



Combating maternal mortality

Despite the UN pledge to reduce the maternal mortality ratio (MMR) by three-quarters by 2015, more than 350 000 maternal deaths occur every year, 99% of them in developing countries. Of all the Millennium Development Goals, least progress has been made on the one to improve maternal health.

In the EU, the average MMR has been low and relatively steady in recent years. There are differences, however, between Member States (MS). Whereas, to some extent, they may be explained by unreliability of statistical data, some studies have linked those variations to differences in obstetrical care.

Numerous UN agencies and international organisations have addressed the issues of women's health and rights. The debate as to which types of initiatives should be prioritised continues.

The EU has been a consistent advocate at UN level, as well as in political dialogue with developing countries, to which it provides substantial aid.

The European Parliament has spoken for increased EU funding and a coherent and multi-faceted approach to women's health, taking into account gender equality and women's empowerment.

In this briefing:

- Context
- Maternal mortality in the EU
- International initiatives
- EU involvement
- The European Parliament 's position
- Main references

Context

Maternal mortality

Maternal (or 'obstetrical') death is [defined](#) by the WHO as the death of a woman while pregnant or within 42 days of termination of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

Maternal deaths may thus be direct or indirect. The former result from complications of pregnancy, delivery or in the post-delivery period; the latter are the consequence of previously existing conditions (such as heart disease, AIDS or malaria) or those developed during pregnancy, which had no direct obstetric causes, but were aggravated by the physiological effects of pregnancy.

About 80% of all maternal deaths are direct deaths. However, in countries with a high prevalence of HIV or malaria, the proportion of indirect deaths may be much higher than 20%.¹

Measuring maternal mortality

It is very difficult to measure maternal mortality. Even in countries with meticulous registration systems, an estimated 25 to 70% (in the EU: 30 to 50%) of maternal deaths are not reported as such.² In developing countries estimates are made on the basis of censuses, surveys and models.

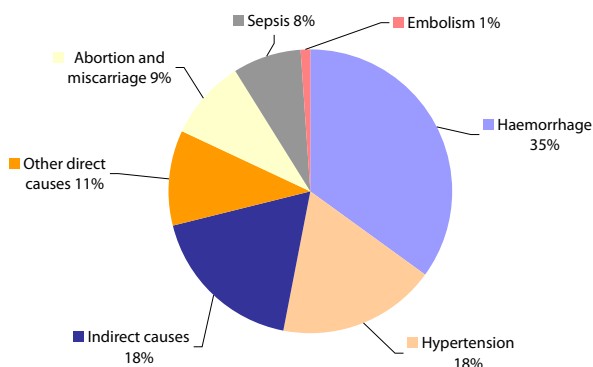


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[Various indicators](#) are used to measure maternal mortality, including:

- Maternal mortality ratio (MMR): the number of maternal deaths per 100 000 live births during the same time period.
- The adult lifetime risk of maternal mortality: the probability of dying from a maternal cause during a woman's reproductive lifespan.³

Figure 1: Causes of maternal deaths in developing regions, 1997/2007 (percentage).



Source: [United Nations](#), 2010

Slow progress on MDG 5

In 2000, UN member states agreed on the Millennium Development Goals (MDGs), to be achieved by the year 2015. As part of [MDG 5](#) (Improving maternal health), two targets were set: reducing the MMR by three-quarters between 1990 and 2015 and achieving universal access to reproductive healthcare.

However, it appears that of the eight goals, least progress has been made on MDG 5. In order to achieve the first target, a 5.5% annual decline in MMR would be required, however the average annual decline between 1990 and 2008 was only 1.3%, ranging from a decline of 8.8% to an increase of 5.5% in individual countries.⁴

Each year, around 350 000 women die from pregnancy-related complications, 99% of them in developing countries. In 2008, 65% of obstetrical deaths occurred in just 11 countries (Afghanistan, Bangladesh, the Democratic Republic of Congo, Ethiopia,

India, Indonesia, Kenya, Nigeria, Pakistan, Sudan, and Tanzania).

In the same year, sub-Saharan Africa and southern Asia had the highest MMR, of 640 and 280 maternal deaths per 100 000 live births respectively. The adult lifetime risk of maternal death was also highest in sub-Saharan Africa (1 in 31), while in developed regions it amounted to only 1 in 4 300.⁵ This elevated risk is due to a combination of a high MMR and high fertility rates: in 2005, 28 countries – mostly in sub-Saharan Africa – had fertility rates exceeding five children per woman.⁶

Universal access to reproductive healthcare is also far from being achieved. In sub-Saharan Africa and southern Asia, half of all births still take place without skilled attendance, and access to emergency obstetric care for delivery complications is very limited.⁷

Further action needed

The meagre progress on reducing maternal mortality is even more striking when one considers the fact that modern medicine can effectively deal with each and every cause of maternal death. It is argued that maternal mortality could be substantially, rapidly and consistently decreased, if only the appropriate actions were taken. According to the World Bank, making full use of all types of possible intervention would reduce maternal deaths by 74%.⁸

Concerned by the limited success of their past initiatives, the EU, WHO and other international organisations are continuing their search for optimal solutions.

