

# GOAL 5

## IMPROVE MATERNAL HEALTH

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## Goal 5: Improve Maternal Health

In 2005, 536,000 women died of maternal causes, compared to 576,000 in 1990. Ninety-nine percent of these deaths occurred in developing countries. The maternal mortality ratio—deaths during pregnancy and within 42 days of termination of pregnancy per 100,000 live births—was 450 maternal deaths per 100,000 live births in developing regions, compared to just 9 per 100,000 in developed regions.<sup>128</sup>

The small decline in the global ratio of maternal mortality reflects mainly declines in countries with relatively low levels of maternal mortality.<sup>129</sup> According to the *2007 Millennium Development Goals Report*, maternal mortality remains unacceptably high in sub-Saharan Africa and South Asia, where most of the deaths occur.<sup>130</sup> By contrast, dramatic improvements were recorded in Southeast Asia, North Africa and East Asia by the *2006 Millennium Development Goals Report*<sup>131</sup>.

Although there are many causes of maternal death, the most common cause is bleeding after birth—post-partum haemorrhage. Others are infections, complications from unsafe abortion, prolonged or obstructed labour, and hypertensive disorders during pregnancy, especially eclampsia. These can occur without warning and require prompt access to obstetric services equipped to provide lifesaving drugs, antibiotics and transfusions and to perform caesarean sections and other surgical interventions.

### Maternal risk begins in girlhood

The foundations for maternal risk are often laid in girlhood. Women whose growth has been stunted by chronic malnutrition are vulnerable to obstructed labour. Anaemia predisposes women to haemorrhage and sepsis during delivery and has been implicated in at least 20 percent of post-partum maternal deaths in Africa and Asia.<sup>132</sup>

**Matrix 14: Global targets and indicators for improving maternal health**

Target		Indicators	
<i>All indicators should be disaggregated by sex and urban/rural as far as possible</i>			
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
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

## A. Issues for a gender-responsive rights-based analysis

### 1. Maternal mortality is difficult to measure without a reliable death registration system

The global target is challenging to monitor because maternal mortality is very difficult to measure without a reliable death registration system, and few developing countries have such systems. It is difficult to collect data on maternal deaths, because when a woman dies, the family unit of which she was a member ceases to exist. If the husband of the deceased woman is asked about deaths in his family, he will tend to answer in the context of his **new** family, and therefore not report the death of his first wife. Some demographers have attempted to overcome this through the ‘sisterhood method’ – collecting data by asking women about their sisters.

Maternal mortality statistics in countries without reliable death registration systems are therefore only estimates, and probably under-estimate the true extent of maternal mortality.

### 2. Maternal mortality is typically approached from a health perspective

UNFPA promotes a three-pronged strategy for improving maternal health that requires:

- all women to have access to contraception to avoid unintended pregnancies;
- all pregnant women to have access to skilled care at the time of birth;
- all those with complications to have timely access to quality emergency obstetric care.

#### Women in developing countries lack reproductive health care

A 2005 report showed that, worldwide, only 60 percent of women had access to contraception. The proportion of deliveries attended by skilled health staff averaged 38 percent in low income countries and was as low as 11 percent in Nepal, 19 percent in Lao PDR, 23 percent in Pakistan and 43 percent in India. By contrast, the figure was 68 percent in Indonesia, 85 percent in Viet Nam, 87 percent in Sri Lanka, 97 percent in China, 99 percent in Mongolia and 100 percent in Jordan.<sup>133</sup>

Many countries are unable to meet these requirements for all women, especially those in poor families and rural and isolated areas.

However, even when these services are available, many women are unable to take advantage of them. Focusing purely on a health perspective, without a gender-responsive rights-based analysis of the issue, means that the reasons women do not access these services may not be identified and addressed.

For example, the health approach tends to emphasize health education rather than women's empowerment as the solution to the widespread failure of women to attend clinics or use the services of trained midwives or doctors. However, the barrier is often that the women lack the decision-making power to choose to use available services.

#### **Lack of empowerment may lead to maternal mortality**

In an isolated area of West Aceh during the 1980s, a team from the Indonesian Institute of Sciences investigated a recent case of a woman who had died giving birth to her second child.

The health clinic said that the woman had chosen not to use the trained midwife because she did not understand the importance of trained care or the risks she faced. The staff recommended more and better health education for other women in the area.

However, the neighbours had quite a different story. The young mother had already experienced a difficult home birth with her first child and wanted to use the midwife at the clinic, where she hoped for better care. However, her husband and her mother-in-law refused to allow this. Since she had survived the first birth, they expected she would also survive this one.

When, after two days in labour it became apparent that she may not survive, the family again refused to allow her to be taken to the clinic. They said that, if she were to die, it was better that she did so at home, and so she did.

