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A Case for Investment in Maternal Survival and Health

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The Impact of Maternal Mortality and Morbidity on Economic Development

Woodrow Wilson Center
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Agenda

- Case for investment
  - Foreign policy
  - Economic and Social
    - Global
    - Bangladesh
    - Afghanistan
- Looking ahead
  - Private sector services
  - Medical interventions
  - Keeping an eye on cost & pregnancy outcomes

Foreign policy case for investing in health/maternal health

- U.S. has a national interest in advancing the well-being, prosperity of other countries. Countries with healthy populations are more likely to grow economically.

- U.S. leadership in global health can help lay foundations for effective working relationships that will be reservoirs of goodwill for the U.S. in difficult times.

- Maternal health has tremendous appeal as an area for U.S. global leadership because it allows us to showcase what others admire most about our country
  - altruism
  - a can do pragmatic approach to solving problems
  - dynamic private sector that can work with the public sector
  - application of science and innovation in service of people.

…Industrial College of the Armed Forces
Department of Defense National Defense University

Foreign policy case for investing in health/maternal health

- We are "pursuing a comprehensive global health strategy [because] the United States has a moral and strategic interest in promoting global health."

- The US National Security Strategy identifies promoting democracy and human rights abroad as a key value. Part of promoting democracy and human rights is "Supporting the rights of women and girls: Women should have access to the same opportunities and be able to make the same choices as men. Experience shows that countries are more peaceful and prosperous when women are accorded full and equal rights and opportunity."

…*US National Security Strategy May 2010*

Estimated global costs of maternal and newborn ill health

REDUCE Model 2000

- Direct causes, indirect causes, other conditions
- 1995 UN estimate of maternal mortality; 1990 Global burden of Disease
- Assumptions for each complication: case disability rate, average onset age, average duration → lifetime productivity loss calculation
- Global calculation

$6.814 bn	maternal disabilities
.675 bn	maternal deaths
8.249 bn	child disabilities

$15 billion annually

Source: Bart Burkhalter/AED USAID/SARA & other Projects

Estimates of cost for scaling up maternal care

	Intervention/scenario	Additional annual cost for expansion
Lancet Neonatal Survival (2005) **Darmstadt et al**	16 interventions 90% coverage 75 countries	$4.1 bn
WHO (2005)	67 interventions 73% coverage 75 countries	$1 bn (2006) → $6.1 bn (2015)
Commission for Macroeconomics and Health (2001) **Kumaranayake et al**	Multiple interventions 90% coverage 83 countries	$2.1 bn (2007) → $5.5 bn (2015)

Estimated cost $4.1-6.1 bn annual cost for expansion of maternal care to reduce death and disability is substantially less than the $15 bn annual estimated cost of maternal and newborn mortality and disability

Source: Gill et al, Women Deliver, 2007

Economic case for investing in maternal health – household level

Working Paper:

Coping with the Costs of Maternal Illness in Rural Bangladesh

►To determine the costs associated with maternal morbidity and the financial burden these place on the household budget

► To estimate the effect of maternal morbidity on the economic condition of families

► To understand how households cope with any loss of resources

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Coping with the Costs of Maternal Illness in Rural Bangladesh

The financial burden: Household spending & loss of income associated with maternal morbidity