Maternal mortality in the EU

Obstetrical deaths in the EU are rare due to the very low fertility level (less than one child per woman) and good standards of healthcare. According to the [Commission](#) the average MMR in the EU has declined from 9.32 in 1997 to 6.05 in 2006.

In some individual MS the MMR has actually increased. This could simply be a consequence of better reporting. However, it may [arguably](#) also be explained by certain risk factors identified in the EU. They include the growing number of caesarean sections and multiple pregnancies, as well as the increase in women's average age at childbirth. Reduced healthcare budgets in some MS and social inequalities have also been cited. In particular, the MMR among immigrants appears to be higher than among native citizens. One [study](#) revealed that in mainland France the risk of post-delivery maternal death was twice as high for foreign women. This has been linked to uneven quality of care, which may in part be due to communication problems.⁹

Numerous reports confirm that MMR differs throughout Europe. [One study](#), based on data from the years 1992–95, identified two groups characterised by similar (high or low) MMR. Hungary, France, Finland, Denmark, Austria and Portugal had an average group MMR of 10.2, while Germany (Bavaria), the Netherlands, UK, Belgium (Flanders) and Norway only 5.9. These variations were attributed to differences in obstetric care.

Another set of data for the years 2003–04 revealed that Estonia had the highest MMR in the EU (29.6), and Malta the lowest (0). Belgium, Austria, France, and Hungary had ratios around the mean European level, estimated at 6.6.¹⁰

The data collected by MS are however often difficult to compare, if not incomparable.

International initiatives

Major agreements

The past 20 years have seen the proliferation of international initiatives addressing the issue of maternal mortality. The United Nations (UN) has been the principal forum for debate, as illustrated by the MDGs and a range of other initiatives.

In 1994, the UN coordinated the **International Conference on Population**

and Development (ICPD) in Cairo, which led to the adoption of the [Programme of Action](#), the key text on sexual and reproductive rights for the years to come. The debate on reproductive rights revealed serious differences between the participating states. However, a consensus was reached on four goals. One of them was the reduction of the 1990 maternal mortality level by half by 2000 and a further halving by 2015. In addition, disparities in maternal mortality within countries and between geographical regions and socio-economic and ethnic groups should be narrowed.

Another relevant UN document was the 2009 Human Rights Council's [resolution](#) which officially recognised maternal mortality as a human rights issue.

[UN General Assembly resolution \(65/1\)](#), which resulted from the 2010 UN summit on the MDGs, enshrined participants' commitment to redoubling efforts to reduce maternal mortality. It was agreed that progress on MDG 5 should be accelerated by addressing reproductive, maternal and child health in a comprehensive manner, inter alia, through:

- providing access to family planning,
- skilled attendance at birth,
- emergency obstetric and newborn care,
- prevention and treatment of sexually transmitted diseases, and
- strengthening health systems which provide affordable health-care services.

At the same summit, the UN Secretary-General Ban Ki-moon launched the [Global Strategy on Women and Children's Health](#), establishing a roadmap to accelerate progress on MDGs 4 (child mortality) and 5.

Other major international initiatives include:

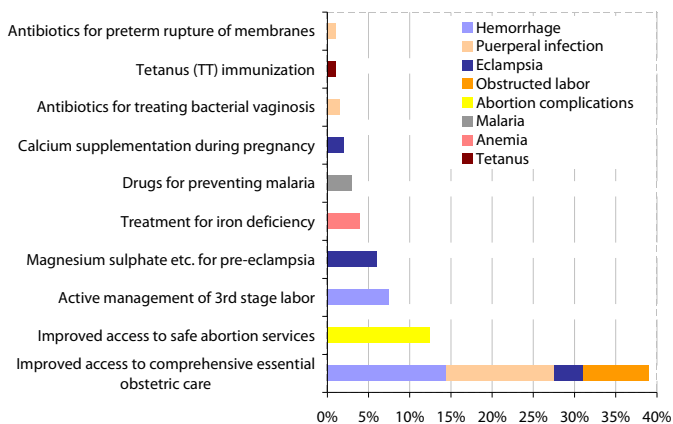
- The World Bank's [Reproductive Health Action Plan for 2010-2015](#)
- the G8's [Muskoka Initiative on Maternal, Newborn and Under-five Child Health](#), to which the Commission pledged US\$70 million in additional EU funds.

