Sexual and Reproductive Health:
Overview of ICPD and MDG Monitoring in Asia
ICPD +15

Della R Sherratt, Senior International Midwifery Adviser & Trainer/ International SBA Coordinator Lao PDR, GFMER RHR Course, UHS, September 2009

Grateful Acknowledgements to Dr Saramma Mathai Regional RH Coordinator UNFPA Asia Pacific Regional Office, for Country and Regional data

Outline of presentation

A. What is Sexual and Reproductive Health (SRH) and why important for national Health & Development
B. How to Measure SRH
C. What progress
D. What is possible Research Agenda for Lao PDR

A. What is meant by SRH? And why is it important for health and development?

Definition 1

- Reproductive Health is a state of physical, mental and social wellbeing and not merely the absence of disease and infirmity in all matters related to Reproductive systems and its functions and processes. Reproduce health therefore implies that people are able to have a satisfying and safe sexual life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.....

First in International Conference on Population and Development (ICPD) 1994, then WHO 1997, WHO 2004

Reproductive Health care

- ...is defined as a constellation of methods, techniques and services that contribute to Reproductive Health and wellbeing by preventing and solving Reproductive Health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations and not merely counselling and care related to reproduction and Sexually Transmitted Diseases.

  UN 1994 Para 7.2

Why does SRH Matter to Lao PDR and other developing countries?

ICPD - An agenda for poverty reduction and therefore national development

- **ICPD gave a broader mandate for poverty reduction through the following:**
  - ***Universal access to Reproductive Health services***
  - Enabling births by choice
  - Reducing child and maternal mortality
  - Promoting gender equality and women's empowerment
  - Universal primary schooling especially of girls
  - Equitable economic growth with pro-poor budget

SRH important for accelerating progress towards MDGs - *because*

- **Death and disability due to SRH account for 18% of the global burden of disease** and 32% among women 15-44 years - Disability Adjusted Life Years (DALYs) which translates to significant loss of GNP 2.
- **High fertility contributes to poverty**: inter-generational transmission of poverty, environmental problems, migration, etc.
- Demographic momentum: cashing in the benefit requires continued investments in FP and social policies to decrease gender inequalities in opportunities for women's development and further contribution to reduction in fertility

2. Vlassof et al, 2004

ICPD - linkage to MDGs

MDG8

Develop a global partnership for development

MDG1 Eradicate extreme poverty & hunger

FP –Smaller families and wider birth intervals as a result of contraceptive use allow families to invest more in each child's nutrition and health
Fertility reduction at the national level enable accelerated social and economic development

MDG2 Achieve universal primary

Families with fewer children, better spaced, can invest in education particularly girls – girls educated more chances of contraceptive use

MDG7 Ensure env. Sustainability

Providing SRH services may help stabilize rural areas, slow urban migration and balance natural resource use

ICPD
PoA
• RH and Rights
•Gender
•Population dynamics

MDG3 Promote gender equality and empower women

Controlling fertility- decision to have or not to have children, when, how many – empowerment of women – greater opportunities for work, education, social participation etc

MDG6 Combat HIV/AIDS, malaria & other diseases

SRH services include prevention of STIs including HIV/AIDS and bring patients to health services thereby early diagnosis and treatment

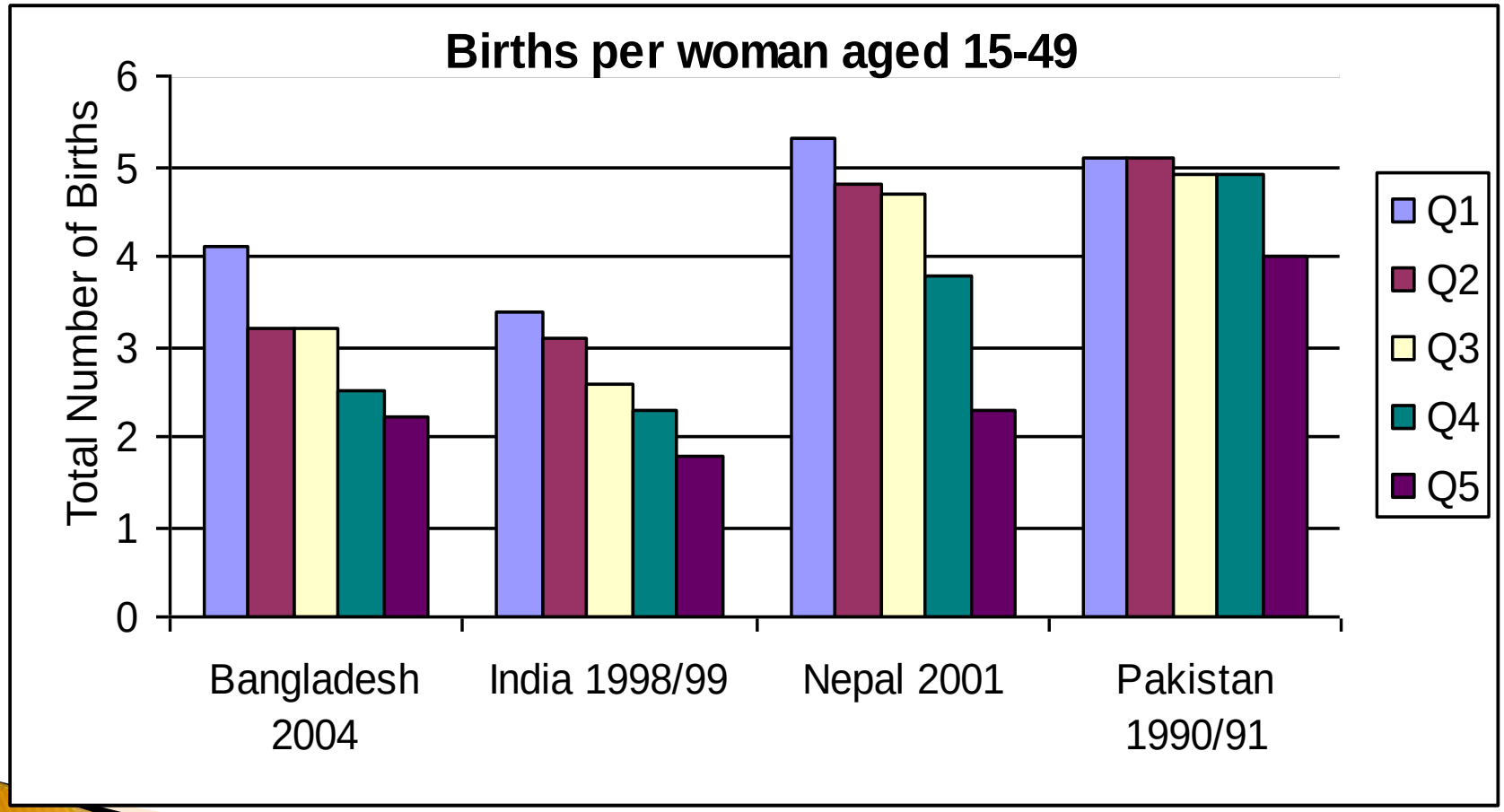
MDG 5 Improve maternal health

Preventing unplanned and high risk pregnancies and providing skilled care in pregnancy, childbirth and PP save lives

MDG4 Reduce child mortality

Antenatal care and care at the time of delivery prevent infant and child births – smaller families less likelihood of deaths among infants and children

Variations in Fertility by Income Quintiles



World summit 2005 outcome

"achieving *universal access to reproductive health* by 2015, as set out in the International Conference on Population and Development (ICPD), integrating this goal in strategies to attain the internationally agreed development goals, including those contained in the Millennium Declaration, ... (*para 57g, Resolution 60/1 adopted by the General Assembly, 2005 World Summit Outcome, 24 October 2005)*

MDG 5: Improve maternal health- ***New Targets (5b) and indicators

Target 5. a: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	•Maternal mortality ratio •Proportion of births attended by skilled health personnel
Target 5.b: Achieve, by 2015, universal access to reproductive health	*•Contraceptive prevalence rate* *•Adolescent birth rate* *•Antenatal care coverage (at least one visit and at least four visits)* *•Unmet need for family planning*

MDG 1, 6 and 7- new indicators

- Full and productive employment and decent work for all (MDG 1)
- Universal access to treatment of HIV/AIDS (MDG 6)
- Significant reduction of the rate of loss of biodiversity (MDG 7)

WHY SRH not been given higher priority?

