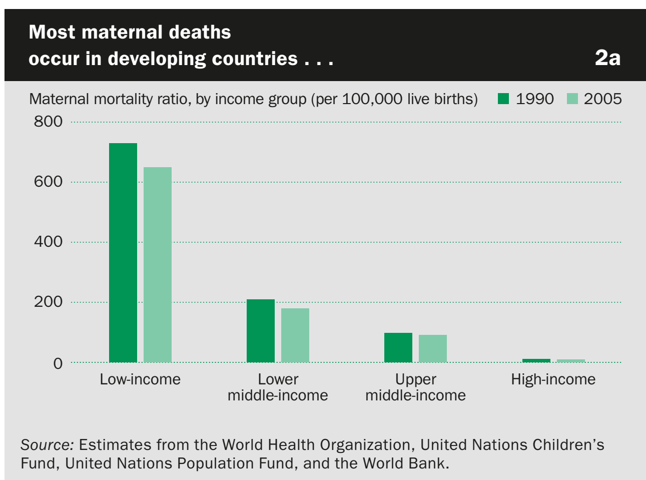
Reproductive health

Keeping mothers alive and healthy is good for women, their families, and society. Prioritizing women's health will help countries meet many of the Millennium Development Goals—first improved maternal and child health, then reduced poverty, universal education, and gender equality. Poor people tend to have large families, suffer disproportionately from illness, and use fewer health services during pregnancy and childbirth. Reproductive health care can enhance poor people's overall health care and help families escape the poverty impact of having many children. When financial resources are divided among fewer family members, more is left for education, health care, and savings, decreasing vulnerability and insecurity (UN Millennium Project 2005a).

This important link between reproductive health and development outcomes was first articulated in 1994 at the International Conference on Population and Development in Cairo. But as fertility declined in many countries and new priorities arose, reproductive health and family planning fell steadily in international priority. Complicating this was the lack of sectoral ownership of reproductive health and the requirement for multisectoral action.

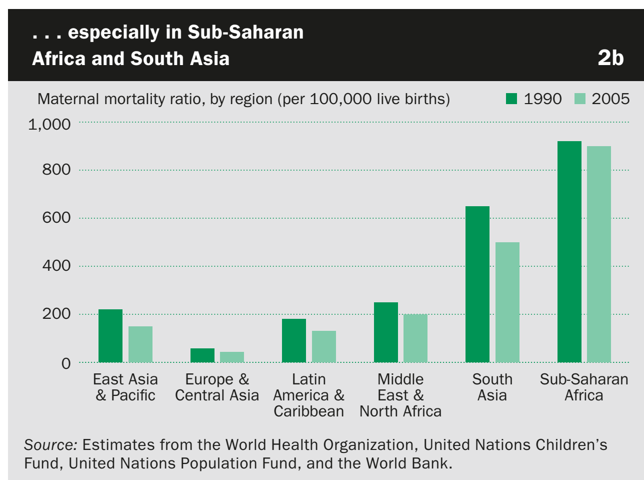
The targets for the Millennium Development Goals, drafted in 2000, ignored the overarching Cairo goal of universal access to sexual and reproductive health services, instead focusing on the target of reducing maternal mortality, a problem of immense magnitude in poor countries (figures 2a and 2b). Millennium Development Goal 5 in 2000 identified two indicators to measure progress: maternal mortality ratios and the proportion of births attended by skilled staff. At an analytical level, however, it is impossible to disentangle maternal health from reproductive health, of which maternal health is just one facet.

Most maternal deaths occur in developing countries . . . **2a**



Source: Estimates from the World Health Organization, United Nations Children's Fund, United Nations Population Fund, and the World Bank.

. . . especially in Sub-Saharan Africa and South Asia **2b**



Source: Estimates from the World Health Organization, United Nations Children's Fund, United Nations Population Fund, and the World Bank.

Why reproductive health now?

