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**Transforming health systems to strengthen implementation of the  
Beijing Platform for Action and the Millennium Development  
Goals.**

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\* The views expressed in this paper, which has been reproduced as received, are those of the author and do not necessarily represent those of the United Nations.

*““Women and children” – a tag line for vulnerability, an “SOS” for rescue, a trigger for pangs of guilt. Change must begin right there. The MDGs are not a charity ball. The women and children who make up the statistics that drive the MDGs are citizens of their countries and of the world. They are the present and future workers in their economies, caretakers of their families, stewards of the environment, innovators of technology. They are human beings. They have rights – entitlements to the conditions, including access to health care, which will enable them to protect and promote their health; entitlement to participate meaningfully in the decisions that affect their lives; entitlement to demand accountability from the people and institutions that have the duty to take steps progressively to fulfill those rights.”*

Freedman et al 2005: *Who’s got the power? Transforming health systems for women and children*. UN Millennium Project Task Force Four report.

## **Health and the MDGs** <sup>1</sup>

The Millennium Development Goals (MDGs) set out a vision of an improved world by 2015, where extreme poverty and hunger is halved, women are more empowered and gender equality is promoted, there is universal access to primary education for boys and girls, child mortality is reduced and maternal health improved, HIV/AIDS, malaria and tuberculosis are all significantly reduced, and environmental sustainability is ensured within a global partnership for development. But, for some, the MDGs have been viewed as yet another set of aspirational targets, high in ideals, but unattainable at the end of the day. Others have raised valid concerns that the goals have been expressed as narrow targets reliant on measurable outcomes, and in the case of the health related goals, targets that are generally disease specific and that fail to address the roots of the existing problems. Within the context of sexual and reproductive health, outrage has been expressed at the deliberate exclusion of sexual and reproductive rights as an explicit goal, a goal that had been hard fought and hard-won at the International Conference on Population and Development (ICPD) in Cairo 1994, and reinforced through the Platform for Action elaborated and agreed upon at the Fourth World Conference on Women, Beijing 1995.

But, the MDGs are a reality and are not going away. To ignore them is to both dismiss the Millennium Declaration from which the MDGs were born, as well as fail to use the opportunity opened up by the MDGs to take bold steps necessary to address the dire situations in which millions men, women and children are struggling to survive throughout the world today.

The Millennium Declaration, representing an unprecedented global consensus reached by 189 member states of the United Nations, advances a vision for improving the condition of humanity by linking poverty reduction and development, peace and security, protection of the environment, and human rights and democracy. Explicit within the Declaration is recognition of the importance of promoting gender equality and women’s empowerment, reconfirming the central role of gender equality from the perspective of the Beijing conference and ICPD.

The purpose of this paper is to explore the opportunity provided by the Millennium Declaration and Millennium Development Goals to review our understanding of health systems, and the role

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1. It must be noted that the conceptual framework, discussion and recommendations presented in this paper are abstracted from UN Millennium Project Task Force Four report: “Who’s got the power? Transforming health systems for women and children.” Lead Authors: Lynn P. Freedman, Ron Waldman, Helen de Pinho, and Meg E. Wirth.

of health systems in forging the kind of equitable and democratic society essential for the successful implementation of the Beijing Declaration and Platform for Action. Much of the discussion in this paper is based on the findings and recommendations of the UN Millennium Project Task Force Four Report.<sup>2</sup>

### **Health, poverty and development**

The links between health, poverty and development are generally described in two ways. The first, in which health is regarded as an intrinsic good, enabling each person to “lead the kind of life he or she has reason to value”<sup>3</sup>. Good health and the conditions that enable it are thus regarded as the essence of a life with dignity<sup>4</sup>. Secondly, health is regarded as a precondition for access to economic assets, enabling people to engage productively within society. This is especially true when considering sexual and reproductive health and rights. As women are better able to control their fertility, increase their education, fulfil their productive role, and enhance their economic status, their vulnerability within society is decreased. The impact of gender-based discrimination and exclusion from services on the health of women is well documented, as is the damaging effects of such poor health on women’s ability to participate within society at all levels.

