

## MDG 5: Improve maternal health

### **Target 6: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio**

The ICPD PoA calls for two reductions in maternal mortality ratios (MMRs): halving them once between 1990 and 2000, and again by 2015. MDG 5 targets a reduction by three-quarters between 1990 and 2015, amounting to the same end result. Furthermore, the ICPD proposes that:

*“Countries with intermediate levels of mortality should aim to achieve by the year 2005 a maternal mortality rate below 100 per 100,000 live births and by the year 2015 a maternal mortality rate below 60 per 100,000 live births. Countries with the highest levels of mortality should aim to achieve by 2005 a maternal mortality rate below 125 per 100,000 live births and by 2015 a maternal mortality rate below 75 per 100,000 live births. However, all countries should reduce maternal morbidity and mortality to levels where they no longer constitute a public health problem.” (ICPD, Para. 8.21)*

The ICPD PoA offered a starting point for MDG 5, as its Chapter VIII gives specific recommendations on how to narrow the gap between 1990 MMRs and the 2015 Targets. These include the promotion of prenatal care, postnatal care, childbirth care, maternal nutrition programmes, adequate delivery assistance, obstetric emergencies, attention to abortion complications, and family-planning services.

In the LAC region, it is estimated that MMRs have remained constant at about 190 per 100,000 births for the last ten years, whereas the number of maternal deaths remained close to 22,000 a year, revealing insufficient progress on the MDG Target (ECLAC, 2005 a). At present, only Argentina, Brazil, Chile, Costa Rica, Cuba, St. Lucia, and Uruguay present levels below 50 deaths per 100,000 births. In Haiti, the MMR is as high as 520 per 100,000, whereas in Bolivia the decline from 390 to 310 per 100,000, between 1994 and 2000 still leaves the MMR well above the ICPD target of 125 per 100,000 set for 2005.

Moreover, the numbers may be underestimated due to under-reporting and misclassification of causes of death. In Brazil, the University of São Paulo verified mortality of women aged 10-49 years, with emphasis on maternal mortality, and found that the MMR in fact would be about 67% higher than what was informed in 2002 for State 25 capitals and the Federal District (Brazil, 2004). Consequently, the Ministry of Health multiplied the 2002 data by a correction factor of 1.4. In Peru, according to adjustments made by UNICEF, WHO and UNFPA, the ratio in 2000 was still as high as 410.

Few countries in the region have managed to reduce maternal mortality rates. Belize is one of them. The country reduced its MMR from 300 to 40 per 100,000 from 1990 to 2003, greatly surpassing the 75% reduction indicated by Target 6. However, the Belize MDGR (2005) alerts that the country is susceptible to drastic shifts in trends due to the diminutive size of its population. Argentina succeeded in reducing its maternal mortality ratio by 33% from 1990 to 2000 (52 to 35 per 100,000). Uruguay's performance stands out among Latin American countries. It has one of the lowest MMRs in the continent (below 20 per 100,000 in 2000), and about 99% of all births are assisted by medical professionals. The Uruguay MDGR (2004) also highlights the fact that the strategy to reduce it even further lies in avoiding high risk pregnancies from the beginning.

Costa Rica's MDGR (2004) considers that about 80% of the potential cases of pregnancy and birth-related deaths were avoided in the year 2000. The target of 97% of the births to take place at hospitals has already been met, since the percentage in 2003 was 99.4%. In Guyana, although about 80% of the births are attended by skilled medical professionals, the MMR remains high, at 122 per 100,000 (2000). Nevertheless, a meaningful advance has been achieved, since it was 230 in 1995. Yet it still lags far behind from the 60 aimed for in 2015. Similarly, in the Dominican Republic, the ratio fell from 229 to 178 per 100,000 between 1996 and 2002. The national MDGR ascribes the change to declining fertility rates and to the use of contraceptive methods, and lists teenage pregnancies and domestic violence as factors that aggravate the present statistics.

Meanwhile, in countries like Jamaica, Nicaragua (ratio of 121 per 100,000 births), Panama (60 per 100,000 births) and Paraguay (160 per 100,000 births), there has been little progress. In Paraguay the situation has apparently even worsened somewhat with respect to 1990, when the ratio was 150. In Nicaragua, maternal mortality was the main cause of death among women in reproductive age throughout the 90s (Nicaragua, 2003). In Brazil, progress is difficult to assess due to changes in the data collection system.

It is generally assumed that maternal mortality is closely associated with poverty, mostly because the risk of maternal mortality is markedly higher in poor households, particularly if they are geographically isolated. Graham et al. (2004), for instance, show that the proportion of women without formal education or access to safe water in Peru, among other countries, is significantly higher among women who died from maternal mortality than among women who died from other causes. It seems plausible that a maternal death may also aggravate the poverty of a household, although the number of maternal deaths, in most countries, is so small, in comparison with the number of poor households, that it is unlikely to cause a major effect on poverty as such. One should also be careful not to attribute high maternal mortality primarily and directly to adverse living conditions. According to Maine (2001) and others, the primary determinant of maternal mortality in developing countries nowadays, as well as historically in the now developed countries, is the ability of the health system to adequately deal with obstetric complications:

*“From 1840 (when the first maternal mortality statistics were available) to the mid-1930s, maternal mortality remained as high in Britain as it is today in many developing countries. This shows that nutrition, education, and general standard of living are not the major factors in maternal mortality. These factors had improved and are credited with causing the drastic declines in infectious diseases. Then, after nearly a century of stagnation, maternal mortality declined so sharply that within 15 years it was no longer a major public health problem. This was largely because the technology to treat obstetric complications - including antibiotics (first sulfa drugs and then penicillin), banked blood, and safer surgical techniques - became available.”*  
(Maine, 2001: 189)

This chapter explores key issues in population and maternal health based on the following schedule:

- 5.1. Additional Targets in national reports
- 5.2. The link between reproductive patterns and maternal health
  - 5.2.1. Inter-pregnancy intervals
  - 5.2.2. Use of contraceptive methods
  - 5.2.3. Very low or very high maternal age
- 5.3. The link between abortion and maternal mortality
- 5.4. The link between maternal mortality and access to SRH services
- 5.5. A new Target under MDG 5: full access to RH

Initially, this chapter focuses on the additional Targets under MDG 5 in national MDGRs. Even before the official introduction of the new RH Target, several countries in the LAC region had decided to widen the scope of Target 6 by including universal access to SRH services and reducing breast and cervical cancer mortality, among others. New indicators for monitoring aspects not captured by the original indicator set have also been widely adopted.

One of the main objectives of the text is to analyse the causal link between reproductive patterns and maternal health. As evidence from diverse studies indicates, changes in reproductive patterns play a decisive role in reducing the maternal mortality ratio. Some of the primary determinants are: inter-pregnancy intervals, use of contraceptive methods, and maternal age. Short birth intervals and very low or very high maternal age are associated with substantially higher maternal mortality risks. High levels of unmet need for contraception found in the LAC region also impact negatively on maternal health outcomes.

Unsafe abortion is another important cause of maternal deaths in the LAC region which has been considered a critical public health problem. Most abortions are illegal and performed under clandestine conditions and by persons lacking the necessary skills. An overview of abortion incidence in the LAC region is presented, as well as research on the characteristics of women who undergo an induced abortion and its health consequences. National MDGRs are examined and some of their observations on the subject are commented on.