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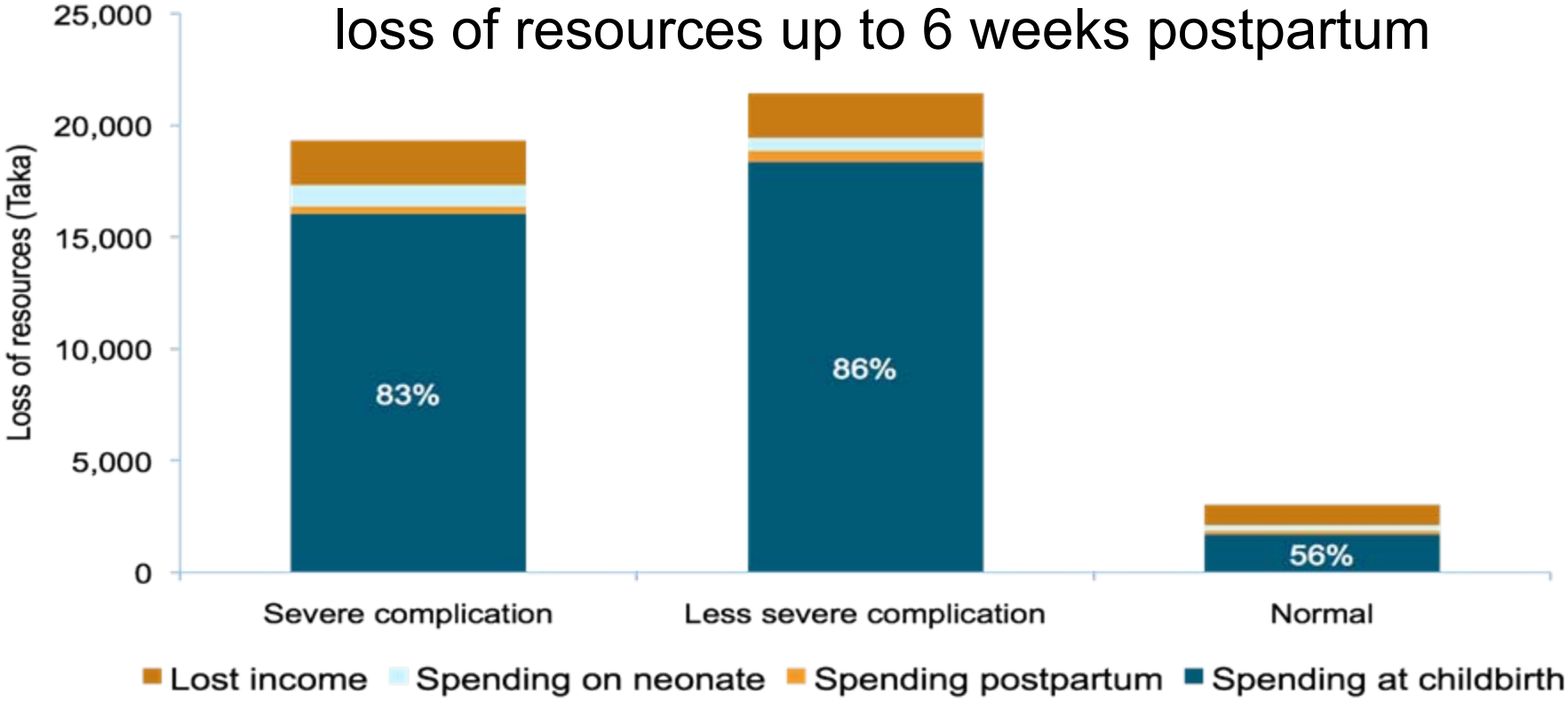
Coping with the Costs of Maternal Illness in Rural Bangladesh

Maternal morbidity leads to a considerable loss of resources up to 6 weeks postpartum



16,000 Taka = $230 US

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Effect of maternal morbidity on household consumption, and coping mechanisms

Mohammad Enamul Hoque (ICDDR,B) Timothy Powell-Jackson (LSHTM)

Coping with the Costs of Maternal Illness in Rural Bangladesh

Sources of finance for maternal care			
Proportion of out-of-pocket payments financed using:	Severe complication	Less severe complication	Normal delivery
Income and savings	30.7%	41.4%	64.8%
Loans	44.2%	31.8%	19.8%
Donations	14.7%	19.7%	11.2%
Sale of assets and other sources	10.5%	7.1%	4.2%

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Coping with the Costs of Maternal Illness in Rural Bangladesh

- Household costs of maternal health seeking are high and the financial burden is greatest among the poorest

►In households where there was a maternal complication, 2/3 incur catastrophic expenditure — more than 10% of their annual budget

► Poorest quintile spends 30% of annual household expenditure on maternal care when there is a complication, compared with 8% for the richest quintile

► In the case of a maternal complication, women borrowed 7,805 Taka ($113), while average monthly expenditure was 13,749 Taka ($199).

