Chapter 5: Millennium Development Goals and Women’s Right to Health

Millennium Development Goals cover only a small part of women’s health issues. Millennium Development Goals regarding women’s health include two aspects like reducing by three quarters the maternal mortality ratio and combating HIV/AIDS, malaria and other diseases. There was also a holistic goal of reducing gender disparity in Goal 3. Generally the indicators are maternal mortality ratio, proportion of births attended by skilled health personnel, universal access to reproductive health, contraceptive prevalence rate, adolescent birth rate, antenatal care coverage (at least one visit and at least four visits) and unmet need for family planning.

But women’s health consist of many issues. Their health problems are much deeper and have multifaceted dimensions. It is deeply related to their social question of equality and empowerment. Gender equality plays a key role in understanding women’s health issues. As long as women lag behind men in terms of their social and economic power, they are not able to take independent decisions (Wang & Pillai, 2001). The issue of inequality and lack of empowerment has been focused in the ICPD Convention, CEDAW and Beijing Declaration. The issue of reproductive rights as a tool of women empowerment has been a major focus in these international conventions. However, no upfront interest has been shown by the Millennium Development Goals in questions of women’s reproductive health (Basu, 2005).

According to Fukuda Par (2004), (pg.401), Millennium development Goals are a clarion call to tackle the enduring failures of human development. Sinding, (2005) mentioned that explicit mention of sexual and reproductive health and rights is missing from the MDGs, however. There is no mention of the core goal of ICPD that focuses on meeting the sexual and reproductive health needs and rights of women, men, and young people globally. This is the only goal set forth at all of the United Nations global development conferences of the 1990s.
that did not become one of the goals included in MDG. The absence of the Cairo goal from the MDGs reinforces the reluctance of an increasing number of member states to support many activities that promote sexual and reproductive health. To achieve the Millennium Development Goals and to address the sexual and reproductive health issues the ICPD recommendations are very much essential (Sinding, 2005, pg.141)

The presence of sexual rights is associated with all of the eight Millennium Development Goals (MDGs) (United Nations, 2005). The presence and accessibility of quality sexual and reproductive health services, information and education in relation to sexuality; protection of bodily integrity; and the guarantee of the right of people to freely choose sexual and marriage partners, to make decisions about child bearing, and to pursue satisfying, safe and pleasurable sexual lives are grounded in and contribute to gender equality and the empowerment of women; access to primary education, particularly for girls; reduction of infant and child mortality, especially of girl children; to improvements in maternal health and mortality; to decreasing vulnerability to HIV/AIDS, sexually transmitted infections (STIs) and other health threats; and also to reduction of poverty (especially among women). Thus, achieving sexual rights for all people will not only contribute to sexual and reproductive health, well-being and quality of life but will also advance the MDGs (Tyndae and Smylie, 2008)

The MDG targets do not focus on the primary health rights of women including access to health services and access to sexual and reproductive health information as revealed in the reports. The over emphasized targets are reduction of maternal and child mortality and halting of HIV/AIDS neglecting the fundamental indicators of women’s health. The sexual rights of adolescent girls and non-mothers are ignored. Too much emphasis has been put on treatment of HIV rather than its prevention which has a deep impact on women’s health. Moreover combating sex-selective abortion has not been a part of the MDGs which is directly related to
The primary health rights like accessibility of healthcare services including family planning services are not properly dealt with (Beaglehole & Bonita, 2008). The mental health issues of women are also not addressed in the MDGs.

Several studies have been done and papers have been published for tracking progress of MDGs and formulating appropriate policies. One such paper (Chakravarty and Majumder, 2008) is based on the Capability Approach of Amartya Sen where the targets are attempts to reduce the extents of capability failures (pg.110-111)

The methodology developed in the paper is then applied to cross-country data to examine the progress made during the period 1990–2000, and to assess the magnitude of further progress demanded over the period 2000–2015 to achieve the targets. The indicators for which the progress is rather low are also identified when the assessment of achieving the targets.

In Bangladesh, India and Pakistan challenges remain in key areas such as youth illiteracy, child and maternal healthcare and sanitation. India is not performing well in Goal 7 i.e. ensuring environmental sustainability and progress of other indicators are rather slow in 1990-2000. In Turkey a high level of improvement in sanitation is needed for the MDG target to be met. The next issue of the major concern is maternal healthcare. Positions in youth literacy, women empowerment and child healthcare are also vulnerable. Indonesia has performed quite well in reducing poverty. In Philippines significant achievements are required in respect of healthcare for women during childbirth, child healthcare, carbon dioxide emission and sanitation improvement. Major attention should also be given to the issues of youth
illiteracy and hunger. Moreover, in Indonesia women empowerment remains a serious problem.\(^9\)

The United Nations released the 2007 MDG progress chart in July 2007. The data in the chart are based on an analysis of trends between 1990 and either 2004 or 2005. The chart indicated that South Asia faces a serious challenge in meeting some of the MDG targets by 2015 (United Nations, 2007) which includes mother and child mortality rates and nutrition (Matbor and Ferdinand, 2008).

