

## **Keynote Address**

### **Reproductive Health and Poverty**

**Sara Seims, Director, Population Program, The William and Flora Hewlett Foundation, USA**

*Summary of the keynote address given at EuroNGOs International Conference, 7<sup>th</sup> September 2009, Riga, Latvia*

How can we protect reproductive health in times of economic crisis? The key is ensuring that the world's most vulnerable people, especially women, have access to good reproductive health services. For that we need money ... and the biggest pots of money are held by powerful people who either do not understand or are indifferent about these issues. The people I am referring to are economists in the development banks (such as the World Bank) and Ministers of Finance in developing countries.

There have been attempts by the reproductive health field to use research and evidence to convince development economists and ministers of finance to support our issues, but this has not been successful. People in our field do not know how to talk to development economists, and they do not know how to talk to us.

A few years ago the Hewlett Foundation decided to try to help development economists to understand the relationship of reproductive health and population dynamics to poverty and economic growth. We asked them what questions they would want answered in order to understand these relationships. It took 18 months just for them to decide what the questions are! It was clear that we speak different languages. Development economists care about one thing: economic growth. What is economic growth? To be simple, it is an increase in per capita income and gross domestic product (GDP). They are primarily interested in causality – does 'A' cause 'B'. If 'A' is just *associated* with 'B', they are not interested; they have set the standards very high. Unless we can show development economists that reproductive health and population dynamics are critical to poverty reduction and economic growth, we are unlikely to interest them.

However, there have been some changes within development economics that are good for the RH field. Development economists became interested not only in GDP growth, but in how income is distributed. A country can have high economic growth and substantial income, but this can, and usually is, unequally distributed. They also became more interested in poverty, which is measured according to what happens at individual household level. Although it seems obvious to us that household poverty is strongly connected to country level economic growth, there actually is a lack of good evidence for this.. So economists at the World Bank, for instance, dismissed micro-level studies on poverty at household level as being irrelevant for economic growth. Since most of what we (in the reproductive health field) do is at household level, it is easier for us to demonstrate the impact of RH. Now that economists have become more interested in household levels this has made our job easier, and we are optimistic that it means economists will be more open to our issues.

### **Hewlett's support for research on reproductive health and poverty**

Hewlett launched a research programme and were fortunate to be joined by the governments of the United Kingdom, the Netherlands, Norway and France, and approached by the government of Ireland to take part. This research is now underway and will come to fruition starting next year and continuing over the next three to four

years. It will provide evidence you can use for your advocacy, to show that what we do is essential to improving lives, health and economic growth.

We all know that poverty affects reproductive health, but we know less about how reproductive health affects poverty ... even though we know it does. This is the driver of the research that Hewlett and our partners have been funding.

### **How poverty affects reproductive health**

To understand the different arguments involved, it is important to cover some familiar territory first. We know that poor women have less access to health systems, are less likely to seek care (e.g. because they are less educated about it, have less autonomy, control and freedom to seek it etc.). This leads to poor reproductive health and fertility outcomes, such as unwanted pregnancy, which leads to unsafe abortion, mistimed or closely spaced births, early childbearing, and women who continue childbearing past the age when it is safe for them to do so. These poor health outcomes increase maternal and child mortality and morbidity, leading to poor fertility outcomes, which poverty promotes.

### **Through an economist's eyes: How reproductive health affects poverty**

Now we will look at it differently – through the eyes of an economist – and show how reproductive health affects poverty. Let's say you are a woman who has an unwanted pregnancy, HIV or another condition. Economists who care about what happens at household level will ask 'how does it affect the income of your household?' From an economist's perspective, it will affect the savings and investments of the household. Poor families do not have many resources, and if mother is sick – keeping in mind that peak economic age of women is also their peak reproductive age – morbidity in that age group affects the ability of the household to save and invest. Some of the money will go to treat the woman or tragically she might die. If she has died, a woman clearly cannot contribute to the income of the household, work in the fields, help kids get to school in the morning etc. Through an economist's eyes, higher health expenditures mean less investment in the home, farm, children, etc. Up until now, there is not a strong evidence base for this – a lot of this research being undertaken by our partners is looking at these issues closely, focusing particularly on sub-Saharan Africa. We are particularly interested in the contribution of RH in helping impoverished families breaking out of the 'poverty trap'. This occurs when the burden of poor RH keeps families mired in poverty.

### **The impact of good reproductive health: An analysis at household level**

What's the other side of this equation, in other words: what happens when good reproductive health happens? There is data from a randomized-control trial in the Matlab region of Bangladesh.

