ADDRESSING INEQUALITIES

The Heart of the Post-2015 Development Agenda and the Future We Want for All

Global Thematic Consultation

Maternal Mortality:
An Indicator of Intersecting Inequalities

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Summary:

Maternal mortality is a key indicator for measuring socio-cultural and economic inequalities that adversely affect women and girls and impede progress in the development goals set for 2015. Gender inequality, poverty and disparities in women's and girls' access to health, education and income as well as socio-cultural status are all key factors that impact maternal health. Based on monitoring developed in Africa, Asia Pacific and Latin America and the Caribbean, diverse Sexual and Reproductive Health and Rights networks, including those working on HIV, researched the linkages between MDG 5 and MDGs 3 and 6. It was affirmed that the only way to improve maternal health is by building and strengthening a comprehensive approach that incorporates cross-cutting issues of gender equality and women's and girls' education and empowerment, elimination of early marriage, poverty alleviation, access to sexual and reproductive health commodities and services including safe abortion, HIV prevention and delivery health care. The debates and findings of this study are presented here, as are the strategies that were developed for addressing gender inequality and ensuring that women and girls are guaranteed full exercise of their human rights, as necessary steps for achieving the development goals leading up to and beyond 2015.

Introduction:

Maternal mortality is a key indicator for expressing socio-cultural and economic inequalities that adversely affect women and girls and impede progress on the development goals set for 2015. Women with less education are more likely to live in poverty than those who have attained higher levels of education. They have lower salaries and precarious working conditions, with fewer benefits such as family and medical leave, health insurance and holidays. Women living in poverty also have less access to health care. These conditions are most often passed onto their sons and daughters, perpetuating the viscous cycle of poverty.

Gender inequality, poverty, and disparities in women's and girls' access to health, education and income as well as lower socio-cultural status are all key factors that negatively impact maternal health, because women who suffer these inequalities also have fewer possibilities of accessing HIV prevention information and contraceptives, putting them at greater risk of unplanned pregnancies. This leads to increased rates of induced abortion, especially unsafe abortion, due to the fact that abortion is illegal or highly restricted in most developing countries. Making these interconnections visible shows how the improvement of maternal health goes hand in hand with the improvement of other social determinants that go beyond women's needs in health care services.

Putting this in the context of the development goals framework, we must recognize that all MDGs are interrelated and none of them can be fully achieved without the others. Regarding the debate about improving maternal health (MDG 5a) and universal reproductive health (MDG 5b), the main cross-cutting issues that cannot be excluded are: poverty alleviation (MDG 1), universal education (MDG 2), empowerment of women and gender equality (MDG 3) and combating HIV/AIDS (MDG 6a). In order to achieve all these goals, women and girls must be guaranteed the full exercise of their human rights, including their sexual and reproductive rights, and the right to live free of all forms of stigma, discrimination and violence.

To highlight the linkages of MDG 5 with MDGs 1, 2, 3 and 6, diverse Sexual and Reproductive Health and Rights networks -including those working on HIV- in Africa, Asia Pacific and Latin America and the Caribbean[1] monitored progress on the fulfillment of these goals and researched what needed to be done to achieve a comprehensive approach to MDG 5. It is from this perspective that the situation of maternal health was analyzed and that maternal mortality was found to be an indicator of broader inequalities.

Maternal mortality and underlying inequalities: A look at MDGs 1, 2, 3, 5 and 6 in Africa, Asia Pacific and Latin America and the Caribbean

The maternal mortality ratio (MMR)[2] is one of the main indicators taken into account for MDG 5: improve maternal health. This MDG established that the MMR be reduced by three quarters between 1990 and 2015. **In 2010 this was still far from being achieved and was considered the MDG where least progress had been made[3].** According to the latest UN Report on the MDGs, although there have been "important improvements in maternal health and reduction in maternal deaths, (…) progress is still slow, [and] reductions in adolescent childbearing and expansion of contraceptive use have continued, but at a slower pace since 2000 than over the decade before".[4]