The Millennium development Goals Report prepared by the United Nations measures the progress of different regions in respect of the MDG targets. If we compare the MDG reports of 2012, 2013 and 2014 we can see that the health status of women have not improved much considering the MDG indicators. An estimated 287,000 maternal deaths occurred in 2010 worldwide, a decline of 47 per cent from 1990. Sub-Saharan Africa (with 56 per cent of these deaths) and Southern Asia (29 per cent) together accounted for 85 per cent of the global burden in 2010, with 245,000 maternal deaths between them. The number of maternal deaths per 100,000 live births—the maternal mortality ratio, or MMR—was also down, from 440 in 1990 to 240 in 2010, for the developing regions as a whole. (MDG Report, 2012) In 2013 MDG report it was stated that globally the maternal deaths per 100,000 live births was 400 in 1990 and was reduced to 210 in 2010. So there is no noticeable development. All regions have made progress, with the highest reductions in Eastern Asia (69 per cent), Northern Africa (66 per cent) and Southern Asia (64 per cent).

Despite reported progress in all world regions, the maternal mortality ratio in developing regions—230 maternal deaths per 100,000 live births in 2013—was fourteen times higher than that of developed regions, which recorded only 16 maternal deaths per 100,000 live births in 2013. Sub-Saharan Africa had the highest maternal mortality ratio of developing regions, with 510 deaths per 100,000 live births, followed by Southern Asia, Oceania and the Caribbean, each registering 190 maternal deaths per 100,000 live births, and then by South-Eastern Asia.

MDG Report 2013, shows that in Latin America, Western Asia, Northern Africa, Caucasus and Central Asia and eastern Asia, the maternal death has become a rare event nowadays, with less than 100 deaths for every 100,000 live births. Most of the maternal deaths in 2013 took place in sub-Saharan Africa (62 per cent), Southern Asia (24 per cent) and Northern Africa (66 per cent). The 2014 MDG report states that meeting the MDG target of reducing the maternal mortality ratio by three quarters will require accelerated interventions, including improved access to emergency obstetric care, assistance from skilled health personnel at delivery and the provision of antiretroviral therapy to all pregnant women who need it.

One critical strategy for reducing maternal morbidity and mortality is ensuring that every baby is delivered with the assistance of a skilled health attendant (medical doctor, nurse or midwife). A birth attendant with the necessary training and medicines can administer interventions to prevent or treat life-threatening complications such as heavy bleeding, or refer a patient to a higher level of care. In developing regions, skilled health personnel attended 68 per cent of deliveries in 2012 compared to only 56 percent in 1990. Southern Asia and sub-Saharan Africa—two regions that have had the lowest rates of deliveries attended by skilled professionals—have increased attendance by 10 percentage points or more since 2000. (MDG Report, 2014)
Giving birth with the assistance of a skilled and supported attendant (doctor, nurse or midwife) can reduce the risk of preventable death or disability. A birth attendant with the necessary training and medicines can administer aid to prevent or manage life-threatening complications, such as heavy bleeding, or refer a patient to a higher level of care.

In developing regions overall, the proportion of deliveries attended by skilled health personnel rose from 55 per cent in 1990 to 65 per cent in 2010. The ante natal care coverage—at least one visit with a doctor, nurse or midwife—has progressively increased in developing regions from 63 per cent in 1990 to 71 per cent in 2000, and then to 80 per cent in 2010. But still the uncovered population is quite high in these countries. The rate of care accelerated in the recent decade in Southern Asia, Northern Africa and Western Asia. In South-Eastern Asia, Eastern Asia, and Latin America a high rate of coverage of about 90 per cent had already been achieved by 2000. (MDG Report, 2012). In the MDG Report 2013 we found that in the developing regions, the proportion of deliveries attended by skilled personnel rose from 55 per cent in 1990 to 66 per cent in 2011. Still, in about 46 million of the 135 million live births in 2011, women delivered alone or with inadequate care. Wide disparities are found among regions in the level of skilled attendance at birth—ranging from nearly universal in Eastern Asia and the Caucasus and Central Asia (100 per cent and 97 per cent, respectively) to a low of about 50 per cent in Southern Asia and sub-Saharan Africa, the regions with the highest levels of maternal mortality. (MDG Report, 2013) If we see the MDG Report 2014 there is a significant increase in the percentage of skilled birth attendance from 2011 to 2013. The proportion of women in developing regions who were attended at least once during their pregnancy by skilled health-care personnel increased from 65 per cent in 1990 to 83 per cent in 2012. In most developing regions, about 80 per cent of pregnant women visited a skilled health-care provider at least once, except in Southern Asia, where only 72 percent of women received this care.(MDG Report, 2014)
However, women who give birth in rural areas are still at a disadvantage in terms of the care they receive. In 1990, 44 per cent of deliveries in rural areas of the developing world were attended by skilled personnel, versus 75 per cent in urban areas. By 2011, coverage by skilled birth attendants increased overall, but the urban-rural gap persisted: More than half (53 per cent) of women in rural areas received skilled attendance at delivery, versus 84 per cent in urban areas. In sub-Saharan Africa and Southern Asia, the gaps were even larger. (MDG Report, 2013)

