Eight Lives: Stories of Reproductive Health

Beatrice

Saratou

Maria

Natalia

Eunice

Maria

Rokeya

Sugna

UNFPA

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Eight Lives:

Stories of Reproductive Health

UNFPA

CONTENTS

PREFACE IV

INTRODUCTION V

Maria

Breaking the cycle of female genital mutilation/cutting

1

Beatrice

A message of hope on HIV prevention

7

Rokeya

Improving women's lives through family planning

13

Natalia

The anguish of sexual violence and trafficking

19

Saratou

Ending the silence and lessening the suffering of obstetric fistula

25

Maria

Becoming a mother as a teenager

31

Eunice

Midwifery: Changing the world one birth at a time

37

Sugna

Maternal health: The pursuit to deliver with dignity

43

WHAT WOMEN AND GIRLS NEED 48

ENDNOTES 50

PREFACE

Ensuring universal access to reproductive health, empowering women, men and young people to exercise their right to reproductive health, and reducing inequities are central to development and to ending poverty. This was recognized more than 15 years ago at the International Conference on Population and Development (ICPD) in Cairo and was reaffirmed in 2007, when universal access to reproductive health became a target of the Millennium Development Goals.

Much progress has been made since the Cairo conference. The concept of reproductive health is now accepted around the world, and in most countries policies and laws have been adopted to protect individuals and to guide programmes to improve access to maternal and child health, to make family planning more widely accessible, to prevent and treat HIV and to provide support to those living with the virus. Through these interventions, many lives have been saved and countless others have been made better. Yet much remains to be done.

UNFPA, the United Nations Population Fund, is proud to present three publications that assess the situation of sexual and reproductive health at this critical time and look at universal access from many different angles.

This publication, *Eight Lives: Stories of Reproductive Health*, relates the tales of eight women who have endured the challenges of poor reproductive health. Each story gives a voice and a face to those most affected by the failures of a dysfunctional health system — and by gender inequality, violation of their human rights, blatant disregard for their social and cultural circumstances, and abject poverty. But it is the commitment and passion with which these women have transformed their personal experiences into change within their communities that is the overarching message. It reminds us to make certain that the global response to sexual and reproductive health puts people, especially women and girls, first.

The two other publications are:

- *How Universal is Access to Reproductive Health? A review of the evidence.* Using the latest available data, this report takes a hard look at trends since 1990, and differentials. It demonstrates clearly that intensified efforts are needed to extend reproductive health to all.

- *Sexual and Reproductive Health for All: Reducing poverty, advancing development and protecting human rights* provides the ultimate response to a few key questions: What is universal access to reproductive health? Why is it important? How far have we progressed? And where do we go from here?

My hope is that these publications will contribute to a deeper understanding of the complexity and the centrality of reproductive health, and that they will lead to accelerated progress, along with heightened commitment and an all-too-real sense of urgency.

Thoraya Ahmed Obaid
UNFPA Executive Director
August 2010

INTRODUCTION

Reproductive health is about supporting women and young people, especially those who are the most disadvantaged, to make choices in their lives. Access to reproductive health services gives women the opportunity to make autonomous decisions and have healthy sexual and reproductive lives. It helps women to decide if and when to have children and under what conditions, and affords pregnant women access to skilled care before, during, and after childbirth. It contributes to safe deliveries and healthy babies. It also helps women to live their lives free from sexually transmitted infections, including HIV.

Quality reproductive health care transforms lives. It can prevent young girls from becoming wives and mothers when they are still children, giving them a greater opportunity to stay in school for as long as they wish. It gives women and girls greater opportunities in life, to enter the labour market and contribute to the well-being of their families and communities. It promotes a more equal world in which women and girls are respected and can live their lives free from violence and coercion.

Reproductive health is about guaranteeing human rights. Yet, too many women and girls do not have equal rights within their communities. This puts their health, especially their reproductive health, at stake. Reproductive health problems remain the leading cause of ill health and death among women in developing countries. Impoverished women, especially those living in developing countries, suffer disproportionately from unintended pregnancies, maternal death and disability, sexually transmitted infections, including HIV, and gender-based violence.

UNFPA created this publication because reproductive health is all about the story of women and their quest for justice and equality. When we interviewed one woman, she was surprised at first to learn that she had any story to tell. Yet, every woman has a story to share about her reproductive health.

The eight women profiled in this publication are living testaments to the dramatic consequences of poor reproductive health in its different forms. But their lives are also testament to the positive change that can happen when women are empowered to transform their situations and are afforded access to good quality, integrated sexual and reproductive health care and services.

The Secretary-General of the United Nations recently launched the Global Strategy for Women's and Children's Health, a worldwide effort to save the lives of, and prevent injuries in, more than 16 million women and children by 2015. It involves a wide range of partners and focuses on strengthening health systems and integrating services so that women can go to one place to have their total health needs met — for family planning, maternal health care and HIV and AIDS services.

UNFPA strongly believes that universal access to reproductive health affords women and girls a chance to better realize their dreams, beyond becoming mothers and caring for their children, if that is what they want.

These eight women represent millions of others in low- and middle- income countries who have overcome obstacles, confronted injustice and demanded the right to a better future. We honour their courage and hope that these few pages on each of their lives will give readers a sense of their strength and resilience, and remind us of what needs to be done to ensure that reproductive health becomes a reality for all.

Maria

▶ *Egypt*

Breaking the cycle of female genital mutilation/cutting

Maria says that it was the most violent day of her life. Even now, thirty years later, she remembers every detail. That morning, her mother said they were going to do something very important, but didn't tell her what. When Maria insisted, her mother said: "We are going to purify you." Maria was ten years old and didn't understand what that meant, but felt she couldn't ask any more questions. She had been taught to obey her elders.

She anxiously waited for hours and then it all happened very quickly.

Her mother, two aunts and another woman came into her room. Her mother told her to take off her clothes and, together with her aunts, grabbed her arms and legs. Maria was frightened and resisted, but the women were too strong for her. Next, the *dhaia* — the traditional midwife and circumciser — took out a razor blade and cut something in her gut. The pain was excruciating. Maria saw blood running down her legs and started to cry. After the women left, Maria kept crying. She felt as though she must have done something awful to be punished like this.

Maria was angry with her mother for several days. When she dared to ask why they had done this to her, her mother said it was their tradition. They did it for her own good so that she would become a decent woman and find a good husband. She told Maria not to speak of this again because "that part of your body, no one sees, no one touches, no one talks about". So Maria couldn't tell her friends what had happened, nor could she ask them whether they had gone through the same thing.

Female genital mutilation/cutting (FGM/C) refers to a number of procedures involving partial or total removal of the external female genitalia, or other injuries to the female genital organs for non-medical reasons. Every year, about three million girls in sub-Saharan Africa, Asia and the Middle East are at risk of undergoing FGM/C. In Egypt, when Maria was a teenager, around 96% of women underwent FGM/C. Those who defend this practice maintain that it keeps women chaste and pure until they get married and faithful afterwards; it enables them to control their sexual desires.

Maria lived with her parents and siblings in Farabeya, a village 250 kilometres south of Cairo, in Lower Egypt. Her father grew grapes, wheat and corn on a little patch of land very close to the Nile. Her life was always the same: she went to school, helped her mother with the household chores and her father with the cows. She did not have time for anything else. In those days, a young girl was not supposed to hang out in the street, play or have any time for herself. It took Maria decades to understand that her life could have been different. Now she says that she would have liked to have had a childhood, but it's too late for that.

Occasionally, a celebration would break up the monotony. When Maria was five years old, her older sister — who had just turned eleven — got married and the whole family celebrated with dancing and feasting. Maria knew that when she grew up, it would be her turn to live as her mother and sister did: to have a husband, take care of a house and raise children. That's why, at first, she did not take much of an interest in school.

After her cutting, Maria realized that school was the only way to avoid getting married too soon. It wasn't easy, because she was pretty and had many suitors — including one of her teachers, a 30-year-old man who visited her house all too frequently. Maria threw herself into her studies, but at age 15, her mother and aunts felt she had learned enough. Luckily, she managed to convince her parents to let her continue. She had come to understand that if she got an education she would be able to find a good husband, someone "better than a local farmer".

When she turned 18, Maria received a high school vocational diploma in commerce. Now there was no way she could keep studying. She had to get married, but she could still set one condition: she wanted her husband to be an orphan, "someone without a father or mother who would try to

organize and control my life." One of her cousins introduced her to a suitor and the standard tradition was followed: the young man sits in the living room with the father and mother; the girl brings in a tray of tea; and, at that moment, the two young people quickly glance at each other. Refat was

Every year, about three million girls in sub-Saharan Africa, Asia and the Middle East are at risk of undergoing FGM/C.

educated and an orphan, so Maria thought he was a good candidate, and, of course, he liked her. A few months later, they got married and moved to Quolosna, a neighbouring town, where Refat had secured a job as an accountant at the health centre.

Maria found married life pleasant, although she had many responsibilities. Helping out at home as a child was not the same as taking charge of a household. But her husband consulted her before making decisions and didn't mistreat her. Four months later, Maria suspected she was pregnant and went to see a doctor at the health centre. Her pregnancy was confirmed and she was told that they would take care of her. Maria wasn't comfortable with that:

These doctors and nurses were people I met quite often, my husband's colleagues. I couldn't allow them to see me and touch me and all that. It was better to have my baby at home and let God take care of it.

When the time came, the same *dhaia* who had cut her helped to deliver her first daughter. She also delivered her second daughter two years later, and her third, two years after that. Maria decided it was time to stop having children and her husband agreed. A few years later, "the women of her family" pressured her to get pregnant again, so she could have a boy. Her last pregnancy was more complicated so she finally accepted to give birth in the town's hospital.

Times were changing. More and more women were having children in hospitals and I thought I could as well.

Maria is pleased with the way she raised her children. She sent them to school and allowed them to do everything that she had missed out on: play, socialize, go to youth clubs and go on school trips. When her eldest daughter turned 12, Maria realized the time had come to cut her. She was unsure of what to do, but let her mother, aunts and sisters-in-law convince her that it was necessary.

And did you do the same thing to her that had been done to you?

No, it was different, because a doctor did it with anaesthesia, clean instruments and no pain.

It was 2002 and, after years of struggle on the part of human rights activists, some aspects of female genital mutilation/cutting had changed.

THE BIG PICTURE

Female genital mutilation/cutting

Female genital mutilation/cutting (FGM/C) refers to a number of practices which involve cutting away part or all of a girl's external genitalia. Mutilated/cut girls and women face irreversible lifelong health risks, among other consequences.

An estimated 100 to 140 million girls and women worldwide are currently living with the consequences of FGM/C.

Until the early 90s, FGM/C was a dominant tradition in Egypt, especially in rural areas. A woman who was not cut was unlikely to find a husband. In 1994, on the eve of the United Nations International Conference on Population and Development (ICPD) in Cairo, CNN aired a report on FGM/C in Egypt that shook the world — the debate intensified. Mohamed Farid, a prestigious doctor, was particularly outspoken and began to educate people about the risks of FGM/C. "We made a mistake. We wanted to do away with a practice that we considered harmful and unfair and we began to warn about the complications, bleeding, infections and risk of death. So people said: 'Ok, let's do it right, then. Let's get a doctor to do it.'"

That campaign paved the way for the medicalization of FGM/C in Egypt. Their intervention, Dr. Farid now says, legitimized the practice, making it seem safe and modern. Maria says that's what convinced her to have FGM/C performed on her oldest daughter.

And did you tell her what they were going to do to her?

No, I couldn't. I didn't know how to. And I am so sorry about that.

In 2003, a year after her daughter was cut, Maria was at home sewing a shirt when someone knocked on the door. A young woman named Sally introduced herself and asked if she could talk to her for a few minutes. Sally was a member of the Coptic Evangelical Organization for Social Services

FGM/C is always traumatic. It entails long-term psychological suffering and immediate health complications including excruciating pain, shock, urine retention, ulceration of the genitals and injury to adjacent tissue. Other complications include blood infection, infertility and obstructed labour.

FGM/C has no health benefits. Cultural norms and traditions underpin the belief that FGM/C is necessary to prepare girls for adulthood and marriage. The practice is often seen as part of a process to reduce sexual drive and make girls clean, well-mannered, responsible, beautiful, mature and respectful adults.

(CEOSS), a faith-based NGO that had begun an FGM/C awareness programme, under the leadership of the National Council for Childhood and Motherhood (NCCM). She invited Maria to attend one of their meetings.

Sally said that far from being a religious commandment (which was a widespread belief), FGM/C was a terrible act of violence against women, a violation of their fundamental human rights, caused women long-term psychological and physical damage, and kept them from fully enjoying their sexuality. This was a shock to Maria."God made us the way we are. Who are we to correct God?" asked Sally. "Neither the Bible nor the Quran says that we have to cut our girls."