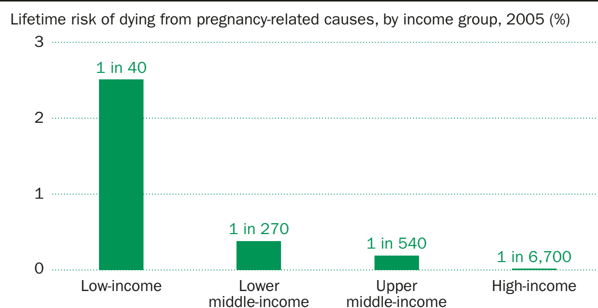
Pregnancy and childbirth are leading causes of death and disability for women of reproductive age in developing countries. In 2005 more than half a million women died from pregnancy-related causes, and about 200 million women suffered life-threatening complications and disabilities (Glasier and others 2006). As a result of reproductive health problems an estimated 250 million years of productive life are lost every year (UNFPA 2005). Over 99 percent of all maternal deaths occur in developing countries, the majority in Sub-Saharan Africa and South Asia (Glasier and others 2006).

In 2005 Millennium Development Goal 5—improved maternal health—was expanded to include family planning and reproductive health services. Reproductive health care was recognized as important for improving maternal health and preventing maternal deaths, but also as essential for achieving all the Millennium Development Goals. A new target was introduced for universal access to reproductive health by 2015, along with indicators measuring adolescent fertility, prenatal care, unmet need for contraception, and contraceptive prevalence.

Poor women disproportionately bear the burden of disability and loss of productive life. Women in low-income countries face a 1 in 40 risk of a pregnancy-related death; those in high-income countries, a 1 in 6,700 risk (figure 2c). The contrast is also larger within countries. In Peru the poorest women are about 7 times more likely than the richest to die of pregnancy-related causes (Ronsman and Graham 2006). Even though cheap and easy methods to prevent unintended or unwanted pregnancies are available, 120 million couples hoping to avoid pregnancy did not use contraception. As a result, 80 million women became pregnant against their will, and 45 million sought abortions, about 20 million of them unsafe, performed by untrained providers (Glasier and others 2006).

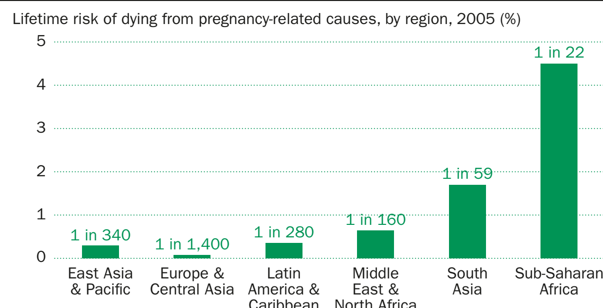
Progress in maternal and reproductive health in recent years has been mixed in developing countries. Several middle-income countries have made rapid progress in reducing maternal deaths, but maternal mortality ratios and the lifetime risk of dying in childbirth remain unacceptably high in Sub-Saharan Africa and South Asia (figure 2d). Within countries, poorer women are more vulnerable than wealthier women.

Women in developing countries are more likely to die of pregnancy-related causes than women in high-income countries 2c



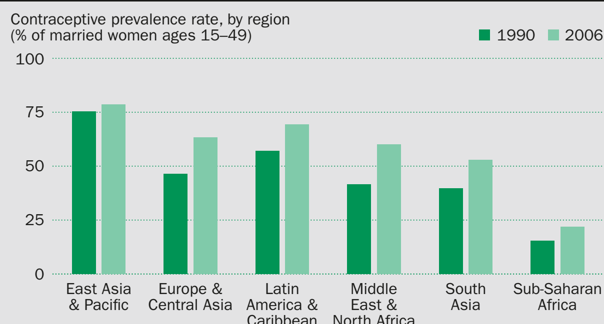
Source: Estimates from the World Health Organization, United Nations Children's Fund, United Nations Population Fund, and the World Bank.

