

**United Nations Commission on the Status of Women
Fifty-seventh session
4 - 15 March 2013
New York**

INTERACTIVE EXPERT PANEL

**Challenges and achievements in the implementation of the
Millennium Development Goals for women and girls**

**THE HEALTH MDGS:
WHAT WORKS FOR WOMEN AND GIRLS?
WHAT HASN'T WORKED? AND WHAT'S NEXT?**

by

**DR CAROLE PRESERN
Executive Director
The Partnership for Maternal, Newborn & Child Health**

1. Summary: The fundamentals for reaching the health MDGs

Healthy populations are the foundation for sustainable social, economic and environmental development, and for peace and security. Every citizen has a fundamental right to the highest attainable standard of mental and physical health and well-being. Yet thousands of women and children die every day from preventable causes. The Millennium Development Goals (MDGs) have been instrumental in prioritizing funding and policies and, therefore, stimulating progress for women's and children's health over the past 13 years, but more remains to be done. While health outcomes have improved, health achievements vary immensely between and within regions, countries, and population groups. In many places progress on health, and in particular on maternal mortality, is insufficient to achieve the goals by 2015.

The Post 2015 Development Agenda provides us with an opportunity to tackle the unfinished agenda of the MDGs while taking on board some of the lessons learned. As we have learned from the MDGs, improving health outcomes will require a focus on equity, integrated health services, and strengthening health systems, as well as a cross-sectoral approach that addresses social determinants of health, such as clean water and sanitation, education, gender equality, and improved nutritional status.

Gender inequality is a critical prohibitive factor for improved health. Child marriage, constrained access to schooling and economic resources, gender-based violence, inadequate access to health care, and other forms of gender-based discrimination, shape girls' and women's health status. They also have a direct impact on their children's health. Expanding proven approaches to reducing gender inequality through action within and outside of the health sector must be a greater priority.

In addition to a focus on gender, a concerted approach from all communities is required to scale up progress for achieving the health MDGs. Such a multisectoral approach will maximize the impact of interventions and efficiency of resources, which is particularly important in these financial times. Efforts within the health sector to increase the coverage of essential interventions and access to essential commodities and to improve data for better planning and accountability is essential.

2. Where do we stand on the Health MDGs for women and girls?

Recent progress is significant

Both maternal mortality and child mortality fell by 47 per cent¹ and 41 per cent² from 1990. Despite population growth, the number of under-five deaths worldwide fell from more than 12.0 million in 1990 to 7.6 million in 2010. And progress in the developing world as a whole has accelerated. Sub-Saharan Africa—the region with the highest level of under-five mortality—has doubled its average rate of reduction, from 1.2 per cent a year over 1990-2000 to 2.4 per cent

¹ WHO, UNICEF, UNFPA and World Bank. Trends in maternal mortality: 1990 to 2010. Geneva. 2012.

² UNICEF, WHO, World Bank, UN. Levels and Trends in Child Mortality: Report 2012 – Estimates Developed by the UN Inter-Agency Group on Child Mortality Estimation. New York. 2012.

during 2000-2010.³ The proportion of women living with HIV has remained stable at 50 per cent globally, although women are disproportionately affected in sub-Saharan Africa (59 per cent of all people living with HIV) and in the Caribbean (53 per cent). At the end of 2010, 6.5 million people were receiving antiretroviral therapy for HIV or AIDS in developing regions- an increase of over 1.4 million people from December 2009, the largest one year increase ever.⁴ A recent World Bank paper⁵ shows that 16 of 20 African countries which have conducted detailed surveys of living conditions since 2005 reported falls in their Under Five Mortality Rate. Twelve had falls of over 4.4 per cent p.a., the rate of decline needed to meet the MDG4 goal. Three countries saw falls of more than 8 per cent p.a., almost twice the MDG rate and enough to halve mortality in a decade. The declines have happened across the continent and across large and small countries, with different cultures and religions, with different rates of economic growth.

But the agenda remains unfinished

The statistics above give reason to hope that a healthier future awaits women, girls and children. But they also highlight the major challenges that remain. In 2011, 273,465 women⁶ and 6.9 million children lost their lives to preventable causes.⁷ While progress on maternal mortality has been substantial, it has been the slowest of all the MDGs. A 5.5 per cent annual rate of maternal mortality rate decline is required to achieve the goal, but the current rate is only 1.9 per cent (since 1990). Sub-Saharan Africa faces the greatest challenge, accounting for 57 per cent of maternal deaths and half of global child deaths. Also 92 per cent of the world's HIV-positive pregnant women live in this region, but only 59 per cent of them received antiretroviral drugs during pregnancy and delivery in 2011.⁸

Progress on the health MDGs is inequitable

The focus on macro goals and national averages masked inequalities within countries. Detailed analyses are necessary to reveal which women face the greatest reproductive risk, which children are the most vulnerable, and which young people are most susceptible to HIV infection. Poverty, social exclusion, and remote location are factors that make some people more vulnerable than others. Everywhere, these factors intersect with gender norms to place some women and children at the highest risk of poor health and hardest to reach. Prioritising dedicated efforts to reach these groups would be a powerful strategy for reducing inequality, advancing the health MDGs, and interrupting the inter-generational transfer of ill health and poverty.