The CEOSS programme raised awareness, built leadership among activists, fostered government involvement and community mobilization. It also provided micro-loans for *dhaias* who agreed to stop performing FGM/Cs to help them find an alternative source of income. Loans were also available for other women in the town. "The idea is for women to have new activities and options that open their minds," explained Sally.

Maria was so excited about the programme that she invited her eldest daughter to come along. This was the first time they had talked about the subject. Maria's daughter asked her why she agreed to have her cut and Maria explained that she couldn't resist the pressure from her elders. She asked her daughter for forgiveness. Mother and daughter both became volunteers and travelled to nearby towns to talk to other women about the issue. Maria's two younger daughters did not undergo the procedure.

I made a mistake the first time, but I didn't do it again. Now I want to help other women not to make it.

In 2007, a bill criminalizing FGM/C was presented to the Egyptian Parliament. Shortly thereafter, high Islamic authorities issued a fatwa — a religious decree — condemning the practice.

A shift towards medicalization of FGM/C can be attributed to early advocacy efforts around the health consequences of FGM/C. However, this overemphasis of the health implications — at the expense of the larger human rights violation — has led to a misconception that medicalization decreases health consequences, and is therefore a more 'benign' form of the practice.

Rooted in a culture of discrimination against women and control of their sexuality, FGM/C is internationally recognized as a human rights violation. It is a manifestation of gender inequality and power imbalances between men and women and is linked to the unequal position of women in political, social, and economic spheres of society.

Following intense lobbying by the NCCM and other activists, the bill was passed in June 2008. Around the same time, the story of Bedour made headlines: Bedour, a healthy and studious twelve-year-old girl, had died from excessive anaesthesia while undergoing the procedure under the best medical conditions. Widespread outrage followed. "FGM/C is not a tradition; it's a crime," cried the activists. With the support of the Coalition against FGM/C, they decided, among other things, to train doctors how to dissuade their patients from getting the procedure.

"We need to use the prestige of a doctor's words to move people in the other direction, to raise consciousness about the problem among the population," said Dr. Farid.

Despite these changes, the 2008 Demographic Health Survey revealed that 74% of Egyptian women between the ages of 15 and 17 had undergone FGM/C. Still, progress continues: following a programme implemented by the NCCM and jointly funded by UN agencies, including UNFPA, more and more villages are declaring themselves "FGM/C-free". A ceremony was held in Nazlet Obeid, near Quolosna, where Maria lives. The Mayor addressed hundreds of women and children, as well as a few men, in a large schoolyard. He explained that he had believed all of the women in his town were cut, but was pleased to learn that the practice — which he had believed to be correct and widespread — was on its way out. He now understood that FGM/C was an atrocity and he was proud that it was on the decline. He also explained that he had learned that FGM/C does not determine social morality. That was a matter of the mind, he said, and hence the practice didn't make any sense.

"The town might not actually be entirely free of FGM/C, but declaring it an atrocity means that a mother might think twice before cutting her daughter," stated a member of the Coalition against FGM/C. "The first thing that must be done is to create a critical mass of people who don't consider it necessary or correct that can influence the others. If the group is large enough, then their behaviour will change."

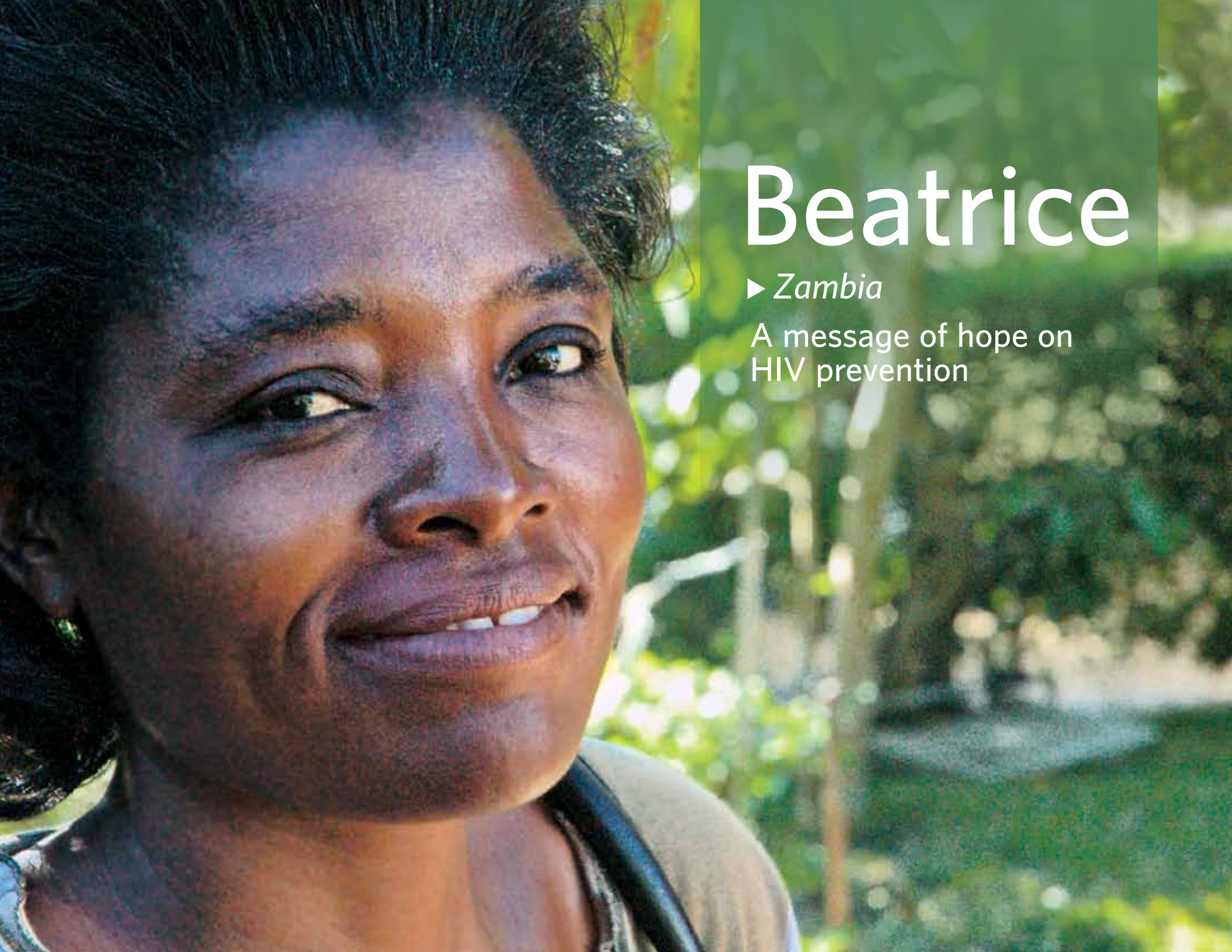
"I made a mistake the first time, but I didn't do it again. Now I want to help other women not to make it."

Maria has already changed. She says that the happiest day of her life was when her eldest daughter enrolled in university. This was proof that she has been able to give her a better life. She hopes that her other two daughters will follow suit:

And they will also be lucky in that no one is going to pressure them to cut their daughters. It's very hard for a mother to have to do that. I did it because everyone did, because it had always been done. You have no idea how much I regret it.

A variety of successful experiences demonstrate that abandonment of this practice is possible, with the enactment of legislation linked to socio-cultural change, community involvement, and ownership of a positive social change process to challenge these societal norms.

In 2007, UNFPA and UNICEF joined forces to actively contribute to the accelerated abandonment of FGM/C by supporting community and national efforts already identified as leading to positive social change. The programme is currently underway in 12 countries.



Beatrice

▸ *Zambia*

A message of hope on HIV prevention

Many years passed before Beatrice could have a home, a family. Shortly after she was born in 1966 in Lusaka, Zambia, her parents migrated to Zimbabwe. Her mother came back, but her father stayed there with another woman. It was 30 years before she saw him again.

Unable to take care of her eight children, her mother sent them to live with different relatives. Beatrice and two of her siblings lived with their grandmother, who moved around a lot; and although she tried to keep food on the table, she was not always able to send them to school. When Beatrice was 12 years old, her grandmother got sick and died. Beatrice cried and cried; she could not understand death, that strange thing that meant she would never see her granny again.

She then moved in with an uncle and his family, but she didn't like it at all. They sent her around the neighbourhood to sell fruits and vegetables and she had to walk barefoot for hours on end until her basket was empty. Some days she was too busy for school, other days she couldn't go because she didn't have a uniform or shoes. And she really liked going to school; she liked learning, singing and playing doctor and nurse with her friends. She wanted to be a nurse when she grew up and help sick people because she had not been able to help her grandmother.

One day, when she was 15 years old, Beatrice got fed up. She walked all the way to the "white people's house" where her mother worked as a maid and told her that she could no longer bear to stay with her uncle's family. So, for a few years, she slept in her mother's room and went to school. She thought she would be able to finish secondary school.

So why did you stop?

Oh… I got pregnant, she says and she laughs.

Beatrice had a boyfriend who was a few years older than her, a neighbour with whom she was very much in love. But she didn't know a thing about contraception. It was only when her mother realized that she had missed her period for a while that she understood that she was pregnant. Suddenly, her world fell apart. The head mistress expelled her from school and her boyfriend became harsh with her and insisted that she take some tablets to terminate the pregnancy. Beatrice was already six months along when she started to feel sick. She went to a hospital and had a miscarriage. She was not allowed back to school and her mother's boss no longer let her live with them.

Beatrice went to live with other relatives in Kafue, a town 20 kilometres from Lusaka. She kept seeing her boyfriend and he insisted that she go back to school so that she could become a nurse. But she no longer believed that she was capable of it and made a living doing odd jobs. Some time later, he left her, and she was "heartbroken". Almost two years went by before she met Maximilian.

Maximilian was an accountant at the University Teaching Hospital (UTH). He approached her when she was visiting a relative. When he saw her again a few days later, he invited her to go for a walk. He had lost his wife, a nurse, two years earlier. He had a home, was well spoken and able to cook. A few months later, Beatrice got pregnant.

Three of her brothers — "very huge boys, you know" — went to speak with him and Maximilian told them he was ready to marry their sister. He had to pay the traditional fee for having impregnated a woman out of wedlock — 200,000 kwachas, the price of a cow — and some more as dowry. Everyone celebrated. Beatrice's first son was born at the UTH in November 1989. For the first time, she had a home of her own and a family of her own.

Beatrice does not remember precisely how and when her life turned into hell. She wanted to work, but her husband would not allow her to; she wanted to study tailoring, but her husband would not allow that either. He came home late and drunk more and more frequently; he hit her more often. Beatrice thought that was what married life was like and she had to accept it. She felt wretched.

The level of violence increased. When she complained, he told her there was nothing she could do about it; she had nowhere to go. Other times he apologized and swore that he would stop beating her. One night, when she was pregnant with their second child, he beat her so badly that she thought she would miscarry. Beatrice took her baby and went to her brother's. Sober and repentant, her husband went after her and promised he would change. He did not; the same kept happening once and again over the years. Beatrice eventually stopped believing him, but she didn't have any alternatives. He knew that, and used it to his advantage.

She suddenly realized that her husband had died from AIDS without telling her.

Years of abuse and sadness went by; Maximilian and Beatrice had two more daughters and countless more fights. Maximilian had become a unionist so he earned more, but he didn't want to pay for his family's food. He bought a flat and a car; he came home later and later, smelling of perfume.

Beatrice started finding condoms in his pockets. When she asked him if he had lovers, he said that it was his life and she should not meddle. She told him that if he wanted to have relations with her, he'd have to use condoms. He told her she was his wife, not his girlfriend, so he wouldn't. Then he beat her even more than usual, and raped her. When she told him that she would report him, he reminded her that he had many friends, as well as a brother in the police department. Beatrice was terrified, but couldn't find a way out. Sometimes, in her dreams, she heard a voice that told her, "Hang on, you'll be all right, hang on." She thought it was God asking her to be patient.

Then, Maximilian got sick. Beatrice noticed him taking tablets every morning, but he looked fine and he told her they were for his blood pressure. One Monday, in early 2001, he felt dizzy and was hospitalized. The doctors said that he had malaria and meningitis. Three days later, he was in dire condition.

That day he wanted to tell me something. He mumbled, and kept saying: 'I'm sorry, there's something I need to tell you. There's a problem, my wife, I'm sorry.' But he was very sick and never managed to tell me what he wanted to say.

When he died, Beatrice felt sorry for him and worried about her children's future. But she also felt an enormous sense of relief:

It was so sad. I was crying, and thinking at the same time that God had freed me from a horrible prison.

A few months later, her youngest daughter, who was two years old, got very sick with malaria and pneumonia. At the hospital, Beatrice and her daughter were offered voluntary counselling and testing. She got the results a few days later

THE BIG PICTURE
HIV prevention

In 2008, women comprised about half of the 33 million people living with HIV. Of the newly infected people (2.7 million), 45% are youth.

