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Women's Rights and the Millennium Development Goals

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Women's Rights and the Millennium Development Goals

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The Millennium Development Goals are one of the first sets of time-bound, attainable goals that directly address and attempt to reduce the number of people living in poverty. Women are disproportionately affected by poor socioeconomic conditions and the recognition of this, via the Millennium Development Goals, is a positive step forward for women's rights. This paper will focus on the fifth Millennium Development Goal, to reduce maternal mortality. The argument will be presented that this goal is insufficient in implementing sustainable change as it does not address the underlying cultural practices such as economic disparity, violence against women, and access to safe abortion. Three nation states have been selected to provide insight into the cultural issues adversely affecting women and their overall health: Afghanistan, Sierra Leone, and Nicaragua. Women's health is finally being recognized as an important factor for sustainable development but in order for these countries to achieve the fifth MDG, these underlying cultural problems need to be addressed in order to alleviate the subjugation of women.

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I. Introduction

Poor economic conditions are now being recognized as a violation of human rights on a global scale and women are disproportionately affected by poverty (Gill et al. 2007). The recognition of these conditions is a positive step forward for women's rights. The Millennium Development Goals are one of the first sets of time-bound, attainable goals that directly address and try to reduce the number of people living in poverty. Nevertheless, this development plan only scratches the surface of how economic disparity violates women's fundamental human rights. The cultural treatment of women systematically denies their rights, especially their reproductive rights. This paper will discuss how the fifth Millennium Development Goal, reducing maternal mortality, is insufficient in implementing sustainable change because it does not address the underlying cultural practices that adversely affect women's maternal mortality and overall health in Sierra Leone, Afghanistan, and Nicaragua.

In 2000, the United Nations commissioned the Millennium Summit to draft the Millennium Development Goals (MDGs). The Millennium Development Goals outline eight objectives that include eradicating extreme poverty and hunger, achieving universal primary education, promoting gender equality and empowering women, reducing child mortality, improving maternal health, and combating HIV/AIDS, malaria and other diseases (Millennium Development Goals Indicators 2011). Along with these goals the committee listed time-bound targets and indicators that can be quantified to monitor the progress toward achieving each goal. Although the Millennium Development Goals do not claim a human rights foundation, the Millennium Summit used a human rights base to form the list of development concerns (UN 2008).

The Millennium Development Goals address human rights violations by focusing on the socioeconomic conditions that plague the poorest people around the world. With the gap between the rich and the poor growing wider than ever before, the developed nations of the world have been charged with the task of helping, primarily through financing programs for poorer countries. However, the MDGs have focused on the financial aspects of development and failed to incorporate the different cultural aspects that marginalize women and restrict their basic human rights. In general, women are adversely affected by economic disparity and violence, but these variables are culture specific and should be recognized as such when trying to lower maternal mortality rates.

II. Topical Overview

Maternal Mortality

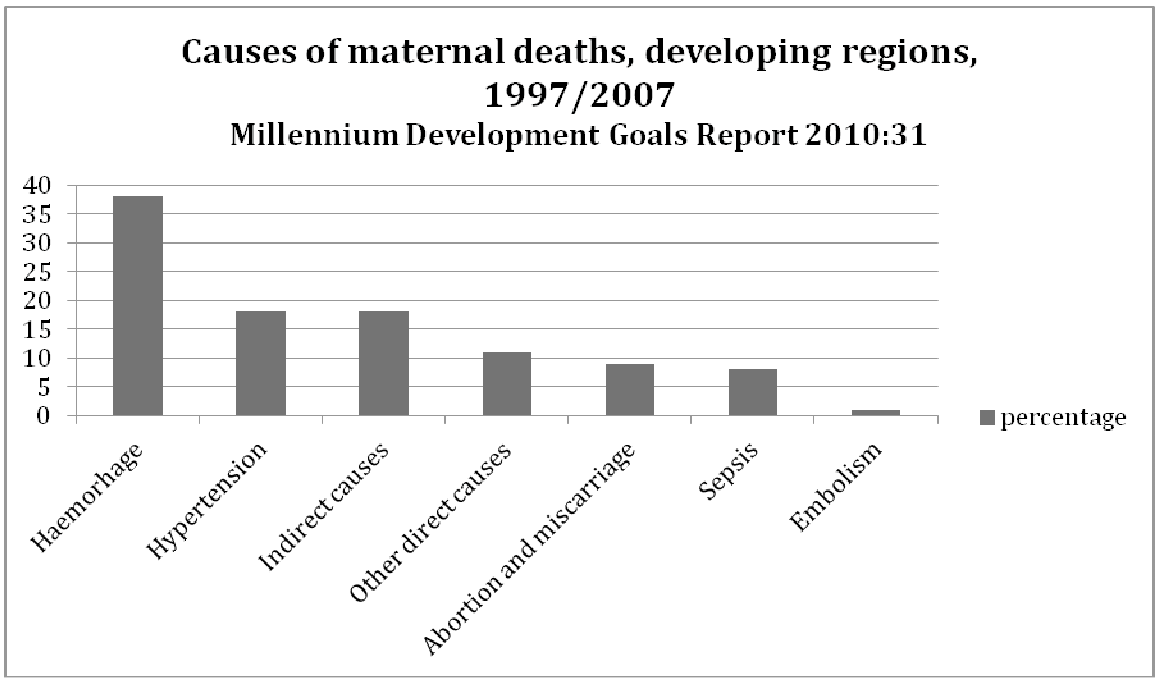
The issue of maternal mortality is important to women's rights and development. Rebecca Cook states that "[t]he universal risk factor [for maternal mortality and morbidity] is the fact of being female." While pregnancy may be the cause of sickness and death it can be exacerbated by "cultural, medical, and socioeconomic factors that devalue the status and health of women and girls" (Cook 1993:73). It is not just the act of giving birth that poses such a high risk for women but the many political and sociocultural reasons that complicate maternity, such as the Catholic Church's influence in Nicaragua or the Taliban rule in Afghanistan. In Nicaragua, the strong Catholic influence over the country has placed many restrictions on women's health such as access to contraceptives and abortion (Lion et al. 2009). The Taliban rule in Afghanistan placed many women under house arrest and made it difficult for them to receive medical attention if they needed it (Ross 2008).

The fifth MDG is to improve maternal mortality (target 5.A.) by reducing the maternal mortality ratio by three quarters between 1990 and 2015 and (target 5.B) achieving universal access to reproductive heath by 2015. Progress on these targets is measured by six indicators: (5.1) maternal mortality ratio; (5.2) proportion of births attended by skilled health personnel; (5.3) contraceptive prevalence rate; (5.4) adolescent birth rate; (5.5) antenatal care coverage[1] (at least one visit and at least four visits during pregnancy to monitor for complications); and (5.6) unmet need for family planning (WHO 2003; see appendix for full listing of MDGs).

Since 1990 there has been an overall 34 percent decline worldwide in maternal mortality (WHO 2010a:1). Nevertheless, the 2.3 percent annual decline in maternal deaths is not on course for the 2015 deadline; a 5.5 percent annual decline would be needed to reach this goal (UN 2010:30; WHO 2010a:1). In 2008, nearly all (99 percent) maternal deaths occurred in developing countries (WHO 2010d:1). As the chart below indicates, one of the greatest causes of maternal mortality in developing countries is from hemorrhaging (UN 2010). Hemorrhaging is classified as a direct obstetric death meaning it can occur anytime during pregnancy, delivery, or postpartum (WHO 2010d:4). The risks associated with pregnancy can be drastically reduced if women are provided with access to proper medical care and emergency obstetric care (EOC).

The leading cause of maternal mortality in developing countries is hemorrhage due to lack of medical care during or immediately after birth (UN 2010). For this reason, one of the Millennium Development Goal indicators (5.2) is the proportion of skilled birth attendants, which shows “regions with the lowest proportions of skilled health attendants at birth…have the highest numbers of maternal deaths” (WHO 2008).

Table 1



High maternal mortality rates are concentrated among poor women in developing countries and this "violates women's rights to life, health, equality, and non-discrimination" (UNFPA 2010:1; WHO 2010a:2). Women from developing countries have a thirty-six time higher risk of maternal mortality compared to women from developed countries (WHO 2010a:1). The United Nations Population Fund finds a correlation between the number of maternal deaths and the number of skilled attendants available (UNFPA 2010:1). Pregnant women who see a skilled professional at least once before, during, or shortly after giving birth have a greatly reduced chance of becoming ill or dying.

According to Philip Alston, the Millennium Development Goals are different from other development programs because the goals are "limited and selective and thus prioritize certain objectives over the many others endorsed every year by the international community" (Alston 2005:756). They are also set up to be measurable, time-bound,

promoted by "institutional apparatus," and supported by industrialized countries (Alston 2005:756-757). Some argue that the targets are not set high enough and are actually lower than goals previously set by the United Nations (Alston 2005:762). Alston (2005) sees this problem stemming from a disconnect between the Millennium Development Goals and human rights discourse. The lack of access to health care is an important issue across the world, and it disproportionately affects women. Progress will stagnate unless the underlying cultural inequalities are addressed.

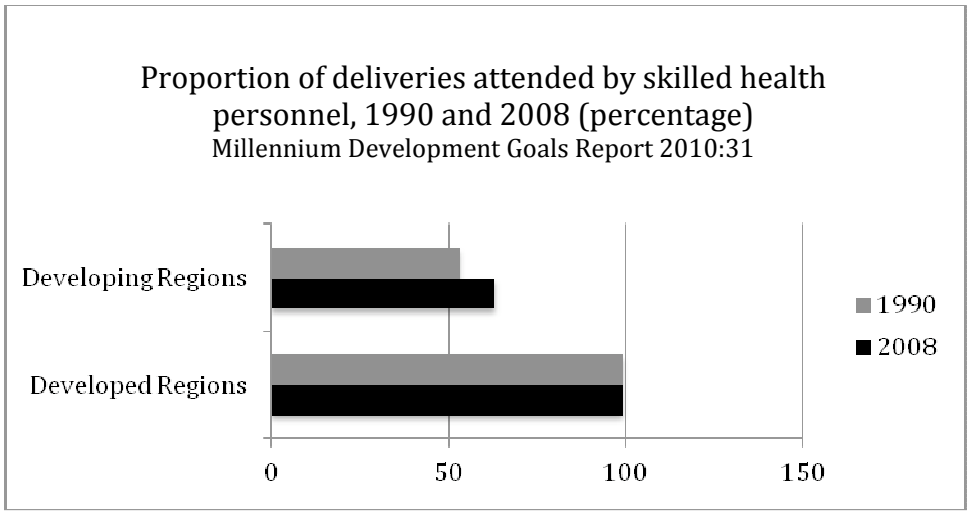
UN Women[2] suggests measures that can be implemented to accelerate the process of reaching the Millennium Development Goals. While target 5B is to achieve universal access to reproductive health by tracking contraceptive use, adolescent birth rates, antenatal care coverage, and unmet family planning needs, it would be more beneficial to tackle the social conditions and restraints on women's empowerment. By "[s]upport[ing] women's greater bargaining power and control" especially with regard to family planning in the number and spacing of their children, making women's health a financial priority in the household and increasing educational opportunities for women and girls, maternal mortality rates may decline (UNIFEM 2010). Many of these suggestions have been noted as missing from the Millennium Development Goals (Bunch 1990; Binion 1995). Taking this into consideration, inclusion of the underlying causes of socioeconomic conditions including access to safe and legal abortion and violence against women will help to improve women's health and reproductive lives. The MDGs do not focus on developing cultural or regional plans for implementation; this has meant that they have focused primarily on developing urban areas over rural. As such, the divide between the

rich and the poor is exacerbated since resources tend to be allocated in urban areas (Freedman 2003; Fraser 2005).

Economic Disparity

Women's reproductive rights are unevenly applied between the global North and global South, as well as the rich and poor. Consequently, maternal mortality rates are higher among poor women in developing nations. Compared to other health indicators, maternal mortality highlights how great the divide is (Fraser 2005:37). According to the Vice President for Human Development at the World Bank, "'[m]aternal deaths are both caused by poverty and are a cause of it'" (WHO 2010a:2). In the global North, maternal mortality is not a public health concern, especially since 99 percent of maternal deaths occur in developing countries (Freedman 2003:99, WHO 2010d:1).

