GLOBAL REPORT ON MDG 5: IMPROVE MATERNAL HEALTH

EXPLORING THE SITUATION IN AFRICA, ASIA AND LATIN AMERICA & THE CARIBBEAN∗

In 2000, at the United Nations, governments from 189 of the world’s nations adopted the UN Millennium Declaration which established the eight Millenium Development Goals (MDGs) and the commitment to reach them by 2015. These governments agreed to meet in 2010 to evaluate progress and address the obstacles which make the commitments difficult to achieve in many countries, especially developing and middle income countries.

MDG 5 was directly oriented to improve maternal health, but was later expanded to include universal access to reproductive health.

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It is important to recognize that improving maternal health goes hand in hand with the improvement of other social determinants that go beyond women’s needs in health care services. Poverty, gender inequity and the obstacles that women face in accessing health, education and income as well as socio-cultural status are all key factors that impact maternal health and increase women’s vulnerability to HIV. All MDGs are interrelated and none of them can be fully achieved without the others, but MDG 1 – poverty alleviation-, MDG 3- empowerment of women and gender equality-, and MDG 6 -combat HIV/AIDS- are cross-cutting issues that cannot be excluded from the debate on maternal health. To achieve all these MDGs, women and girls must be guaranteed the full exercise of their human rights, including their sexual and reproductive rights.

Especially to highlight the linkages of MDG 5 with MDGs 3 and 6, a comprehensive approach must be adopted. It is from this perspective that the current situation of maternal health will be analyzed in Africa, Asia Pacific and Latin America and the Caribbean.

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Maternal mortality ratio

The maternal mortality ratio (MMR) is one of the main indicators taken into account for MDG 5. The goal established that, by 2012, it be reduced by three quarters. However, in 2010 this still did not happen. Of all the MDGs, the least progress has been made in improving maternal health.¹

Globally, the ratio has seen a very small reduction: between 1990 and 2005 it went from 430 to 400 maternal deaths per 100,000 live births.² In developing regions MMR only declined 6%, becoming one of the health indicators that most closely reflect social inequalities. Half of maternal deaths that take place around the world each year (265,000) occur in Sub-Saharan Africa, where the ratio made less progress than anywhere else in the world (declining from 920 to 900 deaths per 100,000 live births).³ Another third of maternal deaths annually (187,000) occur in Southern Asia. Eastern Asia, Northern Africa and South-Eastern Asia showed the most progress as their rates decline 30% or more between 1990 and 2005.⁴

In Africa it is particularly difficult to collect data on this subject considering that a significant number of births and deaths occur at homes or outside health care institutions. This low access to medical care services, due to many different factors, is one of the reasons why Sub-Saharan Africa has the largest ratio of maternal deaths worldwide.⁵

In developing countries in Asia the ratio has only declined, on average, from 395 to 342 per 100,000 live births. Around two thirds of these maternal deaths took place in India and Pakistan, two of the 22 countries in the region where maternal mortality not only did not decline, but has increased. The highest rates in the region are, however, in Afghanistan (1,900), Nepal (740) and Timor-Leste (660).⁶

The situation in Latin America and the Caribbean is better than in Africa and Asia Pacific, with much lower average maternal mortality rates regionally. However, the progress made in this area does not meet the goal set in MDG 5.1. Between 1990 and 2005 the maternal mortality ratio descended from 180 to 130 per 100,000 live births. This reduction still leaves the region far from the goal, which would be an average rate of 45 maternal deaths by 2015. Some countries, like Haiti (630), Guatemala (290), Honduras (280) and Peru (240) are particularly distant from the average target for the region and, consequently, are much further away from achieving the proposed reduction. Chile (16) and Uruguay (19) have very low rates.⁷ Across the region, maternal mortality is highly underreported, mainly affecting most disadvantaged sectors, especially poor and rural populations.

