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Family Planning – Maternal and Newborn Health and the Causes for the Prevalence of Underweight Children with a focus on the Caribbean

by

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The countries of the Caribbean are with the exception of Haiti all considered to be developing countries or territories, while Haiti is considered to be one of the least developed countries. They are all small states that range in population size from less than 20,000 (Montserrat and Anguilla) to about 10 million in Cuba, Haiti and the Dominican Republic; of the English and Dutch speaking countries only Trinidad and Tobago (1.3) and Jamaica (2.8) have populations of over one million, the majority have populations of less than 200,000. The countries of the Caribbean referred to in this presentation include the members and associate members of the Caribbean Community [CARICOM]¹ Cuba and the Dominican Republic. The countries of the Caribbean Region were party to the Declaration of Port of Spain of November 2003 that reaffirmed their commitment to both the Programme of Action of the International Conference on Population and Development and the Millennium Development Goals which includes inter alia issues related to maternal and newborn health and to family planning.

Low Birth Weight is defined by the World Health Organization [WHO] as a birth weight of less than less 2500 grams; infants with this condition are approximately 20 times more likely to die than heavier babies. Low birth weight is the result of premature birth before 37 weeks gestation, or of restricted intrauterine growth. The mother's own foetal growth, her diet from birth to pregnancy, and thus her body composition at conception, affects birth weight. Low birth weight is associated with foetal and neonatal mortality and morbidity, inhibited growth, impaired cognitive development, and with chronic diseases later in life. Almost 25% of newborns in developing countries are born low birth weight, largely due to their mothers' poor health and nutritional status, which results in increased vulnerability to infection and a higher risk of developmental problems. In the Caribbean prevalence of low birth weight is 14%; ranging from 7% in the Bahamas to 13% in Suriname to 23% in Trinidad and Tobago.² It has been widely recognised for many years that there is a direct and powerful link between access to family planning and maternal and

¹ CARICOM member states: Antigua and Barbuda, Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Haiti, Jamaica, St Kitts and Nevis, Saint Lucia, St Vincent and the Grenadines, Suriname and Trinidad and Tobago. CARICOM associate members: Anguilla, Bermuda, British Virgin Islands, Cayman Islands, Turks and Caicos Islands

² Low Birth Weight – Country, Regional and Global Estimates WHO and UNICEF 2004

newborn health, indeed family planning is one of the pillars on which good maternal health and hence newborn health stands.

Across the globe the demand for contraception is rising very steeply, by the UN's projections the number of contraceptive users will grow by more than 38% by 2015- from 552 million people in 2000 to 764 million in 2015³. Donor financing of contraceptive supplies has remained more or less constant since 2001, when inflation and incidental costs that rise over time are taken into account. Once rising demand is also factored into the equation, it becomes clear that donors are supplying a smaller portion of people's needs for contraceptives every year. The estimated cost of providing contraception to the approximately 655 million women and their partners, who are already using contraceptives, in 2007 was US\$873 million (this does not include the 200 million women with an unmet need for contraception) the total requirements are US\$1.4 billion when condoms for HIV prevention are included; in 2007 donors provided US\$223 million or 16% of the total required.⁴ In most developing countries national governments are not dedicating adequate funds from their own financial resources to meet the short fall. "There is a vast and growing financial void between what the international community and national governments contribute to the supply of reproductive health commodities and the cost of providing modern contraceptives to women in the poorest countries" [IPPF Contraceptives at a Crossroads December 2008]

Simply put women need family planning, because without the ability to control their fertility they risk their lives and their health and that of their infants and children.

Each year, an estimated 500,000 women die of pregnancy-related causes, and almost all maternal mortality occurs in developing countries, representing one of the widest, and most unjust, health gaps between developed and developing nations. The risk of dying in childbirth for a woman in one of the Least Developed Countries [LDC] may be as high as 1:7 compared with the risk in the Most Developed Countries

³ Contraception at a Crossroads IPPF December 2008

⁴ United Nations Population Fund, Donor Support for Condoms for STI/HIV Prevention 2007 New York

of 1:47000, and for every woman who dies another 20 are afflicted with serious illness or injuries.

In the Caribbean, the overall level of maternal mortality of the region is 254 per 100,000 and while only 3 countries have ratios over 100 (Haiti 582, Suriname 116 and Guyana 143)⁵ nevertheless these maternal mortality ratios have shown no significant decrease over the last eighteen years. However the profile of maternal deaths has changed: there is a higher concentration now of deaths among adolescents, and also among women of all ages due to complications of HIV, obesity and diabetes. Complications due to unsafe abortion are one of the major causes of maternal death, although the deaths are not always reported as such. The UNECLAC /UNFPA ICPD + 15 report also notes that "indicators on the availability and use of emergency obstetric care facilities, as opposed to the often under- or misreported maternal health figures, reveals that the health care system is overburdened and has limited capacity. Quality of care also seems to be deficient, as demonstrated by the fact that the presence of skilled attendants at birth is virtually universal for most countries and yet maternal mortality ratios do not decline accordingly. This may be due to the equating 'skilled attendants at birth' with 'institutional deliveries'."⁶

