# IX. IMPROVING MATERNAL HEALTH:
## THE NEED TO FOCUS ON REACHING THE POOR

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## A. INTRODUCTION


This paper discusses the relevance of the ICPD Programme of Action for the attainment of the Millennium Development Goal 5 (MDG 5): Improving maternal health. The ICPD objectives and actions are found to be highly relevant for addressing maternal ill-health, but are also considered to be insufficiently targeted to achieve the greatest impact


## B. USING PROXIMATE DETERMINANTS TO TRACK PROGRESS


Estimates for the key indicator for monitoring progress towards MDG 5, the maternal mortality ratio (MMR), are often unavailable because of the absence of measurement systems in many countries or the infrequency and unreliability of data collection. MDG 5 calls for a three-quarters reduction in the maternal mortality ratio between 1990 and 2015, an average reduction of 5.4 per cent per year. Based on an analysis of progress towards all the health-related MDGs carried out at the World Bank (Wagstaff and Claeson, 2004) in the past year, the developing world as a whole was found to be off target towards the MDG 5. The annual population weighted reduction in the MMR during the 1990s was only 3.2 per cent, with only one region making sufficient progress. The decline in maternal mortality in two of the poorest regions (Sub-Saharan Africa and South Asia) was found to be particularly slow.

This estimate is based on applying a model developed by WHO and UNICEF (Hill and others, 2001) to estimate the proportion of all deaths to women of reproductive age for 1990 and 2000, and is subject to considerable uncertainty. However, slow progress in reducing maternal mortality, especially in the poorest regions, has been noted in several other sources as well (Maine and Rosenfield, 1999). Because of the difficulty of measuring maternal mortality, proximate determinant indicators of interventions that are known to contribute towards the goal are often used to track progress. For MDG 5, the agreed proximate determinant is the use of skilled attendance at delivery, but other indicators of processes that contribute to the goal, such as the use of antenatal care is also monitored. In this paper, we will focus on the proximate determinants of MDG 5.

Interventions exist that can substantially reduce maternal mortality. Both preventive interventions (such as family planning and micronutrient supplementation) and treatment interventions (such as skilled attendance at delivery and emergency obstetric care) will have a huge impact on the maternal mortality rate—if these interventions were to reach those who need them most (Wagstaff and Claeson, 2004). But, for a number of reasons, effective interventions are underused, especially by the poor. An analysis of Demographic and Health Survey data in which households are divided into quintiles based on household wealth indicated that women who are in the wealthiest quintile are far more likely to receive skilled attendance at delivery than those in the poorest quintile (figure IX.1) (Gwatkin, 2000). In Latin America and the Caribbean, in East Asia and the Pacific, and in Europe and Central Asia, more than 90 per cent of the wealthiest household received such delivery care, whereas access for the poorest women was much lower. As the poor bear a disproportionate burden of maternal mortality, targeting interventions to reach

those with the greatest need would have potentially the greatest impact on overall maternal mortality reduction and thus on making progress towards achieving MDG 5.

This paper addresses two questions. First, does the ICPD Programme of Action address issues that are relevant for the attainment of MDG 5? Second, this paper will examine whether the Programme of Action, as well as the ICPD +5 document on Key Actions for Further Implementation of the Programme of Action, focused sufficiently on those most in need of interventions.

