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**Securing a Better Future for Mothers
in the Post-2015 Development Agenda:
Evaluating the ICPD Operational Review**

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SECURING A BETTER FUTURE FOR MOTHERS IN THE POST-2015 DEVELOPMENT AGENDA: EVALUATING THE ICPD OPERATIONAL REVIEW

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Preparations for the post-2015 development agenda have led to several inputs from governments, international institutions, civil society and the private sector.

This paper evaluates certain aspects of the UNFPA's operational review of the Programme of Action of the 1994 International Conference on Populations and Development held at Cairo, following General Assembly resolution 65/234 (ICPD operational review), with special attention to maternal health, abortion, contraceptives, and aging.

While the ICPD operational review presents several positive aspects and is generally helpful, it overemphasizes abortion and contraception in its evaluation of maternal health issues to the detriment of maternal health and other fertility issues.

Yet a strong post-2015 development agenda must prioritize maternal health, as was the case in the Millennium Development Goals (MDG).

1. MDG5 on Maternal Health remains unfinished business.

MDG5 on improving maternal health remains one of the goals on which progress has been most uneven. This should not be a cause for downplaying the importance of improving maternal health and reducing maternal mortality in the post-2015 development agenda.

The international community, national and international institutions and private philanthropy should endeavor even more to make progress on improving maternal health and reducing maternal mortality going forward in to the post-2015 development agenda.

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“What mattered most, the study found, were improvements in women’s education and in maternal health care.”

More than ever before, we know what it takes to make childbirth safe for mothers and their children. A landmark study on the measures that effectively reduce maternal mortality from Chile found that during a 50-year period from 1957-2007, the Chilean maternal mortality rate decreased 93.8% to one of the lowest in the world.¹ What mattered most, the study found, were improvements in women’s education and in maternal health care.

Interventions that are universally effective are well known and attainable if resources are devoted to them:²

Measures to Improve Maternal Health:

1. Higher education levels for women
2. Skilled birth attendants
3. Prenatal and antenatal care
4. Access to water and sanitation
5. Emergency obstetric care

2. Maternal health must remain a priority in the post-2015 development agenda as it was in the MDG framework.

Maternal health should remain a separate and distinct priority in the post-2015 development agenda as it has been in the MDG framework. It should either be a stand-alone goal or a principal target separate from reproductive health.

“Improvements in maternal health not only save the lives of mothers and their children, they can have an outsized impact on families and communities more broadly.”

Improvements in maternal health not only save the lives of mothers and their children, they can have an outsized impact on families and communities more broadly. Despite the relatively low number of maternal deaths, compared to deaths from communicable diseases and other leading causes of death, the social and economic costs of maternal health and its repercussion on families and communities amplify their significance.³

Improvements in maternal health care can also have a positive effect on overall health care infrastructure. Mothers are not the only beneficiaries of investments in maternal health. One of the principal concerns of global health experts is how to improve overall health as opposed to delivering fragmented health services. There is evidence that fragmented approaches to global health issues have been proven to weaken overall health.⁴

1 Koch E, Thorp J, Bravo M, Gatica S, Romero CX, et al., “Women’s Education Level, Maternal Health Facilities, Abortion Legislation and Maternal Deaths: A Natural Experiment in Chile from 1957 to 2007,” (2012) PLoS ONE 7(5): e36613. doi:10.1371/journal.pone.0036613.

Other specific measures may have significant impacts in different regions (e.g. better roads in areas where reaching health facilities is difficult, access to anti-malarial drugs where they are needed, and antiretroviral drugs to prevent mother-to-child HIV transmission).

2 <http://www.unicef.org/mdg/maternal.html>

3 “A Price Too High to Bear: The Costs of Maternal Mortality to Families and Communities,” <http://www.who.int/pmnch/media/news/2014/kenya/en/>

4 Laurie Garrett, “Existential Challenges to Global Health,” August 2013, <http://cic.nyu.edu/sites/default/files/>

“The post-2015 development agenda should concentrate on attainable goals and targets as did the MDGs.”