But there is a third relationship between health, health care, poverty and development which is of particular importance as we seek to enhance the implementation of the Beijing Platform for Action. From various assessments of poverty, what emerges is an imperative to regard the experience of poverty as relational, informed by the interactions between individuals/communities and structures of power<sup>5</sup>. If we regard health systems as core social institutions at the interface between individuals and the structures that shape their broader society (rather than as just delivery systems of health care), then the abuse, exclusion (including gender discrimination) and inequality experienced from the health system becomes part of the experience of being poor and being female<sup>6</sup>. The extent to which people are able to engage as citizens in redefining this experience is both a measure of their personal freedom and agency as well as a reflection of a society’s own state of democracy and balance of power. “A new respect for the role of health systems in creating or reinforcing poverty, and conversely, in building a democratic society should be the foundation for policies to achieve the health MDGs”<sup>4</sup>.

For women, to access health care and fulfil their rights to sexual and reproductive health requires a response guided not only by the technical interventions. For the vast majority of women in poor countries to benefit from these interventions, greater attention is needed to address those broader social, economic and political forces that act systematically to result in the enormous levels of inequity and exclusion that are an integral part of women’s and poor people’s lives in many countries.

The interventions to improve women’s health and reduce maternal mortality are generally known, and accepted, and have been represented in the obligations and commitments embodied in CEDAW and the Beijing Platform for Action as well as other regional and national agreements (table 1).

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<sup>2</sup> Freedman, Waldman, de Pinho, & Wirth, 2005

<sup>3</sup> Sen, 2001

<sup>4</sup> Freedman, in press

<sup>5</sup> Narayan, 2000

<sup>6</sup> Freedman, in press; Mackintosh, 2001

*Table 1: Summary of obligations and commitments to improve women's health in CEDAW and the Beijing Platform for Action*

<b>CEDAW</b>	<b>BEIJING PLATFORM FOR ACTION</b>
<ul style="list-style-type: none"> <li>• Eliminate discrimination in the field of health care, to ensure equality between men and women in access to health-care services, including those related to family planning (article 12.1)</li> <li>• Ensure women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary (article 12.2)</li> <li>• Ensure women adequate nutrition during pregnancy and lactation (article 12.2)</li> <li>• Ensure rural women's right to adequate health-care facilities, including information, counselling and services in family planning (article 14.2.b)</li> <li>• Eliminate discrimination in education to ensure women's access to educational information to help ensure the health and well-being of families, including information and advice on family planning (article 10.h)</li> </ul>	<ul style="list-style-type: none"> <li>• Increase women's access throughout the life cycle to appropriate, affordable and quality health care, information and related services (strategic objective C.1)</li> <li>• Strengthen preventive programmes that promote women's health (strategic objective C.2)</li> <li>• Undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS and sexual and reproductive health issues (strategic objective C.3)</li> <li>• Promote research and disseminate information on women's health (strategic objective C.4)</li> <li>• Increase resources and monitor follow-up for women's health (strategic objective C.5)</li> <li>• Eliminate discrimination against girls in health and nutrition (strategic objective L.5)</li> </ul>

And yet, in many countries progress towards improving maternal health, attaining universal access to sexual and reproductive health care and ensuring that women are free to exercise their rights to sexual and reproductive health, is extremely slow, and in some countries the data show regression rather than progression.

### **Understanding the size and shape of the problem**

The proximate causes of poor health and mortality in women of reproductive age have been identified. It is estimated that about 530,000 maternal deaths occur each year, the burden of these deaths falling disproportionately on the poor. While in a handful of countries the maternal mortality ratio has dropped, in the great majority of high mortality countries, there has been little change (Table 2). An increase in maternal deaths has been noted in countries with high and growing levels of HIV/AIDS and malaria<sup>7</sup>. Notable exceptions are Sri Lanka and Malaysia, who have halved their maternal mortality ratios every 6 to 12 years from the 1950s to the 1990s, demonstrating that political commitment to ensure the actual implementation of a step-by-step program to make services available and utilized can work, even when GDP is relatively low<sup>8</sup>.

