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POPULATION AND GENDER DIMENSION OF THE MILLENIUM DEVELOPMENT GOALS

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Population and Gender Dimension of the Millenium Development Goals

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by
Sahir Abdul-Hadi
UNFPA

Population and Gender Dimension of the Millennium Development Goals.

Introduction

UNFPA contribute to the achievement of each of the MDGs through its country and inter-country population and development programs, which are especially targeted towards those countries furthest from the goals contained in the Program of Action of the International Conference on Population and Development (ICPD). The MDGs map closely linked to the ICPD goals and objectives, and to the goals and indicators in UNFPA Results /Framework that provides the basis for its programming focus. Progress towards the MDGs is dependent inter Alai, on making progress towards the ICPD goals of achieving universal access to reproductive health services.

Increased access to quality reproductive health services contribute s to reduced child and maternal mortality, help combat HIV/AIDS, and promotes gender equality, as well as reducing income poverty, supporting the achievement of universal primary education and the promotion of sustainable development.

Goal 1: Eradicate Extreme Poverty and Hunger: Poverty is closely associated with population and health outcomes. Relatively, large numbers of children per women among the poor- a function of high fertility- often lead to inadequate child care and to reduce opportunities for women to improve their status. They are strongly related to early age at marriage and first birth, low contraceptive prevalence rates, short birth intervals, and relatively high risk of infant, child and maternal mortality. UNFPA's programs are to meet the large unmet needs for reproductive health services, including family planning, and to avoid too early and too closely spaced pregnancies. Increasing access to reproductive health services, especially family. Increasing access to reproductive health services, especially family planning, contributes to lower child mortality, which in turn contributes to lower fertility.

Goal 2: Achieve Universal Primary Education: Basic education for both girls and boys is fundamental for human capital development, and for opening up opportunities and choices throughout adolescents and adulthood. UNFPA strongly advocates for universal primary education, especially for girls.
Goal 3: Promote Gender Equality and Empowerment of women. Overcoming cultural, social and economic constrain that limit women's access to reproductive

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health services are essential to promoting gender equality. The highest proportion of women's ill health burden in related to their reproductive health role. Young age at marriage and too early pregnancies seriously impede girls and subsequent

One of the most important features that distinguish the ICPD from others is the centrality with which gender equality and women's empowerment issues were treated. In addition to linking population and development issues with poverty eradication, the ICPD postulated that women must be equal partners in all aspects of development. High on the development agenda is fight against poverty based not only on economic growth, but also on the achievement of social goals, including gender equality. As a consequence the ICPD made it mandatory to undertake and use gender analysis in order to understand population trends and to develop appropriate and relevant indicators.

The POA also called for ensuring that the human rights of women and girls are respected, protected and promoted through development, implementation and effective enforcement of gender sensitive policies and programs. UNFPA programs are based on the premise that overall development requires the recognition and exercise of human rights, such as the right to reproductive health, right to clean water, shelter, and participation in development plans for both men and women.

The involvement and empowerment of women is essential to any effective response to environment and resource degradation. The direct and critical relationship between women and natural resources draws it strength from gender and the socially created roles and responsibilities that continue to fall to women in household, communities and ecosystems throughout the world. Women have primary responsibility for rearing children, and for ensuring sufficient resources to meet children's needs for nutrition. In rural areas of developing countries, they are also the main managers of essential household resources like clean water, fuel for cooking and heating and fodder for domestic animals. In many countries, women work 12 hours or more a day in and out they're of their homes. In Africa and Asia, women work on average 13 hours more than do men.

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Gender in the MDGs

Since the adoption of the Millennium Declaration in 2000, the Millennium Development Goals (MDGs) have rapidly moved to center stage as a key focus of international development co-operation. Governments ' commitment to women's rights and gender equality, agreed in numerous global forums and in the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) was reaffirmed by the world's nations at the Millennium Summit. The Millennium Declaration asserts that gender equality is not only a goal in its own right, but is critical to attaining all of the development goals. It resolves, " to promote gender equality and empowerment of women as effective ways to combat poverty, hunger and disease and to stimulate development that is truly sustainable.