Health education for the woman would not have changed the outcome. Empowerment would have.<sup>134</sup>

Women's empowerment is therefore a vital factor in reducing maternal mortality.

### **3. Men and communities should be targeted for health education on pregnancy and childbirth**

Given the lack of empowerment of many women, it is male decision makers and some senior women who often make decisions about women's access to health care that can mean the difference between life and death. Husbands, male household heads and senior women in the community should be targets for health education on care during pregnancy and the importance of attendance by a trained health professional at the birth.

#### **4. Maternal health should be considered from perspective of women's rights to reproductive health**

Basic health care is a human right, and reproductive health care is a particularly important human right for women. While most pregnant women want to deliver a healthy baby, some women do not choose to become pregnant and should have the right to a safe abortion.

With the introduction of the new global target 5.B—'achieve, by 2015, universal access to reproductive health'—the 2007 revision of Goal 5 recognises the need for a broad approach to maternal health that encompasses women's access to contraception and safe abortion; identification and treatment of sexually transmitted infections and HIV/AIDS; and treatment for the consequences of unsafe abortions or genital mutilation. In addition to contributing to improving maternal health, this is essential to the full realization of women's reproductive rights.

#### **5. Genital mutilation is a serious violation of women's reproductive rights and must be eliminated**

Female genital mutilation is the collective name given to several different traditional practices that appear to be linked primarily to a desire to subordinate women and to control their sexuality. Worldwide, between 100 and 140 million women and girls in the world are estimated to have undergone female genital mutilation and 3 million girls are estimated to be at risk of undergoing the procedures every year.<sup>135</sup> Currently, it is primarily practiced in 28 African countries, with sporadic practice in some nations in the Middle East and in a few ethnic groups in India and Sri Lanka.<sup>136</sup> Prevalence varies significantly from one country to another. For example, the prevalence rate is 92 percent in Mali, compared to 28 percent in Senegal.<sup>137</sup>

Female genital mutilation can damage the health of women, girls and newborn babies. While excessive bleeding—sometimes in resulting in death—and shock are some of the immediate consequences, long-term health effects can include chronic pain, infections, and trauma. Women who have undergone female genital mutilation have higher risks for caesarean sections, longer hospital stays, and postpartum haemorrhaging. Their newborn babies have higher death rates during and immediately after birth.<sup>138</sup>

The Convention on the Rights of the Child and CEDAW both explicitly recognize that practices harmful to women, such as female genital mutilation, are violations of human rights. In 2003 the Cairo Declaration for the Elimination of Female Genital Mutilation affirmed that 'the prevention and the abandonment of female genital mutilation can be achieved only through a comprehensive approach promoting behaviour change, and using legislative measures as a pivotal tool.' Many countries have implemented initiatives to eliminate the practice, including laws which criminalize it, education and outreach programs, and the use of civil remedies and administrative regulations to prevent it. In February 2008, ten United Nations agencies pledged to support governments, communities, and women and girls to abandon the practice within a generation, with a major reduction in many countries by 2015.<sup>139</sup> Experience has shown that, while making female genital mutilation illegal may play a role, ultimately it is women and men in communities and national leaders who must take the initiative in bringing about the social and cultural changes needed to eliminate the practice.

The more extreme forms of female genital mutilation are not widely practiced in Asia. According to a national report in Indonesia, Type I (commonly referred to as clitoridectomy) and less invasive procedures (Type IV) are practiced in many parts of the archipelago. A study in Jakarta and West Java found most female children who were circumcised underwent

ritualistic, largely non-invasive procedures. The government included this practice as a gender issue in its National Action Plan to End Violence against Women in November 2000. The National Ulemas Council supports eliminating female circumcision in stages, currently supporting ritualistic, non-invasive forms.<sup>140</sup>

## 6. Women should have access to transportation infrastructure and communications

To reduce maternal mortality, women must have physical access to health and medical services. Public transport, or at least passable roads, is most important for increasing use of antenatal and post-natal services. When difficult births occur without warning, as can often be the case, it is also vital to have ambulances and good communications to the centre where the ambulance is located, as well as reasonable roads. However, in some least developed countries, many women lack passable roads and/or communication with assistance in an emergency.

## 7. Basic reproductive health services should be free and easily accessible to all women

Basic reproductive health services include family planning information, services and counselling; antenatal, delivery (including assisted delivery) and postnatal care of mothers at the primary health care level; referral to secondary care for the management of obstetric complications; prevention of abortion, management of the consequences of abortion, and post-abortion counselling and family planning; and maternal care. The importance of family planning in particular in reducing unwanted pregnancies and abortions, which are a significant cause of maternal mortality, is recognized in the 2007 revision of the MDGs by the addition of global indicator 5.5—‘unmet need for family planning’.

These services should be free and easily accessible to all women, particularly poor women, women from disadvantaged minorities, adolescent and young women, and women refugees and IDPs in crisis and conflict situations.