Table 2



This epidemic stems from an unequal distribution of health care systems that cannot provide "interventions necessary to save women's lives" in developing countries especially in rural areas (Freedman 2003:100). There is no excuse for the high maternal mortality rates in developing countries, especially since "almost every single maternal death is avoidable with access to appropriate treatment delivered through a health

system" (Freedman 2003:104). This entails that emergency obstetric care (EOC) be not only available but also "…*accessible, acceptable* and of adequate *quality*" (UN 2008:29, emphasis original).

Many of the "non-abortion-related obstetric complications happen suddenly and unexpectedly [to] women with no known risk factors, and even [to] women who are otherwise in good health" (Freedman 2003:101). Often these complications are easily treatable with emergency obstetric care but many women, especially poor women, in developing countries are at risk because they cannot access facilities or skilled health care workers (UN 2008). Even in developed countries, wealthy women are three times more likely than poor women to have a skilled birth attendant present during pregnancy (UNDESA 2010, UN 2008).

The Millennium Development Goals emphasize the use of a skilled birth attendant or push for the utilization of health care facilities. However, cultural traditions can be easily overlooked in health care development plans. Sensitivity to cultural needs and viewpoints need to be taken into consideration when trying to make sustainable health care goals. Development plans do not always match up with local needs such as the prevalence and preference of home births or fear of forced sterilization that can occur at hospitals (UN 2008:30). Maternal mortality is a complex issue and women have varying needs and special circumstances that need to be addressed to allay fears of unwanted medical intervention. Some countries are making significant progress towards the Millennium Development Goals, while others are not. One of the main "indicators of social and economic progress" is mortality rate. Government spending should be allocated accordingly to infrastructure and social services, including health care.

However, the health care system can only do so much to reduce maternal mortality rates, other factors, such as violence against women, need to be addressed in order for an effective strategy or solution to be sustainable in reducing maternal mortality rates around the world (Freedman 2003).

The developing world is more prone to internal and external conflict which disproportionately affects the poor especially when economies are ruined, governments are overthrown, infrastructure is destroyed and people are displaced from their homes and separated from their families (UN 2007a:70). For countries that have experienced political unrest and economic instability for years, they are rebuilding from scratch. According to UN Women, one of the first places these countries need to begin is ending violence against women (UNIFEM 2010). However, women's issues are rarely considered as nations reconstruct after times of conflict.

Violence against Women

Violence against women is "any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life" (UN 1993). This issue is important to maternal mortality because violence is very common during pregnancy with rates ranging from 4 percent to 32 percent in developing countries (UNIFEM 2010). Abused women are twice as likely to have poor health compared to non-abused women (Bernstein and Hansen 2006:4). Domestic violence is extremely common and is no longer being considered a 'private' matter but a public and punishable crime.

Violence against women is not limited to domestic settings; it includes, but is not limited to:

> "female infanticide, sexual abuse of girls, marital rape battering, and emotional abuse like isolation and humiliation… [as well as] harmful traditional practices like female genital mutilation, child and forced marriage, dowry-related violence, femicide, rape, forced sexual initiation, date rape, acid throwing, sexual harassment and intimidation at work, in schools and in public places, trafficking and forced prostitution, and forced sterilization" (UNIFEM 2008:11).

An increasingly common form of violence against women occurs during war or civil unrest where "the systematic use of sexual violence [is utilized] to terrorize whole communities or ethnic groups" (UNIFEM 2008:11).

Conflicts place women at the highest risk for experiencing violence, especially rape and sexual abuse (UNIFEM 2010). Violence, including civil wars, revolutions and political uprisings, place women's health at risk because rape and sexual abuse during conflict can lead to "unwanted pregnancies, gynecological disorders, and sexually transmitted diseases" (UNIFEM 2010; UN 2007a). Violations of human rights such as these, can lead to complications during childbirth or even result in death. These acts have finally been recognized as a "prosecutable war crime in the Rome Treaty of 1998" (Fagan 2010:78).

The affect of sexual violence can last a long time and include mental as well as physical trauma. The physical affects can include "vaginal bleeding or infection, fibroids, decreased sexual desire, genital irritation, chronic pelvic pain, urinary tract infections as well as exposure to various STIs" (sexually transmitted infections) and unwanted pregnancy (Bernstein and Hansen 2006:70). Adolescents are more susceptible to sexual violence, which leads to an increase

risk for unintended pregnancies. This is one reason that adolescent girls are at the highest risk for unsafe abortions (Glasier et al. 2006). In countries where there is "no legal age of marriage, or where that age is low, or where the law is not enforced, adolescent pregnancy is common" and the rates of maternal mortality are highest (Cook 1993:74).

In order for women to have good reproductive health, they must have control over their sexual experiences and be able to decide if and when they want to have children as well as the number and spacing of births. Early or child marriages violate these rights for women since in many cases these young girls will have little control over their sexual experiences (Ross 2008:630; UN 2008:31). Countries that condone the marriage of young girls are "denying them equal opportunities with men" and are subjecting them to live only in maternal and service roles in society (Cook 1993:74). Adolescent pregnancy is a concern, whether or not it occurred within a marriage. While pregnancy rates for girls ages 10 to 19 are low (11 percent worldwide) they are at a much higher risk for complications if they become pregnant from unsafe abortions, fistula, "anaemia, malaria, HIV and other sexually transmitted infections, postpartum haemorrhage and mental disorder, such as depression" (UNIFEM 2010). Fistula is the result of prolonged and obstructed labor where pressure from the baby's "head on the woman's vagina and bladder and/or rectum" causes a hole to form (Bernstein and Hansen 2006:83). If not properly treated, the hole can lead to incontinence and social exclusion (Bernstein and Hansen 2006). Fistula is avoidable and easily treatable with access to emergency obstetric care such as caesarean section and

this condition occurs mostly to young poor women who do not have access to health care (Bernstein and Hansen 2006).

The maternal mortality rate for girls age 15 to 20 is twice as high compared to women in their twenties (UNIFEM 2010). UN Women advocates for programs designed to educate young girls, provide equal social services, and protection from violence (UNIFEM 2010). Education and access to contraception will lower, but not eliminate, the risk of unwanted and adolescent pregnancies; women still need access to safe and legal abortion.

Unsafe Abortion

Many countries prohibit full reproductive care for women and may have laws that criminalize and make abortion illegal.[3] Blanket bans on abortion often carry "prison sentences for women who seek abortions and the doctors who perform abortions under any circumstances" (HRW 2010:6). Consequently, collecting data on abortions can be difficult since many times it will not be reported or will be underreported or misreported. The World Health Organization (WHO) recognizes that deaths from unsafe abortions is a health issue that needs to be addressed, but the true extent of the problem may never be known because of misinformation (Grimes et al. 2005). Nevertheless, most countries allow for abortions under certain conditions, commonly to save the life of the mother (Bernstein and Hansen 2006).

While the United Nations fails to incorporate access to safe and legal abortion as a women's health necessity and right, it does assert that unsafe abortions place women's lives at risk (Pollack Pechesky 1995:154). However, the UN has abstained from making any direct statements on the issue of abortion, mostly because it is such a contentious

issue around the world (Brems 2009; Ross 2008). Feminists and women's rights activists press for abortion rights by citing that the UN does not overtly "preclude the recognition of abortion rights" (Ngwena 2010:787). However, the UN implores states to allow safe and legal abortions as well as review highly restrictive abortion laws and decriminalize abortion, but the UN never condemns these actions as a violation of human rights (Ngwena 2010:788). The World Health Organization does not recommend abortion as a form of birth control but believes that the procedure should be available when other forms of modern contraception fail (Grimes et al. 2005). The use of modern contraceptives can reduce the need for abortion but it will never eliminate it, which is one reason why access to safe and legal abortion cannot be overlooked as a necessity for reducing maternal mortality (Grimes et al. 2005:2).

In the absence of legalized abortions, many women turn to extralegal measures. An unsafe abortion is that which is preformed "either by individuals without the necessary skills or in an environment that does not conform to minimum medical standard[s], or both" (Grimes et al. 2005:1). It is estimated that 97 percent of unsafe abortions occur in developing countries (Grimes et al. 2005:2; see Figure 1 and 2). Even in countries with improved health care conditions and emergency obstetric services, restrictive abortion laws are attributed to a large number of unsafe abortions (Grimes et al. 2005; Berer 2004).

Access to safe abortions is important to women's reproductive health and it is one of the "safest procedures in contemporary medical practice" (Grimes et al. 2005:1). Many developing countries are pressured by religious organizations, political groups, and donor countries to keep abortion illegal or inaccessible for women (Lion et al. 2009). Yet, it has

been shown that women will obtain abortions however they can, and the best way to protect their health is to provide safe and legal procedures (Grimes et al. 2005; Bernstein and Hansen 2006). It is also shown that "[h]igh rates of unintended pregnancies are associated with higher incidences of abortions, and specifically unsafe abortions" (Bernstein and Hansen 2006:84).

Figure 1

	Number of unsafe abortions (thousands)	Unsafe abortions per 100 livebirths	Unsafe abortions per 1000 women aged 15–44 years
World	19 000	14	14
Developed countries*	500	4	2
Developing countries	18 400	15	16
Africa	4 200	14	24
Asia*	10 500	14	13
Europe	500	7	3
Latin America and the Caribbean	3 700	32	29
Northern America	N/A	N/A	N/A
Oceania*	30	12	17

Source: WHO.6 *Japan, Australia, and New Zealand have been excluded from the regional estimates, but are included in the total for developed countries.
N/A=none or negligible incidence.

Table: Global and regional estimates of annual incidence of unsafe abortion, 2000

Source: Grimes 2005:2

Figure 2

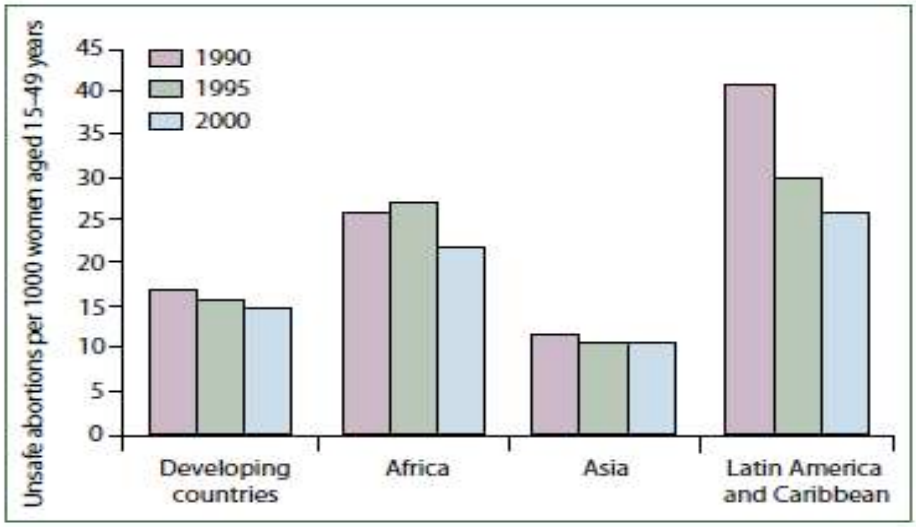


Figure 2: Estimated number of unsafe abortions per 1000 women aged 15–49 years, by region, 1990–2000

Source: Special tabulations using WHO database on unsafe abortion.[6]

Source: Grimes 2005:2

While not all women die from an unsafe abortion, severe complications do arise that impede their future reproductive health including:

> "sepsis, hemorrhage, cervical trauma and uterine perforations, as well as chronic or permanent conditions. Between 20 and 30 percent of unsafe abortions cause reproductive tract infections. Of these, 20-40 percent develop into pelvic inflammatory disease or bilateral tubal occlusion and infertility" (Bernstein and Hansen 2006:85).

Again there is a divide between access and economic standing (see Figure 1). Wealthy women from urban areas have a lower risk (45 percent) of experiencing complications from unsafe abortions than women from rural areas (57 percent) (WHO 2007:4). Rural women are also more likely to experience severe complications from unsafe abortions (WHO 2007).