- Complexities of SRH
- Components for SRH fall under different actors
- Multiple Discourse (globally, regionally and nationally)
- Different constituencies pushing their own agenda
  - Women's status
  - Priority setting
  - Changing Institution

How To Measure SRH ?

What to measure?

- Fertility levels
- Family Planning Usage
- Maternal and Child Health
  - MMR
  - Perinatal
  - Under 5 deaths
  - Abortion
  - Access to services
- HIV/AIDS
- STI
- Gender – women's status and empowerment & GBV

– Indicators (example)

- CBR; age of first marriage; age of first pregnancy
- CPR; % users satisfied with method (all methods)
- MMR (WHO,UNFPA UNICEF methodology)
- Perinatal, infant and under five rates
- ? Morbidity
- Service access and usage by population (HR workload)
- Prevalence Rates HIV, STIs
- Knowledge
- Practices
- Gender (% women on VHC, Parliamentarians etc, etc)
- GBV ?? Various

Capacity of Health System to deliver quality SRH services

Disaggregate data – for better information & decision making

Policies and Strategies ICPD at 10 global survey findings

- **Majority of the countries:**
  - Integrated population concerns into national development plans
  - Do have RH policies and strategies
  - RH integrated into Primary Health Care and health sector reforms
  - Policies for adolescents developed in significant number of countries, but implementation low
  - National legislation for protection of girls and women (comparatively lower), but implementation low particularly gender based violence

Challenges identified

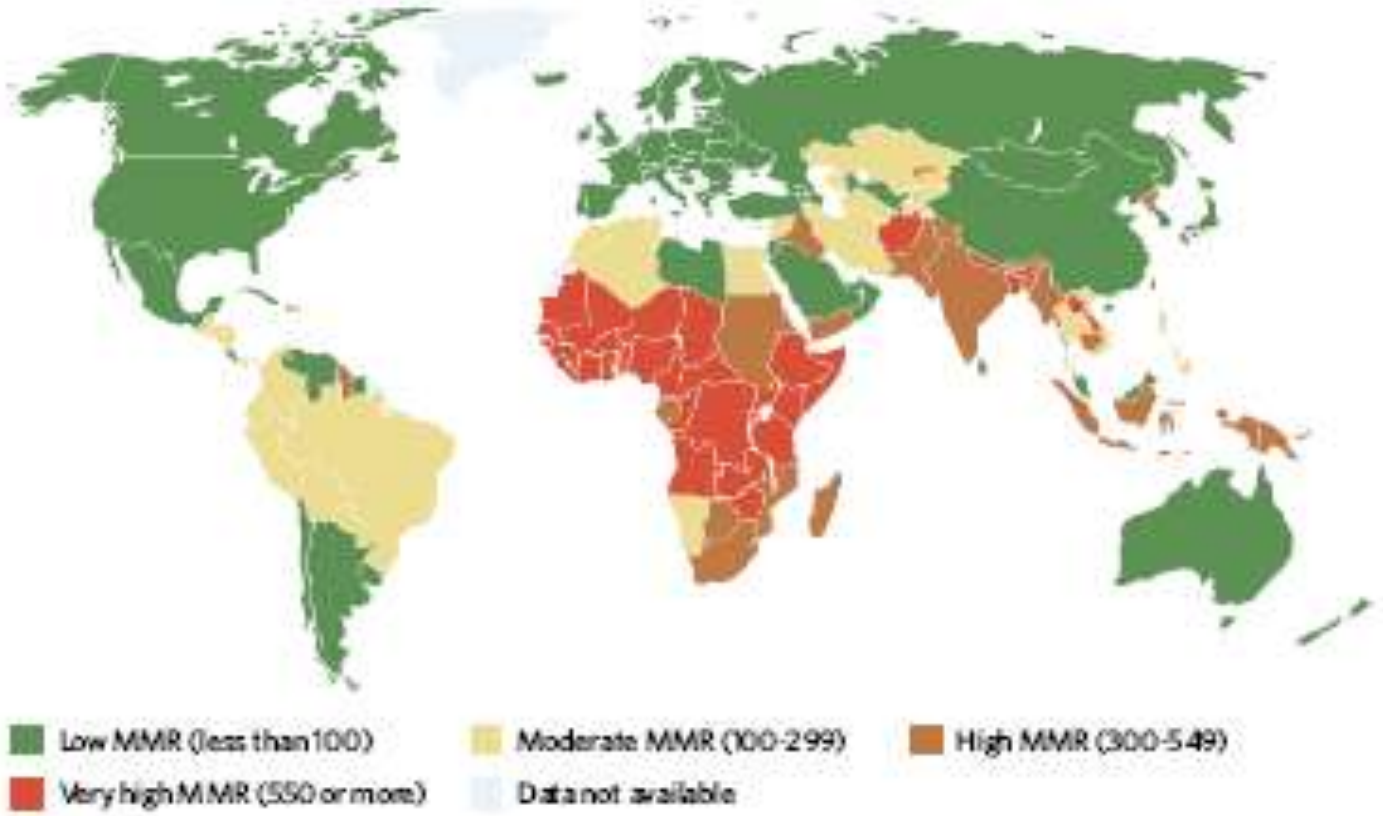
- Capacity of institutions to implementing RH as part of development
- Integration of RH into PHC (actual implementation)
- Insufficient financing and supplies and equipment
- Human resources capacity – who is a SBA?
- Services for men and adolescents

