EUROPE

Fact sheet 08/07
Belgrade, Copenhagen, 17 September 2007

Disparities in progress towards the Millennium Development Goals on reducing child and maternal mortality

All the Millennium Development Goals (MDGs) are relevant to the health and welfare of mothers and children, but MDGs 4 (reducing child mortality by two thirds) and 5 (reducing maternal mortality by three quarters) are specifically so.

Despite substantial progress in recent decades, the WHO European Region still shows unacceptable disparities in maternal and child health both between and within countries. In the country with the highest mortality in children under 5 years of age, the rate is 40 times that in the country with the lowest rate. A child born in the Commonwealth of Independent States (CIS) is three times as likely to die before the age of 5 as a child born in the European Union (EU). The maternal mortality ratio in the central Asian republics remains at least double the average for the Region as a whole, and, although disparities between the EU countries, the Nordic countries and other groups have narrowed in recent years, large differences remain.

Differences between countries are only part of the story; there can be staggering imbalances in mortality rates within a country, too. In the European Region today, some subgroups and districts show mortality rates for mothers and babies that are just as serious as those in sub-Saharan Africa or southern Asia. Almost universally, rural populations have higher mortality than their urban counterparts; rates vary widely by ethnicity and wealth status, and remote areas bear a disproportionate burden of deaths.

For example, according to demographic and health survey data from 2000, 18% of women in Azerbaijan with incomplete secondary education were not assisted by a skilled birth attendant during childbirth, as opposed to only 1% of women with postsecondary education.

In the United Kingdom, although maternal mortality levels were low, women from black African ethnic groups were seven times more likely to die than white women. In urban areas, the risk of maternal and perinatal death often differed significantly between women in poorer areas and those in wealthy suburbs. Recently arrived migrants, refugees and asylum seekers also had less access to care and sometimes concealed their pregnancies from the authorities, including the health services.

Similarly, lower social groups in England and Wales had infant mortality rates considerably higher than the national averages, and the gap was increasing. For example, in 2002–2004, the overall infant mortality rate was 4.9 per 1000 live births, while the rate for those in the routine and manual occupation group was 5.9. Infant mortality had declined for all socioeconomic groups, but the rate of decline was slower for the routine and manual occupation group. The mortality gap between this group and the general population was 13% in 1997, but rose to 19% in 2004. Further, in England and Wales, the infant mortality rate is 10.2 per 1000 live births if the mothers are of Pakistani origin. This is twice the average rate for the general population and has led to the setting of national targets to reduce the gap in infant mortality rates in the United Kingdom.

In 1999, the officially reported infant mortality rate in Romania was 18.58 per 1000 live births, but the rates for different ethnic groups were: 27.1 per 1000 for ethnic Romanians, 19.8 for ethnic Hungarians and 72.8 for the Roma population. Similar inequities continue to exist in many eastern countries in the European Region, and the gap shows no signs of narrowing.

Current and future WHO initiatives for maternal and child health

Learning from experience, the WHO Regional Office for Europe has developed several strategies for maternal and child health, to help Member States to create their own national policies and plans and set priorities in their health systems. These include:

- the European strategy for child and adolescent health and development adopted in 2005, and related tools;
- the European and global reproductive health strategies adopted in 2001 and 2004, respectively;
- the adaptation to the European Region of the global gender strategy endorsed by the Sixtieth World Health Assembly in 2007;
- a draft strategy entitled *Improving maternal and perinatal health: the European strategic approach for making pregnancy safer*;
- the European strategy on measles and rubella elimination adopted in 2005;
- the second European action plan for food and nutrition policy, with its emphasis on breastfeeding, proposed for adoption by the WHO Regional Committee for Europe in 2007; and
- the Declaration of the Fourth Ministerial Conference on Environment and Health in 2004.

These are meant to be implemented within the policy frameworks of national health systems. The challenge for Member States is to translate these strategic frameworks into practical action plans at various levels.

In addition, the Regional Office promotes a number of initiatives that integrate maternal and child health programmes into health systems, such as those being implemented in Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Kazakhstan, Kyrgyzstan, Montenegro, the Republic of Moldova, Romania, Serbia and The former Yugoslav Republic of Macedonia. The Chuvash Republic, in the Russian Federation, has reported impressive results of restructuring in this area.

The countries in south-eastern Europe, in particular, have started a concerted regional initiative, supported by the Government of Norway and the Regional Office, to improve maternal and neonatal health by making specific reforms and strengthening the capacities of their health systems. These countries are carrying out an in-depth evaluation of maternal and child health and identifying the bottlenecks in their general health systems to define the reforms needed.

The Regional Office web site offers further information on the MDGs (http://www.euro.who.int/mdg) and on its work for maternal and child health (http://www.euro.who.int/healthtopics/HT2ndLvlPage?HTCode=maternal_health).

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