

FOCUS ON 5

WOMEN'S HEALTH AND THE MDGs

WOMEN
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WOMEN'S HEALTH AND THE MDGs

INVEST IN WOMEN – IT PAYS!

Of all the Millennium Development Goals (MDGs), **MDG 5 – Improve Maternal Health** – has made the least progress. It is the most underfunded of the health-related MDGs.

Globally, the MDGs are widely accepted as the path to ending poverty. But one central fact is not yet widely understood: none of these goals can be achieved without more progress in promoting women's reproductive rights and protecting maternal and newborn health.

These briefing cards outline why decision-makers should prioritise saving mothers' and newborns' lives and key investments they should make in order to achieve that goal. Designed for use by policymakers, civil society groups, and advocates, Focus on 5 details why the world needs to invest now in maternal, newborn, and reproductive health and the strategic actions needed to improve vital health services for mothers and their newborns in the developing world.

No woman should die giving life.

ENDORISING ORGANIZATIONS

- Action Canada for Population and Development
- Advocates for Youth
- Center for Health and Gender Equity (CHANGE)
- Center for Reproductive Rights
- Centre for Development and Population Activities (CEDPA)
- EngenderHealth
- Family Care International
- German Foundation for World Population (DSW)
- Global Health Council
- Impact
- International Center for Research on Women
- International Community of Women with HIV/AIDS
- International Confederation of Midwives
- International Federation of Gynecology and Obstetrics (FIGO)
- International HIV/AIDS Alliance
- International Planned Parenthood Federation (IPPF)
- Ipas
- Marie Stopes International
- Pathfinder International
- Physicians for Human Rights
- Population Action International
- Realizing Rights, at the Aspen Institute
- United Nations Population Fund (UNFPA)
- Women and Children First (UK)
- Women's Refugee Commission
- World Health Organization (WHO)
- Youth Coalition for Sexual and Reproductive Rights

Prepared by Women Deliver in consultation with Family Care International and selected non-governmental organizations, individuals, and multilateral and UN agencies. This publication was made possible by the generous support of the Danish International Development Assistance (Danida) and the Spanish Ministry of Foreign Affairs and Cooperation.

Designed by Ahlgrim Design Group



Focus on 5: Introduction

In 2000, 189 countries committed to ending extreme poverty worldwide through the achievement of the eight Millennium Development Goals (MDGs). MDG 5—Improve Maternal Health—set a target of reducing maternal mortality by three-fourths by 2015. In 2007, the world's leaders added a second target under MDG 5: achieve universal access to reproductive health.

Every year, between 350,000 - 500,000 girls and women die from pregnancy-related causes. While the numbers of deaths are decreasing, the progress is not enough or fast enough. Between 15 and 20 million girls and women suffer from maternal morbidities every year.¹ Almost all maternal deaths occur in developing countries; especially vulnerable are poor women. In fact, maternal mortality represents one of the greatest health disparities between rich and poor and between the rich and poor populations within every country.

Achieving MDG 5 is not only an important goal by itself, it is also central to the achievement of the other MDGs: reducing poverty, reducing child mortality, stopping HIV and AIDS, providing education, promoting gender equality, ensuring adequate food, and promoting a healthy environment.

We know what it will take to significantly improve maternal, newborn, and reproductive health:

- 1. Access to family planning**—counselling, services, supplies
- 2. Access to quality care for pregnancy and childbirth**
 - antenatal care
 - skilled attendance at birth, including emergency obstetric and neonatal care
 - immediate postnatal care for mothers and newborns
- 3. Access to safe abortion services**, when legal (as per paragraph 8.25 of the Programme of Action for ICPD)²

With increased political will and adequate financial investment in these three strategies, women and their newborns can survive so that their families, communities, and nations can thrive.



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Reasons to take action

Investing in women will produce far-reaching economic and social benefits. The world loses \$15 billion every year in productivity because of maternal and newborn mortality. Targeted investments in maternal, newborn, and reproductive health will have a dramatic, lasting impact on the economic and social fabric of developing nations.

Maternal health is a human right. Maternal deaths are a gross violation of women's human rights. Governments have an obligation to protect women's right to life, health, and equality; the fulfilment of these rights is essential to reducing maternal mortality.

Maternal health and newborn health are closely linked. In poor countries, a mother's death after childbirth is often a death sentence for her newborn baby. Providing good quality care during and after pregnancy and childbirth will substantially reduce newborn mortality as well.

MDG 5 can be achieved - but political will and financial investment are urgently needed. Delivering a package of services essential to making significant improvement in maternal health is estimated to cost less than US\$1.50 per person in the 75 countries where 95% of maternal mortality occurs. Financial investment and the political will to make the investment will drive progress toward achieving MDG 5, and in turn, achieving all the MDGs.

