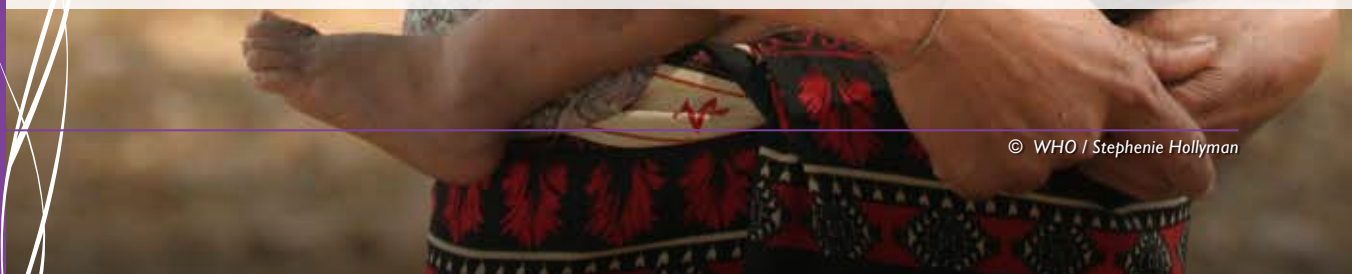
KNOWLEDGE SUMMARY: WOMEN'S & CHILDREN'S HEALTH

2011

1 PROGRESS TOWARDS MDGS 4 AND 5

The Millennium Development Goals (MDGs) 4 and 5 provide a direction to achieve women's and children's well-being. The Global Strategy for Women's and Children's Health provides vital support to this, and catalyses worldwide action to accelerate progress towards achieving the MDGs. Many countries have recorded good progress. But much remains to be done.



The Partnership for Maternal, Newborn & Child Health

Where do we stand now?

Progress on MDG 4 – Reduce under-five child mortality by two thirds between 1990 and 2015

Globally, under-five mortality has reduced by 35% (1990 – 2010).[1] More children survive today than they did a decade ago. In 1990, there were more than 12 million under-five deaths globally, but in 2010, this had reduced to 7.6 million. Child mortality rate dropped from 88 deaths per 1000 live births, in 1990, to 57 in 2010. Although the rate of decline at 2.5% per year between 2000 and 2010, was an improvement from the 1.9% year between 1990 and 2000, it is still insufficient to meet the MDG 4.

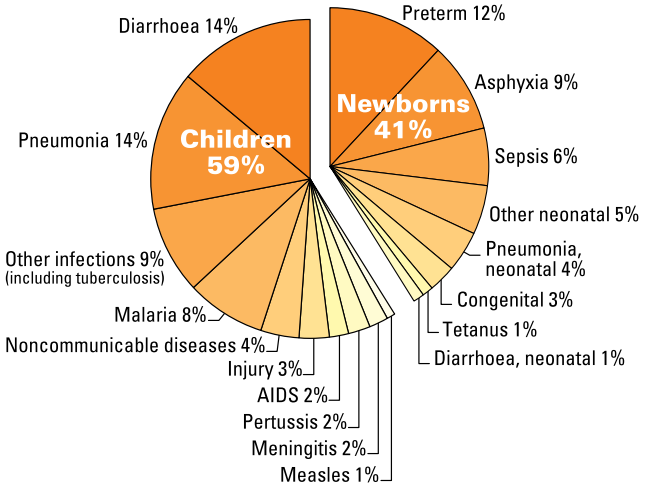
Newborn deaths (41%) form the single largest category of deaths amongst under-fives.[1,2] Preterm complications and birth asphyxia are the major causes for newborn deaths (see Figure 1) . Pneumonia, diarrhoea, malaria and other infections such as tuberculosis, measles, etc. cause more than half the deaths in under-fives. Although not included in this category, as they are not counted as child deaths, there were 2.6 million stillbirths in 2008.[3]

Under-five deaths have declined by at least 50% in some countries, but continue to be particularly high in sub-Saharan Africa.[1,4] About 1 in 8 under-five children continue to die in sub-Saharan Africa, and 1 in 15 under-fives die in Southern Asia. Sub-Saharan Africa, with 121 deaths per 1000 live births, has nearly twice the average rate seen in low- and middle-income countries (see Figure 2). But some large reductions have also been seen here between 1990 and 2010, as four sub-Saharan countries recorded the largest absolute reductions. India, Nigeria, Democratic Republic of Congo, Pakistan and China account for half the under-five deaths.[1]

