Maternal Health in South Asia- Progress and Challenges and Options for accelerating progress

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Outline of presentation

- Why invest in reproductive/maternal health?
- Well known effective interventions and yet women continue to die needlessly
- Progress and Challenges
- UNSG’s Global Strategy for Women’s and Children’s Health and commitments of countries
- Options for accelerating progress
Section 1

INVESTING IN REPRODUCTIVE /MATERNAL HEALTH- WELL KNOWN FACTS, YET INADEQUATE INVESTMENTS
Economic rationale for investing in women’s health

- An estimated US $15 billion in lost productivity every year due to maternal and newborn mortality
- Women are the sole income earners for over 25% of households worldwide
- A woman’s income more likely contributes towards food, medicine, education and other family needs
- Women’s unpaid work equals about 1/3 of the world’s GNP (farming, managing homes, caring for children and others)
- 30-50% of Asia’s economic growth from 1965-90 can be attributed to improvements in reproductive health and reductions in infant and child mortality rates

Source: UNSG’s global strategy for women’s and children’s health
Social and cultural rationale

- A woman’s poor health pushes her family into further poverty
- Mother’s survival is linked to the survival of her newborn or her children below five years
- Mother’s survival is essential for:
  - Instilling social and cultural values
  - Ensuring education of young girls who otherwise would take on responsibility of the family

Source: UNSG’s global strategy for women’s and children’s health
Reducing unmet needs of FP is critical for reducing maternal mortality.
Investing in FP saves costs in achieving other MDGs

- Maternal Health, $102 M
- Water & Sanitation, $68 M
- Immunization, $4 M
- Education, $153 M
- Total Cost of FP $50 M
- Total Savings: $327 M
Section 2

WELL KNOWN EFFECTIVE INTERVENTIONS, YET WOMEN CONTINUE TO DIE NEEDLESSLY
Three pronged strategy to save lives

Social, cultural, political, economic factors

Skilled birth attendants (SBA)

Emergency obstetric care (EmOC)

Health systems

Family and community

Family planning
Reproductive, maternal, newborn and child health continuum of care

Source: Partnership for maternal, newborn and child health: Innovations for every woman and every child
Time of birth most critical period for mother and newborn

~2 million deaths still occur at the time of birth\(^1\)

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage (%)</th>
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<tbody>
<tr>
<td>Contraceptive prevalence</td>
<td>50</td>
</tr>
<tr>
<td>1+ antenatal visits</td>
<td>60</td>
</tr>
<tr>
<td>Skilled attendant at delivery</td>
<td>70</td>
</tr>
<tr>
<td>Postnatal visit within 2 days</td>
<td>80</td>
</tr>
<tr>
<td>Exclusive breastfeeding</td>
<td>90</td>
</tr>
<tr>
<td>Case management of pneumonia</td>
<td>100</td>
</tr>
<tr>
<td>Measles immunisation</td>
<td>100</td>
</tr>
</tbody>
</table>

1. Including 0.5 million maternal deaths, 1 million stillbirths, and 1 million newborns
2. Source: Coverage estimates for interventions across the continuum of care in the 68 priority countries.
Why are women still dying in South Asia

- Cost effective interventions to reduce maternal mortality are well known-----
  - But unattainable for many women due to health system constraints and equity issues
- Despite the economic development in the region, health investments continue to be low
- The region has some of the lowest GDI and HDI indices
Section 3

PROGRESS AND CHALLENGES
Progress

- Much progress in reducing maternal mortality in South Asia – 50% reduction
- Bhutan and Maldives were reported to be on track (Sri Lanka was already on track)
- Other countries are progressing particularly Bangladesh and Nepal, but the required 5.5% annual reduction has not been achieved by all
- Afghanistan has reported impressive reductions
- Sri Lanka has sustained its achievements
Challenge: Inequity most visible with regard to MH indicators

- Faces of exclusion
  - Maternal ill health and death clustered disproportionately in the poor populations
  - Rural and remote populations
  - Social exclusion – caste, religion
  - Political exclusion (migrants)
Inequities South Asia - Deliveries by Skilled Birth Attendants

Lesson: equity in access critical for reducing MMR

Source: DHS (last published) 2006-2008) AFG HH survey 2006
Inequities South Asia - ANC by skilled birth attendants

