

GOAL  
5

## THE 'MATERNAL MORTALITY GOAL'

### Goal 5 Improve maternal health

**Target 6** Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio

**Indicators** *Maternal mortality ratio*

*Proportion of births attended by skilled health personnel*

### A matter of life and death

For millions of women in countries across the world, maternity means unnecessary suffering, illness or death. More than half a million women die annually of pregnancy related complications, a vast majority in Sub-Saharan Africa and South Asia.

As in the case of infant mortality, maternal mortality is not a bio-medical phenomenon. The lack of accessibility and poor quality of health services is only one aspect. Far more serious is the impact of gender inequality.

- **The control of women's sexuality is central to patriarchal societies.** Concerns about 'purity' and 'honour' are the most often cited causes for practices such as female seclusion, female genital mutilation, child marriage and other forms of violence. Apart from the direct impacts of these and similar practices, the indirect effects can include denial of access to education, health care and employment leading to undermining of women's capabilities.
- **The high incidence of nutritional deficits, anaemia and chronic ill-health** are visible reflections of women's subordinate social status. Despite the fact that these increase the risks of childbirth, the construction of motherhood as women's destiny underlies the pressure on women to bear children regardless of the consequences. Early and frequent pregnancies, in complete disregard of the consequences to women's health and lives, are a major cause of maternal death.
- **Women's ignorance about their own bodies and biology** increases their vulnerability during pregnancy and childbirth. While some traditional practices are based on sound principles, some are harmful to the health of both mothers and infants.

- **Women usually bear the entire burden of reproductive and care work**, and continue to do so through pregnancy. Women not only do all the work of cooking, cleaning and caring for children and elders, but have to collect water, fuel and fodder and contribute their unpaid labour to the family farm or enterprise, often while working at another full-time job outside the home. Girls share the burden of care work with their mothers from an early age, often performing heavy and hazardous tasks with long-term negative impacts on their health. The physical consequences of years of overwork greatly increase the risks of maternity.
- Women's subordinate status limits their ability to negotiate the terms of sexual relationships, increasing **vulnerability to violence, abuse and unsafe sex**. The consequences are physical and emotional trauma, unwanted pregnancies and higher rates of sexually transmitted infections including HIV/AIDS, all of which contribute to increased maternal mortality.
- **Lack of information and difficulties in accessing safe and reliable contraception** compounds the chances of unwanted pregnancies. In many countries, the non-availability of legal, affordable and safe abortion services forces women to risk their lives with unreliable and unsafe methods in the hands of unskilled practitioners. Even if safe abortion is available as part of public health services the lack of confidentiality and privacy is a deterrent for most women. Fear of the moral condemnation attached to pre-marital or extra-marital sex and religious pronouncements against abortions force women and adolescent girls to rely on risky methods.
- **The secrecy and silence surrounding sex and sexuality** operate to create taboos and distorted notions about this aspect of life. As a consequence, young women (and men) are ill-equipped to deal with these issues in a mature or informed way, thus increasing the likelihood of unwanted pregnancies, HIV/AIDS and sexually transmitted diseases.

The Millennium Project Task Force on Education and Gender Equality has identified ensuring reproductive and sexual health and rights of women and girls as one of the priority actions for gender equality.

Bringing a gendered perspective to reporting on Goal 5 makes these connections visible and can create an enabling environment for achievement of targets for Goals 3,4 and 5.

