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ACHIEVING MATERNAL and SEXUAL/REPRODUCTIVE HEALTH

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Sexual and Reproductive Health, MDG(5), Beijing

*“Looking ahead to 2015 and beyond, there is no question that we can achieve the overarching goal: we can put an end to poverty. In almost all instances, experience has demonstrated the **validity of earlier agreements on the way forward**; in other words, we know what to do. But it requires and unswerving, collective, long-term effort.”*

United Nations Secretary-General Ban Ki-moon

The case for sexual and reproductive health

The 1994 International Conference on Population and Development in Cairo and the 1995 Fourth World Conference on Women held in Beijing expanded the right to family planning to include the right to better sexual and reproductive health (SRH) information and services. Building on the World Health Organization’s definition of health, sexual and reproductive health was defined in detail. **(Box 1)**

Box 1.

“Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulations of fertility which are not against the law and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being 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.”

This novel, comprehensive and rich description of people’s most intimate part of their lives was a bold step forward in the newly constructed development agenda. It also carried a human rights based approach which included “reproductive rights”. This approach empowered women’s groups everywhere but disturbed conservative constituencies. As affirmed by the Beijing Declaration and the Platform of Action in 1995, the rights of women and girls were “inalienable, integral and indivisible part of universal human rights” and included protection of reproductive rights. These rights encompassed the advancement of

gender equality and equity and empowerment of women and elimination of all kinds of violence against women, and ensured women's ability to control their own fertility.

At the core of this reproductive health movement was the promotion of healthy, voluntary, safe sexual and reproductive choices for individuals and couples, including timing of marriage and decisions on family size that are fundamental to people's well-being. Sexuality and reproduction were indispensable aspects of personal identity.

Sexual and reproductive health comprises normal physiological functions such as pregnancy and child birth, aim to reduce adverse outcomes of sexual activity and reproduction. SRH is also about enabling people of all ages, including adolescents and those older than the reproductive years, to have safe and satisfying relationships by tackling obstacles such as gender discrimination, inequalities in access to health services, restrictive laws, sexual coercion, exploitation, and gender-based violence.

Evidence showed clearly that in addition to improved health, sexual and reproductive health contributes to societal equity, gender equality, economic growth and democratic governance, thus bringing tremendous benefits to women, families and societies.

In the last 15 years, governments and civil society tried in different configuration and models to integrate three main components of sexual and reproductive health namely, family planning, maternal and newborn care and prevention/treatment of sexually transmitted diseases including HIV/AIDS and other gynaecologic and urologic problems in service provision at the primary health care level. This turned out to be a costly and complex commitment in terms of infrastructure, trained human resources and logistics. MDG 5, improve maternal health, and its target: Achieve, by 2015, universal access to reproductive health, still remains a challenge for many countries.

The health benefits of better sexual and reproductive health are the more obvious and perhaps easier to measure and receive more priority than the societal benefits. Sexual and reproductive ill health accounts for 1/3 of the global burden of disease among women of reproductive age and 1/5 of the burden of disease among the population overall. HIV/AIDS accounts for 6 per cent of the global burden of disease.¹[SOURCE] The need for sexual and reproductive health services, and thus the potential benefit of meeting the need, is greatest among the poorest women, men and children in the world's lowest-income countries. Satisfying the unmet need for contraceptive services in developing countries would avert 52 million unintended pregnancies annually, which, in turn, would save more than 1.5 million lives and prevent 505,000 children from losing their mothers.²

Understanding the full benefits of sexual and reproductive health services requires looking beyond medical outcomes to broader individual, family and societal benefits. By keeping young adults healthy and productive, by allowing parents to have smaller families and devote greater time and financial resources to each child, and by reducing public expenditures on education, health care and other social services, sexual and reproductive health services contribute to economic growth and equity. Enabling young women to delay childbearing until

¹ WHO, Estimates of DALYs by sex, cause and WHO mortality sub-region, estimates for 2001, 2002 <http://www3.who.int/whosis/menu.cfm?path=evidence,burden,burden_estimates,burden_estimates_2001,burden_estimates_2001_subregion&language=english>, accessed July 9, 2003.

² UNFPA 2003. Adding it up., Alan Guttmacher Institute

they have achieved education and training goals improves women's social position and increases their community and political participation.

