Why Global Goals and Indicators Matter: The Experience of Sexual and Reproductive Health and Rights in the Millennium Development Goals

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ABSTRACT  This article begins by providing some context for the selection of targets and indicators chosen to measure Millennium Development Goal (MDG) 5, “improvement in maternal health,” considering why the broad vision of sexual and reproductive health and (reproductive) rights set out at international conferences in the 1990s was reduced to maternal health in the MDGs in 2001. We consider the intended and unintended consequences to the sexual and reproductive health and rights agenda based on the choices made with respect to the selection of the targets and indicators under MDG 5, and their conversion into national planning tools. Finally, we set out criteria for the selection of goals, targets, and indicators, which we believe should be applied to the post-2015 global development agenda-setting process.

KEYWORDS: Millennium Development Goals; Sexual and reproductive health; Human rights; Human development; Targets; Indicators; Global goals; Health policy

Introduction

If maternal mortality was already part of a broad global public health agenda since Alma-Ata, or before, it was the 1987 Safe Motherhood Initiative (SMI), which first set out a target to “reduce maternal mortality by 50% by the year 2000” (Starrs et al. 1987). Following the SMI, however, the absence of consensus with regard to key interventions, coupled with the lack of institutional leadership and a resonating frame for maternal health, made for a “protracted launch” of the SMI, and little change was visible until the mid-1990s (Shiffman and Smith 2006). By that time, not only was there a growing consensus on interventions to address maternal mortality, but maternal health was firmly embedded in a broader sexual and reproductive health and (reproductive) rights (SRHR) paradigm, defined in the 1994 Programme of Action of the International Conference on Population and Development (ICPD) in Cairo and reaffirmed in the 1995 Platform for Action of the Fourth World Conference on Women, Beijing (United Nations [UN] 1994, 1995). These outcome documents set global goals and targets for reducing maternal mortality that were differentiated by development level, but they also called for sweeping changes in social structures and gender relations, which were not reducible to quantifiable outcome measures.
The Millennium Development Goals (MDGs) ushered in a new approach to development, focused on basic needs and outcomes, rather than cross-cutting social and institutional changes, and the story of what happened to SRHR vividly illustrates the impacts of that shift (Fukuda-Parr, Yamin, and Greenstein 2013; Fukuda-Parr and Yamin 2013). The only goal related to SRHR in the MDGs was MDG 5, which called for improvement in maternal health and set a target of a 75% reduction in maternal mortality ratios (MMRs) from 1990 levels by 2015 (UN 2001). In 2005, another target (MDG 5B) relating to universal access to reproductive health was approved and indicators for measuring Target 5B were introduced in 2007.

This article builds on a previous article by the principal author (Yamin), which led to the development of the overall Power of Numbers Project (Yamin and Falb 2012). This 2012 article argued that the reductionism of MDG 5 and the selected indicators had deleterious consequences on policy priorities and distorted international norms. The narrow focus of the MDGs, and of MDG 5 in particular, in many ways displaced broader political debates about societal reforms required to advance women’s sexual and reproductive health and rights. In the context of MDG 5, the selection of a limited set of indicators and the acute focus on one—the MMR—effectively neglected the complexities inherent in the realization of comprehensive SRHR by ignoring complex power relations, human rights principles, and established international legal frameworks, and by selectively excluding certain SRHR issues. Efforts to address the root causes of maternal mortality, let alone broader aspects of SRHR and gender inequality, were lost. This article builds upon the previous article and develops the argument further through additional research and interviews with key actors conducted by Yamin.

In this article, we begin by providing some context for the selection of the targets and indicators chosen to measure “improvement in maternal health” and also consider why the broad vision of SRHR set out at international conferences in the 1990s was reduced to maternal health in the MDGs in 2001. We consider what has happened as a result of the choices made with respect to the selection of the targets and indicators under MDG 5 and their conversion into national planning tools, and the consequences both within and beyond the health sector. Finally, we set out certain criteria for the selection of targets and indicators regarding SRHR, which we believe should be incorporated in the post-2015 global development agenda.

