GOAL 4

THE 'CHILD MORTALITY GOAL'

Goal 4 Reduce child mortality

Target 5 **Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate**

Indicators *Under five mortality rate*

Infant mortality rate

Proportion of one-year old children immunised against measles

Child survival depends on gender equality

It is easy to think of infant mortality and child survival as purely health issues which can be addressed through medical interventions such as prenatal and postnatal health care, safe childbirth, good nutrition and timely immunisation. Such a view would however be a seriously limited one. While medical factors and the state of the health infrastructure in the country are important, infant mortality and child survival are closely dependent on multiple social factors, the most critical of which is gender equality.

- **The basic foundation of child survival and health is determined during pregnancy.** Poor health (particularly anaemia and malnutrition) is a fact of life for millions of women, which is compounded during pregnancy by overwork, under-nutrition and chronic ailments that directly affect the health and survival chances of the foetus.
- **The mere existence of infrastructure and facilities for newborn care is not enough to ensure access.** In many instances, decisions around childbirth are taken by the husband and older women in the family – traditional norms, lack of faith in modern methods, misconceptions about immunisation and most of all, the low value placed on the mother's life and health often operate to deprive infants of emergency care immediately after birth.
- **Women's own understanding about safe childbirth and appropriate child care is inadequate.** Access to information is constrained not only by women's lack of freedom in decision-making, but is clearly linked to their levels of capability. Numerous studies have shown that women with even a few years of education are better equipped to locate and access health information, and have more bargaining power within the family on decisions related to her child's health.

- **Patriarchal traditions and cultural norms sanction the neglect of girl children in infancy.** As a result, baby girls are given less care and fewer months of breastfeeding, are less likely to be taken to a doctor when they are ill and may not even complete a full course of immunisation. In some regions of the world, the bias against girls is even more extreme and goes to the extent of female foeticide and female infanticide. While such practices are shrouded in secrecy, the highly imbalanced sex ratios in these countries reveal the true picture of gender inequality.
- **Women's poverty and lack of access to productive resources are a direct cause of infant mortality.** In many countries, the introduction of user charges in the public health system has reduced the access of poor women and children to basic nutrition and essential medical care.
- **Gender inequality in employment and women's dependence on low-paid and insecure jobs.** Without the assurance of minimum wages or paid leave this factor is directly linked to child survival. For poor women in many countries, taking a day off to care for a sick infant or go to a doctor for help, would mean not only the loss of a day's wage, but would put her at risk of losing her job.
- **Infrastructure is a critical factor.** Often, the distance between the home and a health facility, accessible all-weather roads and cheap transport are the factors that can save a child's life in an emergency. However, these links are not always visible to planners and policy makers who take decisions on investments in infrastructure. The vertical segmentation of government departments, with child survival being the concern of the health department and issues such as rural roads and rural transport being dealt with under other departments, acts as a barrier to gender-responsive investments in infrastructure.

How gendered is reporting on Goal 4?

Sex-disaggregated data can provide compelling evidence of the links between gender inequality and child mortality. Unfortunately, only seven of the 78 reports reviewed present sex-disaggregated data on the indicators of infant mortality and child survival. No single report provides disaggregated data against all three indicators.

A positive trend - sex-disaggregated data

- **Infant mortality and under-5 mortality** (Bahrain, Lebanon, Syria, Slovakia, Paraguay)
- **Age-specific death rates** (Poland)
- **Proportion of children immunised against measles** (Syria)
- **Sex ratio** (Tajikistan)

The fact that sex-disaggregated data on infant mortality is available in comparatively few countries is a reflection of the continued prevalence of a bio-medical approach to the issue – particularly unfortunate because the inadequacy of such an approach has been amply demonstrated by studies and researches across the world.

A more encouraging trend is visible in the extent to which women's capabilities have been identified as critical determinants of child survival. Although only seven reports make specific mention of the links between child mortality and gender inequality, as many as 25 mention the mother's health status as a major factor in child survival. The mother's level of education and access to information is mentioned in 16 reports as an important determinant of child survival. This recognition of women's health and education as important issues within the child health discourse is to be welcomed.

