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Gender perspectives on global public health:
Implementing the internationally agreed development goals, including the MDGs

Written statement*

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* The views expressed in this paper are those of the author and do not necessarily represent those of the United Nations.

The Health-related MDGs

The commitment to strengthening health systems has unprecedented urgency as the world moves inextricably toward the deadline to reach the goals and targets of the Millennium Declaration. Clearly, reaching each of the health-related MDGs is vital for their own sake – MDG 4 reducing child mortality, MDG 5 improving maternal health, and MDG 6 combating HIV/AIDS, malaria and other diseases. Sexual and reproductive health, an indisputable key component of MDGs 4, 5, and 6, is essential for general wellbeing, quintessential to women's equality and empowerment, and necessary for socio-economic development.

Inequity and the global burden of disease

Accessing sexual and reproductive health services, including those for maternal health, is a fundamental human right, and a significant determinant of global health status. Sexual and reproductive ill-health accounts for an estimated one-third of the global burden of illness and early death borne by women of reproductive age, and 20 per cent of all people worldwide. In Africa, it accounts for more than 40% of the disease burden. Women in low- and middle-income countries bear the brunt of the ill-health. The most striking inequities occur in accessing sexual and reproductive health services, especially maternal health, by income, degree of social marginalization and urban-rural locale. Of the three MDGs, attainment of MDG 5 has arguably shown the least progress. Despite some gains in select countries, there has been an overall stagnation in maternal indicators between 1990 and 2005, and no progress at all in low resourced countries of Sub Saharan Africa. This contrasts with progress reported in child survival and access to HIV treatment.

Every minute, a woman dies in pregnancy or childbirth, adding up to 536,000 pregnancy-related deaths per year with ninety-nine per cent of these deaths in developing countries. Ten to fifteen million women a year suffer severe or long-lasting illnesses or disabilities caused by complications during pregnancy and delivery, including infertility, depression and obstetric fistula. Maternal mortality represents one of the largest inequities in health. Universal access to sexual and reproductive health services, particularly to family planning services and to skilled birth attendants is not yet a reality and income disparities are a significant predictor of maternal mortality and morbidity. The risk of dying as a result of pregnancy or childbirth differs significantly by economic status from about 1 in 26 in Africa, to 1 in 7,300 in developed countries. Even within countries there is a marked difference in access to skilled birth attendants, a key intervention to improve maternal health, by a magnitude of six times between the lowest wealth quintile and the upper quintile. Similarly, globally, the proportion of women whose family planning desires are satisfied is linked to wealth quintile, with the poorest quintile lagging behind the richest in each region. Family planning is not only a right, it is essential for improving maternal health, reducing unintended pregnancies, limiting recourse to abortion, and lowering the chances of having a high risk pregnancy. These inequities in accessing quality services are heightened for young people who can be even more susceptible to poor sexual and reproductive health, exacerbated by child marriage, early childbearing, sexual coercion and violence, interrupted schooling, and increased vulnerability to HIV. More than 14 million adolescent girls, aged 10 – 19 years, give birth each year, resulting in one in every 10 births worldwide belonging to a teenage mother. Pregnancy and childbirth-related complications are the leading cause of death among 15 – 19 year old adolescent girls. Two-thirds of the 130 million children who are not in school are girls. Two million young girls are at risk of female genital mutilation/cutting every year.

MDG 5, with its target of universal access to reproductive health, is clearly a litmus test for health system capacity. The lack of progress is not only the fault of inadequacies in the health systems, but is related to gender inequality, harmful cultural practices, lack of education, and an increase in fragility of states due to conflict and other humanitarian disasters, all exacerbated by poverty.

Strengthening health services as part of a broader response

Health systems have a substantial potential contribution toward alleviating poor health but they are in dire need of strengthening to effectively deliver on the global promises for improving the lives of women and girls. The direct consequences of the failure to ensure sexual and reproductive health include *inter alia* maternal morbidity and mortality, infertility and unintended pregnancies, obstetric fistula, sexually transmitted infections including HIV, reproductive tract infections, cervical and breast cancer, unsafe abortion, and gender-based violence. And there are other far-reaching socio-economic consequences stemming from poor health status.