In developing regions, which account for 99% of maternal deaths globally, the MMR went from 440 in 1990 to 240 in 2010.[5] **The MMR is 15 times greater in developing regions than in developed regions, being one of the health indicators that most closely reflect socio-economic inequalities.[6]** Over half of maternal deaths that occurred around the world in 2010 (287.000) occurred in sub-Saharan Africa, where the ratio remained at 500.[7] Although the ratio in Southern Asia has been reduced to 220, this subregion has the second highest MMR and almost a third of maternal deaths globally.[8] By 2010, the MMR in Oceania was reduced to 200, in the Caribbean 190, South-Eastern Asia 150, Northern Africa 78, Latin America 72, Western Asia 71, Caucuses and Central Asia 46 and Eastern Asia 37.[9]

Sub-Saharan Africa and Southern Asia are the two subregions not only with the highest MMR, but where almost all other inequalities that contribute to maternal mortality are also highest. A similar trend is found in the Caribbean, Oceania and Latin America, but with lower indicators overall. Although the most direct causes of maternal mortality in developing countries are unsafe abortion and the inaccessibility of or lack of access to health care services due to geographical, economic and/or socio-cultural barriers, poor maternal health and increased maternal mortality are actually rooted in poverty and lack of access to education, decent work and income, which translate into lack of access to other essential services and opportunities for achieving health and wellbeing.

In **Africa** it is particularly difficult to collect data on maternal mortality, considering that a significant number of births and deaths occur at homes or outside health care institutions, and other forms of registering maternal mortality tend to be inaccurate. In Africa, particularly sub-Saharan Africa, barriers to accessing quality health services are created by many factors, including poverty, women's limited access to education and income, nutritional problems and poor or non-existent infrastructure in conflict and post-conflict situations. Poor access to health services also means virtually non-existent access to malaria and HIV treatment, prevention, care and support, modern contraception, and skilled health personnel at delivery. Altogether these factors increase the region's MMR, which is the highest in the world.

Data shows a clear pattern of higher MMRs in rural versus urban areas of sub-Saharan Africa, which has been attributed in large part to differences in geographical access to obstetric care as well as to socio-cultural factors found in rural areas.[10] In Ghana, data about the causes of maternal mortality among different socio-demographic groups shows that mortality decreased when education levels increased.[11] In Mali, where the MMR is one of the highest worldwide - out of reach of the 2015 goal-, besides geographical barriers, traditional practices and the high illiteracy rates among women and girls were also barriers to accessing skilled maternal health personnel.[12] High MMR rates also persist in many poor urban areas, most likely resulting from factors such as high HIV prevalence, unsafe abortion or poor quality of emergency obstetric care in hospitals.[13]

HIV/AIDS, as the leading cause of death worldwide among women aged 15-49, is another key contributor to maternal mortality, especially in regions with elevated HIV incidence, such as Southern Africa and the Caribbean.[14] HIV increases women's risk of death in childbirth, through anaemia, postpartum haemorrhage and puerperal sepsis, or through opportunistic infections, pneumonia, tuberculosis and malaria. In Africa, Namibia and Gabon have made no progress in reducing the MMR, while the MMR has increased in other countries since 1990: Botswana, Congo, Kenya, Lesotho, Somalia, South Africa, Swaziland, Zambia and Zimbabwe; with Botswana and Zimbabwe's MMR having more than doubled from 1990 to 2008.[15] Most of these

countries have large HIV/AIDS epidemics. In 2008 it was found that progress overall would have been greater if the HIV epidemic had not contributed to substantial increases in maternal mortality in Eastern and Southern Africa, and that the MMR would have declined in Southern Africa if HIV-related deaths were excluded.[16] To reduce the incidence of HIV-related maternal deaths, women living with HIV must have permanent and reliable access to antiretroviral drugs, which is especially imperative when they become pregnant and during prenatal and post-partum care.

Other factors of Africa's MMR are political conflict and instability in post-conflict contexts. All eight countries in the region with the highest MMRs in 2008 were in conflict or post-conflict.[17] In those contexts women's access to heath services is poor, due to lack of transportation, roads and communication services. Integral multisectoral responses are needed to increase women's access to a diverse range of resources and services, all of which are necessary conditions for reducing maternal mortality and guaranteeing sexual, reproductive and maternal health.