3. The ICPD operational review reduces maternal health to a sub-category of sexual and reproductive health.

Research shows that the sexual and reproductive health community, of which UNFPA is a leader and focal point, does not prioritize maternal health, and only sees it as one component in a broader agenda that prioritizes power inequalities, fertility reduction, sexual autonomy, abortion, reproductive rights, and other contentious issues instead.⁵

This approach reduces maternal health to just one dimension of the main health category of sexual and reproductive matters. It takes the focus away from saving the lives of women in childbirth to providing women with a broad range of reproductive commodities, for which there may not even be an urgent need (as discussed in section below on “unmet need”).

While there may be some merits to such an approach, it has the potential of diverting attention to issues like sexual autonomy, abortion or reproductive rights instead of focusing on improving health for mothers and their children.

The post-2015 development agenda should concentrate on attainable goals and targets as did the MDGs. It cannot get sidetracked in a debate about contentious social policies.

4. The ICPD operational review disproportionately emphasizes abortion over other more pressing maternal health issues.

The ICPD operational review’s insistence on abortion as a pivotal maternal health issue is the most glaring example of a skewed perspective on population matters that does not pay attention to improving people’s lives as much as ensuring the number of people who are living does not increase.

References to abortion outnumber the combined references to maternal health and maternal mortality and morbidity in both the review and the UN Secretary General’s report on the review.⁶

	Report of the Secretary-General (32 pages)	ICPD Operational Review (234 pages)
Abortion	27 references	192 references
Maternal (health, mortality)	13 references	182 references

garrett_challenges_global_health.pdf

⁵ Hammonds R, Ooms G, “The emergence of a global right to health norm – the unresolved case of universal access to quality emergency obstetric care,” *BMC International Health and Human Rights* 02/2014; 14(1):4.

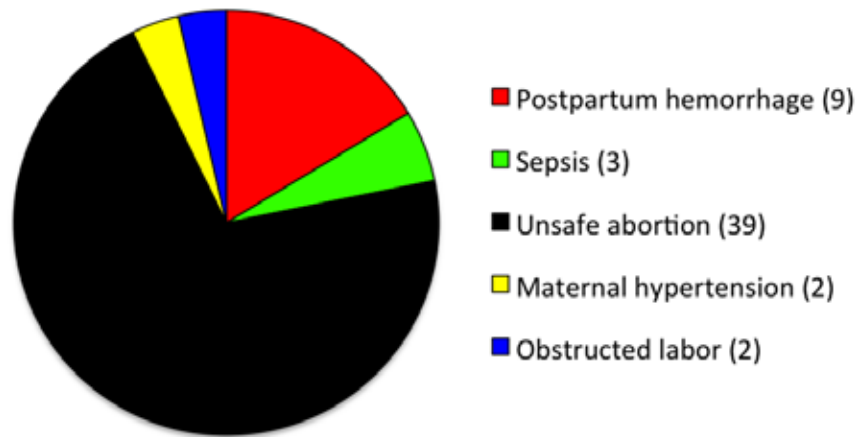
⁶ Within the ICPD framework, abortion is viewed as a potential cause of maternal death or injury that is to be avoided where possible and “safe” where legal. The ICPD Programme of Action also mandates that “[i]n no case should abortion be promoted as a method of family planning.” Programme of Action of the International Conference on Population and Development, 1994.

The ICPD review lists the five leading causes of maternal deaths: “postpartum hemorrhage (PPH), sepsis, unsafe abortion, hypertensive disorders and obstructed labor.” However, “unsafe abortion” received more than twice the number of references than those given to the other four causes combined.

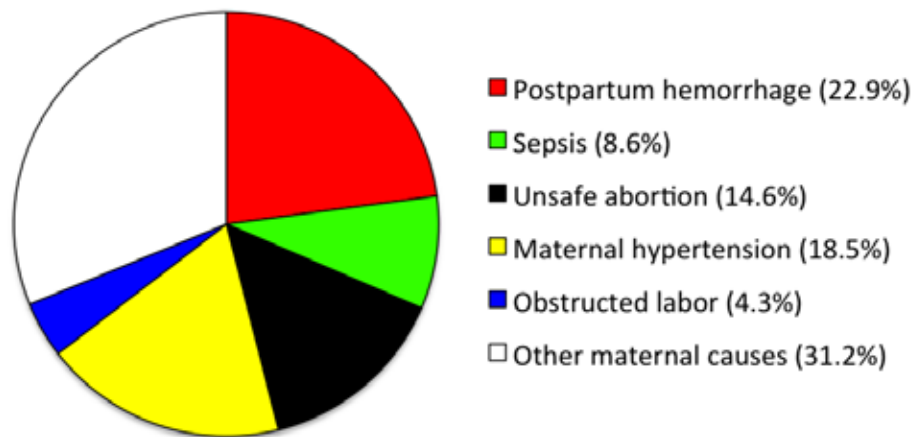
The disproportionate focus of the review report is particularly troubling when contrasted with the fact that abortion is associated with less than a third of the deaths caused by hemorrhage, sepsis, hypertension, and obstructed labor combined (See Figure 1).