We know what to do: cost-effective health strategies save women's and newborns' lives. The great majority of maternal and newborn deaths can be prevented through simple, cost-effective measures. Complications in pregnancy and childbirth are common, but unpredictable.

The action plan

Governments and the international community must commit to the following actions needed to provide essential services to all women in developing countries and to meet MDG 5 by 2015:

Increase investment in maternal, newborn, and reproductive health over current funding levels by at least an additional US\$12 billion in 2010, increasing annually to an additional US\$20 billion in 2015.³

Strengthen health systems for sustaining and scaling-up critical health interventions, and addressing serious gaps including 2.5 million health care professionals (midwives, nurses, doctors) and 1 million community health workers by 2015.⁴

Strengthen maternal, newborn, and reproductive health programmes and institutions, and ensure that information and services are available and sensitive to and respectful of women, especially poor and marginalised women.

Develop monitoring and accountability mechanisms and channels for community engagement that address wider socio-economic, political, and cultural barriers to maternal and newborn health care, and help improve policies and programmes.

FOOTNOTES

- 1 <http://www.prb.org/pdf/hiddensufferingeng.pdf>
- 2 Para 8.25: "In no case should abortion be promoted as a method of family planning... Prevention of unwanted pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion... In circumstances where abortion is not against the law, such abortion should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion..."
- 3 Singh S et al., *Adding it Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health*, New York: Guttmacher Institute and United Nations Population Fund, 2009.
- 4 The Maternal, Newborn, and Child Health Consensus, 2009.



INVEST IN WOMEN – IT PAYS!

Investing in women will produce far-reaching economic and social benefits.

Healthier, better educated women are more productive economically, and are critical to ensuring healthy children, strong families and communities, and productive nations. Targeted investments in maternal, newborn, and reproductive health make women and newborns healthier, and will have a dramatic, lasting impact on the economic and social fabric of developing countries.

HEALTHY WOMEN DELIVER FOR THEIR FAMILIES, COMMUNITIES, AND NATIONS.

A woman's income is more likely than a man's to go toward food, education, medicine, and other family needs,¹ and women in many countries make important family decisions about nutrition, health care, and use of resources. A mother's care is often essential for keeping her children alive.

When a woman dies or becomes ill, her children are much more likely to leave school, to suffer from poor health, and even to die themselves. Her production and income are lost both to her family and to her community.

Many lives are therefore saved—and national income rises—when women have access to high-quality health care from skilled providers during labour, in childbirth, and after delivery. And women who can plan when to have children have greater life choices, face fewer health and financial risks,

and may not be forced into painful decisions (such as whether to spend scarce resources on food or schooling) that can harm their children, especially daughters.

INVESTING IN MATERNAL AND NEWBORN HEALTH IS COST-EFFECTIVE.

Research has confirmed that high-quality antenatal and delivery care are cost-effective interventions: providing a package of essential services in the 75 countries where almost all maternal deaths occur is estimated to cost less than US\$1.50 per person.²

THE RETURN ON INVESTMENT IS ENORMOUS.

Maternal and newborn health has a dramatic impact on economic productivity: in 2001, the U.S. Agency for International Development estimated the global economic impact of maternal and newborn mortality at US\$15 billion in lost productivity every year.³



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Investments in maternal, newborn, and reproductive health also improve other health services. Providing the equipment, facilities, and training for emergency obstetric services, for example, also creates the capacity to perform surgery and provide blood transfusions for accidents and other emergencies. Similarly, women who use maternal health services are more likely to take advantage of other reproductive health services, including family planning and HIV and AIDS testing and treatment. Further, providing family planning services reduces the rate of unintended pregnancy, which leads to fewer unsafe abortions, which in turn brings down health care costs.

IMPROVING MATERNAL, NEWBORN, AND REPRODUCTIVE HEALTH IS ESSENTIAL TO ACHIEVING THE MILLENNIUM DEVELOPMENT GOALS.

Poverty is a relentless and overwhelming cause of illness and disease in developing countries; in turn, poor health pushes women and their families further into poverty.

MDG 5 — Improve Maternal Health — is the heart of the MDGs because fulfilling this goal is critical to achieving the other MDGs and eradicating extreme poverty. The policy and programme changes required to achieve MDG 5 will directly support the other MDGs, by empowering women, reducing child mortality, enabling progress against HIV and other diseases, supporting greater environmental sustainability, and ultimately helping to reduce poverty and achieve universal primary education.

FOOTNOTES

- 1 Jowett M. "Safe Motherhood interventions in low income countries: an economic justification and evidence of cost-effectiveness." *Health Policy* 53(3):201-28. 2000.
- 2 "World Health Report 2005: Make Every Mother and Child Count," WHO (2005).
- 3 USAID Congressional Budget Justification FY2002: Program, Performance, and Prospects - The Global Health Pillar. http://www.usaid.gov/pubs/cbj2002/prog_perf2002.html. As cited in Gill K., et al Women Deliver for Development, Background Paper for the Women Deliver conference. FCI and ICRW, 2007.

