IWHC

ON HEALTH AND RIGHTS

FIVE SEXUAL AND REPRODUCTIVE HEALTH SERVICES THAT WILL MAKE PREGNANCY SAFER FOR ALL

THE REALITIES:

- Ninety-nine percent of women and adolescent girls who die each year from pregnancy-related causes are from developing countries. Half of these deaths occur in sub-Saharan Africa and one-third in south Asia.[1]
- One of every 22 women in sub-Saharan Africa and one in 61 in south Asia will die during her reproductive years from a complication of pregnancy, compared to one in 7,300 in developed regions.[1]
- Methods for preventing pregnancy-related deaths are widely known, yet the global maternal mortality ratio declined by only 5.4 percent between 1990 and 2005.[1]

Every year, more than half a million women die and untold numbers suffer temporary or long-term disabilities from preventable pregnancy-related causes. [1]Any death resulting from pregnancy-related causes—including unsafe abortion, labor, and childbirth, up to 42 days after delivery—is considered a maternal death. [1] Five complications account for the majority of maternal deaths worldwide:

- Severe bleeding (hemorrhage): 25 percent of maternal deaths;
- Infections: 15 percent;
- Unsafe abortion: 13 percent;
- Eclampsia (convulsions in labor due to high blood pressure): 12 percent;
- Obstructed labor (baby cannot pass through birth canal): 8 percent.[1]

The United Nations Millennium Development Goal 5 (MDG 5)[2]* sets specific targets for improving maternal health. Many maternal health advocates focus only on maternity care—antenatal care, skilled attendance at delivery, and emergency obstetric services. These are clearly critical services, but maternity care is just one element of the comprehensive sexual and reproductive health (SRH) package needed to achieve MDG 5. The five essential elements of a comprehensive SRH package are: (1) comprehensive sexuality education, (2) access to contraception, (3) safe abortion, (4) maternity care, and (5) diagnosis and treatment of sexually transmitted infections (STIs), including HIV. This package of services enables girls and women to decide whether and when to get pregnant, to decide whether to carry a pregnancy to term, and to experience pregnancy and childbirth safely.

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* The goal of MDG 5 is to improve maternal health and achieve universal access to reproductive health care by 2015 by reducing the maternal mortality ratio and increasing the proportion of births attended by skilled health personnel. Achieving universal access to reproductive health is measured by: (1) contraceptive prevalence rate; (2) adolescent birth rate; (3) antenatal care coverage (at least one visit and at least four visits); and (4) unmet need for family planning. See: http://www.mdgmonitor.org/goal5.cfm.

SEXUAL AND REPRODUCTIVE HEALTH SERVICES WOMEN NEED TO NAVIGATE PREGNANCY IN GOOD HEALTH

(1) COMPREHENSIVE SEXUALITY EDUCATION

According to United Nations agreements, all individuals and couples have the right to the information and services needed to "decide freely and responsibly on the number and spacing of their children."[3,4] Many people do not yet know how to prevent unwanted pregnancies effectively, however, or where to obtain contraceptive services and supplies.[5] Young people are especially in need of information: [6]

- Less than two-thirds of sexually active women, ages 15-19, know of any modern contraceptive methods in Burkina Faso, Guinea, Nigeria, Chad, the Central African Republic, and Mozambique.[7]
- Among primary school students ages 12 and older in Mwanza, Tanzania, half of them said they knew of no contraceptive method at all, even though 68 percent of the girls and 80 percent of the boys were already sexually active.[8]
- In Nicaragua, almost 90 percent of female and male adolescents did not use a contraceptive the first time they had sex, mostly because sex was "unanticipated" or because they "didn't know they needed it."[9]

In 2007, Femme, Santé, et Développement (FESADE) in Cameroun launched a 21-module comprehensive sexuality education curriculum that promotes gender equality and sexual health and rights for all. FESADE is currently collaborating with the Ministries of Youth, Health, and Secondary Education to incorporate the curriculum into Ministry programs, including in public schools. Over 10 years, FESADE has reached more than 10,000 people nationwide with their French curriculum. Soon, they will also have an English version. [11]

Comprehensive sexuality education programs should be implemented in communities and schools, beginning in the primary grades, and include information and referral to health services. Comprehensive sexuality education does not just give young people biological information about their health. It teaches young people about sex, contraception, and pregnancy, as well as communication and decision-making. It helps them learn how to establish equality in relationships, respect the right to consent in both sex and marriage, and end violence and sexual coercion.[6-8, 10]