It is proven that "[m]aternal deaths are both caused by poverty and are a cause of it" (WHO 2010a:2). Due to economic conditions many women, especially young women, are forced into marriages (Ross 2008). Additionally, women do not have access to health

services including abortion. Violence against women is beginning to be recognized as an epidemic in many countries as a public, not private, issue. International organizations (UN Women, WHO, and UNICEF) recognize that prioritizing women's issues and including sexual and reproductive rights will accelerate and sustain development. However, recognition of the problem does not begin to solve it. In order for women's health to improve and maternal mortality rates to decrease all sexual and reproductive health issues need to be included, especially access to safe and legal abortion.

Nicaragua has one of the highest rates of teenage pregnancy in the world. Access to safe abortion is a health concern in this country, especially with the religious and cultural practices that impact reproductive health care. Sierra Leone's violent civil war has had women and girls living in a violent environment for a decade. The psychological and physical impacts of kidnappings and rape have taken a toll on maternal health. In Afghanistan, decades of war have destroyed infrastructure and economic standing. With little money for social services in general, hospitals and medical supplies are hard to come by. The oppressive Taliban rule kept women and girls at a lower status than men. Women and girls were not allowed to seek medical attention or receive and education without the permission or accompaniment of a male relative. In order to reduce maternal mortality rates, Afghanistan must not only rebuild its infrastructure but also the social status of women. Socioeconomic conditions, violence against women, and access to safe and legal abortion are the underlying problems facing countries such as Sierra Leone, Afghanistan, and Nicaragua but each country must address these issues based on their history and cultural practices.

III. Sierra Leone

Civil conflict engulfed Sierra Leone for eleven years, finally coming to an end in 2002. Despite the years of civil unrest and economic instability, the country has made substantial changes and movement towards achieving some of the Millennium Development Goals. Most of the success has come from over $17 billion in international donor contributions to rebuilding the infrastructure (UNDP 2011). Sierra Leone ranks last in the Human Development Index; more than 70 percent of the population lives below the poverty line (UNDP 2011). Consequently, there are many development concerns and it is doubtful that Sierra Leone will meet its MDG goals by 2015 (UNPD 2011).

The population of Sierra Leone is 5,560,000 with an annual growth of .3 percent. The average life expectancy is 49 years due to "heavy disease burden and high child and maternal morbidity and mortality" (WHO 2011a; WHO 2009). Mortality rates for children under five are among the worst in the world with about a one in three dying. The maternal mortality ratio for the country as a whole is 970 per 100,000 births. This is a significant problem that needs to be addressed, although the country cannot focus on these issues until the basic needs of all people are met. International and national financial resources are earmarked almost exclusively for infrastructural development such as roads (UNDP 2011).

Economic Disparity

Part of the United Nations development strategy for Sierra Leone is the integration of rural areas into the national economy (UN 2009:2). Rural marginalization, coupled with the urban migration, contributes to the "deteriorating social climate" in the country (UN 2009:2). About 70 percent of the population lives in rural areas and has

access to ample water and land resources which could be utilized to help the country become independent in food production and exportation (UN 2009:2). These resources are underutilized but could be developed to help eliminate some contributing factors that led to civil war, such as unemployment among the rural youth (UN 2009:3). Improving the rural economy will also help improve overall health in the country, especially for women.

It is too soon to see an improvement in maternal health since The Reproductive and Child Health (RCH) Strategic plan created by the government was only recently developed in February 2008 (UN 2009:22). The program is part of the UN Joint Vision Plan and is partnered with the United Nations International Children's Fund (UNICEF), WHO, World Food Program (WFP), and the Food and Agriculture Organization (FAO), which have secured $38,000,000 along with an expected $30,000,000 for a program total of $68,000,000 (UN 2009:23). The RCH is the best funded program out of twenty-one Joint Vision programs. The second largest funded is the National Agriculture Response Program with only $50,000 (UN 2009:19-20). The RCH plan is part of the ongoing programs list, already underway, so if programming extensions are given further funding they could be implemented almost immediately (UN 2009:15).

The main concern with the UN Joint Vision is failure. They have set many goals and made promises of success in Sierra Leone. However, this country is prone to civil unrest and "the political situation in Sierra Leone remains fragile" (UN 2009:42). The governmental leadership has stepped up and helped thwart chaos. Failure could also come from the "Vision" and how it is implemented. If the UN and local government "concentrate too much on implementation and on attaining specific outputs… [they]

could miss the broader picture of peace and stability" (UN 2009:42). Benchmarks have been established in an attempt to avoid this, as well as keep donors aware of how the strategy is progressing. On a larger scale, there is concern that lack of support from international development partners and lack of inter-agency coordination could cause problems (UN 2009:43-44). Since all of these programs will be implemented through UN agencies, there is a concern that the UN could be overworked. Once these programs are built and maintained, the issue of health and maternal mortality can be more fully addressed.

Maternal Mortality

Maternal mortality is an important issue facing the development of Sierra Leone. The most noted reason for the high maternal mortality rates is the "deteriorating political and economic conditions over the past decade have led to reduced government and individual expenditures on health" (Fofana et al. 1997:S226). While all people in Sierra Leone suffer from lack of social services, those living in rural areas are especially susceptible.

Rural communities in Sierra Leone suffer the most from lack of access to health care facilities. While this is a problem for health in general, women suffer disproportionately since 73 percent of births occur in rural areas (WHO 2011a:1). Although there is a lack of infrastructure and health facilities, 87 percent of women report having "receive[d] antenatal care at least once from a skilled health provider (i.e. doctor, nurse, or midwife)... [and] 56% of [these] women received [antenatal care] at least four times" (WHO 2011a:2). A large portion of women in general received some sort of antenatal care (WHO 2011a:2). However, poor women did not receive comprehensive

care and were generally, at most, weighed and had their blood pressure checked. More affluent women were "three times more likely" to receive comprehensive care including having blood and urine samples taken as well (WHO 2011a:2).

The number of births that take place at a hospital or other health facility increased between the years 2005 to 2008. The majority of the health facilities are located in urban areas where a majority of births occur. In rural areas, the number of live births in health facilities has increased from 15.5 percent to 19 percent, not a dramatic increase, but substantial for the lack of facilities (WHO 2011a:3). Women in general, are more likely to have a skilled birth attendant (SBA) present during delivery than they are to deliver at a health facility. Once again women living in urban areas are more likely to have a skilled birth attendant present (66.9 percent) than those in rural areas (33.2 percent) (WHO 2011a:3). Since people in urban areas generally have better access to a variety of facilities, it makes sense that their numbers would be higher for utilizing health services.

Sierra Leone has many infrastructure and basic economic problems, and some of these are the underlining reasons that pregnant women do not or cannot seek care at health facilities. In a survey, 80 percent of respondents claimed the number one reason for not seeking treatment is lack of money (WHO 2011a:4). Following this concern is the distance to the facility (52.9 percent) and lack of transportation (50 percent). As previously stated, these two concerns should be addressed with the increased donations and international support to develop the infrastructure. Other concerns that women have about health facilities include: unavailability of medicines (48.7 percent); lack of provider (36.6 percent); no female provider available (20.8 percent); not wanting to go alone (20.2 percent); and inability to get permission to go for treatment (7.9 percent) (WHO

2011a:4). These reasons need to be considered when restructuring health care for women, especially pregnant women.

Postnatal care (PNC) in Sierra Leone follows the pervious statistics, the rich receive better and more care than the poor, but overall the numbers are low on both sides. A 2008 survey showed that "38% of mothers were seen for the first check up within 4 [hours], 8% within 4-23 [hours], 12% within 1-2 days, [and] 5% within 3 to 41 days after the delivery" (WHO 2011a:6). A survey was conducted on types of providers visited. For richer women, 59.4 percent of the PNC visits were doctors, nurses, or midwives. Whereas, for the poorest women, only 13.5 percent of visits were from doctors, nurses, or midwives, most of the PNC visits were classified as 'others' at 25.3 percent (WHO 2011a:6). A 2004 World Health Organization survey reports on the number of medical professionals as: 168 doctors, 1,841 nurses, 1,227 community health workers, and 136 public and environmental health workers (WHO 2006c:4). The growing population of Sierra Leone will need more skilled health professionals to keep the community and women healthy.

The average woman in Sierra Leone will have about five children in her lifetime, four children are said to be 'wanted' pregnancies. Contraceptive use is very low among married women with only 6.7 percent reporting use (14.2 percent in urban areas and 3.8 percent in rural areas). The use of contraceptives for rural women has increased from 1.3 percent in 2006 to 3.8 percent in 2008, but this number has stayed fairly constant among urban women (WHO 2011a:4). The preferred methods of birth control reported are the pill (48.1 percent) and injectables (25.9 percent) (UNDP 2011). More women between the age of 35 and 44 are reportedly using contraceptives, and there has been an increase

among women ages 20 to 29. Teens (ages 15 to 19) have the lowest reported use at 1.2 percent; however with this low number of contraceptive users, teenage pregnancy is reported highest among 19 year-olds.

Teenage sexual health is of high importance since 20 percent of the population is between the ages of 10 and 25 years (WHO 2009:11). Education is an important component of reducing sexually related health risks, but the attendance rates for primary schools are 48 percent and 19 percent for secondary schools (WHO 2009:11). Part of the low attendance rate is due to the young age of marriage for girls; 27 percent are married before they are 15 (WHO 2009:11). With the civil war, many children have not been able to attend school. Many young girls were "married" after being abducted and sexually abused by RUF members (HRW 2003). Virgins were targeted and generally did not survive these attacks (HRW 2003:3). Adolescents have been victimized for over a decade in Sierra Leone and this has had a profound effect on the health of the country.

Violence against Women

The civil war in Sierra Leone is well known for the exploitation and use of child soldiers. Many of the depictions seen in popular media were of boy soldiers but girls were also used in armed conflict (Denov and MacLure 2006:74). Women and girls were kidnapped by the Revolutionary United Front (RUF) and forced to endure verbal, physical, psychological or sexual abuse on a daily basis (Denov and MacLure 2006:77). This is shown in interviews with girls who survived the conflict "report[ing] that it was the pervasive sexual violence that was most debilitating" (Denov and MacLure 2006:77). It was common for girls to be "forced into becoming the sexual 'property' of specific

males in the group…this sexual slavery was euphemistically referred to as 'bush marriages' or AK-47 marriages'" (Denov and MacLure 2006:77).

UNIFEM (now UN Women) states that violence against women is not only "a gross violation of human rights" but also "an obstacle to the achievement of the Millennium Development Goals" (UNIFEM 2008:11). Rape can lead to unwanted pregnancy, and in the case of Sierra Leone this is more likely to happen to very young girls who have a higher risk of dying from complications due to pregnancy. Sexually transmitted infections are another concern for victims of sexual violence. Some of these infections can lead to infertility later in life or death. Psychological treatment and counseling is very important for victims of abuse. Mental health is not addressed in the MDGs, but countries that have been part of violent conflict need to include this as part of comprehensive health care in order for the country to heal and move forward.

A report on the violence in Sierra Leone by Human Rights Watch (2003), details the brutality of the abuse women suffered. The report begins by clarifying that "rape was perpetrated by both sides, but mostly by the rebel forces" (HRW 2003:3). Rape is a form of domination that affects not only the women, but an entire community. In the case of Sierra Leone, the use of rape by the rebels was "to dominate women and their communities by deliberately undermining cultural values and community relationships, destroying the ties that hold society together" (HRW 2003:4). In the aftermath of war women and girls were discriminated against by exclusion from education, employment and political opportunities (HRW 2003:5). Rape has never been considered a crime in Sierra Leone (unless it was rape of a virgin) and therefore many times men were not prosecuted, and women were most often seen as consenting adulterers or seductresses

(HRW 2003). With an unjust court system and the stigmatization of rape, many times it goes unreported which leads to disastrous physical and emotional consequences for women. Women in urban areas have more access to court systems, than those in rural areas. However, regardless of location or access to money "the protection that general law affords women is often only marginally better than that provided under customary or Islamic law" (HRW 2003:15).