However, it should be recognised that a purely instrumental concern for women's health and education – simply because they are necessary to ensure child survival - need not necessarily translate into greater gender equality. Indeed, the majority of the references to the need for women's education and access to information are made in the specific context of equipping women to better care for their babies, rather than as a way of empowering women and strengthening their capabilities across the board.

A positive trend - making connections visible

- **Low status of women as a cause of infant mortality** (Kenya)
- **Inability of teenage mothers to overrule husbands and exercise choices** (Botswana)
- **Early pregnancy related to negative male attitude towards condoms** (Uganda)
- **Cultural preference for educating boys rather than girls** (Uganda)
- **Discrimination in health care for baby girls** (Egypt)
- **Interventions for women's empowerment as part of community health programme** (Ghana, Timor)
- **Son preference** (Albania, Egypt)
- **Gender equality identified as priority** (Egypt)

A more positive indication comes from the fact that reproductive health is mentioned as an important determinant of child survival in nearly one fourth of the reports (17 reports out of 78). Although this term is not defined or unpacked in all cases, it signifies a positive trend, since the reproductive health framework implies affirmation of women's right to control over their own body and fertility.

A major missing link in reporting is the connection between poverty and infant mortality - something that would seem to be the most obviously visible issue. Only three countries (Ghana, Cote d'Ivoire and Rwanda) have mentioned poverty and resource constraints as challenges in meeting Goal 4. Needless to add, the issue of infant mortality does not come up for discussion under Goal 1 in any of the reviewed reports.

How can reporting on Goal 4 be strengthened?

- Presenting **sex-disaggregated data** against the mandatory set of indicators.
- Collecting and presenting data on **additional contextual indicators** such as sex ratio and rates of mother-to-child transmission of HIV/AIDS.
- **Underlining the links** between gender inequality and various determinants of child mortality such as mother's education and health status.
- Using the **reproductive health approach** to make visible the linkages between child survival and women's capabilities, voice and agency.
- Making the **'money trail'** visible by reporting on spending on targeted programmes to enhance women's capabilities, make the health system more accessible to women and increase women's access to reproductive choices.

Additional indicators

The Task Force on Child Health and Maternal Health of the UN Millennium Project has recommended that the target for Goal 4 be reworded to underline the fact that efforts to reduce child mortality must accord priority to the poor and other marginalised groups.

The Task Force also suggests the inclusion of two additional indicators to track Goal 4 – neonatal mortality rate and the prevalence of underweight children in the under-5 age group.

Figure 11 **Causes of infant mortality**

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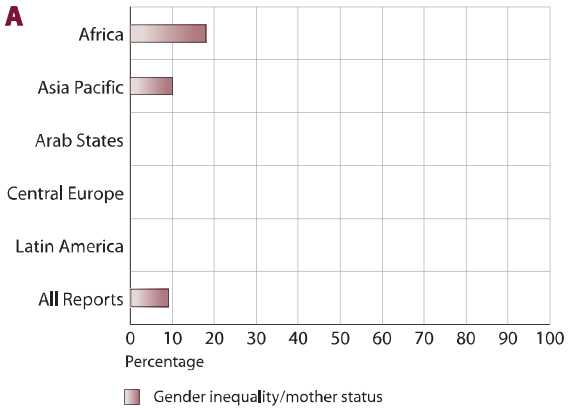
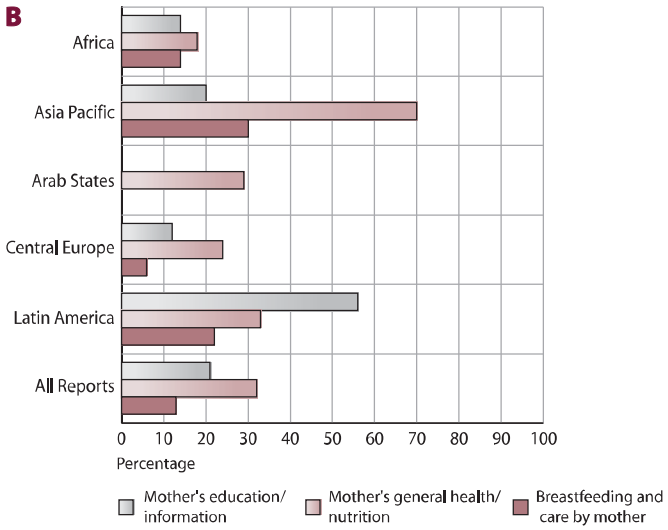