Sexual and reproductive health for all should not be difficult to achieve. There are methods of contraception that prevent almost all unwanted pregnancies. Simple technologies that have existed for decades make childbirth in the 21st century very safe. People can be taught skills that enhance safe-sex practices and most sexually transmitted infections are treatable; even HIV is no longer as fatal as before. Yet worldwide, the burden of sexual and reproductive ill-health remains enormous.

MDGs – A new agenda?

In 2000, world leaders again agreed to a broad development agenda. This agenda aimed to promote democracy, human rights, good governance and improved global security, based on previous commitments in UN Summits aimed at achieving a fairer and more equitable world, reducing poverty, hunger, disease, illiteracy, environmental degradation and discrimination against women. This agreement was turned into 8 simple, concrete goals with measurable targets, named the Millennium Development Goals (MDGs), which were people centered, time-bound and measurable. In spite of all the previous commitments and the fact that unsafe sex is the second most important risk factor for disease, disability, or death in the poorest communities, sexual and reproductive health was not explicitly included among the eight Millennium Development Goals. Only one goal, number 5, captured an important component of SRH- with euphemism- “improve maternal health” rather than “reduce maternal mortality”.

Even though not an explicit goal in itself, sexual and reproductive health underpins and is essential to achieving the MDGs. In 2007, after intensive negotiations and pressure from the reproductive health community, “achieving, by 2015, universal access to reproductive health” was added as a target.

This new social compact between North and South called for a report card of all countries by 2015 and expected the leaders of all countries to intensify their political commitment and budget allocation to reach the MDGs. These goals were not only for developing countries to achieve but expected contributions of developed countries through fair trade, development assistance, debt relief, access to essential medicines and technology transfer.

Improving maternal and newborn health, MDG 5

Health is central to the achievement of the MDGs, especially Goals 4, 5 and 6, and a contributor to the achievement of all other goals. Goal five (5) calls for a 75 per cent reduction in maternal mortality ratio between 1990-2015. **(Box 2)**

Box.2. Millennium Development Goal 5: Improve maternal health*	
Targets	Indicators
5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	5.1 Maternal mortality ratio 5.2 Proportion of births attended by skilled health personnel
5.B: Achieve, by 2015, universal access to reproductive health	5.3 Contraceptive prevalence rate 5.4 Adolescent birth rate 5.5 Antenatal care coverage (at least one visit and at least four visits) 5.6 Unmet need for family planning

* The revised Millennium Development Goals framework agreed by the United Nations General Assembly at the 2005 World Summit, with the new official list of indicators effective as of 15 January 2008, has added a new target (5.B) and four new indicators for monitoring Millennium Development Goal 5.

Source: United Nations, Millennium Development Goals Indicators: The official United Nations site for the MDG indicators, <<http://mdgs.un.org/unsd/mdg/Host.aspx?Content=Indicators/OfficialList.htm>>, accessed 1 August 2008.

Even though pregnancy and childbirth are times of joy and happiness for the parents and families - in many developing countries, they are also periods of great risk to the health and survival of women and newborns. The health and survival of mothers and their newborns are linked and many interventions to save mother's lives also benefit their newborn infants. With almost five years to reach the targets of Goal 5, the picture on maternal and newborn health is quite bleak.

Every year, an estimated 210 million women have life-threatening complications of pregnancy, often leading to serious disability, and a further half a million women die in pregnancy, child birth, and the puerperium, nearly all of them in developing countries. Three million babies die in the first week of life and about 3.3 million infants are stillborn every year. More than 120 million couples have an unmet need for contraception and 80 million women each year have unwanted or unintended pregnancies, 45 million of which are terminated. Of these 45 million abortions, 19 million are unsafe, 40 per cent of them are performed on women below the age of 25, and about 68 000 women die every year from complications of unsafe abortion. Every day, 1500 women continue to die from complications related to pregnancy and childbirth. Since 1990, almost 10 million maternal deaths have occurred.³

It is unacceptable that 99 per cent of these deaths and disabilities and ill-health take place in developing countries. The divide between North and South is greater on maternal mortality than on any other issue. Latest data shows, the average life time risk of a woman in a least developed country dying from complications related to pregnancy and child birth is more than 300 times greater than for a woman living in an industrialized country. No other statistic is so unequal.⁴