What Progress in SRH?
PART II

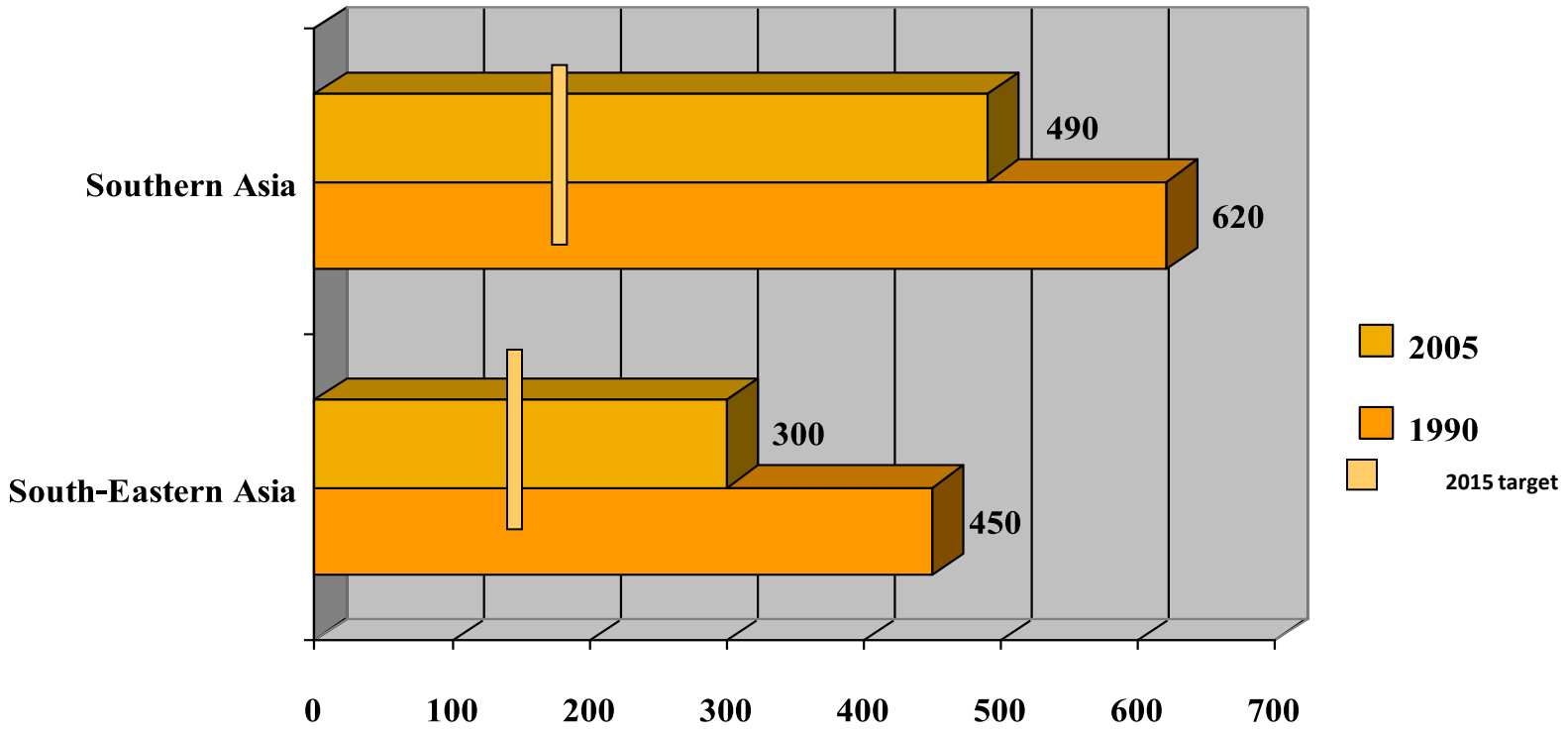
(reading assignment)

The high risk of dying in pregnancy or childbirth continues unabated in sub-Saharan Africa and Southern Asia

Maternal deaths per 100,000 live births, 2005



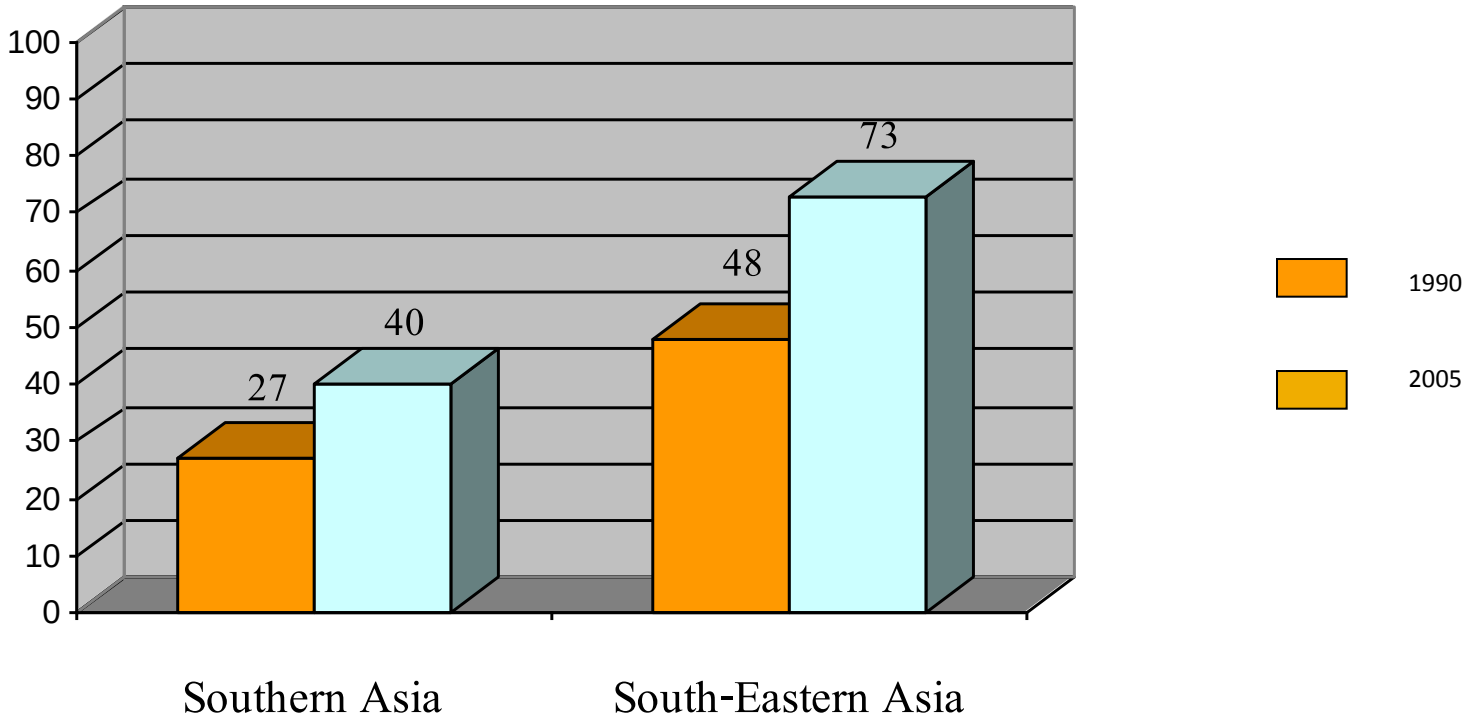
Maternal deaths per 100,000 live births, 1990 and 2005



Source: United Nations, The Millennium Development Goals Report 2009

Maternal Health Indicators

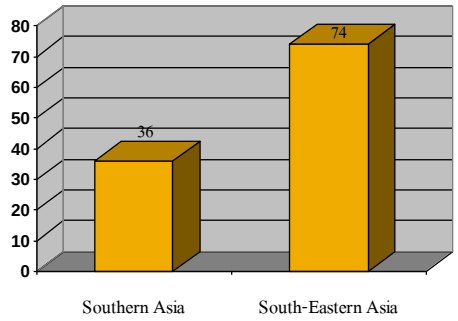
Skilled health Workers at delivery - Proportion of deliveries attended by skill health care personnel



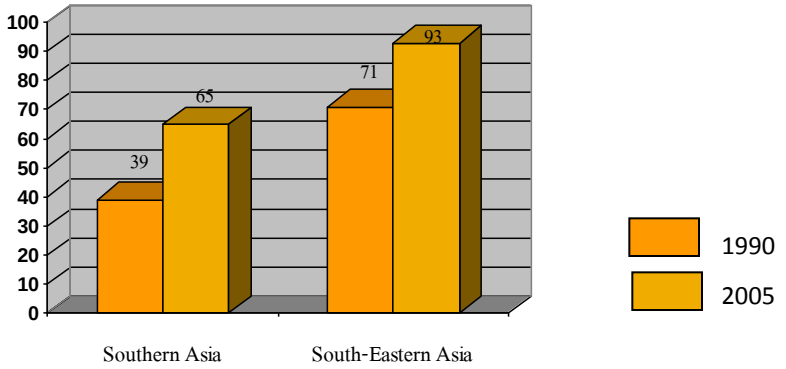
Source: United Nations, The Millennium Development Goals Report 2008.

