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International Conference on Population and Development Beyond 2014

Universal Access to Reproductive Health Services: An Unfinished Business

WORLD POPULATION DAY | 11 JULY 2012 | JAKARTA, INDONESIA

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Reproductive health is defined as *a state of complete physical, mental and social well-being, and not merely the absence of reproductive disease or infirmity* [7]. The implications of this definition are far-reaching. Addressing RH demands a comprehensive approach that accounts for physical, mental, and social well-being, rather than focusing singularly on RH-related disease and deaths.

Universal access means *services and information are available, accessible, and acceptable to meet the different needs of all individuals*. In the context of RH, universal access entails services that are: (1) easily and safely accessible to all, including those with disabilities; (2) available at a low cost to the poor; and (3) considerate of social, cultural, religious, and other local values. These values must be embodied by a range of services encompassing information provision, prevention, diagnosis, counseling, treatment, and care.

Universal access to reproductive health is central to human development

- **Reproductive rights are human rights,** on recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children, and to have the information and means to do so, as well as the right to attain the highest standard of sexual and reproductive health (ICPD Programme of Action) [2].
- The reproductive age group (15-49 years old) is often the most productive of the population; their health status and well-being are imperative to human development and the growth of a nation. However, this has not been fully recognized, as **reproductive health problems remain the leading cause** of ill health and death for women of childbearing age worldwide [3].
- Reproductive health is a **critical component of human capital**. Investment in RH has been connected with lower fertility and lower maternal and child mortality, which consequently improves overall health and quality of life [6].
- **Investment in reproductive health creates significant dividends for economic development** by improving family and child health, protecting the environment, increasing security, and advancing women's rights [5].
- **As the fourth most populous country, Indonesia** faces both opportunities and challenges. Over 80 percent, or 123 million, of Indonesia's productive age population (ages 15-64) are at reproductive age. At least 50 percent of this group is female. Strong strategies to address their health and improve their potential are needed for the development of human capital [4]. A failure to recognize this opportunity will be a major loss for the country's development.

A walk through time: The journey of RH from ICPD to the MDGs

Over six decades ago, global recognition of human rights began with the announcement of the Universal Declaration of Human Rights in 1948. This was followed by stronger global commitments, such as the landmark inclusion of reproductive health as a critical component of human rights, including access to RH services. Aligned with this global progress, in 2009 Indonesia passed legislation, Law No. 36, encompassing reproductive health in the National Health Laws.

- 1948 Universal Declaration of Human Rights issued.
- 1987 Safe Motherhood Initiative Conference held in Nairobi.
- 1989 Indonesia formed the *Bidan di desa* programme, educating and training over 54,000 midwives in villages throughout Indonesia.

- 1993 United Nations World Conference on Human Rights in Vienna affirmed women's rights as human rights.
- 1994 The International Conference on Population and Development (ICPD), held in Cairo, resulted in over 179 governments agreeing that population and development are inextricably linked, and that empowering women and meeting people's needs for education and health, including reproductive health, are necessary for both individual advancement and balanced development. Concrete goals of the ICPD centered on providing universal access to education, particularly for girls; reducing infant, child, and maternal deaths; and ensuring, by 2015, there is universal access to reproductive health care, including family planning, assisted childbirth, and prevention of sexually transmitted infections, including HIV.
- 1994 Indonesia's National AIDS Commission established.
- 1996 Indonesia's National Reproductive Health Commission and Working Groups established.
- 2001 Introduction of the Integrated Essential Reproductive Health package, which integrates four essential components of RH, i.e. antenatal care and safe delivery, family planning, management of STIs/RTIs, and ASRH, to be provided in the primary health care clinics (*puskesmas*).
- 2001 The Millennium Development Goals (MDGs), including MDG 5 on maternal health, issued.
- 2004 The 57th World Health Assembly adopted the World Health Organization's first strategy on reproductive health.
- 2005 Endorsement of Indonesian National Strategy of Reproductive Health by the Ministry of Health.
- 2005 The World Summit adds universal access to reproductive health by 2015 as a strategy to attain development goals, including the MDGs.
- 2007 Integration of MDG Target 5B, "Achieve by 2015 universal access to reproductive health" within the revised MDG framework as a component of Goal 5, "Improve maternal health." The indicators under the target include contraceptive prevalence rate, adolescent birth rate, antenatal care coverage, and unmet need for family planning.
- 2009 Health Law No. 36, which includes a reproductive health component, is passed.
- 2010 MDG Review Summit renewed commitments to universal access to reproductive health by 2015, gender equality, and ending discrimination against women.
- 2012 Indonesia leads the Getting to Zero campaign in ASEAN, with the three goals of reducing to zero instances of new HIV infections, discrimination, and AIDS-related deaths.
- 2012 The London Summit on Family Planning will be held 11 July, at which Indonesia will share its successes and future challenges.