**Figure IX.1. Attended delivery by a medically trained person -- rates among poor and rich[a]**
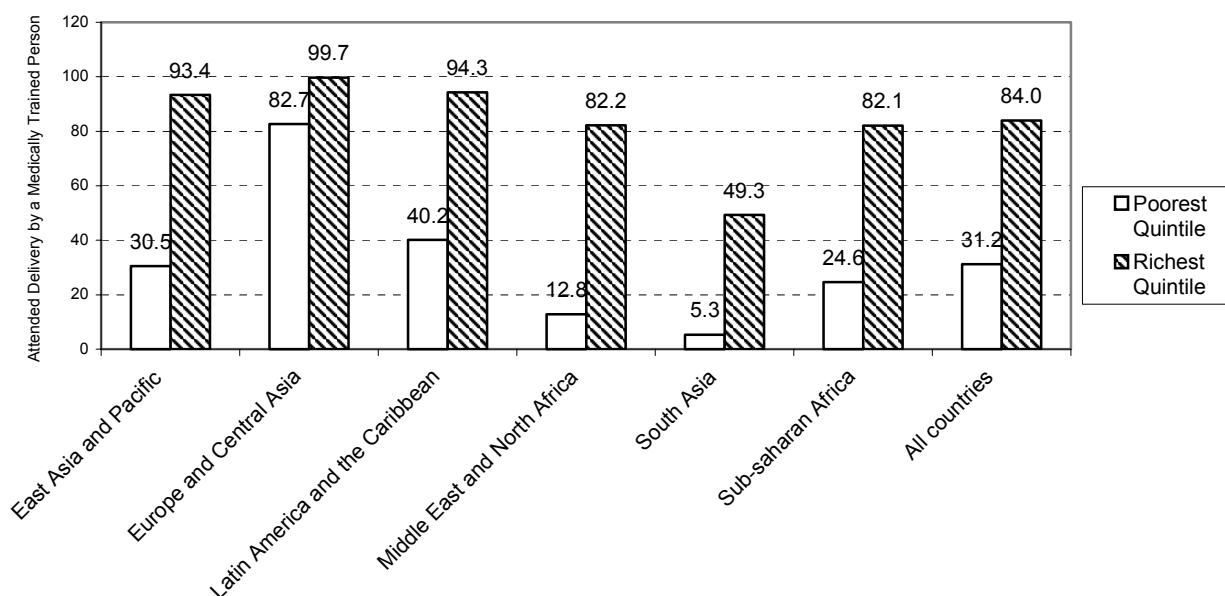


[a] East Asia and Pacific (3 countries); Europe and Central Asia (4 countries);Latin America and the Caribbean (9 countries); Middle East and North Africa (3 countries); South Asia (4 countries); Sub-saharan Africa (22 countries); All countries (45 countries).

C. MATERNAL MORTALITY REDUCTION IN THE ICPD PROGRAMME OF ACTION

The MDG 5 is extensively covered in the ICPD Programme of Action, and the objective of a 75 per cent reduction in the maternal mortality ratio that is set as the Millennium Development target is the action that was established and agreed on at the ICPD. The exact wording of the targets is somewhat different: whereas the ICPD called for a reduction in maternal mortality of one-half of the 1990 levels by the year 2000, and a further one half by 2015, the MDG only stipulates the overall reduction between 1990 and 2015. The ICPD Programme of Action further specifies certain levels to be achieved by 2005 at the country level, depending on the initial level of maternal mortality.

Issues related to maternal mortality are covered in detail in the chapter on health, morbidity, and mortality (chapter 8), and are also included in the discussion on gender equality (chapter 4), population growth and structure (chapter 6), reproductive rights and reproductive health (chapter 7), population, development and education (chapter 11), technology, research and development (chapter 12), and national action (chapter 13).

Chapter 8 of the ICPD Programme of Action includes a detailed discussion of the significance of maternal mortality ("basis for action"), and provides a number of interventions to address the problem, including promotion and use of prenatal care, maternal nutrition programs, adequate delivery assistance, obstetric emergencies, referral services for pregnancy, childbirth, and abortion complications, and post-natal care and family planning. These recommended actions are wide-ranging, including preventive and curative measures. Successful implementation of the recommended interventions in ICPD Programme of Action that would achieve high levels of coverage could be expected to have a substantial impact on maternal mortality reduction. Therefore, it is beyond question that the ICPD Programme of Action recommendations are consistent with MDG 5.

D. ACHIEVING MATERNAL MORTALITY REDUCTION FOR THE POOR

The second question this paper deals with is whether the ICPD Programme of Action sufficiently addressed the needs of women in poor households. It is clear that the MDG for reducing maternal mortality by 75 per cent will not be reached if services that contribute to the reduction largely exclude those who have the greatest needs for them. As indicated in Section 1 above, it is the poor who often lack access to services, because of physical and financial barriers, lack of information, unavailability of care, and other factors. A recent analysis showed that young women from the poorest households in 12 low- and middle income countries were more likely to enter in early marriages, to have given birth at an early age, and to be less likely to be using maternal health services (Rani and Lule, 2004).

