

Chapter 8

MDG 5: Maternal Health

Maternal deaths are largely avoidable, but prevention depends upon a range of factors, including security, nutrition, safe water and sanitation, education, primary health care, skilled attendance at childbirth, reduction in multiple pregnancies, birth control and continued technical monitoring of those most at risk.

Reported maternal mortality rates across the 46 small states are uneven, with the number of deaths per 100,000 live births at just 8 in Malta and 1,100 in Guinea-Bissau in 2005. This Big Divide underlines the need for greater priority to be given to this MDG and to those countries in greatest need.

Goal 5. Improve maternal health

Target 5A: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio

Indicators:

- 5.1 Maternal mortality ratio
- 5.2 Proportion of births attended by skilled health personnel

Target 5B: Achieve, by 2015, universal access to reproductive health

Indicators:

- 5.3 Contraceptive prevalence rate
- 5.4 Adolescent birth rate
- 5.5 Antenatal care coverage
- 5.6 Unmet need for family planning

MDG 5 has two targets and six indicators. Under target 5A, to reduce the 1990 maternal mortality by three-quarters by 2015, there are two indicators. Indicator 5.1 relates to the number of maternal deaths per 100,000 live births: the maternal mortality ratio. This target has a different value depending on the baseline value of 1990 for each country. Indicator 5.2 reflects the proportion of births attended by skilled personnel and has an implicit universal target of 100 per cent.

Target 5B is to provide universal access to reproductive services and has four indicators. Indicator 5.3 is the

contraceptive prevalence rate for married women, which for this report we assume has as its target an increased level on the 1990 baseline. Indicator 5.4 is the adolescent birth rate, which we assume has the target of a reduced level on the 1990 baseline. Indicator 5.5 is antenatal care coverage, which has an implicit universal target of 100 per cent. Indicator 5.6 is the unmet need for family planning, which has an implicit universal target of 0 per cent.

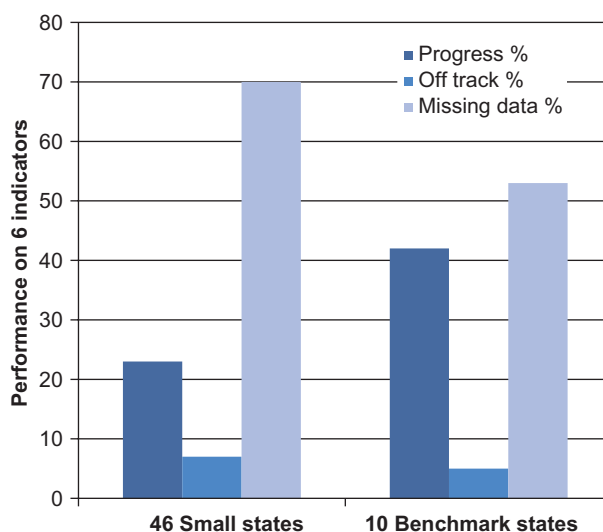
8.1 Overall performance

Within the six indicators, three have universal target values, each of which is concerned with the delivery of professional services. These include two target values for 100 per cent service (indicators 5.2 and 5.5 on professional birth attendance and antenatal care).

In addition, indicator 5.6 has a universal target value of 0 per cent and is concerned with eliminating the unmet need for family planning services. Figure 8.1 summarises the performance of the 46 small states and the 10 benchmark states for MDG 5.

At first glance, the 10 benchmark states, with 42 per cent progress across all the indicators, far exceeded the performance of the 46 small states, with only 23 per cent.¹ But 67 per cent of the total data relating to this MDG are absent: 70 per cent are missing for

Figure 8.1 Performance on MDG 5: Maternal mortality



Source: UN MDG database 2010

the small states and 53 per cent are missing for the benchmark states.

When missing data are included in the denominator, the 46 small states achieved 30 (11%) of the targets across all the indicators in this MDG, while the 10 benchmark states achieved just nine (15%). Excluding missing data, the 46 small states achieved 36 per cent and the 10 benchmark states achieved 32 per cent.²

8.2 Target 5A: Reduce the maternal mortality ratio

8.2.1 Indicator 5.1: Maternal mortality ratio³

Each of the 56 states in the study had data absent for this indicator, inhibiting an assessment of performance status. In all cases data on 1990 baseline values were lacking. Where latest values were reported, the lowest among the 46 small states was in Malta with a maternal mortality ratio (MMR) of 8.