The text also investigates the link between maternal mortality and access to SRH services – particularly the facility-based health system and emergency obstetric care. Meeting health needs during pregnancy, childbirth, and the postpartum period is a proven way to save women's lives. As findings from national data indicate, interventions must consider discrepancies between urban and rural areas in order to address maternal mortality ratios in the LAC region. Focusing on underserved areas, as demonstrated by the case study of Honduras, may optimise efforts in promoting maternal health.

Finally, the new Target under MDG 5 (to achieve universal access to RH by 2015) may be an essential means not only for reducing maternal mortality ratio, but also to improve women's health in general. From the viewpoint of UNFPA's mandate, this might appear to be the most significant Target of the entire MDG agenda.

### 5.1. Additional Targets in national reports

Several countries in the LAC region consider that Goal 5, in its original conception, is heavily biased towards maternal health and that its achievement will not necessarily cause a drastic change in the health status of women, especially as the proportion of women's life cycle spent in maternity functions has greatly decreased. They have decided, therefore, to widen the scope of this Goal, adding new Targets and indicators to be monitored within their national MDGRs. Brazil, for instance, has included the Target of ensuring universal access to SRH services and of reducing breast and cervical cancer mortality in its 2005 MDGR (Brazil, 2005), before the Target to this effect became official. The MDGR also added 4 indicators:

- 1 Proportion of maternal deaths by group of causes;
- 2 Proportion of coverage of prenatal visits by the mother's region of residence;
- 3 Number of hospitalisations due to abortion in the Unified Health System (SUS), by major regions;
- 4 Proportion of deaths of women aged 30-69 years by selected causes of neoplasm.

The following excerpt from the 2005 MDGR of Ecuador is an example of how several crucial aspects of the SRH agenda have been presented within the context of MDG 5, even before the latter contained the present specific RH Target:

*“To reduce the risks of maternal morbidity and mortality and to attain the proposed target, it is necessary to develop actions which will tend to improve the general wellbeing and the reproductive health of women, particularly the poorest ones. To this end, the following are priorities:*

- *Promote and protect the rights of women, their options and autonomy through the effective and timely application of the existing legal framework in the area of sexual and reproductive health and gender equity.*
- *Guarantee universal access in the educational system to information about sexuality, reproduction, contraception and sexually transmitted infections and HIV/AIDS, according to the Law on Education in Sexuality and Love.*

- *Establish human resource policies which favour their adequate availability in areas of difficult access and guarantee the provision of high quality reproductive health services.*
- *Develop sustained information, education, and communication campaigns which, while incorporating different cultural visions, prioritise among their objectives: the empowerment of women and the justiceability of their rights; the diffusion of reliable key information about risk signals during pregnancy, delivery, and puerperium, as well as about sexual and reproductive health; and communication about the availability of services so that women know where and when to seek attention.*
- *Ensure the funding of the Law on Free Maternity and Attention to Infancy, and guarantee the timely provision of equipment, supplies and qualified human resources to the health units, so that they may respond to plans and programmes seeking the reduction of maternal mortality.*
- *Implement differentiated attention strategies to provide care to adolescents of both sexes and give an adequate response to their sexual and reproductive health needs.*
- *Implant a functional communication system between the different levels of the health system, for the appropriate referral and counter-referral of cases and the use of obstetric services, with the participation of women in the planning and evaluation of services, so that these respond to the local needs of this sector.*
- *Implement mobilisation strategies of the social networks that allow the early identification of obstetric complications and guarantee the timely delivery of services, particularly in rural and/or poor areas.*
- *Improve and modernise the registration systems and implant monitoring and evaluation systems that incorporate the perspectives of providers and users.” (Ecuador, 2005: 30)*

In addition, some countries consider that, in order to safeguard the issue of maternal health, more Targets should be specified. Argentina, for instance, has included an extra Target of reducing by 20% the inequality among Provinces, which, at present, reaches a ratio of 1:20 between the extremes. Colombia elaborated six extra national Targets, among them to reduce the MMR to 45 per 100,000 (1998 baseline: 100 to 100,000); to raise to 90% the number of pregnant women attending at least four prenatal exams; to raise to 75% the use of prevention methods among the sexually active population and to 65% among 15-19 year-olds; to limit early pregnancies to 15%; and to reduce cervical cancer to 5.5 deaths per 100,000 women.

Costa Rica added new national Targets under MDG 5 as well: to reduce maternal mortality rates to 2 per 10,000 at the national and sub-national levels; to raise to 97% the number of births carried out in hospitals; to assure that 75% of the pregnancies are detected and examined in the first three months; and that 75% of all pregnant women receive full prenatal care. The Peruvian MDGR (Peru, 2004) added other maternal health-related indicators to be monitored until 2015. They are: 1) unsatisfied demand for family-

planning services (gap between actual and desired fertility); 2) rates of teenage pregnancy; and 3) incidence of gynaecological cancer.

## 5.2. The link between reproductive patterns and maternal health

In order to meet the reduction foreseen in Target 6 in due time, an average reduction of 5.4% per year would be necessary. Nonetheless, the statistics surfacing in the developing world are far from promising, showing a relative stagnation of the ratio (Bos, 2004). Worldwide, about 200,000 maternal deaths annually result from the lack, or failure, of contraceptive services and a total of 120-150 million women who want to limit or space their pregnancies are still without the means to do so effectively (Limanonda, 1998). Preventing unplanned and high-risk pregnancies and providing care in pregnancy, childbirth, and the postpartum period save women's lives. Thus, the provision of SRH has a direct impact on maternal morbidity and mortality, as fewer and better spaced births might result from it, as stressed by the ICPD PoA:

*“Increasing access to contraception can significantly reduce maternal deaths simply by reducing the number of times that a woman becomes pregnant – and so the risks from related complications. If the unmet need for contraception were filled and women had only the number of pregnancies at the intervals they wanted, maternal mortality would drop 20–35%. In addition, unsafe abortions – those performed by untrained providers, under unhygienic conditions or both – kill an estimated 78,000 women a year, or about 13% of all maternal deaths. Thus achieving Goal 5 will require rapidly expanding access to reproductive health care.” (UNDP, 2003: 99)*

*“Reducing maternal mortality depends on many factors, including the availability of contraception, skilled attendance and availability of emergency obstetric care. The role of high fertility, particularly where childbearing begins early and is thinly spaced, plays a major role in maternal mortality.” (UNFPA, 2004 a: XV-5)*

Furthermore, the consequences of pregnancy complications tend to be more serious without prior access to SRH. Meeting the existing demand for family-planning services would reduce pregnancies in developing countries by 20% and maternal deaths and injuries by at least as much (Sadik, 2001). In this context, what some of the national MDGRs have to say about the causes of maternal mortality is relevant, e.g. the MDGR of the Dominican Republic which, as mentioned earlier, attributes the change in the national MMR to declining fertility rates and to the use of contraceptive methods, and lists teenage pregnancies and domestic violence as factors that aggravate the present statistics. The first MDGR of Nicaragua (2003) notices that “high fertility rates, normally associated with the poorest sections of the female population, favour maternal mortality.” Apparently no direct evidence of this relationship has been compiled in the LAC region,<sup>1</sup> but Allison, Cheong, and

<sup>1</sup> This is due to the lack of reliable data on maternal mortality by birth order. Many civil registration systems in the LAC region do not collect information on birth order and neither do the standard questions for the application of the sisterhood method in the DHS surveys. The data base of the Latin American Centre for Perinatology and Human Development (CLAP), in Montevideo, has the relevant information, but to our knowledge it has not been analysed from this perspective.