Tables IX.1 to IX.3 show differences in proximate determinants of maternal health for the poor and non-poor for a large number of developing countries. For some of the indicators, such as antenatal care and skilled attendance at delivery, there is little room left for achieving a reduction in maternal mortality through increasing use of these services to women in wealthier households, as rates have already reached, in many countries, over 90 per cent. It is, however, critical that interventions reach the poor in order to make further progress. Differences between poor and wealthier households are in many countries much larger for reproductive health indicators than for child health indicators, such as immunization rates, signifying the particular importance of focusing on the poor for the maternal health goal.

A search of the ICPD Programme of Action reveals little emphasis on the needs of the poor, with a few exceptions. In Section 8.10, it is stated that "Special attention should be given to the living conditions of the poor and disadvantages in urban and rural locations". In other sections, the inclusion of the poor is implicit, as in Section 8.11: "All Governments should examine ways to maximize the cost-effectiveness of health programmes in order to achieve increased life expectancy, reduce morbidity and mortality and ensure access to basic health care services for all people". Several other references to the poor are made in chapters dealing with the environment and population distribution, but no specific actions are recommended, nor are indicators for monitoring progress among the poor included.

The ICPD+5 document on the implementation of the Programme of Action shows an evolution towards greater emphasis on the poor. Section II-18 recommends that governments "strengthen health care systems to respond to priority demands on them, taking into account the financial realities of countries and the need to ensure that resources are focused on the health needs of people in poverty"; section V-76 discusses the importance of partnerships that "bring benefits to poor people's health, including reproductive and sexual health". Most explicit is section VI-101, which states: "Governments of recipient countries are encouraged to ensure that public resources, subsidies, and assistance received from international donors for the implementation of the goals and objectives of the Programme of Action are invested to maximize benefits to the poor and other vulnerable population groups, including those who

suffer from disproportionate reproductive ill health". Thus, the importance of targeting interventions to the poor was more fully recognized in the ICPD +5 documents than in the Programme of Action.

TABLE IX.1. USE OF ANTENATAL CARE

|  | Poorest Quintile | Richest Quintile |
|---|---|---|
| East Asia, Pacific | 64.9 | 96.2 |
| Indonesia | 73.7 | 99.1 |
| Philippines | 71.5 | 97.5 |
| Vietnam | 49.5 | 92.1 |
| Europe, Central Asia | 78.2 | 96.3 |
| Kazakhstan | 89.5 | 97.9 |
| Kyrgyzstan | 96.3 | 98.7 |
| Turkey | 32.9 | 92.2 |
| Uzbekistan | 94.1 | 96.2 |
| Latin America and the Caribbean | 57.5 | 95.6 |
| Bolivia | 38.8 | 95.3 |
| Brazil | 67.5 | 98.1 |
| Colombia | 62.3 | 95.9 |
| Dominican Republic | 96.1 | 99.9 |
| Guatemala | 34.6 | 90.0 |
| Haiti | 44.3 | 91.0 |
| Nicaragua | 67.0 | 96.0 |
| Paraguay | 69.5 | 98.5 |
| Peru | 37.3 | 96.0 |
| Middle East, North Africa | 13.7 | 73.0 |
| Egypt | 16.9 | 80.0 |
| Morocco | 8.0 | 74.4 |
| Yemen | 16.1 | 64.6 |
| South Asia | 16.8 | 70.9 |
| Bangladesh | 14.3 | 58.6 |
| India | 24.5 | 88.6 |
| Nepal | 21.5 | 66.5 |
| Pakistan | 6.9 | 69.7 |
| Sub-Saharan Africa | 61.1 | 93.6 |
| Benin | 59.1 | 98.7 |
| Burkina Faso | 42.9 | 92.7 |
| Cameroon | 52.7 | 98.5 |
| Central African Republic | 40.0 | 91.8 |
| Chad | 11.5 | 70.4 |
| Comoros | 68.3 | 95.3 |
| Côte d'Ivoire | 62.6 | 98.2 |
| Ghana | 75.8 | 97.3 |
| Kenya | 87.9 | 96.1 |
| Madagascar | 67.1 | 95.6 |
| Malawi | 84.0 | 96.7 |

TABLE IX.1 (*continued*)

|  | *Poorest Quintile* | *Richest Quintile* |
|---|---|---|
| Mali | 20.2 | 84.5 |
| Mozambique | 46.6 | 98.3 |
| Namibia | 82.8 | 89.8 |
| Niger | 24.6 | 84.3 |
| Nigeria | 30.9 | 90.7 |
| Senegal | 66.8 | 96.3 |
| Tanzania | 82.4 | 96.0 |
| Togo | 68.2 | 96.8 |
| Uganda | 86.6 | 95.7 |
| Zambia | 91.3 | 99.6 |
| Zimbabwe | 91.0 | 96.2 |
| All countries | 55.0 | 91.0 |

*Source*: Gwatkin and others, 2004.

