HEALTH AND DEVELOPMENT IN THE THIRD WORLD:

RESEARCH PROPOSAL: MATERNAL HEALTH

Global health partnerships, neoliberalism and challenges for achieving Millennium Development Goal 5

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TOPIC: MATERNAL HEALTH IN THE DEVELOPING WORLD

TITLE: GLOBALIZATION, NEOLIBERALISM AND CHALLENGES FOR ACHIEVING MILLENNIUM DEVELOPMENT GOAL 5

GOAL

The purpose of this study will be to critically analyse the implications of globalization on maternal health in the developing world, and to determine potential methodologies for pursuing a study on this topic. Neoliberalism is often associated with declining funding for public health initiatives, privatization and a generally negative impact on health. This research will make ties between neoliberal economic structure and the structure of Global Health Partnerships (GHP). The structure of GHPs is crucial to understanding complications attaining appropriate pharmaceuticals (Ngoasong, 2009, p. 949), particularly contraceptives, as well as the accessibility of abortion. Millennium Development Goal 5 (MDG5) intended to provide both, along with reducing the maternal mortality/morbidity rate 75% from 1990 to 2015. It is imperative to discover the roadblocks that MDG5 has encountered in the face of globalization and neoliberalism.

RESEARCH OBJECTIVES

1.) To study how NGOs/GHPs pursuing MDG5 have evolved with the onset of globalization and growing pressure for privatization of health services.
2.) To study how maternal health in the developing world has changed since the onset of MDG5 and uncover the main obstacles they face.
3.) To gain better understanding of intellectual property trade agreements and whether they have remained steadfast, or made exceptions for the sake of improving maternal health as they have for AIDS and Malaria (Ngoasong, 2009, p. 951).

QUESTIONS

- How do GHPs distribute health services across public and private sectors?
- What are the main issues of maternal mortality and morbidity and are they proportionately funded?
• Since the beginning of MDG5, some countries have excelled while others have made no progress. What went differently between these countries and how can this information be used to restructure public health initiatives?
• Can the challenges facing maternal health be justifiably attributed to globalization and neoliberalism?

HYPOTHESES

1.) GHPs formed by globalized entities, both public and private, will have shifted with neoliberalism in favour of the private sector at the expense of maternal health.
2.) The most crucial health services for improving maternal health will be contraceptives and abortion.
3.) The rate at which reduction in maternal morbidity and mortality must happen to achieve MDG5 will not be being met.

RATIONALE

In 2005, approximately 536,000 women died from maternal complications including unsafe abortion, which was reported as a 7% decrease from 1990 when MDG5 began (Kurjak, A. et al, 2010, p. 290; Hogan, M. et al, 2010, p. 1609). Studies which show a general decline in maternal mortality and morbidity rates distort the reality that maternal mortality has remained unacceptable in many places, and this study aims to acknowledge those areas. Women in Ethiopia, for example, still have a one in ten chance of dying from pregnancy or delivery (Kurjak, A. et al, 2010, p. International development assistance in for maternal and neonatal health combined was only $664 million in 2003 and $530 million in 2004 (Gill, K., Pande, R. & Malhotra, A., 2007, p. 1354). In other words, it is declining.

Research has shown that women’s health issues in the developing world can be reduced to 6 crucial factors: gender inequality, access to contraceptives, STIs including HIV, unsafe abortion and adolescent pregnancy (Miller, K. & Rosenfield, A., 1996, p. 359). However, as not to dilute the importance of each individual issue, this study will focus on access to contraceptives (and some other related pharmaceutical company dependencies) and safe abortion specifically.
GHPs comprise of public and private transnational entities sharing a common goal (Ngoasong, M., 2009, p. 949). GHP of the WHO, World Bank and European Union (EU) have formed international health policy in which disease control interventions are given to the public sector and health care to the private sector (Unger, J., Van Dessel, P., Sen, K. & De Paepe, P., 2009, p. 91). This is widely recognized as a neoliberal doctrine, and is especially problematic because the resources allocated to the private sector are the ones that are in demand. If health care was a public sector entity, disease control interventions would not be needed (Unger, J. et al, 2009, p. 91). It is crucial to further investigate if other GHPs have similar neoliberal structure to reiterate that this structure is counter-productive.

