Reproductive health – the millennium goal farthest from being achieved

Reproductive health pertains to aspects of health associated with love life and sexuality. In this area there are great social differences, and of the UN's Millennium Development Goals (MDGs), least progress has been made towards MDG 5 pertaining to reproductive health. It is also one of the most controversial goals. The path forward runs via a greater degree of social justice – not least in terms of access to health services that everyone can afford to use.

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The concept «reproductive health» achieved its international breakthrough and global, political endorsement at the International Conference on Population and Development in Cairo in September 1994 (1). The definition remains valid today (Box 1).

The definition contains many delicate balances. Central in the controversies are the issues of abortion, adolescent sexual health and the right of sexual minorities to freedom from discrimination. There are also many (and more concealed) attacks on the ideas concerning access to contraceptives, including for young people and the unwed. Sexuality is governed by cultural, gendered norms as well as by legal statutes. Therefore, it is not surprising that there is a great deal of sound and fury when the entire world attempts to come to agreement.

Ethical systems on a collision course

In normative ethics, moral standards apply in the form of obligations, proscriptions and prescriptions (2). There are relatively strict norms in all cultures concerning who can have sex with whom, when and in what ways. In consequentialist ethics – utilitarianism – it is the results that count. It is a fact that young people have sex. If health services are not offered, sexual activity will have undesirable consequences for many of them.

It is also a fact that most unwanted pregnancies are terminated. If this cannot be done legally and safely, it is done illegally and frequently unsafely. Thus, it becomes important to argue ethically in favour of doing what results in the least possible harm and causes the least possible unhappiness, even when this entails violating the norms (3).

The global dividing lines

The premises for global change are often laid in international negotiations carried out far away from those who suffer because of restrictions and lack of resources. Government representatives under instructions given by their political authorities meet around the negotiations table of the United Nations. In this respect it is a problem that the Vatican (or to be formally correct, the Holy See) acts as a state in the context of the UN and is part of a consensus when plans of action and resolutions are to be adopted. They uphold very restricted ethical principles and are not democratically elected, although they nevertheless claim to represent more than a billion people.

The Vatican is unilaterally concerned with norms and largely neglects consequences, as opposed to many adherents of the Catholic faith, both individuals and states. But a small number of Catholic countries, particularly in Latin America, comply with the Vatican's views on abortion and have a total prohibition policy, that is, that abortion canot be carried out legally in any case, including when the pregnant woman's life is at risk. Following Nicaragua's closing of the last opportunity for legal abortion it is a known fact that women have died of extra-uterine pregnancies due to the doctors' unwillingness to intervene until after the foetus has died, at which point it may be too late to save the woman's life (4). There is still opposition in the Vatican against all modern contraceptive devices and against the use of condoms to prevent HIV infection (5, 6).

Total prohibition of abortion does not exist in any Islamic country, but many Muslim-dominated countries concur with the Vatican's claims that family structures will break down if reproductive health services are made widely available. There are also dour predictions that parental authority will be undermined if young people are given the right to sexuality education and to confidential health services.

References to sexual diversity, such as the fact that homosexuality is found in all societies, are also rejected by many developing countries on the basis of culture and religion. It is acknowledged, however, in the newly achieved consensus on prevention of HIV and AIDS, that men have sex with men (7). Moreover, developing countries emphasize the importance of respecting national sovereignty, traditions, culture and religion, while the industrialized states place emphasis on universal human rights and the individual's right of free choice. A broad range of non-governmental organizations and research institutions provide a much more nuanced picture than what is put forth by government representatives.

Improvement, after all

MDG 5 is the goal in which least progress has been made, but two recent surveys have shown that there has been a decline in pregnancy-related mortality (8). An article in *The Lancet* in 2010 (9) was the first to

Box 1

Reproductive health is a state of physical, mental and social well-being – not merely the absence of disease and infirmity – in all matters related to the reproductive organs. This includes the right to have a satisfactory and safe sex life, to have the opportunity to have children and to be able to choose whether one wants to have them, and if so, when. This in turn entails women's and men's right to be informed about and have access to contraceptive methods and other means by which to regulate fertility that are not illegal. In addition, this entails the right to access to health services that ensure that women can safely go through pregnancy and childbirth and provide couples with the best chance of having a healthy child. Reproductive health also includes sexual health, with the purpose of improving peoples' lives and personal relations (adapted from (1)).

report this, but it is uncertain whether deaths due to abortion are included in the statistics. In 2010 the UN and the World Bank estimated that there had been a reduction of 34 % from the level during the period 1990 to 2008 (10). The goal of a reduction to 25 % of the 1990 level by the year 2015 is still far from being achieved.