► Families (particularly the poorest) with an obstetric morbidity who took out loans struggle to pay them back – borrowing and sale of assets are indicative of more desperate means to cope with high financial costs of paying for maternal health care

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Coping with the Costs of Maternal Illness in Rural Bangladesh

- Households with maternal morbidity appear to cope – they do not cut back on consumption
- Financial protection is needed for the poorest to encourage use of facilities for delivery and prevent families being impoverished
- Demand side financing should be expanded conditional on evaluation. Sustainable policy options should be considered in the long-term

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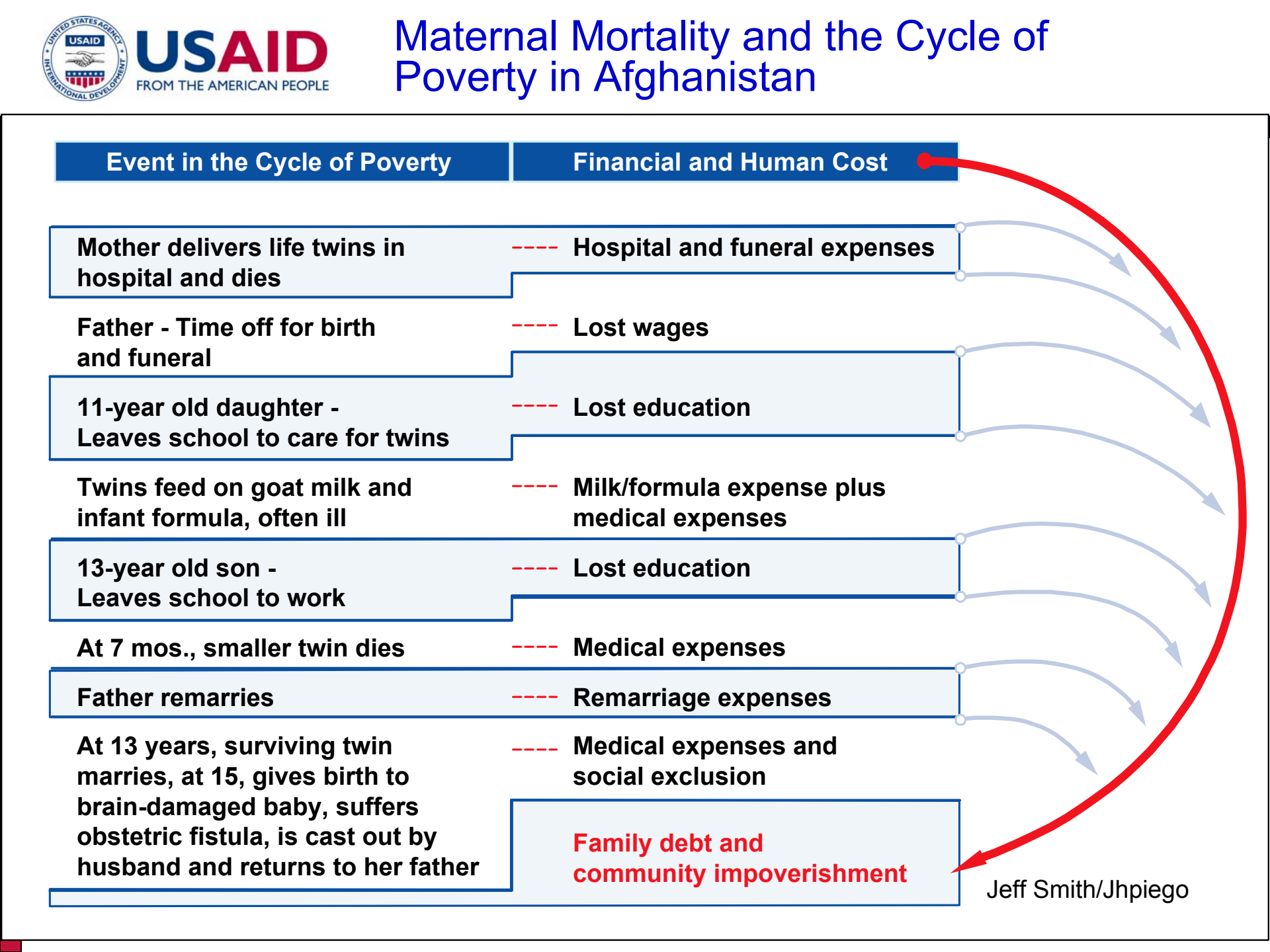
Maternal Mortality and the Cycle of Poverty in Afghanistan

