



‘En-gendering’ the *Millennium Development Goals* (MDGs) on Health



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Proposals for the MDG Storylines

Introduction

In September 2000, 189 nations ratified the *United Nations Millennium Declaration*, an ambitious document affirming the right of every human being to development and laying out a path toward freedom from want for every woman, man, and child¹. To ensure that progress towards this end be measurable, representatives of UN agencies and other international organizations defined a set of goals, targets, and indicators for combating poverty, hunger, disease, illiteracy, environmental degradation and discrimination against women. These measures, collectively known as the *Millennium Development Goals* (MDGs), have become a prime focus of development work throughout the globe -- a gold standard to which programmes aspire, and by which they measure their work. (See Annex 1 for a full list of the MDGs.)

The *Millennium Declaration* explicitly recognises that “the equal rights and opportunities of women and men must be assured”². The MDGs therefore acknowledge that gender -- what a given society believes about the appropriate roles and activities of men and women, and the behaviours and status that result from these beliefs -- can have a major impact on development, helping to promote it in some cases while seriously retarding it in others. MDG number three (out of eight total) is, in fact, specifically about gender, calling for an end to disparities between boys and girls at all levels of education.

There is general agreement that education is vital to development, and ensuring that girls as well as boys have full opportunities for schooling will help improve lives in countless ways. Nevertheless, it would be wrong to conclude -- as a casual reader of the MDGs might -- that the relevance of gender equality to development is con-

¹ *United Nations Millennium Declaration* General Assembly Resolution, 55th session, document A/RES/55/2, Chapter III, number 11. 18 September 2000

² *United Nations Millennium Declaration* General Assembly Resolution, 55th session, document A/RES/55/2, Chapter I, number 6. 18 September 2000

fined to the educational sphere. Men and women, both, participate in nearly every aspect of life in communities throughout the world. Not surprisingly, then, the rules that regulate the behaviours and values of men and women in a given society and the status derived thereof -- that is, its gender system -- have the potential to impact nearly every aspect of life.

Therefore, while only one of the MDGs is specifically about gender, addressing gender is of critical importance to every MDG.

Recognizing this, the Department of Gender and Women's Health (GWH) of the World Health Organization has examined the health-related MDGs (numbers 1, 4, 5, 6, 7 and 8) with a view to identifying areas where gender considerations may have a bearing on work towards each goal. In each case where such an area has been identified, GWH has written a brief paragraph, specifying the relevant gender concern and pointing out factors which programme planners and researchers should keep in mind to ensure that the concern is addressed. These paragraphs are meant for inclusion in the "story-lines" for the MDGs -- accompanying texts meant to contextualize, explain the relevance of, and help operationalize the Goals.

Health-related MDGs are expressed as national averages. They therefore do not reflect what happens to poorer groups, nor do they reflect how development processes impact differently in the lives of men and women. As a minimum, relevant data collected for reporting on the MDG goals and targets should be disaggregated by sex, even where the indicators themselves do not call for disaggregation. The development of indicators that are able to capture gender dimensions is a next step.

It is hoped that these 'storyline additions' will help 'en-gender' the health MDGs, ensuring that those who use the Goals to guide their work will not fall short of maximum success through failure to address important, and relevant, gender realities.

Millennium Development Goal 1

Eradicate extreme poverty and hunger

In some parts of the world, a marked preference for male offspring may result in lower investment of resources in girl children, which could lead to girls being nutritionally disadvantaged in at least two ways: girls may receive "second choice" of available food, after brothers and/or parents, leading to inadequate nutritional intake when resources are scarce; and girls may receive less medical and other care than their brothers, leading to greater ill-health with potential nutritional effects. While this sort of discrimination may be limited to certain parts of the world, it is something that researchers working on the problem should be considering. Most basically by ensuring that all data they collect can be disaggregated by sex, and then analysed with a gender perspective.

Researchers should also watch for and guard against the possibility that, in areas where girls are routinely undervalued, standards of "normal" growth for them (based on average values in the population) may be set at unhealthily low levels.

