Chapter 1: Introduction

1.1: Basic Question:

Gender mainstreaming in development policies is a phenomenon of recent decades. The issue of sexual and reproductive rights of women were initially a matter of policy discussion but it was restored by gender mainstreaming policies in future. The thesis is an attempt to understand why the developing nations perform miserably in the matters of reproductive and sexual health in the broader sense of gender equity. This dissertation focuses on Millennium Development Goals as one of the dominant gender mainstreaming policies and why the reproductive and sexual health goals are not met in spite of their inclusions in policy. It tries to highlight the missing elements in Millennium Development Goals which are quite essential in meeting the health targets of women. The dissertation also mentions the other health policies and emerging issues which center around two broad themes within women’s movement and human rights movement: 1) health equity/right to health and 2) women’s empowerment. Although there is some overlap between these two concepts, they both relate to and have motivated distinctive components of my work.

1.2: Rationale of the Study:

Kumar (2002) stated that gender ideologies pertain to various aspects of women, and the social relations between men and women. Gender issues cannot be tackled through crafty programme design without substantially questioning the dynamics of power and inequity in society. Fundamental understanding about gender is essential while addressing women’s health issues. Women’s development goals cannot be achieved if we do not understand the gender complexities and women’s position in society.

Women are understood primarily as reproducers rather than producers from the perspective of family welfare concern. (Chatterjee, 1996). If we want to understand different
health issues of women we must see women as subjects of research rather than only treating them as objects of meetings development targets. The process of gendering reproductive policy increasingly becomes a euphemism for looking at women’s specific interests out of the agenda of development policy (Rachel Kumar, 1997, 2000). But reproductive health policies should not be confined within maternal and child health. It includes sexual health, primary health and mental health of women. Women’s health is a matter of social existence (Soman, 2005). Like every other human rights issues right to health has gender dimensions. To bring the women’s issues into focus several international conventions and declarations have been adopted. Among them the most prominent ones are ICPD (Cairo Convention, 1994) and Beijing Declaration (1995) which emphasized on women’s reproductive and sexual health and most importantly women empowerment issues. The Millennium Development Goals developed by the United Nations in 2000 was developed in this backdrop which speak directly to improve human lives (Fukuda-Parr, 2004)

The Millennium Development Goals developed by the United Nations consists of eight goals and twenty one targets.

Fukuda Par (2004,pg 395) pointed out:

The goals put human development – poverty and people and their lives- at the centre of global development agenda for the new millennium. The MDGs are not just aspirations but provide a framework for accountability, they do not state ideals but go on to define concrete goals that can be monitored. They also address inputs from rich countries, thus holding a compact that holds both rich and poor governments accountable for opening markets, giving more aid and debt relief, and transferring technology. They speak directly to improve human lives. The MDGs are the clarion call to tackle the enduring failures of human development.
Antrobus (2006) posited that they provide a common framework agreed to by all governments, complete with measurable targets and indicators of progress, around which governments, UN agencies, international finance institutions and civil society alike could rally (p.39).

Fukuda Par stated (p. 396) that the idea of MDG was developed from the idea that the priority of development was to meet the basic needs (see Paul Streeten, Frances Stewart and others in Mahbub Ul Haq’s Reflections on Human Development, 1995) and Amartya Sen’s (1984) idea of development as expanding people’s capabilities to lead lives that they value. Human Development Report is developed each year on this idea. The concept of human development defines development as a process of creating creative an environment in which all people can lead full, creative lives. Mahbub Ul Haq launched the annual Human Development Reports in 1990 to track the progress of countries according to measures of human well-being rather than economic growth. The Human Development Index (HDI) was introduced to reflect capabilities in three critical areas: to survive, to be knowledgeable, and to enjoy a decent standard of living. The vision of the MDGs and human development considers people not only as beneficiaries of progress but also as the key agents of change. (Fukuda-Parr, 2004)

The MDGs cover over 20 targets and 60 indicators. Goal 5 deals with women’s health especially maternal health. Goals 4 and 6 deals with child health and communicable diseases (United Nations, 2000). Out of these goals the major thrust areas are maternal and child health, reproductive healthcare, communicable diseases and HIV/AIDS issues. Thus there is a gap that needs to be filled and it can only be done if the policy makers include the issues of

primary healthcare, mental health and sexual health of women. To solve the problem of women’s health inequality the issues of sex-selective abortion, low spacing between two children and several gynaecological issues of women (including pregnant women, mothers, unmarried women and childless women) should be addressed both in the household and in the policy level. Goal 3 of the MDG mentions about promoting gender equality and empowering women. Women’s health status cannot be improved if we do not speak about empowerment and equality of women. The gender inequality plays a key role in understanding the lack of reproductive rights of women. (Wang & Pillai, 2001) This growing inequality decrease women’s power and status within the households. (Sen, 1994). Gender politics play a very important role in shaping the development policies. The power relations and the idea of patriarchy have a crucial existence in these policies. That is why emphasis is given on the typical gender roles and identities of women which are motherhood and childbearing. So the real politics of gender is driving the effectiveness of the MDGs. The power relationship in a patriarchal domain has also played a significant role in the Indian context. This power relationship is an important attribute in determining women’s health. This issue can be addressed if women are empowered and enjoy equal rights like their male counterparts.