Unstable government has been constant in Sierra Leone for over a decade. Even when the government was 'stable' it was corrupt, and there was little money given to fund education or hospitals. Security for the country is an important focus that should be added to the Millennium Development Goals (as it has been in Afghanistan), to ensure safety for all people, but women need particular security to protect them from sexual and gender based violence and discrimination. While in general human rights abuses tend to end during moments of peace, sexual violence will still be prevalent (HRW 2003:13).

Under the Sierra Leone 1991 constitution women and men have equal rights, unless customary laws for marriage, divorce and inheritance are considered (HRW 2003:16-17). The World Health Organization does not report the average age of marriage for females, but Human Rights Watch states that "[u]nder customary law, a girl is considered of marriageable age once her breasts have developed, her menses have started and she has been initiated, which could mean as young as twelve" (HRW 2003:17). UNIFEM warns of the dangers of young marriage, which are generally followed by pregnancies, which can be dangerous for young girls. HRW claims that "[e]arly forced marriage is one of the factors contributing to Sierra Leone's high maternal mortality rate since young girls have several children before their bodies are fully mature" (HRW

2003:23). Early marriage for girls also means they may miss out on education as well as "skills training opportunities and are therefore highly dependent on their husbands" (HRW 2003:23). When it comes to sexual intercourse, women by customary law, have little control. A married woman must obey her husband and "can only refuse to have sexual intercourse with her husband if she is physically ill, menstruating, or suckling a young child. She can also refuse intercourse during the daytime, in the bush or during Ramadan" (HRW 2003:18). Customary law for marriage was not followed for those women and girls who were abducted by the RUF and one of the traditional customs, female genital cutting, was changed during this time.

Female genital cutting (FGC) is a common practice in Sierra Leone, with 90 percent of women having undergone this ritual to initiate girls into adulthood (HRW 2003:24). They would spend up to two months with elders learning different skills and traditions such as cooking and dancing. With the outbreak of war the initiation ceremony was modified to focus primarily on the cutting and less on the accumulation of skills (HRW 2003:24). The practice of FGC can lead to many health complications

> "including pain, injury to adjacent tissue of the urethra, hemorrhage, shock, acute urine retention, and infection…[as well as] [l]onger term health effects include[ing] recurrent urinary tract infections, pelvic infections, infertility, keloid scar, and problems during childbirth" (HRW 2003:24).

The sexual abuse many girls experienced during the conflict would have exacerbated these health problems by quickly spreading sexually transmitted infections (STIs) (HRW 2003:24). Many young women and girls became pregnant from rapes; many of the very young girls died during childbirth while others were forced to carry out their pregnancies while performing hard labor and being continuously sexually assaulted (HRW 2003).

Some women who became pregnant tried to abort using traditional herbal methods without the RUF's knowledge (HRW 2003).

Unsafe Abortion

Abortion is legal in Sierra Leone but restricted to certain conditions: to save the woman's life and to preserve physical and mental health (Center for Reproductive Rights 2007). While there is no country specific data on abortions in Sierra Leone, the regional statistics indicate that it is an area of concern. For West Africa[4] the number of unsafe abortions performed in 2003 was estimated at 1,500,000 (WHO 2007). Of this total, 11,900 women died accounting for 13 percent of maternal deaths in Western Africa (WHO 2007). Infection is the most common consequence of an unsafe abortion, which will cause many health complications and lower fertility later in life (WHO 2007). Information on abortion is very difficult to obtain so estimating rates is very common using statistics that are already known.

The unsafe abortion rates in Africa and West Africa far exceed those of the developed countries. The maternal mortality ratio per 100,000 live births is over 100 in Western Africa, and is the same as Africa's total (UN 2007b:13 table 2). The percentage of maternal deaths related to unsafe abortion is equal to the world average. Compared with the other regions of Africa, only Eastern Africa has a higher number of unsafe abortions and associated mortality (UN 2007b:13). Table 3 shows that unsafe abortion is a major health concern in Western Africa. By providing proper medical assistance to women seeking abortions as well as loosening restrictions on abortion, maternal mortality rates should drop.

The history of conflict in Sierra Leone will be a hurdle in trying to achieve the Millennium Development Goals. With a majority of the population subjected to violence for so long the country needs to work on rebuilding the infrastructure as well as the psychological well being of its citizens. While Sierra Leone struggles to recover and improve health and poverty levels, Afghanistan is facing similar obstacles.

Table 3
Global and regional estimates of annual incidence of unsafe abortion and associated mortality in 2003. Rates and ratios are calculated for all countries and, in parenthesis, only for countries with evidence of unsafe abortion

	Unsafe Abortion			**Mortality due to unsafe abortion**		
	Number (rounded)	Incidence rate (per 1000 women aged 15-44 years)	Incidence ratio (per 100 live births)	Number of deaths (rounded)	% of all maternal deaths	Mortality ratio (per 100,000 live births) (rounded)
World	19,700,000	14 (22)	15 (22)	66,500	13	50 (70)
Developed countries*	500,000	2 (6)	3 (13)	<60	4 (8)	°(2)
Developing countries	19,200,000	16 (24)	16 (20)	66,400	13	60 (70)
Africa	5,500,000	29	17	36,000	14	110
Western Africa	1,500,000	28	14	11,900	13	110
Eastern Africa	2,300,000	39	20	17,600	17	160
Middle Africa	600,000	26	12	5,000	10	100
Northern Africa	1,000,000	22 (23)	20 (21)	1,100	11	20
Southern Africa	200,000	18	18	300	9	20

*Japan, Australia and New Zealand have been excluded from the regional estimates but are included in the total for developed countries
°No estimates are shown for regions where the incidence is negligible
Source: UN 2007b:13 table 2 (see appendix for full table)

IV. Afghanistan

According to the World Health Organization the total population of Afghanistan is 27,208,000 and growing annually at a rate of .3 percent (WHO 2011b). Life-expectancy is low largely due to the high rate of neo-natal deaths, of which "38% occur during the first four weeks" (UNDP 2005). The average life expectancy for women is 45 and 47 for men, which is unusual but it "might have its cause in an unprecedentedly high maternal mortality rate" (WHO 2006a:15). Low life-expectancies are normal for developing countries, and typically men and women die around the same age (UNDP 2005; WHO 2006a).

Afghanistan has been subject to decades of war, which accounts for much of the instability and low life expectancy. Additionally, reliable information about the country is unavailable due to the wars, which have caused a disruption and dismantling of government and records keeping systems. The statistics that have been gathered are very recent, from 2003 to 2010, thanks to the efforts of such organizations as the World Health Organization and USAID. While these agencies have collected valuable information, data regarding fertility rates, contraception use and family planning have not been obtained. What has been collected for maternal mortality rates shows that there are major obstacles to improving women's health most stemming from the lack of economic development due to 23 years of war (UNDP 2005).

Economic Disparity

Poverty is prevalent in Afghanistan and the country as a whole is lacking in basic social services (UNDP 2005). The per capita income is the lowest in the world, estimated to be $200; the majority of people live on less than $1 a day (World Bank 2005). Yet,

only 20 percent of the population lives in rural areas, so there is a large demand for resources and services in urban areas (UNDP 2005). With a crippled infrastructure many basic health needs cannot be met.

A survey of hospitals in Afghanistan in 2003 concluded that generally hospitals were ill-equipped lacking beds, medical tools, and even water and electricity (NHA 2004). Hospitals tend to be over-staffed in urban areas, but have an insufficient number of female staff (NHA 2004:1). The most common cause of maternal mortality in Afghanistan is postpartum hemorrhaging, but even if Afghan women had access to health care facilities, the necessary blood supplies are lacking to help these women (UNDP 2005). With a shortage of supplies including tools and blood, 47 hospitals do not provide emergency obstetric care (EOC) (NHA 2004:107).

Along with having inadequate supplies to meet the emergency needs of pregnant women, hospitals may be difficult to reach for those in rural areas. Due to this "less than 7% of all deliveries performed in the country took place in hospitals" where emergency care should be available if needed (NHA 2004:107). This disparity is seen when comparing the urban capital city Kabul's mortality rate of 418 per 100,000 births with the rural district of Ragh's mortality rate of 6507 per 100,000 births (Ronsmans et al. 2006:1197). One of the main goals of the Ministry of Health is to increase the ability for hospitals to provide emergency obstetric care which is believed to be the "key to the reduction of maternal mortality in the country" (NHA 2004:107). The table below summarizes the findings for EOC and available hospital staff. As is shown, the number of patients seen monthly for EOC far outweigh the qualified personnel available.

Table 4 Emergency obstetric care: services , equipment, and human resources (2003)	
Total emergency obstetric care beds	857
Total patients seen in emergency obstetric care (monthly average)	22,625
Number of deliveries (monthly average)	7,961
Number of caesarean sections (average per month)	428
Obstetric operating tables	27
Surgical lights	39
Caesarean section kits	20
Total personnel	13, 247
Support staff	7,635
Doctors	2, 420
Midwifes (employed by hospitals)	340
Gynecologists	365
Source: WHO 2005:32, taken from the Afghanistan National Hospital Assessment 2003	

To combat the continuing health problems of the country, "the Ministry of Public Health developed a national health policy for 2005-2009 and a national health strategy for 2005-2006" which would directly address health issues concerning women and children (WHO 2006a:25). Part of the plan is to provide "family planning, ante and post-natal care and care during delivery and health education…free of charge" (WHO 2006a:34). A major problem facing the country is the lack of qualified and certified health workers especially since "[o]f all health workers applying for testing and certification, more than 50% were found to have fake certificates or certificates which did not meet the national required standard" (WHO 2006a:33).

Maternal Mortality

Afghanistan did not participate in the Millennium Summit in 2000, and so was not able to endorse or give input in the planning of the Millennium Development Goals. Due to decades of war, the country is struggling to rebuild. Nevertheless, Afghanistan adopted all eight of the MDGs and added a goal that addresses security in the country (UNDP nd).

The country is starting from the very bottom with "every single aspect of development – from the incidence of poverty, to health care, agriculture, environment, and education [having] been adversely affected" by 23 years of war (UNDP 2005).

Due to the extreme condition Afghanistan is in, the Millennium Development Goals have been adjusted to meet the specific needs and concerns of the country. Accordingly, the country seeks to reduce maternal mortality by 50 percent instead of the standard 75 percent (WHO 2006a:39 table 7). A comprehensive evaluation of target 6 (reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio) showed that a majority of women are dying during childbirth. The proposed solution is to set the number of skilled birth attendants in accordance with the target (WHO 2006a:5). Marking the baseline for target 6 was difficult, due to the inconsistency in reporting and the differences between health care in various regions of the country. One proposed maternal mortality ratio range was 1600 to 2200. The high end was determined from reports in "one district (the remote rural district of Ragh in Badakhshan) the maternal mortality ratio was 6507 deaths per 100,000 live births…the highest recorded ratio in the world" (WHO 2006a:4). The argument made for using the high range was a concern that the problems in this district were most likely seen in other areas with similar problems such as "poverty and food insecurity" (WHO 2006a:4). It was believed the maternal mortality ratio would "decline more slowly than the U5MR [under 5 mortality rate] and the IMR [infant mortality rate]" so the lower baseline would give the country a reasonable goal to reach (WHO 2006a:5).

Afghanistan has the highest maternal mortality rate of any other country in the world with 1600 to 2200 per 100,000 live births, or about one in six women dying each

year (UNDP 2005; Ronsmans et al. 2006:1190). One of the highest rates of maternal mortality in the world is from "Badakhshan province, [where] seven per cent of all women die during childbirth" (UNDP 2005). Young age of marriage for Afghan girls and lack of trained health care workers are two reasons for this high maternal mortality rate (UNDP 2005).

According to the World Health Organization (2010d:28) "Trends in Maternal Mortality Report" Afghanistan is making insufficient progress with a -1 percent annual decline in maternal mortality rate. The health care system is controlled by the government and all the years of instability and war have made health care hard to come by for both men and women. With the rise of the Taliban women were even further marginalized in the health care sector, not just in receiving care but also giving care. During the Taliban rule, women were severely restricted from working outside the home or going anywhere outside without a male escort (Ross 2008). Along with this many women were not allowed to make their own medical decisions or see a male physician, unless in the company of a male relative (Ross 2008). This has caused many problems today during restructuring, especially in the limited number of skilled women in the health care field (WHO 2006a:22). Due to the shortage of women health workers "[n]ine out of ten rural women deliver babies at home without skilled birth assistance or proper referral services to save lives through essential and emergency obstetric care" (WHO 2006a:22). While women can successfully give birth without the aid of trained physicians, if complications arise poor women or those in rural areas are more likely to die.

