

Evidence from the Realising Rights Research Programme Consortium to the All Party Parliamentary Group on Population, Development and Reproductive Health's enquiry into Maternal Morbidity

Summary of our evidence

Our submission will concentrate on three main areas where the consortium has been working on maternal health and morbidities:

- The urgent need to put in place interventions and services to prevent unwanted pregnancies and improve sexual and reproductive health.
- Research findings on the costs associated with unsafe abortions.
- Information on the scale of the problem of congenital syphilis and entry points for improving action in this area.

Maternal morbidity is a very neglected area of international health and the evidence base badly needs improving. Research funding should give this area much higher priority

Interventions to prevent unwanted pregnancies and improve sexual and reproductive health

Every minute a woman dies from complications related to pregnancy or childbirth. For each woman that dies 20 more are left ill or disabled. That is 529,000 dead women and 10 million more suffering as a result of pregnancy or childbirth every single year.¹

There is general agreement that to tackle maternal ill health we need sexual and reproductive health services (including family planning, services for sexually transmitted infections, safe abortion services where legal and post abortion care), care during pregnancy, skilled attendance during delivery and medical services in the first month after childbirth.²

However our efforts to improve maternal health are hindered by a combination of:

- Weak health systems with inadequate numbers of staff appropriately trained and empowered to assist at births.
- Non existent or inaccessible sexual and reproductive health services to provide family planning advice and contraceptives, safe abortion services where legal, post abortion care and antenatal services including screening and treatment for sexually transmitted infections and HIV.
- Poor quality services which women choose not to use.
- Access to healthcare which is constrained by social, cultural, religious and political norms which de-prioritise women's health and rights or stigmatise full and frank discussion and action on matters related to sex, sexuality and reproduction.

¹ WHO <http://www.who.int/features/qa/12/en/index.html> accessed 12 August 2008

² WHO <http://www.who.int/features/qa/12/en/index.html> accessed 12 August 2008

- Financial barriers, for example, inadequate investment in the area of maternal health and monetary burdens on households which prevent access to health care or leave families impoverished as a result of illness within the family.³

An acknowledgement of the centrality of sexual and reproductive health to maternal health has finally led to the creation of the new target under Millennium Development Goal 5 (MDG) 'ensure universal access to reproductive health by 2015'. Countries are now bound to report against a number of new indicators that track: contraceptive prevalence rate; adolescent birth rate; antenatal care coverage and unmet need for family planning.

Despite this sexual and reproductive health interventions face strong opposition in many settings. Many interventions that would improve maternal health have been disregarded as politically unpalatable despite the fact that they are evidence based. Discussions of issues such as access to safe abortion, family planning and contraception and action to safeguard rights are rare in mainstream maternal health discourse amongst advocates and policy makers alike.

Despite a prevailing narrative to the contrary maternal health is more than mere survival. Action is needed to prevent conditions like obstetric fistula, infertility and to screen and treat for sexually transmitted and reproductive tract infections. Furthermore a focus on contraceptive supplies and family planning education can help ensure that women can freely plan the timing and spacing of their pregnancies.

Maternal health needs to be viewed holistically. As part of health system strengthening we need improved and accessible sexual and reproductive health services, including services for safe abortion where legal. This needs to be accompanied by interventions to encourage and support women in realising their sexual and reproductive rights.

Recommendations:

- Sexual and reproductive health and right advocates in civil society and in Government must engage in maternal health policy debates in order to raise the profile of sexual and reproductive health.
- Greater attention should be given to publicising and operationalising the new target of 'universal access to reproductive health by 2015'. The 15th anniversary of the International Conference on Population and Development (ICPD) which will take place in 2009 provides a useful opportunity to take this work forward and take a harder look at what the universal access target means in practice.

Unsafe abortions

³ WHO

http://www.who.int/making_pregnancy_safer/topics/maternal_mortality/en/index.html
accessed 12 August 2008

Whether abortion is permitted or prohibited by law, women will seek abortion services and obtain abortions. They will seek them because of their social, economic, health or other personal circumstances. They will seek them because they have experienced rape and sexual assault. If safe services are not available, they will turn to unsafe ones. Almost 20 million unsafe abortions occur annually, virtually all in the developing world. Ninety-eight per cent of abortion related deaths are in developing countries, reflecting both restrictive abortion laws and lack of access to safe services even where the law is permissive.