In **developing countries in Asia and the Pacific,** as of 2010, the average MMR had only declined from 395 to 342[18]. Each year, around 140.000 women in the region die as a result of a normal life cycle event: pregnancy and childbirth[19]. The countries still showing the highest MMR in 2010 include: Lao People's Democratic Republic (470), Afghanistan (460), Pakistan (260), Cambodia (250), Bangladesh (240), Papua New Guinea (230), Indonesia (220), India and Myanmar (200) and Nepal (170). India itself accounts for 19% of maternal deaths globally,[20] and is an example of how inequalities produce gaps within a single country. Despite a declining MMR, huge disparities persist between different states and districts, "due to differential levels of socioeconomic development", which "are reflected in access to skilled birth attendance, emergency obstetric care, and overall status of women, marked by levels of various factors such as female literacy, maternal health, and anaemia".[21] To reduce the MMR in the region the response must incorporate not only routine and emergency obstetric care and skilled birth attendants, but also the broad range of factors mentioned above. In Nepal the government has taken measures to reduce maternal mortality, including education for women and girls, improving roads, increasing the legal age for marriage and expanding access to safe abortion services, which began in 2004.[22]

In **Latin America and the Caribbean** the average MMR is much lower than in Africa and Asia Pacific, but, **despite progress, the goal set for 2015 will not be met**. Between 1990 and 2010 the MMR in Latin America descended from 130 to 72, and in the Caribbean from 280 to 190[23]. This reduction still leaves both subregions far from the goal, which would be a rate of 32 and 70, respectively, by 2015. By 2010, Haiti (350), Guyana (280), Bolivia (190), Dominican Republic (150), Guatemala (120), Ecuador and Jamaica (110) and Honduras (100) were particularly far from reaching the proposed reductions. Countries such as Chile (25) and Uruguay (29) have

very low rates.[24] Argentina (77) still has an MMR two to three times higher than Chile and Uruguay, and has not shown a reduction but rather a steady increase since 1995.[25]

These data from LAC and the other regions are provided by the UN[26] and are not necessarily the same as those reported by governments. The UN corrects data to take into account underreporting and other problems in registering information. According to WHO, maternal mortality is difficult to measure accurately and many low-income countries have very little or no data, so, instead, modeling is often used to obtain national estimates.[27] These difficulties found in low-income, developing countries, is also related to the limited availability and/or accessibility of health services, due in part to geographical reasons such as poor roads and communication systems and fewer health centers in rural areas and economic reasons such as user fees, transportation costs or lack of time due to women's heavy time burdens. The lack of adequate reporting mechanisms in the poorest and most affected areas and countries means that the data that is collected is less likely to be disaggregated by age groups, urban/rural populations or socioeconomic characteristics, such as education and income level. These obstacles must be overcome in order to obtain the data necessary for designing targeted interventions that will address the needs of populations most in need and reduce the MMR.

Another key factor that must be considered is **access to contraceptives,** an essential commodity that must be made available through all sexual and reproductive health services. However, **where women consistently lack access to health services –or lack the education and resources that would empower them to exercise their health rights-, they also lack access to essential information and supplies, especially contraceptives.** Globally, contraceptive prevalence increased in the 1990s, but progress slowed in the 2000s. This prevalence rate measures the proportion of women aged 15-49, married or in union, using any method of contraception. In sub-Saharan Africa only 25% of women were in this situation, in Oceania 38%, in Southern Asia 56%, in Western Asia 58%, in the Caribbean 61%, and Latin America 74%.[28] These numbers reflect low availability of contraceptives. However, the use of modern and effective contraception methods, such as the oral contraceptive pill, the male condom or the IUD, is also subject to differing cultural values and social representations. Social and cultural obstacles make it even harder to access such methods and more difficult for women to negotiate their use. Negative consequences include increased unintended pregnancies, which fuel the number of unsafe abortions, as well as increased vulnerability to HIV infection, especially for women. Lower social status compared to men, poor education and religion all limit the extent to which women are able to exercise their reproductive choices, putting their health and lives at risk.[29]

Unmet contraceptive needs measures among women aged 15-49 the gap between their desire to delay or avoid having children and their actual use of contraception[30], but there are

discrepancies in how each country interprets its meaning and many countries do not even provide information. According to available data, levels of unmet need are moderately high for most developing regions (excluding Eastern Asia), reaching as high as 25 per cent in sub-Saharan Africa, 17% in the Caribbean and Western Asia, 16% in Southern Asia, 13% in Caucasus and Central Asia and South-Eastern Asia, 12% in Northern Africa and 10% in Latin America[31]. In sub-Saharan Africa one in every four women has an unmet need for family planning, a reality which has gone almost unchanged since 1995. The fast growing number of women in reproductive age in this sub-region presents an even greater challenge for meeting their unmet needs for contraceptives.