Millennium Development Goal 4

Reduce child mortality

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

Worldwide, the under-five mortality rate is approximately equal for boys and girls. In Asia, more young girls die than young boys; in every other region, rates are approximately equal, or young boys die at a higher rate. Health professionals working on this target should keep these differentials in mind, and, where they result from preventable causes (son preference in Asia, for example), should seek to eliminate them.

Certain diseases (including Millennium Development Goal targets malaria and tuberculosis), when they occur during pregnancy, can lead to underweight and premature babies whose chances of survival are diminished. It follows, then, that treating these diseases in pregnant women will also help reduce under-five mortality.

Reducing the amount of heavy physical labour that many poor women continue to perform far into their pregnancies may also contribute to under-five survival -- as may making greater financial resources and support available to women in their roles as mothers.

Millennium Development Goal 5

Target 5, Indicator 15: Proportion of 1-year-old children immunized against measles

Small scale studies in South Asia find sex differences in the proportion of children who are fully immunized. Generalizing from these studies is difficult but it is possible that, in areas where son preference is common, the lower level of resources devoted to female children might mean that they are less likely to be vaccinated.

Mechanisms need to be established to detect sex differences in immunization coverage, interventions developed to redress these imbalances, and routine monitoring systems established to ensure that immunization systems reach all children.

Improve maternal health

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

Although the direct, first-level targets and beneficiaries of maternal mortality interventions by definition are always women, maternal mortality, and the conditions that heighten or diminish the problem, do have a gender dimension:

- ◆ Poor nutrition of girls and women due to gender discrimination can increase the chances of life-threatening complications at the time of pregnancy.
- ◆ Societal norms that limit women's mobility, or that require that women obtain the consent of a male family member before seeking health care, can dangerously delay, or even prevent, women's access to lifesaving care in the event of an obstetrical emergency.
- ◆ Women's education is strongly correlated with positive maternal health outcomes. High rates of illiteracy/low rates of school attendance among women and girls, which are common in some parts of the world, are likely to contribute to maternal mortality.

Certain diseases (such as malaria, anaemia, hepatitis and possibly tuberculosis), when experienced during pregnancy, can be especially hard-hitting, and contribute to maternal mortality. Targeted efforts to

reduce incidence of these diseases in women should have the additional benefit of reducing maternal mortality ratios.

Furthermore, violence against women by intimate partners is common during pregnancy and is detrimental to the health of the mother and the foetus. It can also result in maternal mortality. This violence, which is an expression of gender inequality, constitutes a major obstacle to achieving women's health.

Millennium Development Goal 6

Combat HIV/AIDS, malaria and other diseases

Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS

Not surprisingly, given its sexual nature, HIV/AIDS affects men and women in different ways. 2002 was the first year when the number of adult women worldwide suffering from the disease approximately equalled the number of adult men, suggesting that the disease is spreading fastest among women. Indeed, in sub-Saharan Africa, the region most affected by HIV, prevalence rates among women are already distinctly higher than those among men. These figures reflect underlying realities of biological sex and social gender that programme planners will have to grapple with if they expect to meet Target 7 of the Millennium Development Goals:

- ◆ Due, probably, to a combination of biological factors relating to the reproductive tract and social norms which facilitate older men having sexual relations with much younger women (and men in general having more sexual partners than women), HIV infection rates are usually distinctly higher among young women than among young men in areas where heterosexual sex is the primary means of transmission.
- ◆ The only two widely available means of preventing HIV transmission -- male condoms and abstinence -- are generally available to men independent of their partners' desires, while they can usually only be practised by women with male cooperation.
- ◆ The stigma of HIV may be felt most strongly by women, who are often physically, socially, and economically more vulnerable than men.

- ◆ Effective prevention of mother-to-child transmission (PMTCT) may require involving both mothers and fathers, even though planners of such programmes may be tempted to address only women. Although it is women who must take PMTCT drugs, they may not have enough autonomy or financial resources to do so on their own, without their partners' consent and participation.
- ◆ Women and girls bear the brunt of the caregiving which this epidemic, by felling so many adults in the prime of life, renders necessary.

