

Reproductive Health: The Foundation for Achieving the Millennium Development Goals (MDGs)

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More than any other UN conference of the 1990s, the International Conference on Population and Development (ICPD) in 1994 provides the base for the Millennium Development Goals (MDGs) adopted at the UN Millennium Summit in 2000. The objectives of the landmark ICPD Programme of Action, as summarized by a special session of the UN General Assembly in 1999, are to: “raise the quality of life and well-being of human beings, and to promote human development...[through] development policies and programs aiming to achieve poverty eradication; sustained economic growth in the context of sustainable development; education, especially for girls; gender equity and equality; infant, child and maternal mortality reduction; [and] the provision of universal access to reproductive health services, including family planning and sexual health.”

This last element—the provision of universal access to reproductive health services—though not itself an MDG, is largely covered by three MDGs, namely, improving maternal health, improving child health, and combating HIV/AIDS. The only piece of the Cairo reproductive health concept that is missing from the MDGs is, ironically, family planning. Nor does family planning appear among the MDG targets and indicators, despite its documented significance for achieving virtually all of the MDGs.

Although universal access to reproductive health is not an explicit MDG, if we correctly design interventions to achieve the MDGs, we will at the same time achieve the Cairo goals. The obverse is also true: we cannot achieve the MDGs unless we fully implement Cairo—and, I would emphasize, the entire Millennium Summit Declaration, which, unlike the MDGs themselves, includes a commitment to build an enabling environment of human rights, social and economic justice, and democratic governance.

Our topic today is vast—setting a coherent and feasible research agenda on reproductive health for the next ten years, an agenda that will help us move forward faster toward the MDGs and also enable us to monitor progress.

I have selected just two imperatives for a possible research agenda to discuss with you today, rather than delineate a comprehensive list of research topics. The first imperative is to approach research on reproductive health in ways that reflect the woman-centered, rights-based framework we agreed on in Cairo. The second imperative for our research agenda is to develop a more solid evidence base that will persuade policymakers to prioritize investment in reproductive health and rights, particularly when development resources are scarce and competition for them is stiff.

To return to the first imperative: research that reflects the woman-centered, rights-based reproductive health approach agreed in Cairo.

For decades, and in many countries today, governments and researchers focused on family planning—indeed, the shift to the broader reproductive health commitment was one of the most important accomplishments of the ICPD. The conventional measures of family planning accomplishments, while important, tend to monitor what the system provides and how many women (or couples) use what is provided. This has been useful, but the standard measures—CPR, TFR, unmet need for family planning—are insufficient together, and separately, to monitor progress toward the reproductive health and rights concept articulated at ICPD.

Given that Goal 5 of the MDGs is to “improve maternal health” (which includes avoiding pregnancy or maternity altogether), we need a set of indicators to monitor women’s ability to exercise their right to choose the number, spacing, and timing of their children (if any), and to have the information and means to do so safely, effectively, affordably, and in a manner that is acceptable to them. Measures such as the CPR and TFR, and even Unmet Need, capture only part of this concept. Two essential ingredients are missing: the proportions of all births that are unplanned (either mistimed or unwanted), and the proportions of induced abortions that are unsafe, that is, performed by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both.

Bearing in mind that reproductive health is a crucial foundation for achieving all the MDGs, not just Goal 5, there is also a compelling need for better data on reproductive health beyond fertility control. Surveys which go beyond family planning should be developed, based on the following essential sexual and reproductive health and rights indicators: sexual initiation and partnerships; fertility intentions; current sexual activity and contraceptive practices; and an assessment of the planning status and outcome (live birth, stillbirth, spontaneous abortion, induced abortion) of the most recent pregnancy. Measures of access to and use of contraceptive and abortion information and services and to skilled antenatal, delivery and postnatal care would be included, together with information collected in current surveys, such as the DHS, relating to knowledge and practices for the prevention of HIV/AIDS and other sexually transmitted infections. Ideally, parallel studies would be done in industrialized countries so that the data gaps there could be filled and the significant inequalities identified among ethnic minorities, low-income groups and adolescents.

This urgently needed research will not happen to nearly the extent necessary, unless we address the second imperative, namely, building a persuasive evidence base for policy makers to prioritize reproductive health, including research. Reproductive health, as defined by UN member countries and technical agencies, includes both disease elements, that is, STDs, including HIV/AIDS; and non-disease elements, that is, contraception, abortion, pregnancy, delivery, and postpartum care, infertility, violence and sexual coercion, and comprehensive sexuality education. We all know that the disease elements of reproductive health, especially HIV/AIDS, currently have priority attention in global health agencies, initiatives, and resource flows. While HIV/AIDS resources still fall short of agreed goals, we nonetheless must give higher priority to the non-disease elements of reproductive health, in their own right and also to reduce and prevent further feminization of the HIV/AIDS pandemic.