TABLE IX.2. SKILLED ATTENDANCE AT DELIVERY

|  | *Poorest Quintile* | *Richest Quintile* |
|---|---|---|
| East Asia, Pacific | 30.5 | 93.4 |
| Indonesia | 21.3 | 89.2 |
| Philippines | 21.2 | 91.9 |
| Vietnam | 49.0 | 99.2 |
| Europe, Central Asia | 82.7 | 99.7 |
| Kazakhstan | 99.4 | 100.0 |
| Kyrgyzstan | 96.0 | 100.0 |
| Turkey | 43.4 | 98.9 |
| Uzbekistan | 91.9 | 100.0 |
| Latin America and the Caribbean | 40.2 | 94.3 |
| Bolivia | 19.8 | 97.9 |
| Brazil | 71.6 | 98.6 |
| Colombia | 60.6 | 98.1 |
| Dominican Republic | 88.6 | 97.8 |
| Guatemala | 9.3 | 91.5 |
| Haiti | 24.0 | 78.2 |
| Nicaragua | 32.9 | 92.3 |
| Paraguay | 41.2 | 98.1 |
| Peru | 13.7 | 96.6 |
| Middle East, North Africa | 12.8 | 82.2 |
| Egypt | 20.5 | 86.4 |
| Morocco | 5.1 | 77.9 |
| Yemen | 6.8 | 49.7 |

TABLE IX.2 (*continued*)

|  | *Poorest Quintile* | *Richest Quintile* |
|---|---|---|
| South Asia | 5.3 | 49.3 |
| Bangladesh | 1.8 | 29.7 |
| India | 11.9 | 78.7 |
| Nepal | 2.9 | 33.7 |
| Pakistan | 4.6 | 55.2 |
| Sub-Saharan Africa | 24.6 | 82.1 |
| Benin | 34.4 | 97.5 |
| Burkina Faso | 25.8 | 86.2 |
| Cameroon | 32.0 | 94.7 |
| Central African Republic | 14.3 | 81.7 |
| Chad | 2.6 | 47.4 |
| Comoros | 26.2 | 84.8 |
| Côte d'Ivoire | 16.8 | 83.5 |
| Ghana | 25.3 | 85.1 |
| Kenya | 23.2 | 79.6 |
| Madagascar | 29.6 | 88.5 |
| Malawi | 44.6 | 77.9 |
| Mali | 11.1 | 80.6 |
| Mozambique | 18.1 | 82.1 |
| Namibia | 50.9 | 91.2 |
| Niger | 4.2 | 62.8 |
| Nigeria | 12.2 | 70.0 |
| Senegal | 20.3 | 86.2 |
| Tanzania | 26.7 | 80.9 |
| Togo | 25.1 | 91.2 |
| Uganda | 22.6 | 70.4 |
| Zambia | 19.3 | 90.5 |
| Zimbabwe | 55.1 | 92.8 |
| All countries | 31.2 | 84.0 |

*Source*: Gwatkin and others, 2004.

