shortfall • National Nutrition Plan (multi-sector approach to nutrition) • Reducing the price of milk powder • Direct food assistance, health based interventions, and poverty reduction programs

HH = household, IDP = internally displaced persons, LPG = Liquid Petroleum Gas.

Note: Limited information available for Bhutan and the Maldives.

Source: UNICEF ROSA 2009.

6.1 Welfarist Approach: Sri Lanka's Approach to Health Services

Sri Lanka is often noted as a country that has achieved high standards of social and health development compared with other countries at a similar stage of economic development. These gains have been attributed to its universal free access policies to healthcare and education services throughout the country.

Box 2: Mapping Health Progress in Sri Lanka: Some Key Milestones

- Maternal mortality ratio declined from 340 per 100,000 live births in 1960 to 43 per 100,000 live births in 2005, and 98% of births now take place in hospitals. Rates of prenatal care (at least one visit) and skilled attendance at birth stand at 99%.
- In 2007 the overall fertility rate was 1.9—compared to 3.0 for the South Asia region.
- The under-five mortality rate has fallen from 32 per 1,000 live births in 1990 to 21 per 1,000 live births in 2007.
- The neonatal mortality rate has also fallen, with around eight per 1,000 births in 2004.
- Net primary school enrolment stands at more than 97% for both girls and boys.
- Literacy rates among young people aged 15–24 are 97% for males and 98% for females.

Source: Adapted from UNICEF (2008b).

In 2008, the total health budget saw an increase of 8.5%—about 1.7% of GDP. According to Central Bank data, the number of government hospitals in the country is 619, with a total of 65,835 beds. This amounts to three beds per 1,000 persons. Qualified doctors in the state sector numbered 13,026, adding up to one doctor for every 1,552 persons. There were also a total of 22,996 qualified nurses—a nurse for every 879 persons—by the end of 2008 (Central Bank of Sri Lanka [CBSL] 2008).

Table 18: Salient Features of Health Services in Sri Lanka

Item	2007	2008[a]
Government		
Hospitals (practicing western medicine) (No.)	619	619
No. of beds	62,197	65,835
Central dispensaries (No.)	387	411
Total no. of doctors	11,442	13,026
Total no. of Assistant Medical Practitioners	1,244	1,229
Total no. of nurses	22,088	22,996
Total no. of attendants	7,201	7,184
Private		
Hospitals (practicing western medicine) (No.)	212	220
No. of beds	8,500	8,850
Total no. of Ayurvedic doctors[b]	18,651	19,094
Total government health expenditure (billion SLR)	68.7	74.5
Current expenditure	51.7	55.9
Capital expenditure	55.9	18.7

Notes: SLR = Sri Lanka rupee; a = Provisional, b = Registered with the Department of Ayurveda.

Source: CBSL (2008).

The private sector serves around 10–15% of inpatients and approximately 60% of outpatients. At the end of 2008, 220 private health institutions with 8,850 health practitioners were registered with the Private Health Service Regulatory Council (CBSL 2008).

The Sri Lankan government has recognized the need to address and rectify the problem of malnutrition. According to the central bank, "a recent Food and Nutrition Policy for 2004–2010 emphasized the need for focusing on the poor and integrating nutrition with other sectoral activities, including health, agriculture, education, economic reform, and rural development" (CBSL 2008).

These plans are in the preliminary stages of development and need to be tracked for progress, as well as to ensure that vulnerable and marginalized groups are being included in programs. According to health ministry sources,[13] these plans are also being developed with the support of a decentralized medical system at the provincial and district levels.

Box 3: Continued Challenges in Sri Lanka, Despite Gains in the Health Sector

- Shortage of healthcare workers. According to World Health Statistics 2008 (WHO 2008), in the 2000–2006 period the country had only six doctors and 17 nurses and midwives per 10,000 inhabitants.
- Services have deteriorated as financial resources have been squeezed, with health spending being insufficient to meet the demand.
- Private spending on health, most of which is out of pocket, accounts for more than half of total health expenditure.
- Ensuring food security has been difficult, and will remain so if global food prices remain high.
- The country still has marked levels of undernutrition among newborns and children under five. More than one in every five newborns is born with a low birth weight, and 23% of children under five are moderately or severely underweight.
- Improving the level of exclusive breastfeeding for children under six months old from its current level of 53% will be vital to sustaining Sri Lanka's gains in neonatal and child mortality.