Yap (1989: 36) estimated that in Pakistan eliminating all births after the fifth would reduce maternal deaths by half. The same report also stipulates that undesired fertility increases the risk of maternal mortality among vulnerable groups, such as adolescents, particularly among those without schooling, although it presents no evidence to this effect.

Changes in reproductive patterns, such as decreasing fertility and expanding inter-pregnancy intervals, may have great impact in reducing the MMR and in improving women's health, in general. Special attention must be given to the use of contraceptive methods, since they prevent unwanted and high-risk pregnancies and thus reduce the need for unsafe abortions:

*“Put simply, if a woman does not get pregnant, she will not die in pregnancy or childbirth. Therefore, increasing access to methods of fertility control can have a significant impact on the number of maternal deaths, by reducing the number of times that a woman runs the risk that a fatal obstetric complication will occur.” (UN Millennium Project, 2005 g: 72)*

### 5.2.1. Inter-pregnancy intervals

Although there have been some statements to the contrary (Ronsmans & Campbell, 1998), most research over the years has demonstrated that maternal morbidity and mortality are associated with inter-pregnancy intervals. Very short birth intervals have long been associated with increased risk of various adverse health outcomes, both for mothers and their infants. Optimal birth spacing can save lives and improve the health and wellbeing of mothers, lowering, for instance, the risk of malnutrition from overlap of pregnancy and breastfeeding, puerperal endometritis, premature rupture of membranes, anaemia, and third trimester bleeding. Birth spacing is also good for women who face health problems, since, if pregnant, they are at greater risk of death and complications.

Table 5.1: Rates of adverse maternal outcomes according to inter-pregnancy interval in a legion of 456,889 Latin American and Caribbean childbearing women delivering singleton infants, 1985-1997

Outcome	Inter-pregnancy interval (months)						Total
	0-5	6-11	12-17	18-23	24-59	60+	
Preeclampsia	3.4%	3.2%	3.3%	3.4%	4.2%	6.6%	4.3%
Eclampsia	0.12%	0.10%	0.12%	0.11%	0.10%	0.20%	0.13%
Third trimester bleeding	1.9%	1.2%	1.1%	1.1%	1.1%	1.5%	1.2%
Premature rupture of membranes	9.8%	5.9%	5.6%	5.6%	6.6%	6.5%	6.7%
Puerperal endometritis	5.1%	4.2%	4.4%	4.0%	3.9%	4.3%	4.1%
Gestational diabetes mellitus	1.4%	1.2%	1.0%	1.4%	1.4%	2.4%	1.6%
Anaemia	7.9%	6.5%	6.3%	6.1%	6.2%	6.2%	6.3%
Maternal death rate / 10,000 women	9.5%	4.4%	4.2%	3.7%	4.9%	5.5%	4.8%

Source: Conde-Agudelo & Belizán, 2000

Conde-Agudelo and Belizán (2000) performed a retrospective cross-sectional study from the LAC region data (1985-1997) and analysed the impact of inter-pregnancy interval on maternal morbidity and mortality. After controlling for major confounding factors, they found that women with inter-pregnancy intervals of 5 months or less, compared with those conceiving at 18 to 23 months after a previous birth, faced higher risks of maternal death (relative risk, 2.54), third trimester bleeding (relative risk, 1.73), premature rupture of membranes (relative risk, 1.72), puerperal endometritis (relative risk, 1.33), and anaemia (relative risk, 1.30). Women conceiving after more than 59 months had significant increase risks of pre-eclampsia (relative risk, 1.83), and eclampsia (relative risk, 1.80). The authors suggest that longer intervals between births allow women the time needed to replenish nutritional reserves.

Table 5.2: Percentage of married women of reproductive age reporting birth intervals less than 3 years, multiple surveys, 1986–2001

Country	Survey period				Years Between first and last survey	Reduction Between first and last survey*
	1986– 1989	1990– 1993	1994– 1997	1998– 2001		
Bolivia	63%		64%	61%	9%	2%
Brazil	63%		51%		10%	13%
Colombia	62%	55%	54%	49%	14%	13%
Dominican Rep.	68%	64%	63%		10%	6%
Guatemala	69%		68%	68%	11%	1%
Haiti			65%	66%	6%	-
Peru	66%	61%	55%	48%	14%	18%

\* Some displayed amounts are rounded from fractions and, therefore, do not appear to add properly. The numbers are correct, however, based on actual calculations.

Source: Demographic and Health Surveys (STATcompiler)

Even though birth spacing is essential for maternal health, it is often under-emphasized in SRH programmes. Birth spacing requires continuity of care, and family-planning programmes often do not meet it adequately. Women who want to space their pregnancies need continuity of care to keep using contraception devices and achieve their preferred birth intervals, to stop use to become pregnant, and, then, after delivery, to start a method that is appropriate during breastfeeding. If these good-quality services are available, they enable people to continue using contraception methods for many years (Setty-Venugopal & Upadhyay, 2002). DHS data confirm that, in many countries in the LAC region, women desire considerably longer birth intervals than they achieve, reflecting a large unmet need for birth spacing. DHS data also indicate that many women are unaware of the risks and state a preference for shorter birth intervals.

### 5.2.2. Use of contraceptive methods

The ICPD gave priority to reducing the unmet need for contraception as a major goal in ensuring births by voluntary and informed choice, stating also that governmental

goals for family planning should be defined in terms of unmet needs for information and services. The UN Task Force on Education and Gender Equality, following this orientation, recommends additional SRH and rights indicators for the Millennium Project (2005 b), such as the proportion of contraceptive demand satisfied, which captures the central connection between a women's control over their reproductive preferences and her decision-making ability.

The term “unmet need” was coined in the late 1970s and has served, ever since, to gauge family-planning needs in less developed countries (Ashford, 2003). According to Singh et al. (2003), although women with unmet need for modern contraceptives make up three in ten women at risk of unintended pregnancy, they account for eight in ten actual unintended pregnancies. In addition, the study also stresses that 29% of the women, in developing countries, at risk of unintended pregnancy have an unmet need – 63% in Sub-Saharan Africa, 29% in the LAC region, and 24% in Asia. ORC-Macro (2004) and the UN Task Force on Education and Gender Equality suggest that the *number of women* who wish to space or limit further childbearing, but are not using contraception remains very high in the LAC region, especially in Haiti and Bolivia, and that outcome has an impact both on the region's reproductive patterns and on the MMR.

