The blind spot of the Millennium Development Goals

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Ten years after the Millennium Summit, and only five years before the deadline to achieve the Millennium Development Goals (MDGs), progress towards MDG 5 – a 75% reduction in global maternal mortality – is most behind schedule.

Worldwide, maternal mortality rates have hardly changed since 1990[1] and they are particularly high in countries recently affected by large-scale conflict. Access to reproductive health (RH) services, including family planning and emergency obstetric care (EmOC), is critical to reducing maternal and child mortality. Skilled providers, backed up by access to EmOC, can prevent up to 74% of maternal deaths. Moreover, making family planning available and accessible can prevent a significant number of the world's maternal deaths – many of which are the result of unsafe abortion – by up to 40%.[2] Family planning also reduces child deaths,[3] as maternal death is a significant risk factor for child health, and the health of the mother is an important protective factor in child survival. UNICEF estimates that a child is between three and ten times more likely to die if his or her mother dies.[4]

Yet it is access to these life-saving RH services that are most often lacking in crisis settings. Security and logistical challenges often pose serious obstacles to ensuring RH services for conflict-affected women and girls and it is easy to assume that an increase in maternal deaths is among the inevitable health outcomes of war and conflict. But is this assumption justified? Do maternal mortality rates in conflict settings have to be as high as they are today? Service delivery capacity may actually increase above the pre-conflict baseline as a result of the arrival of humanitarian actors. In conflict-affected northern Uganda, for example, 2006 data show that more children under the age of five are treated for diarrhoea or symptoms of fever than in the country as a whole, yet at the same time both the unmet need for family planning and the unsafe abortion rate are much higher in the north than the national average.[5] Likewise, the percentage of deliveries that occur in the presence of skilled birth attendants is also far lower in the north.[6]

Mother and baby from conflict-affected eastern Congo.

Most conflict-affected countries rely heavily on international aid and humanitarian assistance for the provision of basic health services and the example of Uganda suggests that conflict does not automatically mean reduced access to health services. Why, then, are RH services not given equal attention as part of the humanitarian response?

Funding

Reliable information on aid disbursements in conflict-affected countries is key to efforts to improve aid effectiveness, yet little was known about aid disbursements for RH in conflict settings. To address this knowledge gap, researchers from the RAISE Initiative, the London School of Hygiene & Tropical Medicine and King's College London investigated disbursements of official development aid (ODA) for RH activities in 18 conflict-affected countries between 2003 and 2006.[7]

The study showed that during this period:

- of the annual average of US$20.8 billion total ODA disbursed to these countries, only $509.3 million, or 2.4%, was allocated to RH
- of this annual average of $509.3 million for RH, only 1.7% was spent on family planning activities
- a 77.9% increase in ODA for RH occurred from 2003 to 2006. This increase was largely due to a 119.4% increase of ODA disbursement for HIV/AIDS and sexually transmitted infection control. In contrast, funding for other main RH activities, including family planning and EmOC, dropped by 35.9%.

A comparison between conflict-affected countries qualifying as 'least developed countries' (LDCs)

and non-conflict-affected LDCs showed that less ODA is disbursed for RH in conflict-affected LDCs, despite generally worse RH-related indicators in these countries. In fact, an annual average of 4.4% of all ODA disbursed to sampled conflict-affected LDCs was allocated to RH activities, compared to 8.9% in sampled non-conflict-affected LDCs. This suggests that funding for RH in conflict is far from sufficient.

Policy

A review of policies and technical guidelines on RH in emergencies, adopted between 1994 and 2008 by policymakers, donors and technical agencies, complements the RAISE funding study. This review pointed to similar trends in the policy environment.[8]

Of 146 policies[9] identified that included some reference to RH, the majority of policies referred to HIV/AIDS and GBV, or a combination of both (51% in total). Only 15% referred to 'comprehensive' RH (i.e. all components of RH, including family planning, safe motherhood, GBV and HIV), and only 1% included specific reference to family planning.