Violence against Women

In Afghanistan women are treated as inferior to men and are valued for their silence and obedience (Ross 2008:24). The low status of women is attributed to the "pervasive violence against women now considered 'a silent epidemic'" (UNDP 2005:4). In some areas of the country "women are not permitted to leave home unless accompanied by a male family member" (Fraser 2005:41). These cultural practices have restricted many rights for women, including "the right to education, to work, to health care, [and] to political participation" (UNDP nd).

According to Carol Riphenburg (2004), Afghan women, even after the fall of the Taliban, do not have full rights. This includes reproductive choices, such as access to contraceptives, which must be made with (or entirely by) their husband or a male relative (Riphenburg 2004; Campbell et al. 2007). Afghan refugees may be denied contraception from "[f]amily planning clinics in northern Pakistan…unless their husband gives permission, even though women with economic means can buy the same products in the local bazaar with-out any intrusive questions asked" (Campbell et al. 2007:1502).

The World Health Organization cites "[t]he high fertility rate, coupled with early marriage and issues of access to modern family planning measures and health facilities" as main reasons for the high maternal and child death rates (WHO 2006a:22). Many women were married very young, "between the ages of 13 and 16, and in certain cases between the ages of 10 and 12, if their parents desired." Marriages tend to be arranged by the parents, or male relatives of the couple (Ross 2008). One reason for young marriages is to protect the family's honor since premarital sex is prohibited (Ross 2008:28).

Women, especially during Taliban rule, have little control over their reproductive lives, especially when they are married at young ages.

While there are many problems that need to be addressed in order to improve maternal health in Afghanistan the highest priority right now is security. This should have a favorable outcome for maternal mortality rates and women in general. Once there is security the country can work on strengthening its economy and infrastructure, including health care facilities and schools. Such facilities would enhance not only the GDP of the country but also the overall health of the nation's people. Right now Afghanistan is suffering from a variety of "cross-cutting issues like the lack of physical infrastructure (rural roads, electricity, water and sanitation), low levels of education, narcotics and the low status of women which impede the improvement of the health status" (WHO 2006a:18). Access to food is a concern for both rural and urban areas, but of particular concern are women, the elderly, children, and disabled (WHO 2006a:19). Great care must be taken to ensure that gender equality and women's rights are also part of the restructuring of Afghanistan to ensure sustainability for women and the country as a whole (Ross 2008; UNIFEM 2010).

For Afghanistan, a country that has been ravaged by war for so long, security is a priority. The "Police Performance and Public Safety" survey showed that since 2009 people have been increasingly trusting of the police and felt more secure in their own homes. This is very promising for Afghanistan to achieve its ninth goal; at least that is for male police officers. Many of the respondents said that they trust male police officers more than female police officers, but a majority would support a female member of their family joining the force. One thing is certain, "peace and stability are preliminary

conditions for the successful implementation of the health and nutrition programme" (WHO 2006a:36). The success of Millennium Development Goal nine will accelerate the achievement of Millennium Development Goal five. The security of the country is important to providing a stable government and social services for everyone, but many women still struggle to secure their reproductive lives.

Unsafe Abortion

Abortion is illegal in Afghanistan except to save the life of the mother (Center for Reproductive Rights 2007). If an illegal abortion is performed legal repercussions may occur in the form of imprisonment or a fine (UN Population Division 2002). Women who induce their own abortions can be subject to either a fine or punishment, such as jail, whereas medical personnel (doctors, nurses, pharmacist, etc.) are subject to the maximum punishment (UN Population Division 2002). The fertility rate and population are considered to be too high for Afghanistan and the use of modern contraceptives is very low (UN Population Division 2002). There are no statistics on unsafe abortions in Afghanistan; however, there are statistics for the region.

Afghanistan, classified as part of South-central Asia,[5] has the highest number of unsafe abortions totaling 6,300,000 in 2003 (WHO 2007:13 Table 2; see Table 5). The number of deaths in 2003 from unsafe abortions in Asia total 28,400 of which 24,300 occur in South-central Asia (WHO 2007:13). That is 86 percent of deaths from unsafe abortion occur in this area of Asia. While this is a large number, this is also a highly populated area. The numbers from Eastern Asia were excluded from the statistical analysis (Table 5) because there was no evidence of unsafe abortion and its inclusion would have skewed the data (UN 2007b).

Table 5
Global and regional estimates of annual incidence of unsafe abortion and associated mortality in 2003. Rates and ratios are calculated for all countries and, in parenthesis, only for countries with evidence of unsafe abortion

	Unsafe Abortion			**Mortality due to unsafe abortion**		
	Number (rounded)	Incidence rate (per 1000 women aged 15-44 years)	Incidence ratio (per 100 live births)	Number of deaths (rounded)	% of all maternal deaths	Mortality ratio (per 100,000 live births) (rounded)
World	19,700,000	14 (22)	15 (22)	66,500	13	50 (70)
Developed countries*	500,000	2 (6)	3 (13)	<60	4 (8)	°(2)
Developing countries	19,200,000	16 (24)	16 (20)	66,400	13	60 (70)
Asia	9,800,000	11 (20)	13 (18)	28,400	12 (13)	40 (50)
Eastern Asia*	°	°	°	°	°	°
South-central Asia	6,300,000	18	16	24,300	13	60
South-eastern Asia	3,100,000	23 (27)	27 (31)	3,200	14 (16)	30
Western Asia	400,000	8 (13)	7 (10)	1,000	11 (12)	20 (30)

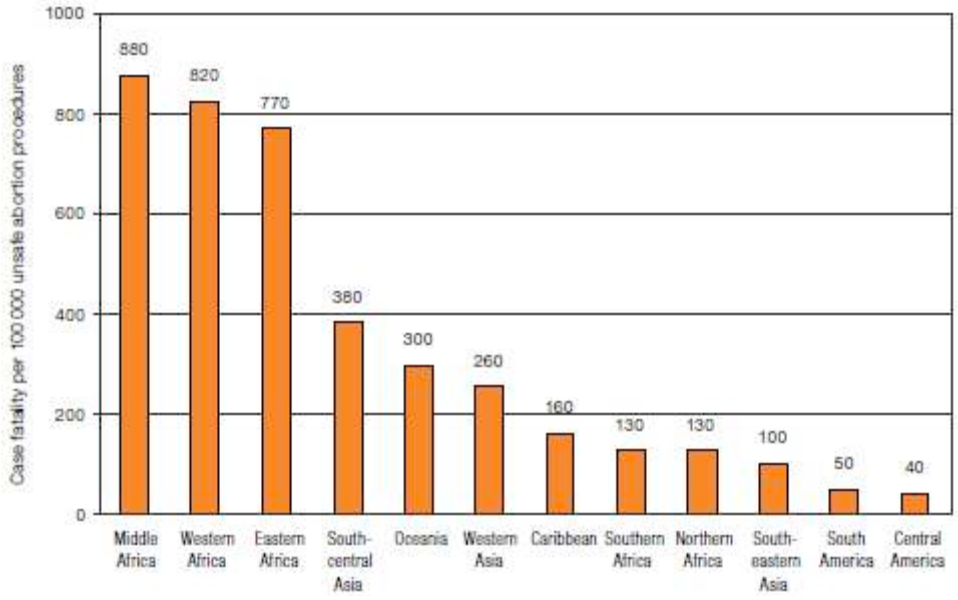
*Japan, Australia and New Zealand have been excluded from the regional estimates but are included in the total for developed countries
°No estimates are shown for regions where the incidence is negligible
Source: excerpt from UN 2007b:13 table 2 (see appendix for full table)

With the large population, birth control and use of contraceptives should be incorporated into development plans because as the population grows social services are strained (UNFPA 2011). Afghanistan's government has not endorsed the use of modern contraceptives and, in fact, many traditional methods are used but generally for increasing fertility (UN Population Division 2002). For the region contraceptive use is rated as 'modest' for 42 percent of married women, with sterilization being the method

for two-thirds for this group (UN 2007b:3). There is a lack of information on family planning and limited options for contraceptives. Increased information, access and choice would help reduce maternal mortality, the number of unwanted pregnancies and the number of deaths due to unsafe abortions (UN 2007b:3).

In 2003 30 percent of women under 25 and 80 percent of women under 30 have had an unsafe abortion in Asia (UN 2007b:6). South-central Asia's unsafe abortion rate dropped from about 22 percent in 2000 to about 17 percent in 2003 (UN 2007b:16). The 2003 report states that South-central Asia has 380 deaths per 100,000 unsafe abortions, well below Middle Africa (880 per 100,000), Western Africa (820 per 100,000) and Eastern Africa (770 per 100,000) (UN 2007b:18; see Figure 3).

Figure 3 Number of deaths due to unsafe abortion per 100,000 unsafe abortions, by subregion, 2003



Source: UN 2007:18 figure 7

Afghanistan has the highest maternal mortality rates in the world as well as one of the lowest per capita incomes (UNDP 2005;Vogl nd). Recovering from decades of war,

the hospitals are ill-equipped to handle many emergency cases and blood supplies are too low to help hemorrhaging, which is the number one cause of maternal deaths (NHA 2004; UN 2010). The MDGs have been adjusted to meet Afghanistan's sociocultural concerns to help ensure success in meeting the specified targets. The Taliban influence has had a profound effect on the cultural treatment of women and is a continuous barrier to their reproductive health. Women in Nicaragua face a similar struggle against gendered culture norms.

V. Nicaragua

Nicaragua, the largest and one of the poorest countries in Central America has a population of about 5,667,000. The rate of growth is currently .1 percent per year, and life expectancy is high--into the 70s (WHO 2011b). Although the annual growth rate is low, the country is struggling to maintain itself with a large spurt of population growth experienced in the mid-90s (PAHO/WHO 2001:4). A majority of the population lives in poverty due to the unequal distribution of income, poor economy, and lack of stable social services. These variables signal that, in Latin America, there is something wrong with the setup of the social, economic and political systems "causing the rich to get richer and the poor, poorer" (USAID 2009; Walker 1991:2). National revolutions, Catholic influence, and changing political leadership have determined the social and economic structure of Nicaragua for centuries. The country has found it difficult to recover from years of fighting and unstable economies. While many developed countries and the International Monetary Fund (IMF) have provided development funds, the country is still plagued with poverty and lack of social services (Vogl nd).

Economic Disparity

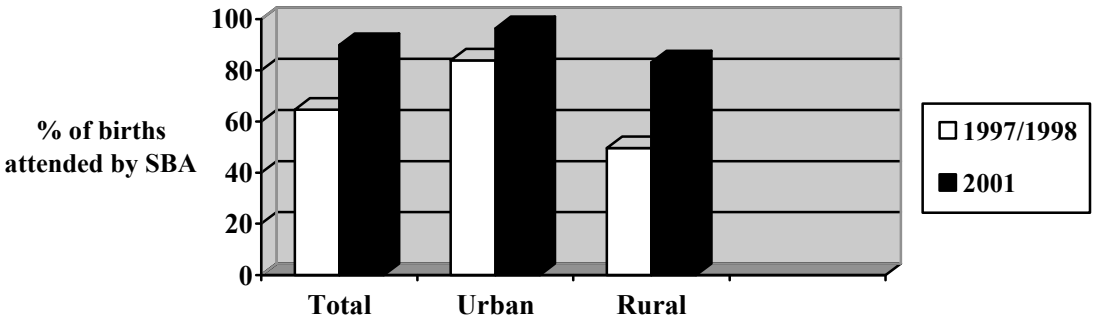
The formation of different grassroots organizations in the 1960s and 1970s, including the Sandinista Front for National Liberation (FSLN), was, in part, due to this vast inequality between the rich and the poor and corruption of the authoritarian Somoza dynasty (Political Conditions 2011). The end of the Somoza dynasty began in 1978 and by 1979 the Sandinista guerrillas unified and tried to improve the economy and the living conditions in the country (Political Conditions 2011). Many improvements made while the Sandinistas were in power including access to health care and education (Wessel 1991:537). Women's issues and health improved through the addition of paid maternity leave; increased access to education; fairness in legal actions including divorce, adoption and parental responsibilities; financial freedom; and inclusion of sex education in schools (Prevost 1996:308). However, in 1990 in the first democratic elections in Nicaragua, Violeta Chamorro was elected President. Her new administration upturned many of the Sandinista's socioeconomic accomplishments (Goma and Font 1996:741).

