Goal 5: Improve Maternal Health

In the Asia and Pacific region, **maternal mortality** ranges from 1 per 100,000 live births in Hong Kong, China to 1,800 in Afghanistan. The People's Republic of China (PRC) has a rather low rate of 45 but over 300 women die in childbirth per 100,000 live births in Bangladesh, India, Indonesia, and Pakistan. There is fairly strong evidence that maternal mortality ratios are reduced when a **trained health worker is present. Adolescent birth rates** have generally been falling since 1990 and in some cases the falls have been dramatic. But seven economies reported increases.

Introduction

Goal 5 has two targets:

5.A: *Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio.* This ratio is calculated as the number of deaths in child birth per 100,000 live births. It is not yet possible to assess progress toward this target because data for earlier and more recent years are not sufficiently comparable for a number of economies. A related indicator is the number of births that are attended to by a health worker who has been trained to conduct deliveries and care for newborns.

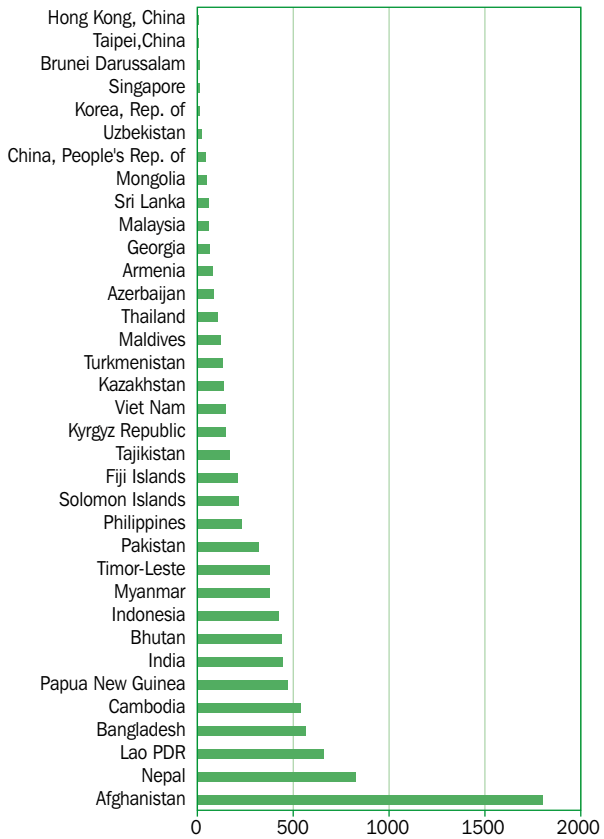
5.B: *Achieve, by 2015, universal access to reproductive health.* These services should cover advice on contraceptive methods and family planning, antenatal care, and advice on transmission of HIV/AIDS and other sexually transmitted diseases. This is a new target introduced in the revised MDG framework.

Key Trends

Maternal mortality is unacceptably high in many countries. Figure 5.1 shows the number of maternal deaths per 100,000 live births in 2005. Afghanistan had an extremely high ratio of 1,800. Of the five most populous economies, the People's Republic of China (PRC) has by far the lowest ratio: 45 per 100,000 live births in 2005. Bangladesh, India, Indonesia, and Pakistan all have maternal mortality ratios well above 300 per 100,000 live births. Other economies showing relatively high mortality ratios over 500 were Cambodia, Lao People's Democratic Republic, and Nepal. In many of these countries, tradition encourages young girls to marry at ages when their bodies are not yet fit for the rigors of childbirth.

The richer economies of Brunei Darussalam; Hong Kong, China; Republic of Korea; Singapore; and Taipei,China reported less than 15 maternal deaths per 100,000 live births, with Hong Kong, China having the lowest ratio of 1. By comparison, maternal mortality rates for the developed countries of Western Europe and North America are rarely over 10 per 100,000 live births.