FIGURE 1

References to causes of maternal mortality¹



Maternal deaths by cause²



1. Framework of Actions for the follow-up to the Programme of Action of the International Conference on Population and Development Beyond 2014

2. Global Burden of Disease Study 2010. Percentages may not add up to 100% because of rounding.

“There is no clear association between making abortion legal or more widely accessible and a reduction in the proportion of maternal mortality due to abortion.”

5. Making abortion legal or more widely accessible does not eliminate or even necessarily reduce the relative contribution of abortion to maternal mortality.

However exaggerated the focus on abortion in the ICPD operational review, abortion is in fact a significant cause of death and injury to women. But the review could have emphasized more the best ways to address maternal mortality resulting from both legal and illegal abortions.⁷

The authors of the ICPD operational review recommend expanding access to legal abortion as a way to reduce maternal deaths, implying that removing legal restrictions on abortion leads to fewer deaths attributable to “unsafe” abortion, much like WHO.⁸ However, these correlations are deceptive.

There is no clear association between making abortion legal or more widely accessible and a reduction in the proportion of maternal mortality due to abortion.

Levels of maternal mortality have improved dramatically in Latin America since the 1990s, yet remain stubbornly high in sub-Saharan Africa. These regions offer the most legal protections for unborn children, but also have greater levels of poverty and lack of infrastructure. As a consequence these regions report high levels of maternal mortality.

If making abortion legal and more widely accessible were a key measure to improving maternal health, one would expect to see lower relative percentage of maternal mortality attributable to abortion in countries with more liberal abortion laws. No such evidence exists. This can be easily found by looking at abortion-related mortality as a function of maternal mortality as a whole in the countries of the region (See Figure 2).

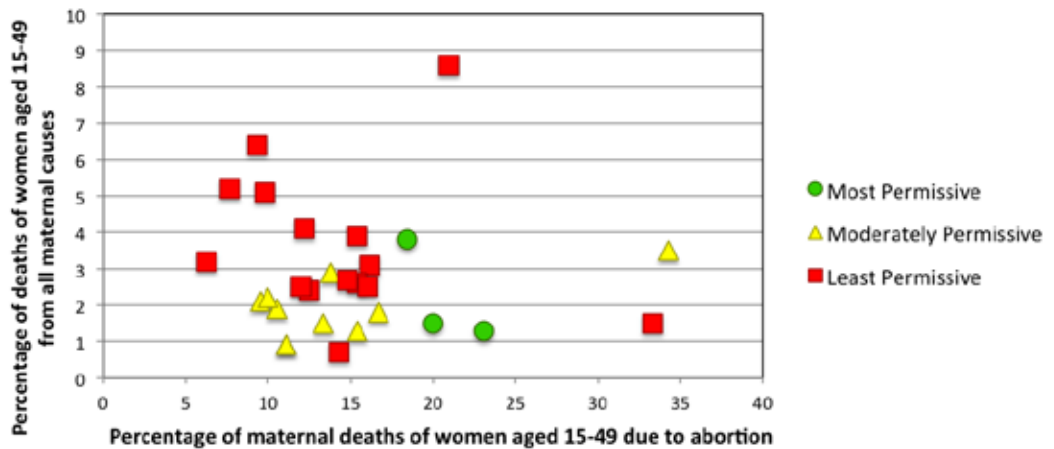
⁷ It should be noted that while the review only attempts to assess deaths due to “unsafe” abortion, it ignores deaths due to so-called “safe” abortion. This concern, long expressed by pro-life advocates, was recently echoed by the World Health Organization (WHO), which admitted that they “historically used a pragmatic operational construct that measures safety in terms of only one dimension – legality.” The WHO now intends to apply a “multi-dimensional risk continuum” in making the distinction.

