Hearings on Maternal Morbidity

Written submission from the Population and Sustainability Network

Introduction

The Population and Sustainability Network welcomes these hearings on Maternal Morbidity; the emphasis within the field on maternal mortality masks the fact that the appallingly high numbers of women who die annually from causes related to pregnancy and childbirth leave behind them many more who live on with disabilities, diseases and infirmity resulting from the same causes, which prevent them from leading happy, healthy and productive lives.

The factor that makes maternal morbidity and mortality a human rights scandal is that the disease and the disability is preventable. We know what needs to be in place for women to go through pregnancy and childbirth safely; there is a strong degree of global consensus about the four core programmes that need to be in place, namely:

- Family planning and other reproductive health services;
- Skilled care during and immediately after pregnancy and childbirth;
- Emergency obstetric care when life threatening complications develop;
- Immediate postnatal care for mothers and newborns.

For those women who want to have a child, who are happy to be pregnant, and for whom the pregnancy is a desired state, whether planned or not, the risks associated with pregnancy and childbirth “go with the territory”; while it is the duty of the global community to minimize those risks as far as possible by ensuring that, of the four interventions described above, the last three are in place, it will never be possible to identify and/or prevent 100% of high-risk pregnancies and deliveries.

PSN’s submission focuses on the responsibility of the international community to ensure that all women who do not want to have a child, who are not happy to be pregnant, and for whom the pregnancy may signal disaster are in a position to avoid these risks entirely by having access to family planning services which will enable them to avoid the pregnancy that would expose them to these risks. This is the first of the four elements on which there is international consensus, but it is most often ignored in this context, possibly because the other three deal more directly with making pregnancy and childbirth safer by reducing the risks associated with them, whereas family planning prevents exposure to those risks for those who do not wish to become pregnant.

Other medical experts testifying at these hearings are better placed to advise on specific strategies to address maternal morbidity caused by prolonged obstructed labours, obstetric fistula, eclampsia and pre eclampsia, haemorrhage and anaemia, infections including HIV and postnatal depression.

PSN is keen to draw attention to the prevention of unplanned pregnancies and unsafe abortion partly because of the huge numbers of women that face unplanned pregnancies every year because they do not have access to family planning, and partly because the financial support for these services is crumbling.

PSN would emphasize the following three points in connection with these important hearings:

- In the overwhelming majority of cases, unplanned pregnancies and unsafe abortions are often the result of women who would like to use contraception, but do not have access to it.
- Increasing access to family planning will reduce maternal morbidity and mortality: understandable and appropriate emphasis on morbidity associated with particular conditions
related to pregnancy and childbirth mask the health benefits of enabling women to avoid pregnancy if they so wish, thereby avoiding the morbidity and mortality associated with it.

- Family planning saves lives, families, and helps to sustain the planet for future generations.

**Is this really relevant?**

Worldwide, the burden of disability and premature death due to sexual and reproductive health problems is “enormous”, and is growing. Unsafe sex is the second most important cause of morbidity or untimely mortality among the world’s poorest populations, and the ninth most important cause in developed countries. Despite significant increases in access to contraceptives globally, more than 120 million couples have an unmet need for modern contraception and an estimated 80 million women have unintended or unwanted pregnancies, with 45 million ending in abortion annually. The approximately 210 million women who become pregnant every year face pregnancy-related complications which will kill more than half a million women, and leave millions more disabilities, including obstetric fistula. An estimated 340 million new cases of STIs and five million new HIV infections occur annually. The potential of ensuring that comprehensive family planning services is available to these people to alleviate this suffering is huge.

A recent UNICEF report states that for every woman who dies from a pregnancy-related cause, around 20 experience injury, infection, disease and disabilities, so an estimated 10 million women who survive their pregnancies experience such adverse outcomes. In many developing countries these conditions are untreated and can result in lifelong pain and psychological suffering.

One such disabling condition is obstetric fistula, which occurs when the pressure of the baby’s head during prolonged and obstructed labour restricts blood flow to areas of tissue within the birth canal; the tissue may die, causing holes to form in it during the period after birth. This results in uncontrollable leakage into the vagina from the bladder or the rectum, leaving the woman incontinent. The social consequences of this can be devastating. We will return to this issue later in this presentation, since, like so much morbidity, it is the dignity of women that is most devastated by the condition, and surgical repair is possible with a relatively simple operation, so the question arises; is this a tragedy, or is it an egregious human rights violation?