Figure 5.1 **Maternal Mortality Ratio, 2005 or Latest Year (per 100,000 live births)**

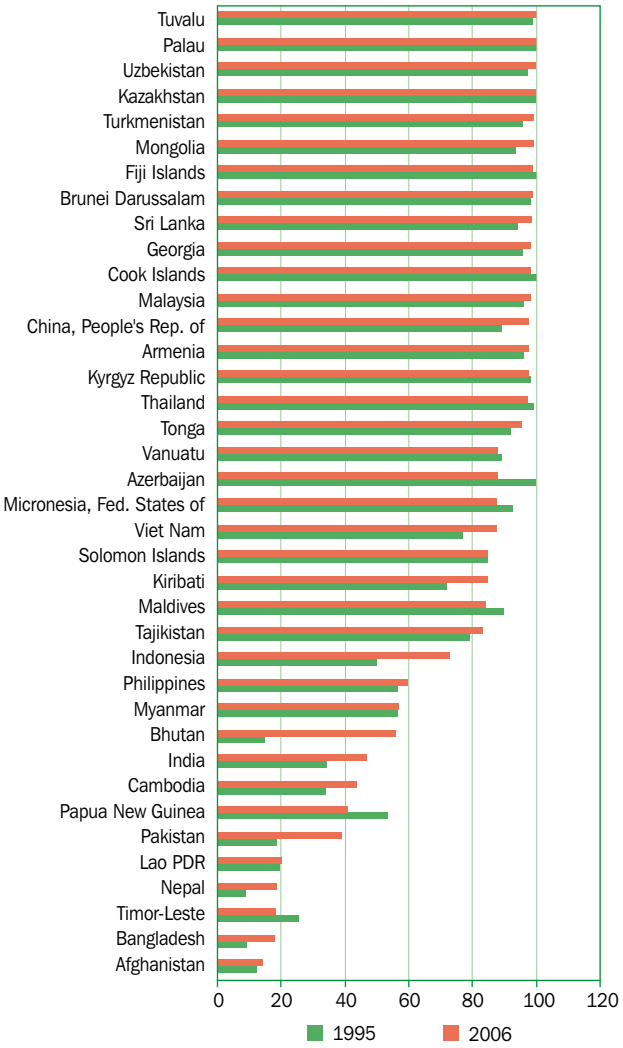


Source: Table 5.1.

Properly trained midwives are scarce in many countries. Figure 5.2 shows that in the latest year for which data are available, skilled health personnel assisted in 90% or more of childbirths in 17 of the 38 economies; of these, nine economies reported that 99–100% of births were professionally attended. Of the five most populous economies, the PRC reported that 98% of births were professionally attended. For Indonesia, the figure was 73%. The others were much lower: India 47%, Pakistan 39%, and Bangladesh 18%, which is the lowest in the region apart from Afghanistan.

In 2006, the percentages were higher or remained the same in 28 economies, compared with those in 1995. Sharp rises occurred in Bhutan, Indonesia, and Pakistan. On the other hand, 10 countries reported falling percentages. These were usually quite small but larger falls were reported by Azerbaijan, Papua New Guinea, and Timor-Leste.

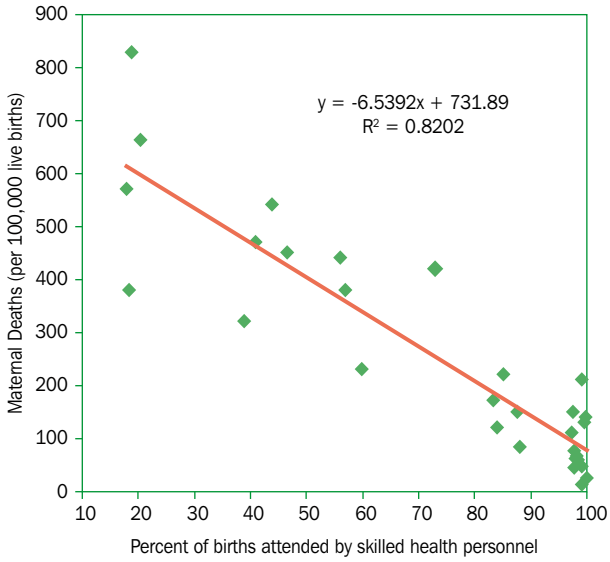
Figure 5.2 **Births Attended by Skilled Health Personnel, 1995 and 2006 or Nearest Years (percent)**



Source: Table 5.1.

Maternal deaths are reduced when a trained health worker is present. Figure 5.3 plots maternal deaths per 100,000 live births against the percentage of births attended by skilled health personnel for 30 selected member countries that have data for both variables for recent years. (The dates of the two variables are fairly close but not identical.) The linear regression suggests that over 80% of the variation in maternal mortality ratios between economies is explained by whether or not skilled health personnel are in attendance. The regression results also suggest that maternal mortality ratios fall by about 6.5 per 100,000 live births for every percentage point increase in the percentage of births attended by skilled health personnel.