- Health 4 – a joint programme of three UN specialised agencies (UNFPA, UNICEF and the WHO) and the World Bank, later joined by UNAIDS, meant to support countries with the highest rates of maternal and newborn mortality.

Which path to take?

The causes of maternal mortality can be addressed in various ways, not equally efficient (see figure 2).

Figure 2: Full use of existing services would dramatically reduce maternal deaths



Source: [United Nations Development Programme](#), 2005

In 2005, the MDG Task Force on Child Health and Maternal Health critically assessed most previously used methods. The Task Force questioned the assumption that obstetric complications could be prevented or predicted by good antenatal care. It also argued that regular screening for known risk factors can only have limited impact on maternal mortality. Furthermore, training programmes for traditional birth attendants have proved ineffective.

The Task Force further argued that the relevant programmes should be based on the principle that every pregnant woman is at risk of complications which may lead to her death. It is therefore essential that all women have access to high-quality delivery care, comprising:

- management of delivery by skilled attendants, and
- access to emergency obstetric care in case of complications.¹¹

EU involvement

Advocate for women's health and rights

Cooperating with a variety of international organisations, UN agencies and NGOs, the EU has advocated the improvement of sexual and reproductive rights and women's health. At the March 2011 session of the UN Commission on the Status of Women, the EU delegation [reaffirmed its commitment](#) to accelerating progress on MDG 5. This is in line with the EU position on the MDGs, as [expressed](#) by the Council before the September 2010 UN summit.

Sexual and reproductive rights and women's health are also mainstreamed in political dialogue with developing countries. The 2010 [Plan of Action on Gender Equality and Women's Empowerment in Development 2010-2015](#) stated that by 2012, guidelines will be adopted for policy dialogue on maternal mortality and universal access to reproductive health, as part of the overall guidelines for policy dialogue on national health strategies.

The world's largest donor

In September 2010, Commission President Barroso [pledged](#) to provide €1 billion to developing countries under the so-called MDG Initiative to speed up work on the goals on which least progress has been made.¹²

The EU already provides more than half of the world's aid to developing countries. The Commission alone accounts for 13% of aid flows, including programmes related to MDGs. Between 2003 and 2008, the Commission [provided](#) €32 million worth of assistance to ACP countries. One objective of this aid was reducing maternal mortality.

The overall financial contribution of the EU for maternal and child health amounts to €310 million a year. This amount refers to funds for strengthening health systems and universal access to healthcare, the EU contribution to the Global Alliance for Vaccines and Immunisation (GAVI) and part

of its contribution to the [Global Fund to fight Aids, Tuberculosis and Malaria](#).

Searching for increased effectiveness, the EU has changed its approach towards providing aid to developing countries and placed greater importance on 'country ownership' and on the use of budget support. It is argued however that, as a result, it has become more difficult for the EU to address specific problems. This is because the authorities of the partner countries choose the policy domains to which the budget support funds are allocated.¹³

Aid programmes

Two types of programme are used for financing EU action in the area of health in developing countries:

Geographical instruments

These [programmes](#) include the European Neighbourhood and Partnership Instrument, the European Development Fund (for the ACP countries), and the Development Cooperation Instrument (for Latin America, Asia and South Africa). They are the main source of EU support for health in developing countries.

The thematic strategy 'Investing in people'

The [strategy](#) is the only EU thematic programme covering almost all the MDGs. €280 million (i.e. 56% of its budget for the years 2011-13) has been allocated to health-related issues. These include improving access to health systems and promoting sexual and reproductive health.

Women's health in the EU

In its 2006 [conclusions on women's health](#), the Council invited the Commission to integrate gender aspects in health research and to strengthen the comparability and compatibility of gender-specific information on health across MS and at EU level. The 2007 [EU health strategy](#) takes account of this gender dimension. The main instrument implementing the strategy is the [second programme of Community action in the field of health \(2008-13\)](#).

Health-related research in the EU is mainly financed through 'Framework Programmes' (FPs). The current one, [FP7](#) expires in 2013.

The European Parliament's position

The Parliament repeatedly addressed the issue of the EU's involvement in the achievement of MDGs in the run-up to the relevant UN high-level meetings.

In a 2008 [resolution](#), the EP expressed concern about the lack of progress since 2000 on reducing maternal mortality. The Parliament also condemned the US's 'global gag rule' (also known as 'Mexico City Policy'), preventing foreign NGOs which received [USAID](#) family-planning funding from using their own funds to provide legal medical services related to abortion. This policy was later [overturned](#) by President Obama.

In a 2010 [resolution](#) on progress towards the achievement of the MDGs, the EP concluded that the EU was around €20 billion short of its MDG spending commitments. The Parliament proposed:

- The allocation of 20% of EU and MS' spending to health and education
- An increase in contributions to the [Global Fund](#)
- Prioritising maternal health among MDGs.

