

## Guest editorial

# The Millennium Development Goals: women's health 10 years on

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At the Millennium Summit in 2000, 189 world leaders agreed to adopt the United Nations (UN) Millennium Declaration, which consisted of a number of goals to reverse the extreme poverty, hunger and disease that are experienced by much of the world's population. Millennium Development Goal (MDG) 3 aims to promote gender equality and empower women, MDG 5 to improve maternal health by reducing the maternal mortality ratio by 75%, and MDG 6 to reverse the spread of HIV by 2015, including among pregnant women. Yet five years later, in setting up the Knowledge Network on Women and Gender Equity as part of the Commission on Social Determinants of Health, the World Health Organization (WHO) still acknowledged gender as a key determinant of health inequalities. Although life expectancy is improving globally, there still exist massive disparities, female life expectancy in the UK being 82 years, in the USA nearly 81 years, but in Angola 49 years, South Africa 53 years, and in Afghanistan 44 years (World Bank, 2011a).

'The differences in reproductive health between the rich and poor – both between and within countries – are larger than any other area of health care' (UN Millennium Project, 2005, p.82). In 2008 an estimated 358 000 maternal deaths occurred worldwide, or 290 per 100 000 live births (range 11 in developed regions; 640 in sub-Saharan Africa: United Nations, 2010a). Although this represents a 34% decrease since 1990 it is short of the MDG target, and a number of inequalities within and between countries still exist. Sub-Saharan Africa and South Asia account for 87% of maternal deaths (MDG indicators). Even within poor countries great discrepancies exist, with the richest 20% of women being three times more likely to be attended by a skilled health worker during labour than the poorest 20% (83% and 28%: United Nations, 2010a). In Europe 99% of women receive skilled healthcare during labour. The most effective means of reducing maternal deaths in poor countries are considered to be access to contraception to reduce unintended pregnancy and possibly unsafe abortion, skilled birth attendance, and the availability of obstetric care in cases of emergency. Yet paying for reproductive health services

places a high burden on women, even in supposedly 'free at the point of delivery' care systems. For example, in Chad, public funding of healthcare is only 56% of the total spending on health, and maternal mortality is 1200 per 100 000 live births. Of the rest 96% comes from direct payments by patients and their families (World Bank, 2011b). Direct payments are likely to deprive more women than men from accessing healthcare as women own less property than men, are less likely to be engaged in paid employment, and earn much lower incomes (World Health Organization, 2010a).

Barriers to care in some countries include lack of freedom for women to move around freely and possession of little power over family resources. In rich countries, for a variety of reasons, women generally access health services more frequently than men, but in some South Asian and sub-Saharan African countries women are not allowed to make decisions concerning their own health, and studies in South Africa found that women do not always consider themselves entitled to invest in their own health (World Health Organization, 2010a). In this issue Osipenko and Szczepura (2011) discuss the continued higher value placed on males as demonstrated by the use of over-the-counter sex selection tests to ensure male offspring in the developing world and the Asian diaspora. Women are able to access healthcare more easily, even in poor countries, where entitlement to healthcare does not depend on employment in the formal economy. Even very low income countries can, with investment in services and political will, reduce maternal mortality, and this has occurred in, among others, Bangladesh, Bolivia and Honduras.

Emergency situations and displacement create the biggest threat to pregnant women and their unborn children. During the Sudanese conflict in 2003, one in nine women who were expecting a child was estimated to have died in pregnancy or childbirth. In Gaza, delays at checkpoints have resulted in unattended roadside births (UNFPA, 2005). Until recently, reproductive healthcare was seldom available during emergencies and the displacement of populations. There have, more recently, been some success stories. Following the

tsunami of 2004 hygienic delivery packs were delivered to the most badly affected countries of Indonesia and Sri Lanka, and primary care for women has improved in Iraq in recent years (UNFPA, 2005).