Even in countries with the most punitive of laws, there are flourishing markets in providers who offer abortion services; this leaves poorer women more vulnerable to impairment, illness through infection and death than middle-class women who are able to pay for safer options. For the poorest women, and for young women with no money and no access to information about what services might be available, the only option is self-abortion, despite the steep risks it involves. Women stand a massively higher risk of dying or suffering disability as a result of pregnancy in countries with restrictive abortion laws than in countries where safe services are legal and fully available.⁴

Berer, analysing data from more than 160 countries, found that where legislation allows abortion on broad indications, the incidence of unsafe abortion and ensuing mortality is much lower compared to countries where legislation greatly restricts abortion.⁵ MDG 5 will not be met unless the burden of mortality from unsafe abortion is addressed. MDG 5 requires a 75% reduction in the maternal mortality ratio (MMR) by 2015 and some key countries, which will determine the overall success of this MDG, are seriously off track in meeting this target. Unsafe abortion is the second leading cause of maternal mortality worldwide, and in some countries more than a third of maternal deaths are due to post-abortion complications.

The latest WHO review of deaths and disabilities due to unsafe abortion estimates that nearly five million women annually suffer medical complications so serious that they require hospitalisation. These complications result in temporary or permanent disability, reproductive tract infections and secondary infertility.⁶ As well as their terrible consequences for the woman concerned and other family and household members, treating the effects of unsafe abortions has serious consequences for already overstretched medical facilities in poor countries. For example, it is estimated that 80% of Kenyan women who have unsafe abortions become ill as a consequence, and close to 21,000 women every year are hospitalised in Kenya due to unsafe abortion.⁷

⁴ Cornwall, A., Standing, H. and Lynch, A. (2008). Putting Unsafe Abortion on the Development Agenda. In *Unsafe Abortion: A Development Issue. IDS Bulletin* Vol. 39 no.3 Institute of Development Studies, Brighton.

⁵ Berer, M. (2004) National laws and unsafe abortion: the parameters of change. *Reproductive Health Matters*, 2004;12 Issue 24:1-8.

⁶ World Health Organization (2007) *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2003*, Fifth edition, Geneva: WHO

⁷ IPPF (2006). *Death and Denial: Unsafe Abortion and Poverty*, London: International Planned Parenthood Federation.

Thus, for every woman who dies, dozens more suffer such impairment that they will never be able to give birth again, and many more suffer chronic uterine and abdominal pain. For the survivors, the costs of unsafe abortion can have lifelong effects on the quality of their health, and their lives, on their livelihoods and on their contributions to development.

The economic cost of unsafe abortion is enormous, burdening public health systems, the households in which these women live and also the economies of the countries themselves. A study of these costs undertaken by researchers under an initiative funded by the Hewlett Foundation in 2007 and taken forward by an expert group convened by the Institute of Development Studies in 2007, to determine the global costs of unsafe abortion used two different methodologies to examine the cost of unsafe abortion-related morbidity and mortality to health systems.⁸ This found that the cost to the developing world lies between \$375 and \$838 million (USD 2006), with a central estimate of around \$500 million.

Regional cost estimates show that in relation to purchasing power, abortion complications are considerably more expensive to treat in sub-Saharan Africa than in Latin America. Furthermore, millions of other women with serious complications receive no treatment from the health system. If they were able to do so, an additional \$375 million or so would be expended, although this is a speculative figure without more systematic data. Also speculatively, the cost of long-term morbidities, mainly infertility and chronic reproductive tract infections, may cost many billions of dollars annually, while the losses to the economies of developing countries from lower productivity caused by unsafe abortion-related morbidity and mortality may be more than \$400 million. Out-of-pocket expenses to the women and their families may amount to a further \$600 million. In sum these estimates suggest that the total cost of unsafe abortion-related morbidity and mortality is likely to be many times greater than the direct health costs.