Maternal Mortality Goal: Historical Evolution of an International Agenda

Origins

In 1987 the SMI was launched in Nairobi, calling for a goal to “reduce maternal mortality by 50% by the year 2000” (Starrs et al. 1987). The SMI sought to capitalize both on the success of the Child Survival Initiative as well as the urgency of the approaching end of the “UN Decade for Women,” in order to firmly establish maternal health on the global radar (Shiffman and Smith 2006). The SMI faced a series of challenges from its inception, but a combination of factors in the mid-1990s led to the possibility of real change. First, strategies aimed at predicting and preventing obstetric complications through antenatal care and training of traditional birth attendants had proven ineffective; and second, a global consensus emerged within the public health community on the importance of access to emergency obstetric care (UNICEF, WHO, and UNFPA 1997; Maine and Rosenfield 1999; Freedman et al. 2007).

At the UN World Summit for Children in 1990, global pledges and financial resources were generated for a set of goals aimed at child survival, protection, and development, which included a restatement of the SMI goal as well as additional goals related to access to information and services by couples to prevent and space pregnancies, universal access to primary education, and access by all pregnant women to prenatal care, skilled birth attendance (SBA), and referral facilities for obstetric emergencies and high-risk pregnancies (UN 1990; UNICEF 1990).

Three years later, in 1993, the World Conference on Human Rights in Vienna proved an important testing ground for the women’s movement as they achieved agreement that women’s rights—long neglected as “private” issues—were human rights (UN 1993; Sen, Govender, and Cottingham 2007).

At the ICPD held in Cairo in 1994, the women’s movement advanced further, achieving a historic paradigm shift where demographic imperatives ceded importance to reproductive rights (Sen,
For the first time, previously disparate issues ranging from gender-based violence, to family planning, to access to obstetric care were captured under the umbrella of “reproductive health.” The reduction of maternal morbidity and mortality (MMM), together with family planning and comprehensive reproductive health services, were set as goals, along with graduated country-level targets based on baseline MMR levels (UN 1994; Sen, Govender, and Cottingham 2007).

The Fourth World Conference on Women in Beijing in 1995 built upon the ICPD agenda by recognizing that the protection of women’s SRHR is an essential condition for their equal and full participation within society (UN 1995). The 13 targets set in the Beijing World Conference Platform for Action were disaggregated, with individual targets for women and poverty, education, health, violence, power and decision-making, economy, and human rights (UN 1995).

Conservative forces, however, quickly mobilized at national and global levels in response to the ICPD and Beijing World Conference advances (Berer 2001; Hulme 2009a; Yamin and Falb 2012). By the time of the ICPD+5 review in 1999, there was strong dissension over provisions relating to sexual and reproductive health and (reproductive) rights, and the best that advocates could achieve was a simple reaffirmation of the language from the original ICPD outcome document (Center for Reproductive Rights 1999).

In addition to these political battles, it proved challenging to achieve the broad goals of the ICPD and Beijing World Conference agendas, which required, among other things, devising new indicators and approaches to programming that transcended sectoral divides (WHO 2004; Berer 2012; Yamin and Falb 2012; Yamin 2013).

The mainstream development community at the time was concerned with garnering increased international aid. In 1996, the OECD’s Development Assistance Committee launched a document entitled “Shaping the 21st Century,” which outlined seven global International Development Goals (IDGs) adapted from the recent flurry of UN conferences, and included a goal on reproductive health as “access through the primary health-care system to reproductive health services for all individuals of appropriate ages as soon as possible and no later than the year 2015” (DAC 1996; Hulme 2009b).

The MDGs drew heavily from the themes of the IDGs.

Conservative opposition to the ICPD agenda resulted in the notable absence of SRHR from the otherwise “people-centered” Millennium Declaration (UN 2000; Hulme 2009a; Yamin and Falb 2012). After the Millennium Declaration was approved, specific targets and indicators were established in a Road Map document to monitor progress on the broad aspirations set out in the Declaration. In the resulting MDGs, there were only two significant deviations from the IDGs: first, MDG 8 was added to develop a “global partnership for development”; and second, the IDG reproductive health goal, separate from the goal on maternal health, disappeared (DAC 1996; UN 2001; Hulme 2009b)

The target set for MDG 5A drew from the ICPD target of “a reduction in maternal mortality by one half of the 1990 levels by the year 2000 and a further one half by 2015” (UN 1994). Unlike ICPD and the Beijing World Conference, however, differential targets that accounted for country-specific starting points, development levels, and resource availability were not included in the MDG framework.