Progress for MDG 5 is possible – we know what to do. We know the cost and sadly, we know the cost of not doing enough.



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INVEST IN WOMEN – IT PAYS!

Maternal health is a human right.

The right of all women to quality health care must be ensured to prevent avoidable maternal deaths and injuries. Maternal health care must be available, accessible, and of high quality; failure to provide such care is a violation of women's rights to life, health, equality, and non-discrimination. Women also have a right to make informed and voluntary reproductive health decisions based on accurate information; to prevent unintended pregnancies; to be free from gender-based discrimination and violence; to have access to HIV and AIDS prevention, treatment, and care and to participate in the planning and implementation of health policies that are essential to making pregnancy and childbirth safer.

ALL WOMEN ARE ENTITLED TO THE CARE THEY NEED TO SURVIVE PREGNANCY AND CHILDBIRTH.

Failure to ensure the human rights of all women has resulted in vast disparities in maternal mortality across and within countries. In Canada, where education, family planning, and health care services are widely available to all, one out of 11,000 women dies from complications of pregnancy and childbirth. The situation is vastly different in Niger, where poverty and a shattered health care system are combined with a high fertility rate: there, pregnancy-related causes will kill one of every seven women.¹

HUMAN RIGHTS TREATIES THAT REFERENCE THE RIGHT TO HEALTH

- United Nations Charter
- Universal Declaration of Human Rights
- International Covenant on Economic, Social, and Cultural Rights
- Convention for the Elimination of all Forms of Discrimination against Women



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In all countries, rural, indigenous, and poor women, as well as women who live in conflict zones, face the highest risk. Women living with HIV also have the highest risk of maternal mortality.

RESPECT, PROTECT, AND FULFIL WOMEN'S HEALTH.

Governments have an obligation to take action to prevent maternal deaths, which represent a gross violation of women's basic human rights.² Various international treaties establish the state's obligation to respect, protect, and fulfil women's human rights. Among them is the right to the highest attainable standard of health, and includes four interrelated and essential elements: goods, services, facilities, and conditions necessary for the realization of this right. These elements must be available to all, accessible to all without discrimination, acceptable, and of good quality. Treaty monitoring bodies have explicitly recognised maternal mortality as a violation of women's right to life.^{3,4} Where human rights have been violated, individuals and organizations have turned to the courts at the national, regional, and UN levels. (see box)

FOOTNOTES

- 1 Gill K et al, Women Deliver for Development, Background Paper to the Women Deliver Conference, FCI and ICRW, 2007.
- 2 Center for Reproductive Rights, *Using the Millennium Development Goals to Realize Women's Reproductive Rights*, September 2008, page 12.
- 3 United Nations Human Rights, Office of High Commissioner for Human Rights, "What are human rights?" <http://www.ohchr.org/EN/Issues/Pages/WhatareHumanRights.aspx>, 2008.
- 4 Committee on Economic, Social and Cultural Rights, General Comment 14, The rights to the highest attainable standard of

Sandesh Bansal v. Union of India and Others

A public health activist in India has taken the state of Madhya Pradesh to court over the staggering number of women in the state who die during pregnancy and childbirth. The public interest lawsuit was brought in July 2008 by Sandesh Bansal, the coordinator of Jan Adhikar Manch, a network of local health NGOs. Mr. Bansal contends that the government of Madhya Pradesh has failed to properly implement maternal health policies in the state. He has requested the court to order the state government to establish health facilities where needed and ensure that they are fully functional; guarantee that no person is denied free health services; and create a surveillance mechanism to identify and review maternal deaths.⁵

- health, U.N. Doc. E/C. 12/2000/4 (2000), at para 12. <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>
- 5 Center for Reproductive Rights. India activist sues state for neglecting maternal mortality. <http://reproductiverights.org/en/press-room/indian-activist-sues-state-for-neglecting-maternal-mortality>. Accessed 06/25/09.

Adapted from "A Call to Global Leaders on Maternal Health as a Human Right," International Initiative on Maternal Mortality and Human Rights, September 2008.

MDG 5 is achievable if we put women's human rights at the centre of the equation.

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INVEST IN WOMEN – IT PAYS!

Maternal health and newborn health are closely linked.*

The health of newborns is inextricably linked to that of their mothers. Providing good quality care during and after pregnancy and childbirth will substantially reduce newborn mortality. MDG 4 — Reduce Child Mortality— sets a target to reduce the under-five mortality rate by two thirds by 2015.

NEARLY FOUR MILLION NEWBORNS DIE EACH YEAR.