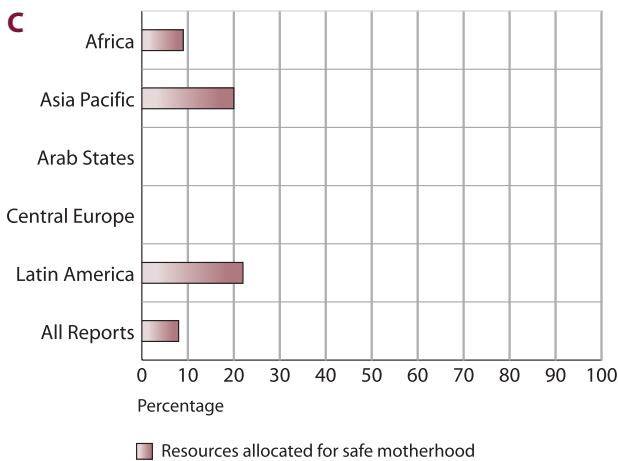
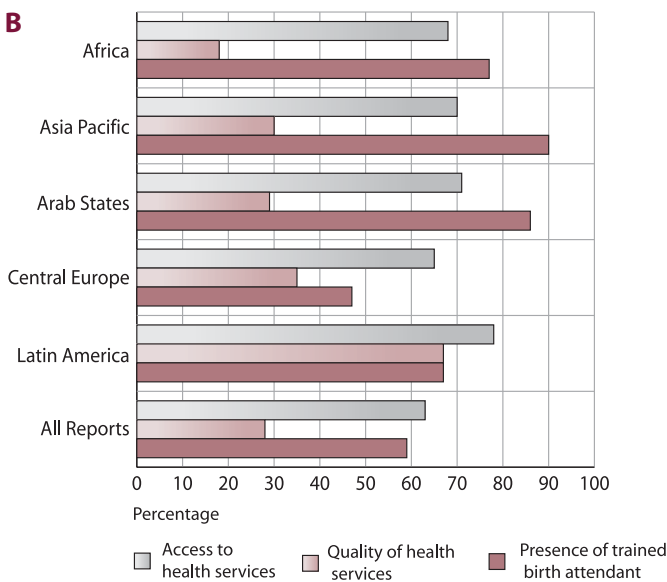
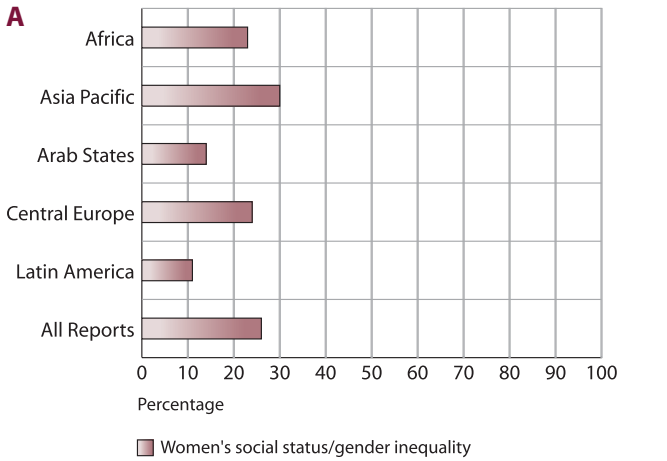
### How gendered is reporting on Goal 5?

Other than Goal 3, Goal 5 is the one most directly concerned with women. However, only 20 of the reviewed reports (about a quarter of the sample of 78 reports) mention gender inequality and women's status as causes of maternal death.

The continued dominance of a techno-medical approach to maternal mortality is reflected in the fact that more than three quarters of the reports identify lack of physical access to health services and low coverage of health infrastructure as the main causes of maternal mortality. The quality of health services – in terms of infrastructure, equipment to handle emergencies and trained personnel – is mentioned in 22 reports.

There is wide variation between reports in the extent to which the connections between maternal mortality and the status of women have been made visible. Recognition of the instrumental value of building women's capabilities is indicated by the fact that the mother's health status is highlighted in 24 reports and level of education is highlighted in 29 reports. In contrast, women's inability to take decisions regarding their own health – a factor that reflects women's agency and is a critical marker of gender inequality – is not widely visible in reporting and is mentioned in only six reports, or less than a tenth of the sample.