Official data on infant mortality may have inbuilt biases. The Kazakhstan report points out that data collected from women in the course of a survey on fertility history indicated higher rates of infant mortality than the official figures.

Official figures are based on registered births. In many countries, a girl infant who dies soon after birth is buried quietly and never enters the statistics.

B



Ten reports (13 per cent) mention insufficient or inappropriate care by mothers as a leading cause of infant mortality.

In the absence of any data to substantiate this assumption and without any explanation of the reasons underlying it, this statement appears in tune with the tendency to place the entire responsibility of child care and child survival on mothers.

On the other hand, placing this statement in context by juxtaposing it with the limited resources, support and freedom of choice available to women, would be an effective way to draw attention to the need for a sharper focus on gender equality within strategies for reduction of infant mortality.

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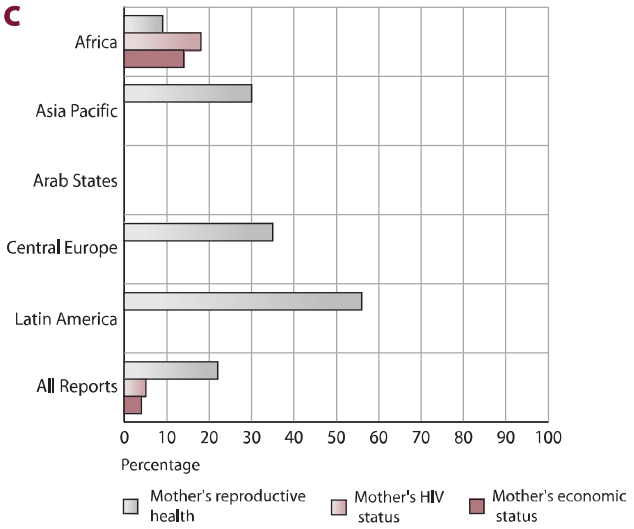

The **Botswana** report points out how the policy of restricting the access of pregnant women to information about their HIV positive status prevents them from taking precautions to prevent mother-to-child transmission of the virus.

GOAL 5

THE 'MATERNAL MORTALITY GOAL'

Goal 5 **Improve maternal health**

Target 6 **Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio**

Indicators *Maternal mortality ratio*

Proportion of births attended by skilled health personnel

A matter of life and death

For millions of women in countries across the world, maternity means unnecessary suffering, illness or death. More than half a million women die annually of pregnancy related complications, a vast majority in Sub-Saharan Africa and South Asia.

As in the case of infant mortality, maternal mortality is not a bio-medical phenomenon. The lack of accessibility and poor quality of health services is only one aspect. Far more serious is the impact of gender inequality.

- **The control of women's sexuality is central to patriarchal societies.** Concerns about 'purity' and 'honour' are the most often cited causes for practices such as female seclusion, female genital mutilation, child marriage and other forms of violence. Apart from the direct impacts of these and similar practices, the indirect effects can include denial of access to education, health care and employment leading to undermining of women's capabilities.
- **The high incidence of nutritional deficits, anaemia and chronic ill-health** are visible reflections of women's subordinate social status. Despite the fact that these increase the risks of childbirth, the construction of motherhood as women's destiny underlies the pressure on women to bear children regardless of the consequences. Early and frequent pregnancies, in complete disregard of the consequences to women's health and lives, are a major cause of maternal death.
- **Women's ignorance about their own bodies and biology** increases their vulnerability during pregnancy and childbirth. While some traditional practices are based on sound principles, some are harmful to the health of both mothers and infants.