Millions of women suffer from anaemia and infertility due to complications of childbirth. Intrapartum and post-partum haemorrhage can cause severe anaemia, which contributes to chronic morbidity. Anaemia interacts with malaria to heighten vulnerability, adds to the risk of death in cases of haemorrhage and when severe, can lead to cardiac failure in women. Infertility can result when pelvic inflammatory disease is untreated with antibiotics, and from unsafe abortion.

**Does increasing access to family planning reduce maternal morbidity and mortality?**

Reducing the number of unwanted pregnancies will also reduce the risk of maternal death over the course of a woman’s reproductive years. One MDG indicator is the contraceptive prevalence rate, or the percentage of women aged 15–49 currently married or in union using a method of contraception. An additional MDG target – to have universal access to reproductive health by 2015 – has given new priority to addressing sexual and reproductive health issues, but the extensive lobbying that was required to add this target testifies to the original neglect of reproductive health and family planning in the MDGs. This neglect contributed significantly to decreased attention, reduced funding and increased risks for women and children.

The contraceptive prevalence rate is 61% in the developing world as a whole and just 30% in the least developed countries. In sub-Saharan Africa, only 23% of women who are married or in
union use any form of contraception; of the 11 countries in the world where fewer than 10% of women aged 15–49 who are married or in union use a contraceptive method, all but three are in this region.

Access to effective contraception contributes to maternal health by averting disabilities and death. It is estimated that the promotion of family planning, in line with national policies, could prevent about one third of maternal deaths in countries where birth rates are high. The data suggest that unwanted pregnancies carry a greater risk than those that are wanted, and that women with unwanted pregnancies are less likely to receive early antenatal care or give birth under medical supervision. In addition, spacing pregnancies by at least two years increases the chance of child survival.

Moreover, contraception can prevent women from seeking unsafe abortions; it thereby contributes to the reduction of maternal death and disability.

A related MDG indicator is the ‘unmet need’ for contraception, which refers to women who do not want a child or who want to postpone their next pregnancy but are not using any contraceptive. Around 137 million women who want to space or limit their childbearing use no contraceptive method at all, while another 64 million use only traditional methods, such as withdrawal. It is estimated that up to 100,000 maternal deaths could be avoided each year if the need for contraception was effectively met.

Adolescent childbearing, common in many parts of the world, carries particular risks. Younger adolescents may not be physiologically mature, and adolescents giving birth for the first time may lack essential information and access to health services and support. Each year, nearly 70,000 girls aged 15–19 die from pregnancy-related complications, which are responsible for most mortality for this age group. Mothers younger than 15 are at even greater risk, being five times as likely to die in childbirth as women in their twenties. Annually, an estimated 2.2 million to 4 million adolescents resort to unsafe abortion, which adds significantly to the number of deaths and permanent injuries.

Adolescent fertility is exceptionally high in sub-Saharan Africa. The 10 countries with the highest adolescent birth rates are found in this region, and the highest rates of all are found in the Democratic Republic of the Congo (225 births per 1,000 girls and young women aged 15–19), Liberia (221) and Niger (204).

If we assume that the vast majority of these pregnancies are unwanted, the dereliction of duty in allowing the lack of family planning services to continue becomes clear, and the moral responsibility for the morbidity and mortality that ensues inescapable.

**Did we get tired, or did we just get lazy?**

Talking of family planning sounds so old fashioned; it is itself a euphemism that betrays the need to come up with a term that neatly masked the fact that most people practising it were thinking neither of families, nor of planning: they were taking responsibility for their wish to be sexually active, but not in the process to risk a pregnancy. It also sounds old fashioned because we now talk about sexual and reproductive health and rights instead, which doesn’t matter in conceptual terms, because the concept includes family planning, but, unfortunately, in real terms investment in family planning has fallen considerably during the last decade. This is important because the investment made in family planning from 1960 to 1996 was spectacularly successful in making contraceptive services available; the gains of that investment are being eroded because family planning is no longer seen as a development priority.

From 1960 to 1996, the number of developing countries with official family planning policies rose more than fifty-fold, from two to 115. This increase was associated with a parallel rise in funding for family planning from US$168 million in 1971 to US$512 million in 1985 and also
with a rise in the proportion of married women in developing countries using contraception—from less than 10% to about 60%, between 1960 and 2000. However, between 1995 and 2003, donor support for family planning commodities and service delivery fell from US $560 million to $460 million, as new development priorities, including HIV/AIDS, attracted increasing proportions of the funding that had been available for family planning programmes. Despite declines in fertility rates over the past 45 years, 26 out of 32 countries analysed in Demographic Health Surveys have high rates of unmet need for family planning – 20%. The relevance of levels of donor funding can be seen from the fact that in Asia and Latin America, unmet need in the poorest fifth of the population is twice as high as in the wealthiest fifth.

