Goal 5

Improve maternal health

TARGET
Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

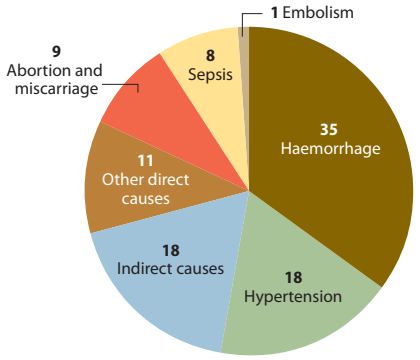
Achieving good maternal health requires quality reproductive health services and a series of well-timed interventions to ensure a women's safe passage to motherhood. Failure to provide these results in hundreds of thousands of needless deaths each year—a sad reminder of the low status accorded to women in many societies.

Measuring maternal mortality—death resulting from the complications of pregnancy or childbirth—is challenging at best. Systematic underreporting and misreporting are common, and estimates lie within large ranges of uncertainty. Nevertheless, an acceleration in the provision of maternal and reproductive health services to women in all regions, along with positive trend data on maternal mortality and morbidity, suggest that the world is making some progress on MDG 5.

New estimates of maternal mortality are currently being finalized by the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA) and the World Bank. Preliminary data show signs of progress, with some countries achieving significant declines in maternal mortality ratios. However, the rate of reduction is still well short of the 5.5 per cent annual decline needed to meet the MDG target. The complete data set will be available at mdgs.un.org

Most maternal deaths could be avoided

Causes of maternal deaths, developing regions, 1997/2007 (Percentage)

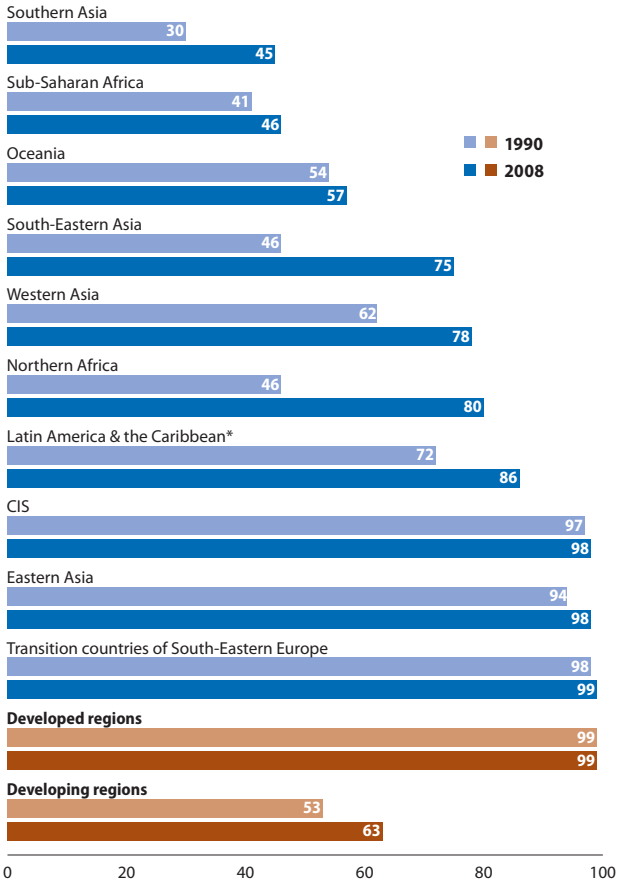


The leading causes of maternal mortality in developing regions are haemorrhage and hypertension, which together account for half of all deaths in expectant or new mothers. Indirect causes, including malaria, HIV/AIDS and heart disease, result in 18 per cent of maternal deaths. Other direct causes, such as obstructed labour, complications of anaesthesia or caesarean section, and ectopic pregnancy, lead to 11 per cent of all deaths during pregnancy or childbirth.

The vast majority of these deaths are avoidable. Haemorrhage, for example, which accounts for over one third of maternal deaths, can be prevented or managed through a range of interventions administered by a skilled health-care provider with adequate equipment and supplies.

Giving birth is especially risky in Southern Asia and sub-Saharan Africa, where most women deliver without skilled care

Proportion of deliveries attended by skilled health personnel, 1990 and 2008 (Percentage)

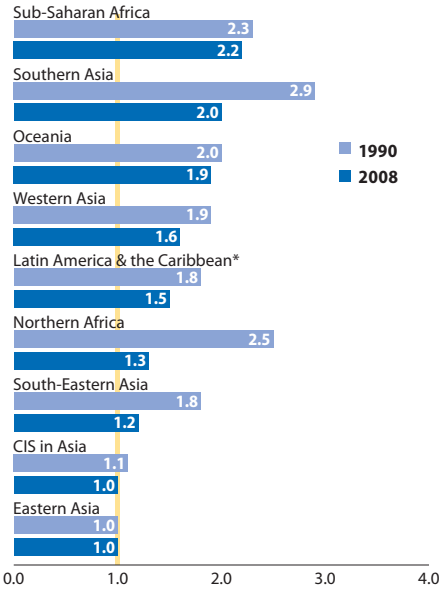


* Includes only deliveries in health-care institutions.