Target 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

Indicator 21: Prevalence and death rates associated with malaria

Indicator 22: Proportion of population in malaria risk areas using effective malaria prevention and treatment measures

Pregnant women (and very young children) have unusually high incidence and mortality rates for malaria, and warrant specific attention in malaria-control programmes. It is also possible that gender norms may affect malaria prevention and treatment via their influence on sleeping and work patterns, on use of bed-nets, and on which family members receive medicines and medical care. The direction of such effects probably varies from place to place -- but their existence highlights the importance of recording and analysing all malaria-related data by sex, in order to notice and respond to any patterns that do exist.

Indicator 23: Prevalence and death rates associated with tuberculosis

Indicator 24: Proportion of tuberculosis cases detected and cured under directly observed treatment short course (DOTS)

Worldwide, TB prevalence as well as latent TB infection rates among adult women are generally lower than those among adult men. Nevertheless, TB remains a leading cause of death among women of reproductive age. Concerns exist that gender differentials in TB case detection and treatment outcomes may be due to a variety of factors such as differences in reporting of respiratory morbidity, gender-distinctive barriers to access, and stigma.

In high HIV-incidence settings like Africa, more young women between ages 15 and 24 are notified with TB than young men of the same age group.

It appears that women of reproductive age who are infected with TB are more likely than similarly aged men to progress to disease. Furthermore, TB during pregnancy leads to significantly higher rates of poor pregnancy outcome, for both child and mother. Both of these gender-related aspects of the disease should be kept in mind by those designing programmes to combat it.

Finally, studies suggest that genital tuberculosis, a relatively uncommon disease in men, may afflict up to 1/8 of women who have pulmonary tuberculosis. Genital TB can lead to infertility, which carries shame and stigma, particularly for women, in much of the world and needs to be addressed.

Millennium Development Goal 7

Ensure environmental sustainability

Target 9: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources

Indicator 29: Proportion of population using solid fuels

Although there is no reason *a priori* to believe that there are major gender differences in frequency of use of solid fuels (since these are generally used by families, not by individuals), there is still an important gender dimension to this issue.

While young children carry the heaviest disease burden in relation to indoor air pollution, it is generally women who do the cooking in households throughout the world. In many places, too, women and children simply spend more time indoors than men do. Hence it is women and children who are most regularly exposed to the health-damaging smoke that arises from burning solid fuels in the home.

Beyond this, in many parts of the world deforestation has meant that wood -- the most widely used solid fuel -- is increasingly distant from the places where people live. Someone must, in such cases, go and collect this distant wood on a daily, or at least every few days, basis. Usually, this task falls to female members of a household, who may spend several hours a day engaged in it.

Making available alternative fuel sources (and the means to use them safely) can thus have a particularly positive effect on the health of women, both by reducing their exposure to damaging fumes, and by reducing the burden on them of a particularly taxing and time-consuming form of labour. Time savings may open up opportunities for education and income generation. This may help break a vicious cycle where solid fuel use restricts economic development, while poverty reduces the ability to switch to cleaner fuels.

Target 10: Halve, by 2015, the proportion of people without sustainable access to safe drinking water

Since access to improved water or sanitation is generally provided to districts and families, not to individuals, there is no apparent reason to believe that there are gender differences. However, there still is an important gender dimension to water supply.

In places where the source of water is distant from the places where people live, the task of collecting water on a daily basis mostly falls to female members of a household. Thus, bringing an improved water supply to somewhere near residential concentrations can both improve the health of a population and reduce the burden of a particularly taxing and time-consuming form of labour, performed largely by girls and women. Improved water supplies located a long distance from homes, on the other hand, might help with the first of these objectives, but not with the second. Having easy access to water may also give women more time for income-generating activities, and makes it more likely for girls to stay in school.