The highest MMR values were in Lesotho (960) and Guinea-Bissau (1,100). Among those benchmark

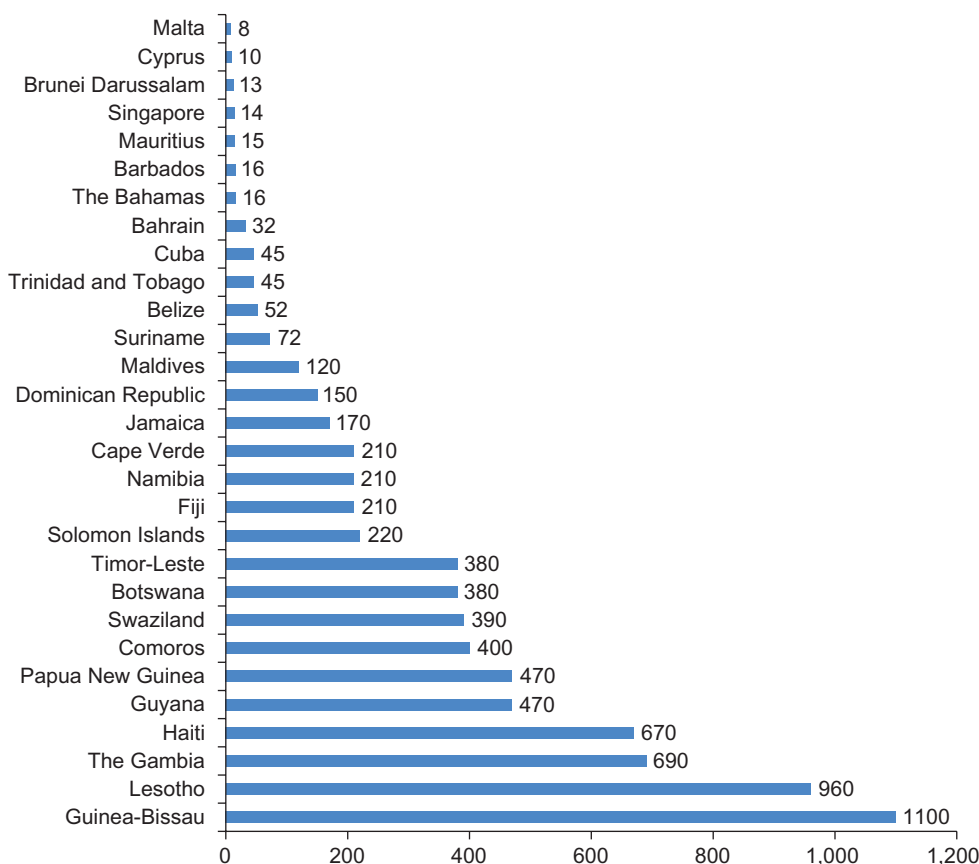
states reporting a latest MMR value, the lowest was in Iceland (4) and the highest was in South Africa (400).

Guinea-Bissau, which is about twice the size of Cyprus, averages more than 600 maternal deaths each year. In contrast, Cyprus has less than 1 per year on average. The high rate in Guinea-Bissau is reflected in its relatively poor levels of service provision and low skilled birth attendance, low contraceptive practice, high adolescent birth rate and low level of antenatal care.

