

Reducing maternal morbidity begins with family planning

International Planned Parenthood Federation

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Introduction

Maternal morbidity is an area of women's health that represents great injustice and inequity, between and within countries. It impedes individual, community, national and global development. Current estimates suggest that more than 54 million women suffer from diseases or complications during pregnancy and childbirth worldwide¹, including complications from unsafe abortion. More easily measured than morbidity, the number of maternal deaths is a reliable indicator to track trends and progress in maternal mortality. However, the ubiquity of this term as a proxy for maternal health means that the non-fatal consequences of pregnancy and childbirth are frequently overlooked. At the recent Panel on Maternal Mortality and Human Rights, hosted by the Human Rights Council, Dr Francisco Songane said: "Besides death, there is also disability. For every woman who dies another 30 suffer from injury, infection and disability... The list of illnesses, or morbidities, is very long."²

Just as morbidity is often ignored in favour of mortality statistics, so too are the determinants of maternal health that extend beyond pregnancy, childbirth and the post-natal period. Maternal health is affected by the state of a woman's sexual and reproductive health (SRH) in advance of any pregnancies she might have, as well as other factors such as her education and decision-making power, the health of her sexual partner(s), and the number and spacing of her pregnancies. Interventions to improve women's health during and after pregnancy and childbirth must therefore contribute to good SRH for women and men throughout their lives. Women, especially, must be empowered; they must have the freedom to make choices. Family planning enables women not only to prevent unwanted pregnancies and have safer sex^{*}, but to plan their families and their lives. Together with emergency obstetric care and the attendance of skilled attendants at every birth, family planning is one of the three pillars of maternal health.

Family planning should be situated within a health systems framework that incorporates a life-cycle approach to health and recognizes a diversity of providers and carers. Male partners, parents, teachers, local and national governmental and non-governmental health care providers, community and religious leaders and village elders each have a role to fulfil in promoting and ensuring good SRH and improving the health of women before and beyond pregnancy and childbirth. Implementing services and programmes that meet the needs of vulnerable groups, including young people and people living with HIV and AIDS, must be given particular attention. When women and couples have access to comprehensive family planning and abortion services, and when they feel safe and supported to decide whether, when and how many children to have, the health and human development of women improves.

The gains that contraception has made possible in women's health makes family planning one of the most successful international development stories, not to mention one of the most cost effective.

* Sex can be made safer with the use of male or female condoms. Only barrier methods of contraception protect against sexually transmitted infections, including HIV.

Family planning is maternal health

Family planning is vital to improving maternal health because it gives women the power to control their own bodies and manage their lives. Millennium Development Goal 5, to improve maternal health, includes the target of universal access to reproductive health by 2015. This is recognition at the international level that family planning is crucial to women's health.

At its most fundamental level, contraception enables women to reduce the number of pregnancies they have, and thus reduce their lifetime risk of maternal morbidity and mortality. When women are aware of family planning but are denied access to it, they will have more pregnancies than they want.^{3,4} Every year, there are 80 million unintended pregnancies.⁵ If unmet need for contraception was met in developing nations, 52 million unintended pregnancies would be avoided.⁶ Preventing unwanted pregnancies in turn prevents unsafe abortion, which contributes significantly to maternal morbidity. One in ten pregnancies ends in unsafe abortion.⁷

Women and their children benefit when women can space their pregnancies through family planning. Pregnancy and breast-feeding draw from a woman's resources and the impact on her health can be severe, particularly if she breastfeeds from one pregnancy to the next,⁸ as is common in developing countries. Nutritional deficiencies, anaemia, protein deficiency and iodine deficiency (goitre) are common outcomes in both mother and child.⁹ Women grow progressively weaker with continuous rounds of pregnancies, and become more vulnerable to infection and illness.¹⁰ The assault is exacerbated if the woman is expected to carry out demanding duties such as housekeeping, childcare and agricultural work throughout.

When women are in good health and empowered to plan their lives by using contraception, they are more likely to continue their education, to participate in the labour force, to engage in society, to be involved in governance and drive development.