The proportion of women in developing countries who received skilled assistance during delivery rose from 53 per cent in 1990 to 63 per cent in 2008. Progress was made in all regions, but was especially dramatic in Northern Africa and South-Eastern Asia, with increases of 74 per cent and 63 per cent, respectively. Southern Asia also progressed, although coverage there, as well as in sub-Saharan Africa, remains inadequate. Less than half the women giving birth in these regions are attended by skilled health personnel.

The rural-urban gap in skilled care during childbirth has narrowed

Ratio of urban women to rural women attended by skilled health personnel during delivery, 1990 and 2008



* Includes only deliveries in health-care institutions.

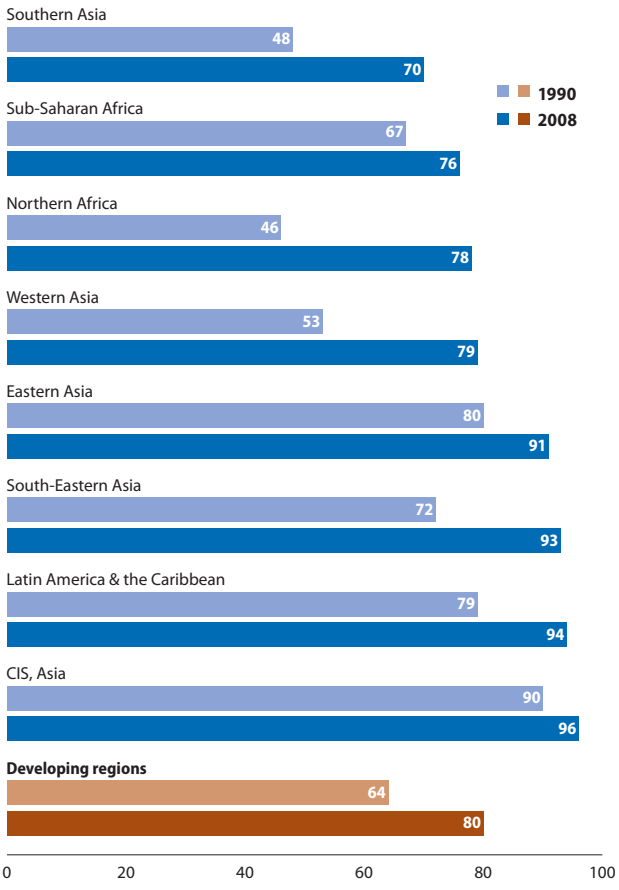
More rural women are receiving skilled assistance during delivery, reducing long-standing disparities between urban and rural areas. In Southern Asia, for example, urban women were three times more likely as their rural counterparts to receive professional care at childbirth in 1990; by 2008, they were only twice as likely to receive such care, indicating some improvement. Still, inequalities persist, especially in regions where attendance by skilled personnel is lowest and maternal mortality highest—notably in sub-Saharan Africa, Southern Asia and Oceania.

Serious disparities in coverage are also found between the wealthiest and the poorest households. The widest gaps are in Southern Asia and sub-Saharan Africa, where the wealthiest women are five times more likely and three times more likely, respectively, as the poorest women to be attended by trained health-care workers at delivery. In the developing regions as a whole, women in the richest households are three times as likely as women in the poorest households to receive professional care during childbirth.

TARGET
Achieve, by 2015, universal access to reproductive health

More women are receiving antenatal care

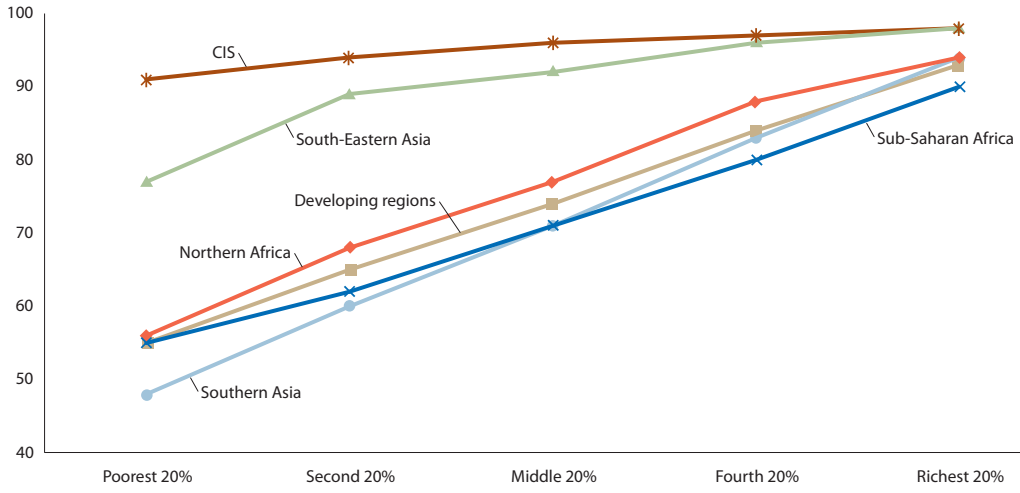
Proportion of women attended at least once during pregnancy by skilled health-care personnel, 1990 and 2008 (Percentage)



In all regions, progress is being made in providing pregnant women with antenatal care. Remarkable gains were recorded in Northern Africa, where the share of women who saw a skilled health worker at least once during pregnancy increased by 70 per cent. Southern Asia and Western Asia reported increases of almost 50 per cent.