*“Levels of unplanned or ill-timed fertility are high in many countries. The unmet need for family planning comprises women at risk of pregnancy who do not desire another birth (limiting desires) or who wish to space their birth at least two years (spacing desires) but who are not using a method of family planning. An estimated 29% of women in developing countries have an unmet need for modern contraception.” (UN Millennium Project, 2005 d: 14)*

Table 5.3: Need for family planning in the LAC region\*

Country (survey period)	Ages 15-19	All age groups
Bolivia (1998)	33.9%	26.1%
Brazil (1996)	19.1%	7.3%
Colombia (2000)	17.5%	6.2%
Dominican Republic (1999)	24.6%	11.9%
Guatemala (1998/1999)	25.4%	23.1%
Haiti (2000)	58.4%	39.8%
Nicaragua (1997/1998)	27.4%	14.7%
Peru (2000)	23.6%	10.2%

\* Percent – Need for family planning is the percentage of currently married women with unmet need for family planning, met need for family planning, and the total needs of family-planning services.

Source: ORC-Macro 2004

The unmet need of contraceptive methods may be related to several issues, such as lack of accessible services and the quality of their personnel, lack of method choices appropriate to the situation of the woman and her family, lack of knowledge about the safety, effectiveness and availability of choices, poor client/provider interaction, side-effects for some, and financial constraints (UNFPA, 2004 a).

*“Reasons for non-use (of contraception) are situation-specific. The primary ones are non-communication or disagreement about fertility preferences (with the former being more important); lack of information about method options and availability; health concerns and fear of side effects (some based on information failures); family or community disapproval; women’s low decision making power (with their partner or his family); cost of services and opportunity or social costs of acquisition; and perceptions of limited availability, access, quality of services as systemic barriers to use of family planning (including natural family planning methods approved in a wide range of cultural traditions).” (UN Millennium Project, 2006: 120-121)*

To reduce these barriers, family-planning programmes are recommended, to counsel women on the full range of available contraceptive methods, so that they can choose the method that best matches their individual needs, to counsel women who are in postpartum, breastfeeding, or approaching the services on what methods might be appropriate for their cases (Ashford, 2003). UNFPA also asserts the need that the SRH services offer multiple methods of contraception and universal access to at least three contraceptive methods at service delivery (UNFPA, 2004 a). In addition to permanent methods, services should offer temporary methods, such as condoms, pills, injectables, implants, or IUDs. The options to switch from one method to another and to choose a different method after giving birth are central to the continued satisfactory use of family planning. Providers should make clear that all clients have the option to switch methods whenever and as often as needed (Setty-Venugopal & Upadhyay, 2002).

Over the past two decades, the use of modern contraceptive methods has increased rapidly. In the past decade, for instance, contraceptive prevalence among couples increased from 55% to 61% (UNFPA, 2004 b). Nevertheless, the use of traditional contraceptive methods – such as withdrawal and periodic abstinence – is still high. Traditional methods are known to have high failure rates and most women who stop using them switch to a modern method (Singh et al., 2003: 18). As the proportion of women who adopt modern contraceptive methods, which are more effective, rises, this change in method will contribute to decreasing MMRs by avoiding unplanned or undesired pregnancies which may jeopardise their reproductive health.

The link between maternal mortality and contraceptive use is frequently not mentioned in the national MDGRs, but some do mention it, as illustrated by the 2003 MDGR for Honduras:

*“Maternal health is closely related to the reproductive health of the woman, family planning, the use of contraception methods, and the active participation of the partner. The trend reflects an increase in the use of modern contraception, such as pills, condoms, IUD, sterilization, and injectable methods, and a significant decrease in the use of traditional methods (Billings, withdrawal, and rhythm). In 1990/1991, out of a total of 46.7% of the women that were married or cohabitating (in the 15-44 age group) and that used family-planning methods, 25% used traditional methods,*

*whereas in 2001, out of the 61.8% that used some kind of method, just 5.5% did so traditionally.” (Honduras, 2003: 39)*

The issue is also briefly mentioned in the Jamaica report:

*“Some of the challenges which may retard further progress towards the goal, or reverse progress already made, are as follows:*

*1. Access to essential obstetric care; associated with this is the need for adequate staffing of facilities with persons trained in midwifery and emerging obstetrics in order to monitor and supervise labour and delivery.*

*2. Access to contraceptives/family planning to reduce risk of maternal deaths and poor perinatal outcomes.*

*3. To reduce deaths associated with the major killers - eclampsia/pre-eclampsia, hemorrhage and infection.” (Jamaica, 2004: 32)*

Even though emergency contraception has become formally available in Argentina, Brazil, Colombia, Chile, the Dominican Republic, El Salvador, Peru, Mexico, Nicaragua, Paraguay, Uruguay, and Venezuela, in practice, this method is still rarely accessible.

### **5.2.3. Very low or very high maternal age**

There is considerable evidence in the literature that very young maternal age (under 16) is associated with substantially higher maternal mortality risks. The study by Conde-Agudelo (2002), mentioned in the previous chapter, analysed the issue while controlling for a wide range of confounding factors. These controls are important in that there is little systematic evidence as to whether the slight elevation of maternal mortality in the 15-19 year age group found in many countries is due to an inherent risk posed by having children at this age, or rather to the fact that very young mothers belong predominantly to the poorest strata of the population. Following this procedure, maternal mortality risks in women under age 16 were found to be 4.09 times higher than in women aged 20-24.

It is often mistakenly assumed, however, that these results are extensive to *all* adolescent pregnancies (i.e. ages 15-19). In fact, the same study found that relative risks in the 16-19 age group, after making the appropriate controls, were the same or even marginally lower than in the 20-24 year age group. The distinction is important because the first group comprises only 16% of all adolescent childbirths and requires rather specific prevention strategies. However, even though the number of adolescents in this situation is relatively small, the difference in mortality risks is so great that the postponement of all births occurring to women under 16, until after they are at least 16, would reduce the overall adolescent maternal mortality rate by over 25%.

The highest MMRs are found in older women, especially women over age 35. According to CDC data, the MMR for women under age 20, in the US, was 8.6 per 100,000 during 1991-1999, but 12.0 for women aged 35-39, 21.6 for women aged 40-44, and 45.4 for

women over age 45. The situation is not much different in developing countries. Pooling data from 25 DHS surveys, Hakkert (2001: Cuadro VII.2) found that, on average, women aged 35-39 have a 50% higher MMR than the overall MMR in the population; in the 40-44 year age group, this excess mortality increases to 155% and in the 45-49 year age group to 525%. Similar figures were also found in the DHSs of Bolivia (1998), Brazil (1996), Guatemala (1998), and Peru (1996). In Haiti (2000), the MMR for women over age 35 was about twice the general average. However, because pregnancies in women over age 35 are not so common, their contribution to the overall number of maternal deaths was only slightly over 25%, i.e. about the same as maternal deaths of women under age 16.

### 5.3. The link between abortion and maternal mortality

Over the six years examined in a world-wide analysis by Daulaire et al. (2002), nearly 700,000 women died as a result of unintended pregnancies. Although more than one third died from problems associated with pregnancy, labour, and delivery, the majority – more than 400,000 – died as a result of complications resulting from abortions carried out under unsafe and often illegal conditions. WHO (2004 a) estimates that 20% of maternal deaths in the LAC region (more than the world average of 13%) are caused by unsafe abortions. WHO also suggests that 10-50% of the women who undergo unsafe abortion have complications, such as cervical tears, perforation of the uterus, fever, infection, septic shock, and severe hemorrhaging. Other serious long-term health consequences faced by women who have unsafe abortions include chronic pelvic pain, problems getting and staying pregnant, infertility, tubal blockage, and ectopic pregnancy (AbouZahr & Åhman, 1998).