Regarding the most relevant causes for maternal mortality: “Obstetric complications—including post-partum haemorrhage, infections, eclampsia, and prolonged or obstructed labour—and complications of unsafe abortion account for the majority of maternal deaths. Anaemia, exacerbated by malaria, HIV, and other conditions, heightens the risk of maternal death from hemorrhage”,⁸ increasing the risks of maternal deaths and the need for emergency obstetric care. As the leading cause of death worldwide among women of reproductive age, HIV/AIDS is another of the key contributors to maternal mortality, especially in regions with the highest HIV prevalence, such as southern and eastern Africa. In 2008, HIV-related deaths accounted for 64.100 of 342.900 total maternal deaths worldwide.⁹

A major explanation for the high rates of maternal mortality in Africa is related to the lack of access to adequate medical care, associated to poverty, mothers’ low education status, and nutritional problems. This includes lack of access to malaria and HIV treatment, prevention, care and support; lack of access to modern contraception and no presence of skilled personnel at birth. In Sub-Saharan Africa, 34% of maternal deaths are explained by haemorrhage alone. In countries with large HIV epidemics in southern Africa, as well as in Nigeria, Chad, Gabon, and Central African Republic, the maternal mortality ratio has increased. Yet, it was found that “progress overall would have been greater if the HIV epidemic had not contributed to substantial increases in maternal mortality in eastern and southern Africa” and the MMR would actually have declined in southern Africa if HIV-related deaths were excluded. To reduce the incidence of HIV-related maternal deaths, it is necessary that women living with HIV have permanent and reliable access to antiretroviral drugs, and this is especially imperative when they become pregnant, and during puerperal and post-partum care.

Unsafe abortion also plays an important role in accounting for maternal mortality ratio all over the world, especially in developing countries.

Unsafe abortion must be understood as a public health issue, but also, and foremost, as a violation of women’s rights. In Africa and Latin America and also in Asia, excluding China and India, unsafe abortion remains a relevant cause limiting the improvement of maternal health, especially affecting poor women. For the year 2003, 14% of all maternal deaths in Africa and 13% in Asia were due to unsafe abortion. However, laws remain highly restrictive in most of the developing world.

In Africa abortion is still widely illegal and such services are often unsafe and available at high cost, which increases the risk of death for pregnant women. Between 1995 and 2003, abortion rates on the continent only dropped from 33 to 29 per 1,000 women aged 15-44. However, Eastern and Western Africa were far behind the average with rates of 39 and 28 respectively. In South Africa abortion is permitted but is not yet always available at public health services. In other Southern African countries, abortion is permitted in certain cases, for example: Swaziland approved a new constitution in 2005 that allows abortion to save the life of the woman or in case of serious threat to her physical or mental health.

In Asia, abortion rates also dropped by 12%, from 33 per 1,000 women aged 15-44 in 1995 to 29 by 2003. The situation is different from the other two regions: here, safe procedures outnumbered unsafe ones because of the large number of safe abortions performed in China due to the population policy of one child per family and abortion is legal and commonly practiced. Most of the reduction in maternal mortality rates in the region took place specifically among safe abortions.

According to the report of ECLAC, in Latin America and the Caribbean direct obstetric causes are the leading cause of maternal death, including toxaemia, haemorrhage, complications of the puerperium and others. Unsafe abortions, however, represent a relevant percentage of these deaths. Taking into account that they are highly underreported, it is estimated that unsafe abortions represent much more than the average 13% indicated in the official figures from countries. In Argentina, Jamaica and Trinidad & Tobago abortion is the leading

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12 Ibid.
16 Ibid.
cause of maternal death. Currently, Chile, Dominican Republic, El Salvador, Haiti, Honduras and Nicaragua prohibit even therapeutic abortion. Nicaragua and El Salvador have restricted their laws after 2005. This shows an alarming step backwards in the region and attempts against achieving the reduction of maternal mortality rate as intended in MDG 5.

**Proportion of births attended by skilled health personnel**

The proportion of births attended by skilled health personnel is considered a relevant indicator for measuring access to quality health care services.

In Africa, Asia Pacific and Latin America and the Caribbean, a high level of inequality remains in access to quality health care services, especially associated with poverty and place of residence. This affects the general population, but especially poor women in rural areas, who continue to die every day due to lack of access to health care services. Fees or any other form of payment also have a negative impact on the accessibility of health care services.

In the case of Sub-Saharan Africa, the maternal mortality ratio appears to be very closely related to this: between 1990 and around 2007 the presence of skilled personnel at birth stayed basically the same, going from 42% to 44%. Meanwhile Northern Africa showed significant progress in this area for the same period, going from 45% to 79% of births attended by skilled personnel.