Inequalities in care during pregnancy are striking

Proportion of women attended at least once during pregnancy by skilled health personnel, by household wealth quintile, 2003/2008 (Percentage)

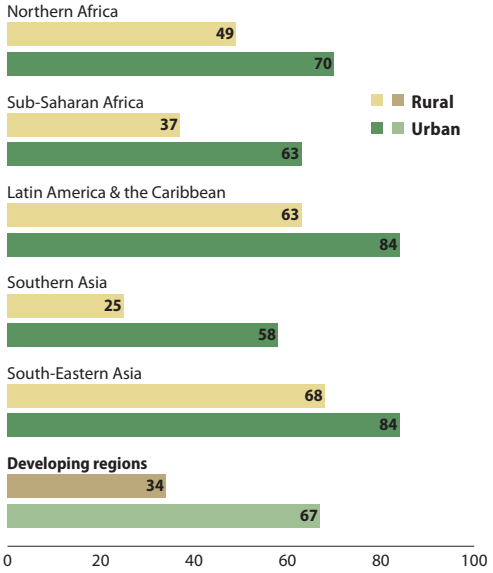


Disparities in the share of women receiving antenatal care by wealth are striking, particularly in Southern Asia, Northern Africa and sub-Saharan Africa. Even in South-Eastern Asia, where over 90 per cent of women receive skilled care during pregnancy, only 77 per cent of women in the poorest households are covered, versus almost 100 per cent of women in the wealthiest households.

Large disparities also exist between women living in rural and urban areas, although the gap narrowed between 1990 and 2008. In sub-Saharan Africa, the proportion of urban women who received antenatal care at least once increased from 84 per cent in 1990 to 89 per cent in 2008. The corresponding proportions for rural women are 55 to 66 per cent, indicating that coverage has improved at a faster pace among rural women.

Only one in three rural women in developing regions receive the recommended care during pregnancy

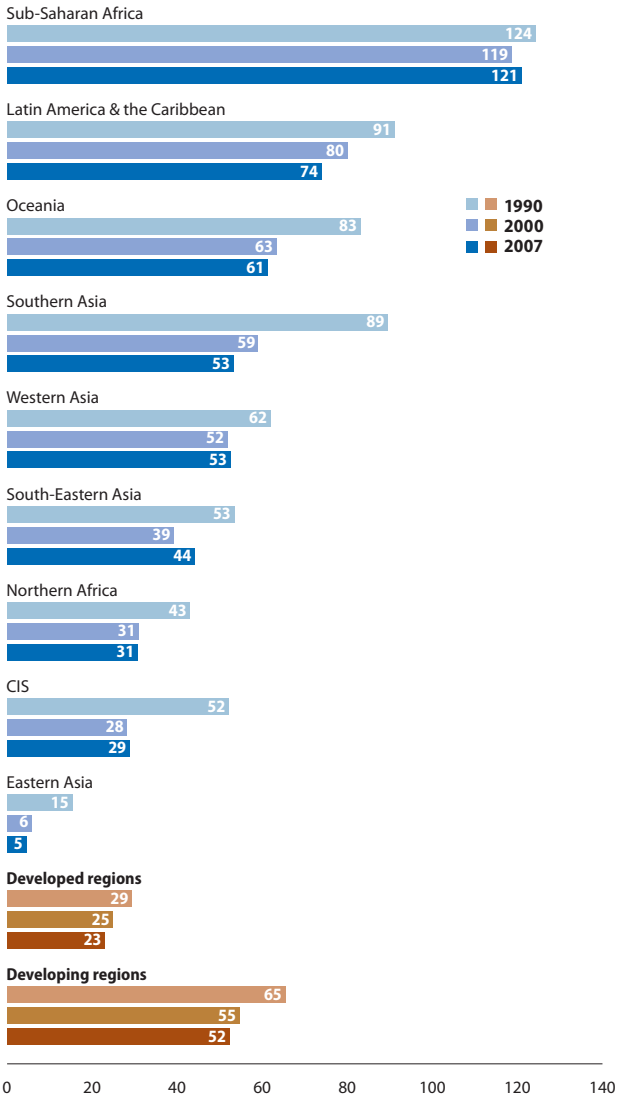
Proportion of women attended four or more times during pregnancy by area of residence, 2003/2008 (Percentage)



Women should receive care from a trained health-care practitioner at least four times during the course of their pregnancies, according to WHO and UNICEF recommendations. However, less than half of pregnant women in developing regions and only a third of rural women receive the recommended four visits. Among rural women in Southern Asia, the share is only 25 per cent.