Ganatra B, Tunçalp Ö, Johnston HB, Johnson Jr. BR, Gülmezoglu AM, Temmerman, M. “From concept to measurement: operationalizing WHO’s definition of unsafe abortion,” *Bulletin of the World Health Organization*, 2014; 92:155.

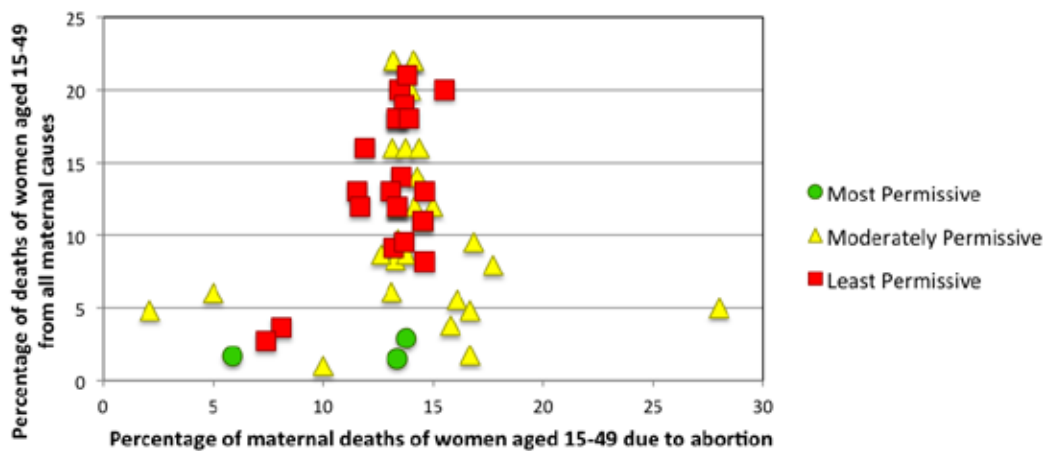
⁸ It notes that “treaty monitoring bodies have highlighted the relationship between restrictive abortion laws, maternal mortality, and unsafe abortion.” *Framework of Actions*, see footnote 2.

FIGURE 2

**Abortion Laws and Maternal Mortality due to Abortion:
Countries in Latin America & the Caribbean**



**Abortion Laws and Maternal Mortality due to Abortion:
Countries in Africa**



Source for maternal health statistics: Global Burden of Disease Study 2010
 Source for abortion law classifications: The World's Abortion Laws map 2014, Center for Reproductive Rights

“Evidence shows that countries can reduce abortion-related deaths by improving maternal health care overall, regardless of their abortion laws.”

Evidence shows that countries can reduce abortion-related deaths by improving maternal health care overall, regardless of their abortion laws (See figure 2).⁹

In the African region, which posts the highest rates of maternal mortality in the world, as maternal health improves deaths attributable to abortion decrease proportionally with all other causes of maternal death. This implies clearly that the reduction in maternal deaths attributable to abortion have more to do with better and more accessible health care, particularly emergency obstetric care, than the legal framework of abortion.

⁹ Koch et al., see footnote 1.

“Suggesting that legal abortion is a panacea for maternal health only clouds the picture when it comes to crafting effective frameworks to reduce maternal mortality.”

6. Making abortion legal is not a replacement for maternal health.

Changing abortion laws rather than improving maternal health care and overall health infrastructure may seem inexpensive and a quick route to reducing maternal deaths, but it is not an effective measure to improve maternal health, according to the evidence. Suggesting that legal abortion is a panacea for maternal health only clouds the picture when it comes to crafting effective frameworks to reduce maternal mortality.

Complications from unsafe abortion, like complications during pregnancy and delivery, can only be addressed with adequate, time-tested improvements in maternal health care.¹⁰

In this regard, there is no quick fix. Maternal health policies must include access to transportation, decent roads, well equipped medical facilities staffed by competent health care workers, and the right medicines and medical interventions. The results of these improvements include reduction of maternal deaths by all causes, including abortion, as well as benefits to the entire populations of girls and women who are not pregnant, as well as men and boys.

