

The Role of Reproductive Health for Attainment of the Millennium Development Goals

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Abstract

Universal access to reproductive health services is a major aim of current efforts towards attaining the Millennium Development Goals, and reproductive rights and poverty reduction are crosscutting issues for this current focus of international development. Political statements should be complemented by financial commitments for mobilizing resources and the formulation of country-owned action plans. Upscaling services will necessitate strengthening health systems, integrating care, and building capacities. Policy makers, service providers, and stakeholders have responsibilities and duties to ensure that frameworks are available for the adequate provision of services. The implementation of multiple international development strategies currently constitutes a priority for reaching the targets by 2015.

Résumé

L'accès universel aux services de santé génésique représente l'un des principaux objectifs des efforts déployés présentement en vue d'atteindre les objectifs du Millénaire pour le développement. Les droits génésiques et la réduction de la pauvreté sont deux sujets qui sous-tendent cet aspect du développement international. Les déclarations politiques devraient s'accompagner d'engagements financiers visant à mobiliser les ressources, et de la formulation de plans d'action particuliers à chaque pays. L'élargissement des services nécessitera le renforcement des systèmes de santé, l'intégration des soins et le renforcement de la capacité. Il incombe aux décideurs, aux fournisseurs de soins et aux parties intéressées de s'assurer de l'existence de cadres de travail permettant la prestation adéquate des services. La mise en œuvre de stratégies multiples de développement international constitue présentement une priorité en ce qui a trait à l'atteinte des objectifs d'ici 2015.

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INTRODUCTION

The Millennium Development Goals (MDGs) largely reinforce actions to support reproductive health that were agreed upon in the intergovernmental conferences of the 1990s, such as the International Conference on

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Population and Development (ICPD) held in Cairo in 1994.¹ This approach was reinforced at the World Summit in September 2005 through support for the goal of universal access to reproductive health care, which was first adopted in the Programme of Action of the ICPD and reiterated in the key actions that were recommended at its five-year follow-up in 1999.^{2,3} A rights-based approach underpins the operationalization of strategies and the implementation of interventions for reproductive health.

Poverty reduction, the subject of the first MDG, has been the focus of international development efforts since the 1990s and was given increased emphasis in 2000 with the Millennium Declaration and the resulting commitment.⁴ Whereas the eighth and last MDG aims at developing a global partnership for development, the other seven MDGs can be specifically related to reproductive health (Table 1): goals 3, 4, 5, and 6, for gender equality, reduced child mortality, improved maternal health, and control of the human immunodeficiency virus (HIV), are directly implicated, and the three other goals are more indirectly involved. The lack of a goal dedicated to reproductive health has been deplored, and the circumstances leading to this situation have been subject to extensive analyses.⁵

Whereas MDG4 aims to reduce child mortality, the improvement of maternal health is the focus of MDG5. There is a major contrast in the formulation of those two MDGs pertaining to mothers and children: health and mortality have similar relationships to biological factors for disease etiology in children, but the situation is very different for maternal health because pregnancy is not a disease. Because family planning is not specifically addressed in the MDGs, it has not received adequate emphasis lately in policy discussions and funding priorities. This situation has stalled improvements in contraceptive prevalence in several countries, thus also affecting sexually transmitted infections, including HIV.⁶

Table 1. The Millennium Development Goals

1. Eradicate extreme hunger and poverty
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV/AIDS, malaria and other diseases
7. Ensure environmental sustainability
8. Develop a global partnership for development

LINKAGES BETWEEN GOALS

MDGs have been related to quantitative targets that should be achieved within defined time spans, usually by 2015, and related indicators have been agreed upon. A cursory glance at the eight MDGs, 18 targets, and 48 indicators demonstrates the substantial linkages between MDGs. The eighth and last MDG promotes global partnerships for resource mobilization, thereby enabling the implementation of action plans. Environmental sustainability, the subject of the seventh MDG, is promoted by family planning to control use of natural resources, encroachment onto agricultural areas, and related issues such as poverty. The first six MDGs have even closer interlinkages.

There is much in common between the second and third MDGs, which address education and gender equality respectively. In developing countries, the risk of school drop-out increases with the number of siblings, and daughters are more likely than sons to stay at home to help with household duties. Teenage pregnancy is another important reason for abandoning education. Access to contraception and the gender dynamics of child marriage are important influences. The promotion of gender equality includes male involvement in numerous aspects of reproductive health to ensure uptake of services, such as antenatal care and family planning, as well as to prevent gender-based violence.⁷ Female genital mutilation and the trafficking of women are also important gender issues with major implications for reproductive health.