- **Women usually bear the entire burden of reproductive and care work**, and continue to do so through pregnancy. Women not only do all the work of cooking, cleaning and caring for children and elders, but have to collect water, fuel and fodder and contribute their unpaid labour to the family farm or enterprise, often while working at another full-time job outside the home. Girls share the burden of care work with their mothers from an early age, often performing heavy and hazardous tasks with long-term negative impacts on their health. The physical consequences of years of overwork greatly increase the risks of maternity.

The Millennium Project Task Force on Education and Gender Equality has identified ensuring reproductive and sexual health and rights of women and girls as one of the priority actions for gender equality.

- Women's subordinate status limits their ability to negotiate the terms of sexual relationships, increasing **vulnerability to violence, abuse** and **unsafe sex**. The consequences are physical and emotional trauma, unwanted pregnancies and higher rates of sexually transmitted infections including HIV/AIDS, all of which contribute to increased maternal mortality.
- **Lack of information and difficulties in accessing safe and reliable contraception** compounds the chances of unwanted pregnancies. In many countries, the non-availability of legal, affordable and safe abortion services forces women to risk their lives with unreliable and unsafe methods in the hands of unskilled practitioners. Even if safe abortion is available as part of public health services the lack of confidentiality and privacy is a deterrent for most women. Fear of the moral condemnation attached to pre-marital or extra-marital sex and religious pronouncements against abortions force women and adolescent girls to rely on risky methods.
- **The secrecy and silence surrounding sex and sexuality** operate to create taboos and distorted notions about this aspect of life. As a consequence, young women (and men) are ill-equipped to deal with these issues in a mature or informed way, thus increasing the likelihood of unwanted pregnancies, HIV/AIDS and sexually transmitted diseases.

Bringing a gendered perspective to reporting on Goal 5 makes these connections visible and can create an enabling environment for achievement of targets for Goals 3,4 and 5.

How gendered is reporting on Goal 5?

Other than Goal 3, Goal 5 is the one most directly concerned with women. However, only 20 of the reviewed reports (about a quarter of the sample of 78 reports) mention gender inequality and women's status as causes of maternal death.

The continued dominance of a techno-medical approach to maternal mortality is reflected in the fact that more than three quarters of the reports identify lack of physical access to health services and low coverage of health infrastructure as the main causes of maternal mortality. The quality of health services – in terms of infrastructure, equipment to handle emergencies and trained personnel – is mentioned in 22 reports.

There is wide variation between reports in the extent to which the connections between maternal mortality and the status of women have been made visible. Recognition of the instrumental value of building women's capabilities is indicated by the fact that the mother's health status is highlighted in 24 reports and level of education is highlighted in 29 reports. In contrast, women's inability to take decisions regarding their own health – a factor that reflects women's agency and is a critical marker of gender inequality – is not widely visible in reporting and is mentioned in only six reports, or less than a tenth of the sample.

Figure 12 Causes of maternal mortality

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In 2000, the average risk of dying during pregnancy or childbirth in the developing world was 450 per 100,000 live births. In countries where women tend to have many children, they face this risk many times. Thus,the chances of dying during pregnancy or childbirth over a lifetime are as high as 1 in 16 in sub-Saharan Africa, compared with 1 in 3,800 in the developed world. This lifetime risk could be substantially reduced if women had the family planning services they desire.