According to The Millenium Development Goals Report (2009), more than half of all births in South Asia take place without the assistance of this kind of personnel, affecting mainly rural populations. This subregion, together with Sub-Saharan Africa, has the lowest proportion of births attended by health personnel in the world. Between 1990 and around 2007 South Asia went from an average of 29% to 42%. India went from 42% in the year 2000 to 47% in 2006. Thailand is one of the countries with better proportion in Asia Pacific, but shows an alarming tendency to go backwards: it went from nearly 100% in 2000 to 97% in 2006. Figures around 2007 show that only East Asia has met the 2005 target (at 97%, but it had started with a 94% figure as early as around 1990).

For Latin America and the Caribbean, the proportion of births attended by skilled personnel is 89% for the year 2008. This figure includes an increase of 29% since 1990 (when the average for the region was 70%). However, there are profound differences within the region: Guatemala (41%), Honduras (67%), Bolivia (68%) and Peru (71.8%) are well below the regional average. In Brazil the indicator has risen from 83% in 1996 to 99% in 2006. Chile, Argentina and Uruguay have reached over 95% since the 1990s. This gap becomes even more significant when comparing the possibilities of accessing the health system in rural and urban areas, especially for poor women, as rural areas generally have poor communication systems and smaller, more poorly equipped and fewer health centers compared to urban areas.

**TARGET 5.B: ACHIEVE, BY 2015, UNIVERSAL ACCESS TO REPRODUCTIVE HEALTH**

**Contraceptive prevalence rate**

Contraceptive prevalence rate for women of reproductive age (15-49) married or in union, as a main indicator for Target 5.B, has increased in the three regions. However, the specific obstacles to overcome in each region differ according to the specific social, cultural and political context of each country or sub region. These particulars make it necessary to consider a broad range of social determinants when analyzing and progress and future challenges for increasing the contraceptive prevalence rate.

According to the report “Assessing Progress in Africa toward the MDGs” (2009), the contraceptive prevalence rate for married people is low across the whole region. For

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24 ECLAC (2009), Annual Statistical Report for Latin America and the Caribbean.
most countries that reported data the rates ranged from 8% in Eritrea to 19% in Central Africa Republic. In Sub-Saharan subregion, the contraceptive prevalence rate went from 12% in 1990 to 21.5% in 2005. And only eight countries in the continent reported a rate over 50%. These low rates reflect the low availability of contraceptives for men and women. Additionally, the use of modern and more effective contraceptive methods in Africa, such as the oral contraceptive pill, the male condom or the IUD, is often subject to disapproval, stemming from cultural values and social representations. Such social and cultural obstacles surrounding modern contraceptive methods make them harder to access and make it harder for women to negotiate their use. In this sense, it is possible to assume that the prevalence rate of these modern methods is even lower. Negative consequences include increased vulnerability to HIV infection, especially for women, and increased possibility of unintended pregnancies, which contribute to the number of unsafe abortions.

In Asia the use of contraception rose from 57% to 68% throughout the region between 1990 and 2005 (77% to 86% in East Asia, 38% to 54% in South Asia, 48% to 61% in Southeast Asia and 43% to 54% in West Asia)27. In some countries, while overall contraceptive use is at a high or moderate level, the use of modern contraception is low. In the Philippines, for example, while overall contraceptive use is at a medium level (51% in 2006), use of modern methods is only at 36%, while the other 15% uses other methods. As also observed in Africa, religion has influenced the extent to which women in this region are able to exercise their reproductive choices. In the Philippines, for example, the influence of the Catholic Church hierarchy and other influential conservative groups has severely limited women’s access to modern contraceptive information and methods, which has also led to very high levels of unintended pregnancy, especially among married women.28

In Latin America and the Caribbean access to modern contraceptives has seen an increase from 62% to 72% between 1990 and 200529. However there are strong regional differences. According to the UN report “Millennium Development Goals: A Latin American Perspective” (2005), “in most countries of the region, contraceptive prevalence rates are between 45% and 70%, and in three of them (Bolivia, Guatemala and Haiti) values observed are even lower. Only Brazil, Colombia, Costa Rica, Cuba and Puerto Rico reported contraceptive prevalence rates exceeding 75%.” The differences in the contraceptive methods among countries presented some special characteristics. For example, in Brazil during the 1990s there was a remarkable increase of sterilization, which has, however, decreased since 2000. In Argentina there was an increase in the contraceptive prevalence rate especially among poor women, due to the Sexual Health and Procreation Law approved in 2002. Before this law, contraceptives and counseling were not provided in public health services and social security due to a government decree from 1974 which forbid Family Planning Services. Since 1987 Family Planning was reestablished in public health services by another government decree but the government did not provide the budget to develop these services.