(2) ACCESS TO CONTRACEPTION

Globally, many women want to have fewer children, and young people who are sexually active want to postpone childbearing. Of the estimated 205 million pregnancies that occur worldwide each year, approximately 80 million are unplanned.[12,13]

- More than 200 million women who want to delay or avoid pregnancy do not have access to the information and contraceptives they need to do so.[12]
- Forty-one percent of married/cohabiting women in Uganda, 38 percent in Haiti, and 25 percent in Bolivia, Kenya, and Pakistan are not using any contraception although they want to avoid pregnancy.[14]
- In an estimated 66 percent of unplanned pregnancies in developing countries, no contraception was used.[12,15]

Emergency contraception (EC) can be taken up to five days after unprotected sex to prevent unwanted pregnancy. Although its use is widely, publicly supported in Peru, conservative forces have repeatedly tried to limit Peruvian women's access to EC. In response, the Centro de Promoción y Defensa de los Derechos Sexuales y Reproductivos (PROMSEX) successfully argued a case before the Peruvian Constitutional Court. In 2006, the Court ruled that the use of EC is constitutional; that EC is not an abortifacient; and that the Peruvian government should dispense EC, including to rape survivors. PROMSEX also bravely spoke out against U.S. Agency for International Development (USAID) policies, promoted under the Bush administration, which prohibited using U.S. funds to inform Peruvian women about EC. In 2007, PROMSEX released *Free Choice Restricted: USAID's Reactionary Policies and the Use of Emergency Contraception in Peru,* which makes the case for women's right to EC as a part of comprehensive SRH services. [20]

The gap between desire for and access to contraception often reflects socioeconomic inequalities and inequitable distribution of services. [16-19] Achieving MDG 5 clearly requires that all women and men have ready

access to contraceptive choices that are affordable and acceptable through services that are readily available and based on confidentiality and informed consent. Further, safe abortion services and maternity care are essential to mitigate the consequences of an unwanted pregnancy for women's health and well-being.

(3) SAFE AND AFFORDABLE ABORTION SERVICES

Every year an estimated 67,000 women die from the complications of unsafe abortion. Worldwide, half of all unplanned pregnancies end in induced abortion, and half of all abortions are performed under unsafe conditions, 97 percent of them in developing countries.[21] All women and girls who decide to end a pregnancy for health, economic, or personal reasons have a right to safe, affordable, legal, and quality abortion services.[22, 23] Early, induced abortion procedures such as manual or electric vacuum aspiration are very safe when performed by a skilled practitioner under hygienic conditions. Pharmaceutical methods such as combined mifepristone-misoprostol regimens and misoprostol alone are safe and effective ways for women to abort at home or under the care of a trained provider.[15, 23-25]

Mujer y Salud en Uruguay (MYSU) in Uruguay is a tireless advocate for access to safe, legal abortion services. In 2008, MYSU's advocacy helped persuade the Uruguayan Senate and the House of Deputies to pass a landmark comprehensive sexual and reproductive health bill that would have legalized abortion in the first trimester, required public and private healthcare institutions to provide abortion services, and created policies to provide universal access to contraceptives. It also would have mandated that the government develop other national reproductive health policies and programs. Although Uruguayan President Tabaré Vázquez signed the legislation, he vetoed the article decriminalizing abortion. The campaign for this legislation, however, built widespread support and engaged the public in promoting and defending sexual and reproductive rights, including women's rights to safe abortion services, providing the foundation for possible passage of legislation under a new president in late 2009. [29]

Currently, 61 percent of women live in countries where induced abortion is permitted for a wide range of reasons, including physical and mental health and socioeconomic grounds, or without restriction as to reason. In contrast, 26 percent of women reside in countries where abortion is permitted only to save the woman's life or is prohibited altogether.[26] Abortion is also permitted in many countries for reasons such as fetal impairment, rape, or incest.[24,26,27] Even where abortion is legal, however, women's access to safe services is limited in most countries by:

- Excessive regulatory and administrative barriers in public and private health care institutions;
- Shortages of skilled abortion providers;
- The refusal by some healthcare providers to be trained in or to provide abortion services; and
- Girls' and women's lack of information, money, or transportation. [23,24,28]

(4) MATERNITY CARE

Maternity care—antenatal care, skilled attendance at delivery, and emergency obstetric services—is essential to enable women to experience pregnancy and childbirth safely.