Progress has stalled in reducing the number of teenage pregnancies, putting more young mothers at risk

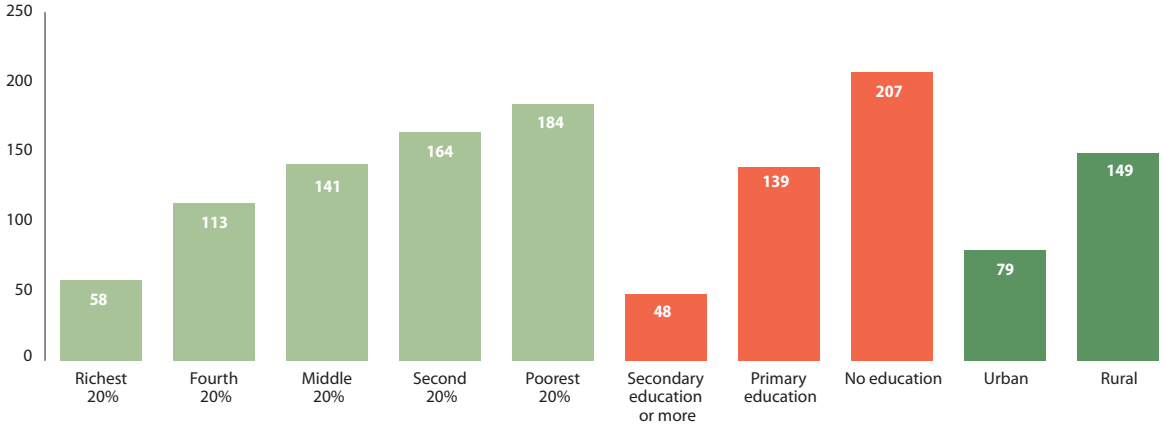
Number of births per 1,000 women aged 15-19, 1990, 2000 and 2007



In all regions, the adolescent birth rate (the number of births per 1,000 women aged 15 to 19) decreased between 1990 and 2000. Since that time, progress has slowed and, in some regions, increases have even been recorded. The highest birth rate among adolescents is found in sub-Saharan Africa, which has seen little progress since 1990. Adolescents, in general, face greater obstacles than adult women in accessing reproductive health services.

Poverty and lack of education perpetuate high adolescent birth rates

Adolescent birth rates by background characteristics in 24 sub-Saharan African countries, 1998/2008 (Number of births to women aged 15-19 per 1,000 women)

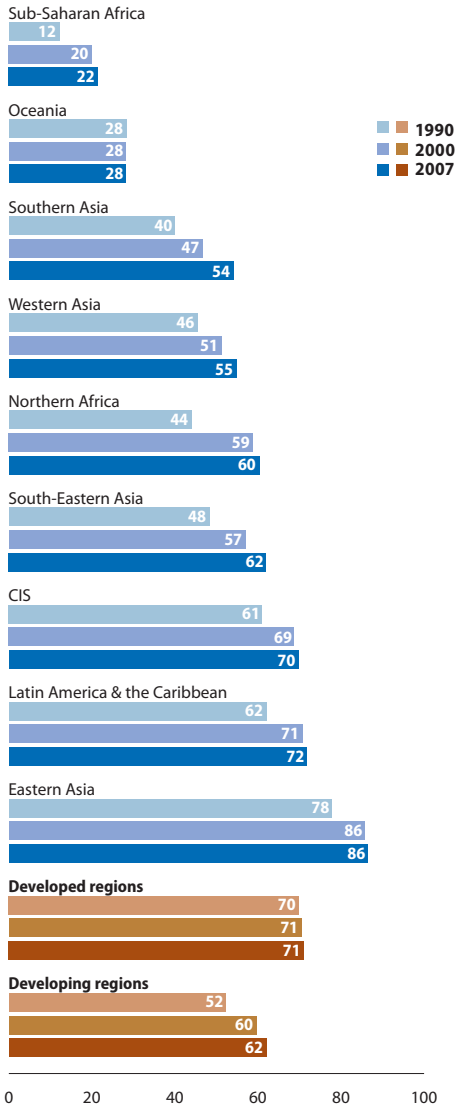


Data for 24 countries in sub-Saharan Africa show that adolescents in the poorest households are three times more likely to become pregnant and give birth than those in the richest households. In rural areas, adolescent birth rates are almost double those of urban areas. But the largest disparities are linked to education: girls with a secondary education are the least likely to become mothers. The birth rate among girls with no education is over four times higher.

Even more worrisome is the widening of disparities over time. The adolescent birth rate declined in 18 of the 24 sub-Saharan countries studied. However, in almost all these 18 countries the decline was largest among adolescents living in urban areas, among those with at least a secondary education, and among those belonging to the richest 20 per cent of households. Thus, disparities between those groups and rural, less educated and poorer adolescents have increased, rather than decreased, over time.