Cleland et al estimate that, in 2000, about 90% of global abortion-related and 20% of obstetric-related mortality and morbidity could have been averted by use of effective contraception by women wishing to postpone or cease further childbearing. Family planning also brings large potential health and survival benefits for children, mainly as a result of wider intervals between births.

**Unsafe abortion**

WHO estimates that 80 million unplanned pregnancies occur each year. Approximately 26 million of these pregnancies are terminated legally and 20 million through unsafe, non-legal means, primarily in developing countries (97%). About 68,000 deaths and “millions” of injuries are caused by unsafe abortions. Abortion-related complications are costly; in some low and middle-income countries up to 50% of hospital obstetrics and gynaecology budgets go on treatment of complications from unsafe abortion. A striking example of the high cost of these complications is the experience of the United Republic of Tanzania, where the per capita cost of treatment for abortion-related complications is more than seven times the per capita Ministry of Health budget. Unsafe abortion is estimated to account for 13% of all maternal deaths worldwide, but morbidity is a much more common consequence of unsafe abortion than mortality, although it is determined by the same risk factors. Complications include haemorrhage, sepsis, peritonitis, and trauma to the cervix, vagina, uterus and abdominal organs. High proportions of women (20 – 50%) of women who have unsafe abortions are hospitalized for complications. The most effective ways of preventing these complications is reducing the need for abortion through contraception; legalization of abortion, the use of safer techniques and improvement of provider skills.

**Family planning saves lives, and protects the quality of those lives**

Obstetric fistula is the development of a track between the urinary system or rectum and the birth canal. Along with vaginal ulceration and sometimes permanent nerve damage in the legs, this morbidity results from extremely prolonged labour without sufficiently early medical intervention, usually a Caesarean section. The woman is left, in most cases, with a stillborn baby and chronic incontinence – sometimes associated with recurrent kidney infections. The smell of leaking urine or faeces, or both, is constant and humiliating, often driving loved ones away. A simple surgery can normally repair the injury, with success rates as high as 90 per cent for experienced surgeons. The average cost of fistula treatment and post-operative care is just US $300. Sadly, most women with the condition do not know that treatment is available, or they cannot afford it.

Like maternal mortality, fistula is almost entirely preventable. But at least 2 million women in Africa, Asia and the Arab region are living with the condition, and some 50,000 to 100,000 new cases develop each year. The persistence of fistula is a signal that health systems are failing to meet the needs of women.
The APPG concluded from its Hearings on the impact of population growth on the MDGs that “the role of family planning in improving maternal health is vital and the evidence is overwhelming”.

PSN concurs wholeheartedly with this conclusion, and also believes that there is a critical link between family planning and MDG 7 (Ensure environmental sustainability for the planet) – a link that the APPG may wish to investigate further at a future date. Further population rises, which will inevitably result from continued lack of investment in family planning services, will put fragile marginal land under pressure from overcropping and overgrazing, with potentially severe outcomes in terms of loss of vegetation cover, soil fertility depletion and soil erosion. This danger is especially acute in Africa, where the ratio of arable land to population engaged in agriculture has already fallen steeply and where rural populations will continue to expand for decades. For these reasons, prevention of unwanted births by family planning might be one of the most cost-effective ways to preserve the planet’s environment for the future.

In this submission, PSN has sought to emphasize that women who do not wish to be pregnant face the same mortality and morbidity risks from pregnancy and childbirth as their sisters, but access to contraception would enable them to be pregnant by choice not chance. A pro-choice badge in the USA states “if you don’t like abortion, don’t have one”. Behind the seemingly facile statement is recognition that those who don’t like abortion can choose not to have one, but do not have the right to make that choice for others. The tragedy of maternal morbidity is that it ruins lives, and, for the estimated 123 million women who have an unmet need for family planning, they are not in a position to choose not to be pregnant; instead they are at risk of one of the estimated 80 million unintended pregnancies that happen worldwide every year, and therefore also at risk of the morbidity and mortality that goes with it. If these risks were unavoidable, that would be a global tragedy. Since we have the technology to eliminate a vast proportion of these risks, it is better described as a human rights scandal.

1 Women Deliver : www.womendeliver.org
2 The Lancet Sexual and Reproductive Health Series. 2006.
14 UNFPA Campaign to end Fistula http://www.endfistula.org/fistula_brief.htm
KN 1 PSN Submission to APPG Hearings on MM