Reproductive Health in Indonesia

1. ACCESS TO QUALITY EMERGENCY OBSTETRIC CARE (EMOC) SERVICES

The huge gap in maternal mortality ratios (MMR) between countries suggests that the majority of complications and maternal deaths are preventable and manageable. It is estimated that around 15 percent of mothers suffer from complications during pregnancies and deliveries. One of the biggest problems is the unpredictable nature of the complications, putting every pregnant woman at risk of dying at any time during her pregnancy, delivery, and post-partum phase. The unpredictability of complications necessitates 24 hour access to a quality continuum of obstetric care at different levels of services, supported by an effective referral system. Access to skilled attendants and quality

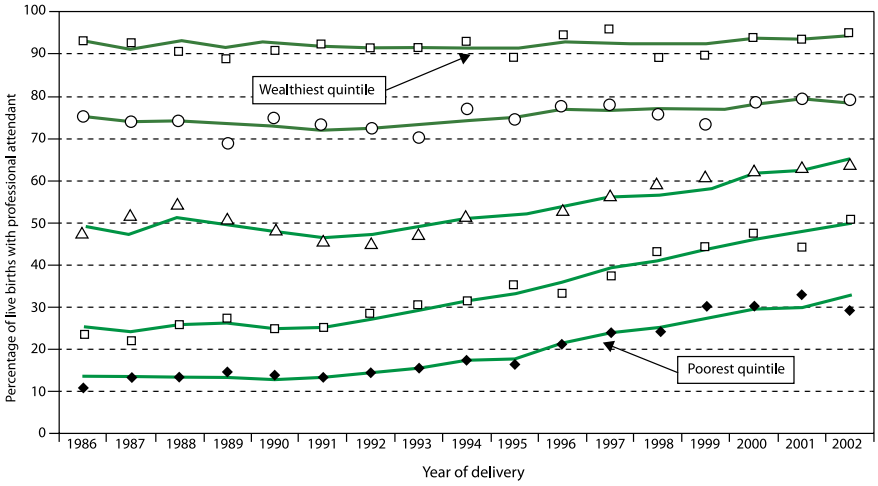
EmOC (including effective referral) will save mothers' lives and prevent illness. Improving a mother's well-being directly improves family well-being and the lives of children.

Indonesia has successfully attained a high level of deliveries by professional attendants; however, comparatively little progress has been made in the reduction of MMR. The latest MMR figure of 228 out of 100,000 live births (IDHS 2007) is well above the targeted reduction to an MMR of 102 out of 100,000 live births by the year 2015, requiring a dramatic acceleration of efforts. The inconsistency between the high proportion of births attended by professional attendants and the high maternal mortality ratio might be explained by the lack of continuity in obstetric care and the lack of quality care at every level of service. Disparities of access by region, residence, and socioeconomic status exist and continue to be a major challenge in Indonesia.

Since the 1990s, Indonesia has initiated the *Bidan di Desa* programme, placing a midwife (or skilled birth attendant) in each village across Indonesia. This program has been successful in increasing the coverage of deliveries by professional attendants, currently around 77.3 percent (Susenas 2009), and narrowing the gap between the poor and rich (Hatt 2007). However, this achievement is still lower than the national target of 90 percent by 2014, including the wide disparities that remain among provinces, evidenced by a ratio of 42.4 percent in Maluku and 98.1 percent in DKI Jakarta (Roadmap 2010). Despite increasing birth attendant rates, the 2007 IDHS results show that the coverage of deliveries in health facilities is still less than half (46.1 percent) of the total deliveries, with coverage in rural areas as low as 28.9 percent, as compared to urban areas at 70.3 percent (Roadmap 2010).