The lifetime risk of dying from pregnancy-related causes is unacceptably high in Sub-Saharan Africa and South Asia 2d



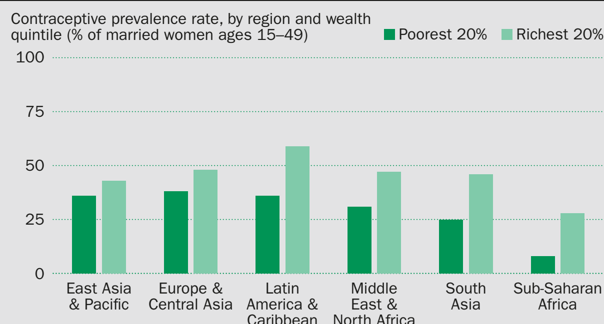
Source: Estimates from the World Health Organization, United Nations Children's Fund, United Nations Population Fund, and the World Bank.

East Asia and Pacific leads in contraceptive use among married women ages 15–49 2e



Source: Household surveys.

Women from the richest households are more likely to use contraception—but contraceptive prevalence rates remain low 2f



Source: Gwatkin and others 2007.

Maternal and reproductive health: current status

The vast majority of maternal deaths and disabilities can be prevented through appropriate reproductive health services before, during, and after pregnancy. Key among them is expanding family planning to allow women to space or limit their births.

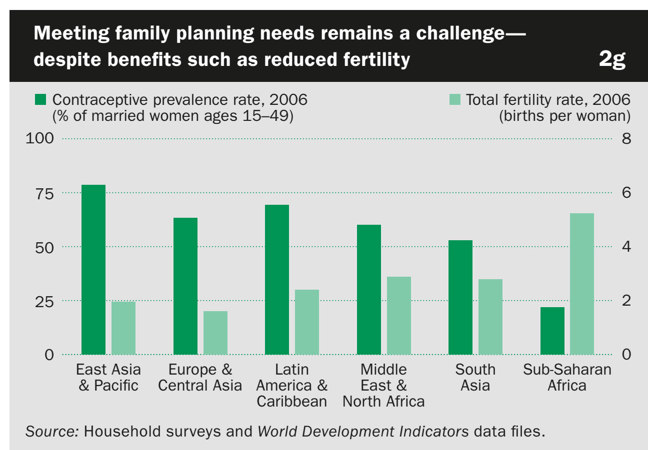
Contraceptive use among women in developing countries has increased steadily, from about 14 percent of married women ages 15–49 in 1965 to 60 percent in 2006. But use is uneven across and within countries. In Sub-Saharan Africa only 22 percent of married women use contraception, compared with 63 percent in Europe and Central Asia, about 70 percent in Latin America and the Caribbean, and about 80 percent in East Asia and the Pacific (figure 2e).

Contraceptive use follows the distribution of wealth, and the poorest women come up short. Differences are especially stark in South Asia and Sub-Saharan Africa (figure 2f). In Sub-Saharan Africa women from richer households are three times more likely to use contraception, but prevalence is still less than 30 percent of eligible women. In South Asia richer women are twice as likely as poorer women to use contraception.

Despite the benefits, many countries continue to face major challenges in meeting their family planning needs (figure 2g), and rates of unmet need for family planning in developing countries remain high (figure 2h). According to surveys, one married woman in seven in these countries has an unmet need for contraception, and in Sub-Saharan Africa nearly one in four does. Regional aggregates mask wide differences: in Asia only 5 percent of women in Vietnam have an unmet need, compared with 28 percent in Nepal (Sedgh and others 2007b). Preventing unplanned pregnancies alone could avert around one-quarter of maternal deaths, including those from unsafe abortions (Sedgh and others 2007b).

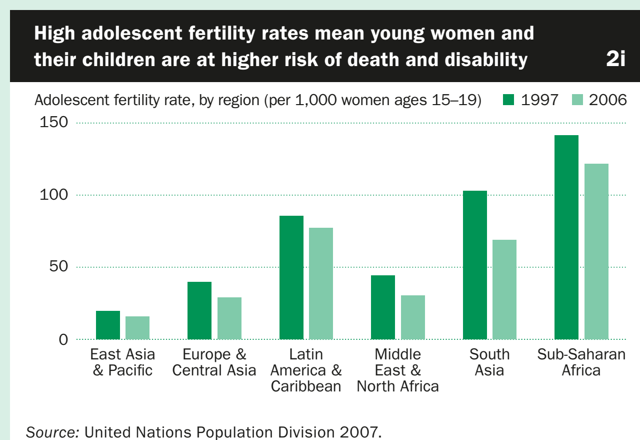
Young girls are particularly vulnerable to maternal death. They have limited information, means, and access to contraception and even less access to good quality maternal health care, especially if they are not married. In regions where the adolescent fertility rate is high (figure 2i), many young women and their children, particularly very young women, face higher risks of death and disability (box 2j). Young girls either continue unintended pregnancies, giving up opportunities