Progress in expanding the use of contraceptives by women has slowed

Proportion of women who are using any method of contraception among women aged 15-49, married or in union, 1990, 2000 and 2007 (Percentage)



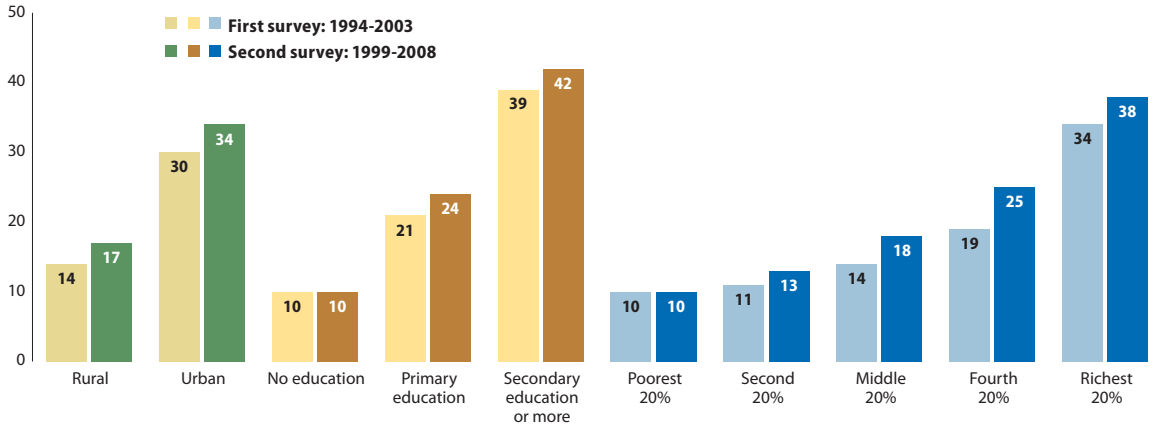
During the 1990s, use of contraceptives increased among women in almost every region. By 2007, over 60 per cent of women aged 15 to 49 who were married or in union were using some form of contraception. Yet this average masks two disturbing trends: a considerable slowdown in progress since 2000 and a widening gap among regions. From 2000 to 2007, the annual rate of increase in contraceptive prevalence in almost all regions was lower than it had been during the 1990s. Moreover, contraceptive prevalence in sub-Saharan Africa and Oceania continues to be very low. And in several subregions, traditional and less effective methods of contraception are still widely used.

Satisfying women's unmet need for family planning—that is, facilitating access to modern contraceptives by women who desire to delay or avoid pregnancy but who are currently not using contraception—could improve maternal health and reduce the number of maternal deaths. Recent estimates indicate that meeting that need could result in a 27 per cent drop in maternal deaths each year by reducing the annual number of unintended pregnancies from 75 million to 22 million. Preventing closely spaced pregnancies and pregnancies among adolescents would also improve the health of women and girls and increase the chances that their children will survive.

The unmet need for family planning remains moderate to high in most regions, particularly in sub-Saharan Africa, where one in four women aged 15 to 49 who are married or in union and have expressed the desire to use contraceptives do not have access to them.

Use of contraception is lowest among the poorest women and those with no education

Contraceptive prevalence by background characteristics in 22 sub-Saharan African countries, surveys around 1994-2003 and 1998-2008 (Percentage of women using at least one contraceptive method among women aged 15-49, married or in union)

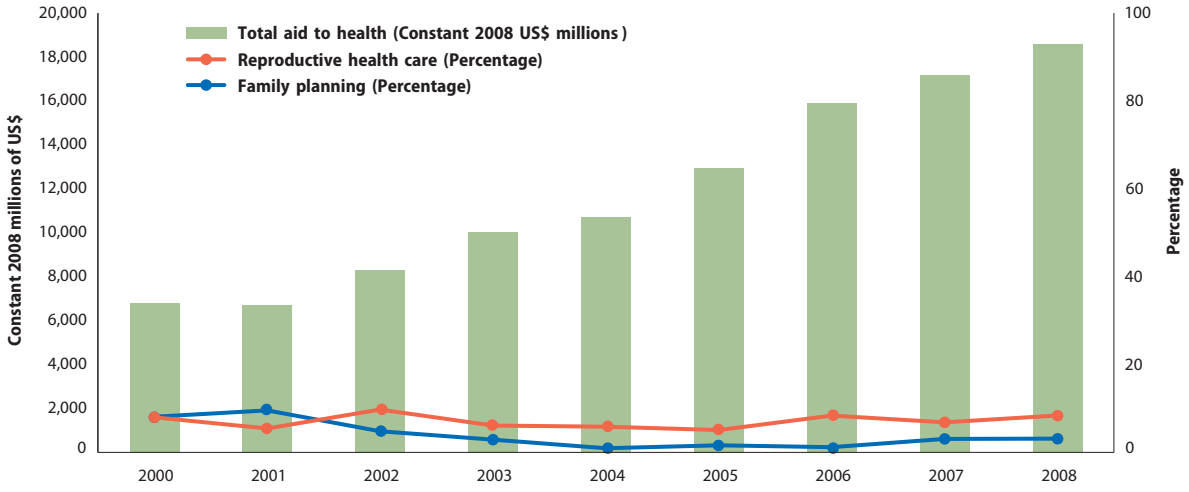


Ensuring that family planning services reach poor women and those with little education remains particularly challenging. Surveys conducted in 22 countries in sub-Saharan Africa show that contraceptive use to avoid or delay pregnancy is lowest among rural women, among women with no schooling and among those living in the poorest households.