Figure 12 Causes of maternal mortality



*In 2000, the average risk of dying during pregnancy or childbirth in the developing world was 450 per 100,000 live births. In countries where women tend to have many children, they face this risk many times. Thus, the chances of dying during pregnancy or childbirth over a lifetime are as high as 1 in 16 in sub-Saharan Africa, compared with 1 in 3,800 in the developed world. This lifetime risk could be substantially reduced if women had the family planning services they desire.*

*From The Millennium Development Goals Report  
United Nations, 2005*

Two reports (**Brazil and Uganda**) have highlighted the issue of how poor women are treated by health care providers. The reports confirm that insensitive or discriminatory treatment by health providers is among the reasons why poor women choose to deliver at home rather than in a health facility.

The reports underscore the need to build the capacities and sensitivities of health care providers both within and outside the formal system.

According to WHO, US \$3 per person per year is the approximate cost of ensuring universal access to health care during pregnancy, delivery and after birth, postpartum family planning, and newborn care.

Adherence to harmful traditional practices is mentioned as contributing to maternal mortality in 10 reports. The uncritical acceptance of traditional practices is again a reflection of women's lack of agency and voice – often, the decisions on management of pregnancy are made by older women in the family rather than by the pregnant woman herself.

The need for births being supervised by trained personnel has been flagged in more than half of the reviewed reports (46 out of 78 reports). These reports stress on the need for building the capacities and skills of traditional birth attendants, and improving the outreach of maternity services to remote and rural areas. However only 20 countries provide data on the number of births attended by trained personnel.

The issue of access to safe abortions is discussed in depth in the overwhelming majority of reports (15 out of 17 reports) from Eastern Europe and the CIS region, where lack of access to cheap and reliable contraceptives pushes women to use abortion as a method of contraception.

Poverty has been identified as a determinant of maternal mortality in 15 reports. However, there is a notable silence on the connections between macroeconomic policies and maternal mortality. Linkages between cuts or stagnation in social sector and health spending, and maternal health, would have enriched the reports and strengthened the case for engendering macroeconomic policies.

**A very positive element of reporting under Goal 5 is the shift away from a purely medical approach to the recognition of some key concerns around reproductive health.** Early marriage and frequent pregnancies are mentioned as factors contributing to increased maternal mortality in 22 reports. Access to contraceptives is highlighted in 42 reports while the need for access to safe abortions is mentioned in 40 reports. The importance of male involvement and male responsibility for ensuring safe motherhood is underlined in 11 reports. In most cases, the connections between these issues and gender inequality are sharply delineated.

Adolescent girls are identified as a high risk group in 13 reports which also include discussions on issues of vulnerability for girls, including the need for reproductive health education and focused policies for adolescent reproductive health.