## TABLE IX.3. ADOLESCENT FERTILITY RATES

| | Poorest Quintile | Richest Quintile |
|---|---|---|
| East Asia, Pacific | 85.3 | 12.7 |
| Indonesia | 75.0 | 15.0 |
| Philippines | 130.0 | 12.0 |
| Vietnam | 51.0 | 11.0 |
| Europe, Central Asia | 83.8 | 31.5 |
| Kazakhstan | 101.0 | 26.0 |
| Kyrgyzstan | 120.0 | 29.0 |
| Turkey | 56.0 | 32.0 |
| Uzbekistan | 58.0 | 39.0 |
| Latin America and the Caribbean | 181.0 | 33.1 |
| Bolivia | 168.0 | 27.0 |
| Brazil | 176.0 | 28.0 |
| Colombia | 180.0 | 24.0 |
| Dominican Republic | 234.0 | 30.0 |
| Guatemala | 203.0 | 54.0 |
| Haiti | 105.0 | 25.0 |
| Nicaragua | 213.0 | 58.0 |
| Paraguay | 181.0 | 34.0 |
| Peru | 169.0 | 18.0 |
| Middle East, North Africa | 88.7 | 42.7 |
| Egypt | 93.0 | 25.0 |
| Morocco | 52.0 | 21.0 |
| Yemen | 121.0 | 82.0 |
| South Asia | 138.3 | 67.5 |
| Bangladesh | 187.0 | 91.0 |
| India | 135 | 45 |
| Nepal | 143.0 | 90.0 |
| Pakistan | 88.0 | 44.0 |
| Sub-Saharan Africa | 176.8 | 93.5 |
| Benin | 178.0 | 33.0 |
| Burkina Faso | 182.0 | 97.0 |
| Cameroon | 208.0 | 101.0 |
| Central African Republic | 155.0 | 138.0 |
| Chad | 178.0 | 205.0 |
| Comoros | 65.0 | 25.0 |
| Côte d'Ivoire | 191.0 | 72.0 |
| Ghana | 149.0 | 72.0 |
| Kenya | 163.0 | 63.0 |
| Madagascar | 271.0 | 78.0 |
| Malawi | 143.0 | 131.0 |
| Mali | 198.0 | 122.0 |
| Mozambique | 191.0 | 126.0 |
| Namibia | 105.0 | 99.0 |

TABLE IX.3 (*continued*)

|  | *Poorest Quintile* | *Richest Quintile* |
|---|---|---|
| Niger | 260.0 | 148.0 |
| Nigeria | 194.0 | 66.0 |
| Senegal | 189.0 | 36.0 |
| Tanzania | 151.0 | 93.0 |
| Togo | 142.0 | 35.0 |
| Uganda | 222.0 | 171.0 |
| Zambia | 210.0 | 86.0 |
| Zimbabwe | 144.0 | 59.0 |
| All countries | 154.0 | 64.8 |

*Source*: Gwatkin and others, 2004.

## E. CONCLUSION

Gwatkin (2004) showed how a goal that is defined in terms of population averages (such as the maternal health goal) can be highly regressive, leading to increased inequities, if interventions are not targeted to reach the poor. Use of antenatal care, skilled assistance at delivery, and avoidance of early adolescent pregnancies are much less favourable for the poor, who also suffer from greater disease burdens, including higher maternal mortality. The ICPD Programme of Action promoted access to health services for all, but did not specifically call for improved access to basic health services for the poor.

In order to accelerate progress towards the maternal mortality MDG, greater efforts to reach the poor must be made. The ICPD +5 started to move in this direction. Policies, actions, and goals must be defined in terms of achieving better outcomes for the poor, rather than as national averages. Additional indicators are needed that provide information on health outcomes and the use of reproductive health services for the poorest women. While it will not be practical to monitor maternal mortality ratios by socioeconomic characteristics, other indicators, such as use of family planning and access to skilled attendance at delivery would be suitable to include in such monitoring efforts.

REFERENCES

AbouZahr, Carla, and Tessa Wardlaw (2001). Maternal mortality at the end of the decade: signs of progress? *Bulletin of the World Health Organization*, vol. 79, No. 6, pp. 561-573.

Gwatkin, D. (2004). Looking beyond the averages, in order to ensure that poor women benefit fully from progress toward reproductive health goals. Paper prepared for the International Conference of Population and Development at 10.

_____, S. Rutstein, K. Johnson, R. Pande and A. Wagstaff (2000). Socioeconomic differences in health, nutrition, and population. Health, Nutrition, and Population Discussion Papers. The World Bank: Washington, D.C.

Hill, Kenneth, Carla AbouZahr and Tessa Wardlaw (2001). Estimates of maternal mortality for 1995. *Bulletin of the World Health Organization*, vol. 79, No. 3, pp. 182–193.

Maine, D., and A. Rosenfield (1999). The safe motherhood initiative, why has it stalled? *American Journal of Public Health*, vol 89, No. 4, pp. 480-482.

Rani, M., and E. Lule (2004). Exploring the socioeconomic dimension of adolescent reproductive health: a multicountry analysis. *International Family Planning Perspectives*, 30 (3):110-117.

Wagstaff, A., and M. Claeson (2004). Rising to the Challenges. The Millennium Development Goals for Health. The World Bank: Washington, D.C.