Meeting family planning needs remains a challenge—despite benefits such as reduced fertility **2g**



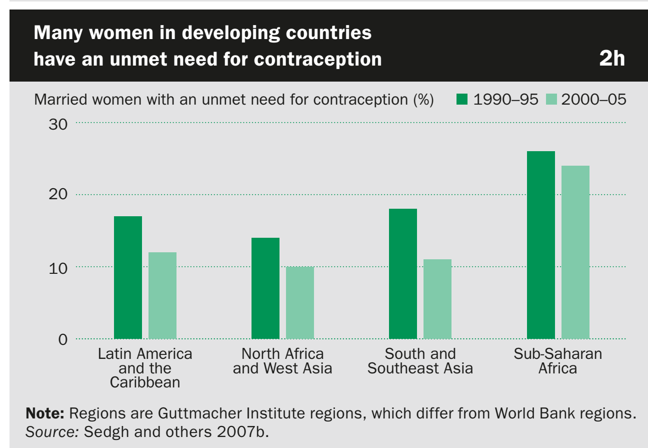
Source: Household surveys and *World Development Indicators* data files.

High adolescent fertility rates mean young women and their children are at higher risk of death and disability **2i**

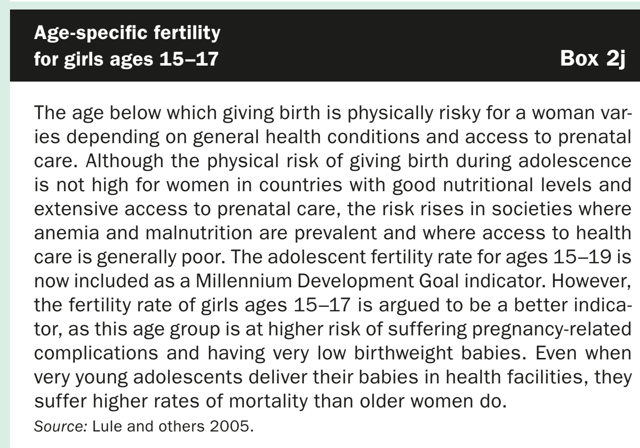


Source: United Nations Population Division 2007.

Many women in developing countries have an unmet need for contraception **2h**



Note: Regions are Guttmacher Institute regions, which differ from World Bank regions.
Source: Sedgh and others 2007b.



Age-specific fertility for girls ages 15–17 **Box 2j**

The age below which giving birth is physically risky for a woman varies depending on general health conditions and access to prenatal care. Although the physical risk of giving birth during adolescence is not high for women in countries with good nutritional levels and extensive access to prenatal care, the risk rises in societies where anemia and malnutrition are prevalent and where access to health care is generally poor. The adolescent fertility rate for ages 15–19 is now included as a Millennium Development Goal indicator. However, the fertility rate of girls ages 15–17 is argued to be a better indicator, as this age group is at higher risk of suffering pregnancy-related complications and having very low birthweight babies. Even when very young adolescents deliver their babies in health facilities, they suffer higher rates of mortality than older women do.

Source: Lule and others 2005.

for education and employment, or seek unsafe abortions. Forty percent of all the abortions are performed on women under age 25 (Glasier and others 2006).

Prenatal care, long at the core of maternal health services, identifies risks, helps plan for safe delivery, and provides entry into the health care system. All regions but Sub-Saharan Africa have made progress in providing prenatal care to women at least once during pregnancy (figure 2k). In South Asia, with the slowest progress, 66 percent of pregnant women have at least one prenatal care visit. But rich women are three times more likely to get prenatal care than are poor women (figure 2l).