Maternal Health Indicators

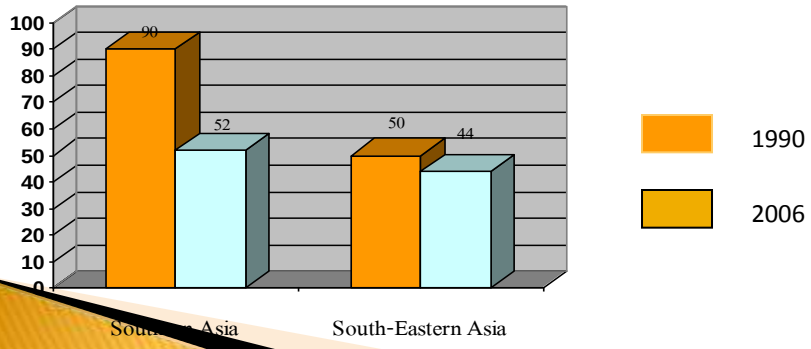
Proportion of women (15-49 years old) attended four or more times during pregnancy by skilled personnel, 2003/2008 (Percentage)



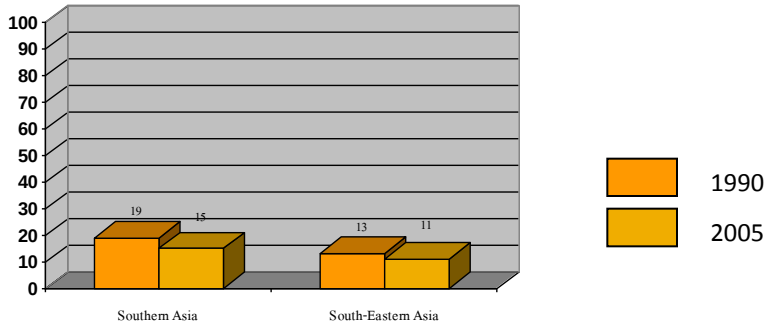
Antenatal care - Proportion of women (15-49 years old) attended at least once during pregnancy by skilled health personnel



Adolescent Fertility-
Births to women 15-19 years old (Number of births per thousand women)



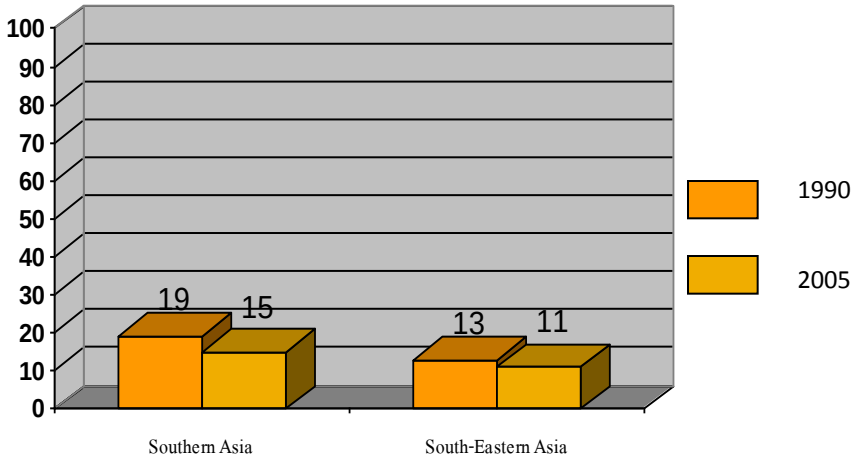
Unmet need for family planning – Proportion of married women aged 15-49 years with unmet need for family planning



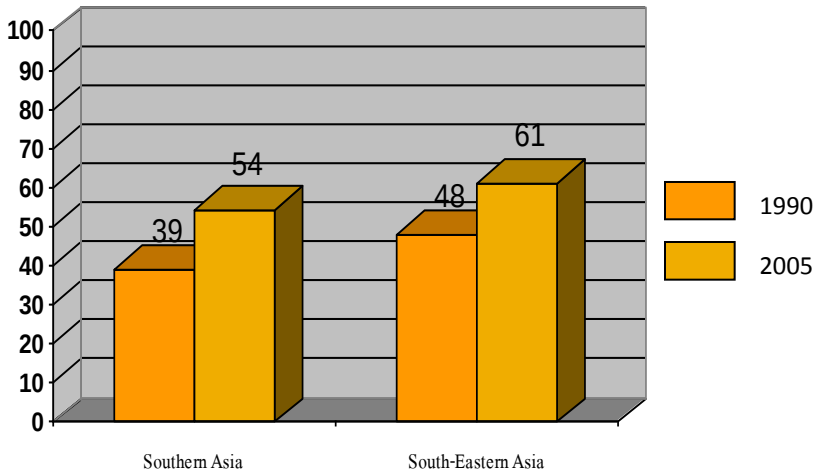
Source: United Nations, The Millennium Development Goals Report , 2008 and 2009.

Maternal Health Indicators

Unmet need for family planning – Proportion of married women aged 15-49 years with unmet need for family planning



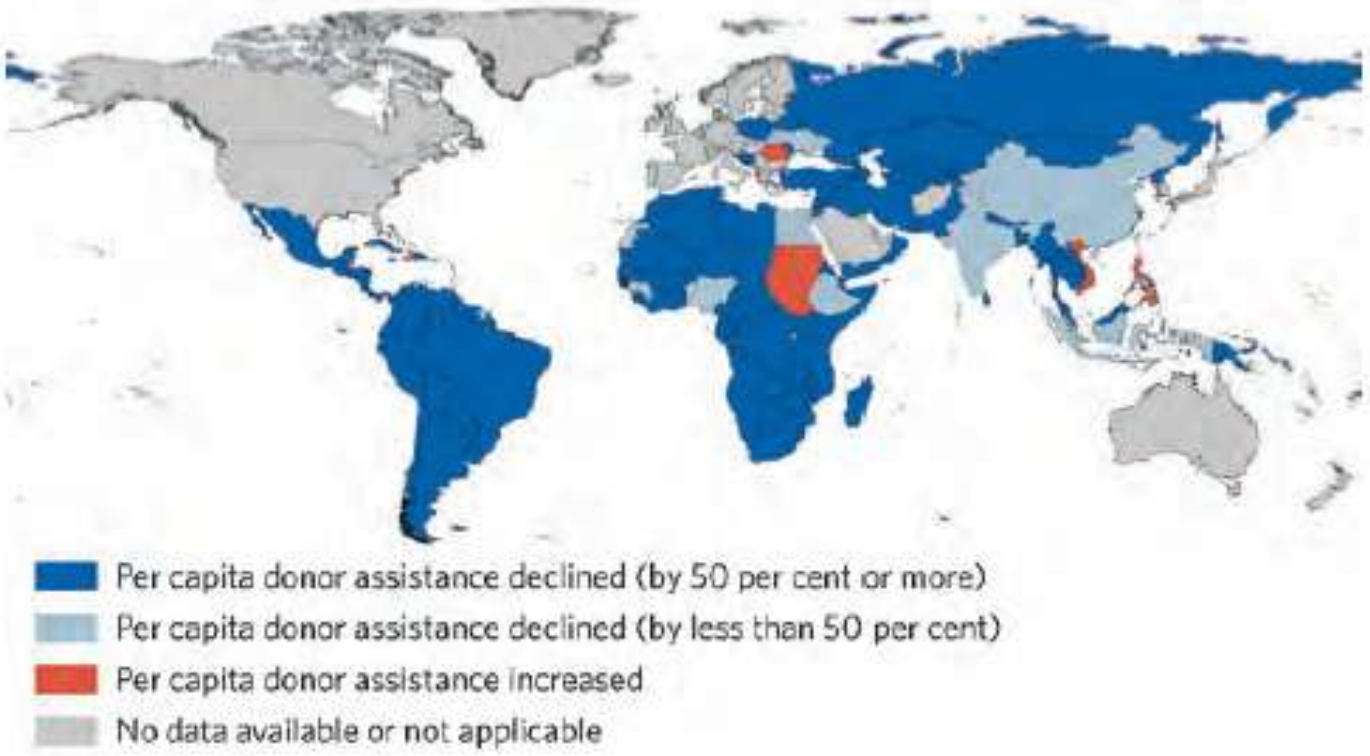
Proportion of women, married or in union, aged 15-49 years, using any method of contraception, 1990 and 2005 (Percentage)



Source: United Nations, The Millennium Development Goals Report , 2008 and 2009.