The MDGs only talk about maternal health, child health and communicable diseases. It does not focus on primary health rights of women including the sexual health of women who have not attained maternity and adolescent girls’ health. Women’s health cannot be ensured without addressing sexual health. Sexual health is not only a matter of reproduction. It includes sexual orientation, pleasure, behaviour and other emotional aspects of women. Sexual right is a meaningful tool for empowerment of women (Miller, 2000). Sexual health does not always indicate reproduction. Unmarried women including adolescents also have rights to protect their sexual health. This fact is missing in the MDGs relating women’s health.
The MDGs does not emphasize the issue of sex-selective abortion which is deeply linked with the maternal health. Women’s rights are violated even before they are born. Women’s inequality is related to the female foeticide. The human rights of unborn females needs protection to achieve the MDGs. In this connection the decision making ability of a woman to protect her reproductive rights comes into question. The women should be able to take decisions regarding her pregnancy. Any kind of abortion without a woman’s consent cannot be practiced.

The issue of spacing between two children is not mentioned explicitly in the MDGs. Women who do not maintain a gap between two children suffer both physically and psychologically. Women in developing countries bear a high proportion of the physical economic and psychological costs of childbearing and childrearing (Wang & Pillai, 2001)

The MDGs do not highlight the area of mental health which is interconnected with biological health. Intriguingly, the health goals almost entirely ignore non-communicable diseases, including mental disorders. Yet there is compelling evidence that in developing countries mental disorders are amongst the most important causes of sickness, disability, and, in certain age groups, premature mortality. Mental health–related conditions, including depressive and anxiety disorders, alcohol and drug abuse, and schizophrenia, contribute to a significant proportion of disability-adjusted life years (DALYs) and years lived with disability (YLDs), even in poor countries. Apart from causing suffering, mental illness is closely associated with social determinants, notably poverty and gender disadvantage, and with poor physical health, including having HIV/AIDS and poor maternal and child health. Yet mental health remains a largely ignored issue in global health, and its complete absence from the
MDGs reinforces the position that mental health has little role to play in major development-related health agendas (Miranda & Patel, 2005)

These points are very crucial in this research because if they are not considered the primary of right to health of women will not be addressed. Without their inclusion in health policy it may happen in certain cases that even if the MDGs are realized, the right to health of women is not fully protected

1.3 Research Question:

The thesis works on the following research question.

- How far the MDGs are protecting or advocating women’s right to sexual and reproductive health? What are the obstacles for working of the MDGs as a policy instrument?

The objective of the study is to see whether the MDGs alone can ensure the right to health to women or there are instances which shows that even if the MDGs are realized the right to health is not ensured and protected.

1.4 Chapterization:

The dissertation is divided into twelve chapters.

Chapter 1: It is the introductory chapter which explores the background of the topic and research question.

Chapter 2: It deals with the review of literature which mainly highlights the issues which are not focused in the Millennium Development Goals, women’s health equality for
achieving the Millennium Development Goals and the paths for achieving the MDGs which includes the human rights based approach towards health.

Chapter 3: It explores the methodology used for carrying the research work, detail explanation of the qualitative and quantitative methods for conducting the research

Chapter 4: It explains the historical evaluation of MDGs after the path breaking Beijing and Cairo Conference and their significance in policy making

Chapter 5: It presents a comparative analysis of the MDG report 2012, 2013 and 2014 to see how the targets have been achieved and progress have been made.

Chapter 6: It gives a description of the geographical area of the conducted study.

Chapter 7: It presents the findings and analysis of pregnant (non adolescent) women including their socio economic status, different health related issues and their perceptions.

Chapter 8: It presents the findings and analysis of adolescent women including their socio economic status, different health related issues and their perceptions.

Chapter 9: It presents the findings and analysis of adult (non adolescent) women who were admitted for causes other than pregnancy (Chapter 7, 8 and 9 deal with the quantitative analysis of the research. The findings have been elaborated by charts and diagrams using statistical software)

Chapter 10: It focuses on the case studies of the three different category of respondents.

Chapter 11: It consists of the epidemiological description of the total sample

Chapter 12: The twelfth chapter is the concluding chapter which concludes with the recommendations in policy making