Core issues for reproductive health are addressed in the fourth, fifth, and sixth MDGs regarding child mortality, maternal health, and the control of HIV respectively. The improvement of maternal and child health goes far beyond mortality reduction, and there is much common ground in the provision of services to mothers and children.⁸ The three pillars for maternal mortality reduction are family planning, skilled birth attendance, and emergency obstetric care.⁹

Many of the MDG targets are expressed in terms of population rates and ratios, particularly for the first seven MDGs. Population growth, however, particularly growth resulting from unwanted pregnancies, can convert a modest change in percentage figures into a significant increase in the number of individuals living in poverty. Shifts in the age structure of the population due to either fast or slow demographic transitions can also affect the potential for, and challenges to, MDG progress: several targets relate to specific, usually young, cohorts. Efforts are required to slow continued population momentum, due to the large proportions of young people in poor countries, through later marriage and longer birth spacing, to achieve faster progress. Lower fertility provides an opportunity to profit from a demographic bonus as dependency levels fall. Some analyses insist that population growth remains as severe a challenge to African development as the impact of the HIV/AIDS pandemic.¹⁰

REPRODUCTIVE HEALTH SERVICES

The central components of reproductive health are maternal health, family planning, and the control of sexually transmitted diseases including HIV and cervical cancer.¹¹ Their interlinkages are exemplified by the role of family planning as a pillar for maternal mortality reduction, antenatal care for the prevention of congenital syphilis, and the availability and use of condoms for dual protection from unwanted pregnancy and sexually transmitted infections. Other components of clinical importance include preventing gender-based violence and traditional practices such as female genital mutilation. A life-cycle approach to reproductive health places appropriate emphasis on adolescence and menopause. The international agreement on reproductive health in the Programme of Action of the ICPD went much further by taking a comprehensive perspective, as reflected in its incorporation of goals and targets pertaining to universal access to primary education, gender equity, and reduction of child mortality, which were subsequently embraced by the MDGs.

The maternal mortality rate is 400 per 100 000 live births worldwide, ranging from 24 in Europe to 920 in sub-Saharan Africa, where higher fertility leads to a lifetime risk of 1 in 16. Unsafe abortion is the cause of 13% of the 529 000 maternal deaths that occur annually. Irrespective of national abortion policies,¹² efforts should be directed towards managing the complications of abortion, including the use of manual vacuum aspiration.

Despite its value in preventing recourse to abortion, emergency contraception unfortunately continues to be a much underutilized method of birth control. As reproductive rights emphasize the informed and voluntary choice of the

individual,¹³ a wide range of safe and effective contraceptive methods should be offered to allow responsible and appropriate decisions. The availability of a wide range of contraceptive methods is only the result of comprehensive research and development. The Programme of Action of ICPD recommended more research for developing new contraceptive methods and better use of available methods.¹ In public health services, unfortunately, scarce resources often require attention to cost-effective methods, and therefore may render some contraceptive methods less widely accessible than desired.

Numerous sensitive topics arise in the delivery of reproductive health services; for example, negative perceptions regarding adolescent sexuality and the provision of contraception, and vaccination against the human papillomavirus. Culturally appropriate solutions need to be found at the national level. The challenge for health professionals is to present scientific knowledge in a form that will enable politicians and policy makers to adapt internationally accepted interventions for incorporation into service delivery.

Health reform should examine the interface between hospital and community and the mutual advantages for service providers and the public. Reproductive health services are provided mainly at the primary health care level, and the procurement of commodities is facilitated by the availability of national lists that draw upon the WHO list of essential drugs.¹⁴

Efforts for increasing the utilization of services should focus on feasible interventions to address unmet needs. Service provision should have features that overcome obstacles, especially for those individuals who find it difficult to seek care. The role of behaviour change communication should become more prominent.

The initial response to the HIV epidemic used the traditional infectious disease model, which, being vertical, failed to consider crucial aspects of HIV control that are now embodied into measures based on a sexual and reproductive health approach: contraception, mother-to-child transmission, and attention to the impact of gender roles and adolescent sexuality. A similar concern can be raised for the earlier control of sexually transmitted infections. While the debate continues on the relative contributions of A(bstinence), B(e faithful), and C(ondoms) to the decline in HIV incidence in Uganda,¹⁵ there is no doubt that there is a need for comprehensive approaches that are tailored to the local dynamics of the pandemic.