Belated Addition of MDG 5B Target and Indicators

Immediately after the MDGs were adopted there was a recognition that issues of gender and reproductive rights had fared poorly. Despite having been told that the MDG framework was not changeable, the Millennium Project Task Force on Child Health and Maternal Health, led by a team at Columbia’s Mailman School of Public Health—Lynn Freedman and Allan Rosenfeld, together with Ronald Waldman on Child Health—insisted on pushing for an additional target on reproductive health, which considered equity concerns.
The Task Force asserted that the new target should be “universal access to reproductive health services by 2015 through the primary health-care system, ensuring faster progress among the poor and other marginalized groups,” which would be measured by the indicators: contraceptive prevalence rate, adolescent fertility rate, proportion of desire for family planning satisfied, and HIV prevalence among 15-year-old to 24-year-old pregnant women (UN Millennium Project 2005). In 2005, as a result of strong lobbying both by the Millennium Project Task Force and Stan Bernstein, consultant to the Millennium Project’s secretariat, together with a partnership across agencies, foundations, European donors, and civil society networks from around the world, it was agreed that Target 5B would be added to the MDGs (United Nations General Assembly 2005; Bernstein 2013). The indicators for Target 5B were officially established in 2007.

If European donors were strongly behind the addition of Target 5B, the Bush administration’s White House was not—in part due to opposition to abortion and in part due to other issues. In a briefing at the US State Department, Stan Bernstein remembers being asked by a US official “isn’t there a greater unmet need for eyeglasses than contraception?” (Bernstein 2013). On the other hand, certain key actors in UN agencies were central to desensitizing the issue of SRHR with the UN secretariat (Bernstein 2013).

In the end, Target 5B called for achieving by 2015 “universal access to reproductive health” and was measured by four health service coverage indicators (contraceptive prevalence rate, adolescent birth rate, antenatal coverage, and unmet need for family planning) (United Nations General Assembly 2007; Hulme 2009b). These indicators were a mix of what might be used to compare countries and mobilize funding, and of indicators meant to be more useful for planning purposes. While the addition of Target 5B was welcomed by women’s health advocates, some of the indicators selected are not without issue.

For example, unmet need for family planning—the percentage of married women (or those in a stable union) that are sexually active, fecund, and not currently pregnant, or who do not want to be pregnant and who are not using and whose partners are not using any contraceptive method—theoretically points to the gap between women’s reproductive intentions and their contraceptive use (Dixon-Mueller and Germain 2007; Millennium Development Goals Indicators 2013). Nonetheless, low levels of unmet need are not necessarily associated with high levels of contraceptive use; even as women’s need increases, the availability and accessibility of contraceptive methods is largely dependent upon social and programmatic factors (USAID|Deliver Project 2013). Moreover, individual preferences vary over time and the survey population is almost always limited to partnered women, although more recently some surveys have begun to include adolescent and adult women who are not in a partnership (Dixon-Mueller and Germain 2007). Perhaps most importantly, as Stan Bernstein notes, “the most significant indicator of unmet need is recourse to safe abortion services, but that was not included for political reasons” (Bernstein 2013). However, the indicator “unmet need for family planning” has gone through significant revision and the currently used algorithm can be applied consistently across datasets over time, and is used both in UNICEF’s Multiple Indicator Cluster Surveys and in Demographic and Health Surveys (Bradley et al. 2012).

The Limitations of MDG 5A Targets and Indicators

Misuse of Targets for National Planning

The MDGs were never intended to be used as national planning targets (Fukuda-Parr and Greenstein 2010). They were conceived of as global goals that would focus international attention on selected issues relating to poverty reduction and, in turn, mobilize aid from the North to the South. The choice of a global target on MMRs is an excellent example of this; 99% of maternal mortality occurs in the Global South, and yet donor countries were being asked to reduce MMRs from 1990 levels by 75% (WHO 2012). The MDG 5A target, as well as other target reductions called for under the MDGs, was based on global figures over the past 25 years. In any given national context, those percentages become almost entirely arbitrary.
Nevertheless, the MDG targets quickly began to be used by donors and national governments to set national planning targets (Fukuda-Parr 2008; Fukuda-Parr, Yamin, and Greenstein 2013). Rankings of countries as being “on track” or “off track” or “very off track,” which are routinely used by the World Bank and other international organizations under the theory that they foster “accountability,” are deeply misleading as they fail to account for differential starting places. For example, 20 of the 25 countries with the highest remaining MMRs that are least likely to “achieve” the MDG target are in sub-Saharan Africa (WHO et al. 2012). Yet an analysis by Fukuda-Parr and Greenstein shows that many countries in sub-Saharan Africa would fare extremely well, in terms of progress made during the MDG period and also in terms of overall improvement since 1990, if rates of change were used as the measurement metric rather than absolute change, analyzing the indicators for which there was sufficient data, across all eight goals (Fukuda-Parr and Greenstein 2010). Later initiatives aimed at promoting “accountability” such as the 2010 WHO Commission on Information and Accountability (CoIA) and the subsequently-formed expert review group were at least acknowledgements of the need for donor and funding accountability, as well as national-level metrics (CoIA 2010).