Concerns over the high level of clandestine abortion in the LAC region are manifested in much of the literature, and it has often been considered a critical public health problem:

*“Each year, more than four million women in Latin America undergo an induced abortion. Because most abortions are illegal, these procedures are performed under clandestine and often dangerous conditions. As a result, the region faces a serious public health problem that threatens women’s lives, endangers their reproductive health and imposes a severe strain on already overextended health and hospital systems.” (Alan Guttmacher Institute, 2005: 01)*

The Argentinean MDGR also emphasizes the seriousness of this problem:

*“The main cause of death of women, related to pregnancy, delivery, and post-partum period is abortion, which concentrates more than a third of all the deaths registered. This practice is carried out under increasingly bad conditions: the hospitalization rates due to complications of abortions grew by 46% between 1995 and 2000. Abortion is an even greater social and health problem, for, according to the estimates of specialists, there will be 500,000 per year in the country. As in the case of other social indicators, the distribution of maternal mortality between the different regions and areas of the country displays a lot of heterogeneity. It is the poorest provinces that present the highest rates, with differences that can be up to about a factor 20 between those with the highest and the lowest rates.” (Argentina, 2003: 43)*

A similar pattern is found in Bolivia, where 30-37% of maternal deaths occur as a result of complications in abortion attempts. Likewise, the Brazilian MDGR (2004) informs that 260,000 hospitalisations take place annually to assist women suffering from abortion complications. The situation is aggravated because aborting women are subject to discrimination in health services. The report also informs that abortion is considered a crime against life in Brazil, except for cases of rape or if the mother's life is jeopardised and if she or her legal representative consents to the procedure. The Federal Supreme Court, however, has often recognised the recourse to abortion if the fetus has anencephaly.

*“In addition to these cases provided for in the law, in July 2004, the Supreme Federal Court (STF) issued a preliminary order with immediate and binding effect (i.e. valid for all judicial proceedings in course in the Brazilian Justice System), recognizing the right of pregnant women to interrupt the pregnancy if the fetus has anencephaly (absence of the brain) confirmed by a medical report. This decision still has to be submitted to the plenary assembly of the STF.” (Brazil, 2004: 54)*

The Mexican MDGR (2005) highlights that the country's Official Family-Planning Service Norm has innovated in stimulating emergency contraception in order to prevent undesired pregnancies that are prone to end up in abortions. The Nicaraguan MDGR (2003) informs that only 3% of all maternal deaths in the country result from abortion complications, whereas 60% are due to hemorrhaging, but it is hard not to believe that a considerable share attributed to hemorrhage in fact had their origin in abortion complications.

Table 5.4: Incidence of abortion in Latin America\*

Country/year	Annual no. of abortions	Rate per 1,000 women	Average per woman
Total	2,768,150	33.9	1.2
Brazil, 1991	1,433,350	36.5	1.3
Chile, 1990	159,650	45.4	1.6
Colombia, 1989	288,400	33.7	1.2
Dom. Republic	82,500	43.7	1.5
Mexico, 1990	533,100	23.2	0.8
Peru, 1989	271,150	51.8	1.8
Latin America*	4,000,000	33.9	1.2

\* Estimation on the assumption that the six countries account for 70% of the population of Latin America, and that all countries in the region have similar hospitalisation levels; rounded out to the nearest 100,000.

Source: Alan Guttmacher Institute, 2005

With respect to the characteristics of women who undergo an induced abortion, a 1990 study carried out by the Latin American Federation of Obstetricians and Gynaecologists in four countries (Bolivia, Colombia, Peru and Venezuela) found that the vast majority of hospitalised abortion patients (79%) were married women, 51% had at least two children, and 50% had 7 or more years of schooling (Pardo & Uriza, 1993). Also, some 86% were aged 20 or older. This suggests that most Latin American women having induced abortions are in their 20s or older, married, and already mothers, while in most developed countries, by contrast, women having induced abortions are often very young, single, and predominantly childless.

Table 5.5: Characteristics of abortion patients in Bolivia, Colombia, Peru, and Venezuela

Characteristics	Percent distribution
Marital status	
Single	21%
Married or in a consensual union	79%
No. of children	
0	26%
1	23%
2-4	40%
>=5	11%

Source: Pardo & Uriza, 1993

As is shown in Table 5.4, the Alan Guttmacher Institute (2005) estimates the percentage of pregnancies in Latin America that end in induced abortions varies between 17% in Mexico and 35% in Chile.

Table 5.6: Outcomes of pregnancies in six Latin American countries

Country (number of pregnancies)	Wanted births	Unwanted births	Induced abortions
Brazil, 1991 (4,693,000)	46%	23%	31%
Chile, 1990 (451,800)	44%	21%	35%
Colombia, 1989 (1,108,400)	50%	24%	26%
Dominican Republic, 1992 (295,500)	52%	20%	28%
Mexico, 1990 (3,112,100)	60%	23%	17%
Peru, 1989 (905,400)	40%	30%	30%

Source: Alan Guttmacher Institute, 2005

It has frequently been argued that rates of unsafe abortion only begin to fall notably in situations where abortion is legal due to fetal impairment, for economic and social reasons or on request (Berer, 2004; UN Millennium Project, 2006). Maternal deaths in Romania, for example, dropped strongly and rapidly after abortion was legalised in the country in 1989 (WHO, 2004 a).

If the main effect of abortion's legal status is on its safety, not on its likelihood, then the abortion rates of various countries are mostly a result of the extent to which women are at risk of unwanted pregnancy and to the prevalence and effectiveness of the use of contraceptive devices. The availability of high-quality contraceptive services would be associated with lower levels of abortion, since women who use an effective method of contraception simply are much less likely to face an unintended pregnancy and the possibility of an unwanted birth or abortion.<sup>2</sup> As was recently stated by UNFPA Executive Director Thoraya Obaid in her address to the Third International Parliamentarians' Conference on the Implementation of the ICPD PoA, in Bangkok, on November 21<sup>st</sup>, 2006:<sup>3</sup>

<sup>2</sup> A study in Bangladesh (Gillespie, 2004) found that women with good access to high-quality family-planning services had an abortion rate of 2.3 per 1,000, compared to 6.8 for women without such access.

<sup>3</sup> UNFPA news: <http://www.unfpa.org/news/news.cfm?ID=901> (last seen: March 2007).

*“We need to work within the spirit and words of Para. 8.25 of the ICPD Programme of Action, in which 179 Governments meeting in Cairo, in 1994, asserted that abortion should never be a form of family planning and that expanding family planning services allows women to plan their pregnancies and to reduce abortion. The agreement also states that, where abortion is legal (and in all but four countries in the world abortion is legal under certain conditions), it should be safe, and that it is the responsibility of each Government.”*

Nevertheless, policies to prevent induced abortion alone are not enough for reducing maternal mortality. Women who undergo an abortion need to be fully assisted in RH services in order to avoid complications that jeopardise their health and lives. Therefore, comprehensive post-abortion care must be considered a priority.

