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The Unfinished Business of MDG 5 on Maternal Health and the Post-2015 Development Agenda

By: Rebecca Oas, Ph.D. and Stefano Gennarini, J.D.

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Mothers "die frequently in unclean conditions, alone, in terror and agony without trained assistants, or access to proper life saving care," says Dr. Robert Walley of MaterCare International. Mothers who survive childbirth may suffer postpartum hemorrhaging, infection or diseases such as malaria or AIDS.

The majority of the 350,000 maternal deaths each year occur in the developing world in the last three months of pregnancy, during childbirth or shortly after childbirth.

MaterCare International provides training for local doctors and midwives in safe delivery techniques, and programs for emergency transport systems to take mothers to the nearest hospital. The charity built and equips an obstetric fistula hospital in Ghana.

"While governments and private agencies spend billions of dollars on reproductive health programs, only a small fraction is spent on life-saving emergency obstetrical care," he told CNA, a news agency.

Funding for reproductive health in the developing world is often focused on eliminating motherhood rather than making motherhood safe.

Dr. Walley says the best solution is to help mothers during pregnancy, delivery and recovery.[1]

Introduction

At this pivotal time, as countries decide the future of the world's development priorities and how billions of dollars will be spent, the fate of mothers lies in their hands.

1 http://www.catholicnewsagency.com/news/global-contraception-push-aims-to-eliminate-motherhood/ (Accessed June 2014)

"Investments in population policies have not done enough to make pregnancy and childbirth safe for mothers and their children over the past twenty years."

Since 1990, deaths from pregnancy and childbirth have declined 22%. This limited progress is troubling. Countries had committed to reducing maternal deaths by 75% by 2015. That goal, even if it might have seemed ambitious, is nowhere near being achieved.

Policies and priorities to achieve Millennium Development Goal 5 (MDG5)—to improve maternal health—have not been enough. To help mothers, we must pursue new ways to re-energize and build on MDG5. The post-2015 development agenda should make maternal health a distinct priority, but a new paradigm is needed.

Investments in population policies have not done enough to make pregnancy and childbirth safe for mothers and their children over the past twenty years. It would be duplicative and ineffective to repeat or reinforce policies from the Programme of Action of the 1994 International Conference on Population and Development (ICPD) in the post-2015 development agenda. ICPD policies emphasized power inequalities, fertility reduction, and particular norms, but did not focus like a laser on the quantifiable and essential goal of helping mothers survive childbirth.

Countries have already committed to implementing the ICPD beyond 2014 and already have a steady flow of resources for ICPD policies through development assistance and private philanthropy. Moreover, ICPD polices have already achieved remarkable success on their own terms. Even in Africa 98% of married women have access to modern methods of contraception. Recent claims that 220 million women in the developing world don't have access to contraception are, at best, misleading. The reasons for this are examined in the following pages.

" Pregnant mothers have received the short end of the stick, when it comes to ICPD policies."

On the other hand, pregnant mothers have received the short end of the stick, when it comes to ICPD policies. That is why the post-2015 development agenda should formulate a new framework for improving maternal health that builds on MDG5.

Insufficient Improvement in Maternal Health

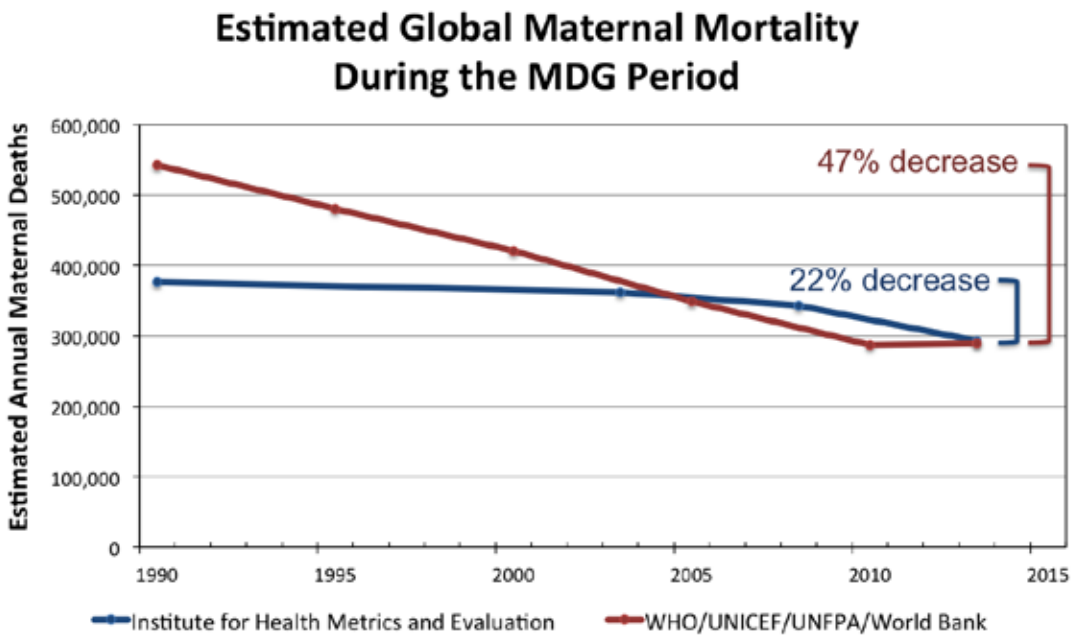
Until recently, the World Health Organization (WHO),[2] [3] and the United Nations Population Fund (UNFPA)[4] reported that maternal mortality had been cut in half since 1990. But more recent research from the respected Institute for Health Metrics and Evaluation (IHME) shows that maternal mortality and morbidity has only declined by 22% since 1990. [5]