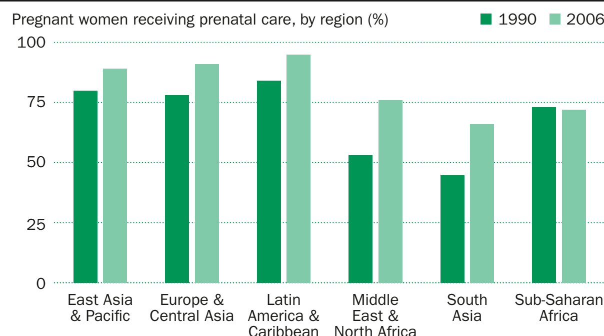
A key factor in lowering maternal mortality is the presence of a skilled attendant during childbirth. Nearly half of maternal deaths in developing countries occur during labor and delivery or just after delivery (Lule and others 2005). The proportion of attended births remains low in South Asia and Sub-Saharan Africa (figure 2m) and is even lower in the poorer segments of these countries (figure 2n). Other regions have made impressive gains, with countries in Europe and Central Asia providing skilled care to nearly all women giving birth.

An improvement, but is it enough?

Both preventive and strategic interventions are needed to treat the many factors that contribute to maternal mortality. The expanded Millennium Development Goal 5 indicators are mainly process indicators to assess reproductive health and address preventive interventions: preparing for birth, including timing and spacing of births for both adults and adolescents; recognizing danger signs in the prenatal period and responding appropriately; and having skilled health staff at delivery.

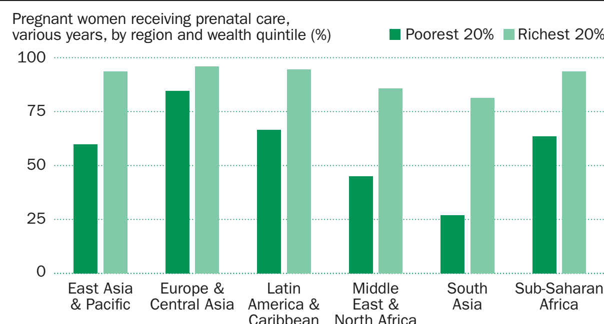
Equally important are the strategic interventions, especially during labor and delivery. Among these are obstetric care, including timely and safe transfers of mothers to a hospital or health care center with the necessary staff, equipment, drugs, and other supplies. The World Health Organization (WHO) has proposed that national public health administrators monitor the availability of essential obstetric care and access to emergency obstetric care at the country level (box 2o). An estimated 15 percent of pregnancies result in complications (Nanda, Switlick, and Lule 2005). But data on complications are collected only by ad hoc studies, usually in limited areas of countries, and no standard definition or methodology is followed.

All regions have made progress in providing prenatal care to women at least once during their pregnancy **2k**



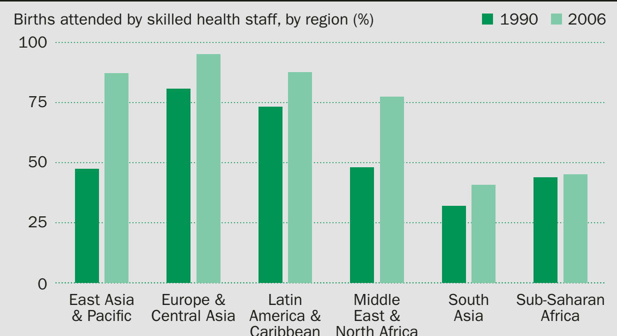
Source: Household surveys.

In South Asia rich women are three times more likely to receive prenatal care than are poor women **2l**



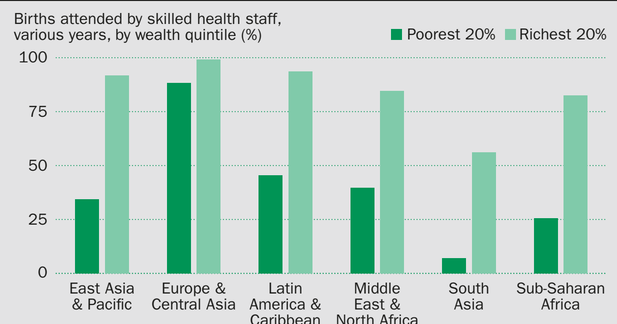
Source: Gwatkin and others 2007.