In Matlab starting in the 1970s, women went door to door offering family planning, while in the rest of region women had access only to the regular government programme. After 20 years (1977-1996), families with easy access to a range of family planning methods reduced their fertility by an average of 1 child compared to the control group. In other words, they had at least one fewer child per family. Overall, fertility in the treatment group dropped from 4.5 in 1978 to 2.7 by 1996. Households with fewer children had 43% greater assets (primarily property/farmland, productive assets like aquaculture etc.) than those in villages without easy access to family planning. Women with easy access earned as much as 1.5 times more in wages for each year of schooling (an increase of 150%). Women and girls in the treatment area were healthier: they weighed one full

kilogram more and had a body mass index (BMI) 0.6 higher. Child mortality decreased by 20% or more and educational attainment increased, and there was also improved access to safe water.

The family planning intervention helped the region to break through the poverty trap. This evidence cost a lot of money to collect, but it is the most compelling evidence we have which meets the high standard of causality that development economists like.

### **Country-level analysis of the impact of reproductive health**

The Bangladesh example was from household level; we can also look at country level and the impact of reproductive health on GDP. For this we will discuss the *demographic dividend*: with good reproductive health, fertility goes down as women avoid unwanted pregnancies. As fertility goes down, there are proportionally more people of working age in the population. If the right investments are made in a country, it experiences the *demographic dividend*. This was what happened among the East Asian 'tigers': Thailand, Taiwan, Korea and soon Vietnam. They had family planning and reproductive health care, as well as the right macro and micro economic policies. Thus money was freed up for other things, such as education. This also promoted gender equity (though more needs to be done on this count). One-third of GDP (economic growth) among the East Asian 'tigers' was attributable to the demographic dividend.

Latin America is seen to have waste its opportunity to capitalize on the demographic dividend, because as fertility went down in the region, the right economic policies were not put in place. All eyes are now on Africa: will they put the right policies in place? Part of our research will look at how the demographic dividend works, and to try to extract lessons from sub-Saharan Africa.

### **The costs of unsafe abortion**

Guttmacher estimates that there are around 20 million unsafe abortions every year globally, and five million result in long-term health disability. However, these may be gross underestimates. Recent research done by the Institute of Development Studies (IDS) at the University of Sussex, led by Hilary Standing, estimates enormous costs associated with unsafely performed abortions, for example: costs to developing world health systems each year is at least US\$ 500 million; another \$375M is estimated to treat the serious complications for women who receive no care at all from the health system, were they to receive care.<sup>1</sup>

There are few empirical studies to judge, but estimates of the long-term costs of unsafe abortion-related morbidity are probably in the billions of dollars in economic losses. The IDS research also suggests that lost productivity may cost another \$400M to developing economies and out of pocket expenses for care after unsafe abortions may cost another \$600M for women and their families.<sup>2</sup>

---

<sup>1</sup> Vlassoff, M, Shearer, J, Walker, D and Lucas, H (2008) 'IDS Research Report 59: Economic Impact of Unsafe Abortion-Related Morbidity and Mortality: Evidence and Estimation Challenges', Brighton: IDS.

<sup>2</sup> Ibid.

### **Why do we care that reproductive health and population dynamics impact economic development?**

We care because stress on public health systems due to broadly poor reproductive health outcomes crowds-out investment in other productive public sectors, such as roads, schools, hospitals etc. Populations with poor health outcomes have fewer incentives to make long-term investments in business and human capital development.

We also care because we believe in reducing poverty and stimulating economic growth. We know this contributes to good reproductive health, and that is our goal as advocates. We also know that poverty is reduced and growth stimulated best when policies consider reproductive health and population issues. We believe the causality works both ways, so we want to promote both economic development and good reproductive health..

People in ministries of finance and planning are concerned about reducing poverty and stimulating economic growth. So being able to talk with them in their language is important as advocates for reproductive health and population activities.

### **Results of the research**

We have been working with four governments on this research. This will bring a huge influx of evidence, which can feed into the policy process. Planning for this is already underway. We will have a framework of a communications strategy, and we hope by next year's EuroNGOs meeting we can work with you to think about how best to communicate and disseminate the data.

To learn more, go to Hewlett's <http://www.hewlett.org/programs/population-program/training-research-and-advocacy-to-create-sound-policy/population-and-poverty> You will find information about the studies, and a paper called the Gaps paper, looking at gaps in the research – research that still needs to be done.