

EXECUTIVE SUMMARY

Why Reproductive Health in South Asia Requires Attention

About 14 years have passed since the International Conference on Population and Development (ICPD) formulated a reproductive health agenda for the world, and about seven years remain for the Millennium Development Goals (MDGs) to be achieved. Whether poor countries will be able to improve health outcomes among women and children through comprehensive, good-quality services that are responsive to the needs of the poor is now an urgent question. South Asia has not yet achieved the momentum required for reproductive health interventions, quality improvements and financing arrangements to ensure that the women of the region – particularly the poorest – are able to achieve the good outcomes called for by these global agendas. However, many countries in the region have embarked on health sector reforms – both the opportunity these reforms present and the challenges they pose need to be met to improve the reproductive health of *poor* women in South Asia.

Among the region's 500 million poor, women are particularly disadvantaged. Its sex ratios reflect the discrimination against females from *before birth* to the age of 35 years. Contributing to the 'missing women' are deaths that occur in pregnancy. Anemia, a condition that is relatively simply prevented or treated, is widespread among women and adolescent girls. The region also has very high rates of undernutrition, beginning with low birth weight among one-third of infants due to chronic or acute undernourishment or infections among their mothers. South Asia accounts for half of all low birth weight babies in the world. Over ten percent of infants die due to this or other preventable causes.

Many women, from adolescents to those in their prime, are bearing unwanted children because of poor access to contraception. Many undergo abortion at great risk to their lives or health: at least four million unsafe abortions take place in South Asia, causing 10 to 20 percent of the region's maternal deaths. Fertility is high in the region as a whole but varies widely across and within countries. An adolescent population of 73 million girls provides momentum for continued high population growth. At the same time, higher life expectancy is increasing the number of elderly. South Asia's health systems are being stretched to deal simultaneously with diseases commonly associated with poverty and a young and growing population, and chronic

2 • **Sparing Lives: Better Reproductive Health in South Asia**

conditions related to old age or affluence. These are among the many reasons why the reproductive health of the region is important and a challenge.

In this context, the overall purpose of this review is to bring attention to the opportunities that five countries in the region – Bangladesh, India, Nepal, Pakistan and Sri Lanka – have to strengthen and expand interventions to improve the reproductive health of poor women. The specific objectives are:

- to provide an accurate picture of the current status of women's reproductive health, describe the use of reproductive health services and barriers to use, and identify the improvements required to increase their effectiveness and improve health outcomes;¹
- to elucidate individual and household characteristics that affect reproductive health status and use of services so that the most important of these can be used to identify women and households with the greatest need for care to achieve better health;
- to describe a simple and effective approach – decentralized action planning – that can be used widely in all five countries to improve reproductive health service delivery and outcomes, and point to a body of best practices in reproductive health that provides models and lessons for improvements in South Asia; and
- to strengthen the case for investing in poor women's reproductive health by demonstrating the links between poverty, inequality, reproductive health care and expenditure.

Reproductive Health Outcomes are Poor and Unequal

A comparison of the reproductive health goals in the MDGs and current status shows that four of the five countries (excluding Sri Lanka) face enormous challenges. Maternal mortality is two to five times higher than the targets set for 2015. Under-five mortality is 1.6 to 2.6 times higher. This is due in part to the low ages at marriage and childbearing of South Asian girls. The median ages at marriage in Bangladesh, India and Nepal are still below or close to the legal age in these countries and, for example, in India, almost twice as many of the poorest rural girls aged 15-19 years are married compared with the richest. In urban areas it is six times as many. Adolescents in several countries have very high fertility rates. Overall fertility is high everywhere except Sri Lanka and a handful of Indian states; and that of the poorest is almost twice that of the richest in Nepal, and still about a third higher in Sri Lanka.