These acts left almost 80 percent of the population to live on less than two dollars a day, drastically increasing the gap between the rich and the poor (Vogl nd:3). Nicaragua is one of the few countries in the world were the discrepancy between the rich and poor is so great. There has been a "decline in the poverty rate, [but] the absolute figures have been rising" especially among rural residents (WHO 2006b). The population is also unevenly distributed across the landscape with a majority (61.5 percent) concentrated on the smallest area of land in the Pacific region (PAHO/WHO 2001:1). About 40 percent of the population lives in rural areas, leaving the other 60 percent to urban areas (WHO 2006b).

The population of urban areas consists mostly of rural migrants, a majority of which are women. Available social services are more accessible in urban areas and could be one reason for the influx of migrants to these already highly populated areas. Regardless of location of residence, women utilize health services if they are available (see Table 6), which helps keep maternal mortality rates low (WHO 2001). It is estimated that in 2001, about 90 percent of women had the use of a skilled birth attendant during pregnancy (WHO 2001:2). This is, of course, on target with the Millennium Development Goals and, if continued, will help keep the maternal mortality rate low. The Chamorro administration reduced the number of childcare centers, health care services, and removed sex education from schools. This is a problem for the growing adolescent population of Nicaragua and a reason for the stagnation in reaching the development goals (UNDG 2003).

Table 6

Utilization of Skilled Birth Attendant (SBA) at Delivery



Source: WHO 2001

Maternal Mortality

The maternal mortality rate in Nicaragua increased between 1990 and 2000 and there has been a very slow decline since then (UNDG 2003). Reasons noted for the increase and slow decline of maternal mortality include inaccessible facilities, lack of

transportation, insufficient funds for hospitals, lack of staff, uneducated population, unreliable data collection as well as "high fertility, domestic violence, complications of unsafe abortions, a large young reproductive age population and hypertension" (UNDG 2003; Lubbock and Stephenson 2008:75).

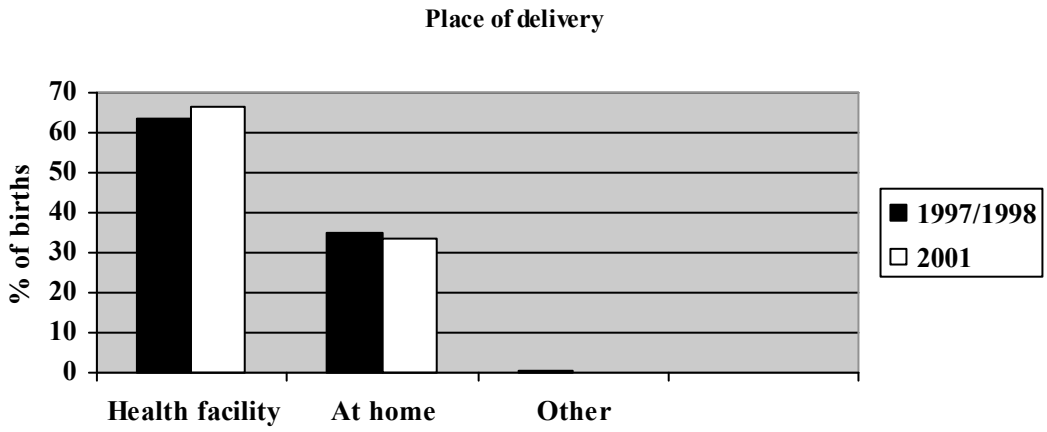
Nicaragua has the highest adolescent fertility rate in Latin America and the Caribbean with 112.1 per 1,000 births (World Bank 2010). This is an improvement from 2000 where the fertility rate was 126 per 1,000 (World Bank 2010). Since maternal mortality rates are highest for women between the ages of 15 and 19, this issue needs to be addressed (Samandari and Speizer 2010:26). A survey from 2002 to 2007 found the national adolescent fertility rate to be 119 births per 1,000 women (Samandari and Speizer 2010:26). Teenage pregnancy is highest among 17 year olds but the pregnancy rate has declined since 1993 (WHO 2010c; Samandari and Speizer 2010:29).The use of modern contraceptives has increased for teenagers which could have helped lower teenage pregnancy rates (WHO 2001).

The use of contraceptives increased across the country from 57.4 percent in 1997 and 1998 to 66.1 percent in 2001. However, these numbers are only for married women. Among married women, contraceptive use tends to increase with age with about 40 percent of women between 20 and 24 and 55 percent of women ages 25 to 29 (WHO 2010b). Adolescents living in low socioeconomic conditions are "more likely to have had a live birth than were those with either medium or high status" (Samandari and Speizer 2010:32). Pregnancies are dangerous for teenagers as many complications can arise, so the availability of emergency obstetric care is especially important for this age group.

In 2001, half of all births occurred in rural areas (WHO 2001:1). While women are receiving the care they need during pregnancy, there is still a discrepancy between the rich and poor. The wealthiest 20 percent of the population has a skilled birth attendant rate of 99 percent, while the poorest 20 percent has a skilled birth attendant rate of 78 percent (WHO 2010d). The high number of nurses and midwives in the country may help in keeping maternal mortality rates low. While physicians may be located in urban areas, nurses and midwives can be found in both urban and rural areas.

Whether or not a woman gives birth at home or in a hospital tends to be based on her experience during her previous birth (Lubbock and Stephenson 2008). Women who have given birth in hospitals and had poor experiences tend to favor home births, even if their life is in danger (Lubbock and Stephenson 2008). More women are giving birth in health facilities (66 percent) than at home (33 percent) in Nicaragua (WHO 2001:3; Table 7 below). These numbers correspond to the number of caesarean sections performed with more reported in urban areas (22 percent) than rural areas (7 percent) (WHO 2001:3). The poor experience from hospitals, such as the ill treatment from doctors and disrespect from staff is a small part of the problem women face with their maternal health.

Table 7



Source: WHO 2001

Violence against Women

Domestic violence is a major risk factor for women in Nicaragua. Mental, physical, and sexual violence are common forms of domestic abuse which typically result in decreasing women's health through injury and persistent pain, increased rates of depression and suicide, and harmful pregnancies (Ellsberg et al. 2001:547). About 34 percent of women see domestic violence as acceptable for certain reasons such as "burning food, arguing with [husband], going out without telling [husband], neglecting the children, [and] refusing sex" (Fagan 2010:76). It is shown that women's social and cultural background influence how they will react in abusive situations (Ellsberg et al. 2001). Women can find it difficult to leave abusive relationships, especially when there are no support systems or social services to help alleviate the financial and emotional burdens. In Nicaragua, several women's organizations have formed to help promote women's rights and change public attitudes towards women.

There is a strong women's movement working towards political and social changes including improving the violent conditions many women face at home. AMNLAE (Asociación de Mujeres Nicaraguenses Luisa Amanda Espinoza), also known as the Nicaraguan Women's Association, is one of the main groups fighting for women's rights and freedom (Ellsberg et al. 1997). In 1979, after the revolution this group started working on 'feminist' issues and supported expanding education, childcare, and campaigning against domestic violence (Kampwirth 1998:272).They also set up Women's Houses in cooperation with the government, which provided health care, psychological and legal counseling, sex education, family planning and job training (Kampwirth 1998:272). After the 1990s elections and the defunding of many social

services, these houses were out of commission. Many of the avenues for women to receive family planning and health services were no longer available since much of the funding can primarily from the government.

Women have limited control over their reproductive lives which can lead them to have unwanted pregnancies. The gender roles assumed by men and women conform to "machismo and conservative religious ideology…[which] has limited women's reproductive health choices and empowered men to make the decisions regarding sex and reproductive health" (Lubbock and Stephenson 2008:77). On average, a woman will have three children in her lifetime; two of them are reported as wanted pregnancies. Motherhood is "the principle identity of Nicaraguan women" (Fernandez Poncela and Steiger 1996:62). The machismo ideology is shown through men "prov[ing] their virility by fathering numerous children, without any societal expectation that they will support those children or the children's mother" (Lion et al. 2009). These gender roles and the restrictive blanket ban on abortion in Nicaragua leaves many women with little to no opportunity to fully control their reproductive lives and health.

Unsafe Abortion

One of the most devastating blows to women's rights was the passing of the blanket ban on abortion in 2008. This ban "provides for lengthy prison sentences for women and girls who seek an abortion and for health professionals who provide abortion services and life-saving and health-preserving obstetric care" (Amnesty International 2009). While abortion has been illegal in Nicaragua since 1974, it has never been fully enforced. A blanket ban on abortion "allows no exceptions" and is considered a human rights violation by many organizations including Amnesty International (2009:8). This

law does not allow for any exceptions even if the life of the woman is in danger. This harms not only women but also doctors who want to help women.

The blanket ban on abortion leaves many doctors in a situation where their "hands are tied…[they] are anxious even about treating a miscarriage for example" (Amnesty International 2009:9). Even more dangerous is the fact that this law makes it difficult for doctors to make important health decisions when complications arise during pregnancy (Amnesty International 2009:9). Amnesty International's (2009) stance on blanket abortion bans states that this law does not fulfill the obligations of the state to "protect, respect and fulfill the human rights of women and girls both under its own constitution and international treaties to which it is a party" (Amnesty International 2009:33). They further state that the blanket ban on abortion is violating women and girls "right to life, health and dignity" (Amnesty International 2009:35). Many countries place restrictions on abortion procedures, but blanket bans are considered especially harmful to the health of women.

Looking at abortion rights around the world as "a medical procedure [it is] considered essential and legal in 97 per cent of countries" (Amnesty International 2009:7). Some of the circumstances that allow for abortions in other countries but are now considered illegal in Nicaragua are:

> "where the life of the pregnant woman is at serious risk if the pregnancy continues, or her physical and or psychological health are at risk as a result of the continuation of the pregnancy; when there is a high probability of foetal impairment; or in cases of rape or incest; for economic or social reasons; without restriction as to reason" (Amnesty International 2009:7).

The first two circumstances mentioned above are called therapeutic abortions, of which very few even occur (Amnesty International 2009). There were only nine per year recorded between 1999 and 2005 (Amnesty International 2009:16). Many women expect that when they go to the hospital to deliver that their doctors will be able to make a sound decision if there are complications. This blanket ban now takes the decision out of the medical professionals' hands and places it in the government and the Catholic Church. Now there are "constraints on medical judgment and limits [to] the treatment that doctors can consider for pregnant women and girls" (Amnesty International 2009:18).

With over half of the population being Roman Catholic the Church has a lot of influence over the country. The Church and other Christian groups led demonstrations at the National Assembly to urge parliament to remove the penal code exemption, and make therapeutic abortions a punishable crime (Amnesty International 2009:11). The Nicaraguan government promoted anti-abortion campaigns in coordination with the United States 'right-to-life- movement criticizing every form of birth control except rhythm (Wessel 1991:545). Before the elections in 1990, Chamorro did an interview with Catholic Radio stating she would close private clinics that carried out abortions as her first priority as president (Wessel 1991:547). This statement alone had such a powerful effect that after Chamorro was elected, in 1990, the clinic stopped performing abortions, fearing what might happen, but they slowly started up again after some time.

Nicaragua has not recovered from the increase in maternal mortality rates during the Chamarro administration (between 1990 to 2000) and is listed as "off track" by the Millennium Development Goal Monitor (2011). There are many cultural obstacles to reaching the MDGs and improving maternal health, especially in addressing the

prevalence of domestic violence and teenage pregnancy (Ellsberg 2001; World Bank 2010). Over the years the changing political climate has caused the gap between the rich and the poor to widen, as well as changed or eliminated the provisioning of select social services. Nicaragua, Sierra Leone and Afghanistan have similar problems but each country is at a different stage of development and has individual country concerns that must be addressed in order to improve maternal mortality rates.