Lesson: equity in access critical for reducing MMR

Source: DHS (last published) 2006-2008) AFG HH survey 2006
Inequities South Asia - C-sections

Source: DHS (last published) 2006-2008
Challenge: High out-of-pocket expenditure - major barrier for the poor

Health expenditure and out of pocket expenditures – selected countries of South Asia

Source: Countdown to 2015 report (2007)
Official development assistance to health, total (Constant 2009 US$ millions) and proportion going to reproductive health care and family planning (Percentage), 2000-2009

Summary of challenges

- Coverage gap – not to the desired level
- Equity gap
- Quality gap
  - ANC: not full package of services – syphilis screening, prevention of mother to child transmission etc
  - Skilled care: are the SBAs competent and is the policy environment enabling them to practice life saving skills?
  - Post-natal care: coverage and quality poor
Summary of challenges

- **FP**: poor quality with continuing high unmet needs leading to unwanted pregnancies, unsafe abortions, complications contributing to Maternal Deaths, frequent stock outs, inadequate investments (only India and SL full investments)

- **Adolescent pregnancy**: while within marriage the levels continue to be high (Bangladesh India, Nepal), evidence of unwanted pregnancy among unmarried
Health system and policy challenges

Coverage of interventions is dependent on the quality and effectiveness of health services

- Human resources - availability and distribution in remote areas particularly skilled birth attendants and specialists

- Poor quality of services – supplies, equipment, following standards of care

- Lack of accountability of duty bearers – attitude of health workers

- Inadequate, inefficient and inequitable spending

Cost of MH care are high for the poor: in most countries, unpredictable and catastrophic in most instances and is a major barrier
Challenge: Lack of Accurate data on maternal mortality

- Different sources quote different estimates
- Maternal death not notifiable except Tamil Nadu in India and Sri Lanka
- Maternal death reviews – facility based and verbal autopsy - limited coverage (good example: Sri Lanka, Bhutan)
- Vital registration – coverage poor (best in Sri Lanka)
Data on MMR from various source

<table>
<thead>
<tr>
<th>Country</th>
<th>UN 2008</th>
<th>Institute of Health Metrics (in Lancet) 2010</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
<td>1400</td>
<td>880</td>
<td>297 (2010)</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>340</td>
<td>247</td>
<td>140 (2010)</td>
</tr>
<tr>
<td>Bhutan</td>
<td>200</td>
<td>189.9</td>
<td>112 (2009)</td>
</tr>
<tr>
<td>India</td>
<td>230</td>
<td>186.5</td>
<td>254 (2009)</td>
</tr>
<tr>
<td>Nepal</td>
<td>380</td>
<td>315.9</td>
<td>229 (2009)</td>
</tr>
<tr>
<td>Pakistan</td>
<td>260</td>
<td>331.7</td>
<td>276 (2006)</td>
</tr>
</tbody>
</table>
Social and cultural challenges – a major issue in South Asia

- M Mortality – *an indicator of the way women are cared for in a society* – the following list the obstacles to care

- **Women’s status**—
  - Lack of education, *early marriage & childbearing*,
  - Unequal power relationships (inability to take decisions),
  - low valuation of women and girls, and
  - poor access to nutrition
  - *son preference* (repeated pregnancies, sex determination and abortion (Vietnam))

- **Family and community beliefs that**
  - prevents early identification of problems
  - lack of awareness of pregnant women’s needs
UNSG’S GLOBAL STRATEGY FOR WOMEN’S AND CHILDREN’S HEALTH
Investing in Our Common Future

Global Strategy for Women's and Children's Health
UN Secretary-General Ban Ki-moon
What is the global strategy?