8.2.2 Indicator 5.2: Births attended by skilled health personnel

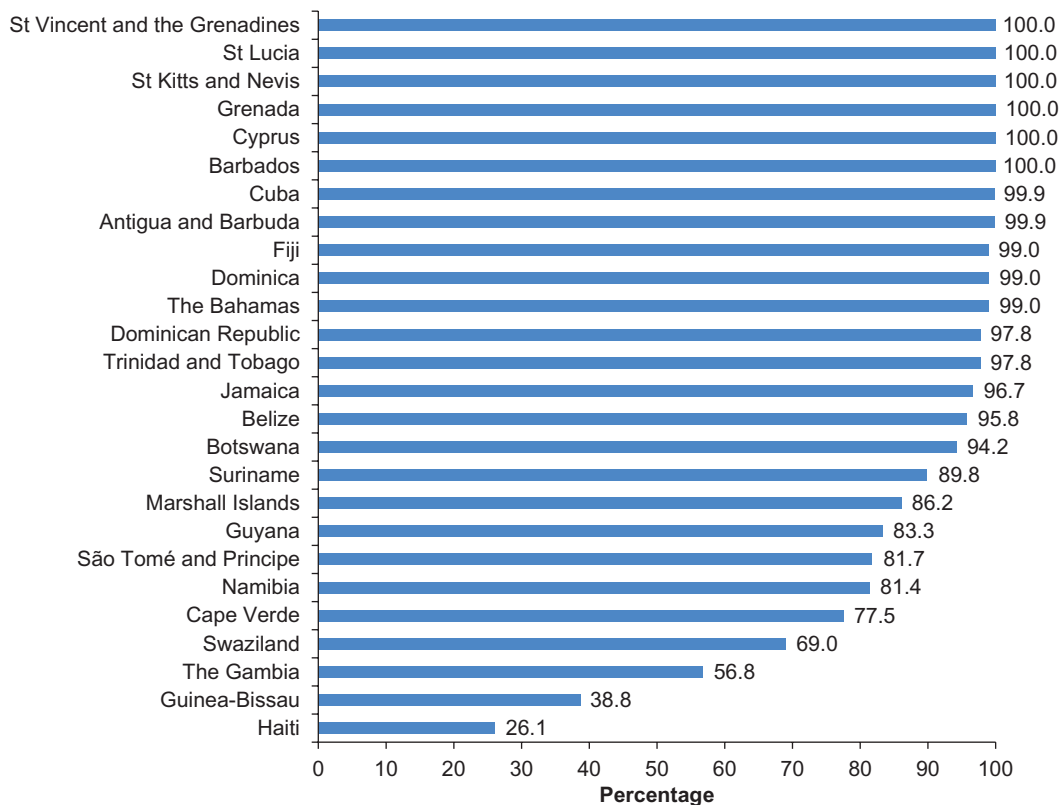
Six⁴ (13%) of the 46 small states had achieved the target by 2006 and reported the attendance of skilled professionals at every birth; four states (9%) were on-track. In the 10 benchmark states, none achieved 100 per cent skilled attendance but 6 (60%) were on-track. When missing data were included for the 46 small states, there was 22 per cent progress and for the benchmark states there was 60 per cent progress.

Figure 8.2 Maternal mortality ratio per 100,000 live births



Note: Data from 2005.

Source: UN MDG database 2010

Figure 8.3 Births attended by skilled health personnel

Note: Latest data were for 2007; where these were not available, data for 2006 or 2005 were used.

Source: UN MDG database 2010

The Big Divide in skilled birth attendance in the 46 small states ranges from 100 per cent or near-100 per cent attendance in six states to the lowest latest rates of attendance by skilled personnel of 26 per cent in Haiti and 39 per cent in Guinea-Bissau.

Figure 8.4 indicates a negative association between the MMR and skilled birth attendance. MMR was lowest in states with the highest levels of skilled attendance. It therefore appears that the involvement of skilled professionals is critical in substantially reducing the risk of maternal death. Yet less than half of the small states have reported the data on both indicators.

8.2.3 Indicator 5.3: Contraceptive prevalence

Only three (7%) of the 46 small states achieved an increase on the 1990 baseline, while just four (9%) were on-track. However, none of the 10 benchmark states achieved it, while 5 (50%) were on-track. If missing data are included, the 46 small states made 16 per cent progress and the benchmark states made 50 per cent.

The lowest reported contraceptive prevalence in married women among the 46 small states was 10 per cent in Guinea-Bissau; the highest was 73 per cent in Cuba. Among the 10 benchmark states the lowest

was 56 per cent in India and the highest was 84 per cent in the UK.

