Chapter 2: Review of existing studies

2.1: Women’s Health: a Debatable Issue:

“Health is a state of complete physical, mental, and social wellbeing and not merely an absence of disease or infirmity” (WHO, 1948). Women’s health is a dynamic concept and does not only signify their biological health or in particular the reproductive health. Women’s health is an outcome of their social existence (Soman, 2005). Women’s health encompasses the emotional, social, and mental well-being. It is a part of development and a fundamental right of women (Park, 2005). Women’s right to health are being violated from a very early stage in the form of female infanticide and foeticide. Women’s right to health have been an important issue in the human rights discourse. Like every other human rights issues right to health have gender dimensions and differentials (Soman, 2005). Gender differences are especially significant for women, since they mean inequality and discrimination (Sen, 1994).

There are significant differences between the health of men and women. A woman's capacity for reproduction makes her vulnerable to a wide range of health problems if she is not able to control her own fertility and to go through pregnancy and child-birth safely. This gives women 'special needs' which must be met if they are to realise their potential for health. However, social differences are also important in shaping male and female patterns of health and illness. All cultures assign specific characteristics to women and to men. These include a range of responsibilities and duties as well as varying entitlements to social and economic resources. As a result, men and women in the same communities or households often lead quite different lives, exposing them to different risks and offering them differential access to health and health care (Doyal, 1995; WHO, 1998).
2.2 Background and list of Millennium Development Goals:

The Millennium Development Goals (MDGs) are the most prominent initiative on the global development agenda. Eight millennium goals have been adopted by the international community (United Nations) as a framework for the development activities of over 190 countries in ten regions to combat various developmental issues like health inequality, poverty, hunger, illiteracy, environmental degradation and empowerment. The goals have been articulated into over 20 targets and over 60 indicators. The Millennium Development Goals are time-bound quantified targets for improving the human condition from different perspectives. Within each Goal several targets have been set, and to each target there corresponds one or more indicators (UN, 2000)

2.2.1 The eight Millennium Development Goals are as follows:

Goal 1: Eradicate extreme poverty and hunger

Goal 2: Achieve universal primary education

Goal 3: Promote gender equality and empower of women

Goal 4: Reduce child mortality

Goal 5: Improve maternal health

Goal 6: Combat HIV/AIDS, malaria and other diseases

Goal 7: Ensure environmental sustainability

Goal 8: Develop a global partnership for development
2.2.2 The Millennium Development Goals Relating to Women’s Health:

Out of the eight goals, Goal 3, Goal 5 and Goal 6 is related to women’s health issues.

Goal 3: Promote gender equality and empower of women

Goal 5: Improve Maternal Health

Target 5a. Reduce by three quarters the maternal mortality ratio

Indicators

5.1 Maternal Mortality Ratio
5.2 Proportion of births attended by skilled personnel

Target 5b. Achieve by 2015 universal access to reproductive health

Indicators: 5.3 Contraceptive prevalence rate
5.4 Adolescent birth rate
5.5 Antenatal care coverage (at least one visit and at least four visits)
5.6 Unmet need for family planning

Goal 6: Combat HIV/AIDS, malaria and other diseases

Target 6a: Halt and begin to reverse the spread of HIV/AIDS

Target 6b: Achieve by 2010, universal access to treatment for HIV/AIDS for all those who need it

Target 6c: Halt and begin to reverse the incidence of malaria and other major diseases

(United Nations, 2016)

Chakravarty & Majumder opined (2008) (p.125) that the MDGs involving concrete targets and indicators present a new approach of escaping poverty and achieve desired
objectives in several dimensions of human well-being. The MDGs follow a performance rather than an entitlement approach to development. Indexing method has been applied by researchers to measure the progress for each indicator, which can be employed to monitor the achievement made towards attaining the Goals.

MDGs form follow a rights-based approach with focus on economic, social and cultural rights. Complete attainment of economic, social and cultural rights requires far more than achieving the MDGs. But achieving the Goals is an important step towards that end. However, “success will require sustained action across the entire decade between now and the deadline” (Annan, 2005). MDGs should work beyond United Nations. Country-driven and nationally owned efforts are necessary for their achievement. Every national development strategy should formulate national policies required to achieve these Goals, monitor progress, identify key obstacles and eliminate them. (Chakrabarty & Majumder, 2008).

