International Journal of Gynecology and Obstetrics 106 (2009) 102–105

Contents lists available at ScienceDirect

International Journal of Gynecology and Obstetrics

journal homepage: www.elsevier.com/locate/ijgo

REPRODUCTIVE AND SEXUAL HEALTH RIGHTS

Fifteen years after the International Conference on Population and Development: What have we achieved and how do we move forward?

Thoraya Ahmed Obaid *

United Nations Population Fund, New York, USA

ARTICLE INFO

Keywords:
International Conference on Population and Development
Global health
Global health funding
Maternal health
Sexual and reproductive health

ABSTRACT

This article surveys the current situation and prospects for attaining the goals set by the International Conference on Population and Development (ICPD) held in 1994, and the health-related Millennium Development Goals (MDGs), set in 2000. Encouraging changes in the policy environment are highlighted, but the available resources do not yet match needs. Global maternal mortality figures, at over 500 000 a year, have not changed since 1990, and morbidity is about 20 million. Some countries have made progress with low-cost, high-yield interventions such as family planning, skilled birth attendants, access to emergency obstetric and neonatal care, management of sexually transmitted infections, and HIV prevention. However, progress in many low-income countries has been slow, and few are on track to meet the goals. There are wide inequities in care among and within countries. Suggestions for priority attention are offered, such as a "continuum of care" approach, integrated services, and comprehensive policies on human resources for health.

1. The current situation

Fifteen years after governments adopted the International Conference on Population and Development (ICPD) Programme of Action [1], countries have embraced the concept and practice of reproductive health as an essential component of poverty reduction, which is critical to reducing high fertility and mortality and the spread of HIV and other sexually transmitted infections (STIs).

Many governments have broadened programs to reach people in need of services, and integrated reproductive health within primary health care. This includes services for family planning, pre- and postnatal care, childbirth services, STI and HIV prevention, cervical and breast cancer screening, and referral for treatment where appropriate. There has been an emphasis on improving quality and access of services for underserved groups, including the very poor and people living in remote rural areas.

There has also been progress in reproductive rights, with many countries establishing in their policies and laws the basic right of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children, and to have the information and means to do so; as well as the right to attain the highest standard of sexual and reproductive health, and to make decisions free of discrimination, coercion, or violence.

However, scaling up sexual and reproductive health services and realizing reproductive rights remain an urgent challenge, reinforced by the fact that the poorest women have the least access to information and services.

Today, sexual and reproductive ill health accounts for an estimated one-third of the global burden of disease and early death in women of reproductive age (15–44 years) [2].

Every year there are an estimated:

- 180–210 million pregnancies;
- 80 million unwanted pregnancies;
- 50 million induced abortions;
- 20 million unsafe abortions;
- 536 000 deaths from maternal causes, including 68 000 deaths from unsafe abortion;
- 20 million postpartum infections and disabilities;
- 340 million people infected by sexually transmitted infections;
- Over 2 million AIDS deaths.

The burden of ill health falls most heavily on women in low- and middle-income countries. Inequalities in accessing services—between rich and poor, urban and rural, the general population and ethnic minorities or other marginalized groups—are greater in sexual and reproductive health than for almost any other health indicator.

Among all health measures, maternal mortality indicators show the greatest difference between rich and poor both within and among countries. In fact, 99% of maternal deaths occur in low-resource countries. A woman in Niger faces a 1 in 7 lifetime risk of dying during pregnancy and childbirth compared with a 1 in 8200 risk for a woman in the United Kingdom [3].

In low-income countries women in the richest quintile are 6 times more likely than women in the poorest quintile to have access to medically-trained birth attendants. One-third of pregnant women in low-resource countries have no prenatal care. In Sub-Saharan Africa,

* United Nations Population Fund, 220 East 42nd Street, New York, NY 11109, USA.
E-mail address: obaid@unfpa.org.

0020-7292/$ – see front matter © 2009 Published by Elsevier Ireland Ltd. on behalf of International Federation of Gynecology and Obstetrics.
doi:10.1016/j.ijgo.2009.03.017