An important note should be made about the necessity of reliable data and valid comparisons. The ICPD review report highlights the case of Uruguay as a success story in reducing maternal deaths due to abortion.¹¹ The ICPD review report attempts to paint Uruguay as a positive example for liberalizing both laws and attitudes toward abortion. Yet strip away the implausible statistics and misleading comparisons,¹² and the case study reveals yet another illustration that improved maternal health care covers a multitude of complications, including those from abortion, whether legal or not (See figure 3).

¹⁰ Hammonds & Ooms, see footnote 5.

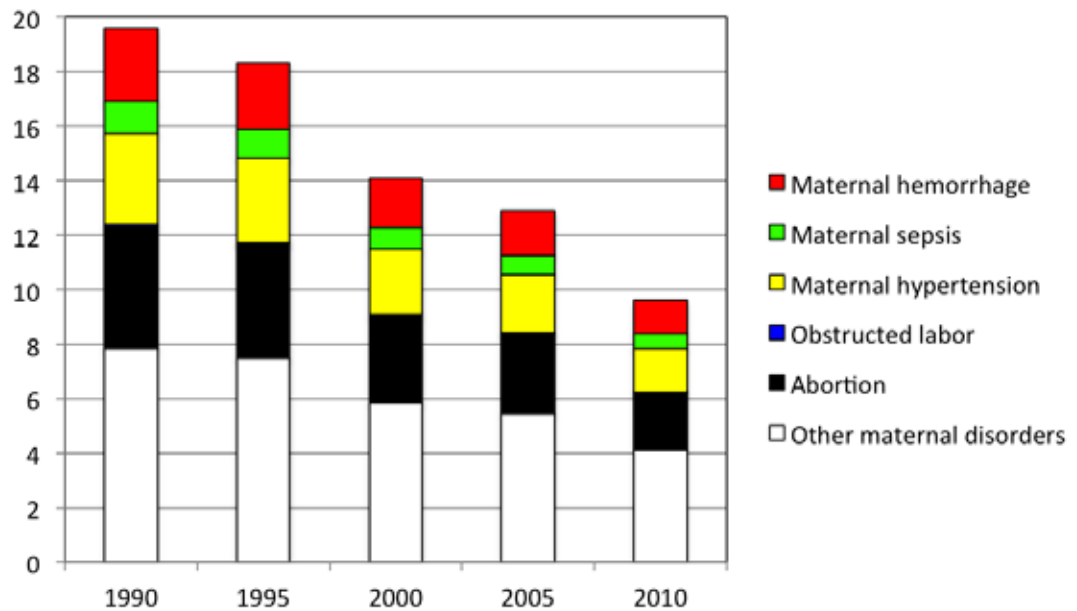
¹¹ *Framework of Actions*, see footnote 2.

¹² The report claims that abortion caused 42 percent of maternal deaths in 2001, 28 percent in 2002, and 55 percent in 2003. These numbers seem dubiously high and the enormous disparity from one year to the next, with no explanation given, raises further questions about the quality of the data used and the methodology employed. The report goes on to say that after implementing its reproductive health program, Uruguay registered “a maximum of 2 cases of maternal deaths from unsafe abortion” from 2004-2007, and none at all from 2008-2011. This narrative immediately raises two questions. First, were there any deaths from so-called “safe” abortions? It is conceivable that the implementation of the program expanded the definition of “safety” in such a way that a subset of abortion-related deaths is suddenly defined into obscurity. Second, the report presents a “before” picture in terms of dubious percentages and an “after” picture in terms of real numbers - in laymen’s terms, a comparison of apples and oranges.

As another reference point, the Global Burden of Disease (GBD) data on maternal mortality in Uruguay paints a clearer picture (See Figure 3). These data come from the group that famously called the World Health Organization to account for overinflating maternal mortality figures in 2010. The first important thing to note is that maternal mortality in Uruguay has dropped by approximately half since 1990, but it wasn’t extraordinarily high to begin with: roughly 20 deaths per year falling to roughly ten. Furthermore, the GBD data reveal abortion-related mortality rates far lower than those listed in the ICPD review for 2001-2003, with no evidence of broad fluctuation from one measurement to the next. Third, the relative proportion of maternal death caused by abortion decreases alongside deaths by other causes, further underscoring the argument that a broad maternal health approach works where an approach targeted at changing abortion laws does not.

