Towards the UN MDG Review Summit 2010 - CONCORD’s recommendations to the EU

MDG 5 - Improve Maternal Health

Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio
5.1 Maternal mortality ratio
5.2 Proportion of births attended by skilled health personnel

Target 5.B: Achieve, by 2015, universal access to reproductive health
5.3 Contraceptive prevalence rate
5.4 Adolescent birth rate
5.5 Antenatal care coverage (at least one visit and at least four visits)
5.6 Unmet need for family planning

1. The global context and tracking progress

In 1994 at the International Conference on Population and Development (ICPD), 179 countries (among which the EU Member States) committed to an ambitious Programme of Action (PoA) for improving sexual and reproductive health and rights (SRHR) over the world, taking a strong human-right’s based approach. The PoA included the goals to reduce maternal mortality and to ensure universal access to reproductive health care by 2015. MDG5 includes targets deriving from the ICPD PoA and should be considered in the context of that comprehensive package of SRHR recommendations.

MDG5 is the most off track of all MDGs, especially in fragile states. No significant progress has been made since 1990. Despite dramatic statistics and the current needs that have grown drastically over the last decade, financial commitments and political will are strongly lagging behind. The interventions needed to achieve MDG 5 are available, but are not being delivered to the mothers (and children) who need them.

Target 5.A: 15 years after the ICPD PoA, maternal mortality is still the most dramatic indicator of global health inequity. Every minute, a woman dies from a pregnancy or childbirth-related cause. It represents 536,000 of women and girls deaths every year as well as 1 million children left motherless. These children are 10 times more likely to die within two years of their mothers' death. 70,000 of these maternal deaths are due to unsafe abortions, one of the leading causes of maternal mortality. 99% all of these deaths occur in developing countries, with ½ of them in sub-Saharan Africa and another 1/3 in South Asia. For every death, at least another 20 women suffer illness or injuries related to childbirth or pregnancy. Although maternal mortality ratios are declining globally, the decline is very limited, slow and unequal between countries and regions. Maternal mortality rates decreased by less than 1% per year from 1990 to 2007, far below the 5.5% annual decline required to achieve MDG5. In sub-Saharan Africa, where maternal mortality is highest, the annual decline has been only 0.1%

A major bottleneck is weak health systems with unavailable, inaccessible, unaffordable, or poor quality delivery services. 4 out of 5 maternal deaths are the direct result of obstetric complications, most of which could be averted through delivery with a skilled birth attendant (SBA) and access to emergency obstetric care. Whereas globally there is an increase of care provided during pregnancy and delivery, the proportion of deliveries assisted by SBAs remains far below the required level of 90% of all births. Only 46% of births in Africa and 68% in Asia are attended by SBAs in contrast to 99.5% coverage in North America and Europe. Moreover the quality of the services remains poor with a general lack of attention given to maternal, newborn and basic SRH services.

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1 Five direct complications account for more than 70% of maternal deaths: haemorrhage (25%), infection (15%), unsafe abortion (13%), eclampsia (very high blood pressure leading to seizures – 12%), and obstructed labour (8%). WHO report 2008
3 The State of the World’s Children Report on Maternal and Newborn health 2009, page 4: “300 million women suffer today from maternal disability (or morbidity) such as severe anaemia, incontinence, damage to the reproductive organs (such as fistula), chronic pain, and infertility
5 70% of maternal deaths result from five well-known and relatively common obstetric complications which can be treated with existing inexpensive medical or surgical techniques. Most of maternal deaths are easily preventable.
6 WHO ‘Proportion of birth attended by a skilled health worker. 2008 updates’
Poor maternal health also reflects the violations of women’s rights in societies and the broader failure of States to respect, protect and fulfill women’s full range of human rights. Early marriages, recurrent childbearing, gender-based violence, including female genital mutilation, are among the indirect factors of maternal ill-health. Exposure to infections having dramatic consequences on pregnant women such as malaria or HIV and AIDS also play a significant role. The provision of comprehensive sexuality education and services for women, men and young people is therefore crucial for improving knowledge, dispelling myths surrounding family planning and maternal health and reducing sexual risk behaviors.