The proportion of births attended by skilled health staff remains low in South Asia and Sub-Saharan Africa **2m**



Source: Household surveys.

Nearly all women in Europe and Central Asia have births attended by skilled health staff—but even there poor women lag behind **2n**



Source: Gwatkin and others 2007.

Complications from abortion are also now recognized as a major public and reproductive health problem, especially in developing countries. Abortions, especially unsafe ones, account for 13 percent of maternal deaths, and good quality post-abortion services and family planning services to avoid unwanted pregnancies are essential. Of an estimated 20 million unsafe abortions worldwide each year, the majority are in developing countries (Nanda, Switlick, and Lule 2005) (figure 2p). Abortion information is particularly difficult to gather because abortion is restricted and stigmatized in many countries, leading to false reporting by women and service providers. Regional estimates of abortion rates are available from the WHO, UN agencies, national authorities, and nongovernmental organizations. But reliable country data are not routinely collected.

In addition to definitional gaps, data collection for these two indicators faces additional hurdles because the infrastructure for collecting data is weak or because there is political, cultural, or moral hesitation. Obtaining accurate values also requires significant clinical resources and technical skills.

The importance of emergency obstetric care — **Box 2o**

Emergency obstetric care encompasses a set of functions performed at health facilities that can prevent the death of women experiencing obstetric complications. Basic emergency obstetric care, usually provided at health centers and small maternity homes, includes administering certain drugs and performing lifesaving procedures, such as for preeclampsia and eclampsia. Comprehensive emergency obstetric care, usually provided at subdistrict or district hospitals, also includes providing Caesarean sections and blood transfusions.

More maternal health programs now recognize that emergency obstetric care is critical to reducing maternal death and disability. Much can be accomplished by upgrading existing facilities. In programming for emergency obstetric care, bottlenecks in accessing services are often assessed using the "three delays" model: delays in the decision to seek care, delays in arrival at a health facility, and delays in the provision of adequate care at the facility.

Source: Nanda, Switlick, and Lule 2005.

Most unsafe abortions take place in developing countries, especially in Latin America and the Caribbean and Africa — **2p**

Note: Regions are World Health Organization regions, which differ from World Bank regions.
Source: WHO 2007.

Challenges ahead

The interventions to prevent the vast majority of conditions that kill women of reproductive age—and to enable health systems to protect and promote women's health—have already been identified. Some are simple, low-tech, and cost-effective, such as the provision and use of contraception. Yet many people in developing countries, especially in South Asia and Sub-Saharan Africa, do not benefit. Behind the failure of these health systems are weak commitments to improving maternal health, poor management systems, inadequate human and medical resources and equipment, and, for most of the poor, the inability to pay for services.

Underlying the failures of the health system is the lack of reliable data for monitoring progress in maternal and reproductive health and in other safe motherhood indicators. And most developing countries have inadequate health information systems or lack them altogether. So, providing timely and reliable information often depends on local, one-off data collection, such as household surveys, which are both costly and unsustainable because they do not establish permanent health information structures. Ideally, there would be vital registration systems, hospital and health service data, and household surveys.

Least available are data on maternal deaths, needed to monitor the Millennium Development Goal target of cutting maternal mortality ratios by 75 percent. While vital registration systems are a rich and valuable source of health data in developed countries, they are incomplete in developing countries. For example, the share of developing countries with at least 90 percent complete vital registration increased from 45 percent in 1988 to 62 percent in 2006. Still, some of the most populous countries—China, India, Indonesia, Brazil, Pakistan, Bangladesh, Nigeria—do not have complete vital registration systems. Hospital or other health service records are sometimes a source of information. But these record only women who have access to health services, and a large number of women, especially in rural areas, do not. Household surveys for estimating maternal mortality ratios are costly and yield unreliable estimates.

The evidence base should be strong enough to provide crucial information on who dies and why—and to generate insights about interventions that are available, accessible, appropriate, and affordable.