Goal (3) of the MDGs specifically addresses gender equality and women's empowerment, but the specific target attached to this goal has a narrow focus on eliminating gender disparities in education. This is in spite of the fact that the Millennium Declaration it self (para 21) addresses the fact that that promotion of gender equality and empowerment of women as effective ways to combat poverty, hunger and disease and to stimulate development that is truly sustainable. The declaration also states in para 6 that men and women have the right to live their lives and raise their children in dignity, free from hunger and from the fear of violence, oppression or injustice.

It is clear that gender issues are highly relevant to achieve the MDGs, be it protecting the environment, achieving sustainable development or enabling universal access to health care particularly reproductive health services.
Although the target of MDGs on gender equality appears to be associated mainly by eliminating. Gender disparity in primary and secondary education, the road map includes three additional indicators of gender equality: a) literacy rates b) the share of women working in agriculture, and the proportion of seats women hold in national assemblies.
The inclusion of these indicators suggests that while equal access of education is an important step towards gender equality, it is by no means sufficient. Even as gender disparities in education are reduced, other gender differences tend to persist, in labor market opportunities, legal rights, and ability to participate in public life and decision-making.

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The poverty goal of the MDGs calls for reducing by half the proportion of people living in extreme poverty by the year 2015 from 29 per cent to 14 per cent. There are 2.5 billion worldwide who live on less than two dollars a day. The definition of poverty has been broadened to encompass other dimensions such as lack of empowerment, opportunity, capacity and security. Meeting the poverty goals then requires multidimensional approach.

There are many variables critical for poverty reduction, both on investment as well as empowerment side. Among the links between gender equality and growth are: a. Investment in human capital, especially girls and women education and health particularly reproductive health b. Increase access to resources, c. time poverty created by poor infrastructure reduce productivity and impact health, such as collection of water and fuel.

Well Being Indicators Of Women (15-49 Years)

Social	Economic	Health
1- Household Type 2- Current Martial Status 3- Education Level 4- Have Surviving Children not living at Home	Engagement in Economic Activity 1- Type of Activity 2- Monthly Income 3- Problems in Economic Activity	1- Prevalence of Disease 2- Knowledge of AIDS and its Transmission 3- Utilization of Maternal Care Services 4- Maternal Mortality

Four indicators are introduced to reflect the social changes resulting from the process of displacement.

UNFPA /and Mugs

Gender issues are highly relevant to achieve the MDGs, be it protecting the environment, achieving sustainable development or enabling universal access to health care including maternal health .It is clear that nations will not be able to cut extreme poverty and hunger in half, slow the spread of HIV/AIDS, ensure universal primary education, and reduce infant and maternal mortality unless greater progress is made toward gender equality and full respect for women's rights, including reproductive health and rights. Moreover, the demographic transition and population dynamics are crucial for understanding development process. High population growth has been shown to have negative impact on economic growth and poverty reduction. Analysis from 45 developing countries

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found that average country in 1980 at poverty incidence of 18.9 per cent, had it reduced its crude birth rate by 5 per cent per 1000 and maintained this level through out the 1980s, poverty would have been reduced to 12.6 per cent, a reduction of 33 per cent.

High population growth /high fertility and poverty are mutually reinforcing. Research had shown that high poverty and lack of access to basic social services are associated with high fertility and that where contraceptive prevalence is low, incidence of poverty is high, while the proportion of unwanted births is substantial.

Evidence suggests that health is a crucial precondition for economic growth and, conversely, that economic development if it is properly directed can yield enormous advances in public health [1].
In fact, while, improvements in health and economic development are connected, experience shows that significant advances in children's health and women health and in life expectancy can occur if the right investment and policy decisions are made, even in the absences of overall growth [2].

The methodology of the Mugs- i.e. selecting priorities, setting targets and monitoring progress – is not a new approach for the child health and maternal health fields. What makes this initiative different is that it puts the health community at the table as a fully vested partner not only with those responsible for the other dimensions of social development so critical to improved public health (education, water, sanitation, nutrition and gender equity, but also with the policy – makers whose decisions both give and take away resources and power.
For the maternal and child health fields, that opportunity presents challenges to our own patterns of business as usual. The experience over many decades with public health initiatives to accelerate progress in women's health and children health teach important lessons. If we have the courage to hear them, the conviction to follow them, and the creativity to implement them, we can fulfill the promise of the MDGs. [13]

Despite the global Safe Motherhood initiative Launched in 1987, overall levels of maternal mortality appear barely to have enough resources in the fifteen years that followed, in some parts of the world they have probably worsened. Obstetric complications are the leading cause of death of women of reproductive age in developing countries today [4].