Antenatal care screens women for health conditions that complicate pregnancy such as malnutrition, anemia, diabetes, high blood pressure, or sexually transmitted infections (STIs) including HIV, and provides or refers clients to additional care as needed.[30,31] Antenatal consultations also offer an opportunity to teach women and their families about danger signs during pregnancy that require immediate medical attention, to arrange for a skilled birth attendant, and to make an emergency plan for possible complications during pregnancy or delivery. The proportion of women having at least one antenatal visit has risen substantially since 1990 in all developing regions except sub-Saharan Africa. Nevertheless, in some countries only one woman in three receives any antenatal care.

Skilled care during childbirth is provided by accredited health professionals such as midwives, nurses, or doctors who have been trained to manage normal, uncomplicated pregnancies, births, and the immediate postpartum period. They are also trained to recognize complications and refer women to medical facilities for emergency obstetric care when necessary. [32] Skilled birth attendants save women's and newborns' lives.[33,34] The proportion of women who have skilled assistance during childbirth and the type of assistance varies significantly across and within countries, however.[18,19, 35,36] Although women's use of skilled birth attendants has risen since the early 1990s in every region except sub-Saharan Africa, only two of every three girls and women living in the developing world today, give birth with the help of a skilled birth attendant. Many countries still fall far short of the MDG 5 target of ensuring that a skilled birth attendant is present at 85 percent of all deliveries by 2010.[18,31,32,37,38]

In a rural district of India's Maharashtra state, a local organization, SANGRAM, helped women mobilize to demand and secure skilled midwifery care; HIV counseling, testing, and referrals for treatment and care; as well as contraceptives in primary health care centers across the district. They assisted the health centers to mobilize men with vehicles in the community to provide reliable and affordable 24-hour transportation to the district hospital for women who experience complications during childbirth. [40]

Readily accessible emergency obstetric services are essential to manage life-threatening complications, which often occur suddenly and unpredictably during labor, delivery, and the immediate postpartum period.[30,37,39] Eclampsia, obstructed labor, vaginal or cervical lacerations including obstetric fistula, and postpartum hemorrhaging or infection can kill quickly if high-level emergency care such as oxygen supplies, blood transfusions, antibiotics, and the surgical capacity for performing Cesarean sections and vaginal or uterine repairs are not accessible and affordable. Supplying universally accessible, emergency obstetric care remains a major challenge for health systems in developing countries, however, especially where resources are limited, populations are widely dispersed, or the terrain is inhospitable.

(5) PREVENTION, DIAGNOSIS, AND TREATMENT OF SEXUALLY TRANSMITTED INFECTIONS (STIs), INCLUDING HIV

If left untreated, STIs and reproductive tract infections can pose serious risks for women, pregnancy outcomes, and infants:

- According to a recent study, women living with HIV in South Africa are between 1.5 and five times more likely to die from pregnancy-related causes than are those who are not infected.[41]
- Women with pelvic inflammatory disease (PID) from untreated STIs may experience chronic, disabling pelvic pain or tubal scarring, which can cause permanent infertility. They are also at higher risk for ectopic pregnancy, which can be fatal without emergency care.
- Up to 40 percent of women with gonococcal PID or chlamydia may miscarry or have a stillbirth. They are also three to five times more likely to experience a premature birth or have a low birth-weight infant.[42,43]

The female condom is the only woman-initiated HIV prevention method that also protects against other STIs and unwanted pregnancy. Since 2004, the Society for Women and AIDS in Africa–Cameroun Chapter (SWAAC) has built a strong and s teadily increasing demand for the female condom through distribution and public education for women and men about its uses and benefits. Their outreach includes demonstrations on life-size models in large urban markets, as well as distribution by traditional male healers who trek through the forests for days to reach rural villages. [46]

Although the diagnosis and treatment of STIs, including HIV, during pregnancy is an essential element of maternal care, prevention is even more important. For married women especially, this can be difficult. In sub-Saharan Africa, 60 to 80 percent of women living with HIV report having had sex only with their husbands, [44] and in Asia, as many as 90 percent of women living with STIs, including HIV, were infected by their intimate partners or spouses.[45] Promoting safer sex, including the consistent and correct use of female and male condoms

with all sex partners, including within long-term couples and marriages, is essential to protect girls and women and make pregnancy safer. Whenever possible, STIs, including HIV, should be diagnosed and treated prior to conception.