2 World Health Organization news release: "United Nations agencies report steady progress in saving mothers' lives" May 6, 2014. http://www.who.int/mediacentre/news/releases/2014/maternal-mortality/en/ (accessed June 2014)

3 World Health Organization. Maternal Mortality Fact Sheet. 2014. http://apps.who.int/iris/bitstream/10665/112318/1/WHO_RHR_14.06_eng.pdf (accessed June 2014)

4 UNFPA press release: "Maternal Deaths Halved in 20 Years, but Faster Progress Needed." May 16, 2012 http://www.unfpa.org/public/home/news/pid/10730 (accessed June 2014)

5 Kassebaum, N. et al. Global, regional, and national levels and causes of maternal mortality during 1990—2013: a systematic analysis for the Global Burden of Disease Study 2013. *The Lancet*. May 2,



In 2010, WHO was compelled to revise its estimates for maternal deaths after IHME showed the accurate numbers were 34% lower than WHO's estimates. Rather than 500,000 each year as WHO claimed, the actual numbers are more likely 350,000.[6]

Given WHO's revisions of its figures to hew more closely to IHME's estimates, there is good reason to take the IHME data seriously.

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The policy implications of IHME estimates cannot be downplayed. States, international organizations, private philanthropy and NGOs need to take stock in order to create a post-2015 development framework that will find effective policies to improve maternal health and reduce maternal deaths, and make pregnancy and childbearing safer for mothers and their children.

Sharpening Focus on the Right Interventions

Recent analysis of maternal health programs currently in place found they are not effective, and the medicines and interventions that are now getting attention are "almost useless."[7]

2014. WHO still claims that half a million maternal deaths occurred in 1990, the baseline year against which current years are compared. WHO maintains there were 523,000 maternal deaths in 1990, compared to the IHME estimate of 376,000 – thus claiming a larger decrease in maternal deaths than in the intervening years.

6 Paulson, Tom. "World Health Organization Eats Crow, Cuts Maternal Death Numbers." Humanosphere blog, September 15, 2010. http://www.humanosphere.org/global-health/2010/09/world-health-organization-eats-crow-cuts-maternal-death-numbers/ (accessed June 2014)

7 Maria Cheng, The Associated Press, "Billions spent on maternal health programs to no avail: UN", June 29, 2014. http://www.ctvnews.ca/health/billions-spent-on-maternal-health-programs-to-no-avail-un-1.1891552#ixzz36nDGy7Xr

MDG5 was a good beginning. It helped focus the world's attention on maternal health, and learn from experiences. We now know what it takes to make pregnancy and childbirth safe for mothers better than ever before.

A landmark study from Chile clarified the measures that reduce maternal mortality. During a 50-year period from 1957-2007, the Chilean maternal mortality rate decreased 93.8% to one of the lowest in the world.[8] What mattered most, the study found, were improvements in women's education and in maternal health care.

Universally effective interventions are attainable if resources are devoted to them:[9]

Measures to Improve Maternal Health
1. Higher education levels for women
2. Skilled birth attendants
3. Prenatal and antenatal care
4. Access to water and sanitation
5. Emergency obstetric care

"Recent analysis of maternal health programs currently in place found they are not effective, and the medicines and interventions that are now getting attention are 'almost useless.'"

These basic measures are signposts to guide countries in designing maternal health policies. And they are best achieved in the context of strengthened health infrastructures that also benefit everyone in the community.

Different Interventions at Different Points Along the Maternity Timeline

The IHME's recent study of the causes and timing of maternal deaths reported, "In 2013, most deaths occurred intrapartum or postpartum." That is, during or after childbirth.[10]

This finding underscores the importance of skilled birth attendants and access to emergency obstetric care during this critical window of time. With regard to the relative predictability of the timing of labor, maternal health care is distinct from many other areas of medical interventions, which must be administered in response to sudden crises with little or no advance warning.

The interventions needed by pregnant women prior to the onset of labor may be effectively provided by sources that fall outside what is typically defined as maternal health.