Sub-Saharan African women bear a disproportionate share of the region's burden of HIV. Of the estimated 22.4 million people living with HIV in the region, 60% are women.

HIV has reduced life expectancy by more than 20 years in highly affected countries; it has slowed economic growth and deepened poverty.

and discovered that they were both HIV-positive. Beatrice was shocked. All she could think of was: "I'm positive, I will die very soon."

But then I thought 'no', we all have our appointed time to die, why should I be afraid of death? I just brushed it off, but I kept thinking 'I have this little child who's HIV-positive, I've got these three others. Who's going to look after them?'

She suddenly realized that her husband had died of AIDS without telling her, and that he had continued to have unprotected sex with her even though he knew he was HIV-positive. And so — though it pained her greatly — she thought that she was lucky he was dead.

Beatrice received counselling at the New Start Center, an NGO with several clinics that work with HIV patients. They explained that if she and her daughter took care of themselves and took their medicine, they could live for many years. At the Center, she shared experiences with other patients and learned how to live with the disease. At first she had trouble talking about what she was experiencing, but through workshops and meetings she gradually opened up. Yet, the stigma persisted. Sometimes even her brothers, in the midst of an argument, would say: "Sure, you talk like that because you are sick."

I would get angry, she says. But then I realized that they lacked information. And so I thought it was important to help everyone learn more about HIV.

Beatrice stayed with one of her brothers for a few months. Then she sold her flat and moved to Kafue with her children, where life would be cheaper. One day, in 2004, she took her daughter to the UTH for a check-up, medicine and food supplements. There, she met Kenan, who worked as a counsellor. He told her that he wanted to see her again. Beatrice was sure that she would never embark on another relationship, but she accepted his invitation.

How can I say it? It was love at first sight…! he says and laughs.

He told her that his wife had let herself die when she found out she was HIV-positive and that he was also positive. She said she was too. That same day he said that he wanted to marry her and

HIV prevention and treatment is part of an integrated package of sexual and reproductive health services. Though prevention is a critical strategy to halt the spread of the HIV epidemic, efforts to prevent new infections have lagged.

In 2005, HIV prevention services were only reaching 20% of people, while coverage for key populations at higher risk of exposure to HIV, in particular women and young people, were considerably lower.

Effective HIV prevention interventions need to focus on the critical elements that put women and girls at risk of HIV infection; including gender inequalities, social inequities, and HIV related stigma and discrimination that will otherwise continue to fuel HIV epidemic.

she said that she did too. Her brothers told her that she could not get married because she was going to die soon, but she ignored them.

> *Now we are very happy. Of course, we use condoms to protect one another, because one's virus may harm the other. We also use them as a form of contraception. Though we might even be able to have a child with the new drugs available.*

Transmission from mother to child accounts for about 10% of all new HIV infections, but the use of antiretroviral drugs can lower the risk of transmission to less than 1-2%.

In 2005, under a large tree in the courtyard of the NGO Christian Children Fund, Kenan, Beatrice and a few others started the Pride Health Community Organization (PRICHO), which helps HIV-positive people in the region. PRICHO also takes care of AIDS orphans, organizes workshops and meetings and trains peer educators. To avoid depending on sponsors, they try to support them-

Evidence shows that use of female and male condoms significantly reduces the risk of HIV transmission. Due to gender norms and inequalities, young girls and women are generally denied information and access to female and male condoms and do not have autonomy to decide about their sexuality and negotiate condom use.

Reversing the factors that put women and girls at risk of HIV infection — gender inequality, poverty, lack of economic and educational opportunity, lack of protection of their human rights — is critical for success.

selves by running a chicken coop and a grain mill, along with other microenterprises.

We didn't want to just stay at home, but to find ways to help our fellow friends, those who share our status.

Beatrice and others started visiting their neighbours to talk to them about HIV. They distribute condoms and recommend ways to protect against the virus. In Zambia, 37% of HIV infections are among partners who engage in casual heterosexual sex. Condom use would greatly reduce those numbers. In 2008, more than 13 million male condoms and half a million female condoms were distributed throughout the country; but, according to the latest reports, condom use, and particularly the consistent use of condoms, needs to increase even more to significantly affect HIV transmission. In Zambia, HIV prevalence has decreased in the last five years through governmental and non-governmental efforts, but remains around 14%, and AIDS kills 50,000 people every year.

Beatrice and Kenan look so happy together; they bought themselves a little house in Kafue and have a small store where they sell fruits and vegetables. Beatrice's children are in school. Her father even wants to move back in with her mother, though she refuses; she says that she is too old for such things. Beatrice, a beautiful woman in her forties, looks very healthy. She says that her marriage helps her to take care of herself because she does not want to lose her newfound happiness.

Are you worried about depending on the antiretroviral drugs and condoms and the government's ability to continue supplying them to you?

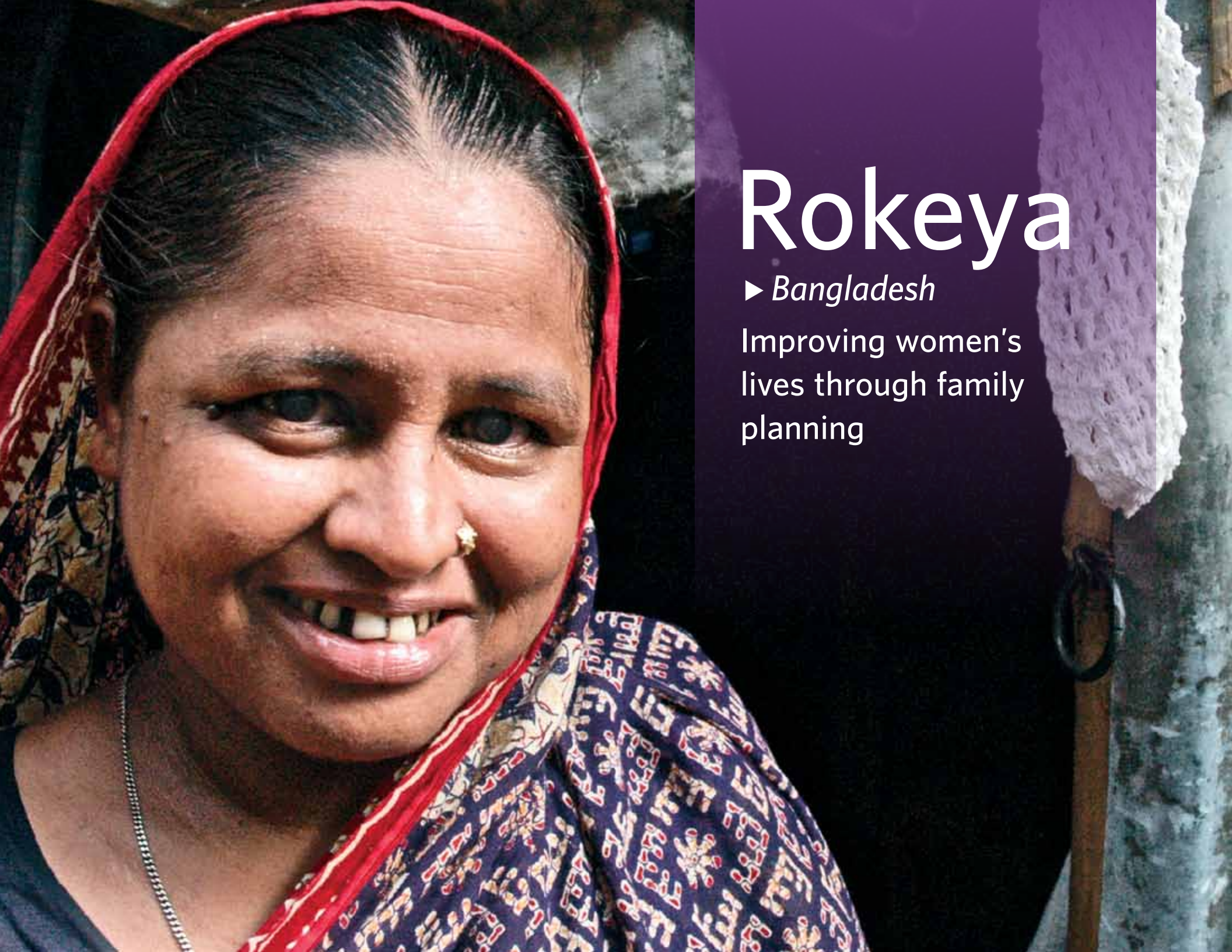
Well, I know that a cure will soon be found. I pray for that, and I'm quite convinced it will happen. And I don't want to live with that kind of worry.

This year, PRICHO received a Red Ribbon Award from UNAIDS for "using creative and sustainable ways to promote prevention and provide treatment, care, and support to people living with HIV." Beatrice and Kenan went to Vienna to receive the award at the XVIII International AIDS Conference and she was very excited about travelling abroad for the first time.

"I would get angry. But then I realized that they lacked information. And so I thought it was important to help everyone learn more about HIV."

The work she does, she says, is almost like being a nurse, her childhood dream. But the strangest thing of all is that all of this — her marriage, her new life, even her trip — is due to her disease. Or, actually, she says, to the way she handled it: she never let it defeat her.

As one of ten co-sponsors of UNAIDS, UNFPA works to intensify and scale up HIV prevention efforts using rights-based and evidence-informed strategies, including attention to the gender inequalities that fuel the epidemic. UNFPA takes a leadership role in male and female condom programming and HIV prevention among young people and women as well as other vulnerable populations. UNFPA is also committed to the human rights of people living with HIV and works to widen their access to sexual and reproductive health care that meets their specific needs.



Rokeya

▶ *Bangladesh*

Improving women's lives through family planning

Her mother was always complaining that there was never enough time or food. It was true: her mother had to raise six children on the little that her husband — a peasant who worked on other people's land — brought home. And, to make matters worse, as her mother used to say, her first three children were girls so they couldn't help their father make a living. In 1970, when Rokeya was born, life in Faridpur, a village 200 kilometres from Dhaka, was hard.

Rokeya does not remember the excitement and celebrations in December of 1971, when the war against Pakistan led to the independence of Bangladesh. What she does remember are the evenings when there was not enough food to go around, her mother complaining and her father sitting silently in a corner. And she vividly remembers the day her mother took her to work at the other people's house.

Rokeya was seven. The lady of the house explained her responsibilities, Rokeya's mother told her to do everything the lady said, and then left her there, all alone. Rokeya was frightened. Little by little, she came to understand her obligations: she had to sweep, clean, wash the clothes and cook. She worked seven days a week, from morning to night and, of course, she didn't earn any money. Her salary consisted of the leftover food she was given to eat. Sometimes, when she missed a corner while sweeping or broke a dish, her mistress would hit her with a wooden stick or kick her. Sometimes, very rarely, she was told that she could go home to visit her family for a few hours. It was on one of those visits, when she was ten years old, that Rokeya learned her father had died. He had developed a strong pain in his stomach and the *kabiraj* — the village's traditional doctor — had given him some herbs, but he died within a few hours.

Rokeya's mistress' husband was a merchant and they had three children under the age of ten who all went to school. Rokeya would hear them talk about what they had done there or hear them recite their lessons and she would ask why she couldn't go to school as well. Her mistress just looked at her and laughed and told her there was no school for the poor. Sometimes Rokeya hated her with all her soul, but she kept quiet. She had learned that if she spoke up, it was worse. Now, many years later, Rokeya says that it still pains her "to have been a slave".

When she turned 14, Rokeya started thinking about what she could do to get out of that place. She didn't have many options: she knew that without an education, she wouldn't be able to get a job, so the only choice she had was to do what her sisters had done and get married. But there was nothing she could do to make that happen, so she just waited around until a good man took notice of her. And someone did.

Rokeya would often go to a well in the morning to fetch water. One of those mornings, two men saw her and thought that she might make a good wife for one of their brothers. They looked into it and since Rokeya's father was dead, they went to talk to her uncle and the father-in-law of her eldest sister. An agreement was reached; there would be no dowry because the bride was so poor.

That very afternoon they picked her up at her mistress' house and took her to her mother's. There, she saw a young man around the age of twenty. Quddus, her husband, smiled at her and Rokeya thought that he might be a good person. There wasn't time for much else; the Imam said the appropriate words and she was married. Before saying goodbye, Rokeya's mother advised her not to make the same mistake that she had by having so many children: "We're poor, my child, and poor people can't afford those luxuries."

Rokeya was happy because she wouldn't have to go back to her mistress' house, but she was also frightened and nervous because she didn't know who this man was, what he wanted from her, how he would treat her. A few days later, though, she started to feel more at ease; Quddus smiled at her and her in-laws had accepted her. He came from a large family with twelve sisters and brothers. The five sons lived in their parents' home with their wives and children. The work she did around the

house was pretty much the same as at her mistress' place, but there was a difference:

I felt that this was my family. I cooked, I cleaned, I took care of my mother- and father-in-law. I was responsible for the well-being of my family. I felt proud and happy to work in my own house as a responsible wife. I felt independent and I had an identity. I was no longer a slave. It was so good.