Meeting all women's needs for contraceptives is one important aspect in reducing maternal mortality. In Eastern Asia, which experienced the greatest reduction in MMR, the contraceptive prevalence rate is 84%, as opposed to only 22% in sub-Saharan Africa, where the MMR declines have been the smallest in the world.[32] In Latin America and the Caribbean unmet demand for family planning is higher in poor population groups. The disparities among and within countries are significant, with poor groups reaching a rate three times higher than among affluent groups.[33] Poverty is the central obstacle to improving maternal health as it keeps women and girls from being able to exercise their sexual and reproductive rights. Difficulties in exercising these rights contributes to higher rates of unintended pregnancies, including adolescent pregnancies, as well as maternal deaths among women of all ages, due to the resistance of health care services to practice safe **abortion when permitted by law.** They also contribute to the feminization of the HIV epidemic, which is observable in Africa and Asia Pacific where contraceptive prevalence rates are especially low.[34]

The **adolescent birth rate** is another relevant index for maternal health, taking into account that adolescent pregnancies are by definition high risk, and are also linked to poverty and lower levels of education.[35] The progress made globally in reducing the adolescent birth rate does not measure up with the goals established in MDG 5b. In developing regions in 2009 it was 52 per 1,000 women aged 15-19, which represents only a slight improvement since 1990 when it was 64. However, there are large sub-regional disparities. Sub-Saharan Africa far exceeds that average, with a rate of 120, followed by Latin America at 80, the Caribbean at 69, Oceania at 62, Western Asia at 48, Southern Asia at 46 and South Eastern Asia at 45.[36]

Early pregnancies are still common, often due in many countries in Africa and Asia Pacific to the very **young ages of marriage**. The latest estimates indicate that "one in three girls in low and middle-income countries (excluding China) will marry before the age of 18", and "one in nine girls will marry before their fifteenth birthday".[37] The prevalence of early marriage is even higher in the least-developed countries: nearly one in two.[38] The two sub-regions with the highest percentage of women aged 20-24 who were married or in union by the age of 18 were

Southern Asia (46%) and West and Central Africa (41%). Among adolescents, the frequency of sexual activity is higher among those in marriage or union, therefore the likelihood of pregnancy in the absence of contraception is greater.[39] In Southern Asia and sub-Saharan Africa adolescent pregnancy outside marriage is not as common as it is in Latin America and the Caribbean.[40] Sub-regional differences indicate socio-cultural norms -in this case early or forced marriage- impact women's freedom to make their own decisions regarding their sexual and reproductive health and can contribute to higher rates of adolescent pregnancies and greater risk of HIV infection. Adopting and enforcing legal changes to deter early marriage contributes to women's self-determination and to reducing adolescent childbearing. This is an urgent measure, considering that, despite existing national laws and international agreements, in more than 100 countries child marriage remains a real threat to girls' human rights, lives and health.[41]

The slow progress in reducing adolescent birth rates raises a question about the lack of policies -or of their implementation- that guarantee girls' and adolescents' right to education, including to comprehensive sexuality education in schools, and to access health services, including youth-friendly sexual and reproductive health services which guarantee full evidenced-based information and commodities. Young people and adolescents in developing countries, and even unmarried women in some countries in Asia, face many difficulties in accessing contraceptives in public health care systems, often because of stigma and taboos denying sexuality in these population groups. In addition to obstacles such as early marriage, the lack of progress in these regards is another factor that keeps the adolescent birth rate high.

These links reveal how broader inequalities, including unequal access to basic social and health services, are shaped by economic, geographic and socio-cultural factors and altogether contribute to maternal mortality. The diversity of inequalities experienced within an across regions must be addressed in efforts to improve maternal health and reduce maternal deaths.