3. Lessons learnt from the MDGs- What has worked? What hasn't?

Although achievement of the health MDGs will almost surely be uneven, there has been accelerated progress on target indicators, in stimulating global political support, and in fostering research and debate on systemic approaches to improve health outcomes. The MDGs coincided

³ UN Millennium Development Report. 2012.

⁴ Ibid.

⁵ World Bank, 2012 Policy Research Working Paper 6057.

⁶ WHO, 2012. Trends in maternal mortality, 1990-2010.

⁷ UNICEF, WHO, World Bank, UN. Levels and Trends in Child Mortality: Report 2012 – Estimates Developed by the UN Inter-Agency Group on Child Mortality Estimation. New York. 2012.

⁸ UNAIDS World AIDS Day Report 2012.

with significantly increased donor financial resources for health (although analysis suggests that the MDGs were less successful in stimulating increased domestic resources). The MDGs also increased global focus on health. The period since the formulation of the MDGs in 2000 has seen, by comparison with the previous decade, an explosion in new global health funding institutions and partnerships (e.g. the Global Fund, GAVI, UNAIDS, UNITAID, GHWA, PMNCH etc.), as well as significant global initiatives to highlight particular issues affecting global public health, such the UNSG's Global Strategy for Women and Children's Health (2010).

“Pass-fail” does not adequately describe progress. Even though many countries will not achieve the MDGs, a significant number of the “failed” countries may be quite close by 2015.

The health MDGs have been **rightly criticized** for a top down, technocratic approach to the selection of goals, targets and indicators, an insufficient conceptual framework for health development and a selection of certain topics and diseases which facilitated verticality and competition, a lack of clarity on definitions, measurement issues and a lack of attention to equity.⁹

There were no universal targets, e.g. for under-five mortality. Thus, countries could have widely different under-five mortality rates and all could be considered to be “on track”. Conversely, countries making speedy progress could be seen as “off-track”, even if progress was accelerating rapidly.

There is a lack of attention to improving monitoring and accountability. Currently much monitoring still has to rely on estimates because of the lack of reliable data. Improvements in e.g. vital registration systems were not monitored. There was no attention to the accountability of different internal and external actors to achieve progress.

Separating health issues into different goals has led to a siloing of disease program and funding and has hampered an integrated approach within health and between health and other social determinants.

4. **Barriers to success: Gender norms and social determinants**

Gender inequality is increasingly recognized as one of the most powerful determinants of health, but the response has far lagged behind. Gender discrimination affects the demand for health care directly and indirectly. Many girls and women lack knowledge about pregnancy-related and HIV risks and threats to child survival. This is the result of low education levels, illiteracy, and lack of access to information such as radio programming. Furthermore, gender norms often limit girls' and women's access to money, along with their mobility, which can delay or prevent them from reaching health services and purchasing essential medicines.

Gender-based violence is now recognised as a major public health problem that cuts across the “Continuum of Care” for reproductive, maternal, newborn and child health, and exacerbates other health risks. In Zimbabwe, women living with HIV reported rates of sexual or physical

⁹ AbouZahr, C. Identifying goals, indicators and targets: key question. <http://www.worldwewant2015.org/health>

violence nearly 30 per cent higher than other women reported.¹⁰ Gender-based violence is individual and societal, and violence against girls and women is rife in conflict situations. Fragile states feature among the countries furthest from achieving the health MDGs.

The synergy between girls' education and their health is widely accepted. While countries have made considerable progress on gender parity in primary schooling – an MDG in itself – girls' post-primary schooling remains a major challenge. This is a health problem because children enter adolescence during these years. Adolescent girls face distinct health risks that they are more likely to avoid when in school. These include child marriage, early pregnancy, and HIV infection. Adolescence also is a formative period for future behaviour, and many secondary school children receive comprehensive sexuality and life skills education. Out of school girls miss the opportunity to gain these assets, which could lay the foundation for health lifestyle choices, empowered futures, and healthier children.

While marriage ages are increasing in all regions, an estimated 142 million girls will be married by 18 (by 2020) if present trends continue. Globally, approximately one in three women aged 20 to 24 were child brides.¹¹ **Child marriage** threatens girls' prospects for education, building skills and a decent livelihood, and accessing social support. It also comes with the risk of early pregnancy, heightened maternal mortality risk, and in heavily HIV-affected regions, increased risk of HIV infection. The babies of young mothers face a higher risk of mortality than babies of women in their 20s.¹²

Other social determinants have distinct effects on girls and women because they are responsible for managing their households and families. They carry the burden of providing adequate nutrition, food security, water, and sanitation – for themselves and for their families. They may face insecurity, violence, and exploitation in order to meet basic personal and household needs. Environmental and climate change threaten access to clean water, adequate nutritious food, stable living environments, and essential services. These forces can combine to reduce girls' and women's resilience, increase their instability, and increase their vulnerability to health problems.