Everything seemed to be working out, but Rokeya didn't get pregnant. At first, her in-laws thought it was because she was too young. But three, then four years went by and the pressure grew. Her husband smiled at her less and less and Rokeya was afraid that he would reject her.

Did you go to see a doctor?

No, there was no doctor in my village. In fact, I didn't know anything about doctors at that time.

One day, her mother-in-law announced that she must be haunted by a mean spirit, so she had to see the *kabiraj*. He confirmed it: a spirit was eating at her ova and it had to be frightened away. To do that, he gave her a thin tin tube with a quote from the Koran and some herbs. The effects of the remedy were not immediate; it took Rokeya almost a whole year to get pregnant. It was a great relief and the delivery was not complicated. She gave birth at home with the village's *Dai* — traditional birth attendant. It was a girl, but neither Rokeya nor her family complained.

Rokeya had her child and never forgot her mother's words. When a family planning worker came to talk to her, she asked him to give her contraceptive pills. At that time, the early 1990s, the population of Bangladesh was more than 110 million. Overall fertility rates had dropped from 6.3 in 1975 to 3.4 in 1993, thanks to intense reproductive health and family planning programmes. Family planning workers reached even the remotest corners of the country, though all they often had to offer was a blister pack of pills. For the time being, that was all Rokeya needed.

For over two years, Rokeya took her pills without telling her husband and never went to see a doctor. One day, her husband saw her taking them and asked what they were. At first she was frightened to

THE BIG PICTURE
Family planning

Reproductive rights implies that people are able to make free and responsible choices about how, when, and how many children they will have only if they can determine how, when and under what conditions they can have sex and marry, and if these decisions are free from coercion and violence and are made with full autonomy.

Providing contraceptive services to the 201 million women and young people with unmet need would cost $3.9 billion per year. Reducing unintended pregnancies by meeting the need for family planning would save $5.1 billion.

tell him because she had deceived him. Then she got up the nerve and explained that she didn't want to get pregnant again, so they would be able to have a small family and raise their children better.

He listened to her, and they argued, but in the end she convinced him. They agreed to have one more child, hopefully a boy. Without a boy, Rokeya now says, a family is not complete.

My husband never beats me. He is a very good person. He always supports the things I say because they are for the betterment of my family.

Their second child was a boy, Milon. The family was happy, but shortly after Milon was born Quddus' father died. His children divided up his land but Rokeya's husband soon discovered that his part didn't yield enough for them to put food on the table every day. A few months later, Quddus said that he would go to Dhaka to look for work. Rokeya would initially stay in town with the children and then they would see.

In the city, Quddus found a job taking care of a house and a few milking cows. He earned 4,000 takas — about 60 US dollars — a month. With that money, he had to eat, rent a bed, wash his clothes and send something home to his wife. It didn't add up. Rokeya was alone and worried, so after two years she and her children headed to Dhaka.

I was interested in coming to the city. I thought that here I would be able to find a job and give our children better food, a better education.

At first, Rokeya thought she would never learn how to live in the city; everything seemed "mechanical and complicated, not simple the way it was in the village." Eventually, Rokeya got a job cleaning at a school, where they paid her 2,500 takas — less than 35 US dollars — a month. The family moved to a ten-square-metre room with tin walls in a slum in downtown Dhaka; thousands of people live in these clusters of narrow passageways with no running water or sanitation. Rokeya shared

Today, an estimated 215 million women worldwide who want to avoid pregnancy and plan their families are not using effective/modern contraception.

Individuals have the right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice. They also have the right to access appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide them with the best chance of having a healthy infant. These services are most useful when they are integrated with other health services.

Seventy-five million women had unintended pregnancies in 2003, and 20 million of these women had unsafe abortions. Today, an estimated 215 million women worldwide who want to avoid pregnancy and plan their families are not using effective/modern contraception. The demand for contraceptives is integrally linked to health, human rights and power relations.

"My husband never beats me. He is a very good person. He always supports the things I say because they are for the betterment of my family."

her kitchen — four open hearths on the ground — with 20 other families.

Things were going well enough, but Rokeya was still concerned about the possibility of getting pregnant again. She remembered her mother and she was afraid of upsetting their fragile economy. She kept taking contraceptive pills until one day a family planning worker came to her house with information on other contraceptive methods. Rokeya decided to explore a more permanent solution. The visitor came from one of the clinics that formed part of the Second Urban Primary Health Care Project (UPHCHP), a programme run by the Dhaka City Corporation in conjunction with international donors, including UNFPA. After

More than 1 billion young people aged 15-24 are entering their reproductive years. They also require access to information and services, including emergency contraceptives. Along with services, adolescents and young people should have access to comprehensive sexual and reproductive health education that promotes gender equality and human rights.

Family planning is one of the wisest and most cost-effective investments any country can make. By keeping young adults healthy and productive, by allowing parents to have smaller families and devote more resources to each child, and by reducing public expenditures on social services, sexual and reproductive health services contribute to economic growth and equity.

their success in the 1970s and 80s, family planning programmes had ceased to be a priority. That's changed now due to recent forecasts, which estimate that even at the present fertility rate of 2.7, by 2050 the population of Bangladesh might be over 240 million, while the territory is likely to contract considerably due to climate change.

Rokeya heeded her visitor's advice; the ligation, or tubectomy, she told her, was simple and she would never have to worry about getting pregnant again. These were the advantages, Rokeya thought, of living in Dhaka. In her town she would never have had access to this option. Rokeya and Quddus agreed to the operation, but she was not entirely convinced:

> *Some religious leaders say that if a woman gets the ligation, she shall not be buried properly and the ground will reject her body and God will punish her. I was afraid. Then I discussed it with a woman at the clinic, who assured me that that was not true, so I decided to do it.*

The operation was performed at Clinic PA-6 near Rokeya's house, which specialized in reproductive health services. There were no complications and she was pleased with the outcome. Afterwards, Rokeya would say, her married life continued as before.

> *I am far better off here than I was in the village. There I lived in an extended family. Here I have only my husband and my children and I am very happy. My lifestyle has improved. There is more mobility; I can visit my neighbours' houses easily. I can watch TV. I can save money for the future. I could put a tin roof on my home in the village. Before I had to ask my husband for money for my daily needs, now I can spend the money I make and I can contribute to a better education for my children.*

Their children go to school and do well. The only thing Rokeya regrets is that in Dhaka she doesn't find trees nor "the spiritual life that she had in the town." There is no *kabiraj* to look after their well-being and sometimes she doesn't know who to turn to "because a doctor can cure you, but it's not the same." But that doesn't concern her all that much, because she knows that, thanks to her efforts, her children are going to have a better life. They will be educated and, God willing, she says, her daughter will be a doctor and her son a soldier! And all of this is thanks to her mother, who was able to teach her not to make the same mistakes she did.

UNFPA works to make reproductive rights a reality by supporting family planning services, as well as the information needed to make choices, as part of a constellation of integrated reproductive health services within functioning health systems. Since 2007, through the Global Programme for Reproductive Health Commodity Security, UNFPA has worked systematically with national governments to help ensure that all individuals can obtain and use affordable, quality reproductive health supplies — including contraceptives — of their choice whenever they need them. The programme supports over 60 countries and is operational in 45 focus countries.

Natalia

▶ *Moldova*

The anguish of sexual violence and trafficking

Natalia's mother died of cancer in 1990 when she was seven. Natalia was convinced that her mother's illness was her father's fault for beating her so much and that she should have protected her mother somehow. But what her father was doing was not unusual. There's a popular saying in Moldova, "A woman without beating is like a house without sweeping."

Natalia was left alone with her four brothers and her father, who worked in the fields. Her father used to beat her and tell her that she was a burden to everyone in the family and that there was no point in sending her to school. Her brothers weren't any nicer, so Natalia started to look for ways to earn some money.

I never understood why they didn't care for me, why they treated me so bad all the time.

At age 14, Natalia was hired to work at a neighbour's house. She cleaned, took care of the animals and cut firewood. Three years later, she asked her neighbour for help to continue her education. Natalia started taking classes to become a gym and martial arts teacher, but then she ran out of money and had to go back to work.

Back at home, she gave her father and brothers almost all of the money she made in an attempt to win them back, but they beat her anyway. When she was feeling very lonely, Natalia would walk to the cemetery and tell her mother her troubles. In time, she decided to move to Chisinau, the capital city, where she found a job in the central market. But her brothers went looking for her and dragged her back home because someone had to take care of the house.

When she turned 19, Natalia agreed to marry a young man from a nearby town. She was not in love with him, but she thought this was the only way for her to start a new life. In the beginning, they were happy. They lived in a room in Chisinau and they each had a job; they laughed and had fun. Then he grew jealous of her and complained about every penny she spent. They began to argue and he started beating her. When the doctor told her she was pregnant, she feared her husband's reaction. At first he seemed pleased, but then he said that if she had to stop working he would be forced to support all three of them. He blamed her for not taking precautions and beat her up again.

One day, her husband suggested that they move to Italy to build their future. Natalia agreed to the idea because, like everyone else, she had heard stories of successful migrants. Her husband introduced her to a friend who would get them papers and lend them money. The friend was a pleasant forty-year-old, smart and sophisticated. Now that everything is over, she calls him Mr. X.

You had never heard about human trafficking?

I didn't watch TV, I didn't read the papers. I heard something, but I never believed it. Anyway, one thinks that those things always happen to other people.

Her husband convinced her to travel ahead of him and said he would follow soon. She was to work as a maid for Mr. X's sister.

I was really looking forward to going. I thought I could give my child a better life.

That afternoon, Natalia got into Mr. X's car and fell asleep. When she woke up, it was dark and she was in a wasteland by a river. In the car, there were two other girls who told her they were in Romania. Mr. X. told them to get out of the car and walk for a while. When Natalia asked him why, he told her to shut up and do it. Natalia started crying; she knew something terrible was going to happen. They walked in the shadows, in the middle of nowhere, until they found a car with three men inside. Natalia saw the men give Mr. X a great deal of cash. She tried to get away but the men grabbed her, beat her up and kicked her to the ground. As she was lying there, Natalia told Mr. X that she was going to go back to Moldova and that he was going to be sorry.

Mr. X laughed and said she was never going back because someone close to her had made sure that this would never happen.

> *It took me some time to realize that my husband had sold me for three thousand dollars. My husband! I can't imagine a worse betrayal.*

Lying on the ground, Natalia screamed. Her new owners handcuffed her and pulled out a syringe to drug her for the trip ahead. Natalia tried to stop them, yelling that she was pregnant, but it was no use. She spent the journey dreaming and hallucinating, as well as being threatened and beaten. She was raped and awoke naked and injured in the back of a jeep. She was terrified. Later, she and six other girls were forced to walk for hours across the mountains. One tried to escape and was killed. One of the guards broke Natalia's arm. The men beat her up until they got tired of it. She ended up in a house in the outskirts of a town, where a man told her that he had bought her and she would have to work hard for him. As a welcome, two thugs tied her up and raped her.

"It took me some time to realize that my husband had sold me for three thousand dollars. My husband! I can't imagine a worse betrayal."

> *I was locked in my room by day. At night, they took me out, gave me alcohol and forced me to do whatever the customers wanted.*

One night she felt sick and told her boss that she was pregnant. The man told her not to worry. A so-called doctor aborted her pregnancy. Natalia spent three days crying. Weeks later, she managed to escape and took shelter in a convent. But soon the nuns asked her to leave because they were afraid of what could happen. Back on the streets, her boss found her immediately, but he

THE BIG PICTURE

Sexual violence and trafficking

The United Nations estimates that between 800,000 and 4 million women, children and men worldwide are sold into slavery every year. Of these, 1.4 million are from Asia and the Pacific; 270,000 from industrialized countries; 250,000 from Latin America and the Caribbean; 230,000 from the Middle East and Northern Africa; 200,000 from countries with economies in transition; and 130,000 from sub-Saharan countries.

Generating an estimated $32 billion dollars annually, human trafficking is the fastest-growing and most lucrative criminal activity in the world today.

was tired of her and sold her cheaply. Her new boss told her that if she was a good girl and paid him back her price he would let her go in a few months. Every night, Natalia had to dance and "satisfy the clients".

> *They were animals, people with no soul. Sick, perverse and violent.*

Natalia wipes away a tear, and looks at it, as if it were the enemy. Her small hands angrily twist a piece of plastic.

Several weeks went by and a regular client offered to help her escape. Natalia sought refuge

The most commonly identified form of human trafficking is sexual exploitation (79%), followed by forced labour (18%). Forty-three per cent of trafficking victims are used for forced commercial sexual exploitation; 98% of them are women and girls.

Sex trafficking frequently results in debt bondage. This is an illegal practice in which the traffickers tell their victims that they owe money (often relating to the victims' living expenses and transport into the country) and that they must pledge their personal services to repay the debt.