Unsafe abortion, often a result of the series of difficulties women and girls face in knowing and exercising their sexual and reproductive rights, is another factor contributing to high MMRs in developing countries. In this sense, unsafe abortion must be understood as a public health issue, but also, and foremost, as a violation of women's rights.

In Africa, Latin America and Asia Pacific -excluding China and India-, **unsafe abortion can be linked to unmet needs for family planning and, just like that indicator, it also represents a principal cause limiting the improvement of maternal health**, especially affecting poor women. In 2008, 14% of all maternal deaths in Africa and 12% in Asia, Oceania and Latin America and the Caribbean were due to unsafe abortion.[42] According to WHO estimates, in developing countries there were 19.2 million unsafe abortions in 2003, and in 2008, 21.2 million[43]. The most recent figures, published in 2011 and 2012, use statistics from 2008, reflecting the

difficulty in registering unsafe abortion incidence. Considering that abortions go highly underreported, especially in countries with highly restrictive abortion laws and where the practice is stigmatized, they actually represent a larger portion of maternal deaths than figures reflect.

According to the most recent Guttmacher Institute report, "studies have found that abortion incidence is inversely associated with the level of contraceptive use, especially where fertility rates are holding steady, and there is a positive correlation between unmet need for contraception and abortion levels"[44]. This might be partly explained by the fact that unmet needs for contraception are lower where there are liberal abortion laws -compared to where there are restrictive laws-, and where there are liberal laws there was found to be lower incidence of abortion.[45] The lack of progress globally in reducing unmet need for contraceptives, especially in developing regions, may then correlate to the fact that unsafe abortion incidence in the same regions has not decreased either[46], and has even increased in some regions. Even where abortion is allowed by law in some cases, it is often denied due to social or religious beliefs of justice, law enforcement and health workers that interfere with their duty to practice according to current legal standards. When safe abortion is unavailable, either because it is illegal or because it is denied despite being permitted by law, women who are determined to avoid an unplanned birth will resort to unsafe abortion. In this sense, legal and other restrictions push procedures outside the law, where they are carried out in unsafe conditions using homemade methods that put women's health and life at risk. It is often the poorest women, who lack resources to access safe abortion services, who reach this situation and face a greater chance of mortality.

In **Africa** abortion is still widely illegal and such services are often unsafe and available at high cost, which increases the risk of death for pregnant women. Between 1995 and 2003, unsafe abortion rates on the continent dropped from 33 to 29 per 1,000 women aged 15-44, but from 2003 to 2008 they remained stable at 29, showing a halt in the reduction rate.[47] Eastern and Middle Africa were far behind the average, with rates of 38 and 36 respectively.[48] In South Africa abortion is permitted by law since 1996 and is increasingly available in public health services, resulting in a 91% decrease in the annual number of abortion-related deaths,[49] but unsafe abortion has not yet been eliminated. This is most likely because, as occurs in many countries, the population in need does not have information on what is available to them by law or on the services that exist so they do not use them. In other Southern African countries, abortion is permitted in certain cases, for example: Swaziland approved a new constitution in 2005 that allows abortion to save the life of the woman or in case of serious threat to her physical or mental health.[50]

In **Latin America and the Caribbean,** unsafe abortion rates dropped from 35 per 1000 women aged 15-44 in 1995 to 30 in 2003, but then saw a slight increase to 31 in 2008.[51] Complications of unsafe abortion are among the leading causes of maternal death, representing 12% of maternal deaths in the region and most likely even more considering underreporting.[52] It is the leading cause of death in Argentina, Jamaica and Trinidad & Tobago[53]. Currently, Chile, Dominican Republic, El Salvador, Haiti, Honduras and Nicaragua prohibit even therapeutic abortion. Nicaragua and El Salvador have restricted their laws after 2005[54]. This shows an alarming step backwards in the region and attempts against achieving the reduction of maternal mortality rate as intended in MDG 5.