<sup>7</sup> McIntyre, 2003

<sup>8</sup> Pathmanathan & Liljestrand, 2003

Table 2: Maternal mortality around the world

<i>UN region</i>	<i>Maternal mortality ratio (maternal deaths per 100,000 live births)</i>	<i>Number of maternal deaths</i>	<i>Lifetime risk of maternal death 1 in:</i>
<b>World Total</b>	<b>400</b>	<b>529,000</b>	<b>74</b>
<b>Developed regions</b>	<b>20</b>	<b>2,500</b>	<b>2,800</b>
<b>Developing regions</b>	<b>440</b>	<b>527,000</b>	<b>61</b>
Africa	830	251,000	20
Asia*	330	253,000	94
Latin America and the Caribbean	190	22,000	160
Oceania*	240	530	83

\*Japan and Australia/New Zealand have been excluded from the regional averages and totals <sup>9</sup>

These striking differences between countries are also evident within countries. An analysis of ten countries with dramatically different maternal mortality ratios, overall levels of human development and GDP per capita, showed that in each of the countries maternal death is associated with poverty-related characteristics. For example, in Indonesia in 1997 the risk of death was four times higher in the poorest quintile than in the richest <sup>10</sup>. In addition to maternal deaths it is estimated that another 8 million women suffer complications from pregnancy and childbirth with lifelong consequences.

Other aspects of maternal health present a mixed picture. Although fertility has declined (from a total fertility rate of 5.0 births per woman in 1060 to 2.7 in 2001), there are still an estimated 201 million women with an unmet need for contraception. The result is approximately 70 – 80 million unintended pregnancies each year in developing countries <sup>11</sup>, and an estimated 20 million unsafe abortions associated with 70,000 maternal deaths <sup>12</sup>. Violence continues to destroy the lives of women globally. Sexually transmitted infections, including HIV/AIDS, ravage whole communities. Women and girls make up almost half the HIV infected population ages 15- 49 worldwide, and in Sub-Saharan Africa the rate is close to 60 percent<sup>13</sup>. Adolescent fertility rate remain high, and young women have higher chances of suffering from complications at birth and have a higher unmet need for contraception.

The interventions needed to address most of these conditions are generally known. The World Bank estimates that 74 percent of maternal deaths could be averted if all women had access to interventions for addressing complications of pregnancy and childbirth (Figure 1) <sup>14</sup>.

<sup>9</sup> WHO, UNICEF, & UNFPA, 2003

<sup>10</sup> Graham, Fitzmaurice, Bell, & Cairns, 2004

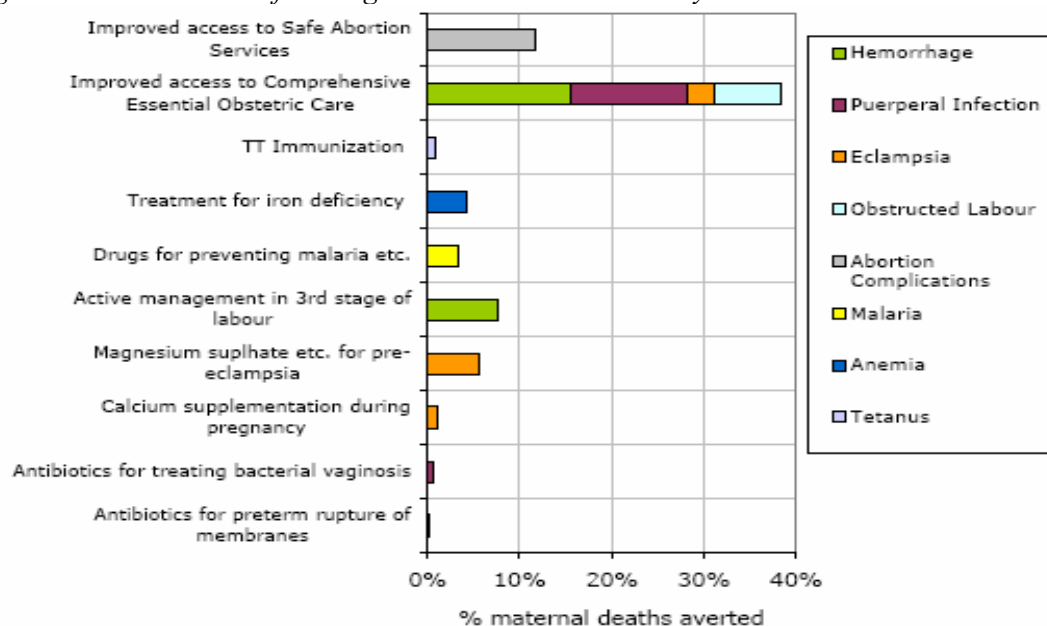
<sup>11</sup> Singh, Darroch, Vlassoff, & Nadeau, 2004