Women and girls are frequently lured into trafficking with the promise of a good job in another country. Sometimes women receive false marriage proposals from men who plan to sell them into bondage. In some cases, young girls are sold into the sex trade by their parents who are trying to earn some money. Many times women are simply kidnapped.

in the client's house, only to find out that all he wanted was the brothel's services for free. She fled. As she was running across a field, she heard a car. It was the brothel's thugs. They grabbed her and tried to shove her into the car. She screamed, saying that she would rather die than go back there. She managed to run away, but they chased her with the car, ran her over, and left her for dead.

What would you do if you found the people who kidnapped you?

Natalia laughs. For the first time in this long conversation, she's really laughing.

I'd run them over with a car.

After three days in a coma, Natalia woke up in a hospital. The doctors told her she might never walk again. She underwent several operations and six months of convalescence; she also learned she had Hepatitis B. Natalia feared that she would never get back to Moldova. Then a lawyer appeared and offered to help and pay for her ticket. Natalia suspected he might have been sent by her boss to make sure that she was not going to turn him in to the authorities. Or maybe that wasn't the case, Natalia never knew.

Nobody was waiting for her when she arrived at the Chisinau airport. She went to her hometown, but her father and brothers didn't want to talk to her. They said that they considered her to be dead. They said that she was ungrateful because she had left and never sent any money home. Natalia did not tell them what had happened to her. She just left and headed for an aunt's house in another town.

"Talking about it is the only way to leave it behind and help others, so that this doesn't happen to other girls like me"

Once trafficked, women and girls are often subjected to starvation, confinement, physical abuse, rape, gang rape, threats of violence towards their families, forced drug use and the threat of shaming them by revealing their activities to friends and families.

Generating an estimated $32 billion dollars annually, human trafficking is the fastest-growing and most lucrative criminal activity in the world today. According to a 2005 International Labour Organization report, a single female held for sexual exploitation yields an annual average of $67,200 in Western Europe and North America.

Ending the trafficking of women and girls will require that governments and the international development community address sex discrimination and put into place and adequately fund measures to ameliorate the socio-economic, political and legal conditions of women and girls.

Her aunt let her stay and heal. Natalia was worried because she couldn't help her around the house and she didn't want people to feel sorry for her. One day, still on crutches, she left for Chisinau to look for a job and a life of her own. She left an audio tape, which told her story, at her aunt's. She wanted her aunt to know what she had been through, but was ashamed to tell her face-to-face. In Chisinau, Natalia slept in the park until she found a job in a kindergarten. The director let her sleep there as long as nobody noticed. She never left the school; she worked during the day and hid at night. Later, a cousin told her about a hotline to La Strada, an NGO that fights human trafficking. Natalia called and was referred to a shelter run by the International Organization for Migration. That's where she is now, trying to recover from her physical and psychological trauma.

When Natalia talks, she looks down; her voice is low and she speaks in a monotone. She is always about to cry. Every word is a search, a stammer, a tremble.

Why are you talking to us?

Well, first, I wanted to hide my story because when people know, instead of treating you like a victim, they think you're guilty. But I have to talk; if I don't, I'm going to spend my life thinking about those months. Talking about it is the only way to leave it behind and help others, so that this doesn't happen to other girls like me.

What do you expect from the future now?

Natalia is silent; she thinks and tries to smile.

What a tough question, she says.

Countries must exhibit the political will to develop effective tools to prosecute traffickers, protect trafficking victims and fully address the demand for women and children for sexual exploitation.

In partnership with UN agencies, UNFPA works to end sexual violence and trafficking of women and girls, in both conflict and normal settings, within the framework of the recently-passed UN Declaration against Trafficking and in line with the International Declaration to End Violence Against Women.

Saratou

▶ *Niger*

Ending the silence and lessening the suffering of obstetric fistula

Saratou has always been proud and enterprising. When she was nine years old, she used to walk twenty kilometres with her friends from Dakwari, her village, to the city of Zinder to sell *doumnya*, a small black fruit they would pick off the trees. She didn't really know how many kilometres they walked. She just knew that if they left when the rooster was crowing, they would arrive when the houses cast no shadows. They had to make the most of the season; each girl carried ten kilos of fruit on her head and with their earnings they bought henna, small pieces of jewellery, a stretch of fabric. Saratou hid most of what she bought in a trunk at a friend's house. She wanted to keep it for her wedding, but she still wore some of it:

I didn't want there to be a single girl around prettier or better dressed than me.

Did you have a mirror?

Yes, a small one, so I could look at my face.

When it was not *doumnya* season, Saratou kept busy by selling fritters and peanut oil, which she made in her adobe hut with no electricity or running water. To help her mother she also cleaned, washed, fetched firewood and water, ground grain, and prepared millet mush, which she would take to the men in the fields. Saratou was the daughter of the richest peasant in the village; his lands produced enough for them to eat every day and, in times of drought, they could even give some millet to their hungrier neighbours. But they could not send Saratou to school because there was no school in the village.

When a school was finally built, her parents took her, but the principal told them that they could not accept her because she was too old. So Saratou had to make do with the Koranic School, where they taught her how to follow the appropriate rituals and repeat some verses in a language she did not understand.

I didn't care. The madrasah was much better than the other school.

Why?

Because what you learn at the other school might help you to get a job or live in the city, but the madrasah helps you forever, to obtain eternal life.

When Saratou was twelve, Kalla, a boy from the next village — an older cousin who had always engaged her in conversation and given her gifts — told her that he loved her and wanted to marry her. Saratou liked the way he spoke to her and she accepted his proposal. Their fathers agreed on the amount of the dowry and the gifts to the bride. A few months later, Saratou got her treasure from her trunk, did her make-up better than ever before and painted her hands and feet with complicated patterns. Her family took her on horseback to her husband's house. The next day, when Kalla announced to everyone that the bride was a virgin, the celebrations began.

Saratou was not only a virgin; she was also pre-pubescent. She was small and skinny and frightened. At first, she felt pain along with fear. A few months later, she got her period for the first time. Within a year, she was pregnant. When her time came, Saratou closed herself in her room, squatted, grabbed on to the bed leg, prayed a great deal and let her baby fall onto a mat on the ground. That's when the midwife arrived. She cut the umbilical cord and put the baby's head on a broom so that it would not get dirty from the sand. Then Saratou sat facing Mecca and the midwife handed her the baby wrapped in a cloth. He was very small and had trouble breathing. Saratou's mother recited some surahs and dowsed him with herb water. The baby died a few hours later. Saratou was sad, but she knew that she was young and would soon have others. The next month she was pregnant again.

Saale was a healthy boy. Saratou brought him up, continued with her small businesses and looked after the house. As soon as she stopped

"It was awful. No one wanted to talk to me; they ran away when I approached. I had been a matchmaker, a respected woman, and suddenly no one even greeted me."

breastfeeding, she got pregnant and gave birth to a daughter. The next year, she had another daughter, and then a son, and then two more sons. Saratou felt blessed by her fertility, but suddenly her luck changed. One winter brought a great deal of rain and humidity and her third and fourth children, who were two and three years old, caught malaria and died. Then her sixth, a girl just a year old, began vomiting and died within a few hours. Some time later, her second daughter, who was seven, died of fever. Saratou gave birth and dug graves time and again. She told herself that her mother had gone through the same thing and that such was life; good God gives, and takes away. But she also suspected that a sorcerer might be killing her children.

Why?

For no particular reason. Sorcerers have no choice; they eat the souls they can get a hold of.

In Niger, the fertility rate is approximately seven children per mother. Only 33% of deliveries take place in health centres and the maternal mortality rate is around 648 for every 100,000 births. Long before she turned 30, Saratou had given birth ten times, with only four surviving children. In 2004, when she got pregnant for the eleventh time, Saratou thought that she would do what she always did. She went into labour in the afternoon, but by dawn, when her husband came back from morning prayers, Saratou was still in bed. She felt strange. Saratou had heard about a neighbour who had gone to a health centre, so she asked her husband to take her there in the cart.

At the centre, Saratou began to feel worse. That night, the nurse broke her water and, using basic suction, removed the stillborn baby. Saratou was exhausted, so it was not until she woke up the next morning that she realized her body and bed were covered in urine.

Obstetric fistula is a hole that forms in the birth canal caused by prolonged labour where no appropriate medical treatment, usually a

THE BIG PICTURE

Obstetric fistula

Obstetric fistula is a hole in the birth canal caused by prolonged obstructed labour. More than 2 million young women live with untreated obstetric fistula in Asia and sub-Saharan Africa.

Each year, between 50,000 to 100,000 women worldwide develop obstetric fistula. The World Health Organization estimates that in areas of high maternal mortality, two to three women per 1,000 pregnancies develop fistula, which would mean that the prevalence is likely to be much higher.

Caesarean section, is available. This devastating condition causes chronic urinary and/or faecal incontinence. Fistula is a relatively hidden problem because it largely affects the most marginalized members of society; poor women from remote regions with no access to health care. It is common among first-time mothers, particularly in those who are married very young, before their bodies are mature enough to give birth.

Fistula can also affect any woman who experiences a complicated delivery without medical help, even if she has delivered normally several times in the past, like Saratou. Like maternal mortality, fistula is entirely preventable. Sadly, at least 2 million women in Africa, Asia and the Arab region live with the condition and there are some 50,000 to 100,000 new cases each year.

Five days later, the nurse at the centre sent Saratou home with no further explanation. Saratou went to her parent's house because she thought that she couldn't go back to her husband in the state she was in. She couldn't control her urine; the smell was embarrassing, her skin was ulcerated due to the continual leaking of urine and her legs ached when she tried to walk. Her neighbours rejected her because of the smell but mostly because fistula is considered to be a shameful condition by the community.

It was awful. No one wanted to talk to me; they ran away when I approached. I had been a matchmaker, a respected woman, and suddenly no one even greeted me.

Saratou was lucky because her husband continued to visit her every day. He told her that he would wait for her. Most women living with fistula are poor and are abandoned by their husbands, which heightens their misfortune. Zeinabou, a woman from a neighbouring village, spent a year trying out different treatments. She finally told her parents that she had been cured because she was frightened that they would sell their donkey — their last possession and means of livelihood — to pay for her treatments. Alone and marginalized, Zeinabou lived with fistula for ten years. Fortunately, Saratou didn't have to wait that long.

The development of obstetric fistula is directly linked to one of the major causes of maternal mortality: obstructed labour. It accounts for 8% of maternal deaths in the developing world. Adolescent girls are particularly susceptible to obstructed labour because their pelvises are not fully developed.

In as many as 90% of fistula cases, the baby is stillborn and the woman is left with chronic incontinence. This often leads to increased social isolation, abandonment or divorce, ridicule and shame, infertility, lack of economic support and the risk of violence and abuse.

A few months after she was diagnosed, a relative told Saratou's mother about a touareg healer. They sought him out, but his potions didn't help at all. Then someone told her that she could be treated in the city. After her experience at the health centre, Saratou distrusted Western medicine, but eventually decided that she had nothing to lose. In the end, she sold her bed and a goat to be able to go to the maternity hospital in Zinder. She spent a month in the pavilion for fistula patients until it was time for her surgery.

A skilled fistula expert performs the operation and the fistula can often be cured with an hour-long procedure that costs about $400. A month after her treatment, Saratou went back to her parent's home, returning to Zinder three or four times over the next six months to complete her treatment. Although her hospital care was free, the cost of travel and food forced Kalla and Saratou to sell their animals and mortgage their land. Three of her goats were poisoned by cassava leaves while she was in hospital. Saratou never found out what happened, but she still thinks that it was an act of revenge by the community for the sickness that she had brought.

They acted against God, because it was him who sent the illness to me.

Why?

Because I am God's slave, and God does what he wants with us. He sure had a reason, but how am I supposed to know it?

In the end, Saratou was able to return home with her husband. She had lost almost everything, but she was cured. At the maternity hospital, Saratou met people from Solidarité Pour un Monde Sans Fistules, an NGO based in Zinder. Solidarité is supported by UNFPA, UNICEF, World Bank and other organizations. It works to prevent and cure women with fistula and help them to reintegrate back into their communities following treatment. With their help, some 150 women from the area recover from fistula every year. At their meetings, Saratou learned what she should do to stay healthy: a good diet, less physical effort, family planning to avoid getting pregnant too soon, and access to medical care if she had a difficult delivery in the future.

Through Solidarité, she received training in starting a small business. They taught her how to make soap and petroleum jelly, but when she returned to her village she could not find the necessary raw materials to make them. She also received 50,000 francs CFA — about 100 US dollars — to start up a new business, so Saratou decided to pay off the mortgage they had taken out on her land and buy two goats to start a new flock. The people from Solidarité also organized a meeting with all of her neighbours to explain what fistula was and to encourage them to accept Saratou again. Some have, but others still marginalize and mistreat her. Saratou doesn't understand why the stigma brought on by her illness has lasted so much longer than the ailment itself. She now plays the role of *femme-relais* to

Malnutrition, poor health services, child marriage and gender discrimination are interlinked root causes of obstetric fistula. This preventable condition mostly occurs among poor women whose status and self-esteem may depend almost entirely on her marriage and ability to bear children. Studies show that over 99% of women who underwent fistula surgery were illiterate.