In all countries, the rate of male condom use among married women 15-49 years old is very low, varying from 22.3% in Argentina in 2001 (the highest rate, more than three-fold the second highest, from Chile, in the same period: 6.5%) to 5.6% in Peru in 2000. Peru is the country that registers the lowest rates, presenting only 2.8% in 1992 and failing to reach more than 8.4% in 2005. Brazil only presented the 1996 rate, which was 4.4%.

The difficulty in accessing modern contraceptive methods affects the levels of unintended pregnancies and maternal deaths, due to the low effectiveness of other contraceptive methods in preventing pregnancy and the resistance of health care services to practice safe abortion when permitted by law. It also contributes to the feminization of the HIV epidemic due to limited access to condoms.30 This is

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30 For example: “In Asia, the female proportion of adults living with AIDS nearly doubled between 1990 and 2007 – reaching 29 per cent. The 2008 AIDS Commission Report for Asia has estimated that 50 million women are at risk of contracting HIV from partners or husbands who engage in unprotected multiple sexual relations or who are injecting drug users. Meanwhile, a 2008 study by UNIFEM..."
observable in Africa and Asia Pacific, which have especially low contraceptive prevalence rates.

Gender equality and women’s empowerment are necessary to increase the rates of contraceptive prevalence, prevent HIV infections and comprehensively improve women’s health.

**Unmet needs for family planning**

The indicator of unmet needs for family planning contributes to a similar analysis. However, very little data exists regarding this matter. According to ECA, for example, in 2006 only three African countries provided information on this matter, and there are differences in how each country interprets its meaning. It intends to measure among married women “the gap between women’s desire to delay or avoid having children and their actual use of contraception”31

According to the same report, levels of unmet need are moderately high for most of the developing regions (excluding Eastern Asia), reaching as high as 25 per cent in the least developed countries. Among the 17 least developed countries with the lowest levels of modern contraceptive use, all except one are in sub-Saharan Africa. This sub region stands out, as one in every four women who is married or in union has an unmet need for family planning, and rate which has gone unchanged since 1995.

In Asia there have been improvements in figures regarding this indicator among married women aged 15-49, though they remain higher than 10% throughout the region except in East Asia (in 2005: 2.3% in East Asia, 14.7% in South Asia, 10.3% in Southeast Asia and 12.3% in West Asia). Philippines, for example, had in the year 2003 a level of 17.3% of unmet needs. It shall be noted that estimates of unmet need for unmarried women in Asia are not available, since surveys in this region often exclude such women, reflecting the region’s tendency of denying sexuality among young and/or unmarried people.

In Latin America and the Caribbean, unmet demand for family planning is higher in poor population groups. “In some countries the disparities are so great that fertility in disadvantaged groups is three times the rate in affluent groups.”32 This implies that, once again, poverty is an obstacle to improving maternal health. There is a mutual reinforcement between poverty and the impossibility of enjoying sexual and reproductive rights, as these contribute to a vicious circle expressed by high fertility rates and lack of adequate information. However, the regional average went down from 12.5% in 1995 to 10.5% in 2005. Bolivia, Guatemala and Haiti remain highly above the average with 22.7% (2004), 27.6% (2002) and 37.5% (2007) respectively.33

Despite lack of advances and despite evidence that adequate financing and resources for family planning are needed to comprehensively improve maternal health, funding for the provision of contraceptives from donors has declined steeply in the majority of developing countries, which face the greatest difficulties in sustaining the provisions without external funding.34

**Antenatal care coverage**

Antenatal care coverage is an important indicator of the quality of health care services.