Underlying the high child mortality of the region are high rates of undernutrition (especially anemia) among mothers, beginning in childhood. Anemia and undernourishment are 25 percent higher among the poorest rural adolescent girls compared with the richest, and in urban areas this increases to 50 percent. Child malnutrition is appallingly high on average, and two to three times higher among the poorest quintile of children than among the richest in India, Nepal and Sri Lanka. The poor:rich ratios in infant mortality in Pakistan and child mortality in Bangladesh, India and Nepal – all between four and five – are particularly distressing. Female

child mortality remains 25 to 50 percent higher than male child mortality in the last three countries. All told, the data leave little doubt that adolescents and poor women have been highly neglected by the health services in South Asia and must be the focus of attention henceforth if reproductive health goals are to be achieved.

Low Use of Services is a Significant Problem

Sri Lanka and the Indian states of Kerala and Tamil Nadu show that better and more equitable reproductive health outcomes can be achieved in the region. Using Sri Lanka as a yardstick to assess health services, we find that coverage with family planning in the other countries falls short by 25 to 60 percent. Contraceptive use among the poorest quintile of women ranges from about 25 percent of that among the richest quintile in Pakistan to 40-50 percent in Nepal and rural India, to 75 percent in Bangladesh and urban India. Overall 'unmet need' for family planning is highest in Nepal and Pakistan (24-28 percent), but substantial even in Sri Lanka (11 percent). Among the poorest women, it ranges from 23 percent higher than among the richest in Pakistan to 87 percent higher in Bangladesh, pointing to service delivery and utilization failures rather than only to 'lack of awareness' or 'desire for more children.'

Although the use of antenatal care (ANC) is higher than that of contraception in four of the five countries (excluding Bangladesh), the poorest quintiles of women in four countries (excluding Sri Lanka) have half to one-third as much coverage as the richest. There is virtually no difference in the coverage of poor and rich women in Sri Lanka. Elsewhere, there are substantial differences even in the simplest intervention, tetanus immunization of mothers. In Pakistan, the poorest women have one-sixth the coverage of the richest; in Nepal and rural India, the ratio is about half; and in Bangladesh and urban India it is about four-fifths. In most countries, the number of ANC visits, their contents and quality, need serious attention to contribute to better reproductive health.

Institutional delivery, an effective intervention to reduce maternal mortality, is under 25 percent in Nepal, Bangladesh and Pakistan; in Sri Lanka it is near universal. The rich:poor ratios for this service are striking: almost 18 in Nepal, 13 in Bangladesh; 6 in Pakistan, and 5 in rural India. Despite supportive policies and guidelines, postnatal care is highly neglected. Coverage and equity in child immunization are most disappointing, given over 20 years of emphasis on 'universal immunization' in the region. Compared to Sri Lanka's 94 percent, coverage in Bangladesh and Nepal is 65 percent, Pakistan 53, and India only 43 percent.² Inequality is high in all countries: the poorest in Bangladesh have 72 percent the coverage of the richest; in Pakistan this is 63 percent; in urban India, 55, and in rural India, 37 percent.

The distortions in health service coverage suggest not only that services need to be targeted to the poor but that concerted attention is needed to the many supply- and demand-side factors that cause inequalities in access, use and outcomes of reproductive health care. The determinants of outcomes and use point to the importance of other sectors in bringing about improvements.

4 • **Sparing Lives: Better Reproductive Health in South Asia**

Girls' education and women's empowerment deserve special attention, and have been improved successfully in some parts of South Asia, but many gaps persist in the formulation and implementation of social policies in the region. Policies to promote the value of girls, increase the age of marriage, reduce son preference, prevent gender-based violence, and increase women's autonomy are important to address South Asia's glaring gender inequalities and improve the reproductive health of poor women.

Health Services Need Great Improvement

Indeed, low service utilization levels can be explained by prevailing demand- and supply-side barriers. Information about services is poor, and awareness even of the *need* for certain services (such as ANC) is inadequate. Demand for services such as family planning and skilled birth attendance is low, in part because of social prescriptions (e.g., to have a child soon after marriage) or proscriptions against use. Cultural norms and social attitudes prevent women from seeking health care even for problems they recognize (such as reproductive tract infections), or cause them to approach the wrong providers (such as 'quack' abortionists). Some crucial supply-side constraints to the use of public reproductive health services are:

- the unavailability of appropriate health facilities within distances that are physically, socially and economically negotiable by women and children;
- a lack of staff, particularly of female doctors and trained paramedical workers, on account of vacancies as well as absenteeism;
- inadequate amenities, equipment and medicines at health centers and for outreach;
- overcrowding and a lack of privacy at health facilities;
- low technical and/or managerial competence among providers and managers;
- inadequate provision of information and counseling; and
- improper behaviors among staff.