2.3: Issues Apparently Missing in the Millennium Development Goals:

. Important issues and indicators of women’s health appear to be missing in the MDG goals relating women’s health. They are as follows:

2.3.1: Sexual Health: Sexual right is a meaningful tool for empowerment of women (Miller, 2000). The recognition of sexual rights as a human right is a recent phenomenon. In July 2005, participants at the 17th World Congress of Sexology asserted their commitment to the World Association for Sexual Health’s (WAS) Montreal Declaration: Sexual Health for the Millennium (WAS, 2008). The first of the eight items that comprise this declaration calls on governments, international agencies, private sector, academic institutions, member organizations and society at large to: Recognize, promote, ensure and protect sexual rights for
According to the resolutions of 1994 Cairo Conference, reproductive rights are inseparable from reproductive health. It also acknowledged that the right to decide freely and responsibly the number and spacing of children is unattainable without women’s empowerment and gender equality. The CEDAW Convention provided another dimension of sexual health by legalizing the rights to abortion in case of unwanted and risky pregnancies although it does mention the word “abortion” directly. The Beijing Declaration (1995) went a step further by recognizing sexual and reproductive health of adolescent girls and the consequences of early marriage, early childbearing, unprotected and coercive sex.

Sexual rights as outlined above are associated with all of the eight Millennium Development Goals (MDGs) (United Nations, 2005). Tyndale & Smiley reflected (pp.107-108) that sexual right is related to 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. Sexual rights enable 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 mortality.

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2 On 18 December 1979, the Convention on the Elimination of All Forms of Discrimination against Women was adopted by the United Nations General Assembly. It entered into force as an international treaty on 3 September 1981 after the twentieth country had ratified it. By the tenth anniversary of the Convention in 1989, almost one hundred nations have agreed to be bound by its provisions.

The Convention was the culmination of more than thirty years of work by the United Nations Commission on the Status of Women, a body established in 1946 to monitor the situation of women and to promote women's rights. The Commission's work has been instrumental in bringing to light all the areas in which women are denied equality with men. These efforts for the advancement of women have resulted in several declarations and conventions, of which the Convention on the Elimination of All Forms of Discrimination against Women is the central and most comprehensive document.

http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm

It is often described as an international bill of rights for women. Consisting of a preamble and 30 articles, it defines what constitutes discrimination against women and sets up an agenda for national action to end such discrimination. The Convention is the only human rights treaty which affirms the reproductive rights of women and targets culture and tradition as influential forces shaping gender roles and family relations.

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). Ensuring 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. Official acknowledgement of sexual rights sets legal and policy guarantees for these recognitions, eradications, access, provisions and promotions which can then be used to develop appropriate programming, service delivery, and legal action. Consequently it is through these mechanisms that sexual rights is essential for achieving MDGs. Since the debates on sexual rights at ICPD and Beijing, there has been increasing evidence of legal and policy changes that embody the sexual rights which is listed in WHO’s working definition. (Tyndale & Smiley, 2008)

Despite the recognition of sexual health in all the international programmes we found that only maternal and child health issues have always been highlighted in MDGs. There is close connection between MDGs and sexual rights But no upfront emphasis has been shown regarding women’s sexual and reproductive health which is part of the core goals of Cairo Programme of Action (1994) focusing on meeting the reproductive health needs and rights of women. Many of the MDGs overlap with ICPD Cairo (International Conference on Population and Development) goals. But explicit mention of sexual and reproductive health and rights is missing from the MDGs. In particular, no mention is made 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 an 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 (Basu, 2005; Sinding 2005) The list of targets to achieve the reproductive health goal is also incomplete in the
MDGs. There is no mention of spacing, the number of children a woman should conceive as a method of family planning and access to contraceptive services and information which were part of the Beijing Proceedings and CEDAW Convention. Another important aspect of sexual health is the legal rights of abortion which has been mentioned in CEDAW indirectly or implicitly without specifically mentioning the word “abortion”. The committee created its own interpretation of the articles of the treaty to find a right to abortion. Most pertinent is the committee’s “general recommendation 24” by which it interprets the Article on Health. That interpretation states that, “When possible, legislation criminalizing abortion should be amended.”