In these countries, contraceptive use is four times higher among women with a secondary education than among those with no education, and is almost four times higher among women in the richest households than those in the poorest households. Almost no improvement has been made over time in increasing contraceptive prevalence among women in the poorest households and among those with no education.

Inadequate funding for family planning is a major failure in fulfilling commitments to improving women's reproductive health

Official development assistance to health, total (Constant 2008 US$ millions) and proportion going to reproductive health care and family planning, 2000-2008 (Percentage)



Ensuring that even the poorest and most marginalized women can freely decide the timing and spacing of their pregnancies requires targeted policies and adequately funded interventions. Yet financial resources for family planning services and supplies have not kept pace with demand. Aid for family planning as a proportion of total aid to health declined sharply between 2000 and 2008, from 8.2 per cent to 3.2 per cent. Aid to reproductive health services has fluctuated between 8.1 per cent and 8.5 per cent. External funding for family planning in constant 2008 US dollars actually declined during the first few years of this decade and has not yet returned to its 2000 level.

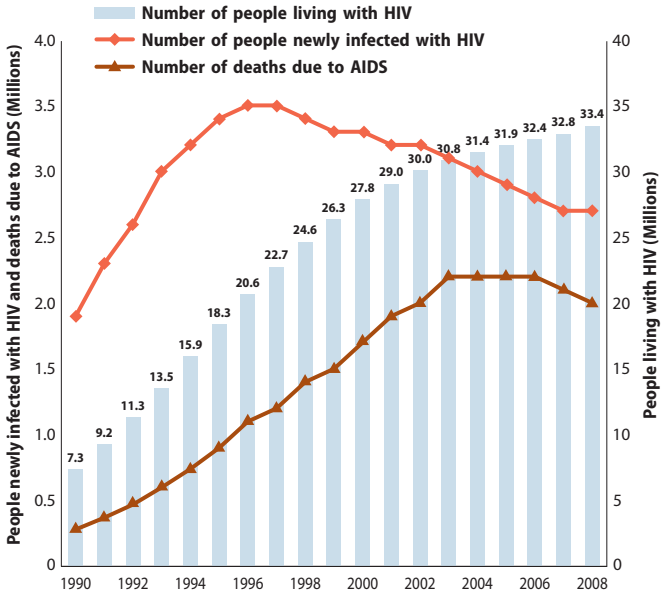
Goal 6

Combat HIV/AIDS, malaria & other diseases

TARGET
Have halted by 2015 and begun to reverse the spread of HIV/AIDS

The spread of HIV appears to have stabilized in most regions, and more people are surviving longer

Number of people living with HIV, number of people newly infected with HIV and number of AIDS deaths worldwide, 1990-2008 (Millions)



The latest epidemiological data indicate that, globally, the spread of HIV appears to have peaked in 1996, when 3.5 million* people were newly infected. By 2008, that number had dropped to an estimated 2.7 million. AIDS-related mortality peaked in 2004, with 2.2 million deaths. By 2008, that toll had dropped to 2 million, although HIV remains the world's leading infectious killer.

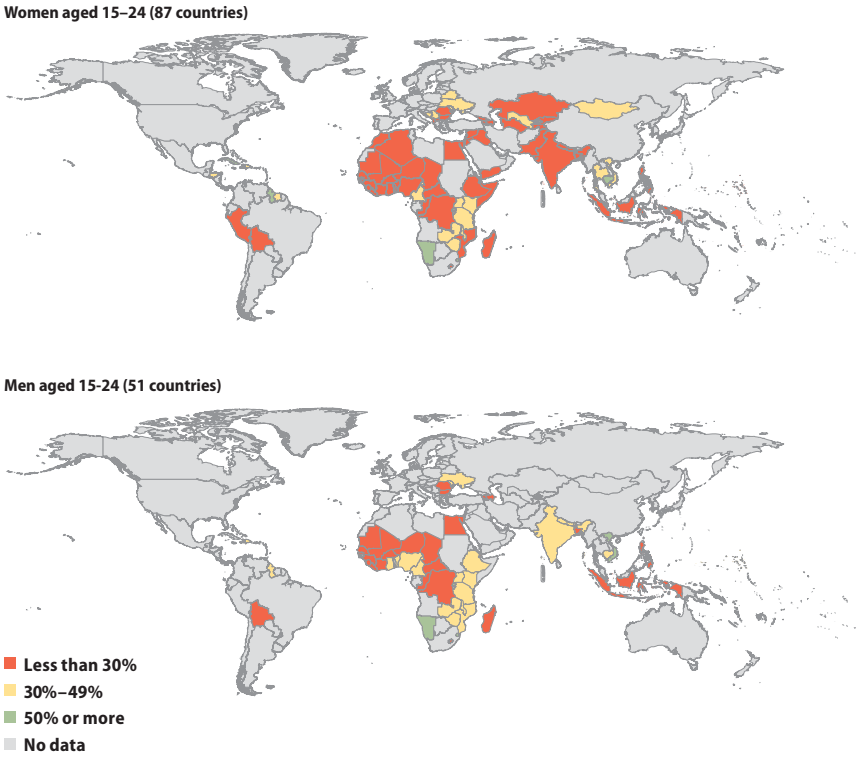
The epidemic appears to have stabilized in most regions, although prevalence continues to rise in Eastern Europe, Central Asia and other parts of Asia due to a high rate of new HIV infections. Sub-Saharan Africa remains the most heavily affected region, accounting for 72 per cent of all new HIV infections in 2008.