SIX INVESTMENTS THAT WILL ENSURE SAFER PREGNANCIES

Saving women's lives requires a functioning health system to deliver the package of sexual and reproductive health services described above. Single, targeted interventions are necessary, but not sufficient, to reduce deaths and injuries related to pregnancy and childbirth. Recent donor and national commitments to strengthen health systems offer major opportunities to deliver comprehensive sexual and reproductive health care in ways that address inequalities due to geographic isolation, poverty, age, race or ethnicity, lack of education, and discriminatory cultural beliefs and practices.[18,19,35,36] Health system investments in women's sexual and reproductive health services provide a strong foundation for health services for all. The following six investments are necessary to make pregnancy safer for all, to protect girls' and women's rights, and to save their lives.

1. INVEST IN WOMEN'S HEALTH, YOUTH, AND HUMAN RIGHTS ORGANIZATIONS to advocate for comprehensive sexual and reproductive health services and to hold governments and donors accountable for providing them. The foundation for advocacy and accountability is the 2009 resolution from the Commission on Population and Development.[47] The resolution reaffirms and strengthens the Programme of Action agreed to at the 1994 International Conference on Population and Development, [3,48] which is the roadmap for achieving the Millennium Development Goals, including MDG 5.

2. BUILD COMMUNITY SUPPORT AND DEMAND FOR COMPREHENSIVE SEXUALITY EDUCATION AND REPRODUCTIVE HEALTH SERVICES. Community health education programs, including comprehensive sexuality education, can build community support and demand for high-quality, acceptable, affordable reproductive health care. Such programs can help women and couples to prevent unplanned pregnancies, safely terminate unwanted pregnancies, recognize when pregnancy complications become life-threatening, and utilize skilled birth attendants and emergency obstetric services.[49-55]

3. MAKE SEXUAL AND REPRODUCTIVE HEALTH SERVICES THE PRIORITY IN HEALTH SYSTEM STRENGTHENING. Women and very young children are the majority of people who are most in need of care where health systems are weak, and services for them should have priority. All primary health care and family planning facilities should be staffed and equipped to offer an integrated package of sexual and reproductive health services that meets clients' evolving needs.[56] These services should be accessible, affordable, and subsidized or free for poor women and families, including adolescents. They should encourage joint counseling for couples on their mutual rights and responsibilities.[57]

4. ENSURE THAT OTHER SPECIAL HEALTH INITIATIVES GIVE PRIORITY ATTENTION TO COMPREHENSIVE SEXUAL AND REPRODUCTIVE HEALTH SERVICES. These special initiatives include the International Health Partnership+, Taskforce on the Health Workforce, and High Level Taskforce on Innovative Financing, among others. In assessing the critical shortages of healthcare workers (especially in sub-Saharan Africa),[52,58] for example, specific investments should be made in the personnel needed to provide sexual and reproductive healthcare. This includes mid-level practitioners who can deliver contraceptive counseling and services, safe abortion and skilled delivery care, and STI diagnosis and treatment, including for HIV. The High Level Taskforce on Innovative Financing should specifically calculate funds needed to provide reproductive health services and make targeted recommendations.

5. PROVIDE EASY AND UNIVERSAL ACCESS TO INFORMATION ABOUT SEXUALITY AND REPRODUCTIVE HEALTH. Popular media and the Internet as well as community organizations, programs, and events should provide information about sexuality and about how to prevent unwanted pregnancies and STIs, including HIV; how to use and where to obtain female and male condoms and other contraceptives, including emergency contraception; and how to find pharmacies and healthcare services.

6. REFORM RESTRICTIVE LAWS AND POLICIES. Policies, laws, and practices that restrict access to sexuality information; safe and affordable contraception, including emergency contraception; and safe abortion services should be liberalized or rescinded so that all girls and women can access the information and care they need to make voluntary and informed decisions.

Sustained financial investment in these six actions must be a priority of international, national, and local initiatives to strengthen health systems. Only then will we save women's lives and health—and ensure the health and well-being of their families and communities.[59]

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Maternal deaths and fertility rates, 2005, selected countries

			Maternal mortality ratio**			
	NUMBER OF DEATHS	LIFETIME RISK*	BEST EST.	LOWER	UPPER	TOTAL*** FERTILITY
SUB-SAHARAN AFRICA						
Niger	14,000	1 in 7	1,800	840	2,900	8.0
Nigeria	59,000	18	1,100	440	2,000	5.9
Ghana	3,800	45	560	200	1,300	4.4
South Africa	4,300	110	400	270	530	2.8
NORTH AFRICA & WESTERN ASIA						
Yemen	3,600	1 in 39	430	150	900	6.2
Egypt	2,400	230	130	84	170	3.2
Jordan	92	450	62	41	82	3.7
Turkey	650	880	44	29	58	2.4
SOUTH & SOUTHEAST ASIA						
Afghanistan	26,000	1 in 8	1,800	730	3,200	6.8
India	117,000	70	450	300	600	3.0
Thailand	1,100	500	110	70	110	1.7
Sri Lanka	190	850	58	39	77	2.0
LATIN AMERICA & CARIBBEAN						
Haiti	1,700	1 in 44	670	390	960	4.7
Guatemala	1,300	71	290	100	650	4.4
Mexico	1,300	670	60	60	120	2.6
Chile	40	3,200	16	16	32	2.0