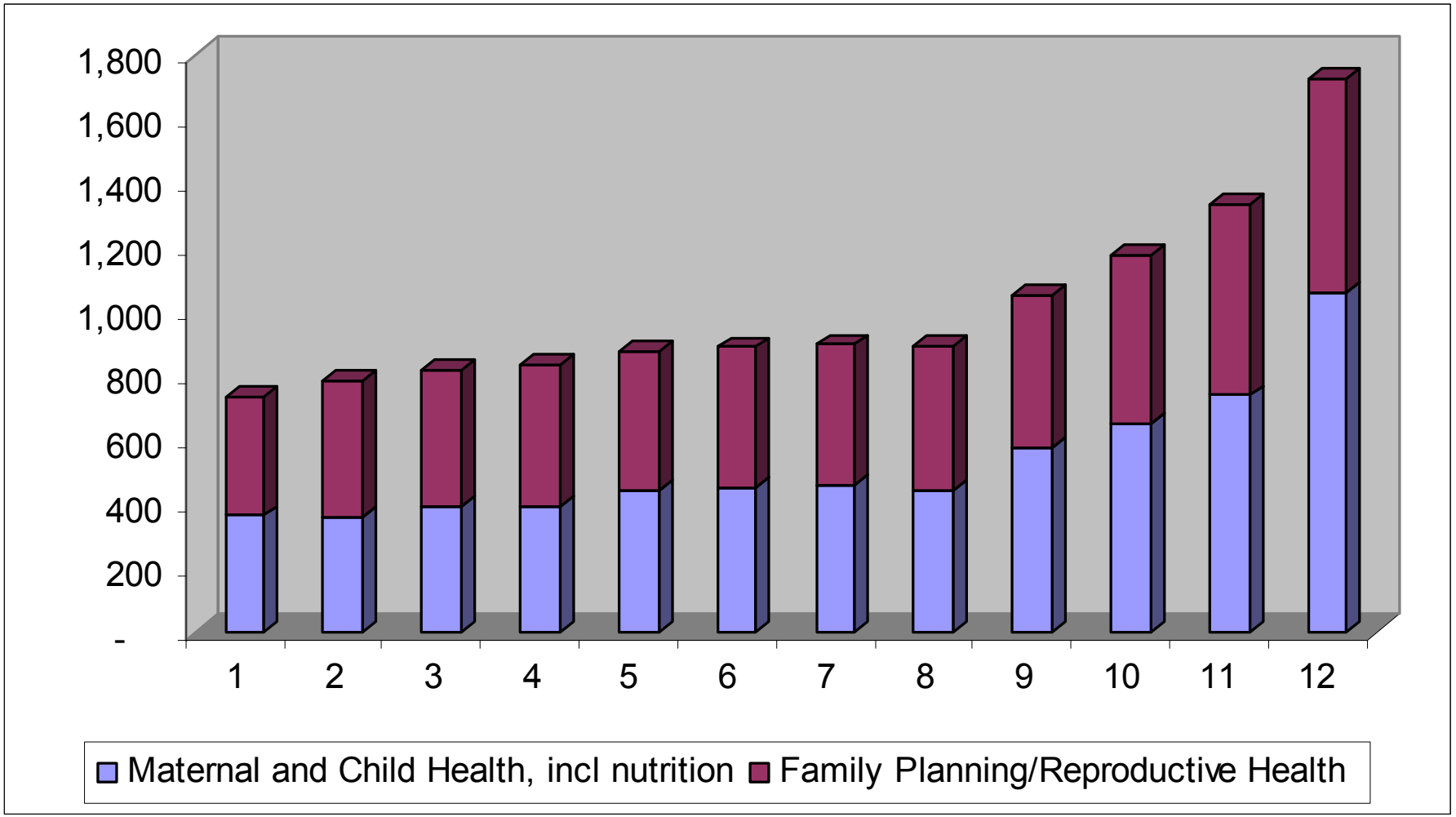
Event in the Cycle of Poverty	Financial and Human Cost
Mother delivers life twins in hospital and dies	Hospital and funeral expenses
Father - Time off for birth and funeral	Lost wages
11-year old daughter - Leaves school to care for twins	Lost education
Twins feed on goat milk and infant formula, often ill	Milk/formula expense plus medical expenses
13-year old son - Leaves school to work	Lost education
At 7 mos., smaller twin dies	Medical expenses
Father remarries	Remarriage expenses
At 13 years, surviving twin marries, at 15, gives birth to brain-damaged baby, suffers obstetric fistula, is cast out by husband and returns to her father	Medical expenses and social exclusion
	Family debt and community impoverishment



