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Annual ministerial review: implementing the internationally agreed goals and commitments in regard to global public health

Statement submitted by International Planned Parenthood Federation, a non-governmental organization in consultative status with the Economic and Social Council

The Secretary-General has received the following statement, which is being circulated in accordance with paragraphs 30 and 31 of Economic and Social Council resolution 1996/31.

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Statement*

The International Planned Parenthood Federation (IPPF) welcomes the theme of the 2009 Annual Ministerial Review "*Implementing the internationally agreed goals and commitments in regard to global public health*". This statement will focus on the importance of ensuring and safeguarding sexual and reproductive health and rights (including HIV) in achieving these development goals and contributing to global public health.

In 1990, an estimated 576,000 women died of pregnancy-related causes. By 2005, this figure had reduced slightly to 536,000. Ninety-nine per cent of these deaths occur in developing regions, with sub-Saharan Africa and Southern Asia accounting for 86 per cent of this figure. According to estimates 35 per cent of women in developing counties do not have access or contact to health personnel prior to delivery. In sub-Saharan Africa, a woman's risk of dying from treatable or preventable complications of pregnancy and childbirth over the course of her lifetime is 1 in 22. The same risk in developed countries is 1 in 7,300. However, the true scale of maternal mortality is under-reported due to a lack of data from countries including some with the worst death tolls, the use of national averages and the lack of information relating to illegal and unsafe abortions –an estimated 19 million are carried out each year in developing countries. This means that the true figure for maternal mortality could exceed 872,000 as estimated by the United Kingdom International Development Select Committee. In addition, maternal morbidity leaves an estimated 10 million-20 million women and girls every year with long-term physical, psychological, social and economic problems. The most shameful aspect is that these deaths are largely preventable. IPPF believes that the failure to decrease the global incidence of maternal mortality is a public health issue and a denial of human rights and is attributable to the failure to prioritise comprehensive sexual and reproductive health in global development frameworks such as the Millennium Development Goals (MDGs). As recognized in 2003 by the UN Commission on Human Rights, sexual and reproductive health are integral elements of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

A related concern is the inadequate coverage of prevention of mother-to-child transmission (PMTCT) services. Nearly 2.1 million children under the age of 15 were living with HIV in 2007 and more than 90 per cent of the 420,000 newly infected children in 2007 contracted HIV from their mothers. While there is plenty of evidence to support interventions for the prevention of mother-to-child transmission (PMTCT), progress to date has been sluggish. Reasons for this are complex and could include: lack of political commitment; fragile national health systems and insufficient resources. Less than 2 per cent of the total HIV funding for 2006-2007 was prioritised for comprehensive PMTCT programmes. In addition to the benefits for both mother and child, PMTCT programmes can lead to improvements in the quality of maternal, newborn and child health services and increase the uptake of additional linked sexual and reproductive health services. Increasing access to and uptake of integrated services will address a number of pressing concerns including:

* Issued without formal editing.

1. Reach: The percentage of pregnant women living with HIV receiving antiretroviral prophylaxis for PMTCT continues to fall short of the proposed targets that National governments committed through the Declaration of Commitment (2001) of the General Assembly special session and the Millennium Development agenda (2001).
2. Counselling: Many pregnant women do not receive appropriate counselling and access to other related services for the primary prevention of HIV, unintended pregnancy and infant feeding.
3. Testing: HIV testing of pregnant women is slowly increasing. Only 18 per cent of pregnant women from middle and low income countries presenting available data received an HIV test in 2007.
4. Prophylaxis: The number of HIV positive women receiving prophylaxis for mother-to-child transmission is increasing — but remains low. In addition it is estimated that only 4% of children under 2 months of age born from HIV positive mothers received cotrimoxazole prophylaxis in 2007.
5. Treatment: Optimal treatment for PMTCT includes the use of combination therapy. Only 8 per cent of countries (from 60 countries presenting disaggregated data) provided a three drug combination following the revised WHO guidelines for treating pregnant women and preventing HIV infection among infants.

   Follow up: More than half of the HIV positive children are lost to follow up after testing. While loss to follow up of adult antiretroviral therapy (ART) clients is also a concern, the proportion of children is disproportionately higher.

More concerted efforts are needed to accelerate the scale up of programmes to provide comprehensive prevention, treatment, care and support programmes. *Guidance on Global Scale-Up of the Prevention of Mother-to-Child Transmission of HIV* released by the Inter-Agency Task Team on Prevention of HIV Infection in Pregnant Women, Mothers and their Children highlights the need to implement a comprehensive approach to PMTCT.

While the MDGs provide a valuable framework, they have serious limitations. Of particular relevance is the lack of a comprehensive approach to sexual and reproductive health, as envisaged by the 1994 International Conference on Population and Development (ICPD). In addition, the MDGs have other notable omissions, such as goals and targets specifically related to young people. Both the ICPD Programme of Action (PoA) and the MDGs approach development as a complex process which necessitates simultaneous advances on a range of interlinked issues: education; gender equality; health; environmental sustainability. Like the ICPD PoA, the MDGs rely on quantifiable targets and indicators. Only belatedly was MDG target 5b on universal access to reproductive health — a direct contribution of the ICPD PoA — added to this development framework. This long term omission of reproductive health has impacted negatively on the likelihood of the MDGs, and MDG 5 in particular, being realized.