Superimposed on the household constraints faced by women, the structures and processes of public health services are particularly daunting for the poor, who consequently remain less covered by health care than they need or want to be. All these problems must be addressed either directly, e.g., by increasing public information, supplies, staff and facilities, or indirectly, e.g., by providing incentives to clients to use services ('demand-side financing'), to public providers to improve their behavior, quality and accountability, and/or to private practitioners to serve more poor women at a cost they can afford.

The ICPD Program of Action was accepted by all the five countries (UN, 1995). Despite this, several key aspects of the 'paradigm shift' have not yet been implemented. These include instituting a 'client-centered women-friendly approach' to services; integrating the essential package of reproductive health services; focusing on adolescents and sexuality; and advancing

reproductive rights. There is also limited evidence of key policy and implementation changes needed to achieve country and global aims such as pro-poor actions, preventive health activities, or measures to reduce cost burdens on the poor.

The Costs of Care Must be Met

Besides the limitations imposed by poor awareness of need and low familial permission to use health services, affordability of care is a serious constraint faced by poor women. This affects the use of private as well as public services, which have direct (often informal), indirect and opportunity costs. Health crises such as hospitalization are known to be major causes of indebtedness and can result in poor people falling deeper into poverty. Private reproductive health expenditure (as a share of GDP) is two to three times higher than public expenditure in Bangladesh and the Indian state of Rajasthan, while in Sri Lanka it is half.³ In Bangladesh, more than half of private spending is on infant care, while in Sri Lanka other outpatient reproductive services account for most private spending. High out-of-pocket expenditure on reproductive health has grave consequences for equity and financial protection against the costs of illness. It is a strong explanation for low care among the poorest and their dreadful outcomes. Despite their greater disease burden, the poorest quintile of women accounts for only 10 percent of reproductive health spending while the richest accounts for 60 percent.

In South Asia, reproductive health expenditures amount to a mere 0.2 to 0.4 percent of GDP. In Bangladesh and Nepal, this spending has been largely on family planning and infant care (mostly immunization), while spending on childbirth and other reproductive health services is relatively small. By contrast, in Sri Lanka, childbirth and other reproductive services for women, particularly in-patient services, make up the largest share of public spending on reproductive health. Over time all the five countries have increased their reproductive health expenditures. In Bangladesh and Nepal, family planning services have received most of the increases, while in Sri Lanka the proportion of total expenditure on family planning has decreased and that on pregnancy/childbirth services and other inpatient obstetric/gynecological care has increased. Donor contributions account for about three percent of reproductive health spending in Sri Lanka (primarily to family planning) but 65 percent of reproductive health spending in Nepal. Donor contributions to childbirth services appear to be insignificant across countries, which is disappointing, given the importance attached to safe motherhood and the MDGs in South Asia, and the global commitment to achieve them.

Not only do South Asian governments have to increase the supply of services to the poor, but they must do so ensuring that poor women do not remain vulnerable to high direct or indirect costs, formal or informal. Resource allocations within reproductive health must redress the imbalance of services/spending, and donor contributions should be increased especially for the most needed, under-funded and costly services.

Actions to Improve Reproductive Health

Improving reproductive health in South Asia will not be easy as a number of actions are required. Many are closely related, presenting dilemmas about what should be done first. Some lie outside the health sector or call for other sectors to collaborate. Nevertheless, several measures can be taken expeditiously by the health sector and would produce good results if implemented well. The most important actions needed to improve poor women's reproductive health are given below.