Access to modern contraception has also improved. For decades, the percentage of women using contraception who are married or in a permanent sexual relationship and who do not want children has been used as an indicator for the degree of access to contraception. This percentage has risen steadily, although there are still some countries with a very low usage rate, particularly in Africa (11). In most of the Sub-Saharan countries plus some countries in Asia (Afghanistan, Jemen, Iraq, Laos, Palestine, Papua New Guinea and East Timor), the fertility rate nevertheless remained at more than four children per woman around the year 2005 (12).

Where there is a high fertility rate, there is also a high risk in each pregnancy. The difference in lifetime risk is thus great and is the indisputably largest inequality in health variables between rich and poor countries and between rich and poor people.

Social inequality

The large social inequalities in pregnancy-related health have been well-known for decades. Nevertheless, it was only in recent years that we acquired more systematic knowledge about these inequalities. The World Bank has shown that the 20 % of people having the lowest income are ranked lowest in terms of indicators such as treatment of sick children and vaccination coverage, as compared with the 20 % having the highest income (13). But the inequality between women giving birth with professional help and those who do not receive help is significantly greater (fig 1) (13).

Furthermore, it has long been known that access to safe abortion is extremely unevenly distributed. Where abortion legislation is restrictive, wealthy women purchase safe abortions, frequently on the private health market. Poor women must resort to untrained quacks or to self-induced abortions (14). A glimmer of hope can be found in the fact that medical abortions are available to a greater extent now than earlier and that mortality due to illegal abortions is declining somewhat. This is largely due to the availability of Misoprostol, an inexpensive medicine registered in most countries.

When there are complications as a consequence of unsafe abortions, women are vulnerable to financial exploitation by health personnel. And in terms of involuntary infertility, the consequences are significantly greater for poor women than for the wealthier, because the poor are often completely dependent on their ability to reproduce in order to lead a decent life. Assisted reproduction technology is basically non-existent in poor countries, and what little exists is reserved for the economic elite.

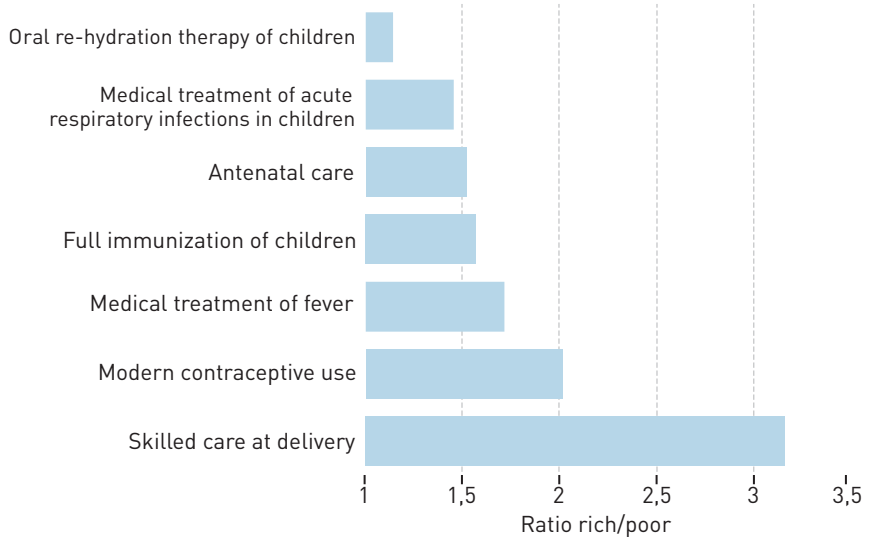

Figure 1 *The figure shows the ratio between use of health services among the richest 20 % of the population as opposed to the poorest 20 %. Based on Campbell White and co-workers (13). Reproduced with the permission of Universitetsforlaget (3)*

Human rights

The fundamental, core value in human rights is non-discrimination. Human rights can be used to resolve controversies, particularly in political, cultural and religious areas of contention. This is absolutely not neutral ground – very many of the controversies in the global health arena involve the very issues of human rights.