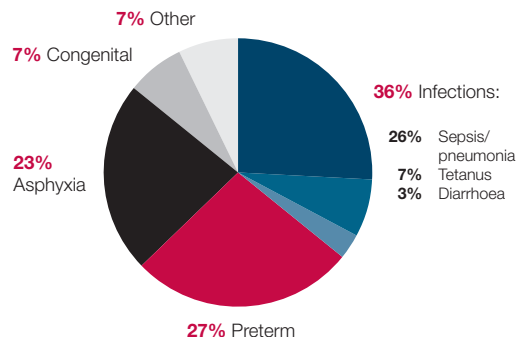
More than 10,000 newborn babies die every day; almost four million deaths each year. An additional 3.2 million babies are stillborn, one third of whom die during labour. Many infants die at home, without receiving any formal health care, unrecorded, and invisible to all but their families.

Almost three-quarters of all newborn deaths occur in South Asia and sub-Saharan Africa; 15 of the 20 countries with the highest neonatal mortality are in Africa. Even within these countries, national averages hide substantial internal disparities: almost everywhere in the developing world, the poorest families have the least access to care, so their newborns bear the most risk.

MOST NEWBORN DEATHS ARE PREVENTABLE.

Top 3 direct causes of newborn death¹:

1. Infections such as sepsis, pneumonia, tetanus, and diarrhoea cause more than one-third (36%) of newborn deaths worldwide.
2. Preterm birth causes 27% of newborn deaths.
3. Birth asphyxia — the absence of breathing at birth — causes 23% of newborn deaths.





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Birth and the first 24 hours of life represent the highest risk of death for a mother and her newborn, yet coverage of care is lowest.

Three-quarters of the four million newborn deaths occurring annually happen within the first week of life, with the highest risk of death on the first day. For mothers, the risks of death and illness are also highest at birth and in the immediate post-partum period.

EARLY POSTNATAL CARE CAN PREVENT MATERNAL AND NEWBORN DEATHS.

A delay of even a few hours can make the difference between life and death for a baby with neonatal sepsis or a mother experiencing post-partum haemorrhage. Because various factors—including distance from health facilities, service fees, and cultural traditions—contribute to low usage of post-delivery health care services, it is important to reach mothers and newborns with affordable postnatal care at or close to home. Through these services, women can learn to care for themselves and their babies and to recognise

danger signs of complications, and can be referred to a health facility if more advanced care is needed.

PREVENTION OF TOO-EARLY CHILDBEARING CAN PREVENT MATERNAL AND NEWBORN DEATHS.

Access to family planning is important to preventing risks associated with too-early childbearing, including increased risk of maternal death and newborn death. Infants of early adolescent mothers are more likely to die before their first birthday than are the infants of older mothers ages 23-29.²

FOOTNOTES

- 1 Lawn, J.E., Cousens, S. and Zupan, J. for The Lancet Neonatal Survival Steering Team. (2005) 4 million neonatal deaths: When? Where? Why? *The Lancet* Neonatal Survival Series. Published online March 3, 2005. <http://image.thelancet.com/extras/05art1073web.pdf>
- 2 Phipps MG et al. Young maternal age associated with increased risk of neonatal death. *Obstetrics & Gynecology*, 2002; 100:481-486.

* Prepared by: Save the Children USA/Saving Newborn Lives Program

Maternal survival is key to fulfilling the promise of MDG 4, and saving the lives of millions of newborn babies.

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MDG 5 *can* be achieved – but political will and financial investment are urgently needed.

Progress on maternal health is far too slow.

UN Secretary-General Ban Ki-moon has noted that MDG 5 “stands as the slowest-moving...of all the MDGs” and is seriously off-track to meet its targets by 2015.¹ Many countries in sub-Saharan Africa and South Asia have shown little progress in recent years; some have even lost ground. Globally, the rate of death from pregnancy and childbirth declined between 1990 and 2005 by only 1% per year. In order to get back on track toward achieving MDG 5, a 5.5% annual rate of decline is needed from 2005 to 2015.²

The Secretary-General has called for a global push to address maternal health needs in developing countries, including the shortage of health workers, and has urged donor nations to step up funding to levels that will provide the basic services needed to achieve MDG 5.



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THE HEALTH WORKER CRISIS

Thirty-six countries in sub-Saharan Africa have severe shortages of health workers. At least 2.3 trained health care providers are needed per 1,000 people to reach 80 percent of the population with skilled care at birth and child immunization coverage.³

INVESTMENT IN MATERNAL, NEWBORN, AND REPRODUCTIVE HEALTH WILL MAKE A DIFFERENCE.

We know the basic health interventions that will reduce maternal mortality in poor countries; the key missing ingredient is money. Financial investment in maternal, newborn, and reproductive health—and the political will to make that investment—will drive progress toward achieving MDG 5.