However, as a result of the neoclassical economic policies discussed under Goal 1, the charging of fees for attendance at antenatal care and for the use of midwives has discouraged many women from using these services, as they lack the financial resources needed. In some cases where financial resources are sufficient, families and even women themselves may be unwilling to spend them on health care for women due to the low status given to women and lack of understanding of the importance of reproductive health care.

### Poor women are least likely to use antenatal care

In all developing regions, the poorest 20 percent of the population are less likely to use antenatal care than the richest 20 percent. In Asia, the ratio of use by pregnant women in the richest to the poorest households varies from 1.3 in Indonesia, 1.4 in Philippines and 1.9 in Viet Nam, to 3.1 in Nepal, 3.6 in India, 4.1 in Bangladesh, and 10.1 in Pakistan.<sup>141</sup>

## 8. Antenatal and delivery services should be prioritized

Most maternal deaths result from preventable causes, many of which can be diagnosed during antenatal checks. Good antenatal care—a minimum of four antenatal visits during pregnancy—helps address problems in both mother and baby, including pre-eclampsia, blood-type incompatibility, diabetes, low birth weight, and birth defects. Tetanus injections are also vital for the health of both mother and child and can be provided during antenatal visits.

These antenatal services must be prioritized and adequately supported with financial resources and qualified health staff in order to help reduce maternal mortality.

However, it is now recognized that antenatal care alone does not have a significant impact on maternal mortality. It must be accompanied by improved care during delivery. The antenatal period presents opportunities for reaching pregnant women with interventions that may be vital to their health and well-being and that of their infants, as well as a route for ensuring that pregnant women do, in practice, deliver with the assistance of skilled health care.<sup>143</sup>

### Many pregnant women are not protected against tetanus

The percentage of pregnant women receiving tetanus injections in 2003 was 46 percent in Cambodia, 78 percent in India, 51 percent in Indonesia, 36 percent in Lao PDR, 69 percent in Nepal, 57 percent in Pakistan, 70 percent in Philippines and 79 percent in Viet Nam.<sup>142</sup>

## 9. Adolescent and young women should be specifically targeted by maternal health initiatives

In the 2007 revision of the MDGs, the new global indicator 5.4—adolescent birth rate—recognizes the importance of improving maternal health among adolescents as a means of reducing the overall high levels of maternal mortality in many developing countries.

The risk of maternal death is about three times higher among adolescent girls aged 15-19 years than for those aged 20-24 years. Adolescents are also more likely than older women to experience miscarriages and still births. About 7 to 12 percent of adolescent pregnancies are terminated by miscarriages and/or still births compared to 6 to 8 percent of pregnancies among women aged 20-24 years.<sup>144</sup>

## B. National long-term targets and indicators

Matrix 15 below suggests a range of long-term targets and indicators for improving maternal health, based on the preceding gender-responsive rights-based analysis of Goal 5. The target and indicators should be adapted and added to so that they are relevant and useful for the individual country.

Since poverty, education, the health and nutrition of girls, women's empowerment and violence against women are all relevant to Goal 5, relevant targets and indicators are also covered under goals 1, 2, 3, 4 and 5.

Women's groups should ensure that data and references to maternal health and mortality in CEDAW country reports are used in the process of developing national and subnational targets

and indicators. The responses of the CEDAW Committee on these matters to the most recent country report may also be useful in providing a global and rights-based perspective.

The relevant sections of the Beijing Platform and National Action Plans based on the Platform also provide information on government commitments to women and gender equality related to maternal mortality under Critical Area of Concern C Women and Health.

<b>Matrix 15: National long-term targets and indicators for improving maternal health</b>	
<b>Target</b>	<b>Indicators</b> (see note # below)
L5.A Achieve, by 2015, universal access to reproductive health <i>(unchanged from global target)</i>	L5.A.1 Proportion of females of reproductive age using contraception L5.A.2 Proportion of males of reproductive age using male methods of contraception L5.A.3 Number of females and males receiving treatment for sexually transmitted infections L5.A.4 Ratio of females to males receiving treatment for sexually transmitted infections L5.A.5 Number of women receiving safe abortions <i>(available for a limited number of countries where this is legal)</i> L5.A.6 Birth interval in months, by sex of previous infant and birth order, where appropriate
<i># All individual level indicators should be disaggregated by sex, rural/urban location and other relevant socio-economic variables, particularly those relating to minority groups and, where relevant, internally displaced persons.</i>	

## C. Gender-responsive rights-based strategies

### 1. Reduce the costs for women of accessing primary reproductive health care

Costs in terms of money, time and opportunity cost—other activities that could be carried out with the money and time used to access care—are important factors in women's use of reproductive health care.