Antenatal care can save lives of both mother and child. The World Health Organization (WHO) recommends a minimum of four visits for antenatal care, including, at minimum, screening and treatment for infections and identification of warning signs during pregnancy. The MDG Report 2012 states that across most developing regions, there has been steady progress in such coverage, with an acceleration in Northern Africa and Southern Asia since 2000. Despite this progress, in 2010 almost half of pregnant women in the developing regions still did not have the recommended number of visits. And in sub-Saharan Africa, the proportion with enough visits has actually fallen since 1990. Data on numbers of visits do not reflect the critical factor of quality of care, which is difficult to measure. Issues like obstetric haemorrhage, eclampsia, sepsis, complications of unsafe abortion and indirect causes, such as malaria and HIV are mentioned in the MDG reports but extensive data is not available. (MDG Report, 2012). Similarly the MDG 2013 report shows that in developing regions overall, only half of all pregnant women receive the minimum recommended number of antenatal visits (four). Regions such as Northern Africa and South- Eastern Asia showed substantial progress during the past two decades in improving coverage of antenatal care, while Southern Asia and sub-Saharan Africa lagged behind. In 2011, only 36 per cent of pregnant women in Southern Asia and 49 per cent in sub-Saharan Africa received at least four antenatal care visits during
their latest pregnancy. Care can vary in terms of quality, a dimension that is hard to measure and is not reflected in the data. Monitoring is required to ensure high-quality antenatal care that actually contributes to improved pregnancy outcomes (MDG Report, 2013).

The proportion of women in developing regions who were attended at least once during their pregnancy by skilled health-care personnel increased from 65 per cent in 1990 to 83 per cent in 2012. Only 52 per cent of pregnant women had four or more antenatal care visits during pregnancy in 2012. Thus there is no difference from the earlier reports and the percentage of women attending four antenatal visits remains almost the same. In most developing regions, about 80 per cent of pregnant women visited a skilled health-care provider at least once, except in Southern Asia, where only 72 percent of women received this care. Substantial differences in access to antenatal care are noticeable across regions. In the Caribbean and South-Eastern Asia, 80 per cent of pregnant women reported at least four antenatal care visits in 2012, compared to 50 per cent in sub-Saharan Africa, and only 36 per cent in Southern Asia. (MDG Report, 2014). Here also we find that the figures have not changed much in MDG Report 2014 because MDG Report 2013 also shows the same data. Therefore there is no such perceptible progress.

Very early childbearing brings with it heightened health risks for mothers and their infants. In all developing regions, the number of births per 1,000 women aged 15 to 19 years decreased between 1990 and 2000. Since that time, the rate of decline has slowed or even reversed in most regions. Sub-Saharan Africa continues to have the highest birth rate among adolescents (120 births per 1,000 adolescent women), with little progress since 1990. In Latin America and the Caribbean, the adolescent birth rate remains high and only recently began to decline. (MDG Report, 2012). The MDG Report 2013 also mentions that in all regions, the adolescent birth rate decreased between 1990 and 2010, with significant progress in Southern
Asia. The highest birth rate among adolescent girls aged 15 to 19 is in sub-Saharan Africa (118 births per 1,000 girls), which has made the least progress since 1990, both in relative terms and absolute numbers. Child marriage (before age 18) is still common in this region and is related with adolescent childbearing. In Latin America and the Caribbean, the adolescent birth rate remains high and has declined very small percentage recently (MDG, Report, 2013). The number of births to adolescent girls aged 15–19 declined across all world regions between 1990 and 2011. In Southern Asia, the birth rate dropped from 88 to 50 births per 1,000 girls, which was accompanied by an increase in school participation, an increase in the demand for contraception, and a decrease in the proportion of adolescents who married. However, the birth rate dropped only slightly in sub-Saharan Africa, and remained at 117 births per 1,000 girls in 2011, a much higher rate than in other regions. The adolescent birth rate also stayed high in Latin America and the Caribbean, at 76 births per 1,000 girls in 2011 which means the progress even slow down after 2011.