**Millennium
Development
Goal 8**

Target 17: In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries

While sustainable access to effective essential drugs and medicines is a problem for both women and men in many parts of the world, women's access can be especially compromised due to a number of factors:

- ◆ In many areas, women do not regularly control a family's cash income, and women's health, furthermore, may not be prioritized as highly as that of the male "breadwinner". These factors combine to prevent women from accessing and paying for necessary medications, and to make women, especially, less likely to be able to access healthcare if associated prices rise. Indeed,

research shows that when user fees are applied to health services, it is women, more than men, whose use of such services falls.

- ◆ Clinics may be situated a long distance from where people live. In such cases, there are opportunity costs to accessing medicines. While both men and women have such opportunity costs, those experienced by women -- whose routine tasks typically include such central and "un-interruptible" jobs as childcare and food production -- may be more burdensome, preventing them from travelling to health facilities for the medicines they need.
- ◆ Often, women's mobility in public spaces is also limited, circumscribed, or forbidden, which, again, impedes their access to health facilities and hence drugs.
- ◆ Because of both financial and opportunity costs and restrictions on their mobility (see above), women often substitute locally available, less-expensive traditional medicines for modern drugs. In cases where the traditional remedy is less effective, this represents a net loss for women's health.
- ◆ Ensuring that women are fully and correctly informed about how to use drugs they receive is impeded, in many places, by lower literacy among women, and by cultural norms that cause medical personnel to give information about the drugs women are taking to their *husbands*, rather than directly to the women themselves.
- ◆ Pharmaceutical research has, historically, been done primarily on men, with results generalized to women. Since women's bodies differ markedly from men's in many ways, -- and since women can undergo physiological processes such as pregnancy that have no parallel in men -- this approach leaves women at risk for unanticipated side-effects, which can be severe -- even deadly -- in some cases.
- ◆ Drug research is largely a for-profit activity, and women generally control less money than men. Not surprisingly, then, pharmaceutical research sometimes neglects the needs of women, just as it does those of poor people.

Annex 1

Millennium Development Goals (MDGs)

| Goals and Targets (from the Millennium Declaration) | Indicators for monitoring progress |
|--|---|
| Goal 1: Eradicate extreme poverty and hunger | |
| Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day | 1. Proportion of population below \$1 (PPP) per day ^a 2. Poverty gap ratio [incidence x depth of poverty] 3. Share of poorest quintile in national consumption |
| Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger | 4. Prevalence of underweight children under five years of age 5. Proportion of population below minimum level of dietary energy consumption |
| Goal 2: Achieve universal primary education | |
| Target 3: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling | 6. Net enrolment ratio in primary education 7. Proportion of pupils starting grade 1 who reach grade 5 8. Literacy rate of 15 to 24 year-olds |
| Goal 3: Promote gender equality and empower women | |
| Target 4: Eliminate gender disparity in primary and secondary education preferably by 2005 and to all levels of education no later than 2015 | 9. Ratios of girls to boys in primary, secondary and tertiary education 10. Ratio of literate females to males of 15 to 24 year-olds 11. Share of women in wage employment in the non-agricultural sector 12. Proportion of seats held by women in national parliament |
| Goal 4: Reduce child mortality | |
| Target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate | 13. Under-five mortality rate 14. Infant mortality rate 15. Proportion of one year-old children immunised against measles |
| Goal 5: Improve maternal health | |
| Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio | 16. Maternal mortality ratio 17. Proportion of births attended by skilled health personnel |
| Goal 6: Combat HIV/AIDS, malaria and other diseases | |
| Target 7: Halve halted by 2015 and begun to reverse the spread of HIV/AIDS | 18. HIV prevalence among 15 to 24 year-old pregnant women 19. Condom use rate of the contraceptive prevalence rate ^b 20. Number of children orphaned by HIV/AIDS ^c |
| Target 8: Halve halted by 2015 and begun to reverse the incidence of malaria and other major diseases | 21. Prevalence and death rates associated with malaria 22. Proportion of population in malaria risk areas using effective malaria prevention and treatment measures ^d 23. Prevalence and death rates associated with tuberculosis 24. Proportion of tuberculosis cases detected and cured under directly observed treatment short course (DOTS) |