#### **5.4. The link between maternal mortality and access to SRH services**

Meeting their health needs during adolescence, pregnancy, childbirth, and the postpartum period is a proven way to save women’s lives. High use of facilities for birthing and the level of maternal mortality are inversely related, since SRH services deliver several benefits, including prevention of illness and death (Koblinsky & Campbell, 2003). Medical benefits are quite evident, and the access to SRH services prevents deaths due to AIDS, cancer, childbirth complications, and unsafe abortion (Singh et al., 2003). A World Bank study suggests that, if all women had access to the interventions for addressing complications of pregnancy and childbirth, in particular emergency obstetric care, 74% of maternal deaths could be averted (Wagstaff & Claeson, 2004).

*“Perhaps more than any other major child health or maternal health condition, reducing maternal mortality depends on a facility-based health system that functions.”*  
(UN Millennium Project, 2005 g: 88)

Studies assert that governments’ investments in RH services and rights policies result in further social advantages and even in financial savings. The economic benefits of investing in SRH services are evident: the cost of averting an unwanted birth in a typical low-fertility Latin American country was estimated at US\$ 133, and savings at US\$ 1,600 – meaning that each dollar spent on family planning saved the government US\$ 12 in health and education costs alone (Singh et al., 2003). An early study in Mexico, for instance, found that every peso the Mexican social security system spent on family-planning services during 1972–1984 saved 9 pesos for treating complications of unsafe abortion and for providing maternal and infant care. Furthermore, SRH services delivered other medical, social, and economic benefits, including the improvements in women’s social position and women’s empowerment (UN Millennium Project, 2005 a: 7).

The more serious issue, when it comes to MDGs, is that they do not address the special needs of the most disadvantaged populations within countries. Unfortunately, in the context of the LAC region, access to these services is still heavily skewed in favour of the non-poor, and it is often considered to be the most unequal region in the world.

The wealthiest 90% receive delivery care and SRH services, whereas that access for the poorest women is much more precarious. MDG 5 will not be met unless both preventive (family planning and micronutrient supplementation) and treatment (skilled attendance at delivery and emergency obstetric-care services) interventions are steered to those usually marginalised (Wagstaff & Claeson, 2004), but there is no guarantee that this will diminish the disparity between different social strata:

*“As the poor bear a disproportionate burden of maternal mortality, targeting interventions to reach those with the greatest needs would have potentially the greatest impact on overall maternal mortality reduction and thus on making progress towards achieving MDG 5.” (Bos, 2004: IX-1)*

*“(...) a goal that is defined in terms of population averages (such as the maternal health goal) can be highly regressive, leading to increased inequalities, if interventions are not targeted to reach the poor.” (Bos, 2004: IX-8)*

Such inequalities also affect, in particular, women who live in remote rural areas, the urban poor who live in marginal areas, those who lack access to education, and those who cannot find work (Limanonda, 1998). As Setty-Venugopal and Upadhyay (2002) suggest, having nearby and broader types of health services is crucial to reducing maternal mortality and morbidity, and also having a nearby contraceptive source is key to continuation of its use. Intra-urban disparities in access to SRH services must be considered:

*“Poor urban women have worse sexual and reproductive health outcomes than other urban women, and their outcomes rival those of rural residents in some settings. (...) Poor urban women are much less likely to use contraception than other urban women.” (UN Millennium Project, 2005 f: 61)*

The 2005 Brazilian MDGR highlights the difference of access to RH services between dwellers of rural and urban areas. While only 9% of the women living in urban areas had no prenatal care, the number rose to 32% in rural areas. In order to diminish the number of maternal deaths in the country, the Panamanian report identifies that it is necessary to bridge the maternal attention gap (prenatal and birth) between urban and rural areas, particularly in regard to indigenous communities. Whereas in urban areas, medical coverage to pregnant women reaches 99.6%, in rural areas it slips behind at 81.3%. The discrepancies between the RH of urban and rural women and the wealthiest and poorest women in Bolivia are alarming. While almost all well-off women in Bolivia give birth with a skilled attendant present, less than one in five of the poorest women do. Rural women have almost twice the number of children that urban women do.

Investments in SRH services, especially emergency obstetric care, must surely be a priority. Therefore, infrastructure improvements must be implemented, and those must include new community health clinics, maternity waiting homes, birthing homes, rural health clinics and hospitals. As Koblinsky and Campbell (2003) stress, facilities such as birthing homes and private clinics may provide a way to ease the overflow of maternity patients without complications in hospitals, and, together with maternity waiting homes, to

access referral care, needed by patients with complications, in rural settings. These facilities may be a primary gateway to provide care for those with greater clinical needs.

### **Reducing maternal mortality: the example of Honduras**

Remarkable improvements in maternal mortality ratios in Honduras point to the potency and effectiveness of a multi-sectoral approach. As suggested in the case study that focuses on Honduras' maternal mortality reduction (1990-1997), by Danel (1998), strategies that had an impact on maternal health included: allocation of resources in promoting social services and health, strong community participation, improved accessibility to emergency obstetric care (EOC) services, increase of health personnel (primarily in areas of difficult access), new EOC services focused on regions with higher MMRs, training of health personnel, including TBAs, use of birthing centres as an intermediate step between home births and hospital births, improvements in emergency transportation, roads, communication, improved referral of high risk women for birth with a skilled attendant, and increased utilisation of prenatal care services. The ratio decreased from 182 to 108 maternal deaths per 100,000 live births, i.e. 38%, between 1990 and 1997.

*“The Honduran story highlights the importance of multiple strategies and the fact that the success of these strategies is interdependent. Success of one amplifies the success of the others.” (Danel, 1998: 20)*

*“If, as in Honduras, these policies are followed by the targeting of resources to needy areas, it is anticipated that other successes in maternal mortality reduction could be achieved relatively rapidly.” (Koblinsky & Campbell, 2003: 26)*

### **5.5. A new Target under MDG 5: full access to RH**

The suggestion of adding universal access to RH as a Target under MDG 5 was made explicit in the report that the Millennium Project presented to the former Secretary General in January 2005, *Preparing National Strategies to Achieve the Millennium Development Goals: a Handbook*. This allows couples to avoid high-risk pregnancies as well as choose the timing and size of their families. One of the “quick wins” identified by the report, therefore, was to expand access to SRH services, including family planning and contraceptive information and services, and close funding gaps for supplies and logistics:

*“Sexual and reproductive health is essential for reaching the Goals. It entails healthy, voluntary and safe sexual and reproductive choices – voluntary choices of individuals and couples about family size and family formation, including early marriage and other exposures to sexual risks. Reproductive health issues thus deal with vital (and frequently sensitive) concerns including sexuality, gender roles, male and female power relations and social and personal identity.” (UN Millennium Project, 2005 d: 14)*

The new Target suggested by the Child and Maternal Health Task Force is to “ensure universal access to reproductive health services by 2015 through the primary health care system, ensuring

faster progress among the poor and other marginalised groups”. The new indicators are the proportion of need for family planning satisfied and the adolescent fertility rate.