A major problem in the analysis of costs associated with unsafe abortion is the almost complete lack of information about the prevalence of cases with serious complications which fail to receive medical attention from a regular health facility. Some informed estimates put this proportion at between one third and one half of those who experience complications in countries where access to abortion is highly restricted.⁹ Using the estimate of Singh, namely that around 15-25 per cent of women undergoing unsafe abortions suffer untreated complications, it may be

⁸ Vlassoff, M., Shearer, J., Walker, D., Lucas, H. (2008) Economic Impact of Unsafe Abortion-Related Morbidity and Mortality: Evidence and Estimation Challenges. *Research Report*. Institute of Development Studies, Brighton. *Forthcoming*

⁹ Alan Guttmacher Institute (1999) *Sharing Responsibility: Women, Society & Abortion Worldwide*, New York: AGI, Benson, J and Crane, B (2005) 'Incorporating health outcomes into cost estimates of unsafe abortion' background paper for Workshop on Research on the Economic Impact of Abortion-Related Morbidity and Mortality, Guttmacher Institute 26 April

estimated that between 3 and 5 million women have an unmet need for Post Abortion Care, in addition to the 5.6 million hospitalisations that occur annually.¹⁰

Some of these women may be treated in non-formal or traditional medical systems and some may receive no treatment at all. Much of the abortion-related mortality takes place in this group of anonymous women. It is also likely that the inadequacies of formal health systems in low-income countries explain a large part of why a significant proportion of such women do not seek care or are unable to access it. Thus, the direct costs to the health system do not tell the whole story. If all the unmet demand for post abortion care were met by the health systems - in other words if the 3-5 million women who presently go untreated were to be treated, in accordance with the main goal of the ICPD - then it is estimated that this would add between \$300-400 million to the direct health-system costs. This points to a critical shortcoming in the current delivery of health services in the developing world. If regional data were available it might well show that costs would increase disproportionately in regions such as sub-Saharan Africa where health systems are poorly organized.

Besides the costs to health systems for treatment of the estimated 5.6 million women receiving care in a hospital setting, there are many other women who suffer from minor complications that can be treated at the primary health care level or privately. Very little is known about how many of the 19.8 million women experiencing unsafe abortion each year fall into this category. One study¹¹ has roughly estimated their number at one million women, based on their survey of several small-scale country studies. Pain management, treatment for anaemia, contraception and counselling are typical treatments that could be delivered at this level of care.

For the developing world as a whole, the unsafe abortion-related morbidity and mortality study estimated that minor complications of unsafe abortion cost about \$23 million each year. If countries followed WHO standards, the global-cost range goes from \$22.7 to \$49.1 million. These costs may be borne by the public health care system if primary health care is provided without charge to all women, while the costs may represent out-of-pocket expenses to women or households in settings where such care is provided privately. In other situations, these costs might be shared between a partially subsidized public health system and private contributions.

We can safely assume that very few women in developing countries, except those with the highest incomes, are able to seek infertility treatment, given the high cost of techniques such as in vitro fertilization, which, in developed countries, can easily cost several thousands of pounds. Also, in developing countries, infertility

¹⁰ Singh S. (2006) 'Hospital admissions resulting from unsafe abortion: estimates from 13 developing countries' *Lancet* 368: 1887-92

¹¹Benson, J and Crane, B (2005) 'Incorporating health outcomes into cost estimates of unsafe abortion' background paper for Workshop on Research on the Economic Impact of Abortion-Related Morbidity and Mortality, Guttmacher Institute 26 April

treatment within public health systems is virtually unknown. We can conclude with certainty that almost all women who suffer from infertility as a consequence of unsafe abortions belong to the group of women with an unmet need for infertility treatment.

From the estimate of infertility morbidity given by Aahman, there may be 1.5 million women annually who become infertile after unsafe abortions.¹² If treatment costs around \$4,000 for each of these women, then the potential cost of the global unmet need for infertility treatment could amount to \$6 billion each year. This estimate would decrease if it was possible to factor in the proportion of infertile women who would not want to be treated, but at the same time it would increase if the average number of IVF treatments needed before a successful pregnancy occurs could be estimated.

Even though infertility treatment has almost never been part of the reproductive health services of public health services in the developing world it is nevertheless important to highlight the magnitude of the cost that would be incurred if every case of post-abortion infertility were to receive adequate treatment. Although lack of data prevents precise estimation of this cost, there is no doubt that it is a very substantial amount indeed.

Indirect costs of abortion-related morbidity include the negative effects of chronic poor health on household income and on women's productivity. There are psychological costs as well. Secondary infertility in many settings is extremely damaging psychologically and stigmatizing to the woman. Chronic pelvic inflammatory disease (PID), teratogenicity¹³ and dyspareunia¹⁴ can also cause marital stress and lead to psychological trauma.