Source: Adapted from UNICEF (2008b).

Other more localized policies and schemes that are noted by experts as having contributed to the improvements in child and maternal health indicators include: (i) mandatory breastfeeding of infants (though this has been noted to have negatively impacted older infants as breast milk is used to supplement other solid food), (ii)

[13] Discussions with the Director of Planning, Ministry of Health, Sri Lanka.

maternity leave extensions (though this applies only to the formal sector), and (iii) localized presence of a midwife.[14]

6.2 Chiranjeevi Scheme: Maternal Health Financing in Gujarat

The high proportion of maternal deaths in the state of Gujarat, India has been attributed to the low quality of services available for pregnant women, especially among the poor, that results in home-based deliveries in unsanitary conditions overseen by untrained personnel.

The Chiranjeevi Yojana program, implemented by the Government of Gujarat, aims to improve the accessibility of institutional healthcare services to poor families. This is done by providing financial services to families and covering their out-of-pocket costs associated with traveling to reach the healthcare facility. The scheme also provides financial support to the accompanying person for loss of wages. The scheme uses the Below Poverty Line card to target poor families. Launched in 2005 as a pilot in one district, the scheme has now been extended to the whole state.

An evaluation of the program (Bhat et al. 2007), undertaken in one district, found that the scheme not only provided a link between the community and the institution, but also provided financial protection to the marginalized section of the population. Government health employees (e.g., auxiliary nurses and midwives) were found to be effective in building awareness and guiding clients to utilize the services, though prenatal and postnatal care services needed further strengthening and neonatal care was recommended to be included in the package. The study also suggests that the availability of required medicines needs to be improved and that despite the advantages of the Below Poverty Line card, not all poor families have access to it to, and thus are unable to avail themselves of these services.

6.3 Social Protection and Safety Nets

Social protection includes policies and programs that are designed to provide assistance to the poor with a view toward meeting basic needs and improving overall wellbeing. These programs can include short and long-term support for food consumption and livelihood (sometimes offering protection against risk and vulnerability), and help to mitigate shocks to household income. Social protection typically revolves around the following elements: (i) social insurance (such as health, life, and asset insurance, which may involve contributions from employers and/or beneficiaries); (ii) social assistance (mainly cash, food, vouchers, or subsidies); and (iii) social services (such as maternal and child health and nutrition programs) (Mendoza 2009).

Clearly the list of social protection programs operating in the region is large (see Appendix 2). In the context of the current crisis, it may be noted that a number of the social protection programs that are in place may focus on the extremely poor. If those direct impacted by the economic slowdown in the region are unlikely to be the extremely poor, such programs should be evaluated in terms of their support of less poor (vulnerable) groups. For instance, many export sector workers may not fall below national or international poverty lines. At the same time, poverty line, gap and squared gap data does not capture groups who have moved into poverty as a result of the crisis. However, it is precisely these workers who are losing jobs as Asia's exports contract (Hasan, Magsombol, and Cain 2009). The Institute of Development Studies (2008) recommends that several key lessons from the 1997–1998 Asian financial crisis be considered:

[14] From key person interviews.

- Expand established safety net programs rather than creating new ones.
- Protect pro-poor spending on key sectors, including health and education.
- Target social protection programs. Some examples include conditional programs that include requirement to work to improve targeting in Argentina, food subsidies in Indonesia after 1997, unconditional cash transfers that can be rolled out faster than more sophisticated conditional cash transfers (e.g., PROGRESA in Mexico).