The resolution also called on MS to reverse the decline in funding for sexual and reproductive rights and to support policies on voluntary family planning and safe abortion. MDG 5 should be addressed in a coherent and holistic way along with MDG 3 (on gender equality and women's empowerment).

Main references

[Trends in Maternal Mortality: 1990 to 2008](#) / WHO, 2010.

Who's got the power? Transforming health systems for women and children / UN Millennium Project, Task Force on Child Health and Maternal Health, 2005. ([electronic summary](#) version also available).

[Where will Sexual and Reproductive Health and Rights be anchored after 2014? - A European Perspective](#) / European Parliamentary Forum on Population and Development, October 2010.

[Improving the Odds of Achieving the MDGs: Global Monitoring Report 2011](#) / World Bank, 2011.

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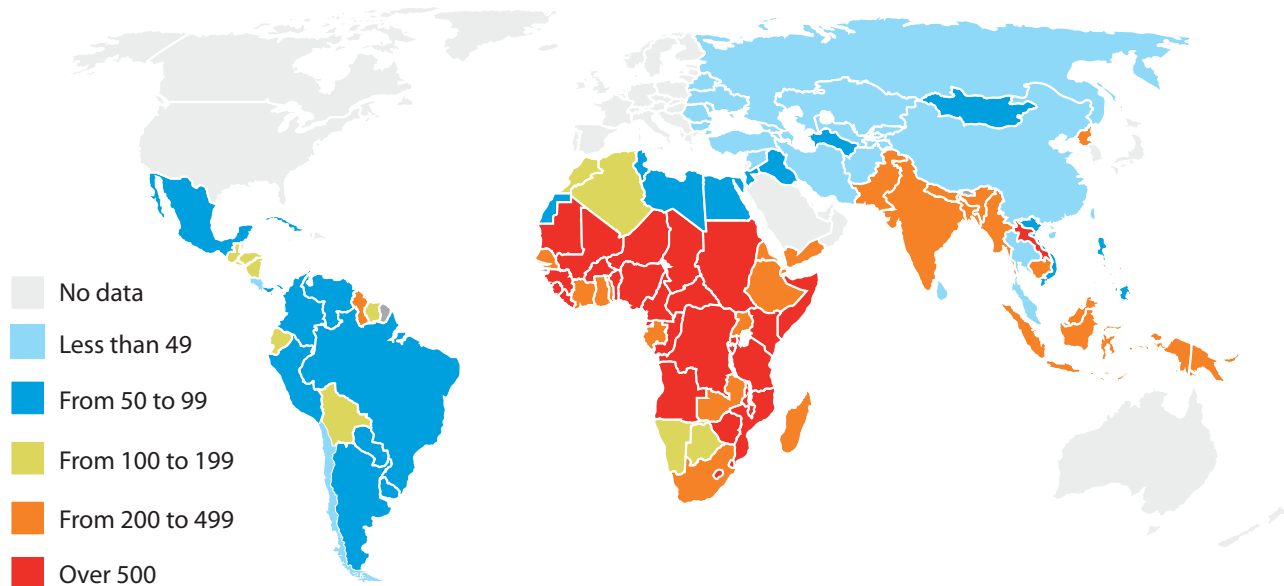
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Annex

Maternal mortality ratio (deaths per 100 000 live births)



Source: [The World Bank](#), 2011

Endnotes

- ¹ Who's got the power? Transforming health systems for women and children / UN Millennium Project, 2005. pp. 79–80.
- ² Ibid. p. 78.
- ³ [Trends in Maternal Mortality: 1990 to 2008](#) / WHO, 2010, p. 5.
- ⁴ [Maternal mortality for 181 countries, 1980—2008: a systematic analysis of progress towards Millennium Development Goal 5](#) / Hogan, M.C. et al. The Lancet, Vol.375, Issue 9726, pp. 1609 - 1623, May 2010.
- ⁵ [Trends in Maternal Mortality: 1990 to 2008](#) / WHO, 2010, p. 5.
- ⁶ [Thematic Paper on MDGs 4, 5 and 6](#) / United Nations Development Group, 2010, p. 2.
- ⁷ Ibid.
- ⁸ Who's got the power? (...), p. 88.
- ⁹ The Euphrates Project [website](#). The project on obstetrical deaths in Europe caused by haemorrhage was funded by the EU Quality of Life and Management of living Resources programme.
- ¹⁰ [The European Perinatal Health Report](#), p. 96.
- ¹¹ Who's got the power? (...), pp. 81–87.
- ¹² The initiative concerns reallocating unspent funds from the tenth European Development Fund and does not involve any additional spending.
- ¹³ [Where will Sexual and Reproductive Health and Rights be anchored after 2014?](#) (...) / The EPF, October, 2010, p. 7.