The long-term health consequences of abortion complications have not been well studied. Among those noted in the literature are secondary infertility, hysterectomy, severe anaemia, and PID. Empirical data on the incidence of these long-term morbidities, however, are almost non-existent, reflecting the neglect of research on maternal morbidity generally.

Recommendations:

- The UK Government should use its position as a global leader on sexual and reproductive health issues to make visible the enormous human and financial costs associated with unsafe abortion.
- Action on unsafe abortion and its consequences should be a central strategy of the various international initiatives that have been created to act on maternal ill health. The UK Government's engagement with the Partnership for Maternal, Newborn and Child Health, the UNFPA Thematic Fund for Maternal Health and Deliver Now for Women and Children provides an entry

¹² Aahman E *et al* (2005) *The global burden of unsafe abortion in the year 2000*, draft working paper, Geneva: WHO

⁽¹³⁾ Teratogenicity: the presence of an agent or factor that causes malformation of an embryo.

⁽¹⁴⁾ Dyspareunia: difficult or painful sexual intercourse.

- point for raising this issue at international level and ensuring that the response is financed.
- There is compelling evidence of the importance of safe abortion services to health system strengthening and the rational use of scarce budgets for health in developing countries. Parliamentarians should use this evidence to support moral arguments around the provision of services.

Congenital syphilis

12 million people are infected with syphilis each year despite the means to prevent onward transmission, through the use of male and female condoms, and the existence of screening technologies and inexpensive treatment.

Syphilis can be transmitted to the unborn child via the placenta. Not all infants born to infected women will be infected but the risk of transmission is higher during the early stages of infection. Every year, at least half a million infants are born with congenital syphilis. In addition, maternal syphilis causes another half million stillbirths and miscarriages annually. The emotional distress caused by these events is unquantifiable and yet thoroughly avoidable.

Syphilis screening and treatment, with a single dose of penicillin, could be provided at relatively low cost. Even in low prevalence settings action on congenital syphilis is a highly cost effective intervention. Interventions in this area would also contribute to health system strengthening. Yet syphilis still constitutes a huge public health burden in many middle and low income countries, hampering our efforts to meet Millennium Development Goals 4 and 5 on child and maternal health and preventing many women from realising their sexual and reproductive rights.

The World Health Organisation has put in place a strategy of action to eliminate syphilis based around 4 pillars:

- **Pillar 1** Ensure sustained political commitment and advocacy.
- **Pillar 2** Increase access to, and quality of, maternal and newborn health services. Ensure that all pregnant women are screened and adequately treated, and decrease the frequency of missed opportunities for screening women outside maternal and newborn care.
- **Pillar 3** Screen and treat pregnant women and their partners. Currently available diagnostic tests for syphilis are effective, affordable and require minimal logistic support. All infected women, and their partners, should be treated, as should infants born to infected mothers not treated during pregnancy.
- **Pillar 4** Establish surveillance, monitoring and evaluation systems. Improve surveillance systems, develop indicators, and strengthen monitoring and evaluation systems.

Lack of research on the prevalence and effects of maternal syphilis has meant that the scale of the problem has often not been appreciated. There is an urgent need to scale up maternal health services. In the developing world, only

an estimated 68% of pregnant women access antenatal care and among those that do the average time of first attendance is late at 5 to 6 months. By this time it is often too late to prevent the transmission of the infection to the foetus.

Women may be inhibited from accessing antenatal care by the distance that they need to travel or other costs incurred. Even where antenatal services are available a lack of knowledge and training coupled with stigma and embarrassment can mean that service providers are uncomfortable in dealing with sexually transmitted infections. In some settings the appropriate tests are unavailable. In addition there is little awareness of the interaction between syphilis and pregnancy on the part of communities which means service users are unlikely to demand testing and treatment.

Recommendations:

- Policy guidance for action on congenital syphilis needs to be integrated into national health and development planning. In its negotiations with national governments the International Health Partnership should help ensure that national planning takes this issue into account.
- UK Government support to programmes for the prevention of mother to child transmission of HIV should be mindful of the need to integrate broader sexual and reproductive health services into these interventions. Action on congenital syphilis is one such service.

Further information

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