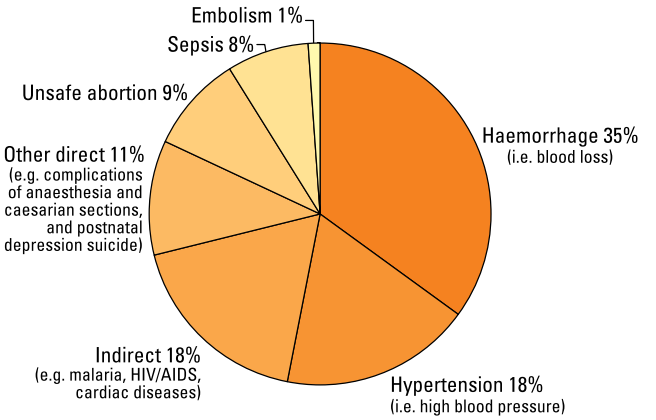
Figure 1

Main causes of death

Causes of deaths in children under 5 years
(7.6 million deaths every year/ around 21,000 preventable deaths every day)



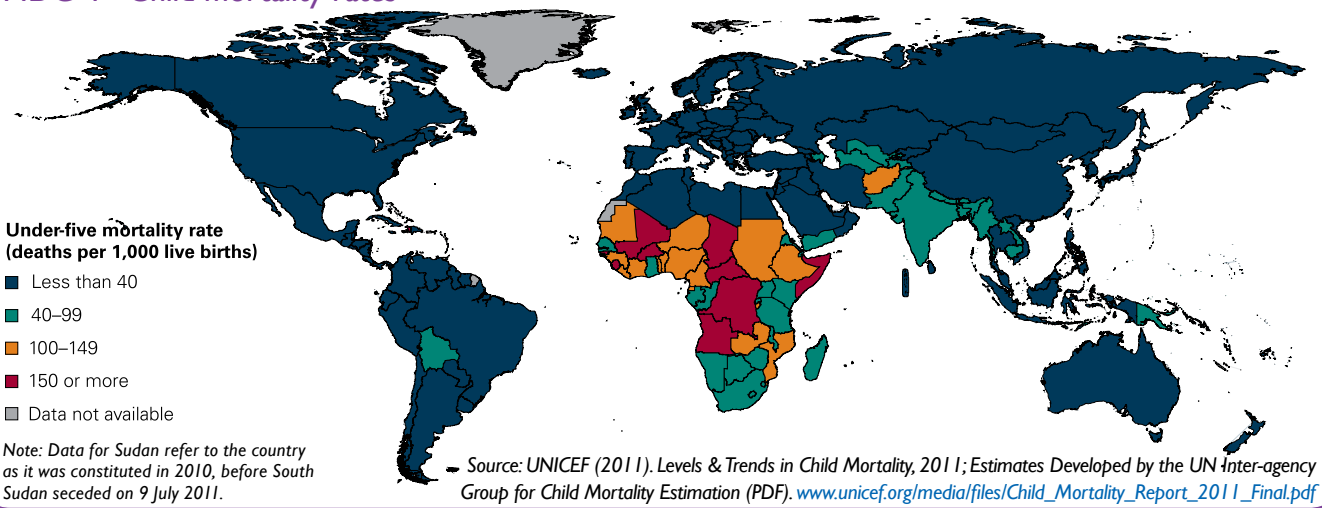
Causes of maternal deaths
(350,000 deaths every year/around 1000 preventable deaths every day)



Adapted from: Countdown to 2015 (2010) and UN Inter-agency Group for Child Mortality Estimation (2011).

Figure 2

MDG 4 - Child mortality rates



Note: Data for Sudan refer to the country as it was constituted in 2010, before South Sudan seceded on 9 July 2011.