According to the report “Assessing Progress in Africa toward the MDGs” (2009), this indicator has seen improvements in the region. In Northern Africa the average between 2003-2008 (56%) exceeds the recommended minimum number of four visits with a coverage rate of 52%.35 Even though the average is below that value (78%), across the region over 26 countries reported a coverage rate of above 80 percent for at least one antenatal visit in 2005.36 However,

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36 ECA (2009), “Assessing Progress in Africa Toward the
countries like Chad (38.9% in 2004), Ethiopia (27.6% in 2005) and Somalia (26.1% in 2006) are still in critical situations. According to all the other maternal health indicators, Sub-Saharan African countries have one of the lowest percentages of women who received at least four visits: 42% during 2003-2008.

The proportion of pregnant women that had at least one antenatal care visit with skilled personnel increased from 80% to 90% in East Asia, 48% to 70% in South Asia, 73% to 92% in Southeast Asia and 54% to 77% in West Asia from 1990 to 2005. Although there has been some significant progress, the recommended four antenatal visits is still not accessible for many pregnant women in the region, especially in South Asia: from 2003-2008, only 34% of women received at least four antenatal care visits during their pregnancy.

In Latin America and the Caribbean, during 2006, 95% of pregnant women between 15 and 49 years of age had at least one visit with skilled personnel. However, only 83% of the region’s pregnant women had at least four visits before childbirth. Even though the region as a whole has shown some progress in these areas, it is not only the number of controls that is important, but also the quality of services women have access to, in regard to medical care, access to diagnostic services, access to antiretroviral drugs for women living with HIV, gender sensitivity from the care providers and confidentiality, among other, all of which affect the status of women’s sexual and reproductive rights. For instance, although Argentina has a very high level of institutionalized childbirth (99%) and a high proportion of 5 prenatal visits to skilled personnel, that does not reflect the high disparities in quality of care between the different provinces, rural and urban areas, possibilities of humanized birth, among other socioeconomic factors. In Brazil, data shows that the percentage of women that had at least one antenatal care visit rose from 85.7% in 1996 to 97.8% in 2006. The percentage of women who had at least four visits has rose significantly, from 75.9% in 1996 to 89% in 2006. The same is true in Peru, where the rate rose from 54% in 1996 to 87.4% only ten years later. Unfortunately, the only data available regarding Chile is from 1993, with a rate of 95%.

An especially important issue to consider is provision of voluntary HIV counseling and testing for women and their partners in antenatal care services. Disclosure of women’s HIV status when tested during pregnancy often makes them subject to blame for HIV transmission and victims of physical and emotional violence. For this reason, antenatal care must be integrated as part of sexual and reproductive health and HIV/AIDS services. Health care providers must be trained to facilitate testing for both women and men and, if positive, provide treatment for vertical HIV transmission in accordance with the MTCT-Plus initiative. Health care providers must also be trained to screen and detect gender-based violence in all HIV-positive women and provide appropriate counseling and referrals to care.

Worldwide, women from the most vulnerable groups, such as women who use drugs, suffer high levels of stigma and discrimination and face significant barriers in accessing antenatal care, often not receiving adequate antenatal care services or information about their specific needs during pregnancy. Pregnant women who use drugs receive little or no accurate information about drug use during pregnancy, prevention of vertical transmission of HIV, access to medications to stop transmission of HIV, or access to opioid substitution therapies during and before pregnancy. In many countries pregnant drug users are threatened or face criminal penalties, are discriminated by health care providers, coerced into having an abortion, sterilization or forced to give up their newborns and/children to the state. Changes in policies and service delivery need to be implemented so women will access programs, treatment, and health care without criminal penalties, imprisonment, fear and discrimination.

**Adolescent birth rate**

Adolescent birth rate is a relevant index for maternal health since they represent pregnancies that are medically and socio-economically of high risk. Globally, the progress made does not measure up with MDG 5 expectations. The global adolescent birth rate went from 61 per 1000 women in 1990 to 48 per 1000 women in 2006.