* All AIDS-related figures cited are the midpoint in a range. The estimate of 3.5 million new infections, for example, is based on a range of 3.2 million-3.8 million. The complete data series of ranges and corresponding midpoints is available at mdgs.un.org

Though new infections have peaked, the number of people living with the virus is still rising, largely due to the life-sustaining impact of antiretroviral therapy. An estimated 33.4 million people were living with HIV in 2008, of whom 22.4 million are in sub-Saharan Africa.

Many young people still lack the knowledge to protect themselves against HIV

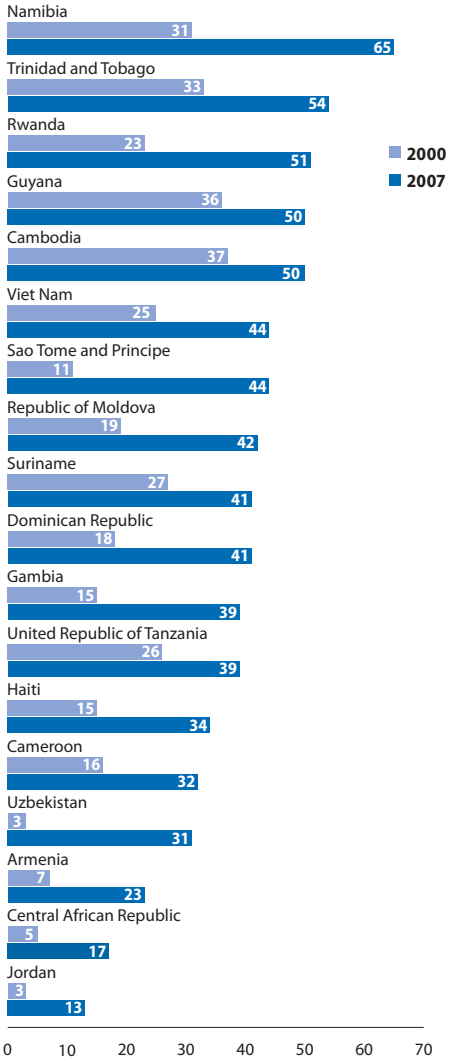
Women and men aged 15–24 with comprehensive correct knowledge of HIV in developing countries, 2003/2008 (Percentage)



Understanding how to prevent transmission of HIV is the first step to avoiding infection. This is especially important for young people (aged 15 to 24), who, in 2008, accounted for 40 per cent of new HIV infections among adults worldwide. Though some progress has been made, comprehensive and correct knowledge of HIV among young people is still unacceptably low in most countries. Less than one third of young men and less than one fifth of young women in developing countries claim such knowledge about HIV. The lowest levels (8 per cent) are found among young women in Northern Africa, according to surveys undertaken between 2003 and 2008. These levels are well below the 2010 target of 95 per cent set at the United Nations General Assembly Special Session on HIV/AIDS in 2001.

Empowering women through AIDS education is indeed possible, as a number of countries have shown

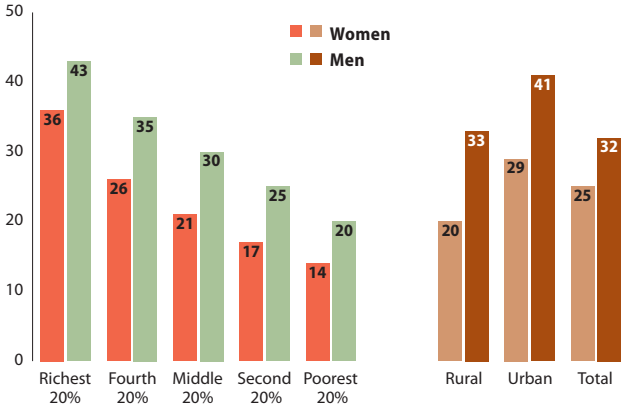
Young women aged 15-24 with comprehensive correct knowledge of HIV in selected countries, 2000 and 2007 (Percentage)



A number of countries have made impressive strides in educating their young people about HIV, despite disappointing global and regional averages. In 18 out of 49 countries with available trend data, comprehensive and correct knowledge of HIV increased by 10 percentage points or more among women aged 15 to 24; the same success was achieved among young men in 8 out of 16 countries. Between 2000 and 2008, Cambodia, Guyana, Namibia, Rwanda, and Trinidad and Tobago reported remarkable increases in knowledge about HIV prevention among young women (reaching levels of 50 per cent or more); similar progress was reported among young men in Namibia and Rwanda.