5. Accelerating progress: What's next?

Promoting global and national leadership

Recognizing the slow and unequal progress on the health MDGs, the UN Secretary General launched a global strategy on maternal, newborn and child health in 2010, *Every Woman, Every Child*.¹³ The strategy is credited with generating new commitments (220 commitments to date), attracting new funding, stimulating novel partnerships, and stimulating high level political support for under-addressed health issues. A high-level commission to improve global reporting, oversight and accountability for women's and children's health – the Commission on Information

¹⁰ UNAIDS 2012. Women out loud: How women living with HIV will help the world end AIDS.

¹¹ UNFPA 2012. *Marrying Too Young: End Child Marriage*.

¹² Finlay JE, Ozaltin E, Canning D. The association of maternal age with infant mortality, child anthropometric failure, diarrhoea and anaemia for first births: evidence from 55 low- and middle-income countries. *BMJ Open* 2011;2: e000226. doi:10.1136/bmjopen-2011-000226.

¹³ <http://www.everywomaneverychild.org/>

and Accountability for Women's and Children's Health – was established in January 2011 following the launch of the Global Strategy. The Commission created an Independent Expert Review Group to regularly report on progress.¹⁴ Accountability is further promoted through Countdown to 2015: Tracking Progress in Maternal, Newborn and Child Survival, which disseminates essential country-by-country data that enables countries to monitor their own progress.¹⁵

Global leadership is important, but it is insufficient. The health problems of the poorest will persist without national ownership of the need to protect women and children's health. Recognising this, parliamentarians have been active partners in promoting government leadership, working regionally and globally through the Inter-Parliamentary Union (IPU). The IPU developed a 2012 resolution calling on parliamentarians to take all possible measures to achieve MDGs 4 and 5.

Improving harmonisation and coherence

In the run-up to 2015, summit meetings, commitments, and new initiatives have proliferated. The intensity is yielding benefits, but it brings the potential for fragmentation, duplication, and inefficiency. The Partnership for Maternal, Newborn and Child Health (PMNCH) aims to bring together different actors of the global health community to design and implement strategies to improve women and girl's health across the Continuum of Care. PMNCH includes over 500 partners working at all levels across constituencies to align their efforts to improve women's and children's health. By sharing evidence and information and aligning advocacy efforts, PMNCH promotes increased investment in health, improved implementation of essential interventions and improved accountability for results and resources. Recent efforts to tackle fragmentation have generated consensus on evidence based Essential Interventions for Reproductive, Maternal, Newborn and Child Health. PMNCH is a unique platform which advocates for the integration of services, health systems strengthening, a cross-sectoral approach to health and increased allocation of resources for accelerating the progress on health MDGs. Given the importance of maintaining a global focus on women and children's health, PMNCH has a vital role to play in ensuring a voice for those of its multiple stakeholders who may not have automatic access to the UN discussions and to continue the focus on the unfinished agenda of health MDGs for women and children.

Addressing the social determinants of health

It will be impossible for health systems to reach those at highest risk of maternal and child mortality and reduce their risk without greater emphasis on the social determinants of health. The need to work across sectors to do so is urgent. Health planners and funders should do more to recognise that effective action outside of the health sector has health benefits, particularly when it chips away gender inequality. Educating girls, eliminating child marriage, and supporting married girls are clear priorities for improving maternal and child health and combating HIV. Engaging men and boys to reduce gender-based violence; empowering girls and women so they can control their reproduction and health care; and providing girls and women

¹⁴ IERG 2012. *Every Woman Every Child*: from commitments to action.

¹⁵ <http://www.countdown2015mnch.org/>

with assets such as micro-credit, financial management skills, and mobile technology are a few examples of social interventions with untapped potential to bring health benefits to the most excluded women and children at highest risk of health problems.

The focus on health MDGs for women, children and girls as a lead up to 2015 and beyond should include a goal focused on the health of populations: where the target should be ending preventable deaths and morbidity, especially amongst women and children who are the most vulnerable. The global community needs to come together to champion the cause of “healthy life expectancy” which addresses intersectorality and universality and moves beyond single theme issues, which have been a major obstacle in achieving the MDGs. Investing in girls’ education, investing in efforts to reduce violence against women and investing in improving gender-sensitive, population centric and equitable reproduction, maternal, newborn and child health policies is an investment in social and economic growth and an obligation to realize the human rights for all.

6. Conclusion

Forward-looking leaders from heads of state to heads of households are starting to recognize how gender inequality and other social determinants threaten women’s and children’s health. It will only be possible to accelerate progress in the lead up to 2015 by tackling the underlying causes of health inequality and through targeted action to those who are most excluded. Beyond 2015, integrating the push for gender equality into deliberations on future goals will be fundamental to sustainable development. This is no small task. But the benefits will be significant for today’s women and children and for generations to come.