In Africa, 35 of the countries with available data reported a decline in adolescent birth rates for 2009, while 10 reported an increase

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Millennium Development Goals. MDG Report 2009”.
since 1990. According to the latest data available, some of them were Cape Verde, Angola, DRC, Malawi, Mozambique, Uganda and Nigeria. Sub-Saharan Africa, however, remains well above the world average: from 1990 to 2006 it dropped from 131 to 123 adolescent births per 1000 women. Despite slow declines, early pregnancies are still common, often due to the very young ages of marriage in many countries.\(^3^9\)

In Asia there have been some important declines, for example in Eastern Asia, where it went from 21.3 adolescent births per 1000 women in 1990 to 4.5 in 2006. However, in Malaysia, Indonesia, Philippines, Thailand and Viet Nam the rate has gone up between 2000 and 2007.\(^4^0\) It’s interesting to mention that out of these countries, Thailand and Viet Nam recognize adolescent reproductive health as part of their national reproductive policies. These cases reveal that, although legal recognition is a necessary step for guaranteeing women’s and girls’ sexual and reproductive rights, by itself it is still insufficient. Indonesia is a special case, as the rate went up at the same time a special plan of action on adolescent reproductive health was developed for the years 2003-2007: the rate went from 46 in the year 2000 to 51 in 2006.

According to “The Millennium Development Goals Report” (2009), early marriage is an important factor that contributes to a large number of adolescent pregnancy in Africa and Asia: “The latest estimates, based on survey data for the period 1998-2007, indicate that in Southern Asia, 49 per cent of women 20 to 24 years old were married before age 18. In countries of Western and Central Africa, 44 per cent of women in the same age group were married before age 18. In Bangladesh, the Central African Republic, Chad, Guinea, Mali, Mozambique and Niger, more than half of all women are married by age 18 and more than a third are mothers by that age.”

In Latin America and the Caribbean, the adolescent birth rate saw very little reduction: between 1990 and 2005 it remained almost stable, declining from 77 to 72 per 1000 women of 15-19 years of age. Colombia, Dominican Republic, Ecuador, Guatemala, Honduras, Mexico y Venezuela still had rates over 90 around 2005.\(^4^1\) Colombia is the only country in the region where this rate increased, going from 92 per 1000 women 15-19 years old in 1993 to 96 in 2005. But as a whole, the rate has remained almost the same for 20 years. The low levels of progress raise a profound question about the lack of youth-oriented policies on sexual and reproductive health, including comprehensive sexuality education and services in the region.

The lack of comprehensive sexuality education in schools overall, as well as low education levels among girls and adolescents, are both factors that keep the adolescent birth rate high. The difficulties that young people and adolescents face in accessing contraceptives in public health care systems also contributes to keeping this rate relatively unchanged. To prevent unintended pregnancies, and also to protect themselves from HIV infection, young women and men should have access to free condoms guaranteed within public health systems. Often this does not happen even where it is required by law, such as in Argentina. Many countries do not have specific sexual and reproductive health youth-oriented policies and, in many countries -especially those with PEPFAR funding-, public policy tends to favor abstinence-only sexuality education for adolescents. This lack of human-rights and facts-based public policy profoundly deters the possibility of achieving the goals set for MDG 5. In addition to measures specifically regarding reproductive health services and supplies, effective policies must include improvements in the quality of education and the elimination of school fees so that primary and secondary education for girls can be reached. Ensuring basic education for girls is one of the principal factors in women’s empowerment and in decreasing their vulnerability to HIV and adolescent pregnancy.

PROPOSING A COMPREHENSIVE APPROACH TO MDG 5:

The set of indicators proposed for MDG 5 needs to be complemented in order to

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\(^4^1\) Prepared with information from United Nations, Department of Economic and Social Affairs, Population Division, 2010 Update for the MDG Database: Adolescent Birth Rate (POP/DB/Fert/A/MDG2010), 2010.
clearly express the current situation of women’s access to maternal health in the world. One of the main problems is that the proposed indicators do not integrate certain fundamental factors affecting maternal health, such as: access to education and income, to health care services and information about sexual and reproductive health, contraceptives, and prevention, treatment, care and support of HIV/AIDS. There is no possibility of achieving universal access to reproductive health unless contraception provision for all people and especially women living with HIV is guaranteed, along with prenatal care and counseling regarding this disease. Considering these as separate issues prevents us from reducing HIV prevalence in the world, and specifically its effects on women, and keeps us from reducing maternal deaths as a whole.