FIGURE 3

Uruguay: Maternal deaths by cause



Global Burden of Disease Study 2010.

7. Addressing “unmet need” for family planning and raising contraceptive prevalence will not improve maternal health.

“Reducing unintended pregnancies does not address the inequalities in maternal health that make it unsafe for women to give birth in the first place even if it may reduce overall maternal deaths.”

The provision of reproductive commodities should not overshadow essential medical care to make pregnancy and childbirth safe for women. Integrating family planning and maternal health will not improve maternal health. It does nothing to improve health care available to mothers and their children. It may reduce overall maternal mortality because of a reduction in pregnancies but will not improve the conditions in which mothers live and give birth.

Contraceptives do not make childbirth safer for mothers or their children. Reducing unintended pregnancies does not address the inequalities in maternal health that make it unsafe for women to give birth in the first place even if it may reduce overall maternal deaths.

Moreover, the countries with the lowest contraceptive prevalence are frequently those with the highest *desired* fertility¹³ and highest levels of maternal mortality.¹⁴ What mothers in those countries want is to be able to have children safely. Giving them contraceptives will do nothing towards realizing that goal.

13 Bongaarts, J. *Can Family Planning Programs Reduce High Desired Family Size in Sub-Saharan Africa?* International Perspectives on Sexual and Reproductive Health. Volume 37, Number 4, December 2011.

14 Glasier A, Gülmezoglu AM, Schmid GP, Moreno CG, Van Look PFA. *Sexual and reproductive health: a matter of life and death.* The Lancet Sexual and Reproductive Health Series, October 2006.

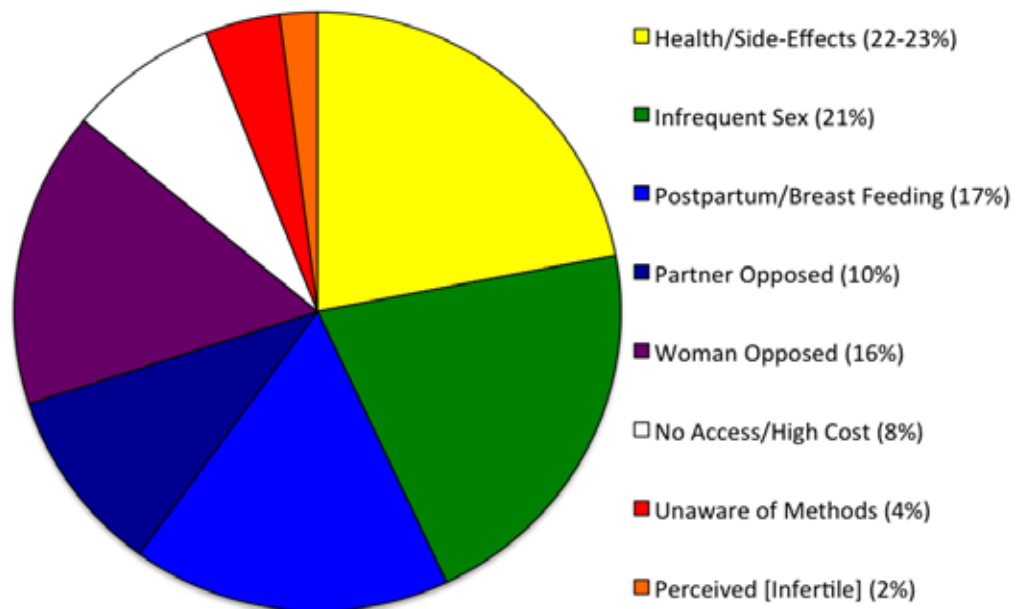
8. Unmet need for family planning is not a helpful concept for addressing inequalities affecting women.

The ICPD operational review discusses contraceptives in terms of both prevalence and unmet need. While prevalence requires no explanation, experts have criticized the concept of unmet need as “an advocacy construct” and “a need with no demand.”¹⁵ Harvard economist Lant Pritchett recently noted that unmet need was predominantly attributed to women with religious or health-related objections to contraceptives, or who had decided against using it for other reasons.