Donor funding for family planning declines, even as progress in maternal health stalls

Percentage change in donor assistance for family planning programmes per woman aged 15 to 49, 1996 to 2006



Source: United Nations, The Millennium Development Goals Report 2009

Progress country-wise: Asian countries (selected)

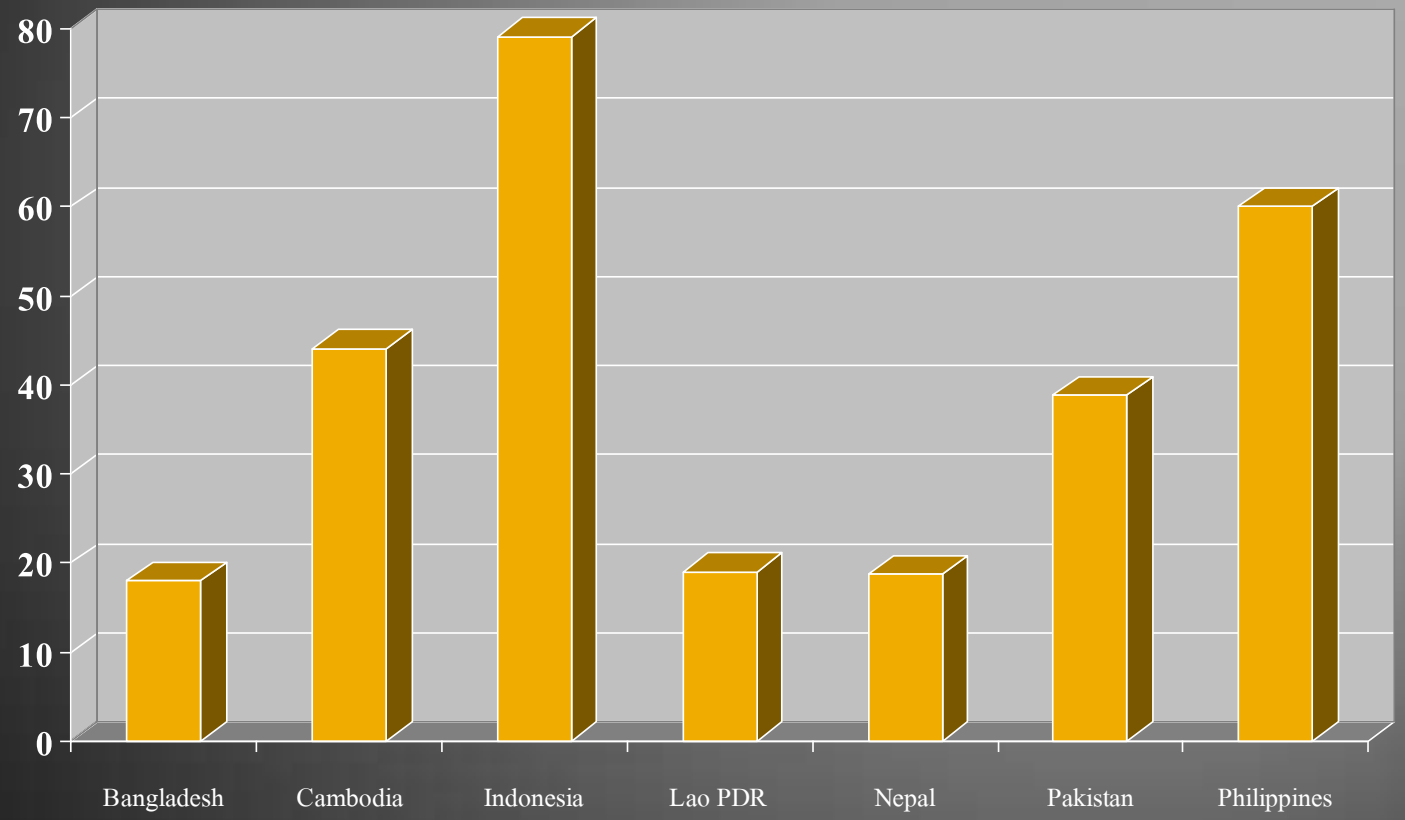
MDG 5 a. a. Maternal mortality reduction b. Deliveries by Skilled Birth Attendants	a. Very little reduction On track in Sri Lanka Doubtful whether the rest will achieve. a. Low levels in Bangladesh, Cambodia, Lao, Nepal, Pakistan
MDG 5.b. a. CPR b. Unmet needs c. Number of births 15-19 years d. Antenatal coverage	a. Progress , but discontinuation high. Pakistan low. b. Reducing, still high(except SL) c. Reducing, still high and highest in Bangladesh d. Progress, but 4 visits lower coverage in most countries

Progress country-wise: Asian countries (examples)

MDG 6: Reduced prevalence of infections	a. Cambodia, Myanmar, Thailand, downward trend b. Being stabilized in Nepal, Pakistan, Vietnam c. Rise in Indonesia (fastest), Lao, Mongolia, Malaysia (drug users)

Acknowledgments

Skilled attendant at birth (but not sure all reports the attendant really comply with definition)