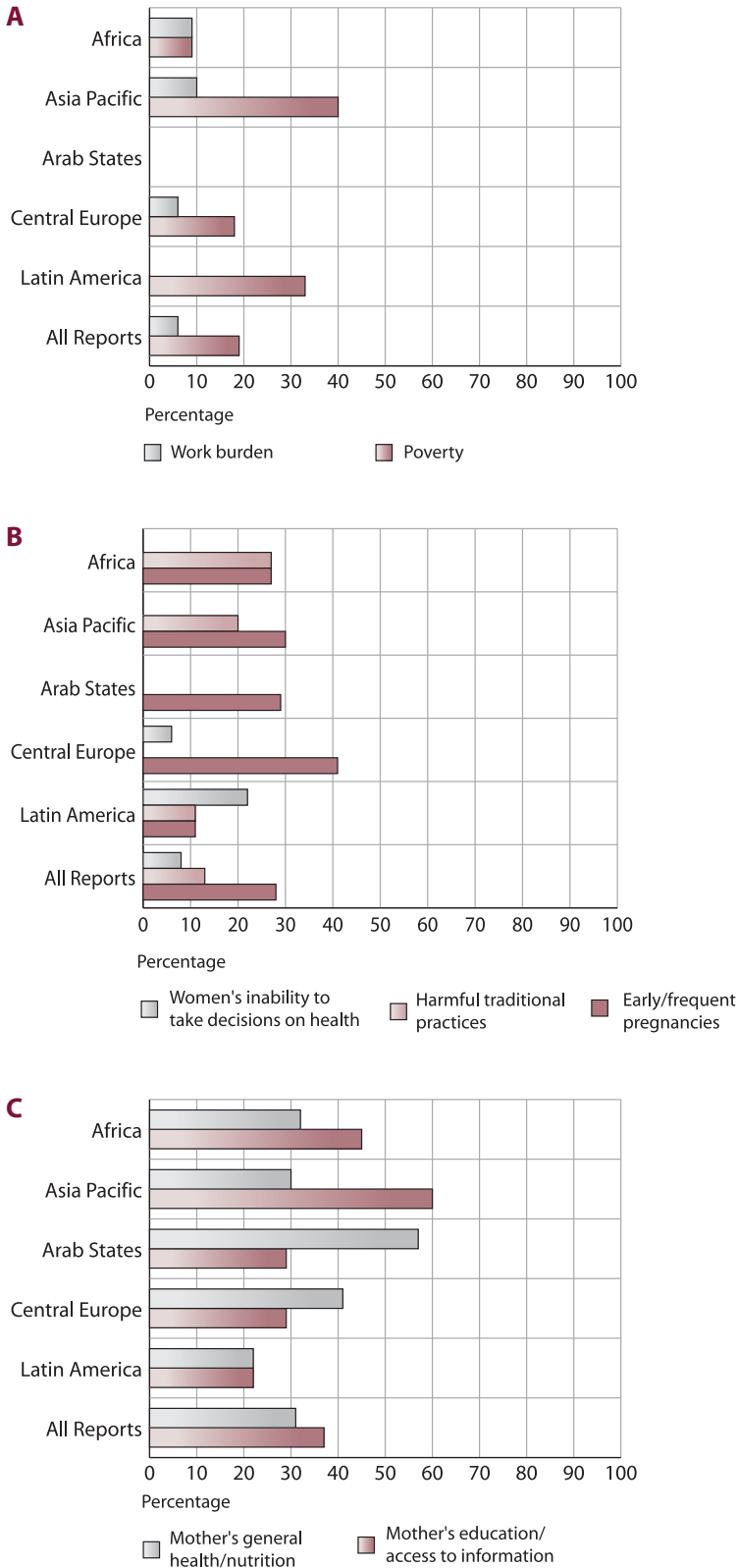
**The issue of HIV/AIDS as a factor in maternal mortality has been mentioned in only 10 out of the 78 reports reviewed.**

Even less attention is given to the crucial issue of resource allocations for maternal health in national budgets. Only six reports (less than one tenth of the sample) mention resources as a concern – an omission all the more unfortunate because most of the countries covered in the review have yet to achieve desirable levels of spending on health.

#### Spending on health

- **Low allocations** (Congo, Senegal)
- **Dependence on foreign aid** (Afghanistan)
- **High investments as reasons for progress on targets** (Mauritius, Paraguay)
- **Need for adequate budgets** (Paraguay)