Table 2: Adolescent Birth Rate in 1990 and 2011 (Source MDG Report 2014)

<table>
<thead>
<tr>
<th>Regions</th>
<th>Year 1990</th>
<th>Year 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern Asia</td>
<td>88</td>
<td>50</td>
</tr>
<tr>
<td>Sub Saharan Africa</td>
<td>123</td>
<td>117</td>
</tr>
<tr>
<td>Latin America &amp; Caribbean</td>
<td>86</td>
<td>76</td>
</tr>
</tbody>
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If we compare the three reports we can see that there is only slight improvement in South Asia in respect of adolescent childbearing. In Sub-Saharan Africa and Latin America there is no significant improvement. The change in all the developing regions is not perceptible if we take the absolute number of females in the population.
The unmet need for family planning—expressing the percentage of women aged 15 to 49, married or in a union, who report the desire to delay or avoid pregnancy, but are not using any form of contraception—has shown a slow decline over time. The rate of progress in the developing regions has even decelerated between 2000 and 2010, indicating the potential for expansion of family planning programmes. In sub-Saharan Africa, for example, one in four women of childbearing age in a marriage or union had an unmet need for contraception in 2010. As changes in contraceptive prevalence and the unmet need for family planning have slowed globally over the past decade, the proportion of demand for family planning satisfied (that is, contraceptive prevalence as a proportion of overall demand for family planning) has slowed as well, increasing from 78 per cent in 1990 to 83 per cent in 2000, and to just 84 per cent in 2010. (MDG Report, 2012) The MDG 2013 report also mentions about the slow progress of contraceptive usage, lowest prevalence are in Sub-Saharan Africa and Oceania. Women in sub-Saharan Africa have lowest level of contraceptive prevalence, and their 2010 level of 25 per cent is even below that of other regions in 1990. However, there is wide variation in contraceptive use within the region, with a rapid increase in some countries and minimal change in others. The coming challenge to family planning programmes and health services is the growing number of women of reproductive age in this region.

The use of contraception in developing regions has increased, due—in part—to improved access to safe, affordable and effective methods of contraception. In Sub-Saharan Africa, the proportion of women between the ages of 15 and 49, married or in union, who were not using any method of contraception, doubled between 1990 and 2012 from 13 per cent to 26 per cent. In Southern Asia, the proportion increased from 39 percent to 57 percent during the same period. The increase in the prevalence of contraceptive use in developing regions between 1990 and 2012 was accompanied by a decline, from 17 per cent to 12 percent, in the unmet need for family planning. This unmet need for family planning was highest in sub-Saharan
Africa, whereas the total demand for family planning there was lower than in any other region. In 2012, 25 percent of women between the ages of 15 and 49, married or in union and residing in this region, reported the desire to delay or avoid pregnancy, but had not used any form of contraception. Large differences in contraceptive use between urban and rural residents, rich and poor households, and the educated and uneducated have persisted in sub-Saharan Africa. (MDG Report, 2014)

Expanding access to information, counselling and supplies for a wide range of contraceptive methods is essential to meeting the target of universal access to reproductive health. In 2011, an average of 62 per cent of women in developing regions who were married or in union were using some form of contraception. When sub-Saharan Africa and Oceania are excluded, at least 50 per cent of such women in all regions were using contraception. Worldwide, 9 in 10 women of reproductive age who are married or in union and using contraceptives rely on modern methods. In developing regions, the contraceptive methods with the highest prevalence are female sterilization and the IUD, which together account for more than half of all contraceptive use. Distinct regional patterns are observed. For example, female sterilization dominates in Southern Asia while injectables are most common in Eastern Africa and Southern Africa. (MDG Report, 2013)

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Table 3: Contraceptive Use in 1990 and 2011 (Source MDG Report 2014)

<table>
<thead>
<tr>
<th>Regions</th>
<th>Year 1990</th>
<th>Year 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub Saharan Africa</td>
<td>13</td>
<td>26</td>
</tr>
<tr>
<td>Southern Asia</td>
<td>39</td>
<td>57</td>
</tr>
<tr>
<td>Latin America</td>
<td>61</td>
<td>73</td>
</tr>
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From the above table it can be seen that there is a slight improvement in the contraceptive use from year 1990 to year 2011. The 2014 MDG report also shows how much the contraceptive use has increased in some regions. However, gap persists in meeting the demands of family planning.

Thus we can see that there has been slight improvement with the MDG indicators in respect to women’s health. But significant improvement is not noticed if we look at the recent MDG reports. If we look at the data of the MDG reports in the year 2011, 2012 and 2013 we do not see much change. No added information can be found in the MDG Report 2013 in respect of women’s health data. Hence there is sufficient reason to suspect that the missing issues of women’s health like primary health rights, female foeticide, mental health and sexual health of adolescents are important determinants. To have a clear picture of women’s health we need to concentrate on the above issues and look at women’s health from a holistic perspective.