³ UNFPA (2007). Accelerating Progress Towards Millennium Development Goal 5, New York

⁴ WHO (2009). Women and Health: Today's evidence, Tomorrow's agenda

The timing and causes of maternal and newborn deaths are well understood. Obstetric complications, such as post-partum haemorrhage, infections, eclampsia, and prolonged or obstructed labour, and complications from abortion account for most maternal deaths. For newborns, the greatest health risks are posed by severe infections, which include sepsis/pneumonia, tetanus and diarrhoea together with asphyxia and pre-term births. They cause 86 per cent of all newborn deaths.⁵

Most of these conditions are preventable or treatable with essential measures such as quality reproductive health services, antenatal care, skilled health workers assisting at birth, access to emergency obstetric and newborn care when necessary, adequate nutrition, post-natal care for mothers and newborns, and education to foster healthy practices for women and newborns. Research has shown that around 80 per cent of maternal deaths could be averted if women had access to essential maternity and basic health-care services.⁶

In addition to the direct causes of maternal and newborn mortality and morbidity where all investment are directed, there are a number of factors at the household, community and district levels that are also a prerequisite for the health and survival of mothers and newborns. These include: lack of education and knowledge for girls and young women, insufficient access to food and micronutrients, poor health facilities, and inadequate and limited access to basic health-care services. There are also basic factors, such as poverty, social exclusion, gender discrimination and political insecurity that serve to entrench the underlying causes of maternal and newborn mortality and morbidity.⁷

Improving maternal and newborn health does not rest solely in the provision of health services. To be truly effective and sustainable, the scaling up of essential interventions must take place within a framework that strives to strengthen and integrate programmes with health systems and promotes an environment supportive of women's empowerment and rights. Without actions to address gender discrimination and inequities that are perpetuated against women and girls, actions to support enhanced primary health care risk being much less effective, sustainable, or even impossible.

It is sad that mothers and newborns are no more likely to survive today than two decades ago with prospects worst in countries battling AIDS, conflict and poverty. Maternal mortality ratio in Africa continues to be 900 per 100,000 live births compared to 400 per 100,000 globally. In Sub-Saharan Africa, half of the maternal deaths (265,000) occur. Interim reporting by countries shows that of all the MDGs, at the global level, less progress has been made towards achieving MDG 5. Instead of the expected 5.5 per cent decrease to reach 2015 target, there is less than 1 per cent decrease.⁸

In 2008, out of the 68 countries where 97 per cent of the world's maternal and child deaths occurred, 56 countries had "high or very high" maternal mortality ratios, far off the track to achieve maternal survival by 2015.

⁵ UNICEF (2009). State of the World's Children: Maternal and Newborn Health

⁶ UNICEF (2009). State of the World's Children: Maternal and Newborn Health

⁷ UNICEF (2009). State of the World's Children: Maternal and Newborn Health

⁸ United Nations, The Millennium Development Goals Report 2009

While the MDGs have contributed to galvanizing national governments, development agencies, NGOs, activists and the entire United Nations system into action, they have been also critiqued as “limited” by calling for narrow interventions that do not address the underlying causes of poverty and gender inequality and are seen as a separate activity than the previous commitments under the Beijing Platform for Action and the obligations under the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).

Recently, in addition to vigorous campaigning by the safe motherhood partners, the Secretary-General of the United Nations and world leaders again called attention to MDG 5. UN Secretary General Ban Ki-moon has called the high death rates from pregnancy and childbirth “an outrage”, the wife of the British Prime Minister Gordon Brown said that “there was no excuse for inaction”, Norwegian Prime Minister Jens Stolten has said “delivering in safety is the most important factor in saving the lives of mothers and newborns”, all indicating that political commitment is there, and there is frustration that despite many partnerships, philanthropists’ interest, scientific evidence, different strategies stressing different components of a simple problem – women continue to die.

Creating a supporting environment for maternal and newborn health in communities as well as strengthening community and primary health care systems with a focus on the continuum of care is a two-pronged approach that has worked in countries where there have been reductions in maternal mortality. However, most of the funding and programmes are concentrated on the medical prong which is easier to conceptualize, to package and deliver. Challenging social, economic and cultural barriers that perpetuate gender inequality and discrimination is too difficult for weak and transient political systems to face and take priority action.