Grosh et al. (2008) note that the following conditions should also be considered when looking at programs and social protection:

- Contexts within which programs are to be implemented matter, hence there is no blanket solution. Whichever program is adopted needs to be adapted to local conditions and the needs of local affected populations. Programs need to be customized to meet local needs instead of being simply replicated.
- The role of systems that work and good implementers are vital for effective programming. Programs often have a limited impact because they can be co-opted for political gain.
- The impact of food stamps on nutrition is not easily demonstrated, but they have been more effective than cash transfers in maintaining food consumption patterns. Similarly, feeding programs may have a positive impact on attendance, but less of an impact on nutritional gain because the type of food that is distributed is not generally sufficient to make this impact or it may be too late to influence long-term nutritional development.

7. ADDRESSING THE CRISIS AND MOVING AHEAD: INVESTING IN LONG-TERM SOLUTIONS

Attempts to address the economic crisis should include continuous engagement on issues related to child and maternal health, including ongoing financial support. The need to consciously focus on these issues and to stay engaged is even more important in poor regions because these areas often lack proper funding in the first place. The current economic crisis could threaten fund allocation to address child and maternal health-related issues and exacerbate conditions, especially among the poor.

The need to focus on children and on supporting their households to overcome poverty is linked to having a strong and healthy population that can sustain the development of a country. Countries should not treat the longer-term impacts of limited investment lightly.

A report on protecting the vulnerable during times of crisis (Office of the Prime Minister of Norway 2009) calls for maternal, newborn, and child health to be prioritized, given that mortality risks for mothers and children are highest in the critical hours and first days around birth. Focusing on the quality of care during birth—skilled attendance and emergency and neonatal care—as well as care in the immediate postnatal period and beyond, including family planning, is of key importance.

Does the crisis provide an opportunity for stakeholders to engage with this issue differently? This is an important question to consider. The crisis can be seen as an opportunity to engage with these issues differently and to prioritize this engagement for future gains. It is important for countries to explore their welfare strategies to examine how they can address growing vulnerabilities, scale-up successful interventions, and downgrade interventions that are costly and provide minimal results. It is an opportunity for non-state (i.e., private sector and non-governmental)

organizations to work to support the state mechanism to make health services for vulnerable groups more affordable, accessible, and meaningful.

As the UNICEF ROSA (2009) report notes, understanding and tracking the effects of this complex interplay of global, evolving trends and their impact on poor and excluded communities in the region is crucial to determining the policies and strategies required. These policies should be multipronged, help cushion the immediate blows of the crisis, *and* take steps to protect the wellbeing of the most vulnerable in the longer term.

7.1 There is a Need for More Information and Research on the Impacts of the Crisis

There is a need to understand the problem at hand in a more concrete way. There is still insufficient data that assesses the immediate impact of the crisis that can inform policies and practices. The data available is based on economic factors and dealing with standard indicators of health and nutrition. This data does not capture the experiences of households in the crisis and is unable to contribute to our understanding of how vulnerable families and children cope with the impact of the crisis. However, this process of data collecting needs to take place in parallel with dealing with the crisis. There is also a need to examine how people access food supplies, what their feeding practices are, and how these have been affected by the crisis and food price increases.

7.2 Investing in Social Protection and Safety Nets is Imperative

A recent conference held to assess the impact of the economic crisis on children identified the importance of scaling up and investing in social protection schemes to cushion affected populations (UNICEF 2009). While investment in the economy to increase jobs seems to be the preferred way to deal with the effects of the economic crisis, investment in social protection can also help combat its impacts.

Countries in the region use a range of social protection schemes, such as poverty-related cash transfer programs. Two examples are the Sri Lankan Samurdhi program and Pakistan's recent initiative—the Benazir Fund—which aims to cover five million poor households, primarily addresses women's needs, and has most recently been expanded to include newly displaced populations (UNICEF ROSA 2009).

Many countries have school meal programs, contributing to school-age children's basic food intake and serving as an incentive to attend classes. Afghanistan, Bangladesh, India, Nepal, Pakistan, and Sri Lanka have well established food-for-work and cash-for-work employment programs. India introduced a large employment guarantee scheme (NREGA) for the rural poor in 2005 and this approach is being replicated in Bangladesh and Nepal. Bangladesh, India, Pakistan, and Sri Lanka use systems of ration cards or price-controlled shops to address food price inflation (UNICEF ROSA 2009).