Family planning prevents unsafe abortion

Unsafe abortion accounts for an inexcusable amount of maternal morbidity. Every single year, there are nearly five million women around the world who suffer temporary or permanent disability as a result of unsafe abortion.^{11,12} In Latin America, at least 30 per cent of hospital beds dedicated to obstetric and gynecology services are occupied by women suffering from abortion-related complications.¹³ These figures are tragic, but in reality unsafe abortion is even more prevalent as it is constantly under-reported and misclassified.¹⁴

When women do not have access to abortion services, they are forced to turn to unsafe abortion and may face a number of serious health consequences. These include: incomplete abortion (when some tissue remains in the uterus); infection of uterine tissue; heavy bleeding; and uterine perforation (may occur if a sharp object is inserted in the uterus).^{15,16} Untreated, these complications may result in disabling and chronic conditions such as chronic pelvic pain, pelvic inflammatory disease, reproductive tract infections and infertility.¹⁷

The experience of the Planned Parenthood Association of Ghana (PPAG) is a clear example of what happens when family planning services and methods are unavailable. PPAG

operates an extensive community-based distribution service for family planning and SRH services. This service network allows PPAG to reach the most marginalized, rural and hard-to-reach people. At its peak, PPAG was the second largest distributor of contraceptives in rural areas and third in the country. But in 2001, after the reinstatement of the Global Gag Rule which prohibits U.S. aid from supporting organizations that provide any abortion-related information or services, PPAG lost a significant amount of funding and was forced to cut services. Contraceptive distribution dropped from 7.8 million to 3.3 million; two clinics were closed; and the number of SRH services provided, including family planning and maternal health services, fell from 2.4 million to 664,176 services. Across the country, people were left without the supplies and services they needed and wanted. As a result, the number of unwanted pregnancies increased, and PPAG saw a dramatic rise in the number of women who were coming to them for care related to unsafe abortion.

Abortion services are a cost-effective intervention that reduces maternal morbidity related to unsafe abortion. Studies in Maputo, Mozambique, observed that treating patients for abortion complications is nine times more expensive than performing a clean, safe abortion.¹⁸ Medical abortion, a proven technology that requires fewer resources than surgery, makes abortion even more cost-effective.

People who are poor, marginalized and under-served are disproportionately affected by maternal morbidity

Adolescents and young women

Adolescent girls and young women are particularly vulnerable to maternal morbidity. More than 90 per cent of the 14 million births to adolescent girls are in developing countries, and the highest levels of adolescent pregnancy are in Africa.¹⁹ Many young women are pregnant or giving birth for the first time, and they may not be ready for the physical, mental and social repercussions of childbearing.

Maternal morbidity among young people is associated with marriage in many countries. Haberland et al. write that “more than half of girls are married by the age of 18 in Bangladesh, Burkina Faso, Chad, Mozambique and Nepal, with more than 40% married in Ethiopia, India, Malawi, Nigeria and the Yemen.”²⁰ Though some cultures encourage marriage at an early age, it is closely associated with sexual relations and pregnancy, which have a negative impact on young women: “it is clear that marriage and pregnancies among very young girls... involve great disadvantages for their education and psychological development, and are harmful to their health”²¹. Because girls and young women often have immature pelvic bones, when they are pregnant they face a real and dangerous risk of prolonged obstructed labour, which can lead to fistula, uterine prolapse, renal failure, pelvic inflammatory disease, infertility and neurological injuries. They also face a high risk of hypertensive disease.^{22,23} Even when they are aware of family planning, girls and young women often have very limited or no power to negotiate its use and/or the ability or resources to obtain it.

The expectation that (unmarried) young women should not be having sex means that they face multiple problems - physical, social and cultural - in accessing family planning methods and services, and as a result, they have more unwanted pregnancies than older women. A conservative estimate of the total number of abortions among adolescents in developing countries ranges from 2.2 to 4 million annually.²⁴ In many developing countries, hospital records of women treated for the complications of unsafe abortion suggest that between 38 and 68 per cent are under 20 years of age.²⁵

The rate of unsafe abortion and maternal morbidity among adolescents is one more illustration of the discrimination that persists in the provision of SRH services worldwide.

Women living with HIV

Like anyone else, people who are living with HIV have a right to sexual and reproductive health. This includes the right to a safe and satisfying sex life and the right to choose whether and when to have children.

Although there is limited research about the prevalence and nature of maternal morbidity among women living with HIV, the experience of IPPF Member Associations shows that pregnant women living with HIV are more vulnerable to infections and illnesses during and after pregnancy and childbirth, and the consequences can be more grave and long-term than among women who do not have HIV. IPPF Member Associations empower and support women living with HIV to prevent unwanted pregnancies and to plan their families. Prioritizing quality of care and access, they provide services to ensure that pregnant women living with HIV are healthy throughout their pregnancies and deliveries, and to prevent mother-to-child transmission.

Health providers must ensure that non-stigmatizing, appropriate family planning services - which include outreach services, peer education and community-based distribution - are available for groups that have a high prevalence of HIV and which are vulnerable to HIV.