The conversion of the MDGs from global goals into national planning targets was particularly detrimental in the case of MDG 5, as MMRs are not apt for assessing progress on the effectiveness of strategies and interventions. Due to poor data quality and availability, most MMR estimation exercises require the use of statistical modeling techniques, resulting in imprecise estimates and complicating the interpretation of results to the point that meaningful discernment of changing trends over time is nearly impossible (Graham et al. 2008; Mola and Kirby 2013).

Take, for example, Nigeria, which accounts for approximately 14% (40 000) of maternal deaths around the world (WHO et al. 2012). In 2012, the UN estimated that Nigeria’s MMR was 630 maternal deaths per 100 000 live births (confidence interval [CI]: 370–1200) in 2010, compared with 1100 maternal deaths per 100 000 live births in 1990, which corresponds to a 41% decline in maternal mortality (WHO et al. 2012). However, a 2010 study by Hogan et al. estimated that in 2008 Nigeria had an MMR of 608 per 100 000 live births (CI: 372–946) (Hogan et al. 2010). This estimate was substantially higher than their estimate of Nigeria’s MMR in 1980, 516 maternal deaths per 100 000 live births (CI: 334–757), suggesting an increasing trend (Hogan et al. 2010). In 2011 a study by Lozano et al. estimated that Nigeria’s MMR was 393 maternal deaths per 100 000 live births in 1990 (CI: 328–475), 673 per 100 000 in 2000 (CI: 607–738), and 487 per 100 000 in 2011 (CI: 398–582) (Lozano et al. 2011). The MMR estimates for the year 1990 alone vary so drastically, from 393 to 1100, highlighting data quality issues, the relativity and inconsistency of the estimates themselves, and the impact of divergent modeling techniques on the outcome. Additionally, as indicated in Figure 1, large, overlapping CIs reveal the variability between and within estimates, indicating the instability of the data points and making any interpretation of the data impossible to state with any certainty.

To assess what might be leading to a change in maternal mortality—or to plan programs that might induce such a change—it is necessary to examine process indicators, including SBA, the other indicator used to measure MDG 5A. SBA coverage in Nigeria is dismally low; in 2008, SBA coverage was 39% nationally and 27% in rural areas (Nigeria DHS 2009). Among the poorest quintile of the population, SBA was an alarming 8% (Nigeria DHS 2009). These numbers have essentially remained unchanged since 1990 when SBA coverage was 33% nationally and 26% in rural areas (WHO 2008). Other critical process indicators also suggest that basic health system measures that would strongly influence MMM have yet to be instituted in Nigeria (WHO 2008; Alkema et al. 2013).

The limitations of MMRs for measuring progress and national planning were recognized when they were selected as the measurement tool for MDG 5, and as a result skilled birth attendance was also included as an indicator under Target 5A (UNDP 2003). Yet SBA is not an unproblematic indicator either. While SBA does reflect societal inequalities, it does not reveal anything about the actual quality of care received as often anyone with a “uniform” is considered a skilled birth attendant by survey respondents (Austvåg 2011). Despite the fact that emergency obstetric care (EmOC) had already been recognized as fundamental to reducing MMM, the lack of data at national levels evidently precluded the use of these indicators in the MDGs (Yamin and Falb 2012; Bernstein 2013). Subsequently, certain EmOC indicators have been included in Countdown to 2015 efforts, including
EmOC facilities per 500,000 population and caesarean-section rates, but they were not adopted by the CoIA for data availability reasons (Countdown to 2015 2008; CoIA 2010).

**Revealing Inequalities**

Owing to the problems of specificity with measuring MMRs, they are also very poor indicators for revealing inequalities, a key issue from a human rights perspective. Despite the inadequacies of SBA and some of the MDG 5B indicators, it is clear that progress has been slow and uneven and enormous disparities and inequalities persist between and within countries. A comparative study of 54 countries published in 2012 showed that SBA coverage in the poorest quintile was only 32%, compared with 84% in the wealthiest quintile, a stark 52% difference (Barros et al. 2012).