MDG 5 is not sufficiently financed. In 2006, donor aid for maternal and newborn health totaled only US\$1.2 billion worldwide; investments in family planning have also declined over several years, falling to under US\$400 million in 2006. This represents less than half of the assistance needed for real progress.⁴

Achieving the MDG 5 targets by 2015 will require additional global investment of at least US\$12 billion per year in maternal, newborn, and reproductive health by 2010 and an additional US\$20 billion annually by 2015.⁵ In addition to increasing development investment overall, developing countries need coordinated, predictable, and long-term donor commitments in order to effectively plan and implement improvements in health care systems and services.⁶

MILLENNIUM DEVELOPMENT GOAL 5: IMPROVE MATERNAL HEALTH

TARGET 5A:

Reduce maternal mortality by three quarters

Indicators:

- **Maternal mortality ratio**
- **Percentage of births attended by skilled health personnel**

TARGET 5B:

Achieve, by 2015, universal access to reproductive health

Indicators:

- **Contraceptive prevalence rate**
- **Adolescent birth rate**
- **Antenatal care coverage**
- **Unmet need for family planning**



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MATERNAL MORTALITY SCORECARD

Region	Country	Gross National Income per capita (2005) (US\$) ⁷	Maternal mortality ratio (2005) (Maternal deaths per 100,000 live births) ⁸
Africa	Rwanda	260	1300
	Mozambique	300	520
Middle East	Morocco	1,885	240
	Egypt	1,370	130
Latin America & Caribbean	Bolivia	1,010	290
	Nicaragua	870	170
Asia	Pakistan	820	320
	Vietnam	610	150
Europe	Estonia	9,970	25
	France	34,290	10
North America	USA	41,490	11
	Canada	34,540	7

WITH POLITICAL WILL AND INVESTMENT, COUNTRIES CAN MAKE REAL PROGRESS.

By committing to the necessary political and financial investment, a number of countries have proven—as the developed world did decades ago—that progress in reducing maternal deaths is feasible and achievable. Both Sri Lanka and Vietnam, for example, have succeeded in significantly reducing maternal mortality, in spite of per capita incomes that are as low as those in Yemen

and Cote d'Ivoire, where maternal deaths remain very high. And by recognizing the human and economic potential of women and making the necessary investments, several other countries—including Egypt, Honduras, Malaysia, and Thailand—have cut their maternal mortality levels by half or more.

Maternal mortality levels can vary greatly, even in countries with similar per capita incomes. Many



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factors play a role in determining a woman's chance of survival during pregnancy and childbirth, including cultural norms, social status of women, and traditional health practices, for instance, along with political stability and military conflict. However, political commitment is essential to ensuring safer pregnancy and childbirth for the world's women.

FOOTNOTES

- 1 9 July 2008, "G-8 Commitment to Maternal and Reproductive Health is a Welcome Boost to Poor Women Worldwide, says UNFPA."
- 2 Hill K et al. "Estimates of maternal mortality worldwide between 1990 and 2005: an assessment of available data." *The Lancet*, October 13-19, 2007, 370 (9555):1311-1319.
- 3 World Health Organization, The global shortage of health workers and its impact, Fact sheet No. 302, April 2006.
- 4 UNFPA/NIDI. 2008. "Table 5A. Final Donor Expenditures for Population Assistance by Category of Population Activity, 1996-2006." Financial Resource Flows for Population Activity in 2006. New York, UNFPA.
- 5 Singh S et al., *Adding it Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health*, New York: Guttmacher Institute and United Nations Population Fund, 2009.
- 6 Countdown to 2015 MNCH: The 2008 Report Tracking Progress in Maternal, Newborn, and Child Survival. 2008: UNICEF.
- 7 UNdata, New York, NY: United Nations Statistic Division.
- 8 *Maternal mortality in 2005: estimates developed by WHO, UNICEF, UNFPA and the World Bank*. Geneva, World Health Organization, 2007.

**Achieving MDG 5 is within our reach –
but only if the global community
and national governments make the
necessary investments now.**

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We know what to do: cost-effective health strategies save women's lives.

Complications of pregnancy and childbirth are among the leading causes of death for women in developing countries. Complications are unpredictable, but remarkably common. Of the estimated 210 million pregnancies each year, 8 million result in life-threatening complications for the woman.¹

When it comes to maternal death, girls are at highest risk for pregnancy-related complications. Every year, approximately 16 million adolescent girls ages 15 to 19 give birth, and complications from pregnancy is the leading cause of death for these young women in developing countries.^{2, 3} Young women often face especially serious barriers to accessing life-saving contraceptives and family planning services, including insufficient knowledge about modern methods and health care providers who discourage use of contraception among unmarried young people.⁴

In general, when health systems are functioning, and quality care is made available to all women, complications are avoided or treated, and maternal deaths are prevented. Thus, maternal mortality is one of the best indicators of overall health system performance.