8 Koch E, Thorp J, Bravo M, Gatica S, Romero CX, et al., "Women's Education Level, Maternal Health Facilities, Abortion Legislation and Maternal Deaths: A Natural Experiment in Chile from 1957 to 2007," (2012) PLoS ONE 7(5): e36613.
Other specific measures may have significant impacts in different regions (e.g. better roads in areas where reaching health facilities is difficult, access to anti-malarial drugs where they are needed, and antiretroviral drugs to prevent mother-to-child HIV transmission).

9 http://www.unicef.org/mdg/maternal.html (accessed June 2014)

10 Kassebaum, N. et al. Global, regional, and national levels and causes of maternal mortality during 1990—2013: a systematic analysis for the Global Burden of Disease Study 2013. *The Lancet*. May 2, 2014 (see footnote 4)

Nutritional iron deficiency, for example, is a common problem among women of childbearing age in the developing world. A 2013 study from WHO found severe anemia was the single most common potentially life-threatening disorder among women who had suffered a severe maternal outcome (that is, a maternal death or "near miss" that could have proved fatal.) The study of women from Africa, Asia, Latin America, and the Middle East, found that 1.6% of women of childbearing age had severe anemia. Women with severe anemia made up 34.4% of those who experienced a fatal or near-fatal maternal outcome.[11]

Nutrition is at the center of the First Thousand Days initiative, which focuses on the critical time frame from conception to the child's second birthday. This program aims to impact the post-2015 development agenda, but falls outside the range of interventions that are specifically targeted at maternal health.[12]

While the majority of maternal deaths occur during or after labor, it is important to remember that some women also die during earlier stages of pregnancy due to untreated ectopic pregnancies, hemorrhaging or sepsis related to a miscarriage, or complications resulting from induced abortion.

What is Needed: A Different Paradigm from the ICPD Programme of Action

"Research shows the sexual and reproductive health community devoted to implementing ICPD does not prioritize maternal health."

Like the MDGs, the post-2015 development agenda should emphasize improving maternal health as a distinct priority. To be effective, it must identify gaps in previous agreements and help countries address them. Repeating or reinforcing the same policies from the ICPD Programme of Action, which have not been effective at improving maternal health and that receive abundant attention from governments, will not produce dramatic changes in maternal health. A new paradigm is needed.

Research shows the sexual and reproductive health community devoted to implementing ICPD does not prioritize maternal health. They see maternal health only as one component in a broader agenda about power inequalities, fertility reduction, sexual autonomy, abortion, reproductive rights, and other contentious issues.[13]

The ICPD approach focuses less on saving the lives of women in pregnancy and childbirth than providing women with a broad range of reproductive commodities, for which there may not be an urgent need (as discussed in section below on "unmet need"). This approach diverts attention to contentious issues instead of focusing on improving health for mothers and their children.
The focus on maternal health in the Millennium Development Goals is a good

11 Souza, JP et al. Moving beyond essential interventions for reduction of maternal mortality (the WHO Multicountry Survey on Maternal and Newborn Health): a cross-sectional study *The Lancet*, May 18 2013 (Vol. 381, Issue 9879, Pages 1747-1755)
12 http://www.thousanddays.org/nutrition-post-2015-development (accessed June 2014)
13 Hammonds R, Ooms G, "The emergence of a global right to health norm - the unresolved case of universal access to quality emergency obstetric care," BMC International Health and Human Rights 02/2014; 14(1):4.

beginning to making pregnancy and childbirth safe for mothers and their children. Yet progress has been held back by controversy over the later surreptitious inclusion of reproductive health as a target of MDG5.[14]

Reproductive health was not originally part of the MDG framework. The term goes beyond maternal health, thus threatening to water down the focus and disperse attention and funding. It was tacked onto MDG5 after the MDGs were adopted, and with much controversy.[15]

"Women (and men and children) of the developing world have unmet needs for basic items for survival and to escape poverty and early deaths."

Unmet Needs

Including ICPD policies as a focus in the post-2015 development agenda would be duplicative and can divert resources from where they are most needed.

Women (and men and children) of the developing world have unmet needs for basic items for survival and to escape poverty and early deaths. For example, the United Nations World Food Programme reports that nearly a quarter of the people in sub-Saharan Africa suffer from hunger.[16] UNESCO reports that 774 million adults, mostly in sub-Saharan Africa, and of whom 64% are women, lack basic reading and writing skills.[17] These inequalities compound the dangers that mothers face in pregnancy and childbirth.

"Yet UNFPA and groups that receive funding for ICPD policies still ask for more and want countries to increase funding to cover a supposed 'unmet need' for family planning of 220 million women."

Since adoption in 1994, countries have invested heavily in the ICPD Programme of Action. According to the Secretary General, $60 billion is spent each year to implement the ICPD.[18] UNFPA, which manages the implementation of the ICPD program, saw its contributions and income more than triple from $309.3 million in 1998 to $976.8 million in 2013.