From **The Millennium Development Goals Report**
United Nations, 2005

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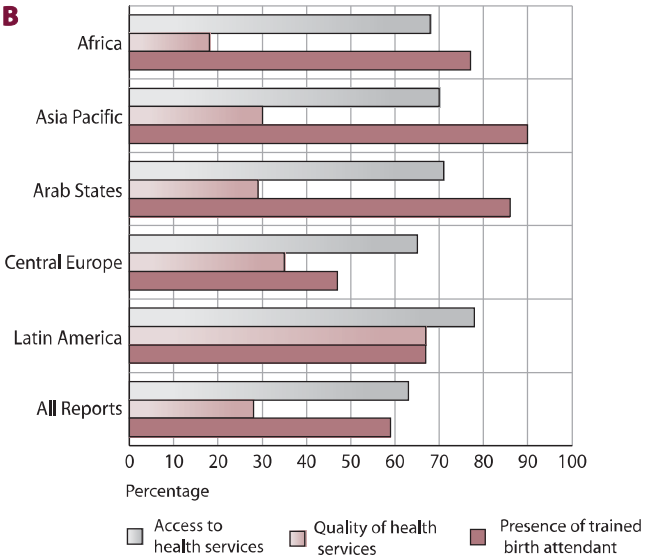

Two reports **(Brazil and Uganda)** have highlighted the issue of how poor women are treated by health care providers. The reports confirm that insensitive or discriminatory treatment by health providers is among the reasons why poor women choose to deliver at home rather than in a health facility.

The reports underscore the need to build the capacities and sensitivities of health care providers both within and outside the formal system.

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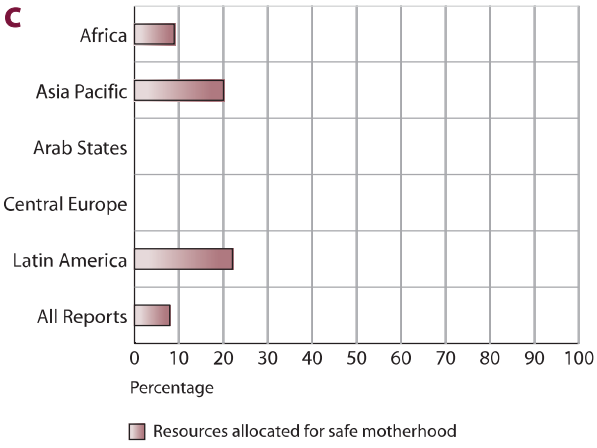


According to WHO, US $3 per person per year is the approximate cost of ensuring universal access for women in low-income countries to health care during pregnancy, delivery and after birth, postpartum family planning, and newborn care.

Adherence to harmful traditional practices is mentioned as contributing to maternal mortality in 10 reports. The uncritical acceptance of traditional practices is again a reflection of women's lack of agency and voice – often, the decisions on management of pregnancy are made by older women in the family rather than by the pregnant woman herself.

The need for births being supervised by trained personnel has been flagged in more than half of the reviewed reports (46 out of 78 reports). These reports stress on the need for building the capacities and skills of traditional birth attendants, and improving the outreach of maternity services to remote and rural areas. However only 20 countries provide data on the number of births attended by trained personnel.

The issue of access to safe abortions is discussed in depth in the overwhelming majority of reports (15 out of 17 reports) from Eastern Europe and the CIS region, where lack of access to cheap and reliable contraceptives pushes women to use abortion as a method of contraception.

Poverty has been identified as a determinant of maternal mortality in 15 reports. However, there is a notable silence on the connections between macroeconomic policies and maternal mortality. Linkages between cuts or stagnation in social sector and health spending, and maternal health, would have enriched the reports and strengthened the case for engendering macroeconomic policies.

A very positive element of reporting under Goal 5 is the shift away from a purely medical approach to the recognition of some key concerns around reproductive health. Early marriage and frequent pregnancies are mentioned as factors contributing to increased maternal mortality in 22 reports. Access to contraceptives is highlighted in 42 reports while the need for access to safe abortions is mentioned in 40 reports. The importance of male involvement and male responsibility for ensuring safe motherhood is underlined in 11 reports. In most cases, the connections between these issues and gender inequality are sharply delineated.