For all MDG 5B indicators, inequities also are stark. One in four women in sub-Saharan Africa has expressed an unmet need for family planning, and contraceptive use is four times lower among women with no education who are poor and live in rural areas (UN 2010). Additional dimensions of vulnerability, including adolescence, exacerbate risk. Adolescents aged between 16 and 19 have twice the risk of dying during pregnancy or childbirth as compared with women in their twenties, while girls under the age of 15 have five times the risk (Center for Reproductive Rights and UNFPA 2013). Adolescent girls in the poorest households in sub-Saharan Africa are three times more likely to become pregnant than those in wealthier households; adolescent birth rates in rural areas are two times higher than in urban areas; and adolescent girls with secondary education are four times less likely than girls with no education to get pregnant and become mothers (Population Reference Bureau 2013). Antenatal care coverage in sub-Saharan Africa remains grossly inadequate, again with enormous variations by socio-economic status, education, and geographic location, as fewer than one-half of all women who give birth in this region are attended by a skilled health provider (UN 2010).

**Consequences**

The MDGs have been the central reference point for global development efforts since they were established in 2001. The choice of MMRs and SBA—the only indicators under MDG 5 for the first half of the MDGs—and the inappropriate conversion of the global goals into national planning instruments had serious consequences across a number of empirical and normative dimensions.
Research and Institutions: A Focus on Measurement; A Move Toward Maternal, Newborn, and Child Health

The selection of the MMR as both target and indicator has generated an unprecedented amount of research and has increased efforts towards measurement. In addition to the complex global estimation exercises, which arrived at differing conclusions, there have been thousands of country-level estimation exercises of maternal mortality (Mola and Kirby 2013). In the absence of adequate vital registration, many high-burden countries rely heavily on less direct and less effective methods to monitor maternal mortality. Multiple shortcomings in the collection of health management information system data are evident in a number of sub-Saharan countries with high MMM prevalence, including: irregular collection of data, incorrect and incomplete recording, proper case definition, data management, and lack of personnel training for routine collection of data.

The MDGs are widely criticized for having adopted a silo-ized approach to health issues, rather than supporting a systems approach (Waage et al. 2010). It is certainly true that such divisions existed before, but the MDGs exacerbated the tendency toward fragmentation through their narrow focus on showing progress through a limited range of indicators. By 2004 there was a widespread sense that the dispersal of reproductive, maternal, newborn, and child health efforts was counter-productive, which led to the launch of the “continuum of care” approach (The Partnership Meeting on Maternal, Newborn and Child Health 2005; WHO 2005).

The continuum of care model was disseminated widely at the international level and suggested in the UN Secretary-General’s Global Strategy on Women’s and Children’s Health as a principal solution to address failures to achieving MDG 4 and MDG 5 (United Nations Secretary-General 2010). While potentially useful in policy-making and programming, even after it included pre-pregnancy intentions, the continuum of care approach reinforced the concept of women as instruments of reproduction, rather than as social citizens entitled to “the full enjoyment of all human rights and the fundamental freedoms … throughout their lifecycle” (UN 1994; Yamin and Boulanger 2013).

The Vicissitudes of Aid for a Controversial Issue

From 2003 to 2010, the percentage of Official Development Assistance (ODA) allocated for maternal, newborn, and child health (MNCH) increased worldwide from 3.4% to 4.7%, and for Countdown countries from 2.6% to 3.6% for the same period (Hsu et al. 2012). The total volume of worldwide ODA to MNCH activities more than doubled from $2566 million in 2003 to $6480 million in 2010, and from $1961 million to $4997 million for Countdown countries (Hsu et al. 2012). Disbursements to the 74 Countdown priority countries have continued to increase for the same period, although they have done so at a slower rate since 2008—from 20.0% in 2008, to 15.9% in 2009, and to 2.9% in 2010 (Hsu et al. 2012).

However, of the funding allocated for MNCH, both worldwide and for the 74 Countdown priority countries with high prevalence, ODA for child health has consistently been allocated nearly twice the amount disbursed to maternal and newborn health. For example, in 2003, 65.2% of overall ODA for MNCH was allocated to child health, whereas 34.8% was allocated for maternal and newborn health; in 2010, 68.6% of overall ODA for MNCH was allocated to child health and 31.4% was allocated to maternal and newborn health (Hsu et al. 2012). The same trend has been observed for aid to Countdown countries (Hsu et al. 2012; Yamin and Boulanger 2013).