Yet UNFPA and groups that receive funding for ICPD policies still ask for more and want countries to increase funding to cover a supposed "unmet need" for family planning of 220 million women.[19]
The Guttmacher Institute analyzed the reasons why married women in developing countries do not use modern contraceptives. They found that only approximately 4 - 8% of the supposed "unmet need" for family planning is due to cost or lack of access.

14 Gennarini S. and Oas R. Securing a Better Future for Mothers in the Post-2015 Development Agenda: Evaluating the ICPD Operational Review. International Organizations Research Group Briefing Paper Number 11. March 18, 2014.

15 Susan Yoshihara, Lost in Translation: The Failure of the International Reproductive Rights Norm, Ave Maria Law Review, Volume 11, no. 2 (Spring 2013).

16 http://www.wfp.org/hunger/stats (accessed June 2014)

17 UNESCO Institute for Statistics fact sheet: "Adult and Youth Literacy" September 2012, No. 20.

18 Flow of financial resources for assisting in the implementation of the Programme of Action of the International Conference on Population and Development (UN Document E/CN.9/2013/5), Report of the Secretary-General, 13 February 2013.

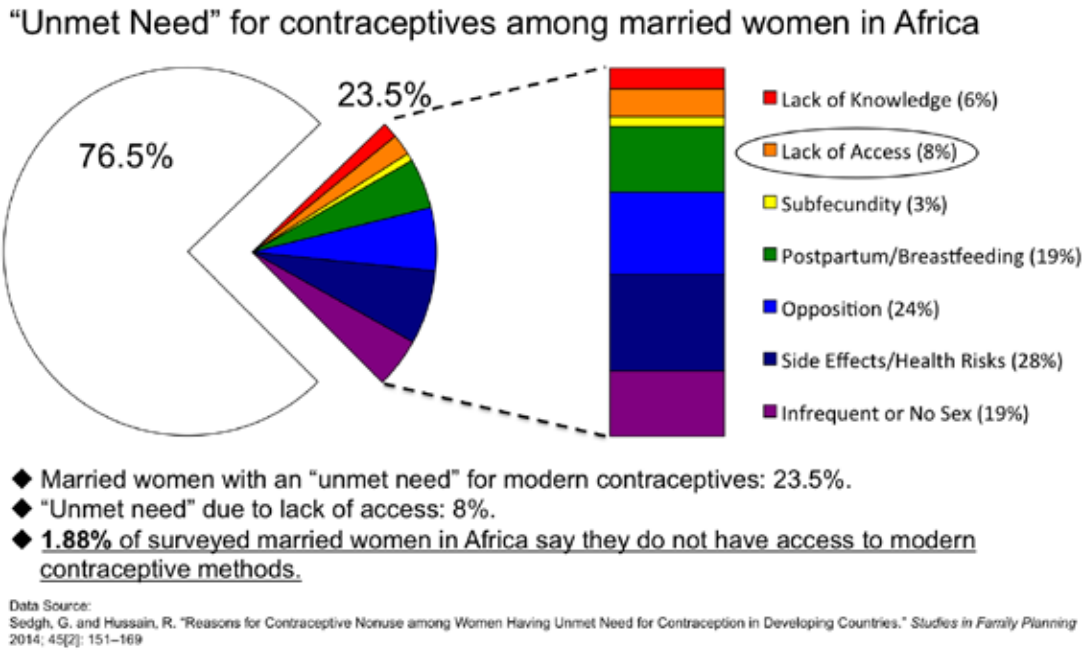
19 UNFPA's "State of World Population 2012" reports, "Recent statistics show that 867 million women of childbearing age in developing countries have a need for modern contraceptives. Of that total, 645 million have access to them. But a staggering 222 million still do not." State of World Population 2012: By Choice, Not By Chance - Family Planning, Human Rights and Development. http://www.unfpa.org/public/home/publications/pid/12511 (accessed June 2014)

Most of the women did not use contraception for other reasons, including concerns about side effects and health risks.[20]

In Africa, 98% of married women have access to modern methods of family planning. The percentage of total surveyed women in the African region with lack of access to modern contraceptives is less than 2%.[21]

"Family planning groups say they need resources to 'increase demand' among women with access but who choose not to use contraception—in other words, to convince women to use contraceptives."