Figure 5.3 **Maternal Mortality and Births Attended by Skilled Health Personnel, 2006 or Latest Year**



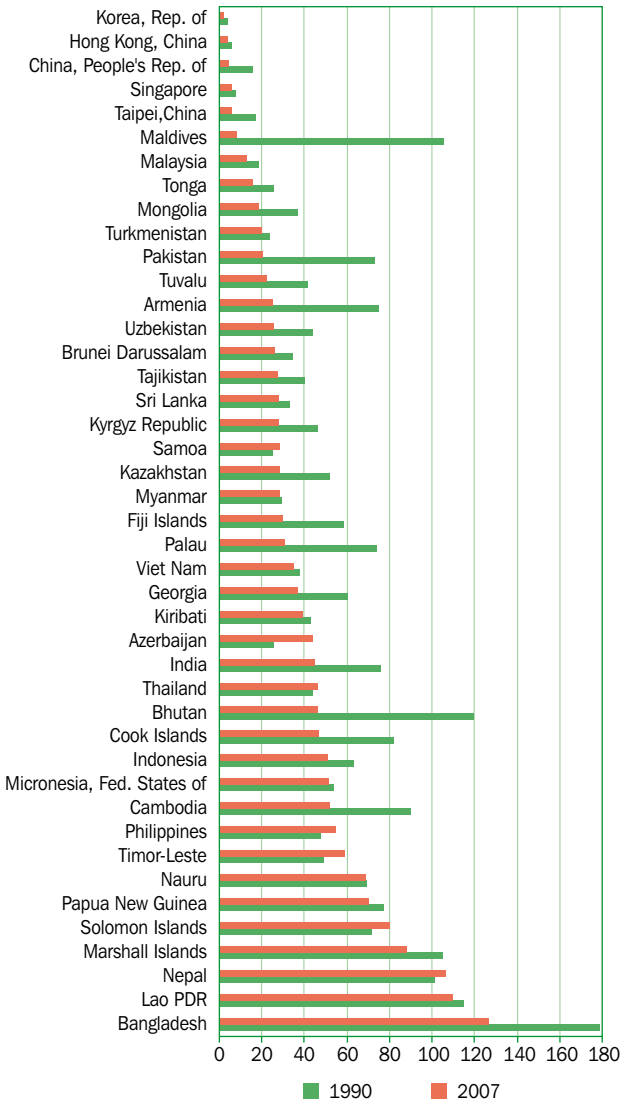
Source: Derived from Table 5.1.

Adolescent births show that in many countries, young women are still poorly advised about reproductive health. Figure 5.4 shows the number of adolescent births as a percentage of the female population aged 15–19 years. This is taken as an indicator of the extent to which women have access to good reproductive health care, including advice on family planning and modern contraceptive methods.

Most of the 43 economies shown in Figure 5.4 have seen reductions in adolescent births since 1990, and in several countries the falls have been dramatic. The number per thousand women of childbearing age fell by 30 or more in nine economies, including Bangladesh, India, and Pakistan. Seven countries, however, reported increases, including Nepal, Philippines, and Thailand.

In the latest year available (mostly in 2005 or 2006) six economies had rates below 10 but three had rates of 100 or higher. Among the most populous countries, the PRC reported the lowest rate (5). Pakistan's rate was also quite low (20). Much higher rates were reported by India (45), Indonesia (51), and Bangladesh (127).

Figure 5.4 **Adolescent Birth Rate, 1990 and 2007 or Nearest Years (per thousand women aged 15–19)**



Source: Table 5.2.

Data Issues and Comparability

The most reliable information on maternal mortality comes from vital registration records or other administrative sources. In many developing economies, however, registration records are not well maintained, with many births taking place at home rather than in clinics, and many not being attended to by trained health workers. Mortality ratios for these economies are based on household surveys of varying reliability. Unfortunately, it is not possible to calculate the progress of many economies toward achieving the target because the maternal mortality ratios are not comparable, having been estimated using different methodologies. There is only 1—year data available for earlier years.

Data on the proportion of births attended by skilled health personnel are collected through national household surveys. However, it is difficult to standardize the definition of skilled health personnel due to the differences in the training of health personnel in different countries.

Data on the adolescent birth rate are derived from vital registration systems or household surveys. Data derived using both sources may suffer from limitations such as the misreporting of the mother's age and exclusion of previous births.