In 2008, there were around 342,900 maternal deaths worldwide, down from 526,300 in 1980, which is a yearly rate of decline of 1.5%. Regarding the effect of HIV in the progression of global maternal mortality ratio since the onset of the epidemic: “In a counterfactual scenario of a global HIV seroprevalence of zero, this number would be 281,500, compared with 526 200 in 1980, which is a rate of decline of 2.2%. (...) With the onset of the HIV epidemic in the early 1990s, there was a slowing in the decline of global maternal deaths, with a rate of decline of 1.8% between 1980 and 1990 and 1.4% from 1990 to 2008”.42 This study, presented in The Lancet in June 2010, presents a new and innovative approach to maternal and reproductive health and rights that includes women’s empowerment, increased income and economic status of women, gender parity in access to education, and HIV/AIDS treatment, prevention, care and support from a human rights perspective.

Poverty is a major factor that negatively impacts maternal health, children’s health and HIV infections, but gender inequity faced by women is as well. Very few of the proposed targets will be obtained through improving health care services if this is not accompanied by policies and commitments that address all of these issues comprehensively.

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RECOMMENDATIONS:

Analyzing this information, the 43 networks from Africa, Asia Pacific and Latin America and the Caribbean that participate in the project “Strategies from the South” affirm that the only way to fulfil MDG 5 is to build and strengthen a more comprehensive perspective of maternal health, by incorporating factors that are absent in the United Nations indicators.

To achieve this, considering the situation of maternal health around the world, we urge governments to adopt the following actions:

- Enable, ensure and strengthen collection of reliable data to evaluate maternal health. This information should have public access as a way of ensuring civil society monitoring of MDG 5.
- Make sexual and reproductive health services and programs a priority in health system strengthening. Secure and increase sustainable investments in women’s health, to guarantee access especially for women and girls in rural areas where accessibility to services is significantly reduced compared to urban areas.
- Promote the integration of HIV/AIDS prevention, treatment, care and support within sexual and reproductive health services and programs, ensuring a gender and rights-based perspective of the health care professionals, and promoting voluntary testing and counselling for adolescents and women.
- Ensure provision and access to safe abortion in public health care services where, to reduce maternal death.
- Guarantee effective access to free contraceptive methods for all populations, particularly modern contraceptive methods by women, especially by poor women. Ensure that women have accurate information about contraceptive methods, in order to enable informed decision-making for preventing unintended pregnancies and HIV infection.
- Improve quality and accessibility of health services for women, especially in obstetrics and gynaecology services and emergency obstetric care.
- Implement policies and programs in the health care system to prevent and eliminate all forms of violence against women and girls. Specifically investigate violence involved in HIV treatment as well as the linkages between HIV and gender based violence in victims of violence and in women living with HIV.
- Recognize and guarantee the sexual and reproductive rights of young people (15-24 years of age), incorporating their effective access to sexual and reproductive health programs, and promoting comprehensive, confidential, gender sensitive and youth-friendly services to meet their specific needs.
- Guarantee access to primary and secondary education for all girls, including comprehensive sexuality education, to increase women’s empowerment, prevent HIV infections and reduce adolescent pregnancy rates.
- Recognize and respect the rights of unmarried and young women to make their own sexual and reproductive health choices in all aspects of their lives.

“Strategies from the South: Building Synergies in HIV/AIDS and Sexual and Reproductive Health and Rights”

7 SISTERS ● Action Aid ● AfriCASO ● AHRN ● AMANITARE ● APCASO ● APN+ ● APNSW ● APR ● APWLD ● ARASA ● ARROW ● ASAP ● AWHRC CAFRA ● CAL ● CARAM Asia ● CHRC ● CIAT ● CLADEM ● CRN+ ● FEMNET ● Girl Child Network Worldwide ● Global NSWP ● IAWC ● ICW Africa ICW AP ● ICW Latina ● ILGA LAC ● INWUD ● IPPF WHR ● LACCASO ● LACWHN/RSMLAC ● Lentswe la Rona ● MLCM+ ● NAP+ ● NAPY ● PATAM RedLA+ ● RedLAC ● Redtrasex ● SWAA ● YCSRR

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