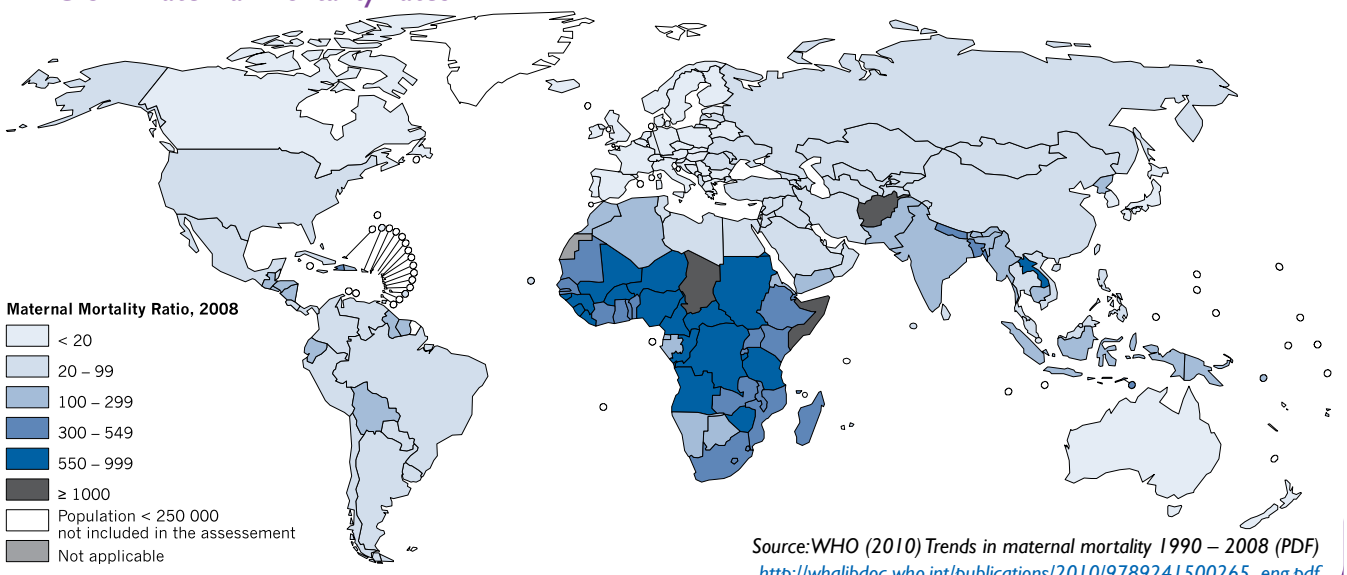
Source: UNICEF (2011). Levels & Trends in Child Mortality, 2011; Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation (PDF). www.unicef.org/media/files/Child_Mortality_Report_2011_Final.pdf

Children in rural areas and from the poorest households are vulnerable. Even in areas where child mortality rates could be generally low, poor children under-five years in rural areas are 1.7 times more likely to die than those in urban areas.[1] Children from the poorest 20% of households face more than twice the risk of dying as children in the richest 20% of households.

Children of mothers with secondary or higher education face less risk of dying.[1,4] Basic primary education among mothers brings down child mortality rates, but with secondary or higher education, the reductions are much more significant. The chances of survival are almost two-fold higher if a child's mother has secondary education. For example, in Latin America and the Caribbean, the ratio of under-five mortality amongst children who had mothers with no education to that of those with primary education is 1.6.[4] This ratio increases to 3.1 between mothers with no education and those with secondary education, implying that higher educational levels bring larger benefits.

Figure 3

MDG 5 – Maternal mortality rates



Source: WHO (2010) Trends in maternal mortality 1990 – 2008 (PDF) http://whqlibdoc.who.int/publications/2010/9789241500265_eng.pdf

Progress on MDG 5 (target 1) – Reduce maternal mortality rates by three quarters between 1990 and 2015

Maternal mortality rates in low- and middle-income countries dropped by 34% (1990 to 2008).[4,5] Despite a significant drop from 440 maternal deaths per 100,000 live births in 1990, to 290 deaths in 2008, the progress in low- and middle- income countries is not at a rate that can achieve the MDG. The progress has been uneven across regions with some regions such as Eastern Asia, Northern Africa, South-Eastern Asia and Southern Asia reporting reductions of 40% or more, while others such as sub-Saharan showing only a 26% reduction.

About 87% of maternal deaths happen in South Asia and sub-Saharan Africa (2008).[5] South Asia has shown a 53% reduction (1990 to 2008), but is still host to a large number of maternal deaths. With maternal mortality rates of 280 deaths per 100,000 live births and 640 deaths per 100,000 live births, South Asia and sub-Saharan Africa respectively bear the largest burden of maternal deaths in the world (see Figure 3).

More than 50% of maternal deaths are due to haemorrhage and hypertension.[6] This high proportion of deaths due to haemorrhage and hypertension reflects the poor access to basic as well as emergency obstetric care. Unsafe abortions, which are also preventable, account for 9% of maternal deaths. About a fifth of the maternal deaths are due to indirect causes such as cardiac diseases, malaria, HIV/AIDS, etc. (see Figure 1).

Skilled birth attendance in low- and middle- income countries increased from 55 to 65% (1990 to 2009).[4] There has been significant progress in many regions, but that is not enough yet. For example, in South Asia, skilled birth attendance improved from 32 to 50% (1990 to 2009), but coverage is still low here as well as in sub-Saharan Africa (46%).

Progress on MDG 5 (target 2) – Achieve universal access to reproductive health, by 2015

Proportion of women who received care from a skilled health worker at least once during pregnancy increased from 64 to 81% (1990 to 2009), but the proportion of those who had the recommended four contacts is only 51%.[4] South Asia and followed by sub-Saharan Africa have the lowest ante-natal coverage. In South Asia the coverage for at least one contact is 70%, whilst that for four contacts is 44%. If India is excluded, the proportion of women having four contacts goes down to 26% in this region.