Adolescent girls are identified as a high risk group in 13 reports which also include discussions on issues of vulnerability for girls, including the need for reproductive health education and focused policies for adolescent reproductive health.

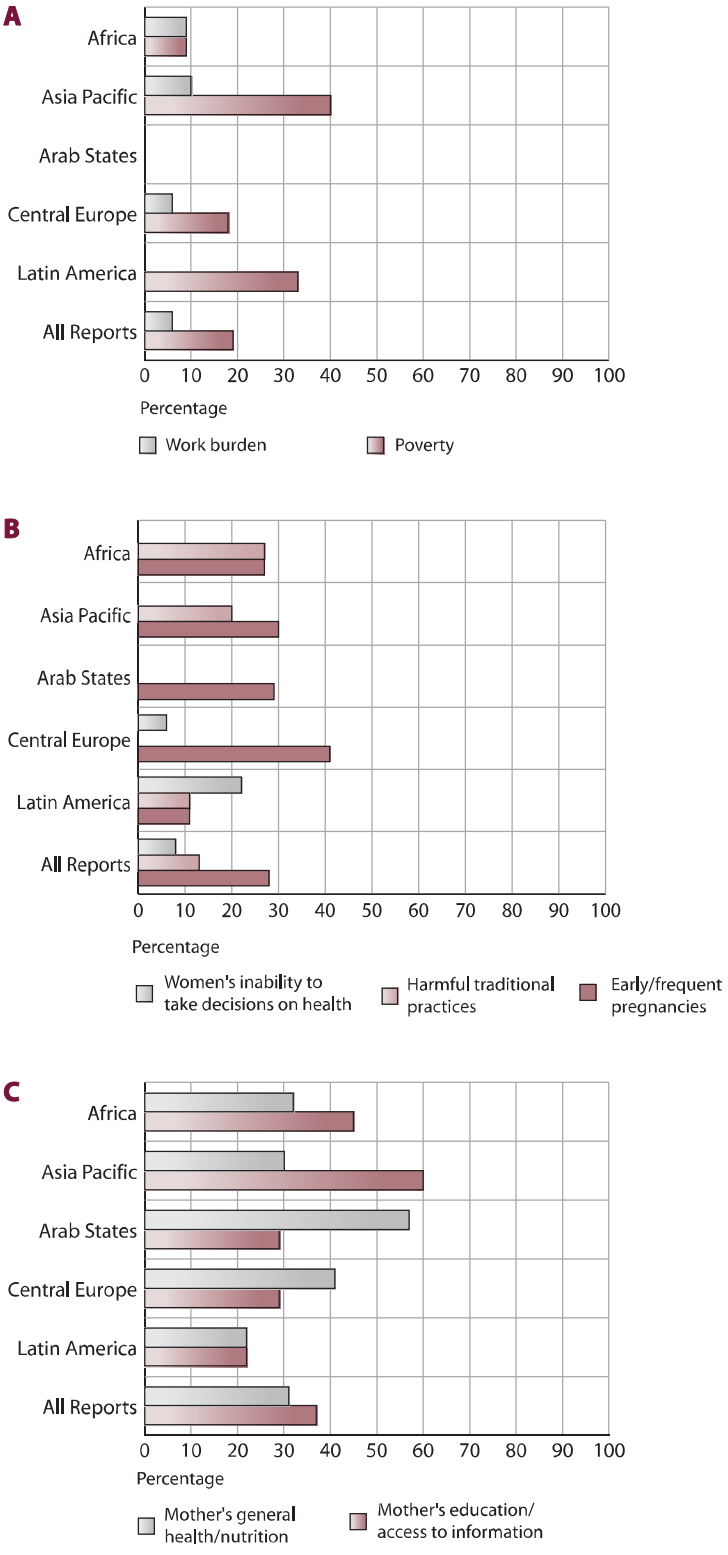
The issue of HIV/AIDS as a factor in maternal mortality has been mentioned in only 10 out of the 78 reports reviewed.