The right to abort in case of unwanted or risky pregnancy is a very important sexual right of women which is not mentioned in the MDGs. There is also no mention of sexual health of adolescents who are more vulnerable than adult women and need special care. The consequences of illegal and unsafe abortion are faced by adolescents and these issues remain silent in the MDGs.

The MDG targets have included the matters that have an impact on, or are components of sexual and reproductive health like maternal and child health, HIV/AIDS, gender equality and education. But sexual and reproductive health were left out explicitly. The list of targets to achieve the reproductive health goal is also incomplete. There is no mention of spacing, the number of children a woman should conceive as a method of family planning and access to contraceptive services and information. The sexual health and reproductive decision making ability of adolescent girls and non-mothers is not addressed. Attempts have been made afterwards to redress this imbalance and to ensure that sexual and reproductive health are there.

for the implementation of the Millennium Development Goals. Addition of specific sexual health targets and indicators are needed for realizing women’s right to health. Explicit modification is needed to incorporate reproductive health goals in MDGs. like proportion of contraceptive demand satisfied and the adolescent fertility rate (Chakrabarty & Majumder, 2008). Otherwise the right to health will not be realized fully.

Promotion of sexual health contributes to achieving the MDGs but there is reluctance by member states to support many activities that promote sexual and reproductive health rights due to the absence of the targets of Cairo goals and Beijing Declarations relating women’s sexual health in the MDGs. Efforts are being made to bring reproductive health into the MDG Project Agenda since many MDGs are part of reproductive health agenda. (Tyndale & Smylie, 2008). There is an increasing trend among donors to national governments to tie development aid to the MDGs, and to use monitoring of implementation of the MDGs for this purpose. Hence, implementation of the Programme of Action of the International Conference on Population and Development 1994 may have been more easily achieved if targets for achieving sexual and reproductive health were fully integrated into the MDG process (Haslegrave and Stan Bernstein, 2005). To achieve the Millennium Development Goals and to address the sexual and reproductive health issues the ICPD and Beijing recommendations are crucial. To ensure women’s sexual rights the topic of abortion should also be focused as discussed in the CEDAW recommendations. Access to contraceptive which is also a part of the ICPD has not been addressed in the MDGs.

(Sinding, 2005) pointed;

As a constructive response to this deeply unsatisfactory situation, the International Planned Parenthood Federation (IPPF) has suggested at several recent meetings and in a
letter to its member associations that the omission of the universal access goal be remedied by recasting two of the original MDGs and adopting indicators to monitor progress. These emendations would serve to promote properly the recommendations of the ICPD, and Beijing conference, re-emphasizing the crucial role that universal access to sexual and reproductive health information and services must play in any long-term antipoverty campaign. (Tyndale, 2009) The politics of the MDG process have severely compromised earlier commitments to sexual and reproductive health and rights, commitments that were strong and clear at the conclusion of the Cairo and Beijing conferences (p.141)

The policy makers have increased the financial and other resources targeting to the HIV/AIDS and placing the reproductive health field in ever-greater danger of being marginalized (Ethelston et al. 2004). Sinding (pg.141) pointed that the absence of the core Cairo goal from the MDGs has financial impact on sexual and reproductive health. The fields of HIV/AIDS research and care and reproductive health unfortunately have grown farther and farther apart since Cairo. The establishment of a Global Fund to Fight AIDS, Tuberculosis and Malaria as separate and distinct from sexual and reproductive health has deepened the gulf. The decision of the World Health Organization to move responsibility for the fight against HIV/AIDS from the sexual and reproductive health unit to the unit on communicable and infectious diseases have added to this debate. However the issues of sexual and reproductive health are interrelated and they cannot be dealt separately. Furthermore, the growing emphasis on AIDS treatment, as opposed to prevention, has correspondingly deepened the isolation of the sexual and reproductive health community and has ensured that HIV prevention gets ever less attention. (Sinding, 2005)
The need of the hour is to ensure freedom for all to use sexual and reproductive health services. Universal access to contraception, STI prevention and treatment, and safe childbirth are the keys to improving sexual and reproductive health. The prevention of unintended child-bearing and the enhancement of women's reproductive freedom are fundamental to improving the economic prospects of families and to reducing the incidence of poverty in every country. A considerable unmet need exists for family planning and complications of pregnancy. Honoring the Cairo goal and accepting the Beijing Declaration and CEDAW Convention would give women the right to choose childbirth and number of children and to protect their reproductive health, one of the most powerful ways to further gender equality and to improve health and general living conditions globally. (Sinding, 2005)