<sup>12</sup> WHO, 1998

<sup>13</sup> UNAIDS, 2004

<sup>14</sup> Wagstaff & Claeson, 2004

Figure 1: Full utilization of existing services would dramatically reduce maternal deaths



Source: adapted from (Wagstaff & Claeson, 2004)

Universal access to sexual and reproductive health information and services could reduce the number of maternal deaths by as much as 20 – 35 percent by simply reducing pregnancies to the number desired<sup>15</sup>. In addition, birth spacing has a significant effect on child mortality, potentially reducing child deaths by as much as 20 percent<sup>16</sup>. With the full complement of sexual and reproductive health services, including interventions for adolescents, the impact on well being and poverty reduction would be even greater<sup>17</sup>.

### **Rethinking our approach to Health systems**

The question remains – if these interventions are known, why is it that millions of women are not benefiting from them? Implementing the Beijing Platform for Action, and achieving the Millennium Development Goals requires that we rethink our approach to health systems

As a starting point we base our discussion on the WHO definition of the health system: “all the activities whose primary purpose is to promote, restore, or maintain health”<sup>18</sup>. This includes interventions in the household and community and the outreach (health information and education, etc.) that supports them, as well as the facility-based system and broader public health interventions, such as food fortification or anti-smoking campaigns. It includes all categories of providers: public and private, formal and informal, for-profit and not-for-profit, allopathic and indigenous. It also includes mechanisms, such as insurance, by which the system is financed as well as the various regulatory authorities and professional bodies who are meant to be the “stewards” of the system. . While it is understood that poor health is connected to broader social,

<sup>15</sup> Daulaire, Leidl, Mackin, Murphy, & Stark, 2002; Maine, 1991

<sup>16</sup> Jones, Steketee, Black, Bhutta, Morris, & Group, 2003

<sup>17</sup> Singh, Darroch, Vlassoff et al., 2004

<sup>18</sup> WHO, 2000

economic and environmental factors, some of which must be addressed from outside the health sector, in many cases the impact of these factors is mediated through the health sector, for example advances in a woman's empowerment and economic status would enable her to take decisions and act to access health care as required.

The Task Force Four report puts forward a second line of analysis, in addition to that based on existing epidemiological data. This second approach focuses on health systems and their unique role in reducing poverty and promoting democratic development.<sup>19</sup>

In many poor countries (and indeed in many rich countries) health systems are in crisis. They are fragmented, unable to ensure access and availability to key health interventions necessary to meet the MDGs or guarantee implementation of the Beijing Platform for Action<sup>20</sup>. For many, the costs of accessing care are prohibitive, often catastrophic<sup>21</sup>. Studies in Tanzania report several deaths of women denied treatment because they could not pay<sup>22</sup>. And, as discussed earlier, health systems act to exclude people from care, deepen inequity and worsen the experience of poverty.