Several key actions are needed, such as educating women and girls and reducing the poverty they experience; protecting them from abuse, exploitation, discrimination and violence; fostering their participation and their involvement in household decision-making and economic and political life; and empowering them to demand their rights and essential services for themselves and their children. Greater involvement of men in maternal and newborn health care and in addressing gender discrimination and inequalities is also critical.

The empowerment of girls and women has a direct impact on maternal health. Education, in particular, can lower the exposure of girls and women to maternity risks. Educated adolescents are more likely to wait until their teenage years to start families. Complications from pregnancy and childbirth are an important cause of mortality for girls aged 15-19 worldwide, accounting for 70,000 deaths annually. In addition to delaying pregnancy, educated mothers are more likely to use improved birth spacing practices.⁹

Child marriage, a violation of rights according to international conventions and many national laws, can rob girls of their opportunities for schooling and lead to pregnancies at younger ages. Girls who give birth before the age of 15 are five times more likely to die in child-birth than women in their twenties. If a mother is younger than 18, her infant’s risk of dying before reaching age one is 60 per cent greater than that of an infant born to a mother

⁹ UNICEF (2009). State of the World’s Children: Maternal and Newborn Health

older than 19.¹⁰ Even if the child survives, the baby has a greater likelihood of suffering from low birth weight, under nutrition, and late physical and cognitive development.

Combating violence and abuse against women and girls is critical to improving maternal and newborn health. The health consequences of violence against women and girls increase the risk of poor physical and reproductive outcomes.

Female genital mutilation/cutting (FGM/C) is a violation of the rights of women and girls and a form of violence that is estimated to have been undergone by around 70 million girls and women aged 15-49 in 27 countries of Africa and the Middle East. FGM/C can significantly increase the risk of complications during delivery and post-partum¹¹.

Other forms of violence, including physical violence by intimate partners and rape, can lead to many health problems of mothers and children. Establishing comprehensive frameworks that cover legislation and its enforcement, research, programmes, budgets and sustained attention on the issue will be imperative to reduce violence against women and girls from its current levels.

Supporting women within the household and in broader society can have multiple beneficial effects for maternal and newborn health. When women are able to participate in key decisions in the household, they are more likely to seek appropriate medical care for themselves and their children. All these issues that go beyond the health sector are a daunting task for politicians of developing countries.

There is no need to wait for a scientific breakthrough or a new paradigm. The knowledge to save the lives of millions of babies and their mothers is available. The framework for actions – the MDGs, Cairo, CEDAW and Beijing Platform of Action – is set. Efforts must now focus on ensuring that human and financial resources are met and invested and the political will is sustained to save the lives of mothers and newborn babies.

Success stories

Women's groups in some countries with high maternal mortality rates inspired communities and governments to contribute concretely to the provision of safe delivery.

- In Djibouti, women have organized themselves to establish a community health fund. The fund supports health care visits during pregnancy and life-saving care during childbirth, including transportation, to ensure a safe delivery.
- In Morocco, in 2004, women's rights activists persuaded the government to pass a family law against gender inequality and protecting children's rights.
- The same year in Mozambique, women's groups successfully campaigned to raise the legal age of marriage by 2 years to 16 with parental consent and to 18 without.