Even less attention is given to the crucial issue of resource allocations for maternal health in national budgets. Only six reports (less than one tenth of the sample) mention resources as a concern – an omission all the more unfortunate because most of the countries covered in the review have yet to achieve desirable levels of spending on health.

Spending on health

- **Low allocations** (Congo, Senegal)
- **Dependence on foreign aid** (Afghanistan)
- **High investments as reasons for progress on targets** (Mauritius, Paraguay)
- **Need for adequate budgets** (Paraguay)

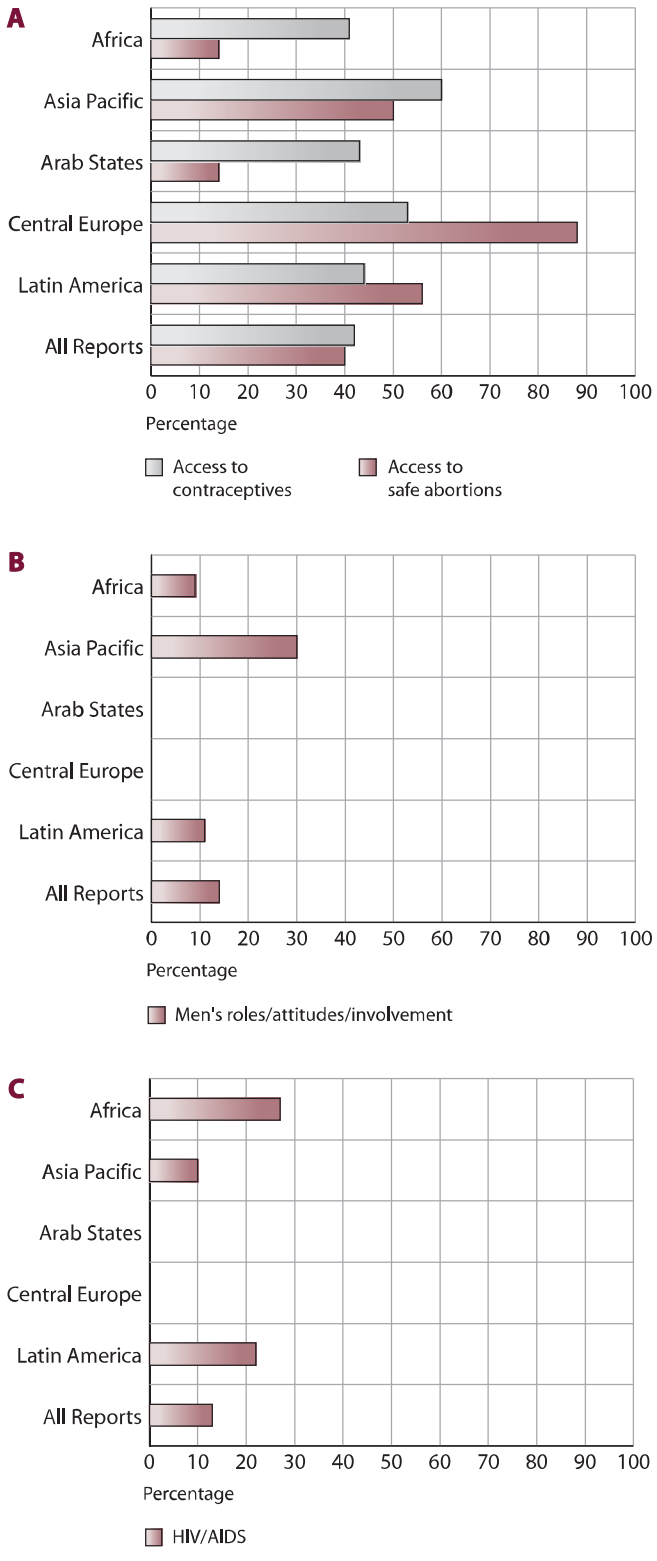
Figure 13 **Causes of maternal mortality**