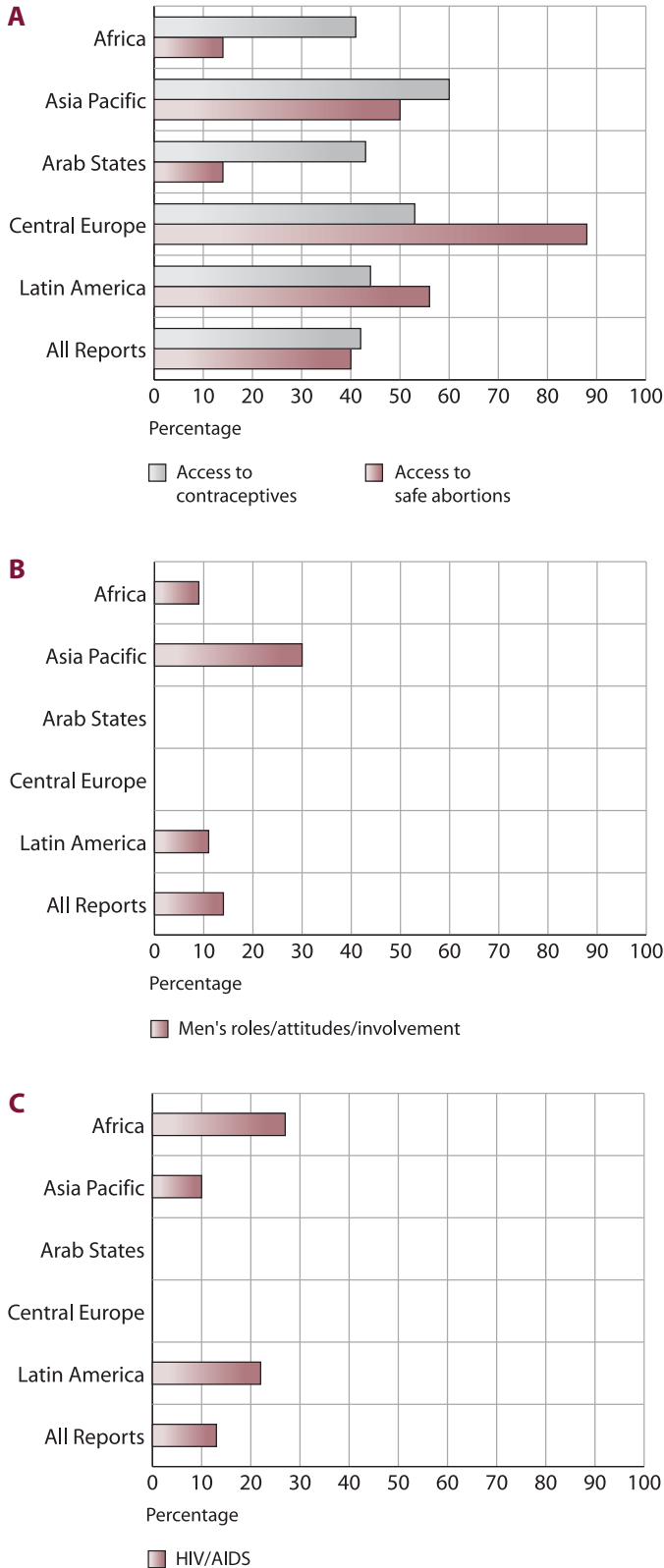
Figure 13 **Causes of maternal mortality**



**A positive trend - unpacking statistics**

- **Exposing the essence of the tragedy.** The issue is dramatically underlined in the opening statement of the **Afghanistan** MDGR: ‘Life is a matter of death, as a woman dies every half an hour trying to give birth.’
- **Unpacking statistics.** The **Vietnam** reports points out that poor families cannot afford to register maternal deaths, and statistics are therefore incomplete.
- **Giving space to women’s voices.** The **Uganda** report highlights the connection between rural infrastructure and maternal mortality. A boxed quote from a woman at a village meeting describes how women in labour give birth on the roadside as they are being carried to the nearest hospital which is 10 km away.
- **Putting reproductive health in a wider social context.** The links between reproductive health and a social environment supportive of gender equality are highlighted in the **Chad** report. Social mobilisation through women’s organisations and the passage of a Family Code are specifically mentioned.

Figure 14 Coverage of strategic issues



The UN Millennium Project Task Force on Child and Maternal Health recommends revised Targets and additional indicators for Goal 5.