Childbearing among teenagers in low- and middle-income countries continues to be high at 54% (2008).[4] Overall, teenage childbearing decreased between 1990 and 2000. But the rate of decline slowed down between 2000 and 2008, and in some places childbearing in this age group has actually increased. In sub-Saharan Africa, however, there has been little change in the past two decades and it still records the highest rate (122 births per 1000 women aged 15 to 19 years).

Although 61% of all married women or those with a partner (15 to 49 years) use contraception (2008), unmet need is high in some areas.[4] In sub-Saharan Africa in 2008, only 22% of women in the above category used any contraception. And the proportion of women in sub-Saharan Africa who wished to delay or avoid pregnancy but did not use any contraception was 25%. These facts point to the low contraceptive prevalence in this region. Donor aid for family planning services as a proportion of total health care aid decreased from 8.2 to 2.6% between 2000 and 2009.

Box 1 – Progress on the other MDGs is important for progress on MDGs 4 and 5

MDG 1 – The proportion of people who are undernourished has not decreased since 2000. Over 40% of under-fives in South Asia are undernourished, not only due to lack of food and poor feeding practices, but also due to low birth-weight and sicknesses which are linked to poor water and sanitation facilities. There has been almost no reduction in levels of undernourishment amongst children from the poorest families here, between 1995 and 2009.

MDG 3 – Girls education levels have been improving at primary and secondary levels, but the progress is uneven. Girls in regions such as Oceania, Southern Asia, sub-Saharan Africa and Western Asia are still at a disadvantage, particularly in terms of secondary and higher education.

MDG 6 – Globally the incidence rate of HIV/AIDS has reduced by 25%. But condom use to prevent HIV is very low in several countries, particularly among women and making them vulnerable to becoming infected and if pregnant, potentially passing it on to their babies. Risk of infecting newborns has reduced due to the anti-retroviral treatment given to the pregnant women who are HIV positive. Globally, between 2004 and 2009, pregnant women living with HIV, who received such treatment has increased from 10 to 53%. Malaria related deaths have reduced by 20% (2000 – 2009) but 90% of the malaria related deaths still happen in sub-Saharan Africa, mostly in children under-five.

MDG 7 – Access to clean drinking water has increased from 77 to 87% (1990 – 2008) globally, but the poorest families and rural areas are still at a disadvantage. The poorest families in urban sub-Saharan Africa are six times more likely than the richest families to use unimproved drinking water. Sanitation is still a big problem as nearly half the population in developing countries do not use an improved toilet in 2008. More than a million people still practiced open defecation, which poses serious health risks. The poorest 40% of families in South Asia have not had any improved sanitation coverage between 1995 and 2008.

Conclusion

The sub-Saharan region is home to the highest maternal mortality rates and teenage pregnancy rates, lowest rates of skilled birth attendance, and contraception prevalence, making it the most unsafe place for a woman to become pregnant. With a growing population in the childbearing age group in low- and middle-income countries, the pressure on reproductive and maternal health services is set to increase. If the current trend of dwindling funds to reproductive health and family services continues, it could exacerbate the high rates of teenage pregnancies and low contraceptive use/prevalence – potentially leading to unsafe abortions and maternal deaths.

Poverty and lack of education are key determinants of under-five mortality rates, high rate of teenage pregnancies, low contraceptive use, lack of access to skilled birth attendance, undernourishment among children, lack of access to clean drinking water and proper sanitation. Improvements in these two key determinants can help accelerate progress in other areas.

References

1 UNICEF (2011). Levels & Trends in Child Mortality, 2011; Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation (PDF). www.unicef.org/media/files/Child_Mortality_Report_2011_Final.pdf

2 Oestergaard MZ, et al. (2011). Neonatal Mortality Levels for 193 Countries in 2009 with Trends since 1990: A Systematic Analysis of Progress, Projections, and Priorities. PLoS Med 8(8): e1001080. doi:10.1371/journal.pmed.1001080 (PDF) www.plos.org/press/plme-08-08-oestergaard1.pdf

3 Cousens, S. et al (2011). "National, regional, and worldwide estimates of stillbirth rates in 2009 with trends since 1995: a systematic analysis," The Lancet, Volume 377, Issue 9774, Pages 1319 - 1330

4 UN (2011). Millennium Development Goals Report 2011 (PDF)

5 www.un.org/millenniumgoals/11_MDG%20Report_EN.pdf

6 WHO (2010) Trends in Maternal Mortality: 1990 to 2008, 2010. Estimates developed by WHO, UNICEF, UNFPA and The World Bank (PDF) http://whqlibdoc.who.int/publications/2010/9789241500265_eng.pdf

7 *Countdown* to 2015 (2010). "Taking stock of maternal, newborn and child survival." (PDF) www.*Countdown*to2015mnch.org/documents/2010report/*Countdown*ReportAndProfiles.pdf

Available on-line at http://portal.pmnch.org/