In **Asia**, unsafe abortion rates dropped minimally, from 12 per 1,000 women aged 15-44 in 1995 to 11 by 2003, which remained at 11 five years later in 2008.[55] However, the situation is different from the other two regions. Although the average number of abortions overall is similar to that in Africa and Latin America and the Caribbean, the proportion of those abortions that is unsafe is dramatically lower, because safe procedures outnumber unsafe ones due to the legal abortions that are commonly performed in China under the population policy of one child per family. Most of the reduction in maternal mortality rates in the region took place due to the increase of safe abortions.[56] Meanwhile, in Western Asia, the increase of the proportion of abortions that are unsafe was partly as a result of declines in the incidence of safe abortion.[57]

Despite the evidence summarized here, abortion laws remain highly restrictive in most of the developing world. Necessary measures to reduce maternal mortality from unsafe abortions include: improving access to sexual and reproductive health services and commodities, increasing effective use of contraceptives and ensuring access to safe abortion services and post-abortion care[58]. Without these measures, which must be accompanied by education and resources to empower women to know and exercise their sexual and reproductive rights, the incidence of unsafe abortions and MMRs will continue to increase.[59]

Debates on building a comprehensive approach to maternal mortality and further advancing basic health and rights in developing regions

The slow progress in reducing maternal mortality and improving reproductive and maternal health is unacceptable. To accelerate progress and reduce disparities within and between countries, the broad equalities that underlie these specific issues must be addressed in a comprehensive manner. But how can this be achieved?

First, we must consider what we are measuring as “progress” and how we go about doing this. Are we using indicators that will help us understand if women’s, young people’s and adolescents’ sexual and reproductive health and rights are being comprehensively addressed?

Do they take into account gender inequalities and collection of sex–disaggregated data, both factors that are central to gender-sensitive responses? What other aspects or perspectives must we take into account in order to comprehensively work toward achieving these interconnected development goals?

In setting out to explore these questions, the networks involved in the study, whose findings and debates laid the groundwork for this paper, came to the conclusion that the set of indicators proposed by the United Nations for MDG 5 needs to be complemented in order to clearly express the current situation of women's access to maternal health in the world. One of the main problems found in the proposed indicators is that they do not integrate a wider array of fundamental factors affecting maternal health. Very few of the targets proposed would be obtained by improving health care services if this is not accompanied by policies and commitments that address all of these issues comprehensively.

Therefore, the networks proposed to consider MDG 5 in relation to *all* the indicators used by the United Nations for MDGs 3, 5a, 5b and 6a,[60] *as well as these additional indicators*: MDG 3: acess to comprehensive sexuality education in primary and secondary education; minimum legal age for girls to marry as established by law; data about violence against women; MDG 5a: MMR disaggregated by cause of death to determine proportion of HIV-related maternal mortality; prevalence of unsafe/safe abortions; MDG 5b: prevalence rate of double protection; access to free condoms by adolescents (15-20 years of age) without the presence of an adult; proportion of women offered voluntary HIV counselling and testing during antenatal care; and MDG 6a: HIV prevalence disaggregated by sex among population aged 15-24; correct comprehensive knowledge of HIV/AIDS disaggregated by sex among population aged 15-24; and information about AIDS orphans. The analysis of these indicators took into account the cross-cutting nature and effects of poverty alleviation and universal education addressed in MDGs 1 and 2 respectively.

Considering the issues addressed by all of these MDGs as separate will continue to prevent us from eradicating the inequalities that drive maternal mortality, which are especially persistent in developing countries. The subregions that have the highest MMR –sub-Saharan Africa and Southern Asia- are also those with the highest levels of extreme poverty, vulnerable employment (except for Oceania), child under-nutrition and mortality, and together are home to 75% of the 61 million children of primary school age that were out of school in 2010: 33 million and 13 million respectively.[61] These are also the two subregions with the lowest proportion of deliveries attended by skilled health personnel, the lowest proportion of pregnant women that received at least one antenatal care visit by skilled health personnel, the lowest proportion of pregnant women that received four or more antenatal care visits by any provider, and the lowest contraception prevalence rates (except for Oceania).[62] These

correlations reveal deep interconnections between the multiple, intersecting inequalities that act together to impede the guarantee of women's and girls' health and rights and sustainable development overall.