Research has repeatedly proved that contraceptive use improves maternal health. The problem facing developing countries is that contraceptives and other medications are in the hands of pharmaceutical companies to provide. With the HIV epidemic, reproduction of the HIV+ population is another major health issue. Over 17 million women in the developing world are HIV positive, and 2 million of them become pregnant every year (Gill, K. et al, 2007, p. 1352). With the evolution of intellectual trade agreements to involve patent expiry, the interest of pharmaceutical companies is held by issues requiring drugs which are still patented. Contraceptives along with other maternal health associated drugs such as magnesium sulphate, oxytocin and misoprostol are all ‘off patent’ (Unger, J. et al, 2009, p. 94). In our globalized, neoliberal GHP structure in which the pharmaceutical companies hold a stake, less profitable issues fall by the wayside. On the local level, contraceptive services are inaccessible via other determinants including cost and physical distance from outlets (Miller, K. et al, 1996, p. 368). The intersection of STI epidemics with contraceptive and abortion accessibility meets at the risk of pelvic inflammatory disease (PID). STIs are extremely complicated by inter-uterine device (IUD) insertion, unsafe abortion and childbirth. PID causes “recurrent infection, ovarian abscesses, ectopic pregnancy (which contributes substantially to maternal mortality rates), and death” (Miller, K. et al, 1996, p. 370).

The WHO defines an unsafe abortion as “a procedure for terminating an unintended pregnancy carried out either by a person lacking the necessary skills or in
an environment that does not conform to minimal medical standards, or both” (Prata, N., Sreenivas, Farnaz, V. & Potts, M., 2009, p. 137). 45 million pregnancies end in abortion every year and approximately 20 million of them are unsafe. 88% of unsafe abortions occur in the developing world and are responsible for between 50 and 100 thousand deaths every year (Miller, K., 1996, p. 375). There are approximately 5 million hospitalizations every year of women who have had unsafe abortions, making it the most common type of gynaecological hospital admission in the developing world (Prata, N. et al, 2009, p. 137). Badly paid health professionals and weak management caused by cost cutting neoliberal policies often leave physicians to manage public facilities without supervision and maximise their own income by adding additional fees to their services (Unger, J. et al, 2009, p. 95). Poor government structure in these countries also often means that colonial abortion legislation is still in place. Both Kenya and Zimbabwe have abortion laws that all but prohibit abortion (Ngwena, C., 2010, p. 832).

Lastly, combating the notion among the public that maternal health has improved universally, areas which have excelled and those which are still suffering and the GHPs that aid them should be contrasted in the study. While the Maldivian maternal mortality rate (MMR) decreased 8.8% between 1990 and 2008, Zimbabwe endured a 5.5% increase (Hogan, M. et al, 2010, p. 1609). MMR levels in south Asia halved between 1990 and 2005, while sub-Saharan Africa remained unchanged (Gill, K. et al, 2007, p. 1348; Kurjak, A. et al, 2010, p. 293). In Sierra Leone, 270 per 1000 children die of neonatal causes (Kurjak, A. et al, 2010, p. 291). Countries including Bangladesh, Romania, Malaysia, Thailand and Sri Lanka have halved their MMRs over a short period of time. Notable strategies have been liberalization of abortion law in Romania, control of infectious disease in Sri Lanka, increased contraceptive use in Bangladesh and improved access to hospitals in Egypt, Honduras, Malaysia and Thailand (Kurjak, A. et al, 2010, p. 293). These results imply that these are the services that must be made publicly available, not progressively privatized by neoliberal structured GHPs.
METHODOLOGY

As the scope of this issue is far too vast to accomplish all the interviews that would realistically need to be done, this study would be better suited for a content analysis, followed by a comparative analysis of the results. A longitudinal perspective, meaning to observe the same sources over an extended period of time, will be utilized to accurately gage the progress of MDG5 since 1990. The content analysis will be applied to MMR, contraceptive use, and unsafe abortion statistics held by the WHO from 1990 until now. The statistics will be needed for aforementioned countries which have made significant progress, for example Bangladesh, as well as for aforementioned countries which have made no progress, for example Zimbabwe. The 3 statistics will be crossed referenced within each country: analysing patterns of progress as it correlates with contraceptive use and unsafe abortion. The various countries will then be contrasted against each other to further identify inaccessibility of contraceptives and abortion as a key determinant of the MMR. This method is called cross tabulation (Vanderstoep, S. & Johnston, D., 2009, p. 48)