Family planning groups say they need resources to "increase demand" among women with access but who choose not to use contraception—in other words, to convince women to use contraceptives.[22]



If contraceptive availability is over 98% in the region with the highest reported "unmet need," progress on MDG 5B, which calls for "universal access to reproductive health" and uses "unmet need" as one of its indicators is almost nearly complete. Even so, experts have challenged the concept of "unmet need" for contraceptives as ineffective for a variety of reasons.[23]

Focusing development efforts on education, nutrition and health care infrastructure benefits everyone. Children of women with higher levels of education are more likely

20 Sedgh, G. and Hussain, R. (2014), Reasons for Contraceptive Nonuse among Women Having Unmet Need for Contraception in Developing Countries. Studies in Family Planning, 45: 151–169.
21 Statistics for Asia and Latin America and the Caribbean can be found at this link http://www.turtlebayandbeyond.org/2014/family-planning/unmet-need-2-0-not-about-access-after-all/ (accessed July 2014).
22 McCleary-Sills J, McGonagle A, Malhotra A. "Women's Demand for Reproductive Control: Understanding and Addressing Gender Barriers." International Center for Research on Women, 2012. http://www.icrw.org/files/publications/Womens-demand-for-reproductive-control.pdf (Accessed July 2014)
23 Pritchett, L. Desired Fertility and the Impact of Population Policies Population and Development Review, Vol. 20, No. 1 (Mar., 1994), pp. 1-55

to escape malnutrition and deadly diseases, and survive to adulthood.

Resources Need to Flow to Interventions That Make Pregnancy and Childbirth Safe for Mothers

Every year thousands of women lose their lives because resources that could improve maternal health are spent elsewhere.

Only a fraction of the $60 billion spent each year to implement the ICPD Programme of Action is invested in improving maternal health. According to the U.N. Secretary General, 20% of all population assistance is spent on reproductive health. But maternal health is only one component of reproductive health in ICPD policies.[24]

"The amount invested in maternal health has not been sufficient to save mothers from dying in pregnancy and childbirth."

The amount invested in maternal health has not been sufficient to save mothers from dying in pregnancy and childbirth. A special focus on maternal health in the post-2015 development agenda will help form policies designed to prevent maternal deaths, and channel resources for that purpose.

Policies with a net effect of reducing fertility receive disproportionate attention, even though they have only an indirect impact on maternal health. Most recently, the Melinda Gates inspired Family Planning Summit in 2012 collected $4.6 billion to initiate the creation of new supplies, distribution systems, and permanent funding for advocacy groups to agitate for more family planning.[25]

Contraception Does Not Make Pregnancy and Childbirth Safe for Mothers

Contraception does not make childbirth safer for mothers or their children. Reducing unintended pregnancies does not address the inequalities in maternal health care that make it unsafe for women to give birth in the first place, even if it might theoretically reduce overall maternal deaths.

"Contraception does not make childbirth safer for mothers or their children."

Family planning should not overshadow the needs of women in pregnancy and childbirth. It does not improve health care for pregnant mothers and their children, nor improve the conditions in which mothers live and give birth. A special focus on maternal health is important to ensure pregnant mothers and their children get the attention and resources necessary for a healthy start in life.

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24 Flow of financial resources for assisting in the implementation of the Programme of Action of the International Conference on Population and Development (UN Document E/CN.9/2013/5), Report of the Secretary-General, 13 February 2013.

25 Cohen, SA. "London Summit Puts Family Planning Back on the Agenda, Offers New Lease on Life for Millions of Women and Girls." Guttmacher Policy Review Summer 2012, Volume 15, Number 3 http://www.guttmacher.org/pubs/gpr/15/3/gpr150320.html (Accessed July 2014)

Reproductive Rights Does Not Fit in a Results-Oriented Development Agenda

The concept of reproductive rights is about changing norms, not about achieving results and objectives, and should not be a part of the post-2015 development agenda. The controversy surrounding reproductive rights may generate discomfort and distrust for programs.

"To be effective, the goal of equality for women needs to prioritize concrete and measurable improvements in the lives of women."

To be effective, the goal of equality for women needs to prioritize concrete and measurable improvements in the lives of women, and should not get bogged down into normative changes best left to the sovereign prerogative of countries' legislative processes. The confusion between normative changes (reproductive rights) and an outcome and results oriented approach (improve maternal health) should be avoided in the post-2015 development agenda.

Goals and targets should help achieve results and objectives that are measurable in terms of outcomes for women in countries and regions. Diverting attention away from results and objectives to contentious changes in law and policy about reproductive rights would be harmful to other more measurable goals and targets about improving women's lives. It could also backfire by interfering with the legitimate prerogative of sovereign states to legislate as they see fit in matters pertaining to reproduction and sexual morals.

U.N. consensus on what constitutes "reproductive rights" is fragmented, and securing appropriate targets and indicators would be intrusive and controversial.[26] It is a term fraught with controversy because of its close association with abortion, and was excluded for that precise reason from the Rio + 20 outcome, The Future We Want. This tension about normative changes within national legislation should be kept out of the post-2015 development agenda, in favor of a pragmatic approach that looks at measurable outcomes and results for women and men.

Introducing the term in the post-2015 framework jeopardizes consensus by drawing countries into a debate about sexual norms and legal change, instead of focusing on improving the lives of women around the world.