Human rights are particularly relevant in terms of the great social disparities in reproductive health (15). «The highest attainable standard of health» is a human right according to Article 12 of the International Covenant on Economic, Social and Cultural Rights. It is dual in nature – it includes the right to health services, but it also encompasses the underlying conditions that promote or harm health (16). Both aspects are particularly relevant for reproductive health.

Women experiencing life-threatening complications in conjunction with deliveries and unsafe abortions may need emergency medical services with a high degree of technology and skills. Therefore pregnancy related care must be given priority within health services; services that are often under strong pressure. The underlying health determinants are crucial for reproductive health. The economic status and the educational level of a woman or girl are decisive in terms of whether she has control over her own sexuality, whether she can choose to use contraceptives, protect herself against sexually transmitted infections, whether she is able to receive qualified help in connection with pregnancy, delivery or abortion, and whether she can get help for infertility (13). Young girls are particularly vulnerable.

All countries that have ratified a convention must regularly report to the treaty body as to how the incumbent obligations are being followed up. A number of conventions have proved to be relevant for reproductive health, and on countless occasions countries have received feedback from the treaty body enjoining them to change legislation and practices in order to offer family planning services, skilled care during pregnancy and abortion care (15).

Regional human rights conventions have courts of law, and verdicts from these have a normative impact, in addition to sanctions implemented against states that breach their human rights obligations. The European Court of Human Rights, for example, has ruled that the Polish government had to pay compensatory damages to a woman who was unable to have an abortion performed and developed serious eye complications, a condition that her doctor predicted would occur. Another woman who had been denied genetic testing and abortion was also awarded indemnification (17).

Political support – and resistance

All of the three millennium goals pertaining to health concern various aspects of sexual and reproductive health. This shows that there is strong political support for reproductive health in the top levels. Our own Prime Minister is a member of a network of state and governmental leaders who support MDG 5, although the part pertaining to births has received more attention that the other aspects of reproductive health services.

But political opposition is also considerable. The USA leads the way. American resistance to safe, available abortion services is strong and increasing (18), and there is continued, strong insistence on

maintaining sexuality education models that have proven to be nonfunctional (19). Countries in Africa, parts of Asia and particularly in Latin America which are heavily Roman Catholic-dominated, still have strict anti-abortion laws that are the legacy of colonial times. Whereas the former colonial powers have long since liberalized their laws, the developing countries, ironically, purport that their anti-abortion laws are a 'part of their culture'. Over time, however, there has been a general tendency towards liberalization of abortion laws throughout the world. The exceptions are countries in which the statutes have become even more restrictive, such as in Nicaragua (20).

Africa is the continent that has the greatest problems associated with reproductive health. But Africa also has a brilliant plan – the Plan of Action on Sexual and Reproductive Health and Rights – also known as the Maputo Plan of Action adopted by the ministries of health in the African Union (21). Good intentions on the national level, however, are far from sufficient. Health services are decentralized in the majority of countries. This leaves local politicians and administrators with great influence – and major transformations are required.

To be sure, «quick fixes» are sought high and low, and unfortunately it is all too frequently said that simple measures are all that is necessary to reduce maternal mortality. This is instrumental in leading decision makers to the conclusion that the task is simple, that only a little good will is required along with a few «delivery kits», mobile telephones to communicate important information and referrals, or financial incentives to women who give birth in institutions. Individual measures such as these may be useful as part of a whole, but alone they may be either ineffective or directly harmful (22).

The wheel has come full circle – fragmentation revisited

The intention behind the term «reproductive health» was to put in place health services based on actual sexual behaviour and its consequences, services that were well integrated at various levels of the health service and with an understanding of the underlying factors such as gender roles and division of power.

This was a reaction to the overzealous focus earlier on family planning, which was frequently implemented «vertically», that is, as a separate service without roots in the general health service. But since parts of reproductive health touch on sensitive areas, and because we live in an era with strong emphasis on measurable results, reproductive health has again become fragmented.

Is there still hope?