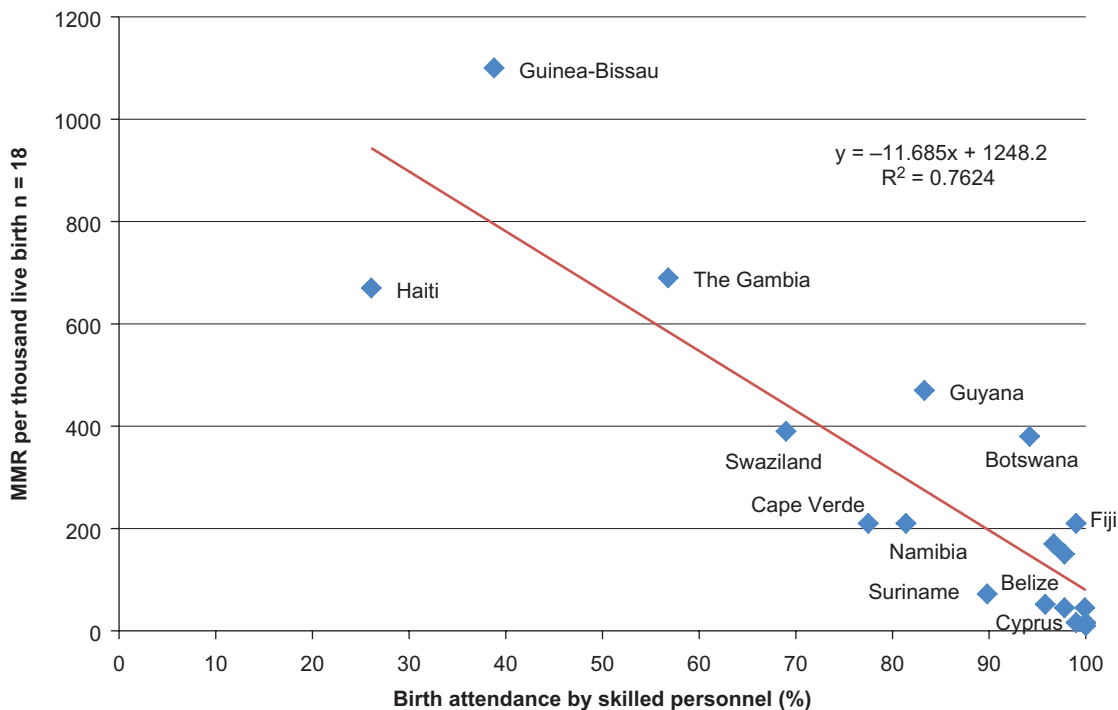
8.2.4 Indicator 5.4: Adolescent birth rate

Of the 46 small states, 19 (41%) secured a lowering of the 1990 adolescent birth rate. In the benchmark states 9 (90%) achieved this. Among the small states the lowest adolescent birth rates were in Cyprus (5.6 per 1,000 women) and Singapore (7.5 per 1,000 women); the highest was in Guinea-Bissau (170 per 1,000 women).

8.2.5 Indicator 5.5: Antenatal care

Five of the 46 small states (11%) achieved 100 per cent antenatal care, at the level of at least one visit, with ten countries (22%) on-track, with higher levels than the 1990 baseline. The seven off-track states had only marginal reductions from their 1990 baseline. None of the benchmark states reported achieving the baseline, but four were on-track. Overall, the small states made 33 per cent progress and the benchmark states made 40 per cent progress.

The Big Divide in antenatal care ranges from the lowest reported level of antenatal care among the small states in Guinea-Bissau, with 78 per

Figure 8.4 Births attended by skilled personnel and MMR

Note: n = number of countries

Source: UN MDG database 2010

cent coverage, to 100 per cent in Cuba, Barbados, Dominica, Grenada, and St Kitts and Nevis. Among the ten benchmark states the lowest reported level of antenatal coverage was in India (74%) and the highest was in Brazil (98%).

It is evident that antenatal care is a significant factor in reducing the risk of maternal death (Figure 8.5), although data were available on the two indicators for only 16 of the 46 small states. Achieving a level of at least 90 per cent antenatal cover is associated with substantially lower levels of maternal death.