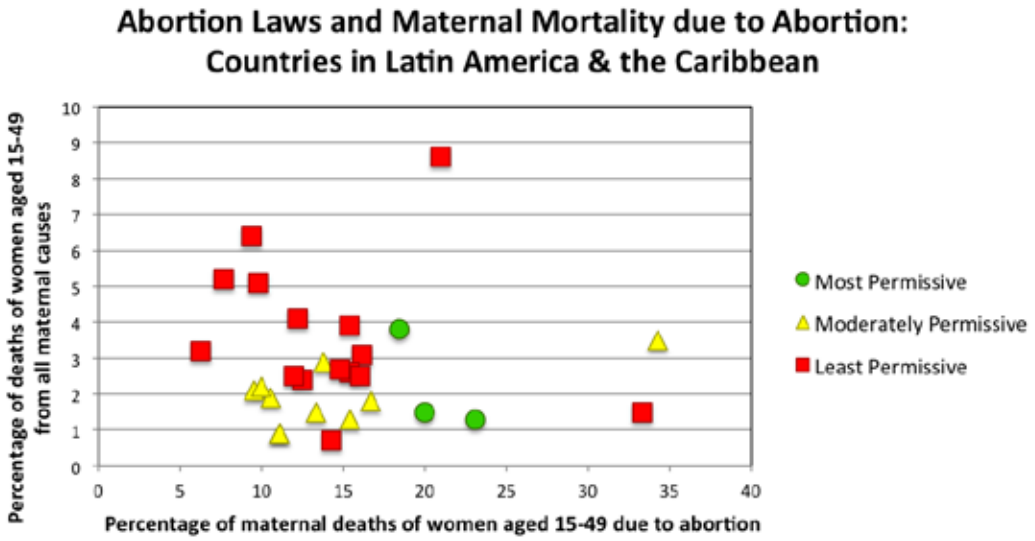
Legalizing abortion does not improve maternal health

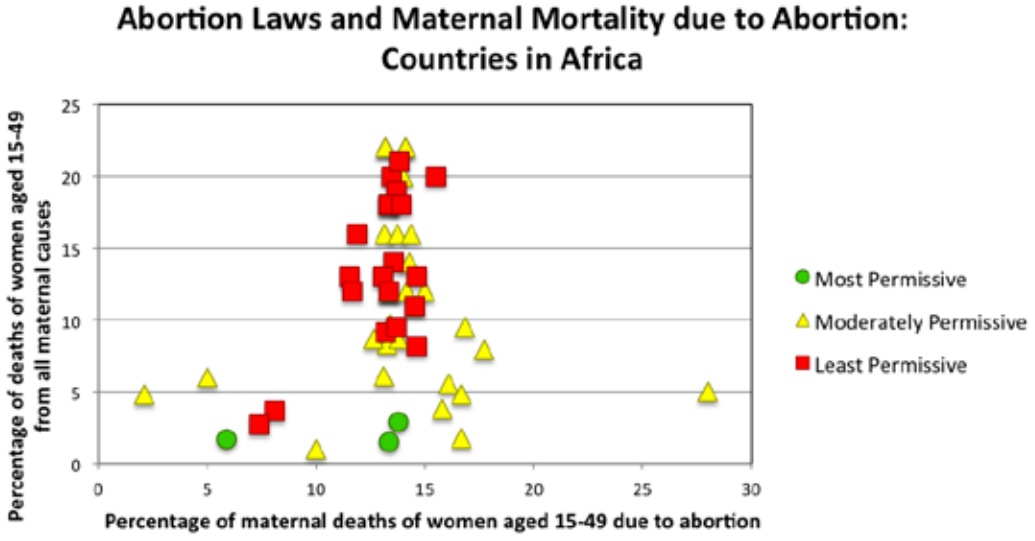
Advocates for reproductive rights often claim that abortion should be made legal as a maternal health issue. But making abortion legal or more widely accessible does not make pregnancy and childbirth safer for mothers, nor result in a reduction in the proportion of maternal mortality due to abortion.

26 The U.N. consensus on abortion in the ICPD Programme of Action is that abortion is a part of sexual and reproductive health. At the same time, it recognizes the sovereign prerogative of U.N. member states to legislate as they see fit, with regard to abortion. *See* Chapter VII and VIII of the Programme of Action of the international Conference on Population and Development (UN Document A/CONF.171/13), Cairo 1994.

If making abortion legal and more widely accessible were key measures to improving maternal health, one would expect to see a lower relative percentage of maternal mortality attributable to abortion in countries with more liberal abortion laws. No such evidence exists.