Understanding why health systems are in such crisis requires an examination of the dominant health policies that have guided health sector reform initiatives, particularly over the past two decades. The IMF and World Bank have been highly influential in health sectors in low and middle-income countries. As advocates of the so-called "Washington Consensus", they have directly and indirectly affected health policies, prioritising fiscal discipline, financial and exchange rate liberalisation, privatisation and deregulation<sup>23</sup>. Healthcare has been conceptualised as a marketable (and tradeable) commodity, to be supplied through competition-driven private sector, with a diminished role of the state in provision of social service. Paradoxically, a weakened state presence has resulted in a weakening of state capacity required to perform the regulatory, governance and gap-filling functions on which a market-based systems depends. Consequently, neither the private nor the public health sectors function adequately and the result is a "wide and chaotic array of services of wildly varying quality".<sup>24</sup>

Within this context, two facts emerge. The first is that to meet the MDGs and Beijing Platform for Action will require a substantial injection of funding, increased spending on health and massive scaling up of interventions. Secondly, if this response is limited ONLY to simply pouring huge amounts of money and resources into scaling up health services and expecting poor and marginalized groups, including women, to benefit through a 'trickle-down' approach, then it will fail, once again. As will allocating funds to seemingly "pro-poor" interventions fail to guarantee a more equitable and non-discriminatory system. It will fail because it does not address head on the power dynamics that operate within health systems resulting in exclusion, discrimination and a denial of people's rights to health care.

The core issue is how to create a health system that encourages supports and sustains increasing inclusion that is redistribution? In marketized health systems, exclusion of those who cannot pay, is deemed legitimate. Cross subsidisation within these health system is exposed and driven out,

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<sup>19</sup> Freedman, Waldman, de Pinho et al., 2005.

<sup>20</sup> Travis, Bennett, Haines, Pang, Bhutta, Hyder et al., 2004

<sup>21</sup> Ravindran, Kikomba, & Maceira, 2003

<sup>22</sup> Mackintosh & Tibandebage, 2002

<sup>23</sup> McGill, 2005(forthcoming)

<sup>24</sup> Freedman, Waldman, de Pinho et al., 2005, page 96

and any redistribution that may occur is regarded as an ‘unrequited gift’ from rich to poor – ultimately a difficult system to sustain<sup>25</sup>.

The UN Millennium Project Task Force Four proposes that building a health system around healthcare relationships conceived not as gifts, but as entitlements may move health systems in a more sustainable direction. The task force outlines a different approach to health systems compared to the conventional, and currently dominant approach described above (Table 3).

*Table 3: Task Force approach to health systems*

	<b>Conventional approach</b>	<b>Task Force Approach</b>
<b>Primary unit of analysis</b>	Specific diseases or health conditions, with focus on individual risk factors	Health system as core social institution, essentially relational
<b>Driving rationale in structuring the health system</b>	Commercialization and creation of markets, seeking financial sustainability and efficiency through the private sector	Inclusion/equity with cross-subsidy and redistribution across the system
<b>Patients/users</b>	Consumers with preferences	Citizens with entitlements/rights
<b>Role of state</b>	Gap-filler where market failure occurs	Duty-bearer obligated to ensure redistribution and social solidarity rather than segmentation that legitimates exclusion and inequity
<b>Equity strategy</b>	Pro-poor targeting	Structural change to promote inclusion

Source:<sup>26</sup>

The focus of the Task force approach is to shift the perception and mindset regarding health systems from the prevailing conventional approach that is intrinsically market driven, towards one that is based on two fundamental principles: human rights and equity.

*Implementing human rights in health:* The right to health encompasses both freedoms, including the right to have control over one’s reproductive capacity, and entitlements, such as access to healthcare. This has been clearly articulated in the Beijing Declaration as well as the Millennium Declaration.