One encouraging global trend is that increasing efforts are being made to call attention to social inequalities, to use human rights and other means in order to promote social justice and to work against religious and cultural practices which harm reproductive health. Moreover, great opportunities lie in the democratization of knowledge that we are currently witnessing. The sexuality of young people and the issue of abortion are areas in which there is a global consensus, but in which there is nonetheless a high degree of political resistance. In both of these fields, access to information is crucial, in terms of both sexuality and the use of Misoprostol to induce abortion in a safe manner. Perhaps the democratization of knowledge can also result in a revolution when it comes to reproductive health in the world. It is urgently needed.

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References

1. Programme of Action. Adopted at the International Conference on Population and Development, Cairo, 5–13 September 1994. New York: FN, 1994. www.un.org/popin/icpd2.htm (31.8.2011).
2. Tranøy KE. Medisinsk etikk i vår tid. 4. utg. Bergen: Fagbokforlaget, 2005.
3. Austveg B. Kvinners helse på spill. Et historisk og globalt perspektiv på fødsel og abort. Oslo: Universitetsforlaget, 2006.
4. The total abortion ban in Nicaragua. Women's lives and health endangered, medical professionals criminalized. London: Amnesty International, 2009.
5. The Holy See's explanation of position, commission on population and development 44th Session, New York, 11–15 April 2011. New York: FN, 2011.
6. Statement of interpretation by the Holy See on the adoption of the political declaration on HIV and AIDS. New York, 10 June 2011. www.hivnorge.no/asset/1613/1/1613_1.pdf (13.6.2011).
7. General Assembly. Political declaration on HIV/AIDS: intesifying our efforts to eliminate HIV/AIDS. 8 June 2011. New York: FN, 2011. www.un.org/ga/search/view_doc.asp?symbol=A/65/L.77 (19.6.2011).
8. Lie SO, Gulati D, Sommerfelt H et al. Tusenårsmålene for helse – rekker vi dem innen 2015? Tidsskr Nor Legeforen 2011; 131: 1904–6.
9. Hogan MC, Foreman KJ, Naghavi M et al. Maternal mortality for 181 countries, 1980–2008: a systematic analysis of progress towards millennium development goal 5. Lancet 2010; 375: 1609–23.
10. Trends in Maternal Mortality: 1990 to 2008. Estimates developed by WHO, UNICEF, UNFPA and The World Bank. Genève: WHO, 2010.
11. Fact on satisfying the need for contraception in developing countries. Updated November 2010. New York/London: Guttmacher Institute/IPPF, 2010.
12. World fertility patterns 2009. United Nations Department of Economic and Social Affairs. Population Division. Wall Chart. New York: FN, 2009.
13. Campbell White A, Merrick TW, Yasbeck AS. Reproductive health. The missing millennium development goal. Poverty, health and development in a changing world. Washington D.C.: Verdensbanken, 2006.
14. Warriner I, Shah I. Preventing unsafe abortion and its consequences. Priorities for Research and Action. New York: Guttmacher Institute, 2006.
15. Cook R, Dickens BM, Fathalla MF. Reproductive health and human rights. Integrating medicine, ethics and law. Issues in biomedical ethics. Oxford: Clarendon Press, 2003.
16. The right to the highest attainable standard of health: 11.08.2000. E/C 12/2000/4 (general comments). United Nations Economic and Social Council. New York: FN, 2000.
17. Zebley J. Europe rights court rules against Poland in abortion case. May 27, 2011. http://jurist.org/paperchase/2011/05/europe-rights-court-rules-against-poland-in-abortion-case.php (19.6.2011).
18. Joffe C. Dispatches from the abortion wars. Boston: Beacon Press, 2009.
19. Fact on American teens' sources of information about sex. In brief: fact sheet. New York: Guttmacher Institute, 2011. www.guttmacher.org/pubs/FB-Teen-Sex-Ed.html (19.6.2011).
20. World abortion policies 2011. Unites Nations Department of Economic and Social Affairs. Population Division. Wall Chart. New York: FN, 2011.
21. Plan of Action on Sexual and Reproductive Health and Rights (Maputo Plan of Action). Addis Abeba: The African Union Commission, 2006.
22. Oxman AD, Fretheim A. Can paying for results help to achieve the Millennium Development Goals? A critical review of selected evaluations of results-based financing. J Evid Based Med 2009; 2: 184–95.

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