¹⁰ UNICEF (2009). State of the World's Children: Maternal and Newborn Health

¹¹ UNICEF (2009). State of the World's Children: Maternal and Newborn Health

ENGLISH only

- In Egypt, Ethiopia, Cote d'Ivoire, Mali and Nigeria, more girls are going to school, more births are attended by skilled health workers, more women and couples are using family planning. There is an increasing action by civil society to end violence against female genital mutilation and cutting.
- In Bolivia, where the maternal mortality rate is the highest in Latin America, indigenous women have demanded that skilled health workers serve their communities and a new midwifery training programme has started.
- Bangladesh has one of the sharpest declines in maternal mortality which is attributed mainly to community mobilization and the work of local women's groups.
- Rwanda, over the last few years, with a committed Government and strong women's health advocates and community involvement, has tripled the use of modern contraception, skilled birth attendance had increased to more than 50 percent and half of the deliveries now take place in health facilities.
- In Ghana, the Government agreed to the requests of women's health groups and decided that pregnant women will not be required to pay into national health insurance schemes.
- In Nepal, the Government has scaled up free maternity services even in hard to reach parts of the country and Local Governance Act (2002) created local governance structures that support safe motherhood activities through district committees.
- In Mozambique, Tanzania, Ethiopia, Cambodia, Yemen, Zambia and Mauritius, more skilled midwives are being trained and deployed. More advanced skills are also being taught to carry out higher level functions. China, Cuba, Egypt, Jamaica, Honduras, Malaysia, Sri Lanka, Thailand, Tunisia and Romania have also halved their maternal mortality by increasing access to family planning and skilled birth attendance with emergency obstetric care. Women's health advocates have been critical in igniting action to raise awareness to gender equality to bring about these changes.

Achieving MDG 5 more equitably will require political, social, legal and economic actions as well as scaling up technical strategies.

To be opportunistic and strategic

Gender inequality is highlighted in CEDAW, Cairo, Beijing and MDG frameworks as a key contributor to poverty. Gender equality and the empowerment of women is a cross-cutting concern essential to achieving all the MDGs on time. The exclusion of many women from education, wealth, social services, labour force and market participation restricts their ability to contribute to the well-being of societies. Whilst disparities in basic rights, schooling and jobs, and ability to participate in public life take their most direct toll on women and girls, the full costs of gender inequality ultimately harm everyone.

We need to be optimistic, opportunistic and strategic and anchor MDG 5 work on previous policies and programmes related to CEDAW and the Beijing Platform of Action.

The obligations and commitments of globally agreed documents like CEDAW and the Beijing Platform for Action should inform, influence and guide all national policies and actions to achieve the MDGs. Comprehensive, effective strategies for gender equality are documented and need to be utilized and integrated into national efforts towards achieving the MDGs. There is a wealth of information and success stories in changing laws, policies, administrative processes that guarantee equal rights for women in public life and within the context of the family.

Synergies between CEDAW/ Beijing/ MDGs are mutually reinforcing processes, and together, will energize the gender equality agenda. Effective action requires also that policy-makers take account of local realities when designing and implementing gender-based policies and programmes. There can be no one-size-fits-all formula for promoting gender equality. Identifying what works requires consultations with stakeholders – both women and men – on key issues and actions. To enhance development effectiveness, gender issues must be an integral part of policy analysis, design and implementation.

Even though so much effort has gone into national analysis, data collection, documentation of ‘good practices’ to achieve gender equality through the CEDAW and Beijing processes, the MDG 3 tries to take a fresh step forward. It is important not to perceive gender equality and women’s empowerment as a single, abstract goal in itself, but use this goal to reinforce and strengthen existing global commitments. Through Goals 4 and 5, governments need to fulfil their commitments to gender equality specifically by implementation of CEDAW and the Beijing Platform of Action, as shown in **Box 3**. Gender inequality is entrenched in social, cultural, political structures and solutions must be sought accordingly.

Box.3. Improve maternal health	GOALS 4 & 5
<p>CEDAW</p> <ul style="list-style-type: none"> ■ Eliminate discrimination in the field of health care, to ensure equality between men and women in access to health-care services, including those related to family planning (article 12.1) ■ Ensure women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary (article 12.2) ■ Ensure women adequate nutrition during pregnancy and lactation (article 12.2) ■ Ensure rural women's right to adequate health-care facilities, including information, counselling and services in family planning (article 14.2.b) ■ Eliminate discrimination in education to ensure women's access to educational information to help ensure the health and well-being of families, including information and advice on family planning (article 10.h) 	<p>BEIJING PLATFORM FOR ACTION</p> <ul style="list-style-type: none"> ■ Increase women's access throughout the life cycle to appropriate, affordable and quality health care, information and related services (strategic objective C.1) ■ Strengthen preventive programmes that promote women's health (strategic objective C.2) ■ Undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS and sexual and reproductive health issues (strategic objective C.3) ■ Promote research and disseminate information on women's health (strategic objective C.4) ■ Increase resources and monitor follow-up for women's health (strategic objective C.5) ■ Eliminate discrimination against girls in health and nutrition (strategic objective L.5)

The way forward would be to consolidate three processes (CEDAW, Beijing, MDGs) together at the national level, to draw on previous work including situation analysis of the country, developing or using indicators that respond to CEDAW and Beijing priorities, improve national statistical capacity on gender equality issues which is currently lacking and to identify appropriate implementation measures that would make an impact on reduction of maternal mortality.