**Targets**

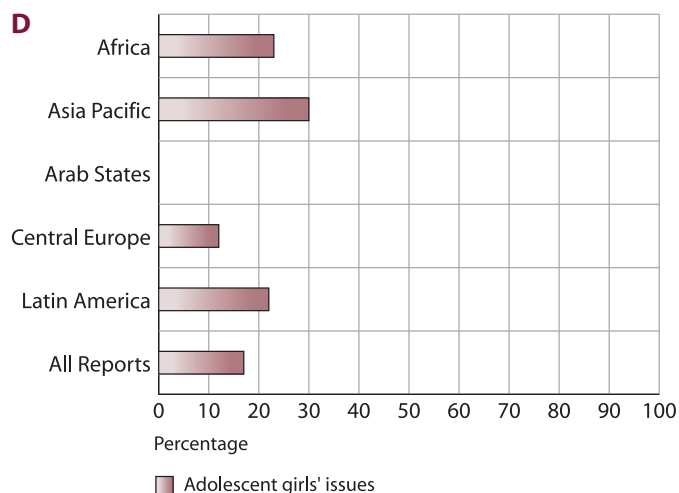
- Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio, ensuring faster progress among the poor and other marginalized groups.
- Universal access to reproductive health services by 2015 through the primary healthcare system, ensuring faster progress among the poor and other marginalized groups.

**Additional indicators**

- Coverage of emergency obstetric care
- Proportion of desire for family planning satisfied
- Adolescent fertility rate
- Contraceptive prevalence rate
- HIV prevalence among 15- to 24-year-old pregnant women

The Task Force Report emphasises the need for particular attention to disadvantaged groups and geographically constrained areas, with data disaggregated accordingly. Multiple dimensions of inequity can be made visible using data collected in Demographic and Health Surveys and Multiple Indicator Cluster Surveys.

From *Who's got the power? Transforming health systems for women and children*  
 Report of the UN Millennium Project Task Force on Child Health and Maternal Health, 2005



### Recognition of adolescents' needs

- **Exclusion of teenage girls from reproductive health services** (Tanzania, Philippines, Indonesia, Georgia)
- **Need for policy on adolescent sexual health** (Zambia)
- **Higher rate of abortions for adolescents** (Kenya, Croatia)
- **Priority attention to adolescents in reproductive health programmes** (Benin, Senegal)
- **Need for reproductive health education** (Mongolia, Georgia, Brazil, Honduras)
- **Data on teenage pregnancies** (Uganda, Brazil)

## How can reporting on Goal 5 be strengthened?

- Identifying and reporting on **non-medical factors** implicated in maternal mortality.
- Identifying and present **data on additional indicators** suggested by the Millennium Project Task Force on Sexual and Reproductive Health
- Flagging issues such as the burden of care work and its impacts on the health of girls and women, to **highlight connections** between maternal mortality and other aspects of gender equality.
- Using a **reproductive rights framework** to highlight key areas for action including access to contraception, access of adolescents to health information and services and vulnerability to violence.
- Highlighting the situation of **specially vulnerable groups**, such as poor women, women living in remote areas, women belonging to marginalised communities, women living with HIV/AIDS.
- Reporting on **costing exercises** and **budgetary allocations** for safe motherhood and reproductive health programmes.

*The WHO's second synthesis report on health in PRSPs found that many do not systematically analyse the health situation of poor people and the barriers that prevent poor women in particular from accessing reproductive health care... although health spending is rising in all countries in nominal terms, projected changes in health spending as a proportion of GDP are typically small and health is not generally increasing in importance within the priority sectors identified for poverty reduction. Although the IMF and World Bank have recently called for scaling up to accelerate progress towards the Goals, their country-level processes are not yet advocating major increases in public health spending (including large increases in donor spending) needed to achieve the Goals.*

*From Who's got the power? Transforming health systems for women and children  
Report of the UN Millennium Project Task Force on Child Health and Maternal Health, 2005*