Although maternal mortality is falling throughout the world, albeit slowly in some countries, the incidence of and mortality from HIV/AIDS continue to rise in women in some of the poorest countries, where it is said that the incidence of HIV has been feminized (UNFPA, 2005). In 2008, 58% of people living with HIV in sub-Saharan Africa were women, and in the Caribbean 53%. Prevalence data show that in 2009 13 women in sub-Saharan Africa became infected with HIV for every 10 men (United Nations, 2010b). Women and, in particular, adolescent girls, have little power to negotiate sexual practices and make decisions that could protect them from HIV infection (UNFPA, 2005). In all regions of the world, female sex workers, IV drug users and the partners of infected men are overrepresented in the numbers of women who are HIV positive. Transactional sex is a necessity for survival for many poor women when access to resources is unequally distributed between the sexes, and this exposes many young women to HIV infection as they have little power in sexual relationships. Rich countries too show inequalities in the incidence of HIV infection, for many of the same reasons. Women with HIV in the USA have a higher mortality rate than men, associated with poverty and homelessness that lead them to engage in more transactional sex (Riley *et al*, 2007). Black women are 20 times more likely to be HIV positive than white women, and four times more likely than Hispanic women.

The massive advance in available treatments for HIV has largely been as a result of research carried out on men (Committee on Women's Health Research Institute of Medicine, 2010). Although women have benefited from these, excess female toxicity caused by treatment, for example anaemia and pancreatitis, was initially missed as women were absent from research studies. There has, however, been a global reduction in the incidence of and deaths from HIV in recent years due to greater use of condoms and the availability of anti-retroviral drugs (UNAIDS, 2010).

Despite many differences in the health status of women throughout the world, one health issue that would appear to be universal is intimate partner violence. In a 10 country study, Garcia-Moreno *et al* (2005) found that between 15% and 71% of women reported experiencing physical or sexual violence by a husband or partner. There is also growing evidence of a link between the spread of HIV and gender-based violence (United Nations, 2010b). Sexual violence on women by their partner is more likely to lead to the transmission of HIV, and fear of violence may deter women

from asking partners to use condoms. Research from the USA reports that prior violence from a partner leads, in subsequent relationships, to the non-use of condoms, continuing the risk of HIV infection (Teitelmann *et al*, 2008). The practice in certain war situations of soldiers deliberately making women from the opposing side pregnant entails both sexual violence and the risk of HIV for those women (UNFPA, 2005). In this issue, Madoc-Jones and Roscoe (2011) note that in the UK it is estimated that one in four women has experienced domestic violence, with physical, psychological and emotional consequences for them and their children. The WHO reports that pregnancy-related complications such as miscarriage and premature birth may result from violence during pregnancy (World Health Organization, 2010b).

In contrast to high HIV and maternal mortality rates, social and economic background is less relevant in intimate partner violence. Most studies report male violence on women as being the most common form of intimate partner violence, but, as it is very much hidden within the household, all forms are widely underestimated, and some research suggests that the incidence is similar within same-sex relationships (World Health Organization, 2010b). Intimate partner violence tends to occur from adolescence onwards in most areas of the world and may be physical, sexual or controlling behaviour, whereas sexual abuse by non-partners occurs from childhood and is directed against boys as well as girls. In many countries there remains a tacit or even institutionalized acceptance of male violence towards women and children, and a greater value placed on men than on women within society (UNFPA, 2005).

In summary, the brunt of health consequences caused by gender inequality is felt by women and girls. A recurring theme connecting HIV status in women, their lack of economic and social power, and intimate partner and sexual abuse is masculine dominance and power which is prevalent in many societies (Teitelman *et al*, 2008; Riley *et al*, 2007; UNFPA, 2005).

Although great improvements have been seen globally in life expectancy of women and in reproductive health, there remain great disparities between and within nations. Without changes to the socio-cultural context of women's lives, amelioration of gender inequalities in health and in access to healthcare cannot occur. The most recent UNAIDS Global Report recommends that MDGs 3, 5 and 6 be addressed simultaneously along with MDG 4 (reduction in child mortality) in order to reduce the linked problems for women's health of reproductive health, gender-based violence and HIV (UNAIDS, 2010).

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