Only eight percent of 222 million women with so called unmet need for contraception cite cost or lack of access as their reason for not using modern contraceptive methods, according to the Guttmacher Institute which surveyed women in developing countries that had high attributed levels of unmet need.¹⁶ Nevertheless, the United Nations Population Fund (UNFPA) has attributed the entire “staggering 222 million” of women described as having unmet need to a lack of access to contraceptives (See Figure 4).¹⁷

FIGURE 4

Reasons for “unmet need” as reported by women in developing countries



Darroch JE, Sedgh G, and Ball H. “*Contraceptive Technologies: Responding to Women’s Needs.*” Guttmacher Institute. April 2011

15 Susan Yoshihara, Ph.D., “Experts Call ‘Unmet Need’ for Family Planning Baseless,” <http://c-fam.org/en/2012/6711-experts-call-unmet-need-for-family-planning-baseless>

16 Darroch, JE, Sedgh, G, Ball H. *Contraceptive Technologies: Responding to Women’s Needs* Guttmacher Institute, 2011

17 *By Choice, Not by Chance. State of World Population 2012*, United Nations Population Fund (UNFPA). 2012.

9. Integrating maternal health, family planning and HIV/AIDS prevention as components of sexual and reproductive health can result in conflicting priorities and negative health outcomes.

The “unmet need” concept has attracted high-profile champions like Melinda Gates and the Women Deliver conference. The Gates Foundation’s priorities for sub-Saharan Africa and South Asian include increasing the use (prevalence) of contraceptives, improving access to contraceptives, expanding both the supply and the demand for contraceptives, and integrating contraceptives into HIV and maternal and child health services “to gain efficiencies and reduce costs.”¹⁸

The initiative has generated controversy with HIV/AIDS groups because family planning methods do little to nothing to block HIV transmission, and, in the case of Depo Provera, may actually increase the risk.¹⁹ Condoms — the only modern method of family planning that may prevent HIV/AIDS transmission — has one of the highest failure rates at preventing pregnancy, because it must be used perfectly every time,²⁰ and its efficacy at preventing HIV/AIDS transmission is equally under scrutiny.

10. Women affected by treatable infertility are not receiving the attention they deserve.

Advocacy of family planning and sexual and reproductive health has paid too much attention to life’s quantity and too little to its quality.²¹

The ICPD operational review conducted by UNFPA emphasizes population activities that have a net negative effect on population growth. Even when addressing matters like fertility and women’s health, it emphasizes practices and interventions designed to prevent childbirth rather than taking care of mothers and their children.

While the ICPD review report devotes many pages and country-specific graphs to contraceptive prevalence, it contains only one brief paragraph to the subject of infertility in the developing world, despite acknowledging that the ICPD called for “treatment of infertility where feasible.” The report makes no mention of efforts to increase the feasibility of treating women in South Asia and sub-Saharan Africa suffering from infertility, despite levels as high as 28-30 percent in some countries, according to the ICPD operational review itself.

18 <http://www.gatesfoundation.org/What-We-Do/Global-Development/Family-Planning>.

19 Heffron R, Donnell, D, Rees H, Celum C, Mugo N, de Bruyn G, Nakku-Joloba E, Ngure K, Kiarie J, Coombs RW, Baeten JM, Partners in Prevention HSV/HIV Transmission Study Team. *Use of hormonal contraceptives and risk of HIV-1 transmission: A prospective cohort study*. The Lancet Infectious Diseases. 2012; 12(1): 19-26. This research was funded by the Gates Foundation.

20 Glasier et al. See footnote 14.

21 Horton, R., “Offline: The laws of stupidity,” *The Lancet*, Vol. 383, 9921, p. 938, 15 March 2014.

“The report makes no mention of efforts to increase the feasibility of treating women in South Asia and sub-Saharan Africa suffering from infertility, despite levels as high as 28-30 percent in some countries.”

11. New population policies to address demographic implosion should receive more attention in post-2015 development agenda.

The ICPD operational review's identification of emerging issues like population aging is welcome and timely. Further aspects of population aging and its different implications for developed and developing countries must be further analyzed.