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In 2003 as in 1980, over half a million women – one every minute – will die in pregnancy and childbirth. Even more telling, of any health indicator, maternal mortality has by far the highest differentials between poor countries and rich ones: where child mortality shows a twenty – fold difference between rich and poor countries [3], maternal mortality ratio shows a one hundred – fold difference [5]. The threat to women's health initiatives is particularly crippling in the context of MDGs. Whether we are talking about income poverty or the social dimensions of poverty, one unassailable lesson is the centrality of women – their status, their roles, and their agency to successful development [13].
Reducing maternal mortality in developing countries brings important social and economic gains because the vast majority of women who die from pregnancy related causes are in the prime of life and are responsible for children and other dependents. It is estimated that a million or more children are left motherless each year as a result of maternal mortality, likely to die within two years than children with both parents alive.

In addition, HIV/AIDS threatens to destroy a whole generation of leaders, workers, parents and youth. Today, 40 million people live with HIV/AIDS, over 95 per cent of them in developing countries. Globally women account for 48 per cent of infected adults, but among young women, the percentage is far higher and likely to become worse. In sub-Saharan Africa, 55 per cent of those infected are women, and in many African countries, females aged 15-24 have prevalence rate of up to six times higher than those of males in the same age. AIDS has orphaned more than 13 million children aged 14 or younger. Female-headed households, including households headed by very young women or elderly grandmothers, are increasingly responsible for the care of orphans.

While the health of women and their children are, at points, intimately bound together, women's health cannot be subsumed into children's health or vice versa.

Hence, analysis of prenatal mortality (and under five mortality more generally) must be kept conceptually distinct from analysis of maternal mortality. We cannot simply assume that an intervention effective for one, necessarily resolves issues for the other – but neither should be set in opposition to each other.

Indeed, there are important reasons for the child health and women's health communities to join forces. The bridge between them is reproductive health. Many dimensions of reproductive health from control over the number and spacing of children to maternal nutrition to prevention and treatment of sexually transmitted

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infections as well as the aspects of reproductive health captured by concepts of women's empowerment and human right to have powerful effects on the health and well being of children, families and women themselves. Thus, reproductive health and deliberate actions to advance, support and monitor it are necessarily and bound to any strategy for meeting MDGs in either child health, or maternal health [13].

MDGs /Gender / Population and sustainable development

In many regions water scarcity and declining water quality disproportionately affect the poor. Some 1.2 Billion people lack access to clean water sources and 2.4 billion lack access to safe sanitation –over the next 12 years almost all of the projected increase of nearly 1 billion in global population, from 6.3 billion in 2003, to 7.2 billion in 2015 will be in poorer countries thereby, making it more difficult to achieve the MDGs and World Summit on Sustainable Development, water and sanitation target.

Declining supply of quality water sources increase poverty through declining employment and income opportunities for the poor, especially in rural areas – access to water for irrigation purpose is critical. Rural poverty, population pressure and dwindling water supplies is a powerful force driving rural to urban migration, as well as cross border movement.

Rapid urban growth often leads to people establishing slums where there are serious problems with water supply, sanitation and industrial waste. This rapid pace also hinders the development of adequate infrastructure and regulatory mechanisms to cope with water pollution and the by-product of population, provision of social services and economic growth.

In developing countries, lack of access to safe water and sanitation, especially in rural areas and poor communities, compels women to spend hours every day collecting water for their households, causing enormous drain on their energy, productive potential and health particularly if they are pregnant. Freeing girls and women from the task of water collection would help empower them through providing choices and opportunities, to go school, employment, self-employment etc.