Recommendations on making family planning universally available

Comprehensive family planning programming and methods

Family planning services should include individual (or couple) counselling about family planning methods and the choice of method from a range of different contraceptives[†]. Family planning services include information, education and communication about what family planning is and the benefits it provides. Health care providers, community leaders and parents should seek to eliminate commonly believed myths and cultural taboos that may prevent people from using contraception, despite a desire to control their fertility. This includes myths about the methods themselves, such as the commonly held belief that prolonged use of oral contraception leads to infertility, and cultural associations such as the belief that only prostitutes use condoms.

Family planning as an integral component of the health system

In order to make family planning universally available, family planning information and services should be integrated into a holistic health systems approach that recognizes health, including sexual and reproductive health, as a fundamental human right. This approach would incorporate a continuum of care. The continuum of care has two meanings: “first, it means care has to be provided as a continuum throughout the lifecycle... second it indicates that care has to be provided in a seamless continuum that spans the home, the community, the health center and the hospital”.²⁶

Family planning should thus be offered at multiple points throughout the life cycle. For example: information and sexuality education for adolescents and young people in particular; family planning methods and counselling for people as they begin their sexual lives; post-natal family planning services; and ongoing counselling and methods for women

[†] In accordance with the 1994 International Conference on Population and Development (ICPD) Programme of Action.

and men to ensure that they are able to use the method that is most appropriate for them throughout their adult life.

While contraception should certainly be an integral part of clinical services, it is also uniquely suited to delivery mechanisms that fall outside of the formal health system. In the context of improving maternal health, Freedman et al. write that the tenet of the health systems approach means addressing: “both the supply and demand side; both home and community dynamics and facility-based services in a home-to-hospital continuum of care”²⁷. A hallmark of IPPF’s service provision is its extensive network of community-based distributors, home-based care providers, mobile clinics, volunteer peer educators, midwives and support groups. This network makes IPPF Member Associations adept at reaching under-served groups and enables them to reach deeply into communities.

Involving male partners to improve maternal health

In the past, maternal health and family planning campaigns have been directed at women, underlining a commonly held belief that women should be held responsible for maintaining good SRH and are the natural guardians of children.²⁸ Neglecting to include men simply perpetuates this attitude: “targeting... women means that, to a certain extent, the burdensome roles imposed by traditional society on its women have simply been re-imposed on them by researchers and policy makers”²⁹.

Lack of discussion about family planning between partners is a serious obstacle to the uptake of contraception and the benefits it provides for maternal health. A study in urban Indonesia found that the husband’s approval was the strongest single predictor of a wife’s use of contraception³⁰. In August 2008, Africa News reported that many women in a southern Malawi district had been abandoned and beaten by their husbands when they found their wives in possession of female condoms.³¹ Women may not use contraception if they fear their partner would object³², and they may risk anger or violence should their partner find out.

The Brazilian IPPF Member Association - BEMFAM - and its partners piloted an innovative programme to instil more gender equitable attitudes among young men. Interactive group education sessions and a social marketing campaign encouraged young men to share responsibility for family planning and to be more supportive partners. After the programme, many of the participants identified changes in their attitudes. One man said, “Before (the workshops) I had sex with a girl, I had an orgasm, and then left her. If I saw her later, it was like I didn’t even know her. If she got pregnant or something, I had nothing to do with it. But now, I think before I act or do something.”

Bringing male partners, husbands and fathers into areas that are usually viewed as the ‘woman’s domain’, can directly benefit every member of the family. In fact, the greater the awareness and acceptance of family planning among different stakeholders, from community leaders to teachers to parents, the greater the improvement in maternal health.

Conclusion

Of all the Millennium Development Goals (MDGs), we have made the least progress towards achieving MDG 5 on improving maternal health. Target 5b under MDG 5 - universal access to reproductive health by 2015 - is recognition that family planning is fundamental to women’s health. Because some unwanted pregnancies are inevitable, even when contraception is used meticulously, women must also have access to comprehensive abortion services. Kofi Annan, former UN Secretary-General, said “The Millennium

Development Goals, particularly the eradication of extreme poverty... cannot be achieved if questions of population and reproductive health are not squarely addressed.”³³ Efforts to reduce inequity in health, in access education and employment, and to opportunities to participate fully in society and development must focus on the poorest people and those who are repeatedly neglected and under-served. The facts are clear: unless there are significant increases in financial and political support for family planning and abortion services, we will not achieve the MDGs on maternal and child health or gender equality. We should take this opportunity to reinvigorate our efforts. We know what we need to do, the time to do it is now.

¹ Holly E. Reed, Marjorie A. Koblinsky, W. Henry Mosley, Committee on Population, National Research Council, Commission on Behavioral and Social Sciences and Education (2000) *The Consequences of Maternal Morbidity and Maternal Mortality: Report of a Workshop*. Washington, DC: National Academies Press.