8.2.6 Indicator 5.6: Unmet need for family planning

In the 46 small states there were 87 per cent missing data on this indicator. Five states (11%) reported increased use of family planning. In the benchmark states there 70 per cent of data were missing and two states (20%) had increased levels of family planning. The lowest levels of provision among the small states were in Lesotho and Haiti with over 30 per cent of unmet need. In India, a benchmark state, there was a reported 13 per cent unmet need.

8.3 Action on MDG 5: Maternal health

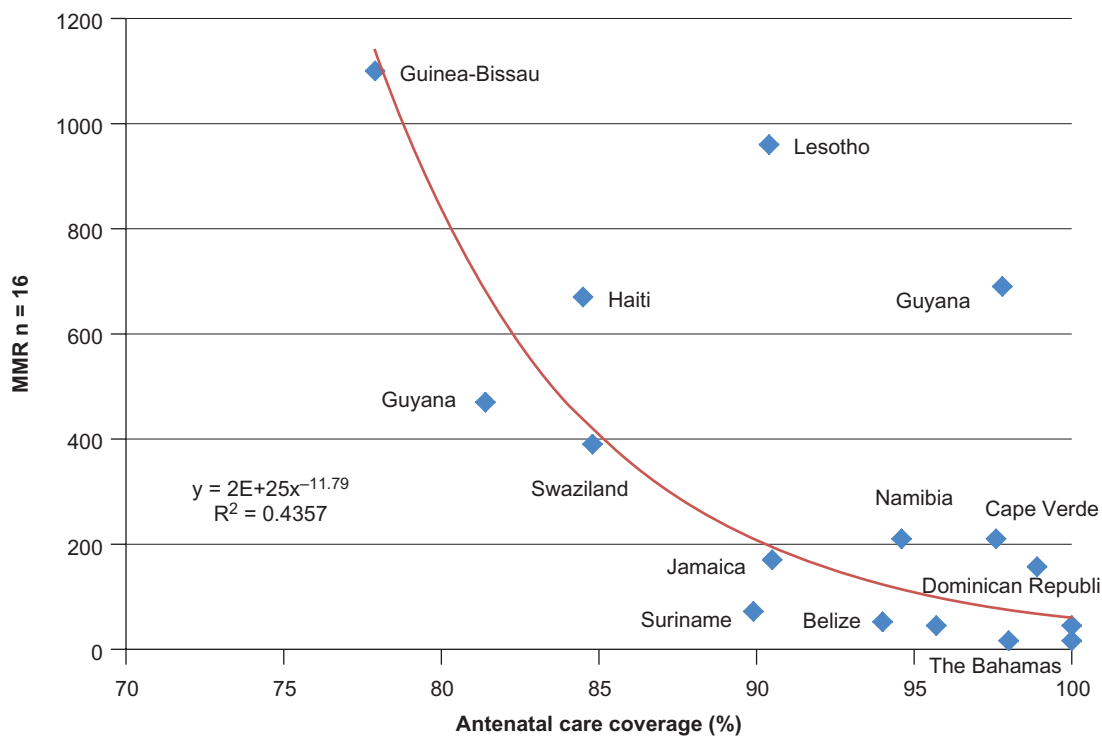
In July 2010, leaders meeting for the fourth African Union Summit in Kampala, Uganda, reviewed the

long-term health situation across member countries. In addition to a commitment to increasing health budgets to 15 per cent of their total government budgets, the African Public Health Alliance observed that although some states have made progress in addressing maternal and child health through expending additional resources, they are still far below the 40 per cent budgetary allocation recommended by the WHO.

Merely allocating 15 per cent of a national budget to health is not considered adequate for African countries. Investment is also required to improve other social determinants such as a skilled workforce, access to water and a better environment. The 2010 Africa Maternal Health Scorecard⁵ and the 2010 Africa Health Financing Scorecard⁶ both indicated that African states have been slow in achieving three of the millennium development goals: MDG 4, which seeks to reduce child mortality; MDG 5 on improving maternal health; and MDG 6 on combating HIV/AIDS, tuberculosis and malaria.