2.3.2: Primary Health: The primary health rights like accessibility of healthcare services including family planning services are not properly dealt with (Beaglehole & Bonita, 2008). Women’s role are not limited to conceiving child. Their healthcare status depend on their basic health rights which includes the primary health care. Women’s problems are not confined in pregnancy issues only. They have severe gynaecological health problems which needs regular attention. The quality and accessibility of health services are important for them to protect their primary health rights.

2.3.3: Sex Selective Abortion: There is no mention of female foeticide issue which is related to maternal and reproductive health. The sex ratio debate is ongoing. Many areas of women’s health will be negatively affected if we do not consider the issue of female foeticide. The rights of unborn females is a burning issue. There is discrimination against females even before they are born (Viswanath, 2001). The reproductive choice and decision making ability of
women will be completely ignored if we do not include the issue of female foeticide in the
MDGs.

2.3.4: Spacing between Two Children: The list of targets to achieve the reproductive
health goal is also incomplete. There is no mention of spacing, the number of children a
woman should conceive as a method of family planning and access to contraceptive services
and information. Abortion as a method of spacing is a highly controversial issue. But the
consequences of unsafe abortion is mentioned in ICPD and Beijing Convention which needed
to be integrated in the MDGs. (Wang & Pillai, 2001), pg.239) mention. The issue of spacing is
very important in many developing countries because women bear a very high proportion of
the physical, economic, and psychological costs of childbearing and childrearing. Wang &
Pillai (pg.239) mentioned that rotracted childbearing with inadequate spacing between
pregnancies is likely to induce both physical and psychological harm. (Wang & Pillai, 2001).

2.4: General Reproductive Health:

The reproductive health approach implies that women’s right to make reproductive
decisions and the improvement in their socio-economic status may increase their reproductive
health and status. The ability to control one’s health status is an important precondition for
improving reproductive health (Wang & Pillai, 2001). Reproductive health cannot be ensured

4 ICPD 7.14 a) To help couples and individuals meet their reproductive goals in a framework that promotes optimum health, responsibility and family well-being and respects the dignity of all persons and their right to choose the number, spacing and timing of the birth of their children

5 Since unsafe abortion is a major threat to the health and life of women, research to understand and better address the determinants and consequences of induced abortion, including its effects on subsequent fertility, reproductive and mental health and contraceptive practice, should be promoted, as well as research on treatment of complications of abortions and post-abortion care.
without ensuring reproductive rights. (Mann, 1997). Reproductive rights are women’s rights, and women’s rights are human rights (United Nations 1994, 1996). Reproductive health may not be obtained without addressing social vulnerabilities. (Mann, 1997) Researchers suggest that the human rights approach provides a useful framework for analyzing and understanding the social-structural roots of reproductive health. The extent of control over women and their reproductive choices is determined by social structural factors. The emergence of reproductive rights is determined by the improvement in a number of key social-structural variables such as economic development and secularization (Ramirez & McEneaney, 1997).