A rights based approach to healthcare regards patients as citizens entitled to healthcare, rather than consumers with choices, ensures the development of constructive accountability mechanisms to make certain that health systems function responsibly and equitably, recognises that the state has an obligation to create the conditions for effective assertion of health claims, and to respect, protect and fulfil these claims<sup>27</sup>. Key to this rights-based approach is the understanding that the right to health will not be fulfilled simply by signing a document, or ratifying a treaty.<sup>28</sup> It takes time,

<sup>25</sup> Mackintosh & Gilson, 2002

<sup>26</sup> Freedman, Waldman, de Pinho et al., 2005

<sup>27</sup> Freedman, Waldman, de Pinho et al., 2005

28. In its approach to human rights, the Task force distinguishes between two concepts:

“ 1. Human rights as formal law, including the international human rights system of treaties and reporting mechanisms (treaty bodies, special rapporteurs, and working groups) and domestic courts as well; and



money, commitment and action. The principle of progressive realisation requires states to take all appropriate steps to realise the right in question “to the maximum extent of available resource”. This means that at a practical level:

- Actions must be concrete, deliberate and targeted, and must signal commitment to fulfilling rights claimed,
- Budget allocations are relevant – and must be monitored to ensure that there is action towards addressing fundamental health needs
- Some interventions must take priority over others – especially when there is a legacy of neglect for example in addressing maternal mortality, and providing sexual and reproductive healthcare<sup>27</sup>.

*Strengthening health systems: ensuring equity:* Identifying the most policy relevant next steps requires addressing issues of exclusion and inequity in a systematic rather than “gap-filler” manner. It is not an invitation (or instruction) that countries start from ‘scratch’ to build up their ideal health system. Instead, the process begins with a recognition of the balance of power between state, the private health sector – regulated or unregulated, the position and strength of the ministry of health and the relative strength of citizens to make claims on the health system, and an understanding that despite past experience with some of the international donors “one size (policy) does not fit all”.

Three basic principles that can usefully inform policymaking committed to increasing inclusion and closing the equity gap (where equity can be defined along a number of axes including wealth, gender, geographical) are proposed.

1. Strengthening government legitimacy - enabling the state to take actions that will increase the currency of redistribution and inclusiveness as social norms. This clearly hinges on legitimacy that is demonstrated through good governance – accountability, competent and respect for human rights and the rule of law<sup>29</sup>.
2. Preventing excessive segmentation by enhancing the norm of collaboration to improve services in the private and public sectors. This requires a supportive policy environment and includes collaborative regulation. For example the accreditation of private medical practitioners who adhere to standardised guidelines for the management of sexually transmitted infections<sup>30</sup>.
3. Strengthen the voice of poor and marginalised people to make claims as part of a rights based approach to strengthening health systems. Developing a culture of constructive accountability, requires building the capacity of communities, civil society and government staff to engage effectively, ensuring that the appropriate mechanisms are in place, adjusting the way information is treated including transparency in budgets and expenditures – allowing for closer monitoring of spending against proposed objectives. In may, in some instances also require compensating people for the time they devote to such engagement, requiring specific allocations in the budget<sup>31</sup>

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2. Rights-based approaches in development practices, in which principles and values derived from human rights are incorporated into policy and program design and implementation (whether or not the term human rights is used). This distinction underscores the difference between doing human rights work on health and doing health work that uses human rights as one of its guiding principles” (Freedman, Waldman, de Pinho et al., 2005)

<sup>29</sup> Standing, 2004

<sup>30</sup> Blaauw & Schneider, 2003

<sup>31</sup> Murthy & Klugman, 2004

## **MDG 5 - Improving maternal health: a tool for strategic leverage?**

It is clear that achievement of all of the MDGs will have a positive effect on the health of women, but only one goal has an explicit connection to women's health: MDG5: "to improve maternal health". This goal is put into action with a target to reduce by three quarters, between 1990 and 2015, the maternal mortality ratio". Two indicators for tracking progress towards the target have been suggested, first the maternal mortality ratio, and second, the proportion of births attended by skilled attendants.

This sets up a serious problem of "fit" between MDG 5 goal and its target. Improvement in maternal health requires more than reducing maternal deaths. It also requires guaranteeing women's and girl's sexual and reproductive health and rights – those aspects of sexual and reproductive health best captured by ICPD and the Beijing Platform for Action. But access to sexual and reproductive health care would have little impact on reducing the maternal mortality ratio (unless access to safe abortion is included). What is required to reduce maternal deaths is to ensure immediate access to emergency obstetric care for all women who require it.