At present, the world's maternal mortality ratio is declining at too slow a rate to reach MDG 5 by the target date of 2015. To achieve it an annual decline of 5.5 per cent between 1990 and 2015 is required. However, the current rate of decline is below one per cent. Indeed, the 2008 MDG Review High Level Event noted least progress has been made on MDG 5.

IPPF's 151 Member Associations working in 176 countries provide vital service delivery points and see the impact that universal access to reproductive health has on the lives of the most poor and marginalised on a daily basis.

Voluntary family planning and counselling is widely recognized as one of the most cost-effective health interventions which would make significant progress towards achieving MDG 5. At least 200 million women want to space or limit their pregnancies, but are unable to because they lack access to safe and effective family planning methods. It is vital therefore that these programmes are scaled up. This lack of access to effective contraceptives is compounded by the fact that only 58 per cent of women in developing countries deliver with the assistance of a midwife or doctor. Access to emergency obstetric care remains low, while birth rates among adolescent girls and young women, who are most vulnerable to complications in childbirth, remain high. Indeed, girls aged 15 - 20 are twice as likely to die in childbirth as those in their twenties with those under the age of 15 five times as likely to die. Indeed, complications of pregnancy or childbearing represent the leading cause of mortality for girls aged 15-19 in developing countries. Only thirty-three per cent of HIV positive pregnant women receive drugs to prevent transmission from mother to child, and many pregnant women do not receive appropriate counselling and access to other related services for the primary prevention of HIV, for unintended pregnancy and for infant feeding, thus impacting markedly on the ability of countries to achieve MDG 6.

The interventions needed to improve maternal health — especially family planning, emergency obstetric care, scale up of PMTCT and the presence of a skilled birth attendant — are widely recognized and cost effective. Access to family planning reduces unintended pregnancies (including amongst HIV positive women), unsafe abortion and maternal mortality and morbidity. The World Bank indicates that maternal mortality can be reduced by 40 per cent through investment in family planning, while ensuring skilled attendance at delivery, backed up by emergency obstetric care, would reduce maternal deaths by approximately 75 per cent. However, donor support for family planning has decreased dramatically. Funding explicitly for family planning as a percentage of population funding declined from 55 per cent in 1995 to five per cent in 2006. Poor access to these interventions is a significant barrier to improving maternal health. If member states were to substantially increase their investment in health systems, including dedicated resources for universal access to voluntary family planning, PMTCT, skilled birth attendants and emergency obstetric care and services to prevent and treat sexually transmitted infections — including HIV — the health of women and families would inevitably improve.

Recognizing that global health inequities within current development frameworks cannot be eliminated without focusing on comprehensive sexual and reproductive health and rights, IPPF believes the following actions must be taken:

- Adopt a comprehensive approach to tackling all aspects of the health related MDGs and recognize their link to population dynamics and poverty.

- Increase political and financial commitment over the next five years to bring MDG 5 back on track with the advances on other health related MDGs.

- Include MDG 5 targets a, and b, in all new financing mechanisms for global public health, particularly those pertaining to MDG 5.

- Give special focus to target 5b in next year's High Level MDG Review.

- Ensure existing financial and political commitments to sexual and reproductive health are monitored and fulfilled.

- Ensure increased financial commitment to the scale up of comprehensive PMTCT responses.

- Recognize that both the ICPD PoA and the MDGs will end in 2015 and urgently require increased political will and resources including reproductive health commodities if they are to be achieved.

- Develop for 2015, a coherent, visionary, rights-based development framework that incorporates the most crucial aspects of the MDGs and the ICPD, including reproductive health and young people's access to sexual and reproductive health services to achieve sustainable social and economic development.

- Prioritise implementation and monitoring of the "universal access to reproductive health" target (MDG 5b), including family planning; pre- and antenatal care; skilled attendance at birth; and emergency obstetric care.

- Scale up and expand PMTCT programmes that offer an under-utilised opportunity to strengthen the links between HIV and sexual and reproductive health (SRH) services.

- Develop a comprehensive package that includes primary prevention of HIV for women of reproductive health, prevention of unintended pregnancies among HIV positive women, counselling and support on safer infant feeding, ART and cotrimoxazole for mother-baby pairs and earlier infant diagnosis and initiation of ART.

- Recognize the need to provide comprehensive sexual and reproductive health services in emergency situations and reduce levels of sexual and gender based violence.

- Prioritize resources to meet the sexual and reproductive health and broader development needs of adolescents and young people across the MDGs, including through the provision of comprehensive sexuality education, access to youth-friendly services and sexual and reproductive health commodities.

- Invest in comprehensive primary care and recognise the importance of supporting programmes to reach the poor and marginalized.

- Ensure access to comprehensive safe abortion care and services in order to decrease maternal mortality and morbidity and where necessary remove existing legal, financial and other barriers.

- Develop and provide sex-disaggregated data and appropriate indicators to monitor progress for achieving the MDGs.

- Ensure adequate financial resources are available to achieve the MDGs. Wealthy nations must fulfil their 0.7 per cent of their Gross National Product (GNP) to Official Development Assistance (ODA) commitment before 2015. Meeting the MDGs costs approximately half of 1 per cent of wealthy nations' GNP.