Globally of the 500,000 annual maternal deaths, complications from unsafe abortion account for approximately 70,000, or 13 per cent, of all deaths. While unsafe abortion is one of the most common causes of maternal deaths, it is also the most easily preventable through the provision of, access to family planning and to safe abortion services and care. However in those Caribbean countries that have restrictive abortion laws accurate data on maternal morbidity and mortality attributable to unsafe abortion is difficult to access. For example information from a situation analysis on unsafe abortion in Trinidad and Tobago conducted by the Family Planning Association revealed that in 2004 the Hospital Annual Basic List Tabulations records treating 1854 women who had abortions; the list classified 333 of these as

⁵ Margaret C Hogan, et al: Maternal mortality for 181 countries, 1980–2008: a systematic analysis of progress towards Millennium Development Goal 5 [www. TheLancet.com](http://www.thelancet.com) Published online April 12, 2010 DOI:10.1016/S0140-6736(10)60518-1

⁶ UNECLAC Sub- Regional Headquarters for the Caribbean , UNFPA: 'Review and Appraisal of the Implementation of the Cairo Programme of Action in the Caribbean (1994-2009)'

spontaneous abortions, 5 as medical abortions, none were classified as legal or as illegal but 1516 were not classified at all.⁷

The World Bank has stated that investment in family planning can reduce maternal mortality by thirty-five to forty percent [35 to 40%]. 200 million women worldwide want to limit or space their pregnancies, but are still without the means to do so effectively, according to statistics from the United Nations Population Fund. Meeting the unmet need for family planning will reduce maternal morbidity and the burden of disease, so increasing individual, child and family and community well-being and economic productivity and link to HIV/AIDS prevention. A third of the burden of disease for women of reproductive age is linked to poor sexual and reproductive health. Surely this is the time to reinvigorate family planning funding, program implementation and ensuring contraceptive commodity security.

The overall Caribbean contraceptive prevalence rate [CPR] is 55 with rates varying across the region from 24 and 33 in Haiti and Guyana respectively to 67 and 72 in Jamaica and Cuba⁸. The UNECLAC/ UNFPA Review and Appraisal of the Implementation of the ICPD Programme of Action in the Caribbean (1994-2009) reports that “high, unwanted fertility still remains a pervasive phenomenon for the poor, pointing to strikingly high unmet need for family planning and hence to the persistence of factors limiting the exercise and enjoyment of human rights, including reproductive rights.” In Jamaica, for instance, there is a high unmet need - around 22 percent- whereas the CPR is also high at around 67 per cent. This paradox may point to important segments of women lacking access to sexual and reproductive health services including methods of family planning.

It is clear that the largest of these segments of the population is the adolescent population. 20% of live births in the Caribbean are to adolescent mothers. The birth rates to girls 15 – 19 vary from 43 per 1000 live births in Barbados to 95 per

⁷ A Situational Analysis of Unsafe Abortion in Trinidad and Tobago. Family Planning Association of Trinidad and Tobago 2009

⁸ Population Reference Bureau 2009 World Population Data Sheet

1000 in Belize; the average for the region is 72⁹. Adolescent mothers under the age of 18 have an increased risk of giving birth to low birth weight infants. The World Bank has noted that the onset of sexual initiation in the Caribbean is the earliest in the world outside of Africa. Pan American Health Organization studies have revealed that forty-four per cent of sexually active youths reported that their sexual debut was before the age of fifteen. Despite these data contraceptive prevalence remains low with only 30 percent of sexually active girls and 24 percent of sexually active boys eighteen and younger reporting that they always use contraception.

Young people continue to face the barriers of cost, stigma and fear of going to a clinic. The lack of information targeted at their needs and (in many countries) the need for parental consent, limits young people's awareness of the issues of sex and sexuality. High rates of unwanted pregnancy and sexually transmitted infections are powerful evidence that programmes are failing to meet their needs. Not only are young people denied access, there is a marked gendered factor as well. Young women in the Caribbean continue to be pushed out of schools due to unplanned pregnancies, despite CARICOM model legislation that some countries have adopted against this practice. They continue to suffer the adverse health consequences or to die from unsafe abortions, and are nearly twice as likely as young men to get infected by HIV. Those adolescent girls who become pregnant are also more likely to delay antenatal clinic attendance until late in their pregnancies with the attendant health risks to themselves and their foetus.

Caribbean countries need to strengthen their response to these unmet needs, they must revisit the commitments made to the Youth Summit in 1998 and scale up their responses to the unmet needs for comprehensive sexuality education, and provide youth friendly sexual and reproductive health services for our young people. As well they must to commit to continuing to provide family planning services as part of comprehensive sexual and reproductive health services to all people. Expenditure on health in most countries of the the region is 3 to 5 % of national budgets

⁹ UNFPA State of World Population 2009

compared to 10% in more developed countries and the current global financial crisis, as well as the energy and food crises that preceded it, will impact and are already affecting the ability of countries to maintain and increase their health and development budgets, to undertake the health system strengthening and the other measures required to achieve the MDGs. The actions that the Caribbean countries have already taken and followed through on the ICPD Programme of Action and MDG programmes have resulted in some improvements in maternal health and newborn health but the goals have not yet been achieved. The gains made have been hard won but are fragile and can easily to be lost again because we are small 'mostly island' developing states and as such very vulnerable to both internal and external changes of fortune.