Women with uncomplicated fistula can undergo a surgery to repair the hole in their bladder or rectum at an average cost of $400. The treatment cures up to 90% of obstetric fistula patients. Yet, since 2003, only 12,000 women in over 45 countries have received obstetric fistula treatment in Africa, Asia and the Middle East.

help Solidarité detect and address new fistula cases among her neighbours and acquaintances.

Saratou can no longer make fritters or peanut oil, or work on any other business projects. Her family depends on what her piece of land produces and on the little that her husband, a *marabou*, or religious teacher, gets for teaching the Koran to the village's children. Some days they don't eat as much as they should and they are especially concerned this year due to the drought. But Saratou is sure that everything is going to get better and that God will allow her to make her wishes come true.

At least 2 million women in Africa, Asia and the Arab region live with fistula and there are some 50,000 to 100,000 new cases each year.

And what are those wishes?

To regain my health, forget that I was ever sick, be able to recite my prayers well, have a better life, get a sheep to sacrifice during the festivities and, when I die, go to heaven. I think I deserve it.

Obstetric fistula can largely be avoided by delaying the age of first pregnancy, by the elimination of harmful traditional practices and by timely access to quality maternal health care, including family planning, skilled care at birth, basic and comprehensive emergency obstetric care, and the overall management of obstetric fistula.

In 2003, UNFPA and its partners launched a Global Campaign to End Fistula. The Global Campaign is now active in 47 countries in Africa, Asia and the Arab region.

María

▶ *Guatemala*

Becoming a mother as a teenager

Every time María went into town he was standing there; looking at her, talking to her. It seemed as if he was waiting for her. Now, seven years later, María says that if she had known then, she would have looked the other way. But then again, you can't know what you haven't learned.

María was born in 1988 in Chocol, a village in central Guatemala whose inhabitants are of the k'ich'e ethnicity, a branch of the Mayans. Her house was a plank shack with a straw roof and dirt floor and no running water. Her father planted corn, potatoes, wheat and carrots on their hectare of land. Her mother did not know how to read but took care of the house, tended to the laying hens and embroidered blouses that she sold at the market. There was never anything to spare, but their eight children ate every day: potatoes, beans, noodles, rice and a piece of meat every so often. Even when the crops were poor and there was not enough food, they always divided up what there was equally. María is still thankful that her parents didn't do what many families in her town did; when food runs short, they give what there is to the men.

María spoke k'iche', one of the 23 Mayan languages spoken in Guatemala. Her parents also knew how to speak Spanish and they sometimes spoke it around María so that she would learn. She also heard Spanish on the small black-and-white television that showed things she had never seen before: hamburgers, pizzas, dolls, balls.

When María turned eight, several things changed in her life. She started helping her mother around the house: sweeping the floor, washing the dishes, taking the corn to the mill, making tortillas. Her older sister also helped out by embroidering blouses and her brothers worked in the fields. Maria was also finally able to go to school; her mother waited until she was old enough to go on her own because she didn't have time to take her.

At first, it was hard. She was the oldest and her classmates teased her, but her mother insisted that she stick with it. She often said that her daughters had to go to school so they wouldn't face the same poverty and discrimination that she had endured and so they could learn how to do something other than cook and raise children. But, three years later María had to start working. She embroidered blouses eight to ten hours a day and as a result she neglected her studies and her grades suffered.

So I had to choose, and it was very sad. I was twelve years old. We needed the money I earned. I had to leave school.

She hoped to go back one day and wondered why others were able to go to school but not her. She couldn't come up with an answer; she kept embroidering and feeling sorry for herself. That was when she met Juan, the one who was always waiting for her.

Juan was 21 and lived in a neighbouring community. María was not yet 14 and hadn't even started thinking about boys, but this one attracted her. She talked to him and they became friends. One day, he asked her if she wanted to be his girlfriend and María agreed. After all, Juan was patient. He listened to her, he understood her. They started to see each other whenever they could, away from her parents' watchful eye. After a few months, María told her parents that she wanted to marry Juan. They insisted that she was too young to get married, that she should wait a few years.

Now I know they were right; I had no experience, I didn't know a thing. But I thought I was in love and I didn't want to lose him. So I ignored my parents' advice. I was like a little girl with a new doll. I wanted to play with it.

Juan and María felt that the world did not understand their love and that they had to stay together. Sometimes disgruntled couples just "leave", so one afternoon when her family was not home, María put her three blouses into a bag and went to Juan's parents' house. She spent her

first night with him, which was one surprise after another. As is often the case, the next day two older people went to talk with her parents to tell them what had happened and ask them to forgive the young couple. María's father told her that she was too young and it was a mistake, but that she had his blessing. Her mother cried. María felt happy and sad at the same time.

"So I had to choose, and it was very sad. I was twelve years old. We needed the money I earned. I had to leave school."

They spent a few months at Juan's parents' house. When María wanted to go back to school, they said she couldn't. She was engaged and it would not be right for her to be out by herself. Juan's father told his son that they were a burden on him. So Juan decided to go to the capital to look for work. María stayed there, in an unfamiliar house, and was rarely allowed to go out or see her relatives. She spent many nights crying.

Juan came home every weekend. They didn't want to have children at the time and María now says that if she had known what to do, she would never have gotten pregnant. At that age, her ideas on the matter were confused. No one had ever explained the facts of life or the signs of pregnancy to her, but she suspected it had something to do with sleeping with a man. The idea tormented her.

María went, almost secretly, to a health centre where a doctor told her that he couldn't do any tests because they didn't have the necessary supplies and equipment, but he could give her some pills. He didn't tell her what they were for. María started taking them and when she realized that she was no longer menstruating, she thought it was because of the pills and went back to the doctor. He sent her to the city for a sonogram, which showed that she was pregnant. María was scared of the delivery and of Juan's reaction. But she was also happy because the nurse told her it was a little boy.

María went to the city to live with Juan and got a job in a pant factory. They rented a room and things were going pretty well, but he insisted that she get an abortion. He said that she might die in childbirth and that they couldn't support a baby. María refused because she "didn't want that weighing on her conscience". He got angry, but eventually accepted her decision.

On October 20, 2003 María turned 15. Juan took her out to a neighbourhood eatery, but she was very tired and they went back to their room early. Four days later, her water broke. Their son was born a few hours later and they named him Jeremy. Juan seemed pleased, though he did tell María not to put their names on the birth certificate. He felt they were too young and it would be better to say that the child was her sister's son. María didn't understand, but she agreed. She is still sorry that she did this because she has spent years trying to recover her son's lost identity.

THE BIG PICTURE
Adolescent pregnancy

There are more young people in the world today than ever before — 1.8 billion, accounting for 30% of the world's population. Globally, almost 9 out of 10 young people live in developing countries.

High levels of fertility among adolescents are associated with child marriage and low levels of education. More than one-third of young women in developing countries aged 20-24 are married before the age of 18. Over half of these girls complete less than three years of schooling.

When Jeremy was a year and a half old, María started to wonder what the matter was with Juan. He didn't give her any money, he went out a lot, he didn't take care of his son and he shouted at her a lot. Then someone told her he was with another woman.

I felt so humiliated, so worthless. I spent hours crying; asking him what was going on. At first he denied it, then he admitted everything.

The next day, María tied her son to her back and returned to her town, to her parents' house. At first they didn't want to believe her, but in the end they took María and her son in. María went back to her embroidering. She was 16 years old and full of sorrow. Because of her past, the neighbours looked at her and talked about her in hushed tones. Everyone, even María herself, held her in disdain. She felt guilty and rarely went out; some nights, she didn't want to go on living.

Her parents were concerned. When she turned 18, they encouraged her to go back to school. María read and read and managed to pass the elementary school equivalency tests. Then she signed up at a high school for adults. It was a major accomplishment; from that moment on, she felt that she could do things, that she was not useless. She no longer accepted the prejudiced idea that she was "that woman whose husband left her and who runs around doing goodness knows what." Her older sister told her about an internship at the NGO Prodesca, which worked with young women from the region. María applied; she was hopeful, though she knew her chances were slim. On the day of the final interview she was very nervous. When they told her she had been selected, she couldn't believe it. She had finally managed to do something important on her own, through her own effort.

María finished high school and joined a health team that visited villages in her region. She learned a lot. Then, in 2008, she was accepted as an intern at the Population Council and UNFPA's Abriendo Oportunidades programme. She started to get training in sexual and reproductive health, leader-

On average, one-third of young women in developing countries give birth by the age of 20: 16% of all births occur in sub-Saharan Africa, 12% in South-Central and Southeast Asia and 18% in Latin America and the Caribbean.

Pregnancy during adolescence carries health risks. Complications from pregnancy and childbirth are the leading cause of death among girls between the ages of 15 and 19. It is estimated that 14% of all unsafe abortions in developing countries are performed on adolescents aged 15-19 years.

Nearly half of all sexual assaults worldwide are against girls aged 15 and younger.

ship skills, community work and other issues that she would then convey to four groups of k'iche' girls. At first it was hard for her to travel for the training meetings. For those three or four days her mother would take Jeremy, but the separation was painful for her and more than once she thought about quitting. To keep at it, she told herself that she was doing it for her son, to give him a better future. It was also for herself, so she would be able to do something with her life. Besides, she was increasingly interested in the work since she learned new things and saw new places.

Maria finished the training successfully. Now, she could teach young girls what she would have liked to have known before she met Juan; about being a teenager, about a woman's body, about relationships. She could teach them that there are more options in life than getting married, having a lot of children and taking care of the house. She could show them that a woman can also study, work and be self-sufficient and tell them that, before taking action, they should think of the consequences. She has a child and although she loves him more than anything, her possibilities are severely limited.

I sacrifice a lot for him. To start, the labour was very risky. And I had to stop doing a lot of things out of my love for him, but I don't mind.

Her internship opened up new worlds for her and gave her a life that she had never imagined. Now she hopes to get a scholarship or a job that will allow her to study law. It's not easy, but she has confidence that she will be able to do it. What she doesn't have, though, is a partner. She did until a few months ago, but she left him because he drank too much and María decided that she didn't want to put herself at risk.

Many young women will risk being mistreated; they don't have enough self-esteem. I have learned to care for myself and so I told him that if he wanted to stay together he had to stop drinking. I told him to set a date. When that date had gone by and he was still drinking, I understood that he didn't care about me enough and I told him we were through. But I don't care all that much because I don't want to get married yet. I need time, a lot of time; five or six years until I can finish my studies and become self-sufficient, help my son to get ahead, do something with my life. So, we'll see.

It is estimated that a total of 67% of married adolescents in sub-Saharan Africa who want to avoid pregnancy for at least the next two years — 54% in South Asia and 36% in Latin America — are not using any form of contraceptives.

Among unmarried, sexually active adolescents who want to avoid pregnancy, only 41% in sub-Saharan Africa and 50% in Latin America and the Caribbean are using a modern contraceptive method.

Teenage pregnancy is both the cause and result of economic, ethnic, generational and gender inequalities. Most adolescents who become mothers suffer social exclusion and their children will most likely face the same dynamics of poverty and marginalization. Girls in the poorest fifth quintiles of the population are four times more likely to become pregnant than those in the richest fifth.

"I sacrifice a lot for him. To start, the labour was very risky. And I had to stop doing a lot of things out of my love for him, but I don't mind."

By enabling young women to delay childbearing until they have completed their education and training goals, sexual and reproductive health services contribute toward empowering them, improving their social and economic position, and increasing their community and political participation.

In 2007 the United Nations Agencies (UNFPA, UNICEF, WHO, UNESCO, ILO, UNIFEM) convened the Inter-Agency Task Force on Adolescent Girls (UN IATF). It is a groundbreaking global initiative that gathers a range of partners to help realize the rights of adolescent girls, covering nearly every aspect of social and economic development relevant in addressing the needs and realizing the rights of the most marginalized and disadvantaged.

Eunice

▶ *Uganda*

Midwifery: Changing the world one birth at a time

One morning, when Eunice was six years old, her mother told her to get dressed at once because she was going to take her and her six siblings on a trip. For several days the sound of gunshots had been growing louder and louder and everyone said that the soldiers were about to arrive. At that time, Eunice did not know what exile meant. Two days later, tired and hungry, she was a refugee in Sudan.

The war had broken out more than a year before, in 1978, when the Uganda National Liberation Army (UNLA) rose up against the regime of Idi Amin. Defeated in Kampala, Amin's army had retreated to the West Nile provinces and the UNLA soldiers were wreaking havoc by burning houses and killing civilians; everyone fled. Eunice's father was a Christian peasant who stayed behind to get some food for his family. The soldiers killed him, along with hundreds of others who sought shelter in an Anglican mission. When fugitives arrived with the news, Eunice's two older brothers — both of whom were married and had several children — decided to go back to bury their father's body. A few days later, someone told their mother that they too had been killed.