Gender inequality plays a key role in understanding the lack of reproductive rights of women. The issue has been addressed in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) The right to decide freely and responsibly the number and spacing of children is also acknowledged by the Cairo Conference. Women’s reproductive rights emphasize on how many children to have and when to have them, the right to have information on and access to reproductive health care, and the right to have control over their own bodies (United Nations, 1994). As long as women lag behind men in terms of their social and economic power, they may not be able to make independent reproductive decisions. (Wang & Pillai, 2001). There are gender based social inequalities in the distribution of land, income, and power in developing countries (Crenshaw & Ameen, 1993). This growing inequality tends to decrease women’s power and status within the household. Women’s subordinate status in their households affect their decision making ability regarding reproductive health. We know that the decision to have children has physical and emotional implications for women. In difference to the emotional and social aspects of fertility it has also contributed to the violation of women’s human rights. (Hartmann, 1998). The social and political forces often work through women by constraining their options including their reproductive choices (Sen, 1994).]
Basu (2005) (p.132) argued:

No upfront interest has been shown by the Millennium Development Goals in questions of women’s reproductive health. Women’s sexual health, sex selective abortion and inadequate spacing between pregnancies are not mentioned in the MDGs. The same kind of dismay was expressed in the protests of the population “control” lobby when it was effectively marginalized during the debate on population and development interactions at the International Conference on Population and Development in Cairo. (Basu, 2005).

We can see that only the fertility issues, maternal mortality rates, antenatal care and contraceptive prevalence rates are focused in women’s health targets of MDGs. But there is hardly any mention of reproductive rights. Basu (2005, p.133) once again argued that many of the Millennium Development Goals are an integral part of any reproductive health agenda. Sustained advances in the MDG agenda require investments in reproductive health and rights which helps in the realization of reproductive rights. Improvements in female education, infant and maternal mortality, HIV infection rates, and even scientific and technological innovations specified in MDGs are likely to lead to significant changes in women's ability to articulate and ensure their reproductive health rights and needs inside and outside the home. There is a link between reproductive health, and social and economic progress. A continued investment in the MDGs will also serve to advance the reproductive health agenda. (Basu, 2005)

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6 Reproductive rights are women’s rights and women’s rights are human rights (United Nations 1994, 1996). The Cairo Programme of Action (United Nations, 1994) noted the importance of reproductive rights as human rights to ensure reproductive and sexual health, bodily integrity, and the security of the person. Mann (1997) suggests that the human rights approach provides a useful framework for analyzing and understanding the socio-structural roots of reproductive health.
2.5: Women’s Health Equality in the Millennium Development Goals: Reality or Paradox?

Gender hierarchy governs how people live and what they believe and claim to know about what it means to be a girl or a boy, a woman or a man. Girls and women are viewed as less capable or able, and in some regions seen as repositories of male or family honour and the self-respect of communities (Fazio, 2004). Restrictions on their physical mobility, sexuality, and reproductive capacity are perceived to be natural; and in many instances, accepted codes of social conduct and legal systems condone and even reward violence against them (Gracia-Moreno et al, 2006).

Sen & Ostlin (2007, pg. Xiii) pointed:

Women are thus seen as objects rather than subjects (or agents) in their own homes and communities, and this is reflected in norms of behaviour, codes of conduct, and laws that perpetuate their status as lower beings and second class citizens. Even in places where extreme gender inequality may not exist, women often have less access to political participation. The other side of the coin of women’s subordinate position is that men typically have greater wealth, better jobs, more education, greater political clout, and fewer restrictions on behaviour. Moreover men in many parts of the world exercise power over women, making decisions on their behalf, regulating and constraining their access to resources and personal agency, and sanctioning and policing their behaviour through socially condoned violence or the threat of violence. Again, not all men exercise power over all women; gender power relations are intersected by age and lifecycle as well as the other social stratifies such as economic class, race or caste. The impact of gender power for physical and mental health – of
girls, women and transgender /intersex people, and also of boys and men – can be profound (Sen & Ostlin, 2007)

Women have special needs which are different from men in all aspects of life. Whitty (1996) posits that women's right to the enjoyment of the highest standard of health must be secured throughout the whole life cycle in equality with men. Women are affected by many of the same health conditions as men, but women experience them differently. (Whitty, 1996) Social and cultural differences assign specific characteristics to women and men. These include a range of responsibilities and duties as well as varying entitlements to social and economic resources. As a result, men and women in the same communities or households often lead quite different lives; exposing them to different risks and offering them differential access to health and health care (Doyal, 1995; WHO, 1998). Women’s reproductive role makes her vulnerable. They experience various gynaecological and sexual health problems. They have restrictions on their physical mobility, decision making, sexuality and reproductive capacity which are perceived to be natural. These issues are not given due importance in the development programmes. The development programmes should recognize the different needs while developing policies. But the real picture is different. In this thesis I have criticised the MDGs in respect of women’s health rights. As Antrobus pointed (pg. 40), a major problem of the MDGs is their abstraction from the social, political and economic context in which they are to be implemented or the “political economy” of the MDGs (Antrobus, 2006).