Largely because of their role in collecting water, washing clothes, cleaning and cooking, in addition to their agricultural tasks in rural areas, women are constantly exposed to the risk of contracting water related diseases that may affect their reproductive health. Exposure to contaminated water sources, and lack of adequate

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sanitation, among other are associated with pregnancy failures, and with infant and child development difficulties, illness and mortality.

MDGs/Gender and Maternal Health

Every day 1400 women dies in pregnancy or child birth, this adds up to more than 500,000 women each year. About 99 per cent of these women are in developing countries. While many health indicators in developing countries have improved over the last two decades, maternal mortality rates have shown little change. Gender inequality in the control of the household 's economic resources, in the right to make decisions and in the freedom of movement outside the household and transportation and other gender dimension contribute to poor maternal health in many settings. So do poor nutrition, high fertility rates, and high level of anemia (a reflection of poor nutrition) and poor quality reproductive health services. Only 58 per cent of women in developing countries deliver with the assistance of a trained mid-wife or doctor, and only 40 per cent give birth in a hospital or health center.

Reducing maternal mortality in developing countries brings important
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Bench Mark Indicators

The "Road Map" toward the implementation of the UN Millennium Declaration" issued by Secretary General in September 2001 includes indicators intended to assist countries in tracking and ensuring progress toward the targets and goals [7]. The reason for indicators is well – accepted: in practice, what you count is what you do and where your resources go. Thus the ideal indicator will perform two functions well: (1) it will vary with the outcome of interest and so serve well as a proxy measurement of change, and (2) it will be causally related to the outcome of interest, so that it can serve as a guide to policy and program, and as an accountability tool to ensure that decision makers take the steps that will actually have impact on the ultimate goal. The two indicators that have been

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chosen for the maternal mortality reduction target play critical roles in safe motherhood initiatives, but both have significant drawbacks as indicators for MDG process.

The maternal mortality ratio MMR (maternal death per 100,000 live births) is a measure of how safe it is to become pregnant and give birth in the geographic area or population for which it is calculated. It is therefore a very telling statistics about this aspect of women's health status and can be used effectively to call attention to the general scope of the problem. But as an indicator in the MDG initiative, MMR has several major limitations. Most importantly it is extremely difficult to measure accurately, for reasons that are carefully explained in the publications presenting the official estimates developed by WHO, UNICEF and UNFPA [5]. Indeed even where there is a strong vital registration system, maternal deaths are under reported by 50% on average [5]. Where in the absence of vital registration MMR is calculated based on the "Sisterhood method" the deaths actually being counted are those, which have taken place over the previous ten to twelve years. Thus, UN agencies have correctly warned that MMR estimates should not be used to monitor short-term trends [5]. In short, country – Level MMR will not be able to tell us whether changes have taken place in the time period covered by the MDGs.

Another issue to be introduced here is the need for demographic and other information about complex conflict, and posts conflict situations, a subject, which needs more attention from the donors and development agencies. There may be around 50 million forced migrants, internally or externally in the world, some temporary. The number, frequency, magnitude, and sheer difficulty of tracking population and development changes contribute to the need for more data in these more recurring situations in the world. Estimating components of population change, such as fertility and mortality, can be very difficult to account for in emergency situations than under normal circumstances. However, estimates of population age and sex composition are needed both for planning services and for estimating and comparing mortality and fertility rates. High-risk groups that require special health interventions, such as pregnant women immunization, and the elderly.

In order to track progress toward meeting the MDG target of MMR reduction in conflict situation for instance, in we need to use proxy indicators. The second indicator, the proportion of births attended by skilled health personnel.

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But, it will be important to supplement it with a measure that captures relevant development of the health system overtime without such a measure in place, the push to meet the skilled attendants indicator is likely to have distorting policy effects that can Jeopardize the very efforts it is intended to promote. A potential indicator to track and ensure health system development by tracking the availability of emergency obstetric care (Emoc) services.