Improving maternal health, decreasing maternal mortality: each part of the equation provides an opportunity to strategically force the issue of strengthening health systems onto the development agenda. To address maternal mortality for a human rights perspective, Freedman proposes four premises<sup>32</sup>:

- One: Dramatic reductions on maternal mortality will not happen until there is widespread, equitable access to Emergency obstetric care
- Two: Emergency obstetric care will only be accessible to all women, rich and poor alike, when countries have functioning health care systems;
- Three: The fate of the health system – including Emergency obstetric care is ultimately tied to broader development processes which are always political driven by explicit or implicit values, as value are always chosen , they can be challenged and changed; and
- Four, that the deterioration of health systems in high mortality countries is a global problem. Rich countries are complicit in what has happened to health systems in poor countries.

On a practical level, ensuring equitable access to quality emergency obstetric care requires functioning, well managed, integrated primary health care systems, with a focus at district level, effective referral systems, an adequate supply of appropriately skilled birth attendants who are linked into the health system via the clinics and first level referral hospitals, and quality care that is affordable to the women. (The Millennium Project has recommended free basic health services). What is immediately evident is that addressing maternal mortality forces attention to wider systemic problems, moving the organisation of the health system away from a collection of vertical interventions (favoured by donors), towards the development of integrated district health systems. What is also evident, is that this shift carries with it the potential to improve the health of the population beyond the women and newborns saved. Likewise, improving maternal health provides an opportunity to ensure access to sexual and reproductive health, key to the achievement of the MDGs.

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<sup>32</sup> Freedman, 2004 page 38

## **Improving global policy and funding frameworks for health systems**

For many low income countries, developing inclusive and equitable health systems that would address the MDGs and enable implementation of the Beijing Platform for Action, requires more than adjusting national policies. It requires serious revisions in the global policy and funding environments upon which many of these countries are reliant.

Although there has been a shift towards commitment to direct poverty reduction and calls for dramatic scale up of official development assistance amongst the leadership of the IMF and World Bank, this has failed to translate into action at country level. The HIPC initiative is complicated and inflexible, debt relief limited and still linked to macroeconomic targets<sup>33</sup>. Poverty reduction strategy papers, key instruments for all concessional loans, were originally viewed as opportunities for outcome-focused, comprehensive national planning through a participative planning process. But, on review these have generally been found to be externally driven, with limited sectoral participation. Rather than reflect the call for scale up in development assistance, strategies developed for poverty reduction have been required to be funded with available resources<sup>34</sup>. From a health perspective, the ministry of health is seldom involved in the poverty reduction strategy process, and in general there has been huge variation in the scope and quality of inclusion of reproductive and women's health issues. Limited analysis of the barriers for women and poor people to accessing healthcare has resulted in strategies that focus on better targeting rather than addressing the issues systematically<sup>35</sup>.

On the positive side, some donors are attempting to harmonize their policies and procedures, and in turn influencing development banks to move away from financing individual projects towards programmatic support to governments, for example the sector wide approach to health funding introduced in Ghana. While these initiatives are generally welcomed, concerns have been raised regarding the fate of smaller programmes that address a particular issue, for example post abortion care, and that run the risk of not being considered within the context of a broader sector wide approach. In addition non-participation of some donors in this harmonization process, notably USAID, has meant the continuation of vertical programmes, further fragmenting already fragile health systems.

The challenge is for the health sector and all health stakeholders to seek opportunities to shift the dominant macroeconomic discourse and use development assistance frameworks in a manner that supports long-term investments in sustainable health systems<sup>36</sup>. Global institutions are critical partners. Poverty reduction strategy processes and funding mechanisms should support and promote actions that strengthen rather than undermine equitable access to good-quality health care<sup>37</sup>. To do so, global institutions will need to commit to long-term investments, remove restrictions on funding of salaries and other recurrent costs, align funding from donors and international financial institutions with national health programs to meet the MDGs and the Beijing Platform for action, and allow health stakeholders to fully participate in the development of funding plans. In line with recommendations of the overall Millennium Project report, "Investing in Development", PRSPs must become "needs based" reflecting what is required to meet the MDGs rather than

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<sup>33</sup> McGill, 2005(forthcoming)

<sup>34</sup> World Bank/Operations Evaluation Department (OED), 2004

<sup>35</sup> WHO, 2004

<sup>36</sup> McGill, 2005(forthcoming)

<sup>37</sup> Freedman, Waldman, de Pinho et al., 2005

planning within a limited envelope of available resources<sup>38</sup>. It is recommended that in developing these needs based PRSPs, full consideration must be given to “what it would take” to implement the Beijing Platform for Action, prioritising those areas that have traditionally been ignored, for example addressing maternal mortality.