A comprehensive reproductive health approach also recognizes the importance of community involvement and community health workers as contributors to functioning health systems. Culture has often been a much-neglected aspect in the planning of reproductive health services. At a superficial

level, culture applies largely to the acceptability of specific topics such as abortion, contraceptive services for adolescents, and public information in the media; but more profoundly, it relates to national and local ownership and support of programs. National experience shows that progress in reproductive health can occur within a variety of cultural settings.¹⁶

PRIORITIES

The selection of priorities for resource allocation should recognize the wide etiology of reproductive health outcomes and the value of stakeholder analysis. With equity being at the forefront of efforts for poverty reduction, reproductive health has been the subject of extensive research: quintile studies have demonstrated the existence of serious inequities that need to be addressed in view of the current large differentials in access to care.¹⁷ Even in the absence of monetary obstacles for access to services, privileged individuals have a better utilization of services than the poor.¹⁸ Demand creation is crucial for reducing the equity gap, and the design of services should emphasize outreach with a community-based approach that targets deprived groups such as rural populations, adolescents, and poor people.

Of the 34 countries in the most precarious position to attain the MDGs, 22 have recently faced humanitarian crises,¹⁹ and it should be recognized that those entangled in crises, whether due to natural disaster or to social disruption, still have reproductive rights. Those rights should be addressed through the provision of appropriate services that extend beyond the conventional components of reproductive health to trauma and malnutrition, while care is taken to avoid coercion leading to "sex for food and shelter" situations.

The United Nations Millennium Project²⁰ identified priority interventions that could quickly produce results and catalyze change in support of attaining the MDGs, and the World Summit² endorsed their national implementation. The Reproductive Health Quick Impact Initiative aims to facilitate access to reproductive health services while decreasing the monetary gap for the availability of commodities.¹⁹ This initiative recognizes the high levels of unmet demand for contraception and safe delivery services, particularly among the poor, and recognizes the importance of effective supply and logistics components in the general strengthening of health systems.

Reproductive health services should be integrated into primary health care through a constellation of services, but quality considerations are necessary to maintain standards of care. The applicability of various strategies that are known to be effective in resource-rich settings should also

be investigated in resource-poor settings so that they may, if necessary, be adapted before being implemented. Much remains to be done to define the practical aspects of integration, which are often misunderstood. Theoretical approaches to the philosophy of integrated services should be considered in the actual context of resource-poor situations. With only one or two health workers to provide comprehensive services at each facility, service delivery is automatically and necessarily integrated. The problem often lies at higher levels of the health services, with a lack of coordination between different directorates for the various components of reproductive health. Better integration at policy and administrative levels can improve efficiency and impact.

Interventions targeting young people exemplify a prime area for the integration of reproductive health services. The risk of dying from complications related to pregnancy or childbirth is much higher for teenagers. Further, the provision of contraception to young people, including young married people, is often contentious. Moreover, more than half of new HIV infections occur among youth.⁶ The technical competence of staff is crucial for quality of care, which in itself leads to increased demand for services. Capacity building should aim to strengthen training institutions in the long term by ensuring a solid base for reproductive health in the basic curricula of health professionals.²¹

Demonstration of the effectiveness of interventions is essential before scaling up services. With increasing coverage, marginal costing becomes more important. There is a lack of relevant data, especially as pertain to the appropriate employment of staff and the impact of socio-economic factors and urban or rural residence.²²

There is an acute need for trained personnel. The lack of human resources for health crises, aggravated by out-migration, is acute and requires innovative solutions. Cadres of non-clinical personnel, including community leaders, motivators, and service deliverers, are also needed to promote health-seeking and preventive behaviours and to improve accountability.

EVALUATION

At the five-year follow-up of the ICPD in 1999, benchmark indicators were approved for monitoring progress in the implementation of its recommendations.³ It was agreed that (a) the gap between contraceptive use and demand should be reduced 50% by 2005, 75% by 2010, and 100% by 2015; (b) the proportion of births assisted by skilled attendants should increase to 80% by 2005, 85% by 2010, and 90% by 2015; and (c) the HIV infection prevalence rate in the age group of 15 to 24 years should decrease by 25% by 2010.

It would be much easier to achieve progress on the MDGs by directing resources to relatively privileged, as opposed to disadvantaged, groups. However, this approach would be inappropriate in view of the need to also address inequity.¹⁷ A strategy to reduce poverty should reflect real progress among the poor, not just relative progress on the aggregate level. Data should therefore be disaggregated by age and gender and, where possible, by geographical area and income quintile to elucidate disparities and to promote their use for policy formulation and decision-making, including targeting interventions.