Eunice, sad and skinny, spent a year in that camp in the Sudan. It was a strange sort of exile because her village, Nyio, was just on the other side of the border, only twenty kilometres away, yet so far! Goaded by hunger, some nights some refugees secretly returned to their houses to steal from their own gardens. After a year had gone by, some of them said that there were no more soldiers to be seen, so the refugees started to go back.

Eunice's house was burnt, along with all the others. Though it was hard, they rebuilt their round huts with grass thatched roofs. Eunice was able to go back to school. The rest of the time she helped her mother around the house and in the field and sometimes she would go to the market to sell fruit and vegetables. Her mother grew cassava, sorghum and maize to feed her children and her five orphan grandchildren. With no father or older brothers, life was very hard for Eunice and the other children.

When Eunice turned 13, she began secondary education and major changes happened. She still remembers the first time her mother bought her a new skirt and blouse so that she would be well dressed at church "because now you are a young lady". The next year, a teacher from the school began courting her. He would often give her a few coins to buy soap or school supplies. One day, the man told Eunice that she had to go to his house with him. Eunice thought that she owed it to him and couldn't say no.

Eunice tried to forget about it. Weeks later, during a health examination at school, they found out she was pregnant. The head mistress told her not to come back. Eunice cried and cried; she didn't even really understand what was happening to her. When the time came, her son was born at the town's health centre. She was fascinated by the dedication of the nurses who looked after her, as well as by their uniforms. "If God helps me," she thought, "one day I'll be like them." Her mother took care of her child and the head mistress agreed to let her go back to school.

Three years later, she graduated. She was determined to study midwifery and she was accepted to the school, but it took her a year to get enough money together. The two-and-a-half-year programme was demanding; the students lived at the school and could only leave once a year, for three weeks. Eunice was enthusiastic, but the first time she saw a woman giving birth she was terrified. The woman screamed and screamed as if she were dying, then suddenly a new life appeared between her legs.

Soon after she got her certificate as a midwife — and the right to be called "Sister" — she got a job with a doctor in Arua, her region's main town. It was at that time that a man from her village went to her mother to ask for Eunice's hand in marriage. He offered her three cows and ten goats but the clan elders told him it was not enough. He countered that Eunice already had a child, so in the end they agreed that he would offer more when he could. Eunice got pregnant shortly afterwards and had a second son.

Married life agreed with her, but her job was bad and poorly paid. After two years, another crisis in the region affected her life. Now exiles were coming to Uganda from Sudan and Sister Eunice found out that there was a UNHCR camp looking for a midwife. She applied and got the job but her husband forbade her to work so far away. He

"The pleasure of helping a mother give birth, seeing how a child comes into the world, cleaning him off, giving him to the mother; I wouldn't trade that for anything."

wanted her at home cooking, doing the washing, looking after him and their son. Eunice needed to work because her mother and her brothers' orphan children depended on the money she made. In Uganda, where so many have died from violence and AIDS, families take care of the children of the dead.

Sister Eunice discussed the matter with her mother, who consulted the elders and they decided that Eunice should return to her mother's house and start working. She could not ignore their wishes. At best, she could wait there until her husband came to fetch her. But he didn't.

I liked living with him. Sometimes he mistreated me, he didn't give me enough money for food, but if he had allowed me to work I'd have stayed with him.

The job at the camp gave her the experience she needed and in 2001 she got a job in a health centre in her district. In 2004, she went back to school since she wanted to become a registered midwife. She spent a year learning life-saving skills and long-term family planning, among other things. When she graduated, she was assigned to a health centre in Vurra, a few kilometres from the Sudan border. She earned 400,000 shillings — around 180 US dollars — per month.

In recent years, with the aid of a number of international organizations, including UNFPA, the government of Uganda has supported midwives as one of the key interventions in the struggle to prevent avoidable maternal and newborn deaths, to promote family planning and to combat HIV. The results are encouraging. In 2006, 42% of Ugandan mothers gave birth in health facilities and during that same period the maternal mortality ratio dropped from 505 to around 435 per 100,000 births. But that means that 60% of women still give birth at home, either under the care of traditional birth attendants or with female relatives and friends, and that 16 women die as a result of complications associated with pregnancy and deliveries every day in Uganda.

In the overwhelming majority of cases, these deaths are the result of home deliveries. If these women do eventually get to health centres, it is often too late. Though the programmes are working, as always, they are not enough.

THE BIG PICTURE
Midwifery

In developed countries, almost 90% of all births are attended by health personnel. In developing countries, however, the figure is 57%. In some of the least developed countries it falls to only 13%. The lowest levels are in Eastern Africa (34%), South-Central Asia (38%) and Western Africa (40%), with much higher levels of coverage in Latin America (93%).

While the presence of skilled health staff in urban areas continues to grow, progress is held back by stagnation in rural areas — mainly in South and Southeast Asia and sub-Saharan Africa, where the population is mostly rural.

We need so many things. Staff, equipments, medicines…

Every morning, Sister Eunice gets up at around six o'clock, bathes, has breakfast, sends her son to school and walks twenty metres to her office. All of the services offered by the Health Centre of Vurra, which sees 21,000 people, are housed in three small buildings with four or five rooms each. All there is in the delivery room is a bare cot and a few posters on the shabby walls. The equipment is also very old, "but it is much better than nothing," she says. As part of her morning routine, she cleans, prepares the materials and, together with the two nurses and the other midwife, begins to see the women who have already gathered under the trees in the yard.

Due to the exodus of medical professionals to countries where they can earn more, Uganda has a dire scarcity of doctors. There is one doctor for every 20,000 inhabitants and only a few health centres have a doctor on staff. Under these conditions, the role of nurses and midwives is

Skilled health workers during pregnancy and delivery, including those with midwifery skills, can significantly reduce/prevent maternal mortality and morbidity. Midwives are at the frontline of efforts to increase the quality and accessibility of reproductive health care including pregnancy, childbirth and newborn care, HIV prevention, family planning and detection of violence against women.

The shortfall of health personnel with midwifery skills is most acute in the poorest countries of the world. The World Health Organization estimates that an additional 350,000 midwives are needed to ensure maternal health coverage in high maternal mortality countries. It is estimated that it will cost about $6,000 per year to train each midwife.

crucial, yet they are also few in number. A recent UNFPA-supported study found that Uganda needs some 2,000 additional midwives, as well as improved recruitment, deployment and retention schemes for those who are currently employed. This means that Sister Eunice not only offers pre- and post-natal care, counselling, HIV testing and immunizations, but she also takes care of cases of malaria, diarrhoea and coughs. She administers basic medicine, but if the case is beyond her she refers patients to the regional hospital. Sister Eunice delivers a baby — sometimes two or three — almost every day and that is still, she says, what she most enjoys:

The pleasure of helping a mother give birth, seeing how a child comes into the world, cleaning him off, giving him to the mother; I wouldn't trade that for anything. And that, even though I know many of the mothers don't know how to raise their children and need my advice, but I enjoy giving it to them too.

Medical supplies are scarce and expecting mothers even have to bring the latex gloves for the delivery. Some women can't afford the cost of 500 shillings — or 0.20 US dollars — so occasionally Sister Eunice has to operate with her bare hands. The risk of contagion is high. At around 3 p.m., she stops seeing patients but sticks around in case there is an emergency. And, when she can, she goes out into the community to give vaccinations, chat with the young people, visit pregnant women to examine and advise them. Until a few months ago, she also took charge of managing the centre but now a clinical officer has taken over and she says that she is so relieved to no longer have to do administrative work.

One of the key factors hampering progress is the inability to retain skilled workers in the very regions of the world with the highest maternal mortality rates. "Brain drain" — the migration of skilled practitioners to better-paying jobs in developed countries — is exacerbating an already dire healthcare situation in much of sub-Saharan Africa.

High-level political commitment, both national and international, is required to address the shortfall of skilled birth attendants. The education, regulation, accreditation and supportive supervision of midwives and others with midwifery skills must be fostered if there is to be a rapid expansion in the number of midwives and a scale-up in the quality of midwifery care.

What's the worst case you have ever seen?

For me, the worst cases are when a woman with a haemorrhage or an obstruction comes in and must be sent to the regional hospital in Arua to see a doctor. We never have ambulances, so we often have to send them by motorcycle, even though they are in dire conditions.

Sister Bella, a midwife at another health centre in the district, tells the story of a woman who went into labour and asked her husband for help. Instead, the man went out to look for a lost cow. One of the most serious problems midwives face is men's lack of involvement in deliveries. That woman spent hours in pain all alone; she couldn't do anything until her neighbours took her to the centre. By the time they finally got a pick-up truck to take her to the regional hospital, she had lost a lot of blood and she died on the way there. Shocked, the authorities in her sub-county enacted a regulation that requires men to take their partners to a health centre when they go into labour. Anyone who fails to do so has to pay a fine of 5,000 shillings — more than 2 US dollars. That money should be used to buy supplies for the centre.

And have there been many fines?

A good number, but they are almost never paid. You know, the men who should pay are friends or relatives of those who should collect the money...

Besides distances and traditions, another reason that expecting women often don't go to the health centre is that "they fear the modern position". At home, they squat, but at the health centres they lie on their backs. Sister Eunice says that she does not allow them to assume that position because she cannot see if the umbilical cord is tangled, or anything else that might require her intervention. Also because the baby might hit the floor on its way out and get hurt. But in other centres, women can choose to give birth in the traditional position as long as they do so in the most hygienic conditions and with proper medical care.

The struggle will be long and it is not always easy. Sometimes, Sister Eunice feels a bit desperate because she has to do so many things at the same time and she does not have all the means or the knowledge she needs. Also, women just don't understand how much better it is to deliver in a health facility under the care of a midwife. But when she feels as if desperation might overwhelm her, she thinks of the women who sometimes come by to show her their healthy baby and to thank her for that. Then, she thinks of her own children, and she keeps moving ahead.

"We never have ambulances, so we often have to send them by motorcycle, even though they are in dire conditions."

In 2008, UNFPA and the International Confederation of Midwives (ICM) launched a joint programme called "Investing in Midwives and others with Midwifery Skills" to create a critical mass of midwives to improve skilled attendance at birth in low-resource settings. The programme helps to develop a sustainable midwifery workforce and works with governments at the national and regional levels to develop policies and programmes to address gaps and improve the availability and quality of midwifery care. The programme is currently underway in some 20 countries.

Sugna

▶ *India*

Maternal health: The pursuit to deliver with dignity

Sugna doesn't know if she is 20, 22, or 19 years old, but mostly she doesn't know why that would even matter. She is sitting on the ground at the door to her husband's family's adobe house in the middle of a desolate landscape. It is the dry season and the land awaits the monsoon to bring it back to life. In Khakhad, it's 45 degrees Celsius in the shade. Located in the hills surrounding Udaipur, in the Indian state of Rajasthan, Khakhad is home to a few hundred peasants that the Indians call the "tribal population". It has no shops, streets or running water. Electricity arrived just five years ago, but it's only used for a few small lamps and doesn't power radios, televisions or any other source of contact with the outside world.

Sugna is shy and it's hard for her to tell her story. In fact, it surprises her to learn that she has a story at all. But she knows that, of all the things she has done in life, what she really disliked was going to school. Her mother sent her when she was little; just 7 or 9, or maybe 6 years old. Sugna didn't mind walking there and she even had a few friends, but she never understood what the teacher was saying and that drove her crazy.

She got sick frequently, so after a few months her worried parents turned to a *bhopa*. A combination healer and dervish, *bhopas* wander the towns of Rajasthan. The *bhopa* examined her, said a few prayers, burned some incense-like sticks and announced that the school was the source of the bad energy. The only solution, he concluded, was for Sugna to quit. She was so happy.

Her joy subsided a few weeks later when her parents told her she would have to work. Her parents lived in Lakma Guda, a town just like Khakhad only five kilometres away. They had a very small patch of land there where they grew corn when the season was right. The rest of the year, they worked in construction as much as they could. Sugma was the third of six brothers and sisters and her parents could not support them all. When a contractor came through town and offered to take Sugna to the neighbouring state of Gujarat to work in construction, her parents agreed.

Sugna went away on a truck with a group of ten or twelve boys and girls. In the beginning, she says, she was a little frightened. She was 11 or 13, or maybe 10 years old, and she spent all day every day carrying rocks and sand in a basket balanced on her head. The materials were used to repair a road or build a house. Sometimes, once every four or five months, she was allowed to visit her family. Sugna spent almost everything she earned — 40 rupees, or 1 US dollar, per day — on food. When she was able to put aside a little money, she bought herself a piece of jewellery: a ring, an earring, a bracelet.

Why jewellery?

I don't know. I think a woman should have her jewels.