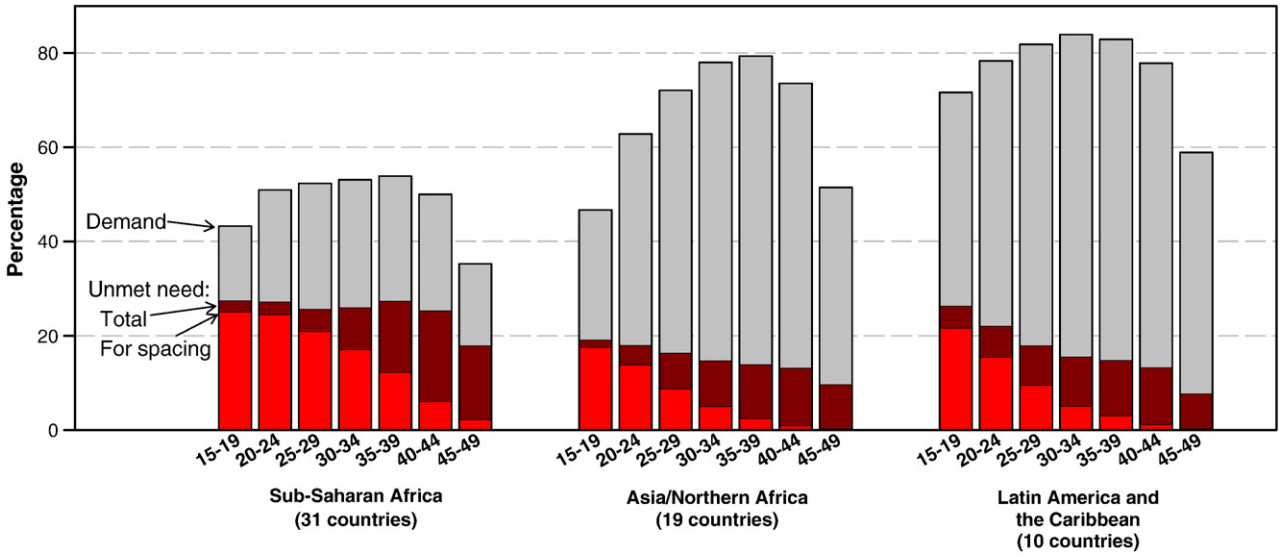

Fig. 1. Mean level of unmet need and total demand for family planning, by region and women's age. Source: Demographic and Health Surveys, DHS StatCompiler, http://www.statcompiler.com/. Accessed December 3, 2007. Note: Unweighted averages based on the most recent available survey for each country.

where most maternal deaths occur, 70% of women have no contact with health personnel following childbirth.

The estimated number of maternal deaths is unchanged since 1990. Maternal mortality has fallen by less than 1% annually between 1990 and 2005, far below the 5.5% annual decline necessary for achieving Millennium Development Goal (MDG) 5. In Sub-Saharan Africa the annual decline has been approximately 0.1%. Unsafe abortions contribute to 13% of maternal deaths. Nearly half (48%) of abortions are unsafe (2003), which is up from 44% in 1995 [4].

Sixty-three percent of women of childbearing age in low-resource countries use a method of family planning, compared with 10% in 1960 [5]. But demand for family planning continues to grow. Some 120–150 million women have an unmet need for family planning. A "woman with unmet need" is a married woman of reproductive age at risk of pregnancy who would like to postpone or stop childbearing now or prior to her last birth, but is not using/did not use a method of contraception (Fig. 1).

Family planning currently prevents 187 million unintended pregnancies per annum, including 60 million unplanned births and 105 million abortions [6]. It saves 140 000–150 000 lives a year, and averts 15 million injuries and disabilities related to pregnancy and childbirth.

Improved access to family planning could avert one-third of maternal mortality and 10% of child mortality. Analyses for the *Countdown to 2015* (http://www.countdown2015mnch.org/) countries suggest a return on investment of between 3:1 and 4:1, assuming satisfaction of current unmet need by 2015. Adding family planning to services for preventing mother-to-child transmission of HIV can also save many lives [7].

Currently, programs do not sufficiently address women's needs for family planning information and services at critical points, for example after puberty, sexual initiation, pregnancy and prenatal care, a healthy birth, and STI infection including HIV/AIDS [8].

Meeting the unmet need for family planning is critical as increasing numbers of adolescents and young people are entering their reproductive years. Young people in almost all regions of the world find it harder than other age groups to access reproductive health services. Girls under 18 years are at considerably greater risk of obstetric injury or infection than their older counterparts. The continuing practice of child and very early adult marriage puts young women at heightened risk of maternal mortality and morbidity, including obstetric fistula and other birth injuries.

According to recent reports from *Countdown to 2015*, only 16 of 68 priority countries are on track to achieve MDGs 4 and 5. Other countries have stalled or in some cases actually regressed [9].

2. The policy environment 15 years after ICPD

Despite these tremendous challenges, there have been encouraging changes in the policy environment which can accelerate progress toward universal access to reproductive health.

The global consensus of 1994 recognized that empowerment of the individual with access to information and services for reproductive health, including voluntary family planning, was essential for sustainable development. The ICPD agenda stressed the importance of advancing human rights, gender equality and the empowerment of women, and eliminating all kinds of violence against women. The consensus reconciled the reproductive rights of individuals and couples, and particularly women's rights, with overall development goals. ICPD adopted a detailed Programme of Action [1] with goals for 2015.

Many of the ICPD goals, including universal primary education and reductions in maternal and child mortality, are reflected in the MDGs, which were elaborated after the 2000 Millennium Summit and have become the guiding framework for development. However, despite extensive civil society pressure, the ICPD goal of universal access to reproductive health by 2015 was left out of the MDGs. It was added in 2005 in the outcome document of the World Summit and subsequently included as a target in the monitoring of the MDGs, which paves the way for faster progress.

The targets for MDG 5 are to reduce the maternal mortality ratio by three-quarters between 1990 and 2015, and achieve universal access to reproductive health by 2015. Indicators for the targets are:

- maternal mortality ratio;
- proportion of births attended by skilled health personnel;
- contraceptive prevalence rate;
- adolescent birth rate;
- prenatal care coverage (at least 1 visit and at least 4 visits)[1];
- unmet need for family planning.

In recent years, there has been increasing national and global attention paid to the "health MDGs" (MDGs 4, 5, and 6: reducing

[1] This in fact corresponds to 2 different indicators "at least one visit" and "at least four visits". Although the indicator for "at least one visit" refers to visits with skilled health providers (doctor, nurse, midwife), "four or more visits" refers to visits with ANY provider (skilled or unskilled) because national-level household surveys do not collect provider data for each visit. In addition, standardization of the definition of *skilled* health personnel is sometimes difficult because of differences in training of health personnel in different countries. Reference: UN Statistics Division: http://unstats.un.org/unsd/mdg/Metadata.aspx?IndicatorId=0&SeriesId=763 (Accessed June 2009).