Sri Lanka has adopted a national nutrition plan that includes access to nutritious food for low-income households. While all eight countries feature public sector old-age pensions, Nepal has a unique system of non-contributory old age pensions for all citizens over the age of 70, which reaches even remote areas of the country (UNICEF ROSA 2009).

Other ideas under discussion include:

- provision of nutritional supplements as part of public employment schemes (Nepal);

- universal pensions for the elderly and disabled (India);
- health-related grants, such as maternity benefits or transport grants, to cover delivery expenditures (India and Nepal); and
- the adoption of a comprehensive social protection package, spanning universal free primary healthcare, a social pension, and state contributions to ease food and transport prices (Maldives) (UNICEF ROSA 2009).

Yet barriers to utilization still exist and this prevents even free programs from being accessed by the poor. Social insurance schemes for the informal sector are almost nonexistent (UNICEF 2009), but can serve to protect vulnerable populations, such as those at risk of job losses.

Similarly, programs that offer universal coverage can help support the most vulnerable children and mothers. Universal targeting helps protect all children and mothers. The Sri Lankan example of free healthcare and education and the state's commitment to continuing these programs will help provide for the basic healthcare and educational needs of children and mothers. What is also needed is ongoing support of such programs, especially during these times, to ensure that past gains are not affected.

7.3 Integration of Food Security into Social Protection

The promotion of food security is critical within any social protection scheme that aims to ensure adequate nutrition—especially for infants and young mothers—and make sure that food (particularly staples) is available at an affordable price. Nutrition of vulnerable infants and mothers should be monitored, with provisions for supplementary feeding for those at risk (Harper et al. 2009).

7.4 Supporting Households to Cope with the Crisis

"Policy should not underestimate the agency of households, including children, in responding to crisis. The challenge is to support constructive coping mechanisms and seek to discourage unconstructive ones" (Harper et al. 2009:1). It is essential that we focus on the short, medium, and long-term impacts as they are all integrally interlinked. Addressing one set of impacts does not necessary serve to mitigate the overall negative impacts of the crisis on households.

It is also important to focus on the "irreversibles"—including nutrition, access to education, being pushed into work, and unsafe working conditions—that result in an irreversible cycle of poverty (Harper et al. 2009). Factoring in the role of children in dealing with the crisis at the household level is also important. How children perceive the impact of the crisis and how they feel about it affects them and their families, and can also provide valuable insights into possible policy directions. The short, medium, and long-term effects of economic deprivation on children result in the development of coping strategies that can further destabilize their lives.

7.5 State Interventions that Mitigate Vulnerabilities Resulting from the Crisis

In South Asia, a number of countries have recently implemented fiscal stimulus policy, including India (US$4 billion) and Sri Lanka (US$141 million) (Kohler 2009 in Harper et al. 2009). Yet this needs to come with a commitment to channel these resources to key sectors, including healthcare. In Sri Lanka, there have been numerous warnings that fiscal gains are being channeled into certain areas (post conflict) or are being

used to support loan payments rather than to address critical sectors in light of the crisis.

The role of the state is critical, both in recognizing the consequences of the crisis, and in working to mitigate its impacts. In Sri Lanka there seems to be no sense of urgency in addressing the effects of the crisis beyond its economic impact. This could be because of Sri Lanka's long-standing welfare approach that provides free access to healthcare and educational services. As a result of these policies, households have been cushioned to a certain extent. Yet, this system suffers from issues of accessibility and quality of services that means it does not reach some segments of the population. Discussion with health sector professionals revealed that workers in the tea plantation sector are one such group. Access to healthcare services is limited in these areas and already poor conditions could be further affected by the crisis as a result of the sector being affected by export market cutbacks.

In countries like Sri Lanka that are grappling with multiple emergencies (e.g., as a result of conflict), greater efforts are being made to address some immediate needs over others. However, these efforts will obscure the needs of other vulnerable groups, including those affected by the economic crisis, if policymakers and practitioners do not consider the crisis to be an emergency situation that must be addressed over both the short and long term. The discussions with practitioners gave some indication that this crisis is not perceived as an emergency situation.