Human resources must be strengthened, both in number and in quality. Health providers are often overworked, under- or even not paid, deprived of access to equipment to practice universal precautions, and not sufficiently supported through facilitative supervision. Capacity building is sorely needed to train health providers in state-of-the-art approaches, and to support their continued development through in-service training, including addressing judgmental and stigmatizing attitudes that some health providers exhibit toward people living with HIV, young people, and marginalized populations. Better deployment of health staff is needed to increase coverage to under-served areas. Reproductive health commodity security is also a neglected component of the health delivery equation. Clinics need to have a sustained supply of commodities, including contraceptives, female and male condoms, drugs, and other medical supplies. Functioning logistics systems need improvement to ensure they can forecast supply needs and respond better to real time demands. Each \$1 million shortfall in commodity support results in 360,000 more unintended pregnancies, 150,000 additional induced abortions, 800 maternal deaths, 11,000 infant deaths, and 14,000 additional deaths of children under 5.

Community outreach cannot be overstated as an essential ingredient in effective health systems. It takes community support and participation to help women access services, including changing harmful norms and practices, finding innovative solutions to health constraints such as transport, creating demand for services, following up clinic visits, linking health systems approaches with other important interventions such as income generation and education, and instilling an understanding of the value of sexual and reproductive health and reproductive rights. Participation of clients is a basic principle for improving health services, meaningfully engaging women's groups, youth coalitions, networks of people living with HIV, representatives of marginalized populations, and other stakeholders in the planning, implementation, monitoring and evaluation of programmes. New financing mechanisms can be devised such as vouchers that increase facility-based child birth and caesarean delivery when needed, improving outcomes for both the woman and her newborn. And monitoring and evaluation is absolutely essential, especially in the setting of increased accountability and financial crisis, to ensure better programme performance and quality of care.

Effective interventions

For most health goals, there is a well defined set of interventions that can have the most impact. For maternal health, here is a simple triad to save women's lives: 1) universal access to

contraception to avoid unintended pregnancies, 2) access to skilled care during delivery, and 3) rapid access to quality emergency obstetric care when required. Family planning has an optimal cost effective return, particularly in low-resource settings and when associated with the other two interventions in the 3-pronged approach. It can substantially reduce, by about 15 to 35%, the risk of mortality and morbidity associated with pregnancy and childbirth. Delay in the onset of pregnancies, by keeping girls in school, and through effective contraception once they are sexually active, affects the total number of pregnancies and avoids high risk childbirth. Secondly, skilled attendance at all births by professional midwives at the primary health care level combined with effective referral to facilities in case of complication have been fundamental in most of the countries that have succeeded in reducing maternal mortality and morbidity. But even under the best circumstances, 15% of pregnant women will experience complications, mostly unpredicted, but manageable. The World Bank has estimated that 74% of maternal deaths can be prevented with access to Emergency Obstetric Care. But as effective as these approaches are, safe motherhood programmes should ideally extend beyond health services and mobilize the community to encourage delayed marriage and childbearing, increase access of girls and young women to education and socio-economic opportunities, improve women's status thereby removing barriers to accessing health and social services, eliminate violence against women, and engage men and boys in these processes.

Linking HIV services with sexual and reproductive health services generates important public health benefits. A recent review of the evidence concluded that linkages improved access to and uptake of services, including HIV counseling and testing, health and behavioural outcomes, condom use, knowledge and the overall quality of the linked services. One of the pillars of sexual and reproductive health and HIV linkages is the four-element comprehensive approach to prevention of mother-to-child transmission of HIV (PMTCT). There have been significant gains in the percentage of pregnant women living with HIV receiving antiretroviral prophylaxis for PMTCT from 14 per cent in 2005 to 34% in 2007. However, more needs to be done to implement the full package of interventions required for effective PMTCT - primary prevention of HIV among women of childbearing age and prevention of unintended pregnancies among women living with HIV within a wider package of rights-based sexual and reproductive health. Moreover, integration of services is not the full extent of scope of linkages which should also address the structural determinants affecting both HIV and sexual and reproductive health such as gender inequality, poverty, youth, and rights issues. Linkages are grounded in human rights, bi-directional, require multiple models, and should address policy, systems and service delivery.