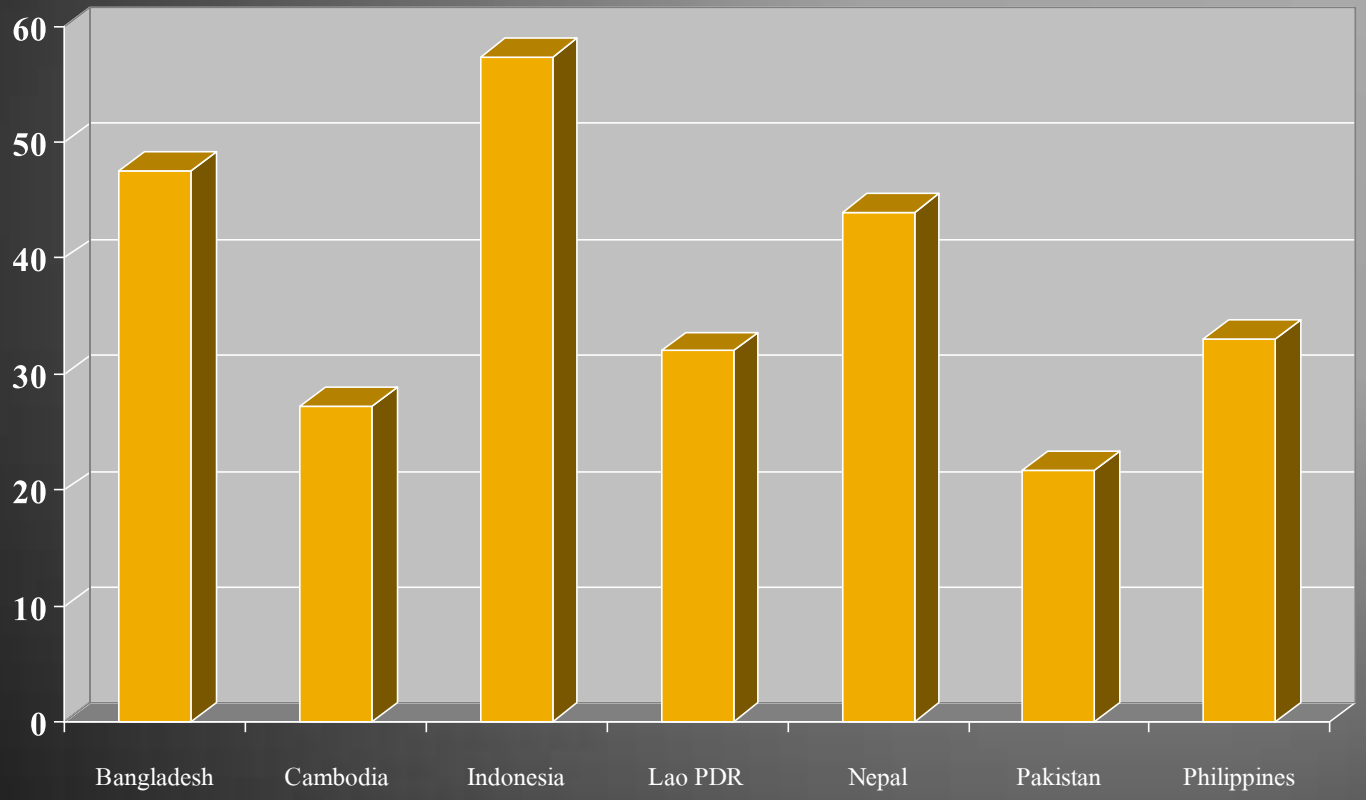
Source: DHS Survey – Bangladesh (2007), Cambodia (2005), Indonesia (2007), Nepal (2006), Pakistan (2006-2007), Philippines (2003)

Who is a skilled attendant?

- An accredited health professional (such as a midwife, doctor, nurse) who has been Educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period and in the identification, management and referral of complications in women and newborn

(*ICM, FIGO, WHO 2004*)

Percentage distribution of currently married women age 15-49 by modern contraceptive method currently used



Source: DHS Survey – Bangladesh (2007), Cambodia (2005), Indonesia (2007), Nepal (2006), Pakistan (2006-2007), Philippines (2003)

Challenges

- Challenges in achieving targets
  - Employment opportunities for women limited
  - Child malnutrition with increasing food prices
  - Target of reducing gender disparities in primary and secondary education missed
  - Negligible progress in maternal mortality
  - Slow progress in access to Skilled Birth Attendants
  - Sanitation, safe water, living conditions

- **National figures mask differentials**
  - within the countries, between various social groups, ethnic groups, economic groups and give a false sense of achievement

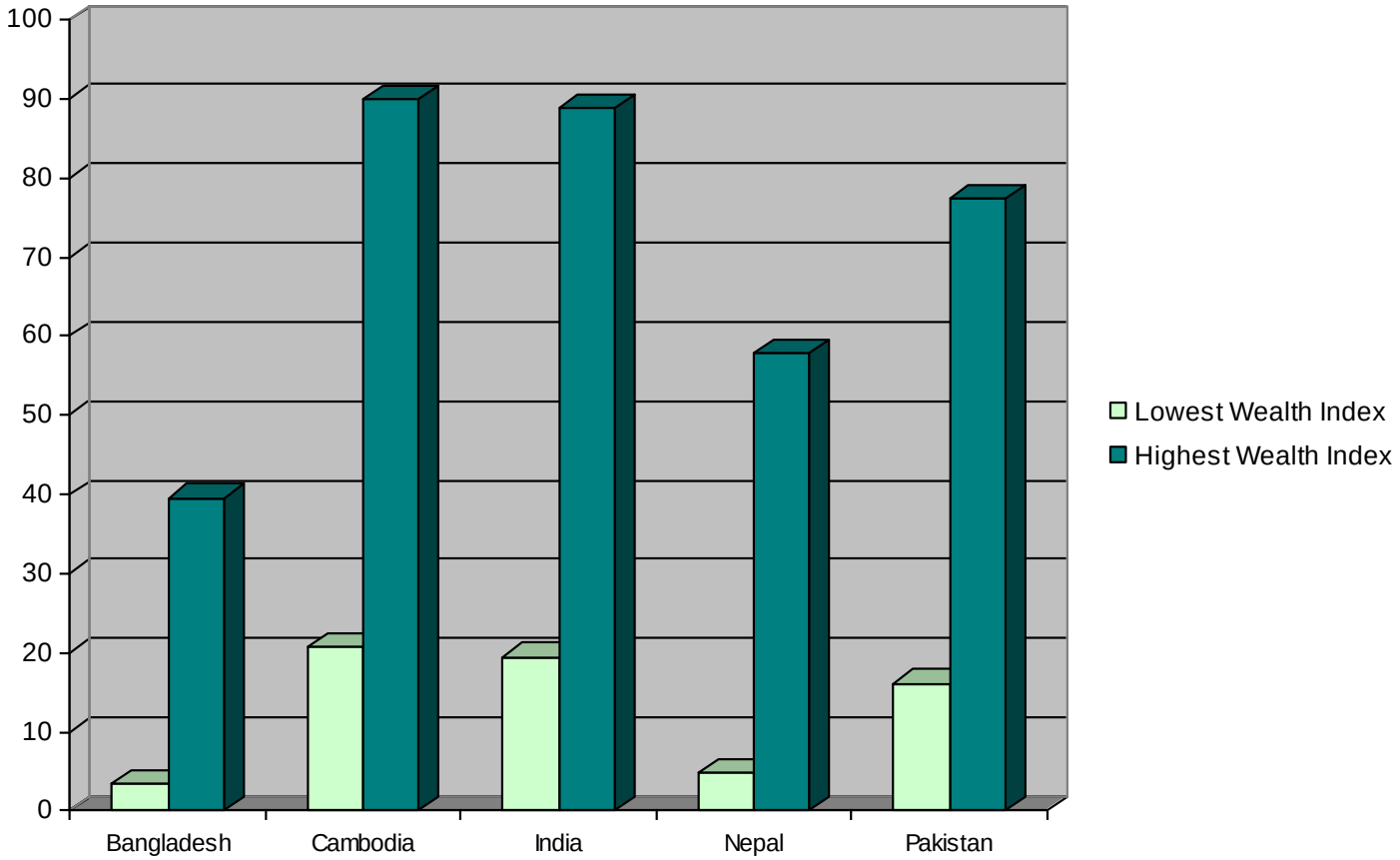
Challenge of tracking progress

- What are the exact levels of MM (SL reliable data with its excellent maternal death audits –community and facility based)
- Which is the best indicator for tracking progress in maternal mortality?
- Use health systems process indicators to monitor progress in MDG 5 such as EmOC indicators
- Definitional problems – Skilled Birth Attendants
- Sub-national data