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APPENDIX 1: KEY PERSONS INTERVIEWED

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APPENDIX 2: SOCIAL PROTECTION IN THE REGION

The following types of safety net schemes also provide some useful insights into programs that could be implemented to mitigate the risks brought on by the crisis (Grosh et al. 2008).[15] Some of these focus on maternal and child health, while other are targeted toward the household but can still be useful to consider given the related impact of the crisis on child and maternal health. The safety net schemes include:

- *Transfer programs (in cash and in-kind)*—developed to support poor households in maintaining a minimum level of consumption. These can be used to support people who are vulnerable in times of crisis. They include unconditional transfers to households in the form of cash, vouchers, coupons, and stamps. Some examples in the region include Sri Lanka's Samurdhi poverty alleviation program, which provides a regular monthly transfer to selected beneficiary households; Bangladesh's non-contributory pension scheme that provides households with 10% of the average 2003 per-capita income; the Zakat program, a cash transfer program managed by the Religious Affairs Ministry and the Food Support Programme in Pakistan; and the old age pension program in India.
- *In-kind food transfers and other food-based programs.* These programs make food available to vulnerable families in the form of food rations, supplementary and school feeding programs, or emergency food distribution. Food-based programs are often targeted and can help maintain the nutritional standards of mothers and children during crisis periods. They can also help vulnerable households to participate in social programs. These programs could use universal price or tax subsidies for basic commodities. Some examples include a targeted, need-based program in India in which certified poor consumers who fall below the poverty line can purchase wheat and other commodities at reduced prices through public distribution systems; the Vulnerable Group Development Programme in Bangladesh that integrates food security and nutrition with development and income generation among poor rural women; supplementary feeding programs at child feeding centers in Bangladesh; the mid-morning snack program for school children in Bangladesh; the Food for Education Programme in Bangladesh, which provides wheat or rice to families via children in primary schools and has since been changed to a cash stipend program.
- *General subsidies*. These are implemented with the aim of controlling price changes of food and essential commodities. These programs are not targeted and all have access to these subsidies.
- *Income generation programs*. These programs supply low-skilled jobs in community-level infrastructure projects and provide wages in cash or in-kind to contracted people, providing some cushioning against job losses. The programs do not need to target public works exclusively, but can also focus on job training, job placement, and microcredit programs that can support livelihood activities. Income generation programs can also complement transfer programs, which can be used to protect households in the shorter term rather than building dependence on transfers. Some examples include the infrastructure reconstruction work after the 2004 Tsunami in Sri Lanka, the Food for Work Programme in Bangladesh, the Maharashthra Employment

[15] See Appendix B in Grosh et al. (2008) for detailed descriptions of the mentioned safety net programs.

Guarantee Scheme in India, and the Jawahar Employment Programme in India.

- *Protecting human capital and providing access to basic services*—conditional transfers that encourage the use of educational and health facilities. These programs help ensure that vulnerable groups, such as women and children, have access to services and are not forced into other activities to help support the household during crises. Examples include Bangladesh's Female Secondary School Assistance Programme and the Primary Education Stipend Programme.
- *Fee waivers, exemptions, and scholarships*—helping poor households access services at a subsidized rate. These can include fee waivers, vouchers, and scholarships to access health and educational services. Some examples include Sri Lanka's free universal public and curative healthcare system and primary, secondary, and tertiary education systems; and its Year 5 Scholarship program aimed at improving the accessibility of public secondary education;[16] stipend programs for girls in Bangladesh and Pakistan; performance-related grants for education in Bangladesh, Pakistan, and Nepal; targeted bursaries in India; free text books in Pakistan, India, and Sri Lanka;[17] free learning material in Bangladesh and India; and free school uniforms in India and Sri Lanka.[18]

[16] Not mentioned in Grosh et al. (2008) but noted here given its significance to the topic of the paper.

[17] Not mentioned in Grosh et al. (2008) but noted here given its significance to the topic of the paper.

[18] Not mentioned in Grosh et al. (2008) but noted here given its significance to the topic of the paper.