Jeff Smith/Jhpiego

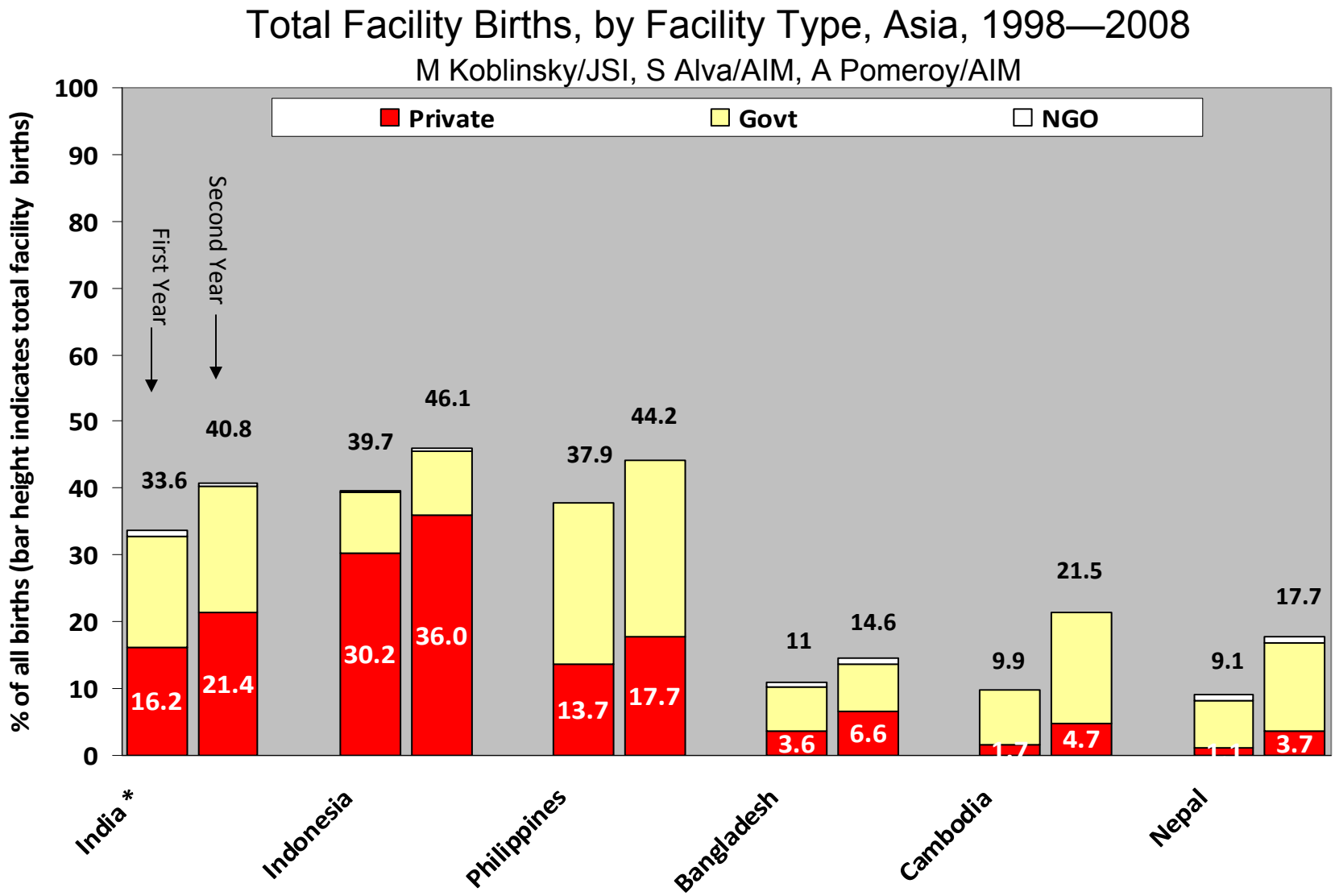
USAID support for maternal health

FY 2000: 363 MCH + 372 FP/RH = **$735m** **FY 2010**: 739 MCH + 596 FP/RH = **$1,334m**



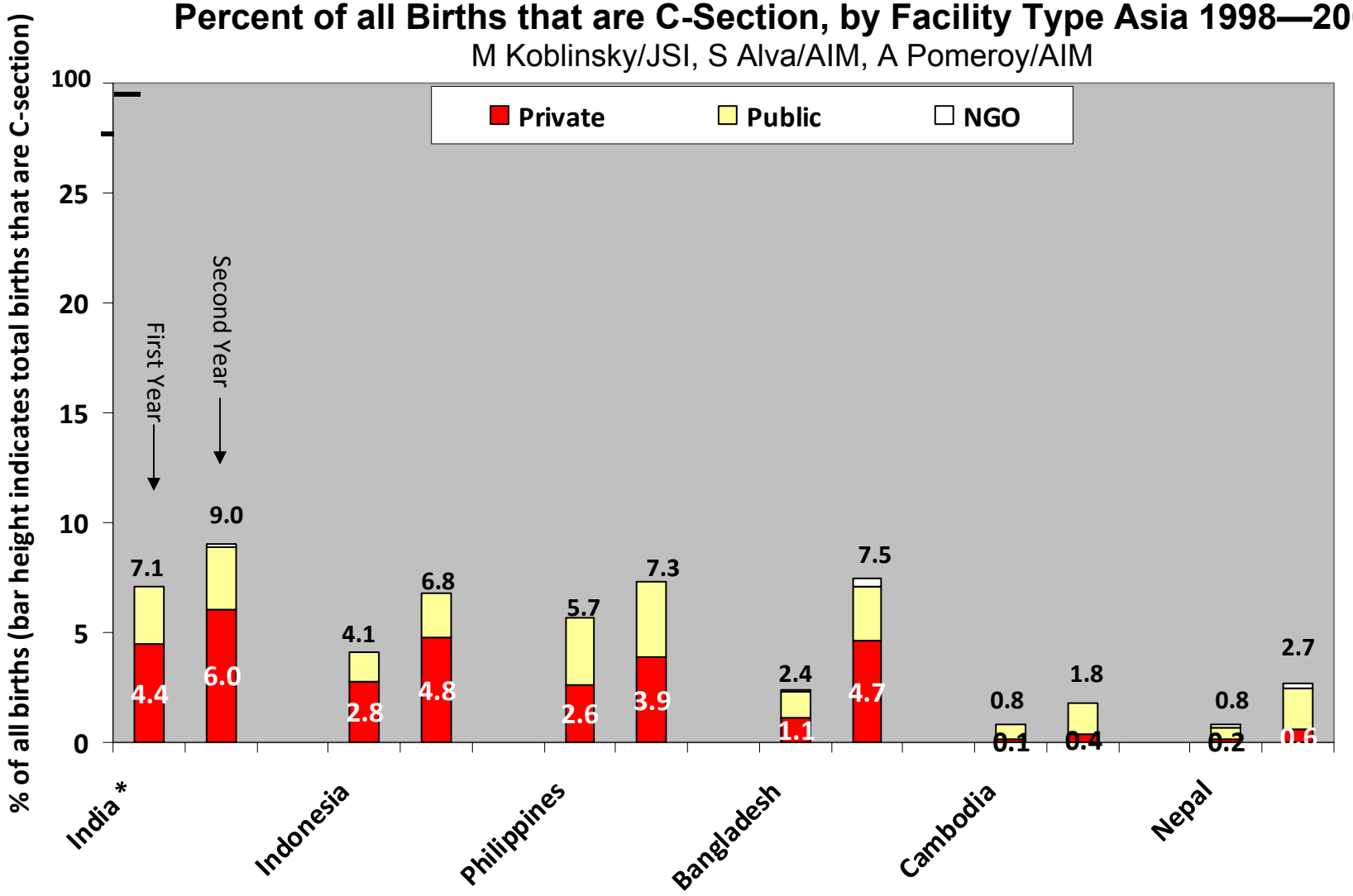
1-11 = FY 2000-2010 enacted; 12 = FY 2011 request ($1.724m)

The private sector is the site of a substantial and growing proportion of facility births



*India facility rates are for three years preceding the survey, because the 1998 data do not have information on births five years preceding survey. For all other countries, these rates are for all births five years preceding survey. All DHS data; first time point was chosen to be from the fourth round of DHS survey collection (1997-2003) while the second time point was chosen to be in the fifth phase (2003-Present).