Figure 1.1. (Hatt, et al. 2007)

Trends in rates[a] of professional attendance in Indonesia 1986-2002, by wealth quintile



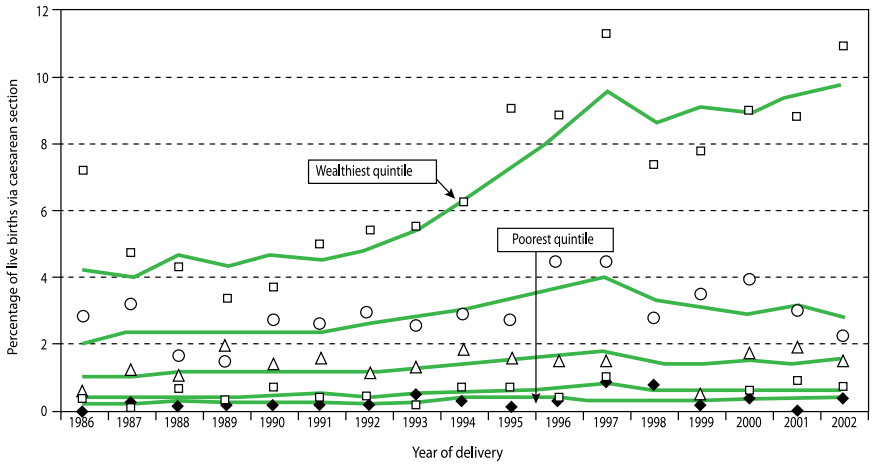
[a] Predicted rates were calculated from the adjusted logistic regression model and overlaid on observed rates, by quintile and year.
Source: Demographic and Health Surveys, Indonesia, Reference 15.

The Government deployed more than 60,000 midwives to villages through *Bidan di Desa*, yet but the programme was not able to maintain their availability; less than 50% of these midwives currently remain in villages. Many who remain lack skills and competency due to improper recruitment, unstandardized pre-service education, and lack of technical supervision. Review of the programme is needed, and if maintained, requires development of a full scale-up plan with appropriate supervision and in-service training. The recent World Bank report "'...and then she died...': Indonesia Maternal Health Assessment" (2010) concluded midwives are necessary but not sufficient by themselves to reduce maternal mortality.

Unlike relatively high access to professional attendants at birth, access to emergency obstetric care, such as caesarean sections, is very low, at less than 1 percent among the poorest, with little signs of increasing. It is estimated that around 5-15 percent of deliveries require a caesarean section to save a life, thus suggesting that a high proportion of the poor in need of caesarean sections are not getting the lifesaving services they need.

Figure 1.2. (Hatt, et al. 2007)

Trends in rates[a] of caesarean section in Indonesia 1986-2002, by wealth quintile

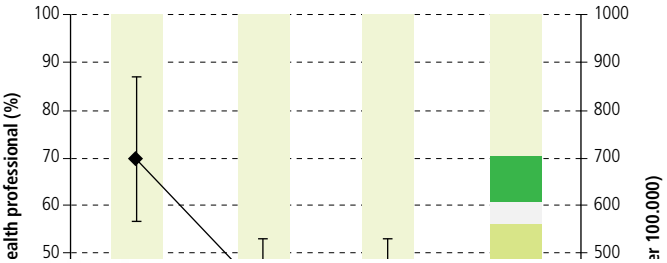


[a] Predicted rates were calculated from adjusted logistic regression model and overlaid on observed rates, by quintile and year.
Source : Demographic and Heath Surveys, Indonesia, Reference 15.

Access to EmOC is also challenged by ineffective referral mechanisms that create delays in obtaining adequate care. A thorough study examined the types of delays experienced in 104 maternal deaths in two districts in Indonesia. The study revealed that delays happen at every level of the system, and that sometimes one woman may experience multiple delays (D'Ambruoso 2009). The primary delays occur in decision-making (45%); reaching the care (66%); and receiving quality care (44%). Another study in the same districts conducted a qualitative assessment on the quality of services provided by midwives and concluded that clinical care was sub-standard, thus contributing to the late identification of complications and late decision-making for referral (D'Ambruoso 2008).

Figure 1.3.

Birth assisted by a health professional at home or in a health facility and maternal mortality ratio, by wealth quartile range, Serang and Pandeglang districts, Java, Indonesia, 2004-2006



The issue of quality of care is highlighted in the study below comparing births attended by professional attendants, either at home or in a health facility, and the maternal mortality ratio. Results show that MMR among the poorest was double that of the wealthiest. However, even the MMR among the richest is still relatively high (232 per 100,000 live births), indicating the existence of quality of care problems. The results also show that the poorest primarily deliver their babies with non-professional birth attendants. Only a small percentage of poor women who delivered in hospitals suggest they went to hospitals only after serious