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No woman should die giving life. Yet women continue to die from preventable causes at unacceptable rates.

THREE CORE STRATEGIES IMPROVE OUTCOMES.

While there is no magic bullet that solves all maternal health problems, the great majority of maternal deaths can be prevented through simple, cost-effective measures, which can be implemented even where resources are scarce.

The core strategies that have been demonstrated to improve maternal and newborn health are:

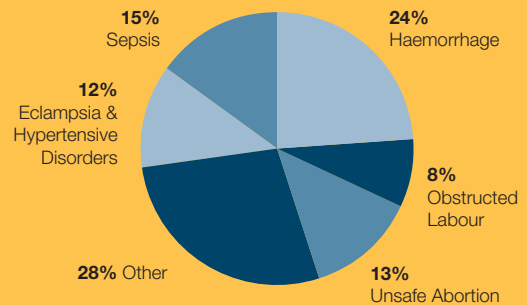
- 1. Access to family planning**—counselling, services, supplies
- 2. Access to quality care for pregnancy and childbirth**
 - antenatal care
 - skilled attendance at birth, including emergency obstetric and neonatal care
 - immediate postnatal care for mothers and newborns
- 3. Access to safe abortion services**, when legal (as per paragraph 8.25 of the Programme of Action for ICPD)

FUNCTIONING HEALTH SYSTEMS CAN PROVIDE PRACTICAL SOLUTIONS FOR CAUSES OF MATERNAL MORTALITY.

A functioning health system, with a well-trained, motivated workforce, can deliver effective, safe, and high-quality health services to all segments of the population. Universal access to high-quality health care—provided in health facilities, staffed by skilled attendants; stocked with essential drugs, contraceptives, and reproductive health supplies; and equipped to provide the full range of essential services—prevents maternal and newborn death and injuries.

Why Women Die

In developing countries, five causes are responsible for nearly three-quarters of all maternal deaths.



OTHER:

HIV, tuberculosis, anaemia, accidents, murders, suicides

Ronsmans C and Graham WJ on behalf of The Lancet Maternal Survival Series steering group, "Maternal mortality: who, when, where, and why." *The Lancet*, Maternal Survival, September 2006.

Four million newborn infants also die each year, mostly due to the mother's poor health or to inadequate care in the critical hours, days, and weeks after birth.



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The following are specific interventions proven to prevent or effectively treat the major causes of maternal death:

HAEMORRHAGE is excessive bleeding or an abnormal blood flow.

Practical Solution:

- **Oxytocin and Misoprostol**
These medications can prevent or stop bleeding during and immediately following delivery. Skilled attendants should be trained in their administration, along with other techniques to stop postpartum bleeding such as controlled cord traction and uterine massage.^{5, 6, 7}

OBSTRUCTED LABOUR occurs when the foetus cannot pass through the birth canal. It is most common among young girls whose bodies are not yet mature and women whose pelvises are underdeveloped due to malnutrition.⁸

Practical Solution:

- **Caesarean Section**
Skilled attendants must be trained to perform this surgical procedure—delivery through an incision in the abdominal wall and the uterus—to ensure safe childbirth when obstructed labour or other complications make vaginal birth impossible or unsafe for the mother and baby.⁹

UNSAFE ABORTION is the termination of an unwanted pregnancy by a person lacking the necessary skills or in an unsanitary environment. Every year, an estimated 20 million unsafe abortions take place.¹⁰

Practical Solution:

- **Family Planning**
Family planning information and access to contraception and reproductive health supplies are needed in order to prevent unintended and unplanned pregnancies, which often lead to unsafe abortion.

- **Safe Abortion**

Effective reproductive health services include safe abortion, when legal, a medical procedure for terminating unwanted pregnancy. Safe abortions are performed by trained health care providers using proper techniques (including medical abortion and vacuum aspiration) under sanitary conditions.¹¹

- **Post Abortion Care**

Post abortion care (PAC) includes emergency treatment for complications from spontaneous or induced abortion, family planning counselling and supplies, and follow-up and referral to other reproductive health services.

SEPSIS is a severe infection, most common during the postpartum period.

Practical Solution:

- **Antibiotics**
A hygienic delivery, and postpartum care in a health facility, can usually prevent infection in mothers and newborns. Since infection is still a leading cause of both maternal and infant death, access to antibiotics is critical to improving maternal and newborn health.

ECLAMPSIA AND HYPERTENSIVE DISORDERS

are blood pressure complications, which can cause convulsions and even death for pregnant women before, during, or after birth.¹²

Practical Solution:

- **Magnesium Sulphate**
Skilled attendants must be trained in the use of magnesium sulphate, an effective, safe, and inexpensive medication that reduces the risk of eclampsia (convulsions) and maternal death caused by hypertensive disorders of pregnancy.