Growth in private C-Section births is largely responsible for the growth in overall C-Section births



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Maternal health care costs can skyrocket… sometimes without improvement in health outcomes

In the United States in 2005 Sakala and Corry, Evidence-Base Maternity Care 2008

- Maternity care was the leading cause of hospitalization/office visits
- Medical induction of labor, cesarean sections, and repair of obstetric lacerations were the top 3 procedures billed to Medicaid
- The US had the greatest overall health expenditure per capita of 30 OECD countries
- Meanwhile, many trends were headed in the wrong direction, including rising preterm births and low birth weight; the US was ranked behind 29 other countries in maternal mortality and 33 other countries in neonatal mortality

In WHO surveys (2004-2008), hospital rates of cesarean section

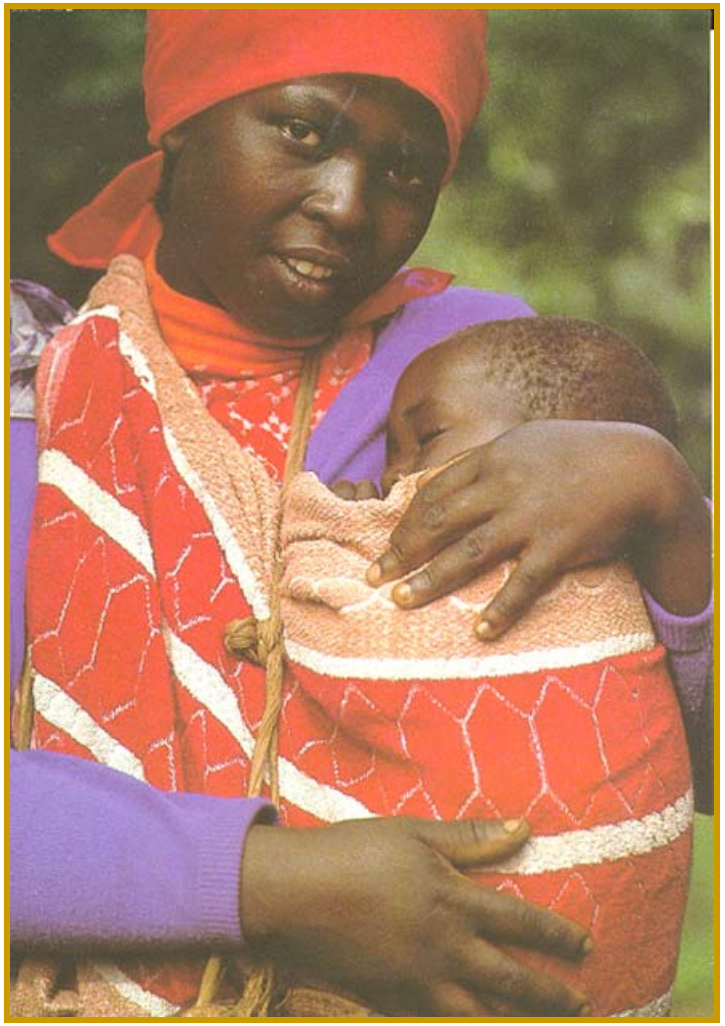
- 27.3% in Asia – C/S without a medical indication was associated with higher maternal mortality and severe morbidity
- 33% (49% elective) in LAC Asia — increased C/S rates associated with severe maternal morbidity and mortality, fetal mortality, preterm delivery and neonatal mortality
- <9% in Africa – need to expand availability of C/S

C/S costs 2 X as much as a vaginal birth in Uganda,[1] 4-5 X as much in Malawi,[1] 5-6 x as much in Ghana,[1] 10 x as much in Burma,[2] and 18 x as much in Mauritania.[3]

[1] Levin et al [2] Stanton [3] Soors et al

If we are successful in increasing the investment in maternal health…

We need to invest wisely to eliminate financial, geographic, and social barriers to quality maternal newborn care, while at the same time, guard against promoting or incentivizing invasive medical procedures without medical indication that drive up health care costs unnecessarily and may contribute to adverse outcomes for mothers and their babies.



Not investing in maternal health, including family planning, brings unwanted consequences

Adversely affects the quality of life for women

Contributes to high rate of population growth that adversely affects environment, economy, and state stability.

Subjects women to unnecessary risk of death

Increases possibilities of abortion

Increases health care costs associated with unwanted pregnancies

Decreases women's productivity

Decreases chance for women to engage in civil society to promote good governance and security

"Women are not dying because of diseases we cannot treat . . .

. . . they are dying because societies have yet to make the decision that their lives are worth saving "

Mahmoud Fathalla