**Probability that a 15-year-old girl will die during her reproductive years from a pregnancy-related cause, based on current maternal mortality ratios applied to total fertility rates.*
***Number of maternal deaths per 100,000 live births. The table includes lower and upper estimates demarcating the range of uncertainty of MMR estimates in each country.*
****Average number of children per woman based on current age-specific fertility rates.*
Sources: *Mortality estimates for 2005 are from the World Health Organization (reference 1); fertility data from Population Reference Bureau,* **2005 World Population Data Sheet,** *to correspond to the date of the mortality estimates.*

Contraceptive use, planning status of recent births, and total fertility rate, selected countries

		% Contraceptive use		% Birth planning status			TOTAL FERTILITY RATE
		UNMET NEED*	CURRENT USER**	WANTED LATER	WANTED NO MORE	TOTAL UNPLANNED	
SUB-SAHARAN AFRICA							
Uganda	2006	41	24/18	33	13	46	6.7
Ghana	2003	34	25/19	24	16	40	4.4
Ethiopia	2006	34	15/14	19	16	35	5.4
Kenya	2003	25	39/32	25	20	45	4.9
NORTH AFRICA & WESTERN ASIA							
Armenia	2005	13	53/20	9	7	16	1.7
Jordan	2007	12	57/42	15	11	26	3.6
Egypt	2005	10	59/56	7	12	19	3.1
Morocco	2004	10	63/55	15	15	30	2.5
SOUTH & SOUTHEAST ASIA							
Pakistan	2007	25	29/22	13	11	24	4.1
Philippines	2003	17	49/33	24	20	44	3.5
India	2006	13	56/48	10	11	21	2.7
Indonesia	2003	9	60/57	10	7	17	2.6
LATIN AMERICA & CARIBBEAN							
Haiti	2005	38	32/25	21	26	46	3.9
Bolivia	2003	23	58/35	23	29	62	3.8
Honduras	2005	17	65/56	24	26	50	6.5
Colombia	2005	6	78/68	27	27	54	2.4

** Percentage of married or cohabiting women who say they do not want to get pregnant right away, who are at risk of pregnancy, and who are not using any contraceptive method.*
***Percentage currently using any contraceptive method/modern method.*
Source: *Macro International Inc, MEASURE DHS STATcompiler, http://www.measuredhs.com, 18 March 2009. For recent fertility and contraceptive data from all countries see 2009 World Population Data Sheet (Washington, DC: Population Reference Bureau) at http://www.prb.org/pdf09/09wpds_eng.pdf.*

Percentages of women who gave birth in past five years according to type of assistance, selected countries

SUB-SAHARAN AFRICA		DOCTOR	OTHER HEALTH PROFESSIONAL	SKILLED (A+B)	TRADITIONAL PRACTITIONER	RELATIVE OR OTHER	NO ONE
Ethiopia	2005	0	6	[6]	28	60	5
Niger	2006	1	17	[18]	64	0	17
Nigeria	2003	7	30	[37]	20	26	17
South Africa	1998	29	56	[85]	1	10	2
NORTH AFRICA & WESTERN ASIA							
Yemen	1997	16	7	[23]	21	52	4
Morocco	2004	16	47	[63]	21	15	1
Egypt	2005	69	6	[75]	23	1	1
Armenia	2005	93	5	[98]	0	0	0
SOUTH & SOUTHEAST ASIA							
Bangladesh	2004	8	6	[14]	14	72	1
Nepal	2006	10	12	[23]	19	52	7
Indonesia	2003	1	66	[67]	32	1	0
Vietnam	2002	50	35	[85]	5	10	0
LATIN AMERICA & CARIBBEAN							
Haiti	2005	16	10	[26]	66	5	3
Guatemala	1999	38	4	[42]	49	8	1
Bolivia	2003	56	5	[61]	6	31	2
Dominican Rep.	2002	29	66	[95]	4	1	0

Source: *Macro International Inc, MEASURE DHS STATcompiler, http://www.measuredhs.com, March 18, 2009.*

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