Sadly, the persistence of unnecessary—indeed, entirely preventable—mortality and morbidity associated with sexuality and reproduction forces me to suggest that we need to demonstrate to policymakers that reproductive health investments benefit not only women, but also society as a whole, to such an extent that priority must be given to it despite intense competition for human and financial resources in the health sector. As a community, we need to make a more concerted effort to assess the costs and benefits of investing in reproductive health and rights, in particular the non non-disease elements. Such analyses could focus on the following six areas, the balance among them determined by country conditions:

First, establishing the extent of the problem. Perhaps our biggest challenge is that inadequate investment in reproductive health services results in inadequate data collection—and vice versa. We are further hampered by lack of or inadequate vital registration systems and population-based surveys that would correctly measure maternal mortality, morbidity, and suffering, and its direct causes, especially unsafe abortion. Data on the extent of sexual coercion and violence against women and girls is increasing but still has major gaps.

Second, the impact of women’s reproductive ill health and death on families and societies. Take, for example, the effect of maternal mortality on infant survival, especially during the neonatal period. A 1974 study—still the only study I see cited—showed that 95% of infants whose mothers died giving birth, died within 1 year. More current and broader research is vital to establish the full returns on investment in the pregnant woman’s nutrition, pregnancy care, and skilled care during and after delivery.

Third, other important externalities of maternal death and illness, violence against girls and women, and infertility. For example, we need better data on child nutrition and school attendance after the mother of a family dies or is incapacitated; on the myriad negative effects of domestic violence, including not only the immediate, debilitating—and often deadly—physical injuries, but also the relationship of such violence to increased HIV/AIDS vulnerability, for example. As far as I know, only one study has looked at this relationship—a study in South Africa, published this year.

Fourth, we must establish productivity losses due to unwanted or complicated pregnancy, unsafe abortion, complications in delivery and postpartum, and sexual coercion and violence. Such research can help us assess more objectively than we now can the contributions that investments in reproductive health would make to poverty reduction at both the family and societal level.

Fifth, evidence on the “cost effectiveness” of reproductive health interventions. Family planning efficacy has been well estimated for 20 years. Other non-disease reproductive health interventions, including access to safe abortion services and even emergency obstetric care, have little hard cost/benefit evidence from poor countries. Evaluations of behavior and social change interventions are few and generally quite poor, especially in regard to sexuality education, interventions to end violence against women, and effective means to encourage responsible male behavior at all ages. In these areas, we must begin by designing valid and reliable research methodologies. Today’s 2 billion young children and adolescents, the majority of whom live in poor countries, are or soon will be at major risk of HIV/AIDS and unplanned pregnancies, and we need to reach them sooner than later. We will only be able to do so if we can

convince policymakers that the positive results of such interventions far exceed the costs—including the political costs—of implementation.

Finally, we must assess the ways that reproductive health services help reduce and prevent HIV/AIDS infection in the vast majority of girls and women who are not so-called core group transmitters, but are nonetheless at significant risk. A key focus should be operations research on the costs and benefits of strengthening and expanding reproductive health services to encompass HIV/AIDS and the feasibility of doing so. Priority funding for both biomedical and social sciences research on development and delivery of improved female condoms and microbicides could greatly enhance both contraception and disease prevention as soon as two to five years hence. We must also prioritize assessments of the impact of health education and outreach to husbands and partners on sexual and reproductive health and rights.

Neither the ICPD reproductive health agenda, nor the Millennium Summit Declaration (including the goals), is utopian. In the decade since ICPD, we have made significant progress. Contraceptive access has improved markedly, and fertility rates have dropped. Even in Africa, contraceptive use among married women since the early 1990s has grown from about 15 to 25 percent, and in Asia, from 52 to 66 percent. Between 1998 and 2001, Brazil reduced maternal deaths from roughly 34 to 29 per 100,000 hospital admissions, through the efforts of the government and nongovernmental organizations. In Bangladesh, thanks to a coordinated government and civil society initiative, the percentage of women receiving antenatal care went from 26 percent to 47 percent, female life expectancy increased from 58 to 60 years, and maternal mortality fell from 410 per 100,000 live births to 320, between 1998 and 2002. The mortality rate for children under five in Bangladesh dropped by 24 percent.

On the other hand, we must make much more progress. Maternal morbidity and mortality, HIV/AIDS, unsafe abortion, and commodity shortages remain inexcusably high. Keeping the Cairo promise and achieving the MDGs require us all to think anew about priorities for a reproductive health research agenda, and to create new research methodologies especially to assess and monitor interventions. Together, the HIV/AIDS, women's health and rights, human rights, development, and family planning communities can mobilize political will and hold the world's governments accountable to the Cairo Programme of Action and the Millennium Summit Declaration. Only by doing so will we ensure that the MDGs are transformed from goals to realities for all.

Thank you.

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