Moreover, while some components of reproductive health garnered increased funding during the MDGs, family planning did not—a fact that is in part attributable to the Bush administration, not only to the MDGs (Saona 2004). Contraception or “family planning” re-emerged strongly in the second half of 2012 in the discussions around SDGs to succeed the MDGs, and the dismal data collected by then on MDG 5B indicators may have reinforced this renewed concern. The London Family Planning Summit held in 2012 resulted in $2.6 billion in new aid commitments from civil society organizations, donor and developing countries, multilateral agencies, and the private sector, including, among others, substantial commitments from the Bill & Melinda Gates Foundation (an additional $560 million...
by 2020, totaling more than $1 billion in investments), the British Department for International Development ($800 million over eight years), and UNFPA ($378 million over 8 years) (London Summit on Family Planning 2012). The women’s movement has raised concerns, however, over whether this renewed interest in contraception—“family planning”—is motivated by a genuine interest in advancing women’s health and autonomy, particularly given the focus on large commitments for purchasing commodities and targeting women in sub-Saharan Africa (Bill & Melinda Gates Foundation 2012; Ryerson 2012).

Narrow Interventions

If issues beyond the health sector that are crucial to the advancement of SRHR, such as comprehensive sexuality education, were left out of funding and programming priorities because they were not on the MDG agenda, even within reproductive health, the adoption of MDG 5A, and its indicators, may have incentivized narrow technocratic agendas that focused largely on vertical interventions (Behague and Storeng 2008).

The four pillars of addressing MMM within the health sector, which require a focus on health systems strengthening, are widely recognized to be contraception, skilled birth attendance, EmOC, and a functioning referral system (Freedman et al. 2007). Indeed, the main report from the Task Force of the Millennium Project on Child Health and Maternal Health underscored the importance of adopting a health systems approach (UN Millennium Project 2005). Yet the SBA indicator, coupled with MMRs, the sole indicators for the first half of the MDGs, contributed to a narrow focus on delivery care.

Additionally, the MDGs may have exacerbated the divide between HIV and sexual and reproductive health (SRH) both by the adoption of a narrow vision of SRH only as maternal health and of HIV as only an infectious disease, ignoring its roots in human sexual behavior, and by separating HIV and SRH under different MDGs with distinct targets and indicators aimed at measuring solely these dimensions (Germain, Dixon-Mueller, and Sen 2009).

Abortion: Out of Funding Priorities; Encouragement of Political Agendas

If contraception (at least until 2012) was pushed to the periphery of the international agenda, addressing broader aspects of SRHR, including the estimated 13% of maternal mortality due to unsafe abortions around the world, was often explicitly excluded from technocratic approaches to maternal mortality (Barot 2011; Culwell and Hurwitz 2013; Yamin and Boulanger 2013; UNFPA 2013).

At the same time, the prominence of MMRs and their inadequacy to measure changes on the ground may have had another unintended consequence. While pro-choice advocates sometimes utilize high MMRs to demonstrate need for SRH services, pro-life advocates have vociferously begun to argue during the MDGs that declining global MMR trends show that lifting abortion restrictions is unnecessary, as reductions in maternal mortality can be achieved without addressing abortion (Goodenough 2010; McGee 2010). For example, in Nicaragua the law was changed in 2008, imposing a complete ban on abortion. As elsewhere where there has been striking retrogression, pro-life groups in Nicaragua have used the government’s MMR data, which due to surveillance issues cannot trace trends from year to year, to argue that the ban has not impinged on women’s health (Amnesty International 2009).

Looking Forward: Considering Criteria for Goals, Targets, and Indicators in the Post-2015 Development Agenda

The SDGs will no doubt again adopt the structure of goals, targets, and indicators. If the new framework is not going to repeat some of the flaws of the MDGs, lack of data availability on certain aspects of SRHR cannot preclude the inclusion of critical issues on the agenda this time. We have learned from the MDGs that political will can generate appropriate data collection, and once an item is on the agenda, then effort is invested in finding ways to measure it. However, it is yet to be seen how
much of a shift there will be in terms of generating the “data revolution” needed to measure new issues, such as gender-based violence and women’s desires regarding child-bearing, in reliable ways that capture the concept and purpose for which they are being measured (UN 2013; United Nations Secretary-General 2013).