First, in all five countries (including some areas and services in Sri Lanka) mechanisms to increase the supply of reproductive health services to *poor* women must be strengthened. This should start with those services, such as birth spacing, for which there is considerable 'unmet demand' among poor women. The chief approaches are to target poor geographic areas for special planning and resource allocations (at the national, state/province/etc. and decentralized levels), and the poorest villages and households for attention through local outreach mechanisms (e.g., fieldworkers, camps, mobile services, etc.) and demand-side financing (discussed further below).

Reproductive health services must also target adolescents (married and unmarried) as they are *central* to the achievement of reproductive health goals. They require information as well as services. These can be provided through frontline health workers if they are given a clear mandate and training in the social and counseling skills required to reach this difficult group. These interpersonal efforts must be bolstered by behavior change communication (BCC) programs through mass media, schools and community institutions. Many innovative approaches have been developed that could be supported through public grants.

Second, a corollary of targeting is to enhance demand among the poor for services that are inadequately understood and underutilized, notably ANC and safe delivery. For this, BCC efforts must be made relevant to *poor women*, and demand-side financing used to reduce cost barriers, particularly for the use of indoor services and purchase of medicines. Supply-side improvements that address the problems listed above would also enhance demand.

Third, all countries need to deliver the Essential Package of Reproductive Health Services in an integrated manner.⁴ The services that should be provided through single-window primary health facilities and workers are: maternal and child health care, nutritional prophylaxis, family planning, safe abortion (where legal), diagnosis and treatment of RTIs/STIs, all relevant counseling, and referral to emergency/surgical/specialized care at secondary facilities. To start with, it is advisable to integrate separate departments of family planning, health, and nutrition, and develop unified policy and program guidelines. In the field, providing clear guidelines, tools and training would help workers implement a client-centered approach efficiently, and managers to encourage and monitor performance on the basis of *a continuum of care*. Creating

and disseminating the know-how for this could be a central function while implementation and management are decentralized. Integration will improve demand for and use of services.

Some neglected aspects of the essential package require special attention.⁵ Throughout South Asia, the incidence of unsafe abortion is unacceptably high, especially in the private sector. Where abortion is legal, the public systems could increase availability of medical abortion and vacuum aspiration facilities, and public financing could help increase the availability of a range of private services. Providing capital grants and/or per-service subsidies (especially for poor women) through contracts, and social franchising of clinics are some approaches that have improved services in South Asia. Simultaneously, governments must implement their regulatory role in this area effectively, cracking down on unqualified providers to eliminate the considerable mortality and morbidity related to unsafe abortion.

Counseling to improve mother and child nutrition, anemia prophylaxis and care of the undernourished are currently inadequate everywhere, and must be enhanced by training health staff better to prevent and manage undernutrition. Their efforts should start with a focus on poor women who are at the greatest risk of bearing low birth weight infants. Health systems must take responsibility for this care because it is central to maternal and infant survival.

While ANC and skilled delivery receive attention and efforts to increase the availability of essential obstetric facilities continue, *postnatal care* needs more emphasis. Improvements in timing and quality could help to reduce maternal and neonatal mortality and morbidity. Women who deliver at home should be visited within 24 hours of delivery by a qualified female paramedic, and transport vouchers, funds or reimbursements provided to those who need medical attention.

Fourth, progress in poor women's reproductive health will depend greatly on improving the quantum and quality of outreach care by frontline women workers: they need to be readily available (i.e., in larger numbers, more efficiently deployed), more highly skilled, adequately equipped, and supplied with medicines. The critical role they play in ensuring South Asia's health must be fully recognized and rewarded as their status is reflected in their behavior toward clients. Women providers must be the focus of the 'health system fix.'

Reproductive Health Needs Reform

The recommendations above: to increase the supply of reproductive health services to poor women and adolescents by specifically targeting the poorest areas and households; to enhance demand among the poor for key services using BCC and demand-side financing; to integrate reproductive health services through a client-centered approach, and strengthen weak services using specific relevant approaches; and to improve the reach, quality and status of women providers by better training, deployment and support are the 'frontline' improvements required

8 • **Sparing Lives: Better Reproductive Health in South Asia**

for better reproductive health among poor women in South Asia. To bring them about three significant reforms are required in the health sectors of the five countries.