The **UN Secretary-General's Global Strategy for Women's and Children's Health** is the first comprehensive roadmap to accelerate progress, deliver results, and ensure accountability for women's and children's health by:

- Galvanizing commitments and action from partners
- Prioritizing women's and children's health in national health plans
- Ensuring access to a comprehensive, integrated package of essential services and interventions
- Addressing critical health system gaps
- Holding ourselves accountable for results
- Addressing social determinants

*This global health initiative builds on existing efforts and aims to gain new commitments*
**Strategy focuses on most vulnerable women and children**

<table>
<thead>
<tr>
<th>Women and newborns</th>
<th>Adolescents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve care during childbirth and first days afterwards - which is the period of greatest risk of death</td>
<td>Ensure adolescents have control over their life choices, including fertility</td>
</tr>
</tbody>
</table>

**Vulnerable groups**

Focus on ensuring equity of access to health; e.g. poorest, those with HIV/AIDS, orphans, indigenous populations and those living furthest from health services

**More than 8 million women, newborns, and children under the age of 5 die from preventable causes every year**
The MNCH global consensus – a framework for coordinated action

- Leadership
- Health workers
- Access
- Interventions
- Accountability
South Asian countries that made commitments to the Global strategy

- Afghanistan (2010)
- Bangladesh (2010)
- India (2010)
- Nepal (2010)
- Sri Lanka (2011)
Summary of commitments (related to MH)

- Increase number of SBAs
- Improve access to SBAs
- Improve CPR and reduce unmet needs
- Free deliveries to poor and hard to reach (NEP)
- Increase health spending (AFG)
- Improve access through mobile clinics, out reach etc (AFG)
- Reduce adolescent fertility (Bangladesh)
- India – technical assistance (South-South)
- Sri Lanka- capacity building of health sector and information technology

Who is going to be accountable in meeting the commitments?
Section 5

OPTIONS FOR ACCELERATING PROGRESS – BASED ON COMMITMENTS MADE
Options to improve coverage by SBA

- MNH work force plan: Assessment of current MNH work force
  HR plan for MNH workforce

- Interim:
  - Identify categories that have the potential to be SBAs- Nurses, auxiliary midwives, etc and plan for upgrading skills (Nepal, Bangladesh)
  - Unemployed – Register, assess skills of those interested in employment, employ on contracts (Eg. Philippines), posting in remote areas with incentives
  - Midwifery led maternity units in remote areas – (Pre-requisites: registration, accreditation and referral linkages, funding, fee structure, sustainability)
Options to improve access to EMOC

- MNH workforce plan should cover issues related to human resources
- Short term courses in EMOC and Anesthesia for non-specialists
- Changes in regulations and policies to enable practice
- Establishing systems for monitoring availability (every Qr)
- Private-public partnership:
  - Provision of services - vouchers to poor to utilize private hospitals Example: Chiranjeevi scheme in Gujarat state of India (pre-requisite: standards, equity concerns)
  - Ambulance services – Pakistan, India
Options for reducing unmet needs for FP

- A plan for contraceptive commodity security based on costed projections - Proportionally increasing allocations from national budget for contraceptives with an exit plan
- Strengthening logistics system
- Expanding the provision of method mix
Options to reduce out-of-pocket expenditures (OOPE)

- Increased financing for MNH (includes FP) and ensuring efficiency and equity

- Track allocations and expenditures for MNH (part of the accountability framework of the global strategy)

- Interventions to reduce financial barriers:
  - Conditional cash transfers, vouchers (Cambodia, India, Bangladesh)
  - Equity funds (Cambodia)
  - Maternal health insurance in Indonesia, Phil health in Philippines

- Important to ensure quality, entitlements, are benefits reaching poor, OOPE reduced, sustainability? (contributions to reducing OOPE and maternal mortality not well documented)
Options for improving accuracy and completeness of data

- Strengthen vital registration
- Interim: Household surveys
- Census - Maternal mortality module
- Strengthen maternal death reviews
- Use of mobile phones to report (Cambodia, India)
Lessons learned from Bangladesh Delivery at Health Facilities 2001 and 2010

Doubled+
Lessons learned from Bangladesh: Reduction in fertility is a major factor in reducing MMR

Source: BMMS 2010
Lessons learned from Bangladesh
Education of women matters and contributes to reducing MMR

Source: BMMS 2010
Role of inter-governmental entities

- ASEAN has a framework on MCH based on UNSG’s global strategy
- Can SAARC take a leading role in accelerating progress of MDGs 4 and 5 as most of the countries have made a commitment to UNSG’s action plan?
Commitment

- Hope the deliberations of this conference will push all of us to make a **SINCERE** commitment to make childbirth a time of joy for our mothers in South Asia