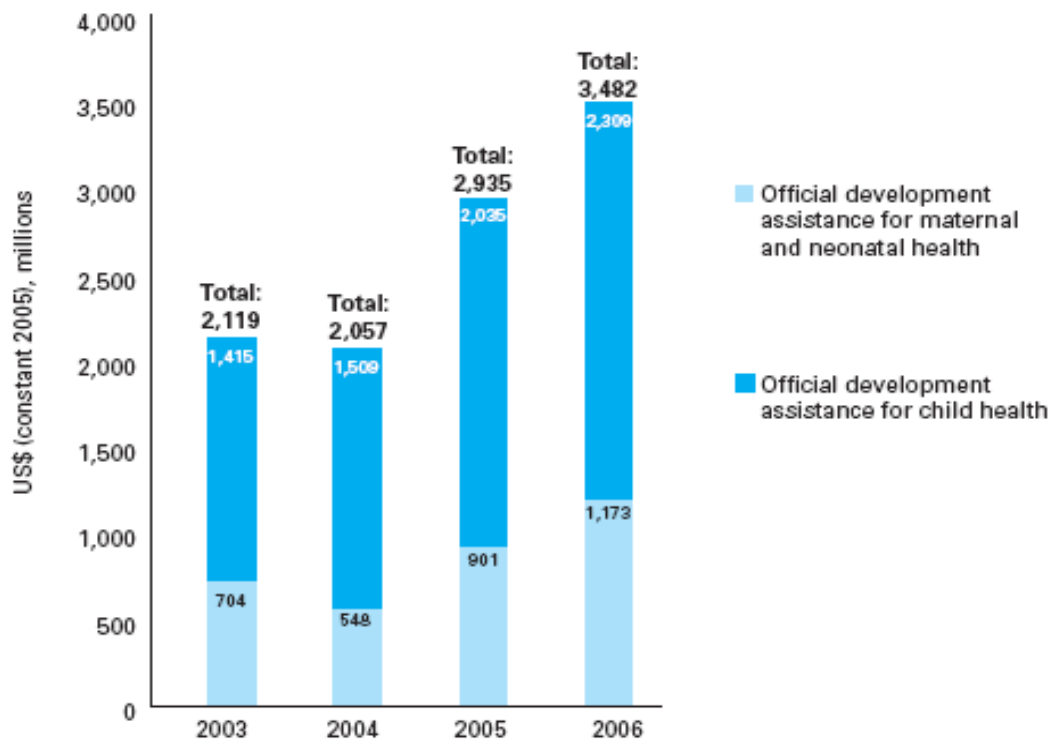
Resources

What would it cost the world to stop women from having unintended pregnancies and dying in childbirths and save millions of newborns? It would only be US\$ 23 billion per year. This is less than 10 days of global military spending. Instead, the world loses more than US\$ 15 billion in productivity each year by allowing young, productive women and newborns to die.

We also have to note that donor assistance to global maternal/newborn health has increased substantially, even though it is still half of the spending on the reduction of under-five child mortality. However, a closer analysis indicates that this increase in resources at global and also at the national level does not have a window of expenditures for activities related to gender equality. This is a sober example of rich rhetoric and no action. (See *Table I*.)

Table I

Official development assistance for maternal and neonatal health has risen rapidly since 2004



Source: Greco, Giulia, et al., 'Countdown to 2015: Assessment of donor assistance to maternal, newborn, and child health between 2003 and 2006', *The Lancet*, vol. 371, 12 April 2008, p. 1269.

If we are serious about gender equality and women's empowerment underpinning women's health, reduction of maternal mortality, universal access to reproductive health services, then, we must consolidate 3 separate implementation paths, i.e. MDG 5, CEDAW and Beijing, especially in the face of the current financial crisis.

Clear goals, simple, creative strategies, gender-responsive budgeting will accelerate achievement of MDG 5.

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