One of the principal factors in women's and girls' empowerment to break the viscous cycle of poverty is ensuring basic education for girls. Basic education itself is a human right and a necessary condition for exercising other rights, as well as a foundation for inclusive development and transformative change.[63] However, poverty, rural residency and gender inequalities altogether condition who accesses education and who does not. Young adolescents from poor and rural households are those most likely to be out of school, and girls from the poorest households are those that face the most significant barriers to education.[64] Again, Southern Asia was the region with the most notable gender gap in literacy rates in 2010, with only 86 literate women for every 100 literate men in the age group 15-24 years.[65] This is also one of the regions with the highest incidence of early marriage among girls and young women, another practice deterring women's and girls' empowerment.

The lack of opportunities in education together with other barriers faced in accessing formal employment mean that "women more often than men turn to the informal economy",[66] working in sectors lacking basic labor protections and often seeing their basic rights violated. These gender inequalities persist not only in wage earnings differentials, but also in access to positions of decision-making and HIV infection rates, while low-income and rural populations in general also have less access to nutritious food, safe drinking water, improved sanitation, and child death rates and stunting are two to four times higher between the lowest and highest wealth quintiles.[67] In accordance with the recent Report to the Secretary General, our conclusions reaffirm that these broader inequalities "are key determinants of both higher mortality and fertility rates among the poor and in low-income regions", and are linked to the "high levels of unintended pregnancy [that] persist in many countries, particularly among the poor and young adults".[68] Therefore, to reduce MMRs and improve maternal and reproductive health, it is necessary to act primarily on the broader inequalities addressed in other MDGs, especially around poverty, education and women's and girls' empowerment, rather than solely concentrating on improving health care services.

Improving access to basic food, water, sanitation, social and education services and decent work are all integral parts of a comprehensive strategy to improve reproductive and maternal health. Within this range of services, primary and secondary education must incorporate comprehensive sexuality education (CSE) as an additional component. Only evidence- and rights-based CSE curricula for all girls and boys will provide them with the specific tools they need to be able to build gender equality in their relationships and exercise their sexuality responsibly, preventing both HIV and unintended pregnancy and reducing adolescent birth

rates which eventually contribute to unsafe abortions and maternal mortality in many developing countries. To make CSE fully effective in the lives of young people and adolescents, it must be accompanied by access to youth-friendly sexual and reproductive health services for young people and adolescents (15-24 years), including free and anonymous distribution of condoms within public health systems without the presence of an adult or any other requirement.

Despite the clear need for CSE and access to contraceptives for adolescents and young people, these rights are often violated. Many countries do not have specific youth-oriented sexual and reproductive health policies, and in those that do they often go unimplemented or favor abstinence-only sexuality education. This occurs due to the influence of socio-cultural taboos and stigma around issues of young people's sexuality that are part of traditional cultures or that come attached to international funding, as was the case with PEPFAR funding, which has relaxed although not completely eliminated abstinence-only restrictions. The lack of human rights- and evidence-based public policy deters the possibility of achieving the goals of improving maternal and reproductive health.

CSE is also an essential tool for addressing harmful cultural norms and practices that are obstacles to women's and girls' empowerment. It teaches equality between women and men and builds awareness about gender-based discrimination and violence against women and girls starting at a young age. This approach is key to transforming socio-cultural factors that underpin the persistence of gender inequalities.

Harmful cultural practices that impact women's and girls' health include gender-based discrimination in access to basic services and rights, early and forced marriages, as well as all forms of violence against women and girls, which represent the most severe and pervasive manifestations of inequality and discrimination. The violence that women suffer inside and outside health care services –including institutional as well as physical, sexual and psychological violence- constitute major human rights violations and are key barriers that impede the advancement of women's sexual and reproductive health and women's empowerment overall. Its elimination must be sought and prioritized first as on rights-based and ethical grounds. However, as a manifestation of broader underlying inequalities it is also a deterrent to progress in all aspects of development, and therefore must be integrated as a priority in all areas of the post-2015 development agenda.

The debates laid out here consider the broader inequalities that drive maternal mortality and represent significant barriers to development. They also identify the basic conditions that will allow women to exercise their fundamental human rights, including the right to the highest attainable standard of health, which encompasses sexual and reproductive health rights. Without taking into account each of the unique, interconnected determinants of maternal

health considered in this paper, it will not be possible to reduce maternal mortality or make the transformative changes needed beyond 2015 to accelerate progress in inclusive human development worldwide.