| Goal 7: Ensure environmental sustainability | |
|---|--|
| Target 9: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources | 25. Proportion of land area covered by forest 26. Ratio of area protected to maintain biological diversity to surface area 27. Energy use (kg oil equivalent) per \$1 GDP (PPP) 28. Carbon dioxide emissions (per capita) and consumption of ozone-depleting CFCs (ODP tons) 29. Proportion of population using solid fuels |
| Target 10: Halve, by 2015, the proportion of people without sustainable access to safe drinking water | 30. Proportion of population with sustainable access to an improved water source, urban and rural |
| Target 11: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers | 31. Proportion of urban population with access to improved sanitation 32. Proportion of households with access to secure tenure (owned or rented) |
| Goal 8: Develop a global partnership for development | |
| Target 12: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system | <i>Some of the indicators listed below are monitored separately for the least developed countries (LDCs), Africa, landlocked countries and small island developing States.</i> |
| Includes a commitment to good governance, development, and poverty reduction – both nationally and internationally | <u>Official development assistance</u> |
| Target 13: Address the special needs of the least developed countries | 33. Net ODA, total and to LDCs, as percentage of OECD/DAC donors' gross national income 34. Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation) 35. Proportion of bilateral ODA of OECD/DAC donors that is untied 36. ODA received in landlocked countries as proportion of their GNIs 37. ODA received in small island developing States as proportion of their GNIs |
| Includes: tariff and quota free access for least developed countries' exports; enhanced programme of debt relief for HIPC and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction | <u>Market access</u> |
| Target 14: Address the special needs of landlocked countries and small island developing States | 38. Proportion of total developed country imports (by value and excluding arms) from developing countries and LDCs, admitted free of duties 39. Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries 40. Agricultural support estimate for OECD countries as percentage of their GDP 41. Proportion of ODA provided to help build trade capacity ^e |
| (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the Twenty-second Special Session of the General Assembly) | |
| Target 15: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term | <u>Debt sustainability</u> 42. Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative) 43. Debt relief committed under HIPC initiative, US\$ 44. Debt service as a percentage of exports of goods and services |

| | | |
|------------|--|---|
| Target 16: | In cooperation with developing countries, develop and implement strategies for decent and productive work for youth | 45. Unemployment rate of 15 to 24 year-olds, each sex and total ^f |
| Target 17: | In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries | 46. Proportion of population with access to affordable essential drugs on a sustainable basis |
| Target 18: | In cooperation with the private sector, make available the benefits of new technologies, especially information and communications | 47. Telephone lines and cellular subscribers per 100 population 48. Personal computers in use per 100 population and Internet users per 100 population |

The Millennium Development Goals and targets come from the Millennium Declaration signed by 189 countries, including 147 Heads of State, in September 2000 (www.un.org/documents/ga/res/55/a55r002.pdf - A/RES/55/2). The goals and targets are interrelated and should be seen as a whole. They represent a partnership between the developed countries and the developing countries determined, as the Declaration states, "to create an environment – at the national and global levels alike – which is conducive to development and the elimination of poverty."

Footnotes:

- ^a For monitoring country poverty trends, indicators based on national poverty lines should be used, where available.
- ^b Amongst contraceptive methods, only condoms are effective in preventing HIV transmission. The contraceptive prevalence rate is also useful in tracking progress in other health, gender and poverty goals. Because the condom use rate is only measured amongst women in union, it will be supplemented by an indicator on condom use in high risk situations. These indicators will be augmented with an indicator of knowledge and misconceptions regarding HIV/AIDS by 15 to 24 year-olds (UNICEF – WHO).
- ^c To be measured by the ratio of proportion of orphans to non-orphans aged 10-14 who are attending school.
- ^d Prevention to be measured by the % of under five years of age sleeping under insecticide-treated bednets; treatment to be measured by % of under five years of age who are appropriately treated.
- ^e OECD and WTO are collecting data that will be available from 2001 onwards.
- ^f An improved measure of the target is under development by ILO for future years.

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