**Target 5.B:** This target was incorporated within the MDG monitoring framework based on recommendations of the world leaders at the 2005 World Summit.

One in four women who want to avoid or space a pregnancy are not using an effective method of contraception. With an estimated 215 million women having an unmet need for family planning, the proportion remains unacceptably high. It represents up to 24% of women aged 15-49 in sub-Saharan Africa. It is however recognised that ensuring universal access to family planning is efficient for reducing maternal and child mortality and is a cost-effective way to help achieving MDG5 as well as other MDGs.

Overall contraceptive prevalence rate remain low despite increases in contraceptive use in most developing regions, generally accompanied by reductions in fertility. The major exception is sub-Saharan Africa, where contraceptive use, though nearly doubling between 1990 and 2005, was still only 22% in 2005 (with some countries facing a prevalence rate still below 10%). Contraceptive needs are however predicted to increase by 40% by 2015 as the world’s 1 billion young people enter their reproductive years.

**Antenatal care** is a crucial service for healthy motherhood and childbirth by monitoring the well-being of both the woman and her baby. However the recommended norm of 4 antenatal visits is still not accessible to many pregnant women worldwide with the lowest proportion in sub-Saharan Africa (55% of women have no access). Pregnancy in adolescence also contributes to the cycle of maternal deaths and indicates limited access to reproductive health services especially for young people. Pregnancy and deliveries are the leading causes of death for young women under 19 in developing countries. But adolescent fertility remained stagnant or increased marginally between 2000 and 2005.

Among the main barriers to the advancement of MDG5 are:

- **Lack of political will and leadership in matters related to MDG5.** Both donors and recipient governments neglect women’s health and rights as well as SRHR in their policies and budgets and are insufficiently addressing gender discriminations and barriers to quality services access.
- **Lack of funding** for maternal health and SRHR, both from domestic and external sources. Current levels are insufficient to cover the needs. Striking is the decline since 1995 of donor funding for family planning, even as progress in maternal health stalls. It has shrunk from 55% of the resource flows for population activities to only 5% from 1995 to 2006. (A decrease of 34% since 2000)
- **Lack of prioritization of SRH services (incl. maternal health) in health system strengthening** as well as lack of linkages between related services such as HIV and AIDS, newborn, malaria and TB, insufficient trained health workers and access to reproductive supplies and equipment.

2. **The role of the EU:**

The EC and the Member States have made strong political and funding commitments for universal access to SRH as set out at the 1994 ICPD PoA and for MDG5 specifically. The November 2004 Council Conclusions

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7 Female genital mutilation-related childbirth complications include an increase in caesarean sections, postpartum haemorrhage and obstetric fistulas as a result of prolonged and obstructed labour.
8 Gutmacher Institute, 2009. Adding it Up : The costs and benefits of investing in Family Planning and Maternal and Newborn Health – 215 million women or 15% of all women aged 15-49 are having an unmet need for family planning
9 Gutmacher Institute, 2007. Adding it Up : The costs and benefits of investing in Family Planning and Maternal and Newborn Health – Ensuring access to family planning can reduce maternal deaths by 25-40% and child mortality by 20%
10 Gutmacher 2009
11 UN Commission on Population and Development report 2009
12 Euromapping 2009 – DSW, EPF, EuroNgos
13 The EC and all the EU MS have subscribed to the ICPD Programme of Action (PoA). The commitment to the PoA full implementation was reaffirmed in the November 2004 Council Conclusions
14 The EU largely recognizes that the MDGs, and especially MDG5, cannot be attained “without progress in achieving the Cairo goal of universal access to SRHR” as stated in both the May 2005 Council Conclusions on the achievement of the MDGs as well as in the EU Consensus on Development (Art 94).
called for significantly more financial resources and support for SRHR and in June 2008, the Council adopted the EU Agenda for Action on MDGs which includes a set of specific milestones and timelines to put back on track MDG5. However, despite strong policy commitments, evidence shows that more needs to be done to ensure their implementation.