The exclusion of the goal of women’s sexual and reproductive rights reflects the power of the forces of religious fundamentalism that emerged during the 1994 ICPD, that continued to gain strength in the context of the ongoing economic struggles of the South against the spread of neoliberalism in the late 1990’s, and that here received a boost from the right-wing control of the current US administration. The MDGs are related to biological and social reproduction
for which women’s equality and empowerment are very critical. For achieving the MDGs
gender biasness should be discouraged. (Fukuda Par, 2004 & Antrobus, 2006) Women’s
equality and empowerment are very much crucial for ensuring MDG targets of women’s
health. Women should have decision making ability and “freedom of choice.” (Sen, 1987).
Sen & Ostlin (2007, pg.xvii) stated that gender imbalances include slow recognition of health
problems that particularly affect women; misdirected or partial approaches to women’s and
men’s health needs in different fields of health research; and lack of recognition of the
interaction between gender and other social factors. Gender imbalances in research process
include: non collection of sex-disaggregated data in individual research projects or larger data
systems; research methodologies are not sensitive to the different dimensions of disparity;
methods used in medical research and clinical trials for new drugs that lack a gender
perspective and exclude female subjects from study populations; gender imbalance in ethical
committees, research funding and advisory bodies; and differential treatment of women
scientists. Mechanisms and policies need to be developed to ensure that gender imbalances in
both the content and processes of health research are avoided and corrected. (Sen & Ostlin,
2007)

There is a gender dimension in the development goals and MDG is not an exception.
Women’s subordination and exploitation represents a major barrier to the achievement of most
of the goals and targets and hinders health equality of women. The MDGs can act as a tool
which can hold both donor agencies and governments accountable. The decision making
position of women should be strengthened and sex role stereotyping should be stopped in order
to achieve women’s equality in health. Access to health services that respect women’s sexual
and reproductive rights and embody the principles of the Programme of Action from the ICPD
should be implemented. (Sen & Ostlin, 2007, Sinding, 2005).
The policy makers should prioritize women’s access to healthcare services, recognition of women’s role as health care providers, and building accountability for gender equality and equity into health systems, and especially in ongoing health reform programmes and mechanisms. Gender bias in health system will be controlled if there are systematic approaches to building awareness and transforming values among service providers. Steps should be taken to improve access to health services and developing mechanisms for accountability.

Antrobus (pg 49) pointed out that we must develop an approach to the MDGs that allows to use a redefined goal of gender equality and women’s empowerment as an entry point for addressing all the other MDGs. This way women’s equality and empowerment might be seen for what it is: both an end and the means for making progress in all the MDGs. (Antrobus, 2006)

2.6: Progress of the Millennium Development Goals:

The eight Millennium Development Goals (MDGs) agreed upon by the United Nations in 2000-01 include ambitious plans to halve poverty and improve the lives and health of people throughout the world by 2015. But the question is whether they are really attainable or not (Sinding, 2005)

There are few reasons regarding the slow rate of achievement of the MDGs. Within the South Asian countries, there are internal disparities between rural poor and urban wealth that must be addressed differently (ESCAP, United Nations, & Asian Development Bank, 2006). Mathboor & Ferdinand (pg.69) mentioned that South Asia faces many challenges in social, political, environmental and economic areas to achieving MDG1. Besides these challenges, another issue that affects the MDG is the lack of adequate statistics being kept by governments. It is difficult to analyze meeting targets if statistics are not available or statistics
are improperly reported. This results in skewed statistics that do not reflect the true picture (Mathboor & Ferdinand, 2008).

The researchers (Mathboor & Ferdinand, pg.63) further added that statistics must not be manipulated either through bribery or corruption to cover for deficiencies. Political crisis and conflict are also major impediments to progress. In spite of funding issues, governments of South Asia will need to take more responsibility for poverty alleviation rather than to rely on so much foreign aid from donors.