Reproductive rights and gender equality

Reaching the targets of the health MDGs will indeed require significant investments to improve the quality and reach of health services, especially for MDG 5. But although necessary, a purely health systems approach will not be sufficient. The health MDGs cannot be reached without a broader development and human rights approach. It will require achieving gender equality, socially and economically empowering women and girls, advancing educational attainment, meaningfully engaging communities and marginalized populations, ending harmful traditional practices such as female genital mutilation/cutting, delaying age at marriage, ending child marriage, improving girls' and women's nutrition, eliminating gender-based violence; sharing responsibility for care-giving, fostering responsible gender-sensitive attitudes of boys and men, and enabling full exercise of human rights, including reproductive rights. Of concern, especially in the setting of potentially weakened social services from lack of financing under economic crisis conditions, marginalized and poor women and girls are often more susceptible to exploitation, including child marriage, transactional sex for survival, more grueling working conditions and less job security, withdrawal from school, and decreased access to health services.

Reproductive rights, enshrined in the ICPD Programme of Action, are a cornerstone in building sustainable development and attaining the MDGs. But gender dynamics resulting in power imbalances between men/boys and women/girls have taken their toll. One in three women around the world is raped, beaten, coerced into sex or otherwise abused in her lifetime. Forty-five per cent of all new HIV infections occur among youth (aged 15-24), with young women accounting for nearly two-thirds, overwhelmingly in developing countries. In Sub-Saharan Africa, adolescent women are 2 to 4.5 times more likely to become HIV positive than their male counterparts. Health programmes that do not take into account the need for linked interventions to support gender equality and human rights, and the needs of young people and marginalized populations will condemn themselves to failure.

Violence against women is pervasive, affecting an estimated 1 in 3 women, often perpetrated by an intimate partner or family member. One woman in four has been abused during pregnancy. According to the World Bank, violence against women and girls worldwide causes more death and disability among women in the 15-44 year old age group than cancer, malaria, traffic accidents and war. The forms, physical and psychological, are varied and include domestic violence, sexual assault, rape, economic abuse, forced pregnancy, battering during pregnancy, sterilization, female infanticide, forced use or non-use of contraceptives, so-called 'honour' crimes, female genital mutilation/cutting, and sex trafficking. The consequences are equally varied and devastating both physically and emotionally. The direct reproductive health outcomes include unintended pregnancies, unsafe abortion, miscarriages, sexually transmitted infections (including HIV), high risk pregnancy complications, gynecological problems (including obstetric fistula) and psychological trauma.

Aside from the cost of this human rights violation to human dignity, there are economic costs. Health services, already overstretched, must cope with the completely preventable consequences of violence against women. Moreover, violence, or fear of it, can cause women to shy away from accessing health services. It can compromise a woman's ability to negotiate safer sex with her partner, and prevent her from accessing HIV information, counseling, testing, and prevention of mother-to-child transmission services, and voluntarily learning and disclosing her HIV status. Effective programmes include those that advocate for elimination of gender-based violence; ensure survivors have access to quality medical, psychological, legal and economic assistance; strengthen the response of the health sector; support revision and enforcement of national laws and policies; conduct public awareness campaigns; build the capacity of uniformed personnel and law enforcement to respond; and promote a minimum package of related services for women in conflict and crisis situations.