In 95 technical guidelines, GBV and HIV/AIDS comprised more than half the total. One technical guideline referenced family planning in the context of HIV/AIDS, and one technical guideline on emergency contraception was identified. Only four technical guidelines mentioned EmOC.

A positive development, however, is the recent inclusion of comprehensive RH among the standards and indicators of the 2009 Health Cluster Guide, a document intended to guide the humanitarian Health Cluster response at national levels.[10]

Conclusion

Overall, the combined review of funding and policies suggests that, to date, there has been inadequate attention to the RH needs of conflict-affected populations and, in particular, a lack of attention to activities directly related to family planning and EmOC. Moreover, it confirms the need for better integration of RH services into emergency health response.

Access to RH services is at the heart of reducing maternal mortality and thus to achieving MDG5 on maternal health. Furthermore, RH is recognised as underpinning all other MDGs – the health MDGs in particular.[11] Yet we find that substantive action to ensure access to RH services is most lacking where the needs are greatest: that is, in crisis settings.

Despite our collective knowledge of effective interventions, the humanitarian community has yet to recognise and support comprehensive RH as a priority and a life-saving intervention. At the same time, the RH needs of crisis-affected populations have received little attention from the development community in their efforts to achieve MDG5.

Despite increasing recognition that developmental and humanitarian challenges are interrelated and interdependent and should be considered simultaneously throughout the recovery process, humanitarian and developmental needs are still too often kept compartmentalised rather than being addressed in a coordinated, integrated manner.

RH needs do not stop or start at the doorstep of a crisis. They present an ongoing challenge and are therefore the responsibility of both the humanitarian and development world. The forthcoming MDG Summit in September 2010 provides a unique opportunity for the international community to acknowledge this reality and to make a real difference by focusing on the RH needs of crisis-affected populations as integral to attaining MDG5 on maternal health.

Recommendations

Humanitarian relief agencies should include the goal of universal access to RH as an integral aspect of its own goals and commitments by its inclusion in policies, needs assessments, action plans and funding, and also through increased investment in supplies, training and capacity building to ensure the provision of life-saving RH services on the ground.

Development and humanitarian agencies should call upon governments and policymakers to recognise and address the RH needs of women and girls in crisis settings as a necessary component of achieving MDG5.

Development and humanitarian donors should do more to recognise the complexity of crisis situations by ensuring flexible and sustained funding flows through a mix of streams, from various stages of relief through development.

Increased collaboration between the humanitarian and the development communities on MDG5 will be critical both to helping to move the MDG agenda forward and to ensuring the reproductive rights of women and girls everywhere, including those who have been displaced by conflict or natural disaster.

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3. UNFPA 'Women Fall Victims as Family Planning Resources Dwindle', 10 April 2007. http://www.unfpa.org/public/News/pid/61

4. UNICEF *State of the World's Children 2009*. New York. http://www.unicef.org/sowc09

5. Uganda Demographic and Health Survey 2006 http://www.measuredhs.com/pubs/pdf/FR194/FR194.pdf

6. Singh S et al 'Unintended Pregnancy and Induced Abortion in Uganda: Causes and Consequences', New York: Guttmacher Institute. 2006. http://www.guttmacher.org/pubs/2006/11/27/UgandaUPIA.pdf

7. The analysis was published in the online medical journal *PLoS Medicine*. http://tinyurl.com/PLoSODA2009

8. RAISE. 'Reproductive health in Emergencies: A review of the Policy Environment for Reproductive Health' http://www.raiseinitiative.org/library/factsheets.php

9. Policies and guidelines adopted between 1994 and 2008 were examined, including those adopted by the US, Canada, nine EU member states, Norway, Australia and New Zealand. In addition, the policies of three EU institutions, the African Union, nine UN agencies, the World Bank, the Global Fund for AIDS, Tuberculosis and Malaria, and 19 private foundations were also reviewed.

10. World Health Organization (2009), *Health Cluster Guide* (Provisional version). http://www.who.int/hac/network/global_health_cluster/guide/en/

11. *The Millennium Development Goals Report 2008* http://tinyurl.com/MDG2008En