Numerous reports, statistics and analyses are available discussing the MDGs and whether or not targets will be met. However, it is time to put these studies into action. The governments of each of the countries of South Asia have the responsibility to their people to implement progressive policies and monitor the progress of their country towards achieving the MDGs. (Matboor & Ferdinand, 2008)

Reddy & Heuty (2008) posited:

A number of strategies to achieve the Millennium Development Goals (MDGs) and associated cost estimates have recently been presented, most influentially by the Millennium Project and the World Bank. An alternative approach to strategic planning could be developed as an institutional framework for continuous informed policy choice by representative decision-makers. The alternative approach to achieving the MDGs can be implemented through a process of periodic and partner review. The process of peer and partner review would enable each country to learn from its own experience and that of other countries, and thereby increases the likelihood of success of achieving the MDGs. (pg.399)
According to Franklin, (2008, pg.421), ‘Results-based management’ is one of the most popular strategies for dramatically accelerating responses and increasing the impact of simple and cheap interventions. The approach requires planning frameworks that include an overview of the local context, the identification and analysis of specific problems, and projections of the measurable results expected from the implementation of proven strategies. Based on strong, shared commitment to reaching the Millennium Development Goals (MDGs), results-based management is helping to stimulate rapid expansion in the education and health sectors. The research based management is neat and satisfying. But it can also have unanticipated and perverse consequences. The establishment and listing of numerical targets has led to the segmentation of the international response, based on the artificial classification of goals by sector, the top–down analysis of needs, and the identification of single issues that can be addressed in stand-alone projects or programmes. They have made it easier for donor countries to pursue results of their own, choosing and ‘cherry picking’ from the list of targets set for each of the MDGs.(Franklin, 2008)

Basu stated (2005, pg,134) that United Nations controls a large part of the money and other resources that go into meeting the Millennium Development Goals. But much must be done outside the formal dictates of United Nations. For attaining the Millennium Development Goals the donor community and national governments should continue to pursue the reproductive health agenda that they specifically and firmly agreed to after Cairo. Indeed, they are duty-bound to honour this commitment until the goals of the Cairo Programme of Action are realized (Basu, 2005).

The discussion on policy issues has been very much country specific. However, often it may be necessary to put priorities on worst-performing indicators globally. This would require the construction of an index, under appropriate assumptions, for the given indicator for all the
countries or for a subset of countries (e.g. in the South Asian region). In such a scenario, country-wise percentage reductions in the deprivation of the indicator can be calculated for policy purpose, another important issue for future research (Chakravarty & Majumder, 2008).

Aton (2005, pg.765) argues:

The MDG process is a top-down rather than a grassroots effort. It is, in effect, an imposition by governments acting through the UN General Assembly. The MDGs do not contain any particular focus on rights, thus effectively sidelining rights as though they were a marginal or token issue. From a human rights perspective the MDGs are problematic because of their selectivity, which also involves the exclusion of certain rights. The MDGs' preparedness to settle for half measures (e.g. halving poverty, instead of eliminating it) is incompatible with the human rights commitment to the right of every individual and the need to seek comprehensive solutions. The MDGs represent a one-size-fits-all prescription, and are not tailored to the specific needs of individual countries. The MDG definition of poverty is too narrow, and its emphasis on specified goals takes poverty out of its broader context. The MDGs are state-focused at a time when privatization and other policies are making the state less capable of responding.

Relationship to other Initiatives MDGs are superfluous because the adoption of the alternative framework of a rights based approach to development would take care of all of the issues. The MDGs process will be used by governments and donors to distract attention from the real human rights issues. The MDGs compete with other frameworks through which NGOs and civil society are already working effectively, such as the Beijing follow-up. (Aston, 2005)
In spite of the above debates regarding the Millennium Development Goals and its relation with human rights approach, the human rights approach is needed for achieving the Millennium Development Goals which is discussed in the next section

**2.7: Need for a Human Rights Based Approach for Achieving the Millennium Development Goals:**

(Franklin, 2008) mentioned that in the 1990’s the Human Rights Based Approach to development was conceptualized for mainstreaming of human rights across all UN programmes and projects. A human rights based approach require community involvement. People can discuss sensitive topics, where all people feel confident enough to exchange opinions and listen to each other, and where people with different and at times conflicting points of view or interests can agree on what needs to be done to change things that they feel need to be changed. Development is a ‘journey without maps’. The international community should balance its need for planned, budgeted, and measurable results with the needs of marginalized and excluded people for intangibles such as dignity, equality, and social justice, it will not be as easy to make poverty history as people sometimes think (pg. 422-423).