If the next development framework is not going to be inherently reductionist, criteria for targets and indicators need to be well thought out in terms of their purposes, not just in terms of data availability, simplicity, and measurability. One of the primary lessons of the overall Power of Numbers Project is that the criteria for the selection of goals, targets, and indicators should be specific, based upon intended purpose, and that the criteria for selection has potential to alter distributions of power and governance (Fukuda-Parr, Yamin, and Greenstein 2013).

While simplicity and narrowness is appropriate for a global goal intended to garner public attention, mobilize concern, and increase funding, the use of MMRs to monitor progress and accountability at the national level proved deleterious. As indicated in Table 1, a global goal or target intended to monitor broad trends should be concrete, measurable, and focused on outcomes; however, targets intended to inform national planning processes—as well as human rights monitoring and accountability mechanisms—should include other kinds of targets related to institutional and social change, which may or may not be quantitative (Center for Reproductive Rights and UNFPA 2013). For MDG 5, the goal of “improving maternal health” and Target 5A, aimed at reducing the MMR by 75%, were easily communicated and outcome focused, albeit with a problematic metric. The target, however, was an ineffective marker for monitoring progress at the national level and was too narrow for guiding policies, omitting critical aspects of SRHR. Target 5B, aimed at achieving by 2015 universal access to reproductive health, despite its belated addition to the MDGs, was an appropriate mobilization tool in that it was an outcome-focused target that addressed originally omitted aspects of SRH, and was drawn from and linked to international norms.

Indicators should also be intrinsically tied to their intended use. The type of indicator that is helpful for communication and political mobilization is very different from the type of indicator that provides

Table 1. Desirable characteristics of goals and targets, developed by Alicia Ely Yamin and Sakiko Fukuda-Parr as part of the Power of Numbers Project.

<table>
<thead>
<tr>
<th>Desirable Characteristics of Goals and Targets</th>
<th>Communication for political mobilisation</th>
<th>Monitoring progress</th>
<th>Monitoring for Human Rights accountability</th>
<th>Programming</th>
</tr>
</thead>
<tbody>
<tr>
<td>GOALS AND TARGETS</td>
<td>Simplicity (memorable but narrow)</td>
<td>Selective proxies for broader objectives</td>
<td>Selective proxies for broader objectives</td>
<td>Broad objectives and comprehensive dimensions</td>
</tr>
<tr>
<td>Scope</td>
<td>Ambitious and aspirational</td>
<td>Realistic and benchmark (evidence based)</td>
<td>Ambitious but realistic, and benchmark (evidence based)</td>
<td>Realistic (evidence based)</td>
</tr>
<tr>
<td>Level</td>
<td>Concrete, measurable</td>
<td>Concrete, measurable</td>
<td>Concrete, measurable/quantifiable and non-quantifiable/qualitative</td>
<td>Qualitative and quantitative objectives</td>
</tr>
<tr>
<td>Quantification</td>
<td>Outcome focus (easy to understand)</td>
<td>Outcome focus</td>
<td>Human outcomes, social/legal arrangements and effort (e.g., budget, policy)</td>
<td>Outcomes, institutional arrangements, policy reforms</td>
</tr>
<tr>
<td>Focus</td>
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<td>Linked to international standards/norms</td>
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useful data for monitoring progress, human rights accountability, or programming. When communicating for political mobilization, the criteria of data availability and reliability become inordinately important because mobilization is impossible without widely available data. This was a principal reason why SBA was chosen over EmOC to measure Target 5A. However, if the indicators are to be used for tracking accountability or monitoring programming, there is a far greater incentive to generate new data that are suited to measuring the concept of interest (see Table 2). For these latter purposes, the frequent measurability of indicators takes on increased significance in terms of policy relevance, so that adjustments to policy and programming can be responsive to changing needs and rooted in an established evidence base. EmOC data, if added to routine data collection in health management information systems, would fit this criterion (Yamin and Falb 2012). The usefulness of survey data where quality standards are not comparable, such as antenatal care and SBA, is limited for human rights accountability purposes. Nevertheless, in a location-specific planning or programming process, these indicators would be desirable as part of a comprehensive set of metrics on access to reproductive health services. In short, we need different indicators for different purposes.