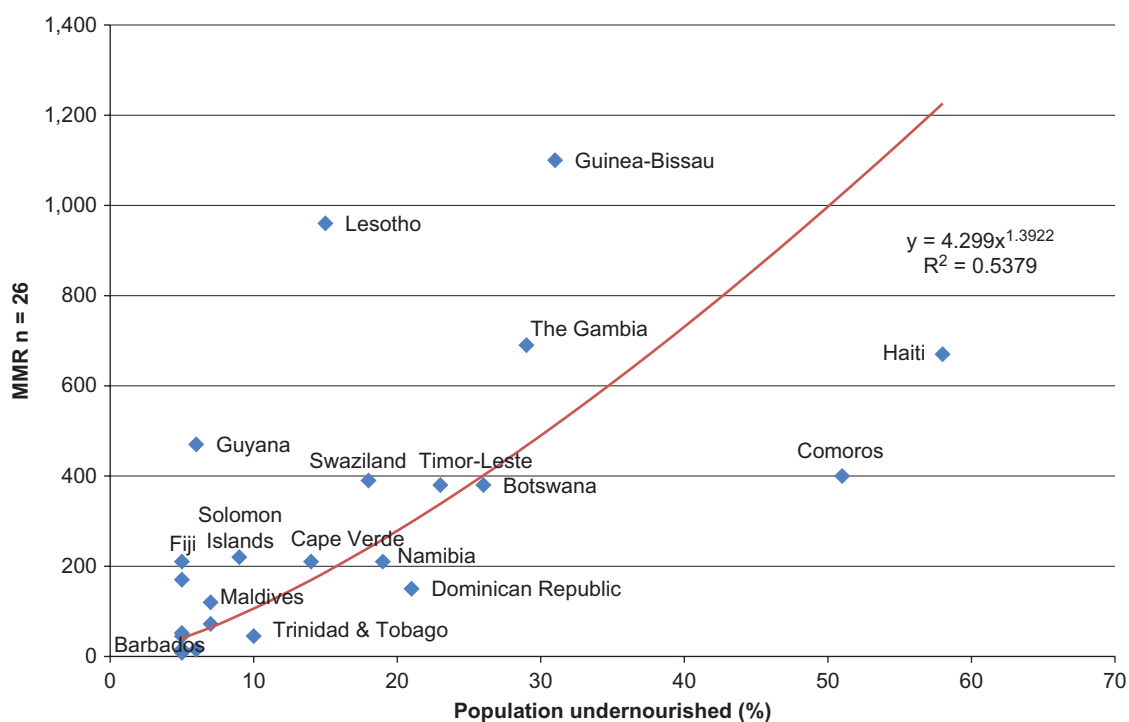
The Africa Maternal Health Scorecard report highlighted the absence of skilled workers at birth, one of the leading causes of maternal death, and called for governments to adopt innovative health financing systems to increase access to health services.

Figure 8.5 Maternal mortality and antenatal care coverage



Note: n = number of countries.
Source: UN MDG database 2010

Figure 8.6 Undernourishment and maternal mortality



Note: n = number of countries.
Source: UN MDG database 2010

Undernourishment is a leading factor in maternal mortality (Figure 8.6), especially when 25 per cent or more of the general population is undernourished. Nutritional support programmes should be targeted at pregnant women (WHO 2003: 30–31).

Recent achievements by Cyprus, Malta, Singapore, Mauritius, Barbados, and Antigua and Barbuda in achieving low levels of maternal deaths offer models of good practice and serve as a stimulus to action.

Notes

- 1 The progress assessment when missing data items are included in the denominator (see Section 2.4 for an explanation of the arithmetic involved and the interpretation of the results).
- 2 The variability of missing data within goals and between countries creates a continuing problem in presenting and interpreting results. The authors have tried to draw attention to the anomalies thrown up by specific large variations in missing data, as in this case, rather than overburden the report with every minor instance. The tables in the Annexes show the full picture, making it possible to examine the variation in results for each country and each indicator.
- 3 Maternal deaths per 100,000 births. For small states the figures are usually averaged over a period of years because of the small number of births per year.
- 4 The six were Barbados, Cyprus, Grenada, St Kitts and Nevis, St Lucia and St Vincent and the Grenadines.
- 5 See: www.who.int/pmnch/media/membernews/2010/20100721_africanunion_pr/en/index.html
- 6 See: www.who.int/pmnch/events/2010/ausummit_2010healthfinancingscorecard.pdf