### **Monitoring progress**

We know that what gets measured is what gets done. We also know that it is too late (and given the politics – unlikely) to include a new goal relating to sexual and reproductive health and rights. For this reason Task Force 3 (Gender) and Task force 4 (Child health and maternal health) have recommended additional indicators and targets that could be used to by countries to track progress as part of their MDG country reports. (Table 4). Both task forces have also called for improved data gathering systems, and a provision that all data, where appropriate, should be disaggregated by sex.

*Table 4 Existing and proposed changes to targets and indicators with specific reference to sexual and reproductive health. (proposed changes in italics)*

<b>Goal</b>	<b>Targets</b>	<b>Indicators</b>
<b>Goal 3: Promote gender equality and empower women</b>		<ul style="list-style-type: none"> <li>• <i>Proportion of contraceptive demand satisfied</i></li> <li>• <i>Adolescent fertility rate</i></li> <li>• <i>Prevalence of domestic violence</i></li> </ul>
<b>Goal 5: Improve maternal health</b>	<p>Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio, <i>ensuring faster progress among the poor and other marginalized groups.</i></p> <p><i>Achieve universal access to reproductive health services through the primary health care system by 2015, ensuring faster progress among the poor and other marginalized groups.</i></p>	<ul style="list-style-type: none"> <li>• Maternal mortality ratio</li> <li>• Proportion of births attended by skilled health personnel</li> <li>• <i>Coverage of emergency obstetric care</i></li> <li>• <i>Contraceptive prevalence rate</i></li> <li>• <i>HIV/AIDS prevalence among 15- to 24-year-old pregnant women (see Goal 6 indicator)</i></li> <li>• <i>Proportion of contraceptive demand satisfied</i></li> <li>• <i>Adolescent fertility rate</i></li> </ul>

In making these recommended changes and additions the Task forces have sought to achieve the following:

- Monitor equity – tracking the extent to which targets are achieved faster amongst poor and other marginalised groups.
- Assess health system strengthening – tracking coverage of emergency obstetric care.
- Monitor human resource availability – through the proportion of births attended by skilled birth attendants. While this indicator should not be used to track maternal mortality as it represents an intervention that can (and often is) deployed outside of the

<sup>38</sup> UN Millennium Project, 2005

health system, it is important, as it is the only goal that explicitly links to human resources.

- Assess the ability of how well a country is able to satisfy the family planning desires of women.

The ability to make evidence – based statements about the level of maternal mortality has been identified as a key factor in mobilizing the political will to address maternal mortality in many countries. The invisibility – the phantom quality- of the death of women in pregnancy and childbirth is, in fact, one more dimension of the social devaluation of women<sup>39</sup>. For this reason, a strong set of indicators for maternal mortality reduction is potentially a powerful way to frame political demands for the fulfilment of women’s rights to the conditions necessary to survive pregnancy and childbirth, and ensure improved maternal health.

Ultimately, no matter what proposals or recommendations are made, in the words of the UN Millennium Task Force Four, “the same question must be asked, answered and confronted at every level in any serious strategy to change the state of child health, maternal health and reproductive health in the world today, namely, “who’s got the power?” How can the power to create change be marshalled to transform the structures, including the health systems, that shape the lives of women and children in the world today?”<sup>40</sup>

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<sup>39</sup> Freedman, Waldman, de Pinho et al., 2005; Graham & Hussein, 2004

<sup>40</sup> Freedman, Waldman, de Pinho et al, 2005, page x

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