From a human rights perspective, data disaggregation is essential in order to reveal disparities and potential patterns of discrimination. At least some indicators should be reliably subject to disaggregation along racial, ethnic, class, and gender lines as well as geographic areas, and other possible grounds. Finally, as discussed throughout this paper, it is critical to ensure that selected indicators do not encourage perverse interpretation or unintended consequences, such as promoting narrow interventions that undermine health systems strengthening or addressing an issue in a way that meets the goal while sideling equity or other important aspects of transformative social change (Langford 2012).

In addition to selecting targets and indicators that are fit for purpose, it is essential for the role of targets and indicators to be limited in the next development framework. A collection of goals, targets, and indicators alone does not make for a transformative development agenda. It can—and, in the case of the MDGs, did—encode a number of values, including through the original exclusion of SRHR in MDG 5. However, a transformative development agenda based upon realizing human

Table 2. Desirable characteristics of indicators, developed by Alicia Ely Yamin and Sakiko Fukuda-Parr as part of the Power of Numbers Project.

<table>
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<tr>
<th>INDICATORS</th>
<th>Communication for political mobilisation</th>
<th>Monitoring progress</th>
<th>Monitoring for Human Rights accountability</th>
<th>Programming</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy relevance</td>
<td>Policy relevant; not subject to perverse interpretation and perverse secondary effects</td>
<td>Policy relevant; frequently measurable</td>
<td>Policy relevant</td>
<td>Policy sensitive (disaggregation/distribution)</td>
</tr>
<tr>
<td>Data availability and reliability</td>
<td>Data availability and reliability</td>
<td>Data availability or promote data creation</td>
<td>Frequently measurable to hold specific administrations accountable, data availability</td>
<td>Data availability and promote data creation</td>
</tr>
<tr>
<td>Level of aggregation</td>
<td>Global aggregate, inter-country comparability</td>
<td>Global aggregate, inter-country comparability</td>
<td>Country and location specific; linked to international standards; subject to disaggregation/distribution along gender, race, etc., as well as income quintiles; comparable across countries</td>
<td>Country and location-specific; subject to disaggregation/distribution, comparable</td>
</tr>
<tr>
<td>Measurable, quantitative or qualitative</td>
<td>Quantitative</td>
<td>Qualitative and quantitative information</td>
<td>Qualitative and quantitative information</td>
<td>Qualitative and quantitative information</td>
</tr>
</tbody>
</table>
rights for all, including SRHR, must embed those goals and targets in a robust narrative of social transformation, which incorporates aspects of progress that are not measurable, but are critical to changing the social relations that impede some people—and women in particular—from escaping poverty, realizing their rights, and living lives of dignity (Yamin and Boulanger 2013; Center for Reproductive Rights and UNFPA 2013).

Conclusions

As Sally Engle Merry writes, “indicators typically conceal their political and theoretical origins and underlying theories of social change and activism. They rely on practices of measurement and counting that are themselves opaque” (Merry 2011, S84). The experience of SRHR in the MDGs illustrates how these numbers are derived through political, often idiosyncratic processes, and end up driving agendas that have enormous normative and empirical impacts. The experience of MDG 5 also acutely demonstrates why global goals and indicators matter to people’s—and especially women’s—lives.

Throughout the MDGs, the narrative of progress relating to women’s health became driven by an extreme focus on measurement of maternal healthcare, and on MMRs in particular. Despite increased funding for some aspects of MNCH, narrow conceptions of progress ignored and even marginalized the root causes of maternal mortality, including the inherently political questions relating to the broader SRHR agenda.

Just as the women’s movement has been active around post-2015, there were efforts throughout the MDG decade to “re-politicize SRHR” (Repoliticizing SRHR Group 2011). Nevertheless, the MDGs should serve as a cautionary tale as we look forward, particularly in light of recent proposals on investing in global health (Jamison et al. 2013). It is essential that gender equality and SRHR retake prominence in the next development agenda; the former as a universal goal and the latter included as targets under a variety of goals, encoding a broader understanding of how SRHR relates to various dimensions of development, not just health. It is imperative that the next global agenda transcends vertical approaches to SRH, and health generally, addressing the interconnectedness of health issues and the distribution of power and resources within and between countries (Yamin and Boulanger 2013). It is also essential that within an emancipatory development narrative, appropriate metrics are set with respect to these complex concepts, which provide for qualitative as well as quantitative measurement, generate new data where called for, and are aimed at transforming social structures and relationships, not merely producing advances in limited outcomes relating to basic needs.

References


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