VI. Discussion

The three countries chosen for this paper have similar historical obstacles to overcome but specific cultural practices that call for customized development goals. Afghanistan and Sierra Leone were initially chosen for this paper because they have the highest maternal mortality rates in the world. Both countries are recovering from recent wars and in Afghanistan the oppressive Taliban rule. Nicaragua was initially chosen because it has one of the highest rates of adolescent pregnancy. The culture and particularly the religious influences have an effect on the laws and medical practices in this country, including access to contraceptives and abortion. While some of the economic conditions are similar, each country can only reach the Millennium Development Goals by catering to the economic and social conditions of their respective country. By looking at the different histories, cultures and socio-economic conditions of all three countries, the complexities of combating maternal mortality have been examined.

Afghanistan, Sierra Leone, and Nicaragua have a history of violent conflict as well as a continuing economic divide among the population. Women are targeted during times of conflict and this is manifested in the continued high maternal mortality rates for

each country. The eleven years of conflict in Sierra Leone led to some of the worst violations of human rights, and women were systematically targeted. Sexual assault and rape were used to intimidate communities and the ramifications are still being seen in the high maternal mortality and especially morbidity (HRW 2003). This type of violence is known to occur in all three countries, however, the statistics are not always available as records have not been kept or been lost during conflict.

Political uprising can lead to the dismemberment of government and reduce the funding available for social services that are desperately needed. Women are disproportionately affected when social services are no longer available (UNDP 2010:16). The decades of war in Afghanistan have destroyed the basic infrastructure, including health care access for all people. Lack of roads and transportation is problematic for those needing to seek emergency care. While services tend to be relatively free in Nicaragua, the cost for transportation and medications stop some women from seeking emergency care (Lubbock and Stephenson 2008). Rich women who live in urban areas are able to attain better medical attention, especially emergency obstetric care. If poor women are denied equal medical attention maternal mortality rates will continue to not progress.

Hemorrhaging is the number one cause of maternal mortality in the world and the lack of blood supplies is an obstacle for Afghanistan and Sierra Leone. Even when supplies are limited, women have a greater chance of surviving if they have access to skilled professionals or a hospital. Women who have experienced or heard of mistreatment may forgo seeking care (UN 2008). In some areas women are afraid that they will be sterilized if they seek care at a hospital (Lubbock and Stephenson 2008).

Midwives are an option for women who do not want to seek hospital care in times of emergency. The Millennium Development Goals do not specify how maternal health care is provided (doctor, midwife, nurse, etc.), which can be problematic for record keeping and data collection.

Maternal mortality is exacerbated by the difficulty in obtaining reliable and consistent data. According to the World Health Organization "[i]n many countries, statistical and health information systems are weak and the underlying empirical data may not be available or may be of limited quality" (WHO 2010c:8). The Maternal Mortality Estimation Interagency Group (MMEIG) finds that it is difficult to obtain reliable information in certain areas because many times it comes from hospitals or government facilities that keep records of deaths and births. However, only relying on information from these institutions ignores the women that do not give birth in hospitals. Therefore, an accurate assessment cannot be made since many women live in rural areas and do not give birth in hospitals. This is one problem with gauging the efficiency of the development goals in general.

As seen in Tables 8 and 9, data collected from the World Health Organization and the World Bank can differ. One reason statistics differ is because they are collected at different times. It is difficult to find corresponding years of data for any one area. Much of the data collected is based off estimates from other health factors because it is difficult to determine if a death was actually related to giving birth (WHO 2010b). Even in developed countries data may be unreliable and misrepresent the problem due to "the definition of maternal mortality used, the sources considered (death certificates, other vital event certificates, medical records, questionnaires, or autopsy reports), and the way

maternal deaths are identified" (WHO 2010b:6). It is important to gather statistics, even if they are based off of estimates from other health factors because they will be used to determine development plans and advocacy efforts both nationally and internationally (WHO 2010b:1). As long as there is stigmatization surrounding pregnancy, and especially abortion, associated deaths may not be reported.

Table 8 Year of data collection place in brackets

Indicator	Afghanistan	Nicaragua	Sierra Leone
5.1 Maternal mortality ratio (per 100,000 live births)	1600 (2002)	77 (2007)	857 (2008)
5.2 Births attended by skilled health personnel (%)	14 (2003)	74 (2007)	42 (2008)
5.3 Contraceptive prevalence (%)	22.8 (2008)	72.4 (2007-2008)	8.2 (2008)
5.4 Adolescent fertility rate (per 1000)	151 (2006)	109 (2005)	146 (2007)
5.5 Antenatal care coverage-at least one visit (%)	16.1 (2003)	90.2 (2006-2007)	86.9 (2008)
5.5 Antenatal care coverage (at least four visits)	No information	77.8 (2006-2007)	56.1 (2008)
5.6 Unmet need for family planning (%)	No information	7.5 (2007)	27.6 (2008)

Source: WHO Global Health Observatory Database. http://apps.who.int/ghodata/.

The issue of reproductive rights is a very contentious issue especially with morality claims that have been placed in the debate, specifically in regards to abortion. Women are faced not only with health risks associated with giving birth but also with "moral, social, and legal responsibilities of gestation and parenthood…[and] carry the exclusive health burden of contraceptive failure" in the case of unwanted pregnancies (Cook 1993:78). The blanket ban on abortion in Nicaragua places many women's lives in danger, especially teenagers since they are at the highest risk for an unsafe pregnancy. Abortion is also illegal in Afghanistan, but exceptions are made if the life of the mother is at risk (Center for Reproductive Rights 2007). Sierra Leone allows for abortion if the life

of the mother as well as her physical or mental wellbeing is at risk (Center for Reproductive Rights 2007).

Looking at the statistics side-by-side for each country show where they have similar and different struggles in meeting the United Nations proposed goals. Tables 8 and 9 compare the maternal health indicators over time for Afghanistan, Sierra Leone, and Nicaragua. Table 8 is the collected data from the World Health Organization's Global Health Observatory Database (2011b) and Table 9 is collected from the Millennium Development Goals Indicators (2010) in collaboration with the World Bank. The United Nations collects information and monitors progress on the MDGs in collaboration with inter-agency and expert groups such as WHO, World Bank, UNDP and the IMF (UN 2010). This shows the international commitment to the MDGs, but it also shows how much information is missing and how hard it is to gather reliable and consistent data. Comparing the two tables shows maternal mortality rates in Nicaragua steadily decreasing between 1990 and 2009 (Table 9). However, Table 8 shows the maternal mortality rate in 2007 to be 77 per 100,000 live births. This dramatic change may be explained by the different sources of information.

The positive correlation between the number of skilled birth attendants available and the maternal mortality ratio is seen between the three countries. Afghanistan has the highest maternal mortality ratio and the lowest number of skilled birth attendants present. The opposite is seen in Nicaragua with the high number of skilled birth attendants present and low number of maternal mortality rates, compared to the other countries observed (see Table 8). Another positive correlation is seen between contraceptive use and unmet need for family planning in relation to adolescent fertility rates in Nicaragua showing the

highest percentage of contraceptive use and the lowest unmet need for family planning compared to the other three countries (Table 9). While unmet need for family planning is unavailable in Table 9 for Afghanistan and Sierra Leone, there is still a correlation between contraceptive prevalence and adolescent births.

While Nicaragua seems to be doing well with contraceptive usage and maternal mortality rates, it is being compared with two of the worst countries in the world in these categories. Nicaragua is not making progress on meeting the Millennium Development Goal for maternal mortality rates. Compared with the developed regions the estimated maternal mortality rate is higher, at 100 per 100,000, for Nicaragua and 14 per 100,000 for developed regions (Table 10). Compared with the Latin America and the Caribbean as a whole, Nicaragua has a lower lifetime risk of maternal death (1/300) and a low number of maternal deaths (150) (Table 10). All three countries discussed in this paper have a higher maternal mortality ratio compared to their respective region's average. The lifetime risk of maternal mortality for each country is also higher in Afghanistan, Sierra Leone, and Nicaragua in relation to their region (Table 10).

The Millennium Development Goals are a step forward for women's rights since many of women's human rights concerns are socioeconomic rights, including rights to shelter, food, and clean water (Bunch 1990). Women's rights are heavily promoted when looking at goal five, reducing maternal mortality, because this goal encompasses many issues that directly concern women. Sierra Leone, Afghanistan and Nicaragua are at different stages of development and should have different plans on how to achieve the specified fifth millennium development goal.

Table 9 Goal 5: improve maternal health				
	1990	**1995**	**2000**	**2009**
Afghanistan				
Maternal mortality ratio (modeled estimate, per 100,000 live births)	1,700	1,800	1,800	1,400
Births attended by skilled health staff (% of total)	..	..	12	24
Contraceptive prevalence (% of women ages 15-49)	..	..	5	15
Adolescent fertility rate (births per 1,000 women ages 15-19)	..	..	146	120
Pregnant women receiving prenatal care (%)	..	..	37	36
Unmet need for contraception (% of married women ages 15-49)	..	..	..	..
Nicaragua				
Maternal mortality ratio (modeled estimate, per 100,000 live births)	190	170	140	100
Births attended by skilled health staff (% of total)	..	..	67	74
Contraceptive prevalence (% of women ages 15-49)	..	49	69	72
Adolescent fertility rate (births per 1,000 women ages 15-19)	..	..	126	112
Pregnant women receiving prenatal care (%)	..	72	86	90
Unmet need for contraception (% of married women ages 15-49)	..	..	15	8
Sierra Leone				
Maternal mortality ratio (modeled estimate, per 100,000 live births)	1,300	1,400	1,300	970
Births attended by skilled health staff (% of total)	..	..	42	42
Contraceptive prevalence (% of women ages 15-49)	..	..	4	8
Adolescent fertility rate (births per 1,000 women ages 15-19)	..	..	140	125
Pregnant women receiving prenatal care (%)	..	..	68	87
Unmet need for contraception (% of married women ages 15-49)	..	..	..	..
Source: Millennium Development Goals Indicators. complied by World Development Indicators database (World Bank). http://mdgs.un.org/unsd/mdg/Data.aspx.				

Table 10
Estimates of maternal mortality ratio (MMR, deaths per 100,000 live births), number of maternal deaths, and lifetime risk by United Nations MDG regions, 2008

Region	Estimated MMR	Number of maternal deaths	Lifetime risk of maternal death: 1 in:	Range of uncertainty on MMR estimates	
				Lower estimate	Upper estimate
World	260	358,000	140	200	370
Developed regions	14	1,700	4300	13	16
Developing regions	290	355,000	120	220	410
Africa	590	207,000	36	430	850
Sierra Leone	970	2,200	21	530	1800
Asia	190	139,000	220	130	270
Afghanistan	1400	18,000	11	740	2600
Latin America and the Caribbean	85	9,200	490	72	100
Nicaragua	100	150	300	57	180

Source: excerpt from WHO 2010d:18 table 2

Religious ideology and cultural practices are contentious issues especially within anthropology. One of the anthropological concerns with development is the impact that it will have on particular cultures. Every culture is different and a development plan that may have worked well in one area may be disastrous in another. So the debate continues today with development and human rights: "whether human rights values are *universal* or whether *cultural relativism* legitimately is factored into international human rights policies"; in particular "feminist scholars have asked why *culture* appears to be a defense only in regard to gender roles and to the governmental and nongovernmental denials of fundamental rights to women" (Binion 1995:521, emphasis in original). Women are marginalized in Afghanistan, Sierra Leone, and Nicaragua and denied their fundamental

human rights increasing their chances of becoming ill or dying from decreased sexual and reproductive health care.

Sexual and reproductive health was not added into the Millennium Development Goals until 2007, however it is "linked particularly to the attainment of health MDGs, but it is also essential to gender equality and progress against poverty" (Bernstein and Hansen 2006:ix). Sexual and reproductive health is defined broadly as "issues related to physical, mental and social well-being in matters related to the reproductive system" and more specifically as "the promotion of healthy, voluntary and safe sexual and reproductive choices for individuals and couples, including such decisions as those on family size and timing of marriage" (Bernstein and Hansen 2006:24). While the MDGs focus on the physical aspects of women's health, the mental and cultural are overlooked in trying to reduce maternal mortality.