Aging populations and eventual population decline could spell disaster for billions of people who live in developing countries without the fiscal and health care infrastructure necessary to deal with elderly populations. Demographers are warning that with continuing declines in fertility low-income countries will not get a chance to develop economically in time to prepare for the challenges presented by aging populations.²²

Countries that are faced with severe challenges from population aging and decline are implementing policies to enable women and men to consider having children. While not all have been a success, there are encouraging signs that emerging population policies with a pro-natalist slant can rejuvenate populations.²³

More policy evaluation and experience is required in this area over the long run, including in the area of work-family balance, and incentives for couples to have children, in order to evaluate their long term effectiveness and impact.

12. While population growth certainly presents challenges it should not be perceived as an obstacle to development.

Too often rapid population growth in poor countries is perceived as a problem *per se* without evidence to support that perception.²⁴ At some point low fertility inevitably becomes a demographic deficit rather than a dividend.

Evidence shows that without population growth economic development is difficult to achieve. Economic growth is now at its slowest in countries where fertility is close to or below replacement level. Even experts who are optimistic about the economic prospects of countries with aging populations warn that without the right policies economic growth in those countries will inevitably slow down, possibly irreparably.²⁵

“Evidence shows that without population growth economic development is difficult to achieve.”

22 Philip Longman, “Think Again: Global Aging,” *Foreign Policy*, November 2010, http://www.foreignpolicy.com/articles/2010/10/11/think_again_global_aging

23 Fabian Slonimczyk and Anna Yurko, “Russia, Assessing the Impact of the Maternity Capital Policy in Russia Using a Dynamic Stochastic Model of Fertility and Employment,” September 2012, <http://www.hse.ru/data/2012/10/10/1247109123/slonimczyk.pdf>

24 *Sustainable Solutions Network, Indicators for Sustainable Development Goals*, <http://unsdsn.org/wp-content/uploads/2014/02/140214-SDSN-indicator-report-DRAFT-for-consultation3.pdf>. Includes Target 02c on Rapid voluntary reduction of fertility among other things.

25 David E. Bloom, David Canning, and Günther Fink, “Implications of Population Aging for Economic Growth,” January 2011, PGDA Working Paper No. 64, http://diseaseriskindex.harvard.edu/pgda/WorkingPapers/2011/PGDA_WP_64.pdf

Moreover, slow population growth does not necessarily result in economic development. The “demographic dividend,” which some have argued accompanies rapid reduction in population growth, has failed to materialize in countries in Latin America and the Middle East where fertility has dropped dramatically in recent decades and population growth has been slow.²⁶

Conversely, countries like Indonesia and Brazil have seen rapid economic development even as their populations grew at a fast pace in the 1980s and 1990s. In fact, as demographic economists have noted, unprecedented development and creation of wealth in the 20th century took place at the same time as the world’s population grew faster than ever before.²⁷

Policy Implications

UN member states should make sure that the post-2015 development agenda addresses maternal health effectively. The MDG framework has mobilized an unprecedented amount of attention and resources on maternal health. We cannot lose MDG momentum for improving maternal health in the post-2015 development agenda.

Maternal health must remain a distinct and urgent priority in the post-2015 development agenda. The ICPD operational review’s focus on abortion generally, and changing abortion laws more specifically, is misleading. It distracts attention from the principal causes of maternal deaths and the proven interventions that reduce maternal deaths, including those from abortions. Similarly, the ICPD operational review at times conflates maternal health with the provision of reproductive commodities.

In addition, countries evaluate and adopt policies to face the unprecedented challenges posed by aging. In this regard the world is embarking in uncharted waters. New population policies that no longer focus on reducing high fertility need to be developed and evaluated in order to address those challenges. Improving maternal health and tackling treatable infertility can be a starting point for new policies that empower women and men to have the children they want to have, and societies badly need.

26 Susan Yoshihara and Douglas A. Sylva (Eds.), *Population Decline and the Remaking of Great Power Politics*, Potomac Books (2012).

27 Lam, David. 2011. “How the World Survived the Population Bomb: Lessons from 50 Years of Extraordinary Demographic History.” PSC Research Report No. 11-743. August 2011.

“Improving maternal health and tackling treatable infertility can be a starting point for new policies that empower women and men to have the children they want to have, and societies badly need.”