*“These indicators monitor two key aspects of improving maternal health not already captured by current targets and indicators. They also supplement other reproductive health indicators already in the MDG monitoring framework. The first indicator monitors a couple’s ability to choose the timing and size of their families, an important aspect of maternal health. The second indicator is important for monitoring Goal 5 since adolescents die more frequently in childbirth than women of other ages. Additionally, teen pregnancies also rob women of other important life opportunities, including education and income-generating opportunities (such an indicator is thus also important for monitoring Goal 3, promote gender equality).” (UN Millennium Project, 2005 b: 78)*

The Task Force also proposes indicators that explicitly track the coverage of emergency obstetric and that monitor the unmet need for family planning.

Campbell-White, Merrick and Yazbeck (2006) also came out strongly in favour of adding this “missing MDG”. In September 2006, former UN Secretary-General Kofi Annan presented his Report on the Work of the Organisation, immediately prior to the General Assembly. Para. 24 of this Report introduced four new MDG Targets, one of which reads “to achieve universal access to reproductive health by 2015”.<sup>4</sup> The adoption of this Target is a landmark decision and the product of a relentless work by the global RH community and, in fact, recognises the centrality of RH in addressing core issues of the MDGs. From the viewpoint of the UNFPA’s mandate, this may be the most significant Target of the entire MDG agenda, with major implications for the agency’s ability to transmit some of its central messages. In her address to the Executive Board on 25 January 2007, UNFPA Director Thoraya Obaid referred to the issue in the following terms:

*“At the global level, we now have a target on universal access to reproductive health by 2015 within the monitoring framework of the MDGs. The new target under MDG 5 to improve maternal health is a big step forward. It will facilitate advocacy, policy dialogue, the expansion of reproductive health services, and better monitoring and accountability. Together, we must make sure that the new target and its indicators on universal access to reproductive health are fully integrated into development strategies, plans and budgets.”<sup>5</sup>*

A set of new indicators to assist regions and countries in their progress monitoring is being developed. In accordance with the recommendations of the Task Force on Child Health and Maternal Health (2005 g), the contraceptive prevalence rate (CPR), which is currently an indicator under Goal 6, will be reallocated to MDG 5.

<sup>4</sup> The Report explicitly refers to reproductive health, not sexual and reproductive health.

<sup>5</sup> UNFPA news: <http://www.unfpa.org/news/news.cfm?ID=926> (last seen: March 2007).

Bernstein and Edouard (2007) suggest that efforts should be directed towards ensuring that an indicator of unmet need is used as a measure of access to services. According to them, unmet need is a vital component in monitoring the proportion of women able to space and limit births and serves as an important instrument to improve the sensitivity of policy dialogue. The authors also hint that the new Target offers a great opportunity to give appropriate attention to unmet need for contraception. In addition, Adam Sonfield (2006: 11) clarifies that:

*“By the time of the ICPD in 1994, the concept of unmet need was also helping to mediate between the concerns of governments and experts focused on population growth and those of people primarily interested in women’s health and rights. Unmet need was helpful as a theory, because the “need” for contraception is largely a matter of whether and when a woman wants a child, or another one. By drawing on what women want, rather than what political leaders want, unmet need helped define family planning as an issue of individual rights”*

While only half the time for the implementation of the MDGs remains, countries must begin to integrate the Target of full access to RH into programme activities. In fact, some national government organisations, such as the Brazilian Ministry of Health, have started providing targeted distribution of contraceptives, both in public services and private drug stores, following the *Programa Farmácia Popular do Brasil*. These public policies have often been declared to be part of a national campaign politically committed to the MDGs, particularly to the reduction of maternal mortality.

*“We argue that sexual and reproductive health for all is an achievable goal – if cost-effective interventions are properly scaled up; political commitment is revitalised; and financial resources are mobilised, rationally allocated, and more effectively used. National action will need to be backed up by international action. Sustained effort is needed by governments in developing countries and in the donor community, by inter-governmental organisations, non-governmental organisations, civil society groups, the women’s health movement, philanthropic foundations, the private for-profit sector, the health profession, and the research community.” (Fathalla et al., 2006: 01)*

*“Of course, including a new target and relevant indicators in the MDGs is only a first step. To have an impact on the ground, determined support from rich countries is necessary.” (Denmark, 2006: 05)*

### **The MDGs, the right to SRH and the human rights-based approach (based on Hunt, 2003 and 2004)**

Initially, the health-related MDGs were conceived in an incomplete manner, not addressing crucial health issues that are essential features of the right to health, such as RH. RH is an integral element of the right to health and has to be incorporated in any strategy that reflects this orientation. At least three of the eight Goals – on maternal health, child health and HIV/AIDS – are directly related to SRH.

The ICPD was a landmark for the recognition by States that SRH is fundamental to individuals, couples and families, as well as to the social and economic development of communities and nations. The Conference placed women at the centre of an integrated approach to reproduction, and recognised that human rights have a crucial role to play in relation to SRH, which was reaffirmed in Beijing.

The international community has confirmed that SRH is an integral element of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, be it through world conferences: ICPD, ICPD +5, Beijing and Beijing +5, be it through international human rights treaties: the Universal Declaration, the Convention on the Elimination of All Forms of Discrimination against Women, the International Covenant on Economic, Social and Cultural Rights, and the Convention on the Rights of the Child.

*“(...) Cairo principle 1 begins: ‘All human beings are born free and equal in dignity and rights.’ According to principle 8: ‘Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health-care services, including those related to reproductive health care, which includes family planning and sexual health.’ (...) In short, the principles provide a human rights framework upon which to construct sexual and reproductive health laws, policies, programmes and projects.” (Hunt, 2004: 7)*

Through the human rights perspective, SRH includes an entitlement to a system of health protection, including health care and the underlying determinants of health, which provides equality of opportunity for people to enjoy the highest attainable level of health. States have an obligation to ensure RH and maternal and child health services, including appropriate services for women in connection with pregnancy, granting free services where necessary. States should also improve a wide range of sexual and reproductive health services, including access to family planning, pre- and post-natal care, EOC and access to information. This also means that women with unwanted pregnancies should be offered reliable information and counselling, including information on where and when a pregnancy may be terminated legally. In all cases, women should have access to quality services for the management of complications arising from abortion.

*“Applying human rights to these questions can deepen analysis and help to identify effective, equitable and evidence-based policies to address these complex problems. Crucially, human rights law places obligations on duty-bearers to do all they can to dismantle the barriers to sexual and reproductive health. In relation to sexual and reproductive health, human rights norms have the potential to inform and empower vulnerable individuals and disadvantaged communities.” (Hunt, 2004: 7)*

This perspective also sees the State's obligations through an analytical framework of specific obligations under international law: to respect, to protect and to fulfil the right

to health, which is especially helpful in the context of policy-making and of sharpening legal analysis of the right to health, including SRH. This relation with international law also demands that the right to health has accountability mechanisms, in order to assure full respect for the right to health obligations.