A positive trend - unpacking statistics

- **Exposing the essence of the tragedy.** The issue is dramatically underlined in the opening statement of the **Afghanistan** MDGR: 'Life is a matter of death, as a woman dies every half an hour trying to give birth.'
- **Unpacking statistics.** The **Vietnam** reports points out that poor families cannot afford to register maternal deaths, and statistics are therefore incomplete.
- **Giving space to women's voices.** The **Uganda** report highlights the connection between rural infrastructure and maternal mortality. A boxed quote from a woman at a village meeting describes how women in labour give birth on the roadside as they are being carried to the nearest hospital which is 10 km away.
- **Putting reproductive health in a wider social context.** The links between reproductive health and a social environment supportive of gender equality are highlighted in the **Chad** report. Social mobilisation through women's organisations and the passage of a Family Code are specifically mentioned.

Figure 14 **Coverage of strategic issues**



The UN Millennium Project Task Force on Child and Maternal Health recommends revised Targets and additional indicators for Goal 5.

Targets

- *Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio, ensuring faster progress among the poor and other marginalized groups.*
- *Universal access to reproductive health services by 2015 through the primary healthcare system, ensuring faster progress among the poor and other marginalized groups.*

Additional indicators

- *Coverage of emergency obstetric care*
- *Proportion of desire for family planning satisfied*
- *Adolescent fertility rate*
- *Contraceptive prevalence rate*
- *HIV prevalence among 15- to 24-year-old pregnant women*

The Task Force Report emphasises the need for particular attention to disadvantaged groups and geographically constrained areas, with data disaggregated accordingly. Multiple dimensions of inequity can be made visible using data collected in Demographic and Health Surveys and Multiple Indicator Cluster Surveys.

From **Who's got the power? Transforming health systems for women and children**
Report of the UN Millennium Project Task Force on Child Health and Maternal Health, 2005

Recognition of adolescents' needs

- **Exclusion of teenage girls from reproductive health services** (Tanzania, Philippines, Indonesia, Georgia)
- **Need for policy on adolescent sexual health** (Zambia)
- **Higher rate of abortions for adolescents** (Kenya, Croatia)
- **Priority attention to adolescents in reproductive health programmes** (Benin, Senegal)
- **Need for reproductive health education** (Mongolia, Georgia, Brazil, Honduras)
- **Data on teenage pregnancies** (Uganda, Brazil)

How can reporting on Goal 5 be strengthened?

- Identifying and reporting on **non-medical factors** implicated in maternal mortality.
- Identifying and present **data on additional indicators** suggested by the Millennium Project Task Force on Sexual and Reproductive Health
- Flagging issues such as the burden of care work and its impacts on the health of girls and women, to **highlight connections** between maternal mortality and other aspects of gender equality.
- Using a **reproductive rights framework** to highlight key areas for action including access to contraception, access of adolescents to health information and services and vulnerability to violence.
- Highlighting the situation of **specially vulnerable groups**, such as poor women, women living in remote areas, women belonging to marginalised communities, women living with HIV/AIDS.
- Reporting on **costing exercises** and **budgetary allocations** for safe motherhood and reproductive health programmes.

The WHO's second syenthesis report on health in PRSPs found that many do not systematically analyse the health situation of poor people and the barriers that prevent poor women in particular from accessing reproductive health care... although health spending is rising in all countries in nominal terms, projected changes in health spending as a proportion of GDP are typically small and health is not generally increasing in importance within the priority sectors identified for poverty reduction. Although the IMF and World Bank have recently called for scaling up to accelerate progess towards the Goals, their country-level processes are not yet advocating major increases in public health spending (including large increases in donor spending) needed to achieve the Goals.

From **Who's got the power? Transforming health systems for women and children**
Report of the UN Millennium Project Task Force on Child Health and Maternal Health, 2005