Underlying factors that contribute to continuing poor level of achievements

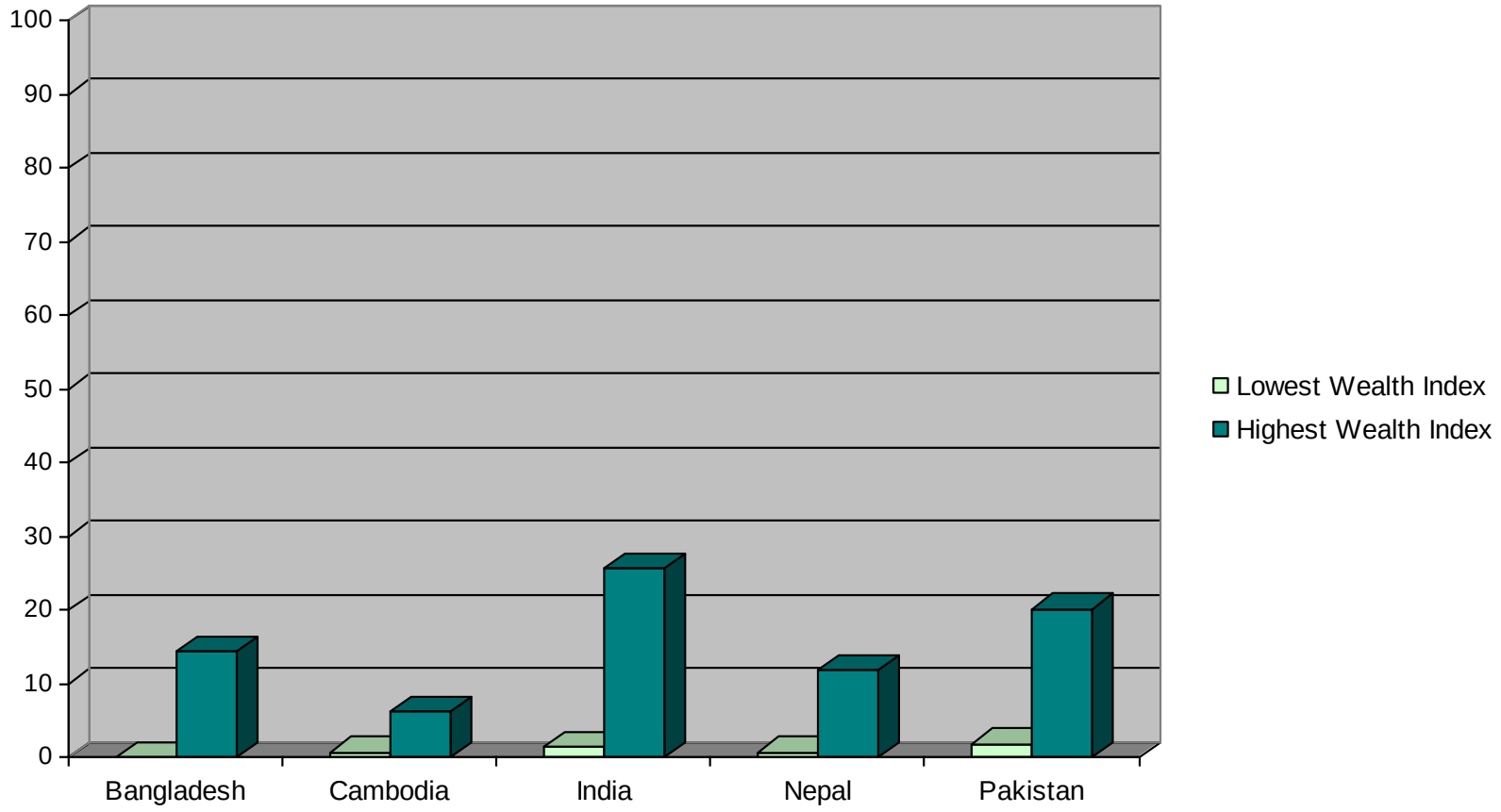
- Inequity – maternal mortality and morbidity clustered disproportionately among the poor
- Exclusion –social, economic, political (poor, minorities, low caste, rural)
- Lack of participation of 'rights holders' (women, families, communities)
- Failure of the state (duty bearers) to uphold rights /entitlements
- Social and cultural factors

Inequity in access: Percentage of births attended by skilled health personnel by household wealth quintile



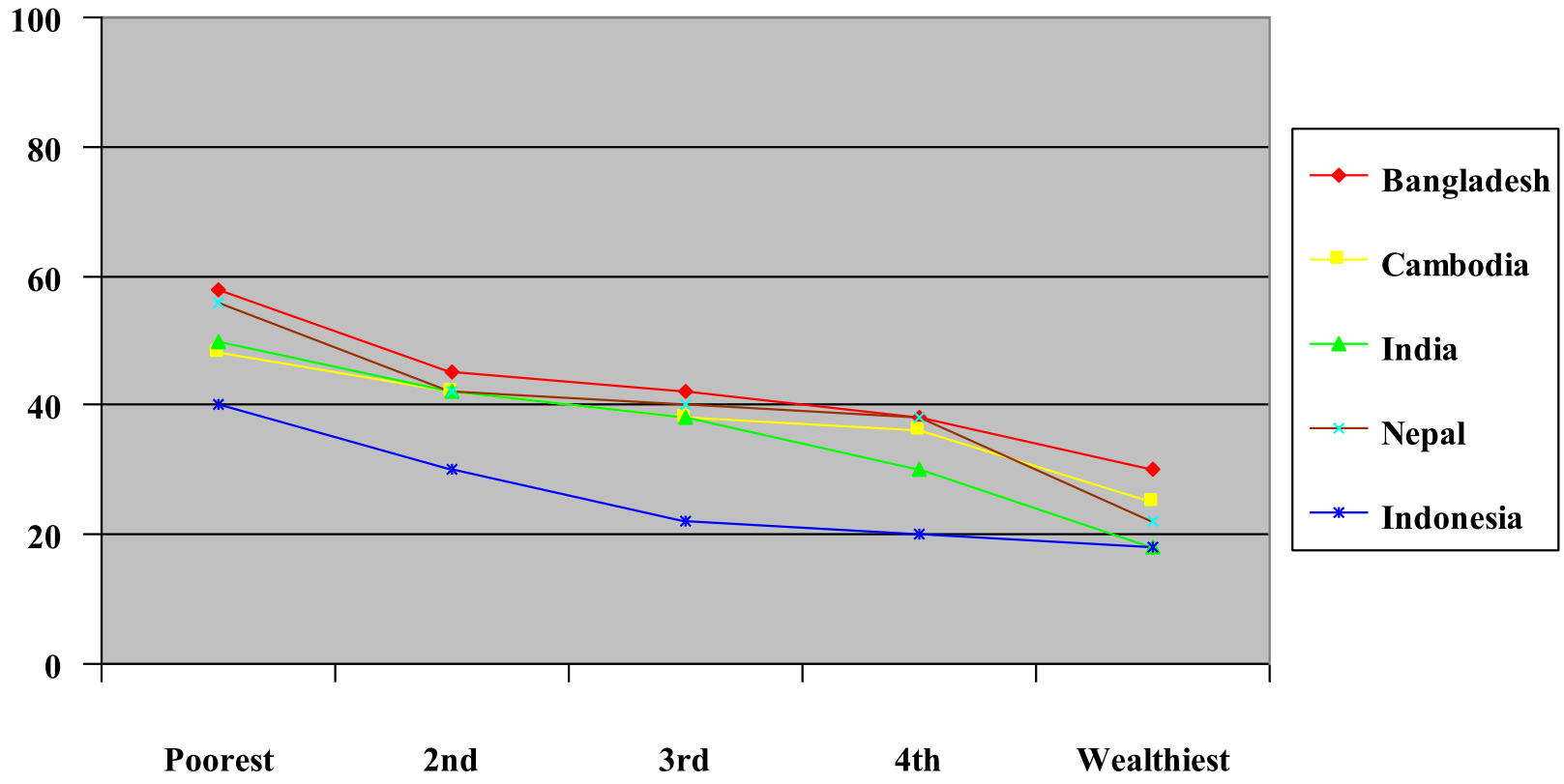
Source: Demographic Health Survey

Inequity in access: Percentage delivered by Caesarean Section by household wealth quintile