First, particularly to improve the supply and quality of services to the poor, outcome-based planning and monitoring must be introduced/expanded. Planning actions and allocating resources should be decentralized at least to the district level in all countries, requiring higher levels to commit to flexibility in decision-making. Decentralized action planning (DAP) identifies what needs to be done and can be done locally, and measures results in repeated cycles using local data. It can improve the effectiveness of available resources by ensuring their application to priority problems, and by helping service providers and managers do what works in local experience or promising examples. DAP can enhance the technical and practical knowledge of those involved as information is shared during the planning efforts. Besides improving the supply of services, it can motivate efforts to create demand and integrate services. In addition to health staff and managers, DAP can involve local government members, private providers, clients and others to ensure that public resources are used efficiently, and to mobilize other local resources. Good results would help attract additional public or private, local or 'transferred' resources. Decentralized and participatory planning could be the cornerstone of increased ownership and accountability in South Asia's health systems.

Second, the recommendations above call for robust human resource development in the five countries, including attention to strategic 'womanpower' planning and to developing staff skills, motivation and performance. Some specific measures are:

- increasing the numbers of qualified female staff (especially doctors and paramedics) at the frontline; the important strategies to achieve this include additional recruitment, contracting in, improved allowances and support, and performance-based incentives;
- providing technical and managerial training, and making appropriate implementation and monitoring guidelines and good practice information available to all levels to enhance the organization and management of integrated reproductive health service delivery;
- improving attitudes and behaviors toward poor women through sensitization programs and accountability measures; and
- increasing accountability for health outcomes among providers and managers using performance incentives in addition to decentralized planning.

Third, in addition to better spending through decentralized planning and monitoring, more public finance must flow to the reproductive health sub-sector. This is necessary to ensure that pressing needs for staff, equipment, medicines, etc., in the public system are met, and that the availability of services to the poor is increased greatly by reducing the costs to them of using private services. From an equity perspective, general revenue financing is desirable as it is a progressive source of health care financing and when combined with low user fees and universal coverage it provides high levels of financial protection against catastrophic ill-health.

Promising demand-side financing options include voucher schemes to assist poor women to have institutional deliveries in the private sector, reimbursement of transport and other out-of-pocket expenses when they use public facilities, and conditional cash transfers (e.g., after completion of three ANC visits). Private resources for poor women's reproductive health can be enhanced through public-private partnerships, including social marketing/franchising schemes, contracting out, grants or subsidies (e.g., for safe delivery or in-patient facilities), and support in cash or kind to services (e.g., for adolescents in schools or communities).

These improvements fit squarely with the overall agenda for health sector reform in the region which includes greater responsibility to sub-national and local authorities for the delivery of essential services, improved efficiency in health spending, and the development of financing mechanisms to reduce the burden on the poor of out-of-pocket spending. As health reforms are strengthened, special attention must be paid to reproductive health. By examining outcomes, use of services and determinants, and planning and financing of reproductive health, this report seeks to contribute to constructive action to improve the health of the region's most vulnerable citizens, women in poverty.

NOTES

1. Chapter 1 presents the conceptual framework and approach of the study, and Annex 2 describes the methodology and indicators used in the analyses. Most of the discussion in this report is based on comparable data for the five countries covered. At the time of writing such data were available only for years around 2000. Subsequently, data pertaining to 2005/2006/2007 have become available and are cited where relevant. Any significant changes between the two sets of data and impacts on the analysis are also noted where necessary.
2. In 2006/2007, coverage levels were: Sri Lanka: 97 percent; Bangladesh, 82 percent; Nepal, 80 percent; Pakistan, 47 percent; and India, 43 percent.
3. Our analysis of health expenditure in Indian states covered only Rajasthan, Andhra Pradesh and Karnataka. The ratio of private:public health expenditure is similar in these three states, and close to the all-India average, but it varies considerably across Indian states, e.g., from 2.7 to 9 among the large states.
4. The Essential Package is described in Annex 4.
5. RTI/STI services are also important and neglected, but emphasized less here because of the paucity of reliable data on morbidity as well as services and their utilization.