Sugna spent about four years hauling rocks in Gujarat, but she barely remembers it. What she does remember is that she washed often, but was still dirty all the time, and that she worked, sewed her clothes, talked with her friends, slept in the common tent. They never went down to the nearby towns because they were afraid. Sometimes, Sugna missed home. When she was 15 or 17, or maybe 14 years old, she stayed home after one of her visits. She thought that she would finally be able to live in her village, but her older brother took her to work with him in the outskirts of Udaipur. For two more years, Sugna carried rocks and sand, washed up, slept. She was curious about the city centre; she wanted to go see its lights, cars, shops, people, but her brother would not allow her to. He didn't let her go home either. She missed her life in the village more and more, but her family made her stay. Sometimes, very occasionally, she wondered what it would be like to not have to work every single day, even Sundays and holidays.

Are you angry at your parents or your brother?

No, why would I be?

"Because if I didn't he'd kick me out of the house and because a woman has to have children."

Sugna was 17 or 19, or maybe 16 years old, when she was finally allowed to go home. She had found another job in construction near the village. When her parents saw that she was determined to stay, they started to look for a husband for her. A few months later, someone spoke to them of a boy from Khakhad. Her parents went to meet his parents and they reached an agreement. They introduced the children and Sugna liked him very much.

Why?

He was in school, in ninth grade, so I thought he would get a good job and I could stop working.

Was that all you liked about him?

No, yes, I don't know. What I liked was that he went to school.

But a few days later, her parents met someone they deemed a better candidate and there was a change of plans. Sugna refused; for the first time in her life she really wanted something. A few days later, Sugna and Prakash met up at a fair and ran off together. There were fights, arguments and negotiations. Her parents took her back and Prakash came after her. Sugna was startled to see that she had become the centre of something. In the end, the boy's family paid 2,000 rupees — around 43 US dollars — and the matter was settled. In her community, the parents of the groom pay the parents of the bride. In the rest of India it is just the opposite: the parents of the bride have to pay a dowry to the parents of the groom, which often forces them to go into debt.

The two families met, they sang, Prakash put garlands around Sugna's neck and Sugna around Prakash's. They walked around the fire seven times and prayed the ancient prayers and they were married. Sugna moved in with her in-laws, with Prakash's father and his two wives (a practice less prevalent today), their unmarried daughters, their sons and their wives and their children. They were fifteen people living in one room with no windows or furniture. There was a dirt-floor, a fire in one corner and straw for the hens in the other, an occasional ray of light that filtered through the thatched roof, the smell of firewood and animals.

Sugna was happy because her husband and his family treated her well. Prakash had found a job repairing the pumping machines for the wells in the neighbouring towns and she didn't have to work. Their first serious argument was when he told her that they should have their first child.

THE BIG PICTURE

Maternal health

Women in many developing countries do not generally receive the care they need during pregnancy and childbirth because there are no functioning health services where they live, health services are too expensive, or getting to them is too costly.

Women do not often use health services because they do not like how care is provided or because the health services are not of high-quality. Traditional practices and beliefs and lack of women's autonomy also prevent them from getting the care they need.

Satisfying the unmet need for contraceptive services in developing countries would avert 52 million unintended pregnancies annually, which, in turn, would save more than 1.5 million lives and prevent 350,000 children from losing their mothers.

Sugna thought it was too soon, that she was too young. Why not wait a little longer? But her husband insisted and she had to obey him.

Why?

Because if I didn't he'd kick me out of the house, she says smiling for the first time, showing her perfect white teeth, and because a woman has to have children.

Just over a year ago, Sugna got pregnant.

Did you want a boy?

I didn't care.

What about your husband?

He didn't care either.

During her pregnancy, Sugna didn't think that much about the delivery. She was born in her mother's house, so her baby would be born in hers. She had of course heard stories of women who had died in childbirth, but she didn't think much about it because sometimes women died giving birth.

When Sugna was in her fifth month, however, one of her sisters-in-law, who lived in the same dirt-floored, windowless adobe house and was in her seventh month, experienced serious pain. When she went into labour, the women of the house called the *dai* — the traditional midwife — to help. Around midnight, the young woman delivered a stillborn baby. She didn't haemorrhage, the pain lessened and she managed to sleep. A few hours later, she woke up feeling extremely thirsty and in a great deal of pain. She was dead by sunrise.

Sugna was frightened and seriously considered going to see a doctor. She decided to call Durga, the Auxiliary Nurse Midwife, who has been working in the village for more than 20 years. "When I first arrived, the people did not accept anything I had to offer," said Durga. "I

vaccinated the children and they came down with fever. Many people complained that I was making their children sick. But with time they realized that the medicine I gave them cured them, solved problems, and I gained their trust."

Durga's mission includes doing outreach work for the Janani Suraksha Yojana (JSY), or "Pregnant Women Safety Scheme", programme. In 1998, in India there were 398 maternal deaths for every

Over 350,000 women die each year due to complications of pregnancy and childbirth. Many more suffer disabilities. Recent estimates show a decline in maternal deaths, but many countries are still off-track to reduce maternal mortality by 75% and achieve universal access to reproductive health by 2015. Sub-Saharan Africa and South Asia continue to have the highest maternal mortality ratios; 51% and 45% respectively of all maternal deaths.

Globally, around 80% of maternal deaths are due to obstetric complications; mainly hemorrhage, sepsis, unsafe abortion, pre-eclampsia and eclampsia, and prolonged or obstructed labour. In sub-Saharan Africa, HIV currently accounts for 6.2% of maternal deaths and has reversed the progress made in maternal health in some countries. Unsafe abortion accounts for 13% of maternal deaths.

100,000 live births and the authorities made important efforts to address the problem. From 2004-2006, the maternal mortality ratio lowered to 254 for the whole country, which represented a major advancement. To build on this success, in 2005, with technical support from the World Bank, UNICEF, UNFPA and other organizations, the government launched JSY, a maternal health initiative designed to reduce maternal and neo-natal mortality by increasing the number of institutional deliveries. The initiative encourages pregnant women to take advantage of health centres and works closely with Auxiliary Nurse Midwives and Ashas — volunteers in each village that help to spread information about maternal health resources. From 1998 to 2006, in a state

"I think two is a good number and I think he agrees. So, after the next one is born, we'll have to get the operation."

Nearly all maternal deaths could be prevented — and countless lives saved —if affordable, good-quality obstetric care were available, together with a package of integrated sexual and reproductive health services to address women's other health needs, including: contraception, diagnosis and treatment of sexually transmitted infections, including prevention of HIV, and comprehensive sexuality education for adolescents.

Some 350,000 health workers with midwifery skills are needed to ensure access to maternal and other reproductive health services in high maternal mortality countries. Access and uptake of family planning, combined with timely Emergency Obstetric Care, can prevent life-threatening complications during pregnancy and delivery.

Reducing maternal mortality and morbidity is a human rights issue.

like Rajasthan, the institutional delivery rate went from 14% to 59% and maternal mortality dropped from 508 to 388 for every 100,000 live births. This progress meant that every year, about 1,500 mothers who would have died in childbirth, survived.

Durga told Sugna that doctors would not only see her, but they would vaccinate her, give her painkillers and all the other care she needed. In fact, under the terms of the JSY, she would also receive a payment of 1,700 rupees — around 36 US dollars — to cover any costs she might incur. When the time came, she and her mother went to the hospital in Jadhol, about 20 kilometres away, where she gave birth to a healthy baby girl.

And what did you do with the money?

I bought several kilos of ghee and sugar. A mother has to eat well to be able to feed her baby, Sugna says laughing like a naughty child.

She then says that her experience at the hospital was very satisfactory. Still, today she is very tired because she spent the whole night with a *bhopa* who killed a hen so that the gods would relieve this pain in her belly.

But if I don't get better, I am going to go to the hospital.

Sugna is like a good student repeating her lessons. Her baby, who is now three months old, cries, demanding food. Sugna says that she really enjoys being a mother.

Why?

Because now I know that my husband won't kick me out.

And how many children are you planning to have?

I don't know, as many as he wants.

But what do you think?

I think two is a good number and I think he agrees. So, after the next one is born, we'll have to get the operation.

Who is going to be operated on?

Me. He won't do it. Men are too cowardly.

And you're not afraid?

Yes, I am. But I am a woman, you know.

In 2008, UNFPA launched the Maternal Health Thematic Fund (MHTF) as part of other global and regional initiatives to provide support to countries with a high maternal mortality and morbidity burden to scale up proven interventions needed to save women and newborns from death and injury.

The thematic fund is currently operational in 30 countries —and in an additional 12 for fistula prevention — and has been catalytic in building partnerships with UN and non-UN organizations to coordinate efforts and maximize results.

WHAT WOMEN AND GIRLS NEED

Integrated sexual and reproductive health packages in national health plans

There is growing momentum to put the health and rights of women and girls at the top of the international agenda. Increasingly, governments are being called upon to offer the cost of affordable sexual and reproductive health packages and include it in their national health plans and budgets.

These packages should encompass a wide range of services, including: family planning, prevention of HIV and other sexually transmitted infections, maternity care, detection and prevention of sexual violence. These services must be made available to all women and girls, especially those who are the most marginalized and vulnerable in society.

Here are some examples of action needed to accelerate progress, focus on gender equality and make universal access to reproductive health a reality for women and adolescent girls worldwide.

▶ FAMILY PLANNING

Family planning is one of the wisest investments a country can make to reduce poverty, improve family well-being and promote economic growth. Efforts by national governments should be intensified to ensure that all individuals can obtain and use affordable, quality reproductive health supplies — including contraceptives — of their choice, whenever they need them. Family planning services are most effective when integrated with other health services.

▶ HIV PREVENTION

Prevention is the only hope of reversing AIDS in the absence of a vaccine or a cure. HIV prevention efforts must target the most vulnerable populations, such as women and young people, and address the factors that put people at risk of infection, such as gender inequality and poverty. Male and female condoms must also be universally available and affordable.

▶ MATERNAL HEALTH

Women need to have access to family planning and skilled health care before during and after childbirth, including access to emergency obstetric care and post-abortion care. In order to reduce maternal mortality by 75 per cent and achieve universal access to reproductive health by 2015, efforts are needed to strengthen health systems, address the critical shortage of midwives, and invest in integrated health services for women throughout their life cycle.

▶ OBSTETRIC FISTULA

Obstetric fistula is especially prevalent in areas with high maternal mortality and is both preventable and treatable. Fistula can be avoided by eliminating child marriage, delaying the age of first pregnancy, ensuring timely access to quality maternal care, including family planning, skilled care at birth and emergency obstetric care. Increased efforts are required to address the root causes of fistula, such as malnutrition, poor health services, early marriage and gender discrimination. More doctors should be trained in fistula surgery to treat all women living with fistula. Efforts to rehabilitate women after surgery are also essential.

Women and girls deliver enormous social and economic benefits to their families, communities and nations. It is time to make universal sexual and reproductive health a reality for women and girls worldwide.

▶ MIDWIFERY

The presence of skilled health workers during pregnancy and delivery can significantly reduce maternal death and disability. Midwives can also play a key role in providing a full range of reproductive health care, including family planning, HIV prevention, prevention of gender-based violence and newborn care. High-level political commitment is required to address the shortfall of midwives, which is especially acute in the poorest countries of the world. Efforts are needed to train more health personnel in midwifery skills. Education, accreditation and supportive supervision are also needed to retain skilled workers, particularly in rural areas.

▶ SEXUAL VIOLENCE AND TRAFFICKING

Human trafficking is the fastest growing and most lucrative criminal activity in the world today. In order to combat the trafficking of women and girls, governments and the international community must implement and adequately fund measures to improve the socio-economic, political and legal conditions of women and girls. Increased political will to prosecute traffickers, protect victims of trafficking, and address the demand for women and children to be used for sexual exploitation is also needed.

▶ FEMALE GENITAL MUTILATION/CUTTING

FGM/C is a human rights violation that causes lifelong health risks for women and girls. In order to abandon this harmful practice, efforts are needed to address power imbalances between women and men and the unequal position of women in all spheres of the societies in which it is practiced. Support for community efforts designed to bring about positive social change, challenge societal norms, and lobby for changes in legislation are also needed.

FOR ADOLESCENT GIRLS

Adolescent girls between the ages of 15 to 19 who are pregnant are at increased risk of complications from pregnancy and childbirth. They often suffer social exclusion and have limited educational opportunities. Access to sexual and reproductive health services can help young women to delay childbearing until they have completed their schooling and training goals. This in turn serves to empower young women and increase their social and economic participation. Programmes to address the needs and promote the rights of adolescent girls, especially the youngest and the most marginalized and disadvantaged, must be scaled-up. Laws against child marriage must also be enforced, along with interventions to keep girls in school.

Comprehensive sexuality and reproductive health education and access to youth-friendly sexual and reproductive health services — for adolescent girls and boys — are critical to help young people protect themselves from unintended pregnancies and sexually transmitted infections, including HIV.

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