Source: Demographic Health Survey

Coverage gap by wealth quintile



Source: Countdown to 2015, 2008 Report

Social and cultural determinants

- **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 (India, Vietnam)
- **Family and community beliefs that**
  - prevents early identification of problems
  - lack of awareness of pregnant women's needs
- **Early marriage and high rates of pregnancy among 15-19 years (high risk for maternal and newborn health)**

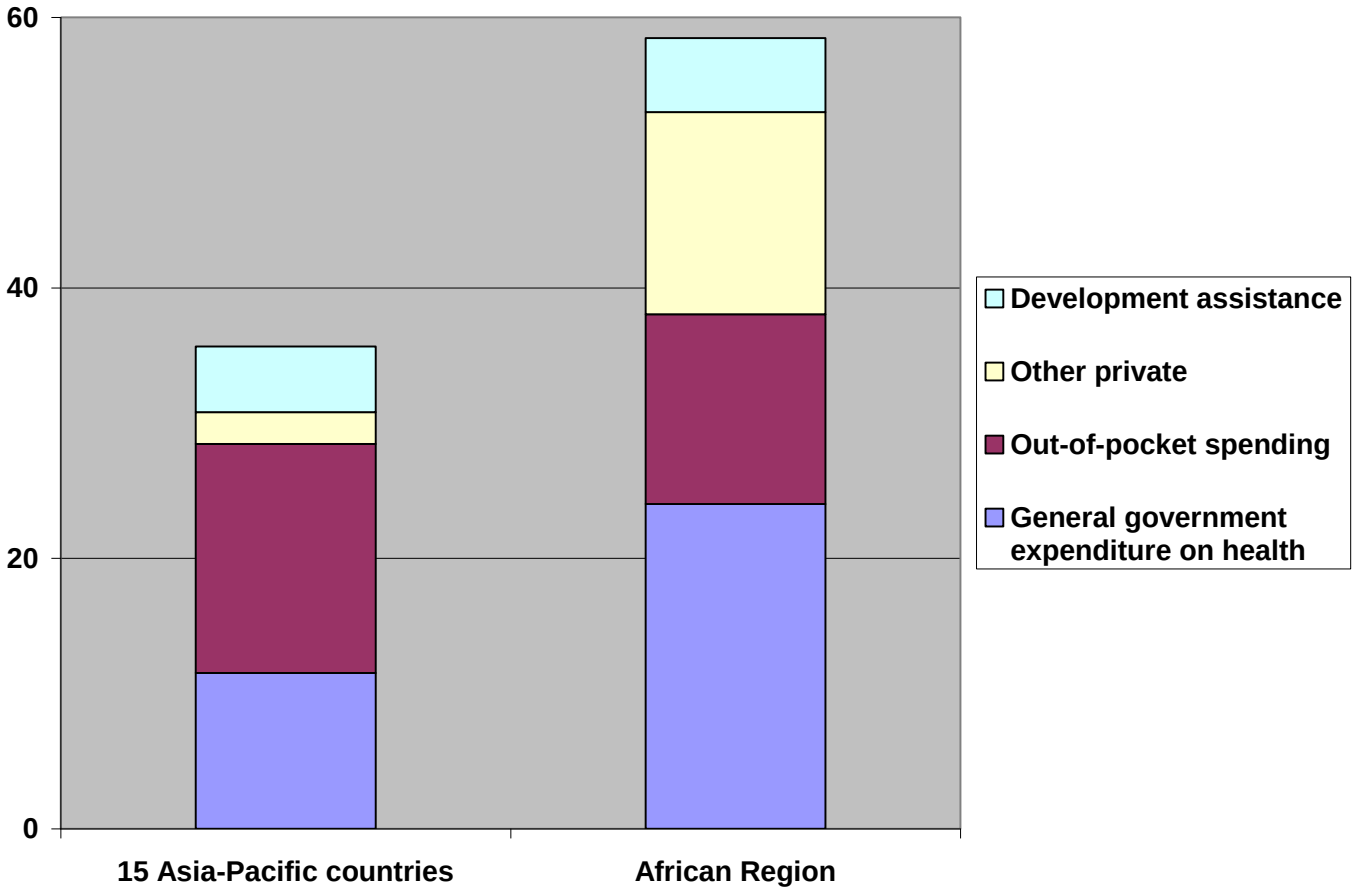
Health system and policy determinants

- **Poor geographical access especially to EmOC** (clustered in urban areas) (success of Sri Lanka, Malaysia, Thailand
- **Poor functioning health system** and lack of supplies and equipment, adequate referral system.
- **Shortage of Human Resources**: Lack of skilled personnel as well as motivated personnel- Skilled care at birth a distant dream for many--
- *Patronizing attitudes of health workers that force women not to seek care even when they recognize the seriousness of the problem*

Health system and policy determinants

- **Inadequate funding:**
  - South Asia spends just US $ 26 per capita on health (from domestic private and public funds and donor) – recommendation is much more than this
  - Spending on MNH even less (less than 20% in in some countries)
- **Inefficient spending:** Inadequate allocations to most cost-effective interventions or fragmented approaches
- **Inequitable spending:** Poor pay high Out Of Pocket Expenditures and 'catastrophic payments' if complications pushes poor families further into poverty
  - Time spent on borrowing money further delays accessing care during complications

Who pays in Asia Pacific? Health Expenditures per capita



Source: Investing in MNH- the case for Asia and Pacific

Lack of safe abortion services

- Unwanted pregnancies high despite increase in CPR (?? Poor quality of services and high discontinuation rates)
- Unsafe abortions a major cause of maternal death even in countries where legal
- Is major cause of Maternal Mortality (in some countries 30% of all MMR)
- “Gag rules” further worsened the situation (hope now is this will be more flexible)

Impact of financial crisis

- Further exacerbates the inequalities faced by women and excluded groups
- Further slowing down of achieving MDG 5, implications for sustaining child health services such as immunization, HIV prevention activities
- Macro level
- Collapse of public expenditures combined with a decline in private income further reduces the access particularly of poor and women
- Impact on pro-poor schemes funded by donors

Impact of financial crisis

- *Macro level (continued)*
- Increasing prices of drugs and supplies leading to
  - Increase in cost of care and insurance coverage may not cover all
  - Shortage of drugs and supplies in health facilities
- At Household level:
- Less money, need to spend more on food
- Women's health care – is not really a priority – even in mind of women themselves, so in times of crisis they will not spend money on themselves
- Poor nutrition and excesses work contribute to Low birth weight

Possible Areas for Research!!

Need for disaggregated information

- National figures mask differentials
  - Only disaggregated can gauge with greater accuracy the effort that the country must exert in order to provide minimal development opportunities to those who traditionally have been excluded in terms of education, health and living conditions.
  - Disaggregate information aids in identifying where the resource need to be invested in order to close the existing social gaps.

Health system strengthening Stewardship

How to MAKE BEST USE OF FUNDS available FOCUS DISTRICT HEALTH SYSTEMS

- How to Improved access
- How to Improve efficiency
- What and how is needed to improved equity especially for EmONC
- How and what is needed to improve Quality of care (particularly pro-poor schemes), regulations, audits
- How to strengthen Accountability
- Strengthen HMIS to track progress

Health system strengthening

- Best practices for production and retention and equitable distribution of SBA- *evidence shows no short cuts in duration of training*
- HR for EmOC – can non-specialist doctors do?
- How to Strengthen (and pro-poor schemes of government (especially for MH) by targeting, ensuring quality and full realization of entitlements
- Strengthen public- private partnership- need to ensure quality of care