Investing in the future through support to sexual and reproductive health

Now more than ever, within the context of the global financial crisis it is imperative that the momentum be sustained to reach our global health, especially women's health commitments and to fully scale up services. In past periods of economic strain, public expenditures on health, education, and other social services dropped, especially non-curative health services, with a disproportionate impact on the poor and most vulnerable, including women, youth, and children. With decreased access to health services, there is a concomitant increase in unplanned pregnancies, unsafe abortion, an overall deterioration in reproductive health, increased child mortality and malnutrition. This underscores the need for an increase in both the absolute amount and quality of both domestic and external resources in support of the MDGs. Given the high returns, investing in health makes good economic sense although according to recent estimates only about 10% of Official Development Assistance (ODA) is allocated directly to

health. An estimated US\$ 25 – 70 billion is needed annually for scaling-up to meet the health MDGs (in the case of Comprehensive MDG 5 US\$ 24 billion is required by 2015). This is set against a backdrop where total ODA in 2006 dropped by around 5% in real terms and further declines have been and are expected. The estimated spending in 2004 for maternal and newborn health totaled \$530 million US dollars. According to the World Health Organization, it should have been ten times as much, about \$6 billion dollars annually to achieve MDG 5 by 2015. Projections show that these funding requirements could be met if countries invested 15 percent of their national budgets in health and if official development assistance climbed further towards 0.7 percent of Gross National Income in the OECD countries. This goal of “15 by 15”, endorsed in the Abuja call for action, is now universally recognized.

Recognizing the importance not only of the quantity of resources but about delivering better outcomes, support to countries is imperative through national processes to align programme resources to areas that will have the greatest impact. Within national processes, there is a need to elevate women's health in the policy dialogue. For instance, while 80% of governments reported national AIDS strategies that had programmes directed to women, only half of these include resource allocation. Innovative and underutilized modalities need to be employed on an expanded scale, including debt relief, safety nets such as contextualized medical insurance, expanded partnerships including with the private sector, protection schemes to offset user fees for primary health services, including family planning, HIV and maternal health, especially for the poorest quintiles, and extra care for conflict/humanitarian settings.

Interdependence among the MDGs

The health MDGs - 4, 5 and 6 - are inextricably linked. Investing to reach the MDG 5 targets - to reduce the maternal mortality ratio by three quarters, and achieve universal access to reproductive health both by 2015 contributes to attainment of MDGs 4 and 6. Maternal health improves child survival immediately by reducing newborn deaths as care at delivery is closely correlated with both maternal and new born health, and in the medium term, since child survival is dependent on survival of the mother. The prevention of mother-to-child transmission of HIV is at the nexus of MDGs 4, 5 and 6, through primary prevention of HIV, prevention of unintended pregnancies among women living with HIV, prevention of vertical HIV transmission, partly through safer delivery, and treatment, care, and support for women living with HIV and their families.

But the benefits of achieving the health MDGs also contribute synergistically to reaching other MDGs, particularly MDG 1 eradication of extreme poverty and hunger, MDG 2 education, and MDG 3 gender equality and empowerment of women. The inconsistent progress thus far in achieving universal access to reproductive health is a failure not only for public health but it compromises the advancement of women and girls, and retards global development in other spheres. In the case of sexual and reproductive health care, investment in and access to contraceptive services, quality maternal health care services, sexually transmitted infection related services, gynecologic and urologic care can all contribute to promoting economic growth, poverty reduction and greater equality.

Health is one of the pillars of a country's development process and a key driver for economic growth, wealth and poverty reduction. The impact of health on a country's Gross Domestic Product (GDP) is significant – an extra year of life expectancy is estimated, under certain conditions, to raise a country's per capita GDP by about four per cent. Sickness and disability adversely impact on the individual and household, with consequences to the wider community and entire country. Ill-health can push individuals and households further into poverty, creating a

vicious circle (ill-health-poverty-ill-health) or can further hinder attempts to move out of poverty.

Universal access to reproductive health – a window of opportunity

With the target date for achieving the MDGs fast approaching, intensified efforts to strengthen health systems are imperative. Because there are significant synergies both within the health MDGs and with other MDGs, particularly those addressing poverty and gender equality, the potential for positive impact is magnified. Improvements in health systems, particularly for sexual and reproductive health, are a worthy investment to contribute to the human rights-based development agenda.