This can be easily seen by looking at abortion-related mortality as a function of maternal mortality as a whole. Evidence actually shows that countries can reduce abortion-related deaths by improving maternal health care overall, regardless of their abortion laws.[27]





Source for maternal health statistics: Global Burden of Disease Study 2010
Source for abortion law classifications: The World's Abortion Laws map 2014, Center for Reproductive Rights

27 Koch E, Thorp J, Bravo M, Gatica S, Romero CX, et al., "Women's Education Level, Maternal Health Facilities, Abortion Legislation and Maternal Deaths: A Natural Experiment in Chile from 1957 to 2007," (2012) PLoS ONE 7(5): e36613. (see footnote 7)

Latin America and Africa offer the most legal protections for unborn children, but also have greater levels of poverty and infrastructure. The risk of maternal mortality has improved dramatically in Latin America since the 1990s, yet remains stubbornly high in sub-Saharan Africa.

In 2011, WHO noted that the risk of abortion mortality in Latin America has become "increasingly similar" to that of Europe: "[A]lthough induced abortion is legally highly restricted in most countries of the region, the presence of a relatively good infrastructure for health services and an increasing reliance on medical abortion has kept the mortality relatively low in Latin America, and the unsafe abortion case fatality rate is just about equal to that in Europe."[28]

"The post-2015 development agenda should focus on outcomes and results, instead of normative changes."

In Africa overall, which posts the highest rates of maternal mortality in the world, as maternal health improves deaths attributable to abortion decrease proportionally with all other causes of maternal death.

The experiences of Latin America and Africa implies clearly that the reduction in maternal deaths attributable to abortion have more to do with better and more accessible health care, particularly emergency obstetric care, than the legal framework of abortion.

This underscores the importance of improving healthcare infrastructure, which will reduce maternal mortality from all causes, as well as other preventable causes of death and injury affecting all women, men, and children. It also shows why the post-2015 development agenda should focus on outcomes and results, instead of normative changes.

Deaths from Abortion Falling Faster than Other Causes of Maternal Death

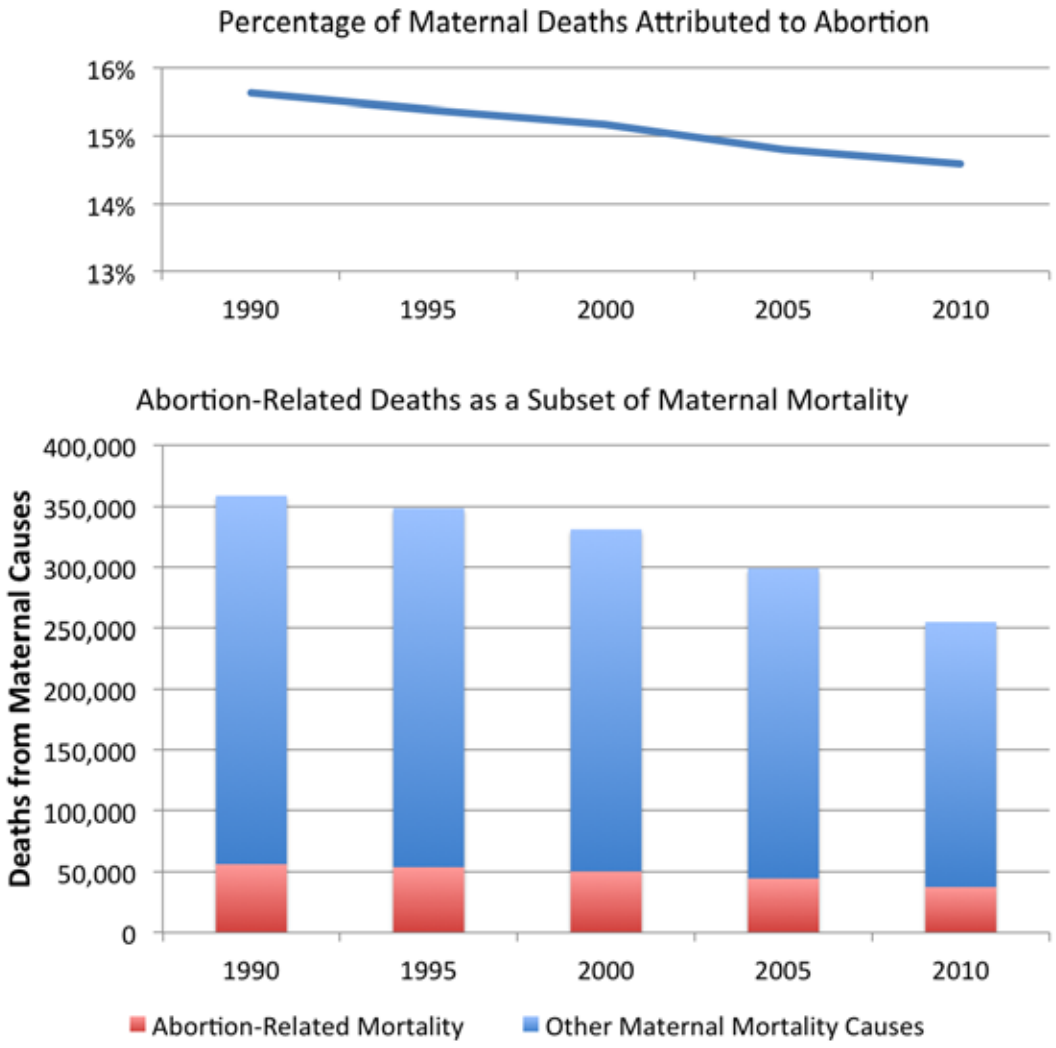
Abortion has received disproportionate focus by some sexual and reproductive health advocacy groups, many of which propose legal rather than medical interventions to solve the problem of abortion-related mortality.