² Songane, F. (2008) Speech on behalf of the Partnership for Maternal, Newborn and Child Health. Panel on Maternal Mortality and Human Rights (Human Rights Council), Geneva, 5 June 2008. Available at: www.who.int/pmnch/media/news/2008/20080606_unhumanrights_songanespeech.pdf [Accessed 31 July 2008]

³ Freedman, L.P., Graham, W.J., Smith, J.M., Ensor, T., Fauveau, V., Themmen, E., Currie, S. and Agarwal, K. (2007) Practical lessons from global safe motherhood initiatives: time for a new focus on implementation. *The Lancet*. Vol. 370, pp. 1383-1391.

⁴ Faundes, A. and Barzelatto, J. S. (2006) *The Human Drama of Abortion: A Global Search for Consensus*. Nashville, USA: Vanderbilt University Press.

⁵ Population Reference Bureau (2005) *Unsafe abortion: Facts and figures*. PRB: Washington.

⁶ Singh S, Darroch JE, Vlassoff M, Nadeau J. (2004) *Adding it up: the benefits of investing in SRH care*. New York: AGI. Available at: www.guttmacher.org/pubs/covers/addingitup.html [accessed 2 October 2007]

⁷ Population Reference Bureau. Ibid.

⁸ Santow, G. (1995) Social roles and physical health: The case of female disadvantage in poor countries. *Social Science Medical*, 40(2), pp 147-161.

⁹ Santow. Ibid.

¹⁰ Kitts, J. and Roberts, J.H. (1996) *The Health Gap: Beyond Pregnancy and Reproduction*. Ottawa, Canada: International Development Research Centre.

¹¹ World Health Organization (2007) *Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003*. 5th edition. Geneva: WHO.

¹² World Health Organization (2007) Ibid.

¹³ Faundes, A. and Barzelatto, J. S. Ibid.

¹⁴ Hindin, M. J. (date?) Contraception, safe abortion, and maternal morbidity. *The Lancet*. Vol 370, pp1294-95.

¹⁵ Population Reference Bureau. Ibid.

¹⁶ Faundes, A. and Barzelatto, J.S. Ibid.

¹⁷ Population Reference Bureau. Ibid.

¹⁸ Faundes, A. and Barzelatto, J.S. Ibid.

¹⁹ World Health Organization (2006) *Pregnant Adolescents: Delivering on Global Promises of Hope*. Geneva: WHO.

²⁰ Haberland, N., Chong, E. and Bracken, H. (2003) *Married Adolescents: An Overview*. Paper prepared for the WHO/UNFPA/Population Council Technical Consultation on Married Adolescents, 9 December 2003. Geneva: WHO.

²¹ World Health Organization (2004) *Adolescent Pregnancy: Issues in Adolescent Health and Development*. Geneva: WHO.

²² Holly E. Reed, Marjorie A. Koblinsky, W. Henry Mosley, Committee on Population, National Research Council, Commission on Behavioral and Social Sciences and Education. Ibid.

²³ This is partly because incidence of hypertension is much higher in first pregnancies than in subsequent pregnancies, and there is a much higher rate of first pregnancies among adolescents than in older women. World Health Organization (2004) Ibid.

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- ²⁴ Olukoya AA, Kaya A, Ferguson BJ, AbouZahr C. (2001) Unsafe abortion in adolescents. *International Journal of Gynecology and Obstetrics*. Vol. 75, pp. 137-147.
- ²⁵ World Health Organization (1993) *The health of young people: A challenge and a promise*. Geneva: WHO.
- ²⁶ World Health Organization (2005) *World Health Report 2005: making every mother and child count*. Geneva: WHO.
- ²⁷ Freedman. Ibid.
- ²⁸ Bernstein, S. and Hansen, C. J. (2006) *Public Choices, Private Decisions: SRH and the Millennium Development Goals*. Geneva: United Nations Development Programme.
- ²⁹ Santow. Ibid.
- ³⁰ Santow. Ibid.
- ³¹ Chirombo, R. (2008) Women abandoned because of condoms. *Africa News*. 14 August 2008. Available at: www.africanews.com/site/list_messages/19914. [Accessed 12 September 2008.]
- ³² Santow. Ibid.
- ³³ United Nations (2002) Press release: Millennium Goals Cannot be Achieved if Population, Reproductive Health Issues are not Squarely Addressed, Secretary-General tells Asian Population Conference. 17 December 2002. Available at: www.unis.unvienna.org/unis/pressrels/2002/sgsm8562.html