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FOOTNOTES

- 1 Kamrul Islam, M., *The Costs of Maternal-Newborn Illness and Mortality*, World Health Organization, Geneva, 2006, p. 7.
- 2 WHO. Adolescent Pregnancy, in MPS Notes. World Health Organization: Geneva, 2008.
- 3 UNFPA, State of World Population, 2004.
- 4 Youth Coalition, *Young People and Universal Access to Reproductive Health*, 2009.
- 5 Nordstrom L, Fogelstam K, Fridman G, Larsson A, Rydhstroem H. Routine oxytocin in the third stage of labour: a placebo controlled randomized trial. *Br J Obstet Gynaecol* 1997; 104:781-6.
- 6 Derman RJ, Kodkany BS, Goudar SS, Geller SE, Naik V, Bellad MB, et al. Oral misoprostol in preventing postpartum haemorrhage in resource-poor communities: a randomized controlled trial. *The Lancet* 2006; 368:1248-5.
- 7 International Confederation of Midwives and the International Federation of Gynecology and Obstetrics. Joint Statement: management of the third stage of labour to prevent postpartum haemorrhage. 2003.
- 8 Kwast BE. 1991b. Puerperal sepsis: its contribution to maternal mortality. *Midwifery* 7(3):102-106.
- 9 Medline Plus, Medical Encyclopedia, <http://www.nlm.nih.gov/medlineplus/ency/article/002911.htm#Definition>
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Access to these practical solutions can save the lives of countless mothers and newborns, and help to fulfil the promise of MDG 5.



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The Action Plan

Saving the lives of mothers and newborns, and achieving MDG 5, will require investment in high-quality health systems that can provide women and families with the essential services they need in order to **prevent** problems during pregnancy and childbirth and to **treat** the complications that do develop.

We call upon governments and the international community to commit to the following actions needed to provide essential services to all women and to meet MDG 5 by 2015:

- **Increase investment in maternal, newborn, and reproductive health** over current funding levels by at least an additional US\$12 billion in 2010, increasing annually to an additional US\$20 billion in 2015.¹
- **Strengthen health systems** for sustaining and scaling-up essential health interventions, and addressing critical gaps. This includes increasing the number of health care professionals and managers by 2.5 million by 2015.²
- **Strengthen maternal, newborn, and reproductive health programmes and institutions**, and ensure that information and services are sensitive to and respectful of women, especially poor and marginalised women.
- **Develop monitoring and accountability mechanisms** that address wider socio-economic, political, and cultural barriers to maternal and newborn health care, to improve policies and programmes.

These urgently-needed action steps will provide the financial and human resources to implement the three core strategies that have been demonstrated to improve maternal health and save lives:

1. Access to family planning, including:

- **counselling** to help ensure choice, correct use of, and satisfaction with a method of contraception
- **services** for voluntarily preventing or delaying pregnancy
- **supplies** such as contraceptive drugs or devices



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When all women and newborns, in every country, have access to these three core strategies of maternal, newborn, and reproductive health, the foundation will be in place for achieving the Millennium Development Goals.

Ensuring that girls and women have access to family planning saves lives by enabling women to avoid unintended and high risk pregnancy. Marginalised women, including HIV-positive women, have the right to access a full range of family planning options and reproductive and sexual health services.

2. Access to quality care for pregnancy and childbirth, including:

- **Antenatal care** where skilled health providers can offer birth preparedness counselling, treatment of syphilis, prevention of mother-to-child transmission (PMTCT) of HIV and AIDS, tetanus vaccination, and other interventions, which benefit mothers and newborns.
- **Skilled care** covers a continuum of care, including:
 - > *Health facilities* offering 24-hour coverage, staffed with skilled maternity care providers, such as doctors, nurses, and midwives.
 - > *Access to emergency obstetric and newborn care* when life-threatening complications occur.
 - > *Access to anti-retroviral therapy*, if appropriate.
 - > *Removal of barriers* to access services, such as fees at point of use, inadequate transportation, poor communication structures, and lack of necessary supplies, drugs, and equipment to provide essential services.
 - > *Educated and mobilised communities* that encourage women to seek skilled care, and assist them in reaching appropriate health facilities in time to receive the help they need.

- **Immediate postnatal care for mothers and newborns** includes monitoring for excessive bleeding, pain, and infection, as well as counselling on breastfeeding, nutrition, and family planning. For newborns, it includes immediate warming and breastfeeding; hygienic care of the umbilical cord; and timely identification, referral, and treatment when there are signs of danger, especially among babies with low birth weight.

- 3. Access to safe abortion, when legal**, (as per paragraph 8.25 of the Programme of Action for ICPD) including medical or surgical procedures to terminate an unwanted pregnancy. Such services must be provided by well-trained health personnel; governed by policies and regulations to ensure access and quality; and supported by a health systems infrastructure, equipment, and supplies.