The selection of indicators for monitoring progress towards meeting the targets of the MDGs that pertain directly to reproductive health (Table 2) had to be restrictive in view of the wide range of available indicators.²³ In the case of reproductive health, the placement of certain indicators, such as contraceptive prevalence, in the sixth MDG under HIV control, instead of in the fifth MDG under maternal health, can be questioned. This situation might yet be redressed. Family planning services definitely improve maternal and child health, and except for the use of condoms, are more relevant to this concern than to HIV control.

A reduction in the maternal mortality ratio is currently the only target for the MDG of improving maternal health (Table 2). With the practical difficulties in its measurement in developing countries, the maternal mortality ratio has major limitations as an indicator. It cannot capture time trends effectively, so its value lies largely in providing a rough estimate of the magnitude of the problem. Therefore, that target has been linked to the presence of skilled attendants at birth as a process indicator. The presence of skilled attendants should not, however, be perceived as a proxy for reduction in maternal mortality: effective availability of emergency obstetric care would be a more direct measure.

Good governance implies attention to the views of recipients of services and transparency in the awarding of contracts to avoid corruption. It would be valuable for the evaluation of service delivery to incorporate direct feedback from targeted groups of intended beneficiaries to supplement proxy measures such as responses from civil society and non-governmental organizations.

FINANCIAL RESOURCES

At the ICPD, countries reaffirmed their commitment to devote 0.7% of gross domestic product to development assistance and furthermore agreed that 4% of official development assistance would be devoted to population activities, but only a few countries have met those commitments.¹⁹ External support has also been received from other donors, such as non-governmental organizations and charitable foundations. National resources constitute most

Table 2. Selected targets and indicators for reproductive health in the Millennium Development Goals

Goals	Targets	Indicators
Reduce child mortality	Reduce by two thirds, between 1990 and 2015, the under-five mortality rate	Infant mortality rate
Improve maternal health	Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	Maternal mortality ratio Proportion of births attended by skilled health personnel
Combat HIV/AIDS	Have halted by 2015 and begun to reverse the spread of HIV/AIDS	HIV prevalence among pregnant women aged 15–24 years Condom use rate of the contraceptive prevalence rate Condom use at last high-risk sex Percentage of population aged 15–24 years with comprehensive correct knowledge of HIV/AIDS Contraceptive prevalence rate

of the funds for reproductive health services in developing countries, but it should be acknowledged that personal out-of-pocket expenditures constitute a substantial portion of domestic spending on reproductive health.

ICPD was unique in the series of intergovernmental conferences of the 1990s in estimating the cost implications of implementing activities pertaining to the central components of its Programme of Action. Supplementary resources are now required for the implications of the MDGs in the area of reproductive health.

Efforts must be directed to increasing the prominence of reproductive health in national action plans for achieving the MDGs. Reproductive health should be fully incorporated into national poverty reduction strategies and included in discussions for health sector-wide approaches. Coordination between donors is crucial, but the role of the private sector should be given more consideration for its financial support and technical contribution beyond its traditional role as supplier to the market.

CONCLUSION

Following the intergovernmental consensus on the MDGs and their implications, it is timely that solutions be formulated for the substantial challenges that are being faced, especially for achieving the ambitious targets in some countries. An intersectoral approach is needed, especially with the potential roles of education, gender, and communications, including transport, for achieving targets related to reproductive health. It is crucial to address the multiple dimensions of exclusion and need when dealing with current inequities in health.

Without any doubt, the reproductive health discourse will touch on controversial issues, but persistent activism for the inclusion of a reproductive health target in strategies to attain the MDGs should not be to the detriment of offering

necessary and supportive services. Political statements should be translated into commitments that lead to resource mobilization for program interventions. Additional resources will be needed, and coordinated efforts will be necessary, with a regional exchange of lessons learned. An international perspective is necessary to overcome obstacles that block progress in achieving targets and attaining the MDGs.

The long-term sustainability of efforts will depend largely on national capacity building, for both individuals and institutions. The allocation and prompt disbursement of funds, through accelerated financial procedures, will reflect commitment to reproductive health. Refinements to budgetary estimates will depend on further assessments of needs, both for direct service provision and for impact and efficiency evaluation to strengthen health systems. This approach will accelerate scaling up of services and increase the priority that is accorded to monitoring and accountability.

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