A human rights-based approach also articulates these rights to their implementation policies, for instance with the criteria of availability, accessibility, acceptability and quality:

*“Analytical frameworks or tools can deepen our understanding of economic, social and cultural rights, including the right to health (...). One framework that is especially useful in the context of policy-making is that health services, goods and facilities, including the underlying determinants of health, shall be available, accessible, acceptable and of good quality. This analytical framework encompasses sexual and reproductive health. For example, sexual and reproductive health services, goods and facilities must be: available in adequate numbers within the jurisdiction of a State; accessible geographically, economically (i.e. be affordable) and without discrimination; culturally acceptable to, for example, minorities and indigenous peoples, as well as sensitive to gender and life-cycle requirements, and respectful of confidentiality; and scientifically and medically appropriate and of good quality.” (Hunt, 2004: 12).*

A human rights-based approach relies on broad participation, so that people partake in decisions that affect their lives. In order to achieve the human right principle of equality and universality, action must be targeted at the ones in greatest need. The human rights-based approach structures the actions of duty bearers (the State, for instance, with its obligation to provide health care) and empowers rights holders (those entitled to claim their rights). In order to assure more sustainable results, it is imperative to address the root causes of human rights violations and to operationalise procedures at the level of budget allocations and public accountability. The approach is complementary to a gender-equality approach, which should be culturally sensitive. Finally, as this approach incorporates human rights, it must conform to international standards, global and regional human rights treaties and conventions, as well as recommendations from both legal and political international human rights bodies (UNFPA, 2006 b).

## **MAIN IDEAS ON MDG 5:**

### **General conclusions**

- In the LAC region, it is estimated that MMRs have remained constant at about 190 per 100,000 births for the last ten years, whereas the number of maternal deaths remained close to 22,000 a year, revealing insufficient progress on the MDG Target. At present, only Argentina, Brazil, Chile, Costa Rica, Cuba, St. Lucia, and Uruguay present levels below 50 deaths per 100,000 births. In Haiti, the MMR is as high as 520 per 100,000, whereas in Bolivia the decline from 390 to 310 per 100,000,

between 1994 and 2000 still leaves the MMR well above the ICPD target of 125 per 100,000 set for 2005.

- The risk of maternal mortality is markedly higher in poor households, particularly if they are geographically isolated. It seems plausible that a maternal death may also aggravate the poverty of a household, although the number of maternal deaths, in most countries, is so small, in comparison with the number of poor households, that it is unlikely to cause a major effect on poverty as such. One should be careful, however, not to attribute high maternal mortality primarily to adverse living conditions, as the primary determinant of maternal mortality in developing countries nowadays, as well as historically in the now developed countries, is the ability of the health system to adequately deal with obstetric complications.

### **1. Additional Targets in national reports**

- Even before the introduction of the new RH target in 2006, several countries in the LAC region had decided to widen the scope of Goal 5, adding new Targets and indicators to be monitored within their national MDGRs. The health status of women, and not only maternal health, is receiving attention. Brazil, for example, has included the Target of ensuring universal access to SRH services and of reducing breast and cervical cancer mortality. Argentina, Colombia, Costa Rica, and Peru, also have adopted new Targets or indicators, which include: attendance to prenatal exams, births carried out in hospitals, family planning, and prevention of cervical cancer.

### **2. The link between reproductive patterns and maternal health**

- Changes in reproductive patterns may greatly impact the reduction of maternal mortality and the improvement of women's health in general.
- Maternal morbidity and mortality are associated with inter-pregnancy intervals. Very short birth intervals have long been associated with increased risk of various adverse health outcomes, both for mothers and their infants. They increase the risks of maternal death, third trimester bleeding, premature rupture of membranes, puerperal endometritis, and anaemia. Conventionally, the critical limit has been placed at 24 months, but more recently there is a trend toward moving the limit to 36 months.
- DHS data confirm that, in many countries of the LAC region, women desire considerably longer birth intervals than they achieve, reflecting a large unmet need for birth spacing. Optimal birth spacing requires continuity of care and access to family- planning programmes.
- There is some evidence regarding the substantial increase of maternal mortality at higher birth orders (5 or more), but due to the scarcity of birth-order specific information on maternal mortality the issue has not received as much attention, particularly in the LAC region, as the issue of birth spacing.

- The link between maternal mortality and contraceptive use has also been emphasized in the maternal health literature. Reducing the unmet need for contraception must be (and recently has been) recognised as a major Target for reaching MDG 5 in the LAC region.
- Very young or very old maternal ages (less than 16 or more than 35) are associated with substantially higher maternal mortality risks. DHS data from several LAC countries support this statement. In terms of the number of maternal deaths involved, the importance of either extreme is about the same, but in practice the first has attracted much more attention than the second.

### **3. The link between abortion and maternal mortality**

- WHO estimates that 20% of maternal deaths in the LAC region (more than the world average of 13%) are caused by unsafe abortions. WHO also suggests that 10-50% of the women who undergo unsafe abortion have complications, such as cervical tears, perforation of the uterus, fever, infection, septic shock, and severe hemorrhaging.
- Concerns over the high level of clandestine abortion in the LAC region are presented in much of the literature, and it has often been considered a critical public health problem.
- MDGRs from Argentina, Brazil, Mexico, and Nicaragua have emphasized the seriousness of health complications due to unsafe abortions.
- With respect to the characteristics of women who face an induced abortion, a 1990 study in four countries (Bolivia, Colombia, Peru and Venezuela) suggests that most Latin American women having induced abortions are in their 20s or older, married, and already mothers. The contrasts with the pattern typically found in the developed countries, where it is more common for young, unmarried women without children to seek abortions.
- The availability of high-quality contraceptive services would be associated with lower levels of abortion, since women who use an effective method of contraception simply are much less likely to face an unintended pregnancy and the possibility of an unwanted birth or abortion.
- Policies concerning induced abortion prevention alone are not enough for reducing maternal mortality. Women who undergo an abortion need to be fully assisted in RH services in order to avoid complications that jeopardise their health and lives. Therefore, comprehensive post-abortion care must be considered a priority.

### **4. The link between maternal mortality and access to SRH services**

- High use of facilities for birthing and the level of maternal mortality are inversely related. SRH services deliver several benefits, including prevention of illness and death.
- A World Bank study suggests that, if all women had access to the interventions for addressing complications of pregnancy and childbirth, in particular emergency obstetric care, 74% of maternal deaths could be averted.

- Governments' investments in RH services and rights policies result in further social advantages and even in financial savings.
- In the LAC region, access to SRH services is still heavily skewed in favour of the non-poor, and it is often considered to be the most unequal region in the world.
- The 2005 Brazilian MDGR highlights the difference of access to reproductive services between dwellers of rural and urban areas. While only 9% of the women living in urban areas had no prenatal care, the number rose to 32% in rural areas. The Panamanian report also identifies that it is necessary to bridge the maternal attention gap (prenatal and birth) between urban and rural areas, particularly in regard to indigenous communities.
- A case study on maternal mortality reduction in Honduras showed a correlation between improvement in maternal health and improved availability of emergency obstetric-care services.

#### **5. A new Target under MDG 5: full access to RH**

- The new Target of achieving universal access to RH by 2015, introduced by the former UN Secretary-General in 2006, recognises the centrality of RH in addressing core issues of the MDGs. It will galvanise better monitoring, policy dialogue, and the availability of RH services.
- More in particular, it offers a great opportunity to give appropriate attention to unmet need for contraception.