The World Bank Study of health investments and their relationship to policies to reduce maternal mortality, concludes that countries never regarded the training of skilled midwives to deliver routine care as competing with the development of the over all health system that would ensure access to Emoc in obstetric emergencies [8]. Health system development priorities moved deliberately and progressively from extending geographic coverage of health facilities, to increasing utilization, to improving quality of services. That progression depended on the development of an adequately trained level of health personnel (especially midwives) who could provide high quality delivery care in communities and in the facilities that were being built and strengthened – and could link the two together. It entailed a commitment to reaching every geographic part of the country and every ethnic group. Regulations regarding tasks to be performed by different cadres of health professionals were modified when required by the overriding goals of truly meeting the needs of the population in underserved areas. Significantly, midwives were the backbone of the system in some countries; decently paid, greatly valued and respected in the community and in the facility, members of a profession that carried real prestige in the society.

Ultimately, both skilled attendants and Emoc are probably necessary to make the system – including its relationship to communities – function well and thus reduce maternal mortality. Countries addressing maternal mortality today must similarly take a tailored and dynamic, evolving approach to the balance between the two strategies. In that calculation, if the reduction of deaths from obstetric complications is to get high priority, as the MDG target would certainly suggest, then the services that are most effective in addressing such complications will need to receive greater attention than has typically been the case in high mortality countries in the past.

But for any balance to be struck, decision makers must be aware of the level of unmet need for Emoc and advocates must use this information to press for the most effective policies.

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Historical studies, show that confidential enquiries and maternal deaths audits, strategically used and followed up, were important factors in maintaining political commitment and ensuring appropriate responsive strategies as maternal mortality steadily declined. [8, 10].

In 1997, WHO, UNICEF and UNFPA issued a publication, Guidelines for monitoring the availability and use of obstetric services, that describes a set of indicators to assess the availability, utilization and use of Emoc. The indicators are: Number of Emoc facilities including Basic Emoc and Comprehensive Emoc, Geographic distribution, parentage births in Emoc facilities, Met need for Emoc, quantity of critical service "Caesarean Section rate" and quality of care - case fatality rate –

. Basic EmOC basic services include:

-Administer potential antibiotic

-Administer parenteral oxytocic drugs.

-Administer parenteral anticonvulsants

-Pre-eclampsia and eclampsia

-Perform manual removal of retained products) e.g. manual vacuum aspiration)

-Perform assisted vaginal delivery.

Comprehensive EmOc services:

Include all the above in addition to:

- Perform surgery (Caesarean section)
- Perform blood transfusion.

Experience with the UN Emoc indicators in several dozen high – mortality countries indicates that, although there is sometimes surprisingly adequate coverage of comprehensive Emoc, there is grossly inadequate coverage of basis Emoc facilities and extremely low levels of met need for Emoc, often under 20% ("met need" being a measure that takes into account both coverage and utilization) [10, 11, 12].

Hence basic Emoc, part of the primary health care infrastructure centered on the skilled attendant, in close proximity and in constructively accountable relationship to the community, is a particularly urgent need.

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To dramatically decrease maternal mortality and meet the MDG target, countries will have little choice: they must ensure that Emoc is available, accessible and appropriately utilized. This means finding the right balance between attention to skilled attendants for all deliveries and Emoc for complicated, life – threading once. Both practically and politically, that balance will only be achieved if there is an indicator that helps generate appropriate data to be used for monitoring and accountability.

For the MDG imitative, then, we recommend that in addition to the skilled attendants indicator, countries also use the first of the UN process indicators to assess Emoc coverage: number of functioning comprehensive and basic Emoc facilities per 500,000 population.

The particularly crucial role of intervention delivered through the formal health care system for maternal mortality is supported by historical evidence; Data from England and Wales, during the first half of the 20th Century, as over all living conditions (Sanitation, nutrition, housing) improved infant mortality stable declined. By contrast maternal mortality stayed virtually unchanged until there was widespread access through the health system to medical interventions developed in 1930s and 1940s to treat life-threatening obstetric complications [6].

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Environment /population and the MDGs Indicators

It is widely thought that poverty is the greatest "cause" of environmental degradation. Our picture of developing countries tends to be one of poverty and ill health. There are possible links between income and environmental degradation population with access to safe water and sanitation are once with certain minimum levels of income have been attained. The data on access to an improved water source measure the population with reasonable and ready access to an adequate amount of safe water for domestic purposes. An improved source can be any form of collection or piping used to make water regularly available while information on access to an improved water source is widely used. It is extremely subjective and such terms as safe, improved adequate and reasonable may have different meanings in different countries despite official world health organization definitions. Even in high – income countries treated water may not always be safe to drink. While access to safe water is equated with connection to a public supply

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system, this does not take into account variations in the quality and cost (broadly, defined) of the service once connected. Thus cross-country comparisons must be made cautiously, Changes over time within countries may result from changes in definitions or measurements in providing adequate sanitation.