A content analysis, in contrast with qualitative methods such as interviews, is a quantitative method (Vanderstoep, S. & Johnston, D., 2009, p. 48). Quantitative method is preferred for the purpose of specificity. It would be desirable to have concrete numbers, percentages and variants in the data. Of particular interest is not only the varying availability of contraceptives and abortion across these countries, but also the percentage of recovered MMR each country accounts for. As mentioned in the rationale, it is important not to dilute the significance of addressing countries individually by looking at an overall global improvement. Dividing the data like this makes the data nominal (Vanderstoep, S. & Johnston, D., 2009, p. 48). Studies have already revealed that these improvements have only occurred in certain places, so while MDG5 has made progress in some regions, it had made absolutely no progress in others. This study aims to expose this flaw and attempt to acknowledge individual countries and their individual circumstances in regards to contraceptives and abortion. It is problematic to over generalize because we then see inaccuracies like reporting MMR as improving, when it only improves in specific regions. The purpose of the content
analysis of WHO statistics is to reveal the reason certain places have improved. It is being hypothesized that access to contraceptives and abortion will strongly correlate with MMR across the board. Areas of obscured data to consider for this hypothesis include regions that simultaneously face the HIV epidemic.

Lastly, it should be explained that quantitative method is being used simply because of the scale of the study. It must be acknowledged that this method of outright counting and contrasting is ignorant of other social, political, historical and economic factors that may be explored through qualitative research methods. Because the data is nominal, the results are ‘rational,’ meaning that there is no grey area and it operates only in concrete measurable facts (Vanderstoep, S. & Johnston, D., 2009, p. 48)
BIBLIOGRAPHY


**ANNOTATED REFERENCES**


This article outlines exactly what Millennium Development Goal 5 is and presents the progress toward it. The article was crucial to my research because it misrepresents the progress the Goal has made by stating the global improvement we have undergone since 1990. This is a misrepresentation because despite rising global levels, certain areas have not made any progress. It still did, however, present the most concise and accurate information about MDG5 and is where I got a lot of the information about the Goal specifically.


This article addresses the aforementioned issue of how improved maternal mortality rates are distributed. This article acknowledges and focuses on the fact that in much of Sub-Saharan Africa, the rates have actually stagnated significantly since the beginning of MDG5.


This article aided the rationale with information about safe abortion and access to contraceptives in the developing world. This article argues that these two things are most essential to improving maternal health which correlates with what the rationale is arguing. This article was particularly instrumental in demonstrating how important these two specific services are.
FINAL COMMENTS

Throughout the composition of this research proposal, the most critical lesson in forming a viable, realistic, achievable and useful study has been that narrowing the topic is key. It is difficult to resist the urge to address every issue falling under an overly broad topic. This process has really shown me that within every broad topic, there is an array of sub-topics, and to attempt to generalize them all under one vague title actually dilutes the significance of every individual issue. Instead of seeing one incredibly broad problem, I now see a series of different contributors and have chosen only to address one of them. By doing this, I am trying to give one individual facet of the general maternal health problem the focus and recognition that it desperately needs.

The second and equally significant lesson learned through this process has been about how to approach a study and decide which methodology is most rational to achieve the desired results. Because of the blind-spots quantitative methods have (social, political, economic, cultural etc.), it is only suitable for specific types of studies. I personally find that concrete facts and numbers, aside from being more accurate for a study of large scale, also emphasize the alarming rate at which an illness may be prevailing. If this type of research were to be done through qualitative methods, I do not think that saying “women in the developing world feel that they need better access to abortion” would establish my message as startlingly as saying “5 million women are hospitalized every year after having an unsafe abortion.”

Coming back to my first point, realizing how easy it is to overgeneralize about any topic will enhance how critical I am when reading other people’s work in the future. I found myself actively critiquing articles as I did my research. For example, some of these articles have been identified in the rationale as overgeneralizing the improvement of the MMR. I was more critical of my own work as I wrote the proposal, and more conscientious of how my writing was worded as not to misrepresent anything. I believe my increased specificity contributed significantly to the effectiveness of the proposal. Being vague, whether in a proposal or in the actual study produced, is generally ineffective and runs the risk of misrepresenting an issue or diluting the significance of numerous individual contributors to an issue.