VII. Conclusion

The recent global recession has been one reasons provided for the leveling off of and reduction in meeting the Millennium Development Goals. Donor countries have not been able to support the goals as much as they signed on to, which is problematic because money is needed to improve the health of women. The amount of funding needed to make "significant improvement[s] in maternal health is estimated to cost less than US$1.50 per person in the 75 countries where 95% of maternal mortality occurs" (Women Deliver 2010:4).

Many governments and states endorse United Nations documents and agree to follow the Universal Declaration of Human Rights, but they do this mainly for the positive publicity (Alston 2005). There are no formal sanctions against countries that

violate the documents they sign. If a country does not endorse or promote one, or all, of the Millennium Development Goals it is unlikely that formal sanctions will be placed on that country. Reduction of maternal mortality is attainable. On the surface Millennium Development Goal five seems easily attainable a country only needs to provide medical services and family planning. However, the low status of women in some countries makes it difficult to receive medical attention and family planning.

Part of reducing maternal mortality rates is to provide sufficient information about healthy sexual relationships, provide contraceptives and health services that can help in the prevention and treatment of sexually transmitted infections (STIs). Women can become infected with STIs at a young age and if gone untreated these can lead to infertility or complications during delivery. Attention needs to be given to sexually active women (and men) to prevent the spread of STIs. This is also where goal five of the MDGs needs to not focus exclusively on women, men need to be aware of how their actions impact women and their family.

There are many other issues that are important to improving maternal mortality that could not be covered in this paper. Many of them are addressed in the other Millennium Development Goals such as improving access to education for women and girls, reducing and combating HIV/AIDS, and empowering women especially in the political arena. The MDGs need to be addressed simultaneously with the cultural and historical considerations of the individual nations. Violence against women and unsafe abortions need to be recognized as detrimental not just to women's health but to the overall economic state of the country. By enhancing women's status and improving

access to medical and family planning services not only will maternal mortality rates be reduced but so will the primary focus of the MDGs, poverty.

NOTES

1. Antenatal care monitors the health of the mother and fetus during pregnancy, before birth, for warning signs and complications. General examinations include testing blood pressure, urine and blood for symptoms such as bacteria or anemia, and checking height and weight (WHO 2003).
2. Created in July 2010 by the UN General Assembly as the "United Nations Entity for Gender Equality and the Empowerment of Women" by merging Division for the Advancement of Women (DAW); International Research and Training Institute for the Advancement of Women (INSTRAW); Office for the Special Adviser on Gender Issues and Advancement of Women (OSAGI); United Nations Development Fund for Women (UNIFEM) http://www.unwomen.org/about-us/about-un-women/
3. Nicaragua, Chile and El Salvador are the three countries in the world with a blanket ban on abortion. This means no abortion procedure can be perform even if the life of the mother is at risk or the pregnancy is a result of rape or incest (Center for Reproductive Rights 2007).
4. Countries in Western Africa include: Benin, Burkina Faso, Cape Verde, Côte d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, and Togo (WHO 2007).
5. South-central Asia consists of the following countries: Afghanistan, Bangladesh, Bhutan, India, Iran, Kazakhstan, Kyrgyzstan, Maldives, Nepal, Pakistan, Sri Lanka, Tajikistan, Turkmenistan, and Uzbekistan (WHO 2007)

Appendix

Official list of MDG indicators
All indicators should be disaggregated by sex and urban/rural as far as possible.
Effective 15 January 2008

Millennium Development Goals (MDGs)	
Goals and Targets (from the Millennium Declaration)	**Indicators for monitoring progress**
Goal 1: Eradicate extreme poverty and hunger	
Target 1.A: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	1.1 Proportion of population below $1 (PPP) per day[1] 1.2 Poverty gap ratio 1.3 Share of poorest quintile in national consumption
Target 1.B: Achieve full and productive employment and decent work for all, including women and young people	1.4 Growth rate of GDP per person employed 1.5 Employment-to-population ratio 1.6 Proportion of employed people living below $1 (PPP) per day 1.7 Proportion of own-account and contributing family workers in total employment
Target 1.C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	1.8 Prevalence of underweight children under-five years of age 1.9 Proportion of population below minimum level of dietary energy consumption
Goal 2: Achieve universal primary education	
Target 2.A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	2.1 Net enrolment ratio in primary education 2.2 Proportion of pupils starting grade 1 who reach last grade of primary 2.3 Literacy rate of 15-24 year-olds, women and men
Goal 3: Promote gender equality and empower women	
Target 3.A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015	3.1 Ratios of girls to boys in primary, secondary and tertiary education 3.2 Share of women in wage employment in the non-agricultural sector 3.3 Proportion of seats held by women in national parliament
Goal 4: Reduce child mortality	
Target 4.A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality	4.1 Under-five mortality rate 4.2 Infant mortality rate

[1] For monitoring country poverty trends, indicators based on national poverty lines should be used, where available.

rate	4.3 Proportion of 1 year-old children immunised against measles
Goal 5: Improve maternal health	
Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	5.1 Maternal mortality ratio 5.2 Proportion of births attended by skilled health personnel
Target 5.B: Achieve, by 2015, universal access to reproductive health	5.3 Contraceptive prevalence rate 5.4 Adolescent birth rate 5.5 Antenatal care coverage (at least one visit and at least four visits) 5.6 Unmet need for family planning
Goal 6: Combat HIV/AIDS, malaria and other diseases	
Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	6.1 HIV prevalence among population aged 15-24 years 6.2 Condom use at last high-risk sex 6.3 Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS 6.4 Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years
Target 6.B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it	6.5 Proportion of population with advanced HIV infection with access to antiretroviral drugs
Target 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	6.6 Incidence and death rates associated with malaria 6.7 Proportion of children under 5 sleeping under insecticide-treated bednets 6.8 Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs 6.9 Incidence, prevalence and death rates associated with tuberculosis 6.10 Proportion of tuberculosis cases detected and cured under directly observed treatment short course
Goal 7: Ensure environmental sustainability	
Target 7.A: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources Target 7.B: Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss	7.1 Proportion of land area covered by forest 7.2 CO2 emissions, total, per capita and per $1 GDP (PPP) 7.3 Consumption of ozone-depleting substances 7.4 Proportion of fish stocks within safe biological limits 7.5 Proportion of total water resources used 7.6 Proportion of terrestrial and marine areas

	protected 7.7 Proportion of species threatened with extinction
Target 7.C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation	7.8 Proportion of population using an improved drinking water source 7.9 Proportion of population using an improved sanitation facility
Target 7.D: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	7.10 Proportion of urban population living in slums[2]
Goal 8: Develop a global partnership for development	
Target 8.A: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system Includes a commitment to good governance, development and poverty reduction – both nationally and internationally Target 8.B: Address the special needs of the least developed countries Includes: tariff and quota free access for the least developed countries' exports; enhanced programme of debt relief for heavily indebted poor countries (HIPC) and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction Target 8.C: Address the special needs of landlocked developing countries and small island developing States (through the Programme of Action for the Sustainable Development of Small Island Developing	*Some of the indicators listed below are monitored separately for the least developed countries (LDCs), Africa, landlocked developing countries and small island developing States.* <u>Official development assistance (ODA)</u> 8.1 Net ODA, total and to the least developed countries, as percentage of OECD/DAC donors' gross national income 8.2 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) 8.3 Proportion of bilateral official development assistance of OECD/DAC donors that is untied 8.4 ODA received in landlocked developing countries as a proportion of their gross national incomes 8.5 ODA received in small island developing States as a proportion of their gross national incomes <u>Market access</u>

[2] The actual proportion of people living in slums is measured by a proxy, represented by the urban population living in households with at least one of the four characteristics: (a) lack of access to improved water supply; (b) lack of access to improved sanitation; (c) overcrowding (3 or more persons per room); and (d) dwellings made of non-durable material.

Source: Bernstein and Hansen 2006:127

States and the outcome of the twenty-second special session of the General Assembly) Target 8.D: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	8.6 Proportion of total developed country imports (by value and excluding arms) from developing countries and least developed countries, admitted free of duty 8.7 Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries 8.8 Agricultural support estimate for OECD countries as a percentage of their gross domestic product 8.9 Proportion of ODA provided to help build trade capacity Debt sustainability 8.10 Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative) 8.11 Debt relief committed under HIPC and MDRI Initiatives 8.12 Debt service as a percentage of exports of goods and services
Target 8.E: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	8.13 Proportion of population with access to affordable essential drugs on a sustainable basis
Target 8.F: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	8.14 Telephone lines per 100 population 8.15 Cellular subscribers per 100 population 8.16 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 and Government, in September 2000 (http://www.un.org/millennium/declaration/ares552e.htm) and from further agreement by member states at the 2005 World Summit (Resolution adopted by the General Assembly - A/RES/60/1, http://www.un.org/Docs/journal/asp/ws.asp?m=A/RES/60/1). 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 "to create an environment – at the national and global levels alike – which is conducive to development and the elimination of poverty".

Table 2. Global and regional estimates of annual incidence of unsafe abortion and associated mortality in 2003. Rates and ratios are calculated for all countries and, in parenthesis, only for countries with evidence of unsafe abortion[§]

	Unsafe abortion			Mortality due to unsafe abortion		
	Number (rounded)[†]	Incidence rate (per 1000 women aged 15–44 years)	Incidence ratio (per 100 live births)	Number of deaths (rounded)[†]	% of all maternal deaths	Mortality ratio (per 100 000 live births) (rounded)[†]
World	19 700 000	14 (22)	15 (20)	66 500	13	50 (70)
Developed countries*	500 000	2 (6)	3 (13)	<60	4 (8)	° (2)
Developing countries	19 200 000	16 (24)	16 (20)	66 400	13	60 (70)
Least developed countries	4 000 000	25	15	24 000	10	90
Other developing countries	15 300 000	15 (23)	17 (22)	42 400	15 (16)	50 (60)
Sub-Saharan Africa	4 700 000	31	16	35 600	14	120
Africa	5 500 000	29	17	36 000	14	110
Eastern Africa	2 300 000	39	20	17 600	17	160
Middle Africa	600 000	26	12	5 000	10	100
Northern Africa	1 000 000	22 (23)	20 (21)	1 100	11	20
Southern Africa	200 000	18	18	300	9	20
Western Africa	1 500 000	28	14	11 900	13	110
Asia*	9 800 000	11 (20)	13 (18)	28 400	12 (13)	40 (50)
Eastern Asia*	°	°	°	°	°	°
South-central Asia	6 300 000	18	16	24 300	13	60
South-eastern Asia	3 100 000	23 (27)	27 (31)	3 200	14 (16)	30
Western Asia	400 000	8 (13)	7 (10)	1 000	11 (12)	20 (30)
Europe	500 000	3 (6)	6 (13)	<60	6 (8)	1 (2)
Eastern Europe	400 000	5 (6)	13 (14)	<50	6 (7)	2
Northern Europe	2 000	0.1 (1)	0.1 (2)	°	3 (22)	° (3)
Southern Europe	100 000	3 (6)	7 (14)	°	11 (19)	1
Western Europe	°	°	°	°	°	°
Latin America and the Caribbean	3 900 000	29 (30)	33 (34)	2 000	11	20
Caribbean	100 000	16 (28)	19 (26)	200	12	30 (40)
Central America	900 000	25	26	300	11	10
South America	2 900 000	33	38	1 400	11	20
Northern America	°	°	°	°	°	°
Oceania*	20 000	11	8	<100	10	20

§ Rates, ratios and percentages are calculated for all countries of each region, except Asia (which excludes Japan) and Oceania (which excludes Australia and New Zealand). Rates, ratios and percentages in parentheses were calculated exclusively for countries with evidence of unsafe abortion. See Section 6.3 for a detailed explanation. Where the difference between the two calculations was less than 1 percentage point, only one figure is shown.

† Figures may not exactly add up to totals because of rounding.

* Japan, Australia and New Zealand have been excluded from the regional estimates, but are included in the total for developed countries.

° No estimates are shown for regions where the incidence is negligible.

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