The Millennium Development Goals is a universal framework of development and have a great deal of similarity with human rights commitments. The ultimate objective of the MDGs is to contribute to the realization of human rights enshrined in national constitutions and international conventions. The human rights based approach is needed for meeting the MDG targets. The relationship between MDGs and human rights needs to be explored for developing an integrated approach. The principles espoused in the HRBA helps in the implementation of MDGs. By adopting human rights based approach in the MDGs the language of rights will magnify and there will also be an increased attention to the entire pantheon of human rights. It
will help in considering the structural causes of poverty among, and impact of MDG projects on vulnerable groups such as minorities and indigenous peoples (Traub, 2009)

Fukuda Par (2004, pg.396) mentioned

The MDGs set standards for the “progressive realization “ of economic and social rights. They are part of a multidimensional vision that integrates political factors such as civil rights and democratic representation, social factors such as education and health, and economic factors such as growth and employment. This vision considers people not only as the beneficiaries of progress but also as the key agents of change. The MDGs address some of the most critical areas of human development, although they do not deal with participation, democracy, and human rights. MDGs are not in themselves a paradigm, but they are benchmark indicators of how we are progressing in human development and economic rights (Fukuda Par, 2004).

A gender sensitive human rights approach is needed for achieving of MDGs. Right to health is a part of human development. A human rights approach is imperative for improving women’s health conditions. A gender-sensitive human rights approach to women’s reproductive health has several implications in terms of theoretical and social policy concerns. First, the social and personal meaning and the costs of having children from a woman’s perspective are often ignored by programs and policies that are designed mostly by men to control fertility. The costs of child bearing have been shifted onto the unpaid labour of women (Sen, 1994). The second aspect of a women sensitive human rights approach points to the importance of contraception and the implementation of a comprehensive women’s public health program,. This implies that women would have a certain degree of control and choice over their sexual and reproductive behaviour. Feminists have always placed contraception in the framework of women’s life cycle and fought for integrated health services including
information, education, and delivery systems (Pitanguy, 1994). Finally, a gender-sensitive human rights approach needs a feminist perspective and holistic measures to reshape the political arena in the women’s discourse of reproductive rights and reproductive health (Wang & Pillai, 2001).

The conceptual issues associated with the MDGs and human rights approaches has been addressed by Guido Schmidt-Traub (2009). Schmidt-Traub reflects on the role of human rights vis-a-vis the achievement of the MDGs. He proposes a concrete process for the development of national MDG implementation strategies – one that incorporates a human rights based approach at each step of the process. How the human rights standards and principles play a potential role for achieving the MDGs have been also discussed by him. In his analysis of the potential role for, and means to operationalise, an HRBA in the implementation of the MDGs, Schmidt-Traub makes a strong argument for the potential to bridge the gap between the ‘evidence based approaches to development’ and the human rights based approach. The resulting amalgamation of the two approaches, he argues, would further both the achievement of the MDGs and the realisation of core human rights standards and principles. (Doyle, 2009; Traub, 2009)

Other researchers for instance Doyal (2009), have suggested that special attention is paid to the plight of minorities and indigenous groups growth for the fulfillment of the MDGs. There should be a proper incorporation of a requirement for states to report on a customized set of MDG targets for these groups. Certain human rights mechanisms, both treaty bodies and special procedures, can more effectively address minority rights. She suggests that these mechanisms provide relevant input to the various actors partaking in the MDG project, thereby
ensuring that ‘the issues of minority and indigenous peoples’ rights are tackled in a more concerted manner’ (Doyle, 2009)