According to the world water assessment program "the 21st Century is the century in which the overriding problem is one of water quality and management The report [14] lays the foundations for the UN to regularly monitor and report on the state of the resource by developing a set of standardized methodologies, data and indicators.

According to the report more than 2.2 million people die each year from diseases related to contaminated drinking water and poor sanitation. Water vector-borne diseases also take a heavy toll [14].

The challenge for sanitation is more daunting," says the report. An additional 1.9 billion people will need improved access. The report explains that cultural factors further complicated.

World's population, 6.3 billion in 2003 reaching 7.2 billion in 2015, that is 7.7 million added annually mainly in developing countries. Majority of global population may be subject to moderate to high water stress in 2015. To achieve MDG water and sanitation target, an additional 1.6 billion persons need access to safe drinking water and 2.2 billion need improved sanitation by 2015. With population becoming more urban especially in developing countries from 47% in 2000 to 53% in 2015, about 75% of population in extreme poverty lives in rural areas – many lack access to quality water. Rural poverty, population pressures and inadequate water supplies important factors in rural – urban migration. Spatial distribution of population significant determinant of sustainability and water consumption patterns and rapid urban growth leads to establishment of slums with serious problems of water supply, sanitation and industrial waste.

Women play a central role in household and water Security. Promotion of women's participation in water projects should not needlessly burden them with extra time and reinforce existing gender positions. Poor women are constantly exposed to risks of contracting water related diseases because of domestic water responsibilities MDGs : Ensure environmental sustainability through sustainable and efficient ground water use, protection of ecosystems, reduction in land

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degradation and erosion and reduced incidence of water – borne disease contribute to environmental sustainability and reduction poverty.

While most poverty reduction strategy papers (PRSPs) recognize impact of water on poverty, few priorities water and sanitation interventions due to: weak poverty diagnostic, lack of clear links between ministries and authorities in planning and the sectors institutional complexity.

As for gender equality and environmental goal, the targets associated with this goal refer to mainstreaming preservation of the environment into policy and programs, reversing the loss of environmental resources and improving access to safe drinking water. The goal on environmental sustainability grew out of the 1992 Rio Earth summit, ***which was viewed by many as a water shed for the way in which it linked environment and gender issues. Since Rio, the importance of pursuing environmental goals through a gender lens has been reaffirmed in successive global fora, including the world summit on sustainable development held in Johannesburg in 2002.

Recommendations

- Investment in women and reproductive health must be sustained or earlier gains can be reversed. Furthermore, there are many poor countries where this process is still at a very initial stage and unmet needs in reproductive health continue to cause too many unwanted pregnancies, unchecked spread of HIV/AIDS and high population growth.

- The international community has made the women of the world a top priority in international development goals. At one time, development was understood to mean improvement s in economic indicators such as growth national product. Today, however, the international community recognizes that economic development; the state of the environment; the health of men, women and children; and the status of women is all intricately inter-woven.

- Development requires improvements in the lives of individuals, usually by their own hand, the status of women empowerment determines the state of development, and women require good reproductive health care for their status to improve, as well as complete fulfillment and enjoyment of civil, cultural, economic, political and social rights.

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- Although the development in conflict situation was addressed in the Millennium Declaration, the MDGs are not addressing this issue; therefore, we recommend that more attention be paid in this regard. Peace- building efforts should be more sensitive to just and equitable sustainable human development in which women, girls and other marginalized groups are accounted for.

- Available social science techniques should be used and adjusted for estimating demographic situations in conflict situations particularly fertility, and mortality.

- Lines of communications should be opened between demographers, humanitarian workers, and advocacy groups so they can share their respective knowledge of population science relief work and public policy.

- Significant progress towards MDG/WSSD targets on water and sanitation will make major contribution to achieving other MDG targets.

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