Comprehensive strategies for eliminating maternal mortality and contributing to the post-2015 development agenda

Considering the critical and complex situation of maternal health around the world, in order to accelerate the progress achieved to date and tackle underlying inequalities which perpetuate disparities and keep us from achieving the established goals, the post-2015 development framework must incorporate, prioritize and hold governments accountable to support, adopt and effectively implement evidence- and rights-based policies, strategies and interventions in accordance with these principles:

1. *Reduce poverty among women and children by guaranteeing decent work for women and gender parity in wage employment in the non-agricultural sector.* Achieving further reductions in extreme poverty is a worldwide debt, particularly in Africa, Latin America and the Caribbean and some Asia Pacific countries. Development growth strategies and macroeconomic policies must be gender-sensitive and directly aim to reduce poverty by building greater opportunities of wage employment for women in the non-agricultural sector.

2. G*uarantee access to primary and secondary education for all girls.* A continued effort needs to be implemented to reach the goals of universal education, increasing enrollment, retention and completion rates and reaching gender parity, increasing literacy rates among girls, putting a special focus on improving the quality of education. In all developing countries, governments must take effective measures to eliminate school fees so that primary and secondary education for girls can be reached. Ensuring basic education for girls is one of the principal factors in achieving women's and girls' empowerment and their ability to exercise their basic rights.

3. *Deliver Comprehensive Sexuality Education to adolescents and young people in all primary and secondary schools.* CSE must be incorporated into all school curricula to build boys' and girls' comprehensive and correct knowledge of HIV prevention and prevention of unintended pregnancies and reduce adolescent birth rates, as well as to increase awareness of and deconstruct harmful cultural norms and practices and contribute to building gender equality from a young age.

4. *Address harmful cultural norms and practices that are obstacles to women's and girls' empowerment, including early or forced marriage. Enact legal changes to deter forced and early marriages as a step towards women's and girls' empowerment and self-determination.* Early and forced marriage impedes girls' and young women's freedom to make their own decisions regarding their lives and health, especially their sexual and reproductive health, which increases the rate of adolescent pregnancies and puts them at risk of HIV infection as well as maternal morbidity and mortality.

5. *Eliminate all forms of gender-based violence against women and girls (VAWG) to guarantee their integrity and full exercise of their basic rights.* All forms of violence against women - sexual, physical and psychological- constitute major violations of women's rights and a primary impediment to women's empowerment; yet continue to be on the rise worldwide, undermining efforts to reach all development goals. Further progress before and beyond 2015 depends on advances that are made on this goal.

6. *Guarantee effective access to safe abortion when permitted by law, and enact legal reform to expand the conditions under which abortion is permitted by law.* Both of these actions are needed to reduce the incidence of unsafe abortions that consistently put the health and lives of millions of girls and women at risk and that continue to be one of the leading causes of maternal mortality in developing regions.

7. *Make sexual and reproductive health services and programs a priority in health system strengthening and improve the quality, availability and accessibility of all health services for women*, including primary health care, sexual and reproductive health care and essential commodities, and maternal health care, especially routine and emergency obstetric and gynecology care. Secure and increase sustainable investments in women's health and ensure the elimination of user fees for these services, prioritizing increased accessibility among rural populations who face greater barriers to services than urban populations.

8. *Recognize and guarantee the sexual and reproductive rights of all populations, especially of poor and marginalized women and adolescents and young people (15-24 years of age).* To meet the specific health needs of adolescents and young people, they must be guaranteed access to comprehensive sexuality education and confidential, gender-sensitive and youth-friendly health services that provide evidence-based information on sexuality and free access to a range of modern contraceptive methods as well as accurate information about those methods, to enable informed decision-making for preventing unintended pregnancies and HIV infection.

9. *Promote the integration of HIV/AIDS prevention, treatment, care and support within sexual and reproductive health services and programs*, ensuring that health care professionals

incorporate a gender and rights-based perspective and promote voluntary counseling and testing for adolescents and women.

10. *Strengthen data collection and reporting mechanisms at country level, including data disaggregated by age groups, urban/rural populations and socioeconomic characteristics - education and/or income level.* This information is necessary to design targeted interventions that will address the needs of populations most in need and reduce the MMR.

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