In sub-Saharan Africa, knowledge of HIV increases with wealth and among those living in urban areas

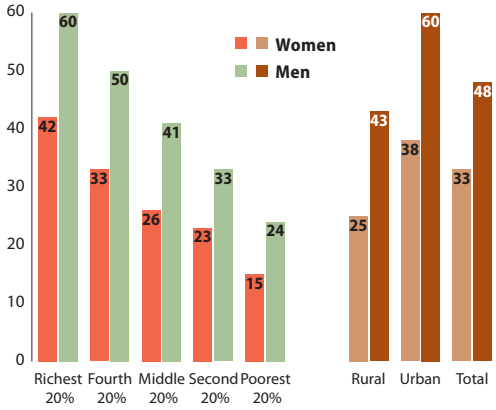
Young women and men aged 15-24 years in selected sub-Saharan African countries with comprehensive correct knowledge of HIV by sex, residence and wealth status, 2003/2008 (Percentage)



In sub-Saharan Africa, disparities in knowledge about HIV prevention among women and men aged 15 to 24 are linked to gender, household wealth and place of residence. For both men and women, the likelihood of being informed about HIV increases with the income level of one's household. Gender disparities in knowledge also diminish slightly among the rich and among those living in urban areas.

Disparities are found in condom use by women and men and among those from the richest and poorest households

Young women and men aged 15-24 years in selected sub-Saharan African countries who used a condom with the last higher -risk sexual partner by sex, residence and wealth status, 2003/2008 (Percentage)

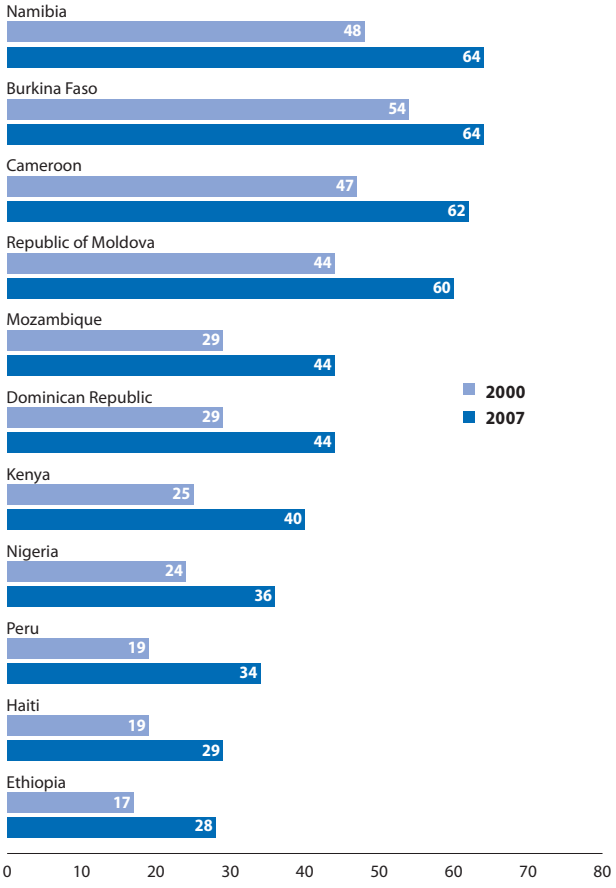


In most developing countries, the majority of young people fail to use condoms during sex, even when there is the risk of contracting HIV. On average, less than 50 per cent of young men and less than a third of young women used condoms during their last higher-risk sexual activity.

In sub-Saharan Africa, men aged 15 to 24 are far more likely to use condoms than women of the same age. For both women and men, condom use increases dramatically with wealth and among those living in urban areas. Similar disparities were observed in all countries with available data.

Condom use during high-risk sex is gaining acceptance in some countries and is one facet of effective HIV prevention

Condom use at last higher-risk sex among young women aged 15-24 in selected countries, 2000 and 2007 (Percentage)



Although the use of condoms during high-risk sex remains low overall, young people in some countries are proving that the right policies and interventions can yield results. Between 2000 and 2008, increases of 10 or more percentage points in condom use during risky sex were reported among women in 11 of the 22 countries where trends can be documented, reaching levels of 60 per cent or more in some of them. A similar increase was found among men in 11 of 17 countries with available trend data. Such progress is ultimately the result of individual action, supported by a combination of behavioural, biomedical and structural interventions and the collective efforts of government, development partners and civil society.