FOOTNOTES

- 1 Singh S et al., *Adding it Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health*, New York: Guttmacher Institute and United Nations Population Fund, 2009.
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Glossary of key terms

Adolescent birth rate

The annual number of births to women aged 15-19 per 1,000 women in that age group.

Antenatal care coverage

The percentage of women who have given birth who received antenatal care from a skilled attendant at least once during their pregnancy.

Birth asphyxia

A condition in which insufficient oxygen is delivered to the foetus during labour and childbirth, leading to risk of death (stillbirth or neonatal death) or lifelong disability in the surviving infant.

Contraceptive prevalence rate

The percentage of women of reproductive age (15-49) who are practicing, or whose sexual partners are practicing, any form of contraception.

Continuum of care

An approach to maternal, newborn, and child health that includes integrated service delivery for women and children from before pregnancy to delivery, the immediate postnatal period, and childhood. Such care occurs across the life cycle and within the health system and is provided by families and communities, through outpatient services, clinics, and other health facilities.¹

Family planning

The conscious effort of couples or individuals to plan the number of their children and to regulate the spacing and timing of their births through contraception; also includes the treatment of involuntary infertility.²

Gender

The socially-defined roles and responsibilities of men and women, boys and girls. Gender equality is the equal treatment of women and men in laws and policies, and equal access to resources and services within families, communities, and society at large.³ Gender equity is the fair and just distribution of benefits and responsibilities between men and women, boys and girls.⁴ Gender-based violence targets women or men, girls or boys, based on their gender. It includes, but is not limited to, sexual assault and domestic violence, and is often used as a weapon of war.

Maternal death

The death of a woman while pregnant or within 42 days of the termination of pregnancy, due to complications during pregnancy or childbirth.⁵

Maternal health

The health of women during pregnancy, childbirth, and the postpartum period.

Maternal mortality rate

The number of maternal deaths during a given time period per 100,000 women of reproductive age (15 to 49) during that same time period.⁶

Maternal mortality ratio

The number of maternal deaths during a given time period per 100,000 live births during the same time period.⁷

Medical abortion

A safe option for terminating pregnancy using medications (e.g., mifepristone and misoprostol or misoprostol alone).⁸

Manual vacuum aspiration

A safe option using a hand-held instrument to create a vacuum and evacuate the uterus in order to terminate a pregnancy or to treat an incomplete abortion, either spontaneous or induced.⁹

Newborn health

The health during the first four weeks of a child's life.

Percentage of births attended by skilled health personnel

The percentage of women who deliver with a skilled health worker (doctor, nurse, or midwife) in attendance.

Prevention of mother-to-child transmission (PMTCT)

Efforts undertaken to prevent mother to child transmission of HIV and includes the following components:

- Primary prevention of women and men of reproductive age from becoming HIV-infected
 - > Avoiding unwanted pregnancies among HIV-positive women



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- > Preventing the transmission of HIV from positive mothers to their infants during pregnancy, labour, delivery, and breastfeeding by providing voluntary counselling and testing and the following interventions:
 - ARV therapy to mother on the onset of labour and to both the mother and the infant upon delivery
 - Safe delivery practices (if available) such as elective caesarean section
 - Safe use of infant formula or other foods instead of breastfeeding
- > Providing care and support for HIV-infected women, men, and families.¹⁰

Reproductive health

The state of complete physical, mental, and social well-being—not merely the absence of infirmity—in all matters relating to the reproductive system and to its functions and processes.

Sexual and reproductive health and reproductive rights

The right of all couples and individuals to information, education, and the means to decide freely and responsibly the number, spacing, and timing of their children, and to attain the highest standard of sexual and reproductive health. These rights also include the right of all people to make decisions concerning reproduction free from discrimination, coercion, and violence. Furthermore, all individuals have the right to pursue a satisfying, consensual, safe, and pleasurable sexual life.¹¹

Skilled attendants

Individuals with midwifery skills (for example, midwives, nurses, and doctors) who have been trained to proficiency in the skills necessary to provide competent care during pregnancy and childbirth. Skilled attendants must be able to manage normal labour and delivery, recognise the onset of complications, perform essential interventions, start treatment, and supervise the referral of mother and baby for interventions that are beyond their competence or not possible in a particular setting.¹²

Unmet need for family planning

The gap between women's stated desires to delay or avoid having children and their actual use of contraception. Generally expressed in demographic

and health surveys as a percentage of currently married women aged 15-49 with unmet need.

Unsafe abortion

The termination of an unintended pregnancy, either by persons lacking the necessary skills or in an environment lacking minimal sanitary and medical standards, or both.¹³

Unwanted/unintended pregnancy

A pregnancy that a pregnant woman or girl decides, of her own free will, is undesired.

FOOTNOTES

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