Gender-responsive rights-based strategies to address this issue include:

- remove attendance fees from clinics providing primary health care, including reproductive health services;
- implement national or local health insurance schemes to help women cover other health costs;

- in isolated villages, organize for women in the last weeks of pregnancy to move to hostels or other accommodation nearer to qualified medical assistance—free, or at only a nominal charge;
- provide a midwife within a reasonable distance of at least 90 percent of the population and a health clinic staffed by qualified personnel in all centres of population;
- adjust the hours of operation for primary health care clinics to open at times when women are not busy with work or priority household tasks;
- provide training to staff in primary health clinics, hospitals and midwives on CEDAW and other human rights instruments to ensure that they are aware of women's rights to reproductive care and to treatment that respects their human dignity;
- monitor the quality of services provided by primary health clinics, hospitals and midwives to ensure that the care provided is culturally sensitive and respects women's human rights.

#### Community support schemes for pregnant women

In some Indonesian villages, small sums of money are collected regularly within the community to provide a fund to support pregnant women with transport costs to clinics, particularly for the birth. The schemes include arranging beforehand for transport providers to be ready at any time to transport the woman to the clinic.

## 2. Improve women's access to transport and communications infrastructure

Improving transport and communications infrastructure benefits all people in need of emergency treatment, and therefore contributes to reducing child mortality as well as improving maternal health. It may also contribute to reducing poverty by providing better access to information and markets. Strategies under Goal 8 to improve access to new technologies are relevant.

#### Mobile phones improve access to health care

Grameen Bank brought telephones to distant villages in Bangladesh. Loans were given to almost 139,000 poor rural women to pay for the phones, and radio and mobile phones are now in almost half the villages of Bangladesh. The women set up call centres in their homes where villagers pay a small fee for using the phone. The phones provide access to emergency care, and enable women to get information on health services, health care and other matters.<sup>145</sup>

Gender-responsive rights-based strategies to address this issue include:

- provide all women, including those in rural and isolated areas and poor women, with access to emergency delivery services for childbirth
- in isolated areas, organize communities to monitor the health of women during the last weeks of pregnancy and prepare emergency transportation and communication with qualified obstetric services in case of a difficult delivery;
- where technically feasible, provide at least one mobile or radio-phone for public use at a modest charge.

## 3. Involve men and communities in maternal health care

Women are often unable to access antenatal care and/or the services of a qualified midwife because of the decisions of male members of their households or of older women who are not

well-informed on the importance of these services for the health of women and their children. The support and active participation of men and communities is essential for the effective implementation of some of the suggested interventions to improve women's physical access to maternal health care.

Gender-responsive rights-based strategies to address this issue include:

- conduct information workshops or other events for men and communities on women's reproductive health, maternal health and the importance of antenatal care and for births to be assisted by a qualified midwife;
- conduct information workshops or other events for men and communities on women's rights, particularly women's reproductive rights, and on men's and communities' responsibilities to help reduce maternal mortality.

### D. National intermediate targets and indicators

Matrix 16 below suggests a range of national intermediate targets and indicators for improving maternal health, based on the preceding analysis and suggested strategies. They should be adapted and added to so that they are relevant and useful for the individual country.

Intermediate targets and indicators should be used by women's groups and civil society, as well as by policy makers and programme managers, to assess whether a particular strategy is achieving the intended result and to indicate where and when a strategy may need to be adjusted or replaced.

<b>Matrix 16: National intermediate targets and indicators for improving maternal health</b>	
<b>Targets</b>	<b>Indicators</b> <i>(see note # below)</i>
15.a Increase women's access to reproductive health services by 2 percent* per year until all women are covered	15.a.1 Average distance or time to nearest antenatal care clinic 15.a.2 Average waiting time for women attending clinics for antenatal care 15.a.3 Average distance or time to nearest midwife 15.a.4 Average distance or time to nearest qualified emergency obstetric care 15.a.5 Availability of ambulance or equivalent to transport women needing emergency obstetric care 15.a.6 Average cost of accessing antenatal care 15.a.7 Average cost of accessing services of a qualified midwife 15.a.8 Proportion of women accessing reproductive health services, by type of service and socio-economic category of women

Matrix 16: National intermediate targets and indicators for improving maternal health	
15.b	<p>Involve men and communities in maternal health care</p> <p style="margin-left: 40px;">15.b.1 Number of health education initiatives working with men and communities on maternal health care</p> <p style="margin-left: 40px;">15.b.2 Number of participants attending maternal health care workshops or events, by age and sex</p>
<p><i>* Numeric targets are important for monitoring and accountability. Suggested percentage targets should be adapted to suit what is both feasible and necessary to achieve national targets. Suggested timeframes should be adjusted in accordance with how often data are available to measure progress.</i></p> <p><i># All individual level indicators should be disaggregated by sex, rural/urban location and other relevant socio-economic variables, particularly those relating to minority groups and, where relevant, internally displaced persons.</i></p>	