In practice, health, especially maternal health and SRHR are not sufficiently prioritized in the Country Strategic Papers (CSPs). None of the CSPs under the 10th EDF has chosen SRHR as a focal sector and only a handful of CSP had chosen Health. Moreover, it was shown that in sub-Saharan Africa where maternal health is the worst, the EC financial support to health remains low. Allocations to the health and maternal health sector have not increased since 2000 as a proportion of total ODA despite the EC's commitments to the MDGs. Moreover, whereas the EC has a thematic budget line on SRHR under “Investing in People”, the average funding level per year decreased from the period 2003-2006 when it was 18 million Euros/year to the period 2007-2013 when it became 12 million Euros.

3. Recommendations to the EU

Internationally (and specifically at the UN Summit on MDG+10), the EU and its Members States should:

- Show strong political will and play a leadership role in prioritising MDG5 with a particular focus on prevention, human rights and gender equality.

- Call for improvement and enforcement of gender and SRHR laws and policies with specific focus to legislating against traditional harmful practices (early marriage, FGM) and gender-based violence as well as eliminating discriminations against women in the field of access to health care.

- Take leadership in accelerating investments in SRHR, with a focus on sexuality education, family planning as well as quality delivery services and training of skilled birth attendants.

- Encourage international health initiatives (Global Fund, GAVI, UNITAID, IHP) to expand funding for SRH (including maternal health) as well as reproductive health supplies in their activities so as to place MDG5 at the centre of global health initiatives and funding mechanisms.

The EU and its Members states should work towards the following objectives between 2010 and 2015:

Reversing the trend in declining assistance to MDG5, the EU should:

- Fulfil the health ODA financial targets set out in the EU Agenda for Action on the MDGs (8 billion Euros by 2010) by allocating adequate, long term and predictable funding for SRHR in the EU budget, the EDF and national development budgets.

- Commit to further contribute to the 2010 Milestones of the EU Agenda for Action on the MDGs which call for 1) Urgent support for attainment of universal access to RH; 2) Have 35 million more births attended by skilled personnel each year, 13 million of which in Africa and 3) Provide 50 million more women in Africa with modern contraceptives and access to family planning.

- Ensure that SRHR programmes are funded through a mix of funding mechanisms including general as well as sector budget support earmarked funding as well as partnerships with civil society, UN agencies and private sector. Guarantee inclusion of monitoring and evaluation tools.

Prioritising MDG5 at EU policy level as well as in policy and political dialogue with partner countries,

- Promote a clear political and financial commitment towards achieving MDG5 through supporting the development of national action plans on gender and SRHR, including maternal health services.

- Ensure that the EU policy commitments on MDG5 are reflected in financial agreements with developing countries by including systematically gender and SRHR-related performance indicators.

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15 Only 4% of the 9th EDF was dedicated to health funding
16 Main recommendations of the European court of auditors report on EC financing for health in Sub-Saharan Africa (2008)
17 The private sector organisations are key actors in supporting health systems, including through large scale public private partnerships (PPP) and performance based financing which can dramatically increase the use of SRH services.
Support policy dialogue at country level with partner countries on the importance of gender and SRHR for poverty reduction. The dialogue should include the following areas:

- Commit to **effective health systems** that ensure the delivery of a **quality package** of SRH and maternal health services (incl. skilled health workers) and guarantee **accessible and affordable services to all people**, including marginalised and vulnerable groups.
- Support the **strengthening of the linkages** between SRHR and related services such as prevention, treatment and care of STIs (including HIV), child health, malaria and tuberculosis.
- Give special attention to the SRH needs of **young people**, by involving them in the design, formulation and implementation of relevant health policies and programmes and by ensuring access to youth-friendly health services as well as comprehensive sexuality information and education.
- Promote the **empowerment of women** by encouraging policies and support programmes aimed at enhanced social position of women in societies and recognition of their rights.
- Support **gender-sensitive approaches** which also meaningfully include boys and men.