Fueling this tendency, some advocates for legalizing abortion worldwide, including former UNFPA head Nafis Sadik, have recently claimed that no progress has been made in reducing abortion-related deaths as a subset of maternal mortality.[29],[30] This claim is grossly misleading.

Data from IHME show that women's deaths from maternal causes including abortion have declined steadily, although slowly, since 1990. Deaths attributed to abortion have declined proportionally, and the relative percentage of total maternal

28 Åhman E, and Shah, IH. New estimates and trends regarding unsafe abortion mortality. International Journal of Gynecology & Obstetrics. November 2011 (Vol. 115, Issue 2, Pages 121-126.)
29 UNFPA Press Release: "Reproductive Rights Are Crucial for Development, Asia-Pacific Meeting Reaffirms." January 22, 2014. http://www.unfpa.org/public/home/news/pid/16170 (accessed July 2014)
30 http://america.aljazeera.com/opinions/2014/4/abortion-stigma-globalmaternalhealthfundingusaid.html (accessed July 2014)

deaths attributed to abortion has declined modestly as well during that time period.[31]



Source data: Institute for Health Metrics and Evaluation (IHME). GBD Cause Patterns. Seattle, WA: IHME, University of Washington, 2013. Available from http://vizhub.healthdata.org/gbd-cause-patterns/.

In fact, the IHME estimates for abortion as a subset of maternal mortality are higher than those cited elsewhere. A recent report from WHO attributes only 8% of maternal deaths from 2003-2009 to abortion-related causes,[32] down from the 13% figure they cited in 2005.[33] If accurate, this would reflect a 40% decrease in the percentage of maternal deaths due to abortion, which is the largest reduction associated with any specific cause.

31 Institute for Health Metrics and Evaluation (IHME). GBD Cause Patterns. Seattle, WA: IHME, University of Washington, 2013. Available from http://vizhub.healthdata.org/gbd-cause-patterns/. (Accessed June 2014)

32 Say L, Chou D, Gemmill A, Tunçalp Ö, Moller AB, Daniels J, Gülmezoglu AM, Marleen Temmerman M, Alkema L. Global causes of maternal death: a WHO systematic analysis. The Lancet Global Health June 1, 2014 (Vol. 2, Issue 6, Pages e323-e333)

33 The world health report 2005 – Make every mother and child count. Geneva, World Health Organization, 2005 http://www.who.int/whr/2005/en (accessed June 2014)

"If the new WHO numbers are reliable, then not only have abortion-related deaths decreased proportionally with other causes of maternal mortality, they've actually outpaced other causes with very few substantive changes in laws."

The reported decline could be even higher if you take into account the methodology behind the sorting into categories. In 2005, WHO had a separate category for "unsafe abortion," which required that the fatal abortion be "performed by people lacking the necessary skills or in an environment lacking the minimal medical standards, or both." By contrast, the "abortion" category in the 2003-2009 review dropped the "unsafe" qualifier for induced abortion and also included deaths due to ectopic pregnancy and spontaneous abortion (miscarriage).

If the new WHO numbers are reliable, then not only have abortion-related deaths decreased proportionally with other causes of maternal mortality, they've actually outpaced other causes with very few substantive changes in laws.

Policy Recommendations

1. U.N. member states should focus on improving maternal health in the post-2015 development agenda. Development and health policies so far have only reduced maternal deaths 22% since 1990. Concrete measures that improve maternal health are well known, and include (1) Higher education levels for women, (2) Skilled birth attendants, (3) Prenatal and antenatal care, (4) Access to water and sanitation, (5) Emergency obstetric care.

2. It would be duplicative and ineffective for the post-2015 development agenda to simply recommit countries to already existing agreements like the ICPD Programme of Action. Despite a remarkable flow of resources to ICPD policies over the past two decades, their implementation has not improved maternal health anywhere near the target reduction of maternal deaths by 75% by 2015. ICPD policies divert resources away from maternal health to fertility reduction measures and contentious social policies.

3. The notion of reproductive rights should not be included in the post-2015 development agenda. The term "reproductive rights" refers to changing norms, not concrete measurable outcomes or results. The post-2015 development agenda must be about outcomes and results. Including the notion of reproductive rights in the post-2015 development agenda diverts attention away from policies that